

Suicide Prevention: *Changing the Narrative*



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The writing of this report was a collaborative effort between Mariwala Health Initiative (MHI) and India Development Review (IDR).

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CONTENT WARNING

Mentions of suicide, self-harm, caste-based discrimination, gender-based violence, depression, and heterosexism. In the case of material being triggering or upsetting, you can reach out to iCALL at (+91) 9152987821 or icall@tiss.edu



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In Memory of Mr. Keshav Desiraju (1955-2021),
Former Secretary, Ministry of Health and
Family Welfare, India who worked tirelessly for
justice in mental health and disability rights
and championed them in public health systems.

Foreword

Almost every suicide is a death that can be avoided. And for every death that happens by suicide, there are about 60 people who are impacted due to the loss of a loved one, and more than 20 who attempt suicide. In India, almost 140,000 people died by suicide in 2019 alone, accounting for 17 percent of the global deaths by suicide. In spite of these numbers, there is almost no conversation on suicide prevention, both globally and in India.

Just like any other social issue, prevention work needs to start with a thorough understanding of the issue. Unfortunately, conversations around suicide tend to be heavily stigmatised. **Worse still, suicide is almost always seen as a personal choice, rather than something that can be prevented. Rarely is it framed as a social issue that needs to be addressed by the government, health systems, nonprofits, workplaces, mental health professionals and the communities we live in.** The conversation needs to move beyond talking about it as an individual issue, to one that is rooted in structures and systems. It is important to understand that social structures of oppression adversely impact certain communities more, e.g. people marginalised by gender, caste, religion, class, or sexuality. This puts them at a higher risk of suicide and self-harm. Last, but not least, suicide prevention measures also need to be community-based rather than individual-focused. Simply put, these

measures need to be delivered not only by mental health experts, but also by people from the community. At the same time, there is a need to create support systems for people who are experiencing suicidal ideation.

At Mariwala Health Initiative (MHI), we are creating the space for many long-overdue conversations on suicide prevention. And we are publishing this report with a commitment to focusing our efforts on suicide prevention through our grant-making and advocacy work.

The UN Sustainable Development Goal 3, Target 3.4 states that by 2030, countries need to work towards reducing deaths by suicide by one-third. As a country, India needs to prioritise this. We need to have a National Suicide Prevention Policy that is accepted by different stakeholders, including people who have survived suicide and those who have lost someone to suicide. We need a public health approach to preventing suicide, where multiple stakeholders work together to make an impact. It needs to be a priority agenda not only for the health department (for accessible and quality support during a crisis), but also for the education department (to prevent suicide amongst school and college students), and the women and child development department (to reduce deaths by suicide amongst married women, which exceed 20,000 annually).



Additionally, we need to change how we think and talk about suicide as a country, because that reflects in our systems and our society. For instance, even though suicide in India today is decriminalised, the National Crime Records Bureau reports deaths by suicide as part of crime data, under the category of 'accidental death and suicide'. Instead, deaths by suicide should be under the health department, as is the case in so many countries worldwide. The media is notorious for sensationalising celebrity deaths by suicide, and giving detailed descriptions of the methods used. They continue to use the language 'committed suicide', as if it were a crime (rather than the more neutral 'die by suicide'). All of this is despite research having proven that language is crucial when reporting about suicide, and that describing the means used can increase the incidence of 'copycat' suicides.

Without question, there is a lot of work to be done. That's why this report focuses on what suicide prevention work should look like. It articulates the complexities of this work, and the various lenses that organisations need to develop, before beginning. It also shares evidence of global and local programmes and interventions with proven results in suicide reduction. Importantly, it emphasises a psychosocial approach to suicide prevention, i.e. interventions that include both—providing psychological support through counselling—

and enabling access to social benefits like employment, health services, and education, among other things.

'Suicide Prevention: Changing the narrative' is the first step in what we hope will be a long-term, collaborative, multidisciplinary effort towards preventing suicide in India. We're inviting you to be a part of The Alliance for Suicide Prevention. If you believe that suicide prevention in India needs a psychosocial, intersectoral, and public health approach, please join our effort.

In order to decisively make a difference, all of us—funders, civil society, the media, healthcare professionals, the health department, policymakers—need to come together first. To find out more about the alliance, visit our website: mhi.org.in/asp or write to asp@mariwalahealthinitiative.org

Priti Sridhar
Chief Executive Officer, MHI

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Introduction



If each of us were to look back at our lives, we might find that our connection to suicide is closer than we realise. Go ahead, take a minute to think about it. Perhaps someone you knew died by suicide, or has considered it on more than one occasion. Maybe someone close to a friend attempted it, and survived.

This makes more sense when you think about the facts: Every year, more than 800,000 people die by suicide across the world, and India accounts for around 17 percent of these deaths.¹ In fact, the Lancet Commission on Adolescent Health and Well-being found that suicide was the leading cause of death among young Indians aged 10-24. Among children aged 10-14 years, it was the seventh most common cause of death.² This means that far too many children who should be worrying about their multiplication tables, are instead contemplating taking their lives. Yet, there is little conversation—private or public—on the topic. Whenever suicide does get covered in the media, it is often dealt with in an insensitive and superficial manner—as we have seen with the deaths of Dalit PhD scholar Rohith Vemula, Dr Payal Tadvī, actor Sushant Singh Rajput, and many others.

At Mariwala Health Initiative, we are committed to changing the conversation around mental health in India, and suicide prevention is a key part of this effort. In our work on funding mental health, we have seen that suicide prevention is conspicuous by its absence from the wider development discourse in India. Much of the work that does take place on suicide prevention narrowly focuses on the individual, and ignores the fact that suicide is a complex, intersectional, intersectoral, public health issue.

The good news is that suicide is preventable. Unlike many other health issues, the tools to decisively reduce suicide are available. What we need right now is for governments, philanthropists, civil society, and communities to come together, acknowledge this issue, and commit resources to addressing it.

We see this report as a tool to start these conversations and unite multiple stakeholders in a collective effort to prevent suicide. In it, we highlight some of the key approaches to suicide prevention, evidence-based strategies to reduce the incidence of suicide in India, along with tangible steps various stakeholders can take.

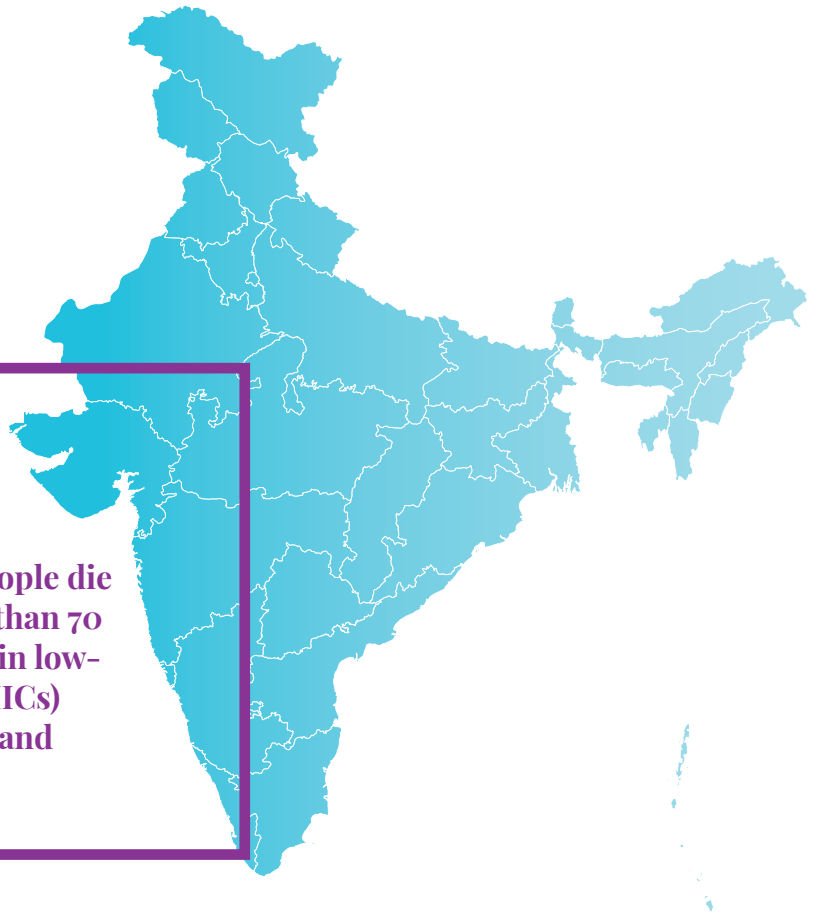
Very often, mental health and suicide are seen as ‘serious’ topics that only ‘experts’ or mental health professionals are equipped to talk about. This approach often ignores the perspectives and expertise of those with lived experiences of suicide. In other words, the experiences of people who have themselves survived suicide attempts, suicidal ideation, and/or self-harm; along with those bereaved due to the loss of a loved one to suicide.

To give voice to these realities, this report centres people at multiple intersections of privilege and marginalisation—those with lived experiences of suicide or suicide loss—and integrates their perspectives with those of experts. Over a period of 12 months, we held multiple individual conversations, two expert group consultations, and one broader consultation. The experts included individuals who have worked on different aspects of suicide prevention in India over a number of years. The broader consultation brought together a diverse set of people with lived experience of suicide, as well as people from communities that are disproportionately impacted by suicide. Together, their perspectives and experiences have contributed to our understanding of how we can build a comprehensive approach towards suicide prevention in India.³

• **Myth:**
• Someone who is suicidal is determined to die.

• **Fact:**
• On the contrary, suicidal people are often
• ambivalent about living or dying. Suicidal thoughts
• are usually temporary and in response to a
• stressful situation. Access to emotional support at
• the right time can prevent suicide.

Suicide Waits For No One



Why India needs to look at suicide prevention now

Every year, more than 800,000 people die by suicide across the world. More than 70 percent of these deaths take place in low- and middle-income countries (LMICs) where there are limited resources and services for suicide prevention.⁴

India, in particular, accounts for 17 percent of the suicide deaths globally. Between 1990-2016, the country saw a 40 percent increase in the number of suicides. In fact, in 2016, more than one-third of the world's suicide deaths of women and one-quarter of suicide deaths of men occurred in India, and suicide ranked as the leading cause of death in young Indians aged 15-39.⁵ Among young women in particular, suicide is the leading cause of death, ahead of maternal mortality.⁶ Furthermore, estimates suggest that for each person who dies by suicide, more than 20 others attempt it.⁷

The most telling marker of this public health crisis, however, is the fact that suicide deaths in India are heavily under-counted, particularly among women and young people. This is largely because the National Crime Records Bureau (NCRB) collates suicide data annually as a crime indicator from police records, rather than as a health indicator. Though the Mental Healthcare Act of 2017 decriminalises suicide and aims to reduce the risk, and incidence of suicide, there has been little to no implementation of an agenda to destigmatise talking about the issue. As a result, many suicides

continue to go unreported. When they do get reported, due to a lack of awareness about the Act, the police continue to book attempted suicide under Section 309 of the Indian Penal Code, which criminalises suicide attempts.

From the numbers, it is clear that addressing suicide in India is crucial to reducing the global burden of suicides and achieving the Sustainable Development Goal (SDG target 3.4, indicator 3.4.2) of a one-third reduction in the suicide mortality rate by 2030. Beyond improving health and well-being, suicide prevention work is also critical to achieving the targets set out in the other SDGs, such as those related to ending poverty and reducing inequality.

The COVID-19 pandemic and lockdowns have further compounded many of these already worsening trends, with a recent study finding a 67.7 percent increase in online news media reports of attempted suicides and deaths by suicide.⁸ With marginalised communities, women, daily wage workers, and youth disproportionately affected, we need to act on preventing suicide in India right now.

Language matters

The language we use to talk about suicide is a reflection of our attitudes towards it. For instance, the expression 'committed suicide' is one that is commonly used across media outlets and in everyday conversations. While it may seem harmless, it is laden with blame and can be damaging. For most people, the use of the word 'committed' brings up negative associations such as 'committing a crime' or 'committing a sin', which frames suicide as something illegal or morally wrong. In fact, the use of the phrase 'committed suicide' is a legacy of the not-so-distant past when suicide was considered a crime.

So, changing how we talk about suicide has the power to influence our attitudes, perceptions, and those of others. Using language that is compassionate, neutral, and free of judgement can help reduce the stigma surrounding suicide.

Here are some of the key terms used in this report, to talk about the different aspects of suicide and its prevention.

1.

Suicide:

Suicide is the act of deliberately killing oneself.⁹

2.

Suicidal Ideation:

Suicidal ideation (also known as suicidal thoughts or ideas) is a broad term used to describe a range of contemplations, wishes, and preoccupations with death and suicide.¹⁰

3.

Self-harm:

Self-harm refers to a preoccupation with deliberately hurting oneself without conscious suicidal intent, often resulting in damage to body tissue.¹¹

4.

Suicide Attempt:

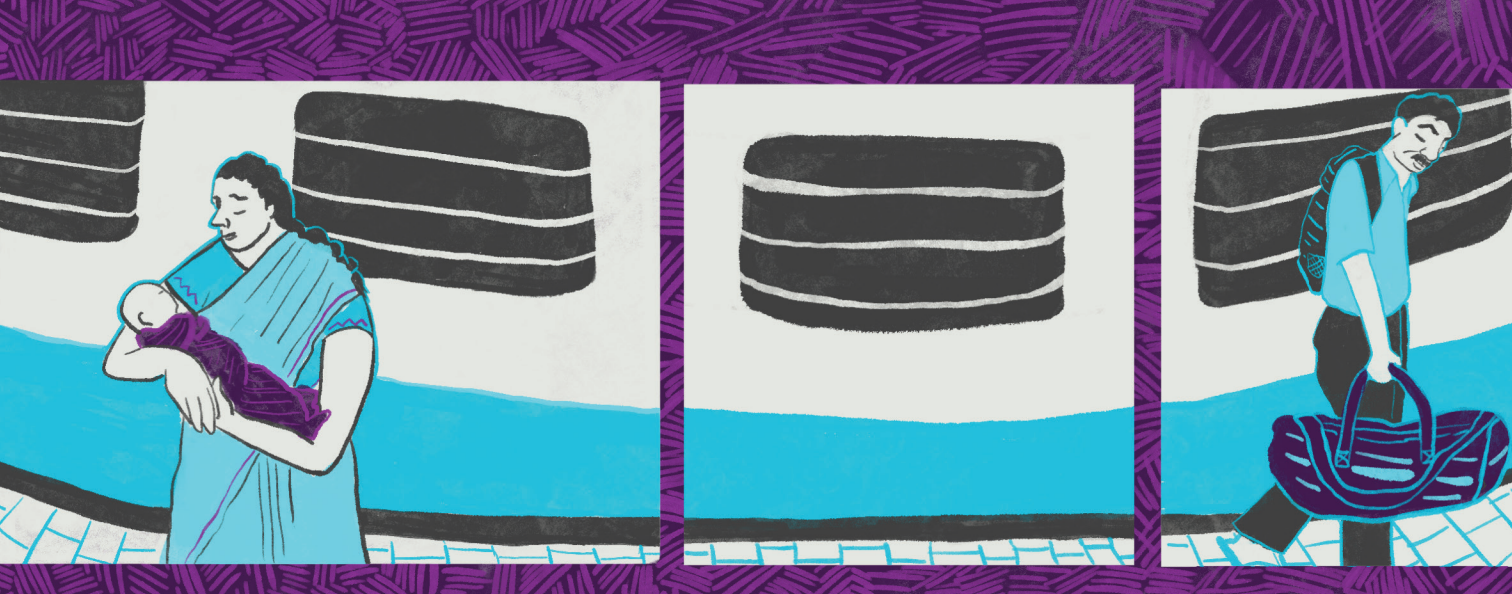
Suicide attempt is used to mean any non-fatal suicidal act. It refers to intentional self-inflicted injury or self-harm, which may or may not have a fatal intent or outcome.¹²

5.

Suicide Attempt Survivors:

Suicide attempt survivors are individuals who have survived a prior suicide attempt.¹³

The Suicide Prevention Approach We Need



When Mahesh Paswan's life changed

When Mahesh Paswan arrived in the metropolitan city of Kolkata from Jamui district, Bihar, he brought just three things with him: Sixty-nine rupees for his next two meals, a small suitcase with his belongings, and a big dream. His wife Manju Devi had just given birth to their fourth child, and he was resolute that unlike his other children, this one would go to school. It's the one promise he made to his wife before boarding the train to Kolkata.

Mahesh's uncle, Hariram, had a friend who owned a few taxis, and he had agreed for Mahesh to drive one of them. As a Dalit man in his late twenties, Mahesh could feel his life just beginning. He worked day and night for the next six months, sending the majority of his income back home. Hard as it was, his life finally seemed to be improving, one taxi fare at a time.

And then, COVID-19 happened.

The government's stringent national lockdown that followed saw most migrants like Mahesh stranded, homeless, and desperate to return to their villages. From earning INR 14,000 per month, his income mostly vanished. He could no longer cover his rent nor his living expenses in Kolkata. Worst of all, he had no money to send home. Mahesh worried that because of him, his wife and mother would have to return to working as contract labourers in the fields, facing poor conditions and with very little pay. And, on top of it all, he was afraid of contracting the virus and having no documents and no access to healthcare in the city.

The despair he now felt extinguished the hope with which he had come into the city six months ago. On more than one occasion, he considered taking his own life.¹⁴

Chances are, if Mahesh does end up taking his own life, we may never learn about it because the national dailies won't feature the story of a poor, Dalit migrant who died by suicide in a remote slum of Kolkata. So, does his death matter less? Does it matter at all?

To effectively respond to and prevent suicide in India, we need a fundamental shift in how we view and understand suicide. Current approaches to suicide prevention often reduce it to an individual problem ("Mahesh couldn't handle the pressures of being the sole breadwinner in his family"), and as a result, miss the complexities of suicide risk and prevention.

Any approach towards understanding and working on suicide prevention must have a comprehensive lens that takes into account the various risk factors that are at play.

6

approaches to suicide prevention

1.

**A Systemic
Approach**



2.

**A Community-Based
Approach**



3.

**An Intersectional
Approach**



Myth:

Only people with mental disorders are suicidal.

Fact:

Suicidal thoughts and actions indicate deep unhappiness but not necessarily mental disorders. Many people living with mental disorders are not affected by suicidal thoughts, and not all people who take their own lives have a mental disorder.



4.

A Psychosocial
Approach



5.

A Rights-Based
Approach



6.

An Intersectoral
Approach



1.

A Systemic Approach



In popular discourse, suicide is commonly seen as an individual problem or ‘choice’. Such a perspective fails to account for the range of social, economic, and/or political factors that lead a person to think about or attempt suicide.

For instance, in Mahesh’s case, there were many factors that could have led him to have suicidal thoughts. Had he not been a victim of poverty and caste discrimination, he may never have had to leave his family and migrate to the city for better employment opportunities in the first place. The same structural oppression also meant that Mahesh faced barriers in creating his own bank account and building up some savings. Had there been an easily accessible social security system in the country, he might have been able to get by in Kolkata; as well as cope with the sudden loss of his livelihood during the national lockdown. The list goes on.

While the suicide rate in India is highest in the 18-29 age group; within this group, the numbers tilt disproportionately towards youth from marginalised groups, particularly those from Dalit, Bahujan, Adivasi (DBA) communities.¹⁵ According to media reports, in less than a decade, at least 25 Dalit students in India have died by suicide due to caste discrimination and institutional casteism in India’s

premier educational institutions—a number that is likely to be an underestimate. The role of systemic factors in suicide is also seen among religious minorities, where Christians have the highest suicide rate of 17.4 per 100,000 people, significantly higher than the national average of 10.6.¹⁶

Not only are marginalised groups at a higher risk of suicide, they are also less likely to have access to institutional relief or support that would help prevent suicide, such as government benefits, healthcare, employment, and mental health support, among others.

For this reason, acknowledging and addressing systemic discrimination is a necessary part of suicide prevention. It helps move the focus away from the misleading narrative that suicide is an individual choice and acknowledges the role of structures and systems in suicide. Shifting the focus to the wider system also allows for a more holistic approach, where multiple strategies work together to address a range of risk factors. We have seen this systemic approach in action many times before, be it in the extremely successful campaign to eradicate polio in India in the 1990s, or in the efforts to get all children enrolled in primary schools across the country. A systemic approach to suicide prevention, in this specific regard, is no different.



“Like women face misogyny, Muslims face Islamophobic discrimination & bigotry. The pressure to prove themselves worthy of education via career success causes stress, anxiety & physical illness.”

– Sabah Khan

2.

A Community-Based Approach



Much of the present work around suicide prevention is rooted in the idea that only mental health practitioners or ‘experts’ can work on suicide prevention. But people are the experts of their own lives, and the impacts of suicide are felt most strongly by individuals, their families, and communities. Therefore, suicide prevention necessarily requires a decentralised, community-based approach that leverages the tangible and intangible resources within communities to boost well-being. It is communities who understand the unique stressors of their members, and are therefore best placed to support their recovery.

Broadly understood, communities are groups of people living in the same place, or having one or more shared characteristics in common, such as gender, caste, or ability, among others. Community-based care, therefore, involves individuals from the communities or local organisations providing support and services to those in need of assistance. This can take many forms such as survivor support groups, awareness campaigns, collecting information on support provided in case of suicide attempts, among others.

In Mahesh’s case, one can’t help but wonder: Might he have felt less distressed had he been able to draw upon the support of others who were facing a similar situation? Unfortunately, being new to Kolkata, he didn’t have access to a community of his own. All his social networks were back home, and so he had no one to turn to or seek support from, especially when he felt most at risk of taking his life.

A community-based approach is therefore crucial to removing some of the key barriers to accessing care and support. Listed below, are some aspects of this:

- A community-based approach focuses on making services available where people already are,

Myth:

Most suicides happen suddenly without warning.

Fact:

The majority of suicides have been preceded by warning signs, whether verbal or behavioural. Of course there are some suicides that occur without warning, but it is important to understand what the warning signs are and look out for them.

making such programmes accessible during times of crisis. Not only does this reduce the need for costly, expert-led interventions, but also reduces the cost of accessing care for individuals—both of which are important in low-resource settings.

- Interventions aligned with this approach are usually led by people from the community and with lived experience. This creates a space of greater trust and understanding for the users of these services, which makes it more likely that they will seek out support.
- Community-based care can provide support in multiple languages, and demonstrate a deeper awareness of the context of the individual, making it more inclusive. This is particularly important for people from marginalised communities who might face discrimination in other settings.
- This approach leverages the existing expertise of communities to create a collective effort to address not only crisis situations, but also to provide support to prevent crises from arising in the first place. It can encourage public conversation, help combat stigma, support people bereaved by suicide, and provide culturally-appropriate support.

Especially when it comes to suicide prevention, a community-based approach is likely to be more impactful because suicide is not a homogenous issue; the factors that cause it vary significantly from one context to another. For instance, farmer suicides cannot be addressed in the same way as student suicides, and so a one-size-fits-all approach would not work. Instead, we need approaches that are tailored to the unique stressors of each community.

3.

An Intersectional Approach



There is no single explanation for why people die by suicide. More often than not, it is a range of everyday life events and experiences that create distress within individuals, and that lead to suicide. Intersectionality is an approach that recognises these multiple levels of oppression, across gender, race, class, caste, sexual identity, religion, sexual orientation, and ability. It looks at how they may intersect and interact with each other, to affect the health and overall well-being of an individual. For instance, a Muslim woman with an intellectual disability will experience oppression stemming from not just her gender but also her disability and her religion. Similarly, Mahesh will experience oppression on account of his caste and his class. And he will experience it in different ways, at different points, throughout his life.

An intersectional understanding of suicide prevention ensures that we recognise the many sites of oppression, and how they may work individually, or together, to further marginalise people, and increase the risk of suicide.

Myth:

People who talk about suicide do not mean to do it.

Fact:

People who talk about suicide may be reaching out for help or support. A significant number of people contemplating suicide are experiencing feelings of hopelessness, despair, and anxiety, and may believe that there is no other option.

4.

A Psychosocial Approach



A person's social context (e.g. where they live or what community they belong to) continuously influences and interacts with their psychological responses (emotions, thoughts, feelings, and reactions). For instance, on account of being a Dalit man (social context), Mahesh faces caste discrimination constantly, which is disempowering and affects his sense of agency (psychological response). And so, a psychosocial approach to suicide prevention explicitly focuses on this continuous link between a person and their environment. In doing so, it avoids a narrow perspective that looks at an individual only from a biological or medical lens, that discounts how a person's surroundings may contribute to how they feel. Such an approach would allow us to view (and respond to) suicide as the result of the complex ways in which a person experiences their daily life.

According to the latest data from the National Crime Records Bureau (NCRB), 'family problems' was listed as the cause for nearly one-third of all the suicides in India.¹⁷ This is why taking into account the relationships and sociocultural factors that influence a person's state of mind is critical in providing support and care. The provision of social support, in addition to medical care, can be preventative and/or response-based in nature, when it comes to suicide. Such interventions are intersectoral and include food security, water, housing, shelter, education, sanitation, legal support, and employment support, among others.

5.

A Rights-Based Approach



In line with a psychosocial approach, suicidal thoughts and actions cannot be separated from the social, political, and cultural context in which they take place. Research shows that poverty, social and economic exclusion, violence, discrimination, and limited access to social and reproductive health services are strongly linked to mental distress, and as a result, increased suicide rates.¹⁸ In India, for instance, death by suicide among young women is higher than that among young men—a clear contrast to global trends. This trend worsens post-marriage, with young married women accounting for the highest proportion of suicide deaths among women. It is clear that for young women in India, rigid norms around gender and sexuality, a lack of agency, limited mobility, and the threat of early marriage and pregnancy significantly affect their mental and physical health.¹⁹

Explicitly acknowledging these societal factors and the adverse effect they have on people's well-being is at the heart of a rights-based approach. Addressing power imbalances and inequalities in a person's environment by helping them secure social services, labour rights, children's rights, right to housing, among others, can contribute to reducing the incidence of suicide in India. For instance, in Mahesh's case, if we worked on making government schemes more accessible for him and other informal and migrant workers, or we helped them access these schemes, we would be taking a rights-based approach.

In other words, this kind of approach focuses on creating an enabling environment through efforts to reduce stigma, discrimination, violence, and inequity. It centres the voices and narratives of people with lived experience of suicide, and emphasises their participation in the creation of suicide prevention strategies.

6.

An Intersectoral Approach




By looking at suicide through the narrow lens of diagnosed mental health, we miss the forest for the trees, and might miss some of the other factors that increase the risk of suicide. Therefore, beyond the provision of mental healthcare services, there is a need for intersectoral engagement and collaboration across the fields of law, social work, health services, and public policies, among others. All successful strategies will need to involve the healthcare sector, along with other relevant sectors such as agriculture (e.g. where suicide by self-ingestion of pesticides is a major issue), education (e.g. where student suicides are more prevalent), or employment (e.g. where suicide due to loss of livelihoods is widespread). It is through this collaboration that we can address the other social, political, and economic factors contributing to suicide in India—the widespread availability of lethal pesticides, gender-based violence, and acute indebtedness, to name a few.

Mahesh's story illustrates how every effort—whether it's mental health support, peer support, advocacy for social welfare policies, or provision of healthcare and employment—has a role to play in suicide prevention. Once we build our understanding of suicide prevention around these principles, we can see how multiple strategies, working together, can take us a step closer to the larger goal of reducing suicide in India.

It isn't that everyone must work across all these approaches. In fact, we might want to focus on 'lower-hanging fruit', or on areas where we feel we have the expertise and motivation to make a difference. Since the work of suicide prevention is very nascent in India, there is opportunity to do a lot, partner with others, and together, build an enabling environment for affected communities. Grounding our efforts in some of these six principles will help us tackle the issue of suicide prevention in an effective, holistic, and humane way.

Suicide Prevention And Public Health - A WHO Framework





Revathi Adikal's 17th birthday was unlike anything she had imagined. It began with her father announcing that he had spoken with the family of a 'promising young man from Kochi, who would make a wonderful husband'. She was to marry the man by the end of the year, he said.

Growing up in a traditional household in the small town of Kozhikode, Kerala, Revathi had always anticipated a battle when it came to her marriage. But not once had she expected being cornered like this. Even though she put up a fight in the coming weeks—appealing to her mother and grandmother to intervene—her father would not bend. She was after all, one of the few girls in their community that was 17 years old and still unmarried.

Revathi had always dreamed of becoming a doctor. Instead, she was moving to a city where she knew no one, to marry a man she had never met. She began feeling increasingly distressed. Within six months, she was on her way to Kochi, to start a new life with Manoj. By her 18th birthday, she was pregnant.

All alone in a new city, wholly dependent on a husband she was only just getting to know, she felt helpless. Still quite young, she was also physically and mentally unprepared to undergo pregnancy and childbirth, and everything that comes along with it. This early into her marriage, she didn't feel like she could reach out to her parents either. Even at the doctor's clinic, she had no space to voice her insecurities and anxieties around having to raise a child as a young woman.

As she approached her second trimester, she grew more and more depressed. And this feeling weighed down on her even well after her baby was born. In total, she suffered upwards of 18 months of perinatal depression (depression during pregnancy and childbirth, that can last for up to a year post-delivery). Inflicting self-harm became the only thing she could think about. And the guilt that came along with those thoughts created a vicious cycle, making her feel more trapped. For Revathi, it felt like there was no escape from this suffocation.

Revathi's story is more common than we realise. Between 6 percent and 48 percent of new Indian mothers experience depression.²⁰ And in 2019, more women homemakers died by suicide than farmers.²¹ Typically, when women are forced into early marriages, many are compelled to drop out of school. They may also then become entirely financially dependent on their husbands, which affects their decision-making power in the household and makes them more vulnerable to domestic violence and abuse. Importantly, it affects their own sense of agency regarding their sexual and reproductive health and rights. It is these social determinants—circumstances that surround how people live, work, grow, etc—that affect their mental and physical health. Yet, there is little to no attention paid to understanding the reasons for this and how it can be prevented.

Not only did Revathi's perinatal depression put her at the risk of suicide, but it also increased the risk of poor nutrition and stunting for her child.²² When it comes to suicide, it is clear that the social and biological risk factors are inextricably linked, and it is important to take a holistic view to understanding and preventing it.

Preventing Suicide: A global imperative

In 2014, the World Health Organisation (WHO) published its report, Preventing Suicide: A global imperative, which puts forth a public health model towards suicide prevention. In doing this, it pointed out that despite being a leading cause of death worldwide, suicide has remained a low public health priority.

At its core, a public health approach is one that attempts to prevent or reduce a particular illness or social problem (e.g. violence against women) in a population by identifying risk factors, and then targeting policies and programmes to address the underlying risk factors. In Revathi's case for instance, regressive gender norms might be one of the risk factors for her mental illness; and a programme that works on changing practised gender norms at the community level might be one of the targeted approaches to address the risk factor.

Any public health approach is designed to provide the maximum benefit at a population level. It also emphasises input from diverse sectors including health, education, social services, the private sector, among others.

Looking at individual health in the wider context of population health is likely to be more effective when it comes to suicide prevention for two key reasons:

- The stigma associated with suicide and suicidal acts makes people reluctant to reach out for support. Revathi, for one, felt unable to seek help from her doctor because of this stigma. And so, casting a wider net automatically covers a broader range of people, and shifts the onus of seeking support away from individuals.
- It allows us to examine and address a range of factors that influence suicidal ideation and actions. It is widely acknowledged that suicide is the outcome of a range of biological, social, economic, psychological, and cultural factors, and so, we must take a multipronged approach to suicide prevention (rather than focusing on a singular approach).

The public health model consists of four interconnected steps:

1. Using data to identify and define the problem:

The 'who', 'what', 'when', 'where', and 'how' of suicide varies widely between communities, geographies, and over time. Therefore, gathering and analysing up-to-date statistics and high-quality data on suicides and suicide attempts is a critical component of any suicide prevention strategy.

2. Establishing the causes of acts of self-harm:

Once the data is collected, the next step is researching the factors that increase or decrease the risk of people thinking about, attempting, or dying by suicide. Doing this is important for identifying where prevention efforts need to be focused.

3. Developing, implementing, and evaluating interventions:

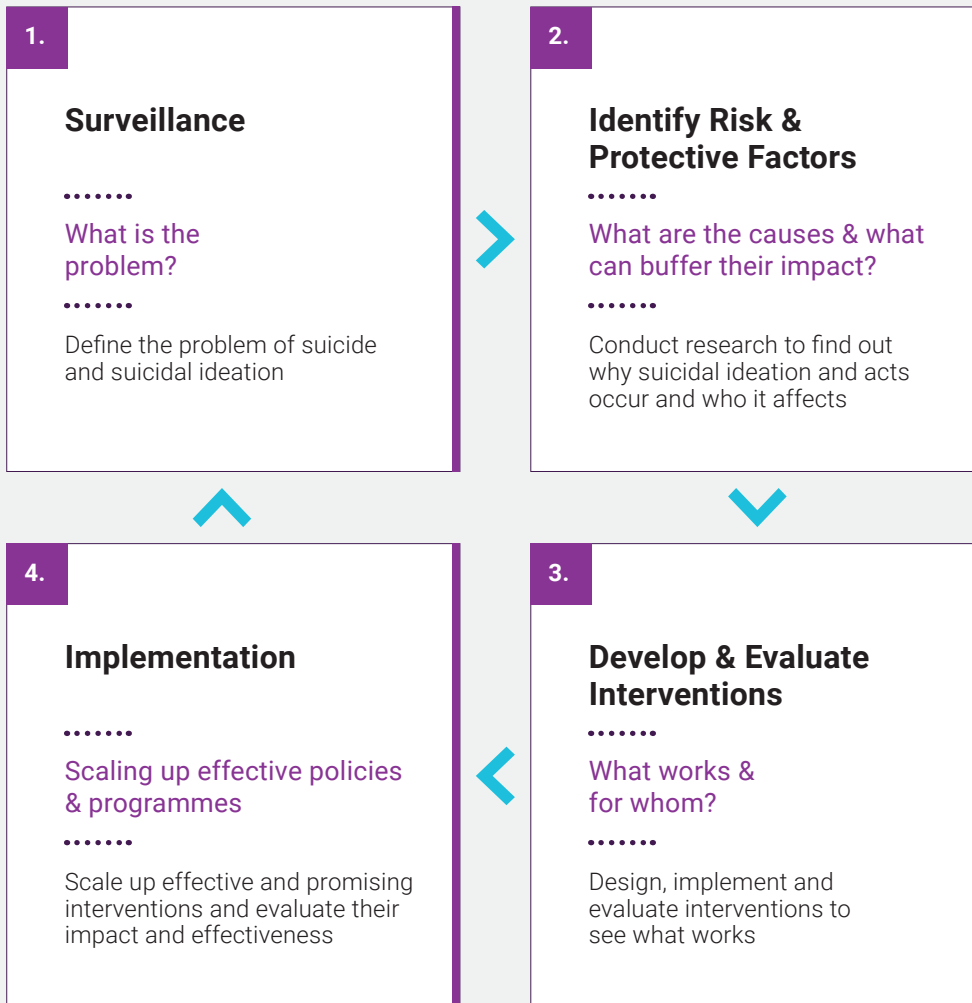
On the basis of the findings, programmes can be designed and regularly monitored to understand what works for suicide prevention, and for whom.

4. Ensuring widespread adoption:

This entails scaling up promising and effective policies and programmes in a wide range of settings, and monitoring their impact on an ongoing basis.

- **Myth:**
Once someone is suicidal, they will always remain suicidal.
- **Fact:**
Heightened suicide risk is often short-term and situation-specific. While suicidal thoughts may return, they are not permanent and an individual with previously suicidal thoughts and attempts can go on to live a long life.

Figure 1: The public health model



By virtue of being a public health model, the public health system—all public, private, and voluntary entities contributing to the delivery of public health services—can play a critical role in suicide prevention. In particular, the creation of national suicide prevention strategies by health ministries is one key way for governments to integrate suicide prevention into the public health system. Beyond this, health ministries also have a responsibility towards engaging with other ministries, to align their suicide prevention mandate with other schemes including pensions, unemployment, farm loan waivers, and disability allowances.

What are the risk factors for suicide?

Simply put, a risk factor is something that increases an individual's vulnerability to having suicidal thoughts and/or acting on them. More often than not, several factors combine in the lead up to a suicide attempt. That being said, it's also important to note that the mere presence of risk factors, doesn't automatically lead to a person thinking about or attempting suicide. For instance, not everyone experiencing unemployment and financial losses has suicidal thoughts.

Any effective prevention strategy requires an understanding of the risk factors for suicide. Focusing on how individual factors interact with a person's environment, the WHO report categorises risk factors at five levels: system, society, community, relationship, and individual. None of the levels are mutually exclusive, and more often than not they interact with and influence each other. In Revathi's case, risk factors may have included a

lack of social support in the city of Kochi; a tenuous relationship with her husband; societal pressures around a woman's role in the household; and the fear that her husband would find out if she reached out to her doctor for support (as physicians often discuss matters of women's health with men in the family, who are treated as the decision makers on behalf of the women). These weren't mutually exclusive, and together created circumstances that compelled her to contemplate self-harm.

Level	Explanation	Examples of associated risk factors
Individual	Biological factors or an individual's personal history, that increase the likelihood of thinking about or attempting suicide	<ul style="list-style-type: none"> • Family history of suicide • Job or financial loss • Mental illness or disorders • Substance use
Relationship	The nature of an individual's interpersonal relationships with family and friends	<ul style="list-style-type: none"> • Social isolation or lack of social support • Relationship conflict or loss
Community	Social settings such as schools, workplaces, and neighbourhoods that might contribute to suicidal thoughts or actions	<ul style="list-style-type: none"> • Discrimination • Disaster, war, ethnic conflict, etc
Society	Societal factors that put people at risk of suicide, such as policies that help to maintain economic or social inequalities between groups	<ul style="list-style-type: none"> • Access to means such as guns or pesticides • Inappropriate media reporting • Stigma associated with help-seeking behaviour • Institutional marginalisation and exclusion
System	The inaccessibility of healthcare systems puts people at a higher suicide risk	<ul style="list-style-type: none"> • Barriers to accessing healthcare

What are relevant, evidence-based interventions for suicide?

Based on the risk factors, the public health model organises interventions at three distinct levels: at the population level (universal strategies), among marginalised subgroups (selective strategies), and among those at a particularly high risk of suicidal thoughts or actions (indicated strategies).

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“To make a decisive difference, one must enter the government health system. India’s population and scale make it imperative to do so. While many organisations are making a difference, we need more adequately trained people, in difficult locations, in public facilities.”

- Keshav Desiraju

Strategy	Definition	Examples
Universal prevention (ie. at a population level)	For everyone in the population	Raising awareness about suicide; restricting access to the means of suicide (eg. pesticides)
Selective prevention (ie. at the subgroup level)	For subgroups within a population who are at a higher risk of ideating or attempting suicide based on characteristics such as age, gender, occupational status, or family history.	Interventions for groups experiencing displacement, disaster, war, conflict, etc
Indicated prevention (ie. for high-risk individuals)	For specific individuals who are at high-risk of suicide	Programmes for people who have previously attempted suicide

Effective Suicide Prevention Interventions Across the World



When designing approaches towards suicide prevention in India, we need not reinvent the wheel entirely. In fact, there is ample evidence of strategies that have successfully reduced the incidence of suicide in other parts of the world, that we can draw from and build upon.

In this section, we highlight five such examples, which span policy changes, social entitlement programmes, and suicide helplines, among others.

1.

How **Sri Lanka** reduced its suicide rate by half in just ten years

2.

How a conditional cash transfer programme in **Indonesia** cut suicide rates by almost 20 percent

3.

How **Tamil Nadu** halved student suicide rates with better exam systems

4.

How **The Trevor Project's** supportive and intersectoral approach helps LGBTQ youth struggling with suicidal ideation

5.

How **care transitions** for psychiatric clients prevent suicide at a crucial turning point in their journey

Myth:

Talking about suicide is a bad idea and can be interpreted as encouragement.

Fact:

Given the widespread stigma around suicide, most people who are contemplating suicide do not know whom to speak to. Rather than encouraging acts of self-harm, talking openly can give an individual other options, or the time to rethink their decision, thereby preventing suicide.”

1.

How Sri Lanka reduced its suicide rate by half in just ten years

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Sri Lanka—the small island country with a population of about 20 million—used to have one of the highest suicide rates in the world. Between 1950 and 1995 suicide rates in Sri Lanka had increased eight-fold, to a peak of 47 per 100,000 people in 1995.

By 2005 however, rates halved. What led to this dramatic drop?

Sri Lanka's suicide rates declined because of strategic policy measures to regulate access to pesticides. At the time, 87 percent of the suicides in Sri Lanka occurred by poisoning, with pesticides being the most commonly ingested substance.²³

Sri Lanka took four measures that contributed to this decline:

- Appointing a 'Registrar of Pesticides' in 1983, a post that carries the authority to set regulations and standards for pesticides
- Establishing the National Poisons Information Centre in 1988
- Creating a Presidential Task Force on Suicide, which developed a National Policy and Action Plan on the Prevention of Suicide in 1997
- De-criminalising suicide in Sri Lanka in 1998

Evidence suggests that of all the measures introduced, it was the comprehensive ban on the import and sales of WHO Class I toxicity pesticides in 1995, and endosulfan in 1998, that ultimately created the most impact on reducing the overall suicide rate.²⁴ Between 1996-2005, 19,769 fewer suicides occurred, as compared with the previous decade (1986-95). Secular trends such as unemployment, alcohol misuse, divorce, and the years associated with Sri Lanka's civil war did not appear to be associated with these declines.

Pesticides are one of the most frequently used methods of suicide worldwide.²⁵ In low-income countries, they are readily available in most rural households, and are commonly used by young people in moments of crisis. Because the overwhelming majority of pesticide suicides are on impulse, substituting with another method is rare. It follows then, that accessibility plays a major role in an individual's choice of ingested agent.

And so, production and/or import controls on the most toxic pesticides seems to be an effective strategy to curb suicide rates. The WHO also recently emphasised that policies of means restriction—reducing the access or availability to means and methods of deliberate self-harm—can make a huge difference at a population level.

2.

How a conditional cash transfer programme in Indonesia cut suicide rates by almost 20 percent

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With a population of 270 million, Indonesia is the world's fourth most populous country. In 2007, the government introduced a conditional cash transfer programme, Programme Keluarga Harapan (PKH), which was part of a wider effort to reform the Indonesian social security system, and provide targeted assistance to the poorest households. The pilot version, introduced in 2007, reached 600,000 households, and was later expanded to cover 5.2 million households in 2014 (close to 60 percent of subdistricts across the country).

PKH provided families with yearly cash transfers worth about 10 percent of their annual consumption, over a period of six years. The programme was designed to improve poor households' health and education through a cash transfer, conditional on their participation in health and education services. And so, the programme targeted subdistricts with high levels of poverty rates, and sufficient access to health and educational institutions.

A randomised control trial of the programme found that both the cash transfer's rollout and the randomised cash transfer, caused a large reduction in suicides—approximately 18 percent.²⁶ Plus, agricultural productivity shocks (like drought) had a big impact on the incidence of suicide. We know that negative economic shocks can have adverse effects on mental health. Social

welfare programmes can help ameliorate those circumstances, just as this one did.

The success of PKH points to the important role that government policies play in alleviating the consequences of poverty on mental health.

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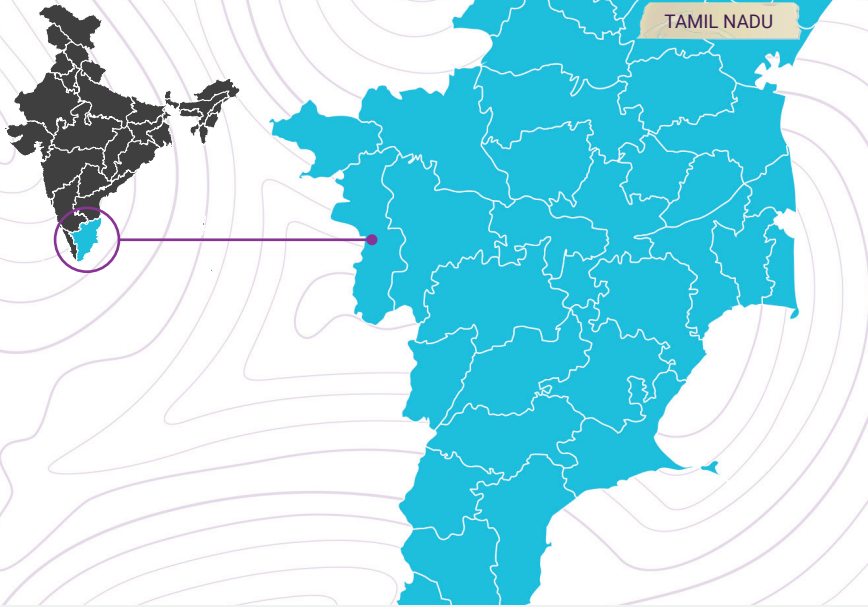
“Not being able to access rights with respect to wages or retirement support, for instance, can be a trigger point for people in considering suicide. Working on the accessibility of rights is important.”

– *Christy Nag*

3.

How Tamil Nadu halved student suicide rates with better exam systems

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Every year, around the time when the results of the 10th and 12th grade board exams are published, student suicides in India make the news. Year after year, we see the same thing play out, where students die by suicide upon receiving their exam results.

In the state of Tamil Nadu however, this pattern was partly reversed, thanks to a relatively simple policy change: A 2004 state government order allowing students to write supplementary exams in the event that they failed to secure the minimum percentage to pass in their first attempt. All of a sudden, the pressure of one moment deciding a student's college admissions, and by extension their future, vanished. And for many young students, that marked the difference between despair and hope. Between 2004 and 2014, the number of exam failure-related suicides fell in Chennai from 38 to 15.²⁷ Across the state, the numbers dropped from 407 in 2004, to 247 in 2014.

While an academic study of this approach is still awaited, the early findings are encouraging. We know from the evidence available, that punishment for poor performance or bad behaviour is not effective with adolescents.²⁸ As this initiative points out, thinking beyond the individual to include systemic factors, has a better chance of addressing the problem.

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“I don't know how many lives may have been lost because somebody scored 5 percentage points less in a board exam. There is an overemphasis on academics and performance, and comparisons with peers. If we address the intense parental pressure on young people, it can save many lives.”

- Vijay Nallawala



4.
How The Trevor Project's supportive and intersectoral approach helps LGBTQ youth struggling with suicidal ideation
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The Trevor Project was founded more than two decades ago to respond to a public health crisis impacting LGBTQ²⁹ youth: suicide. In the United States, where The Trevor Project is headquartered, suicide remains the second leading cause of death among all young people.

In fact, a recent survey conducted during COVID-19 highlights the extent of the issue. The respondents were LGBTQ youth between the ages of 13 and 24, and close to half of those surveyed said that they had 'seriously considered' attempting suicide in the last year.³⁰ Moreover, it reiterated how people who experienced discrimination due to their sexual orientation, gender identity, race, or ethnicity reported much higher rates of suicide attempts. Thirty six percent of those who experienced discrimination said that they had attempted suicide, compared with only seven percent of those who did not report discrimination.

These findings offer a sobering look at how much more work is still needed when it comes to protecting the lives of LGBTQ youth. They underline how the COVID-19 pandemic has disproportionately affected young people, but they also point to trends that we've been seeing for a few years now. With its work across interventions and groups, as well as public awareness and advocacy, The Trevor Project has grown to become the world's largest suicide prevention and crisis intervention organisation for young LGBTQ people.

Its five key programmes include:

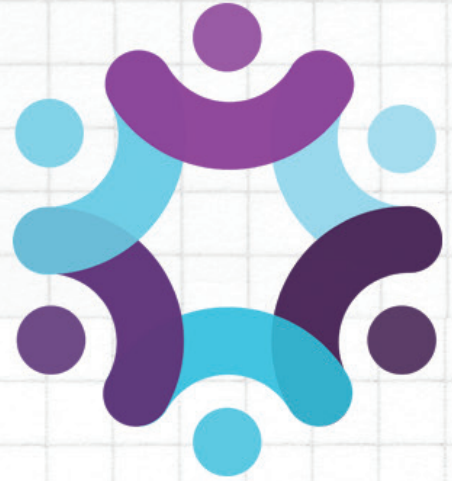
- 1. Crisis Services**
Direct suicide prevention and crisis intervention services to support LGBTQ youth 24/7 via phone, text, and chat
.....
- 2. Peer Support**
The world's largest safe space social networking community for LGBTQ youth
.....
- 3. Research**
Evaluations and external research that support The Trevor Project in strengthening its services
.....
- 4. Education and public awareness**
Programmes, trainings, and content promoting awareness around issues and policies relevant to LGBTQ youth and the adults who support them
.....
- 5. Advocacy**
Advocacy at the federal, state, and local levels to fight for policies and laws that protect LGBTQ youth

This kind of supportive, multi-pronged, and intersectoral approach is what is needed, if we are to meaningfully help young LGBTQ people today—in the United States, or anywhere in the world.

5.

How care transitions for psychiatric clients prevent suicide at a crucial turning point in their journey

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When people transition from being in an inpatient psychiatric facility to outpatient care, it's a crucial time not just for them, but also for the healthcare system and the healthcare providers who support them. This is because this transition marks the point when a client moves from the structured environment of a facility to the outside world, where the nature of care and reliance on healthcare providers is often quite different.

Inpatient care is typically designed to reduce immediate risk, offer treatment, and prepare clients for when they may leave the facility. Outpatient care on the other hand involves an ongoing relationship with the client to help them move towards better health and well-being. When clients move from one to the other, many tend to fall through the system's cracks. In fact, in the month after clients leave inpatient psychiatric care, their suicide death rate is 300 times higher than that of the general population in the first week and 200 times higher in the first month.³¹

There are many reasons why this happens, from a lack of clinical care being available when the clients is in-between inpatient and outpatient care providers, to families being unsure of how best to support their loved one, and to clients themselves experiencing greater vulnerability upon leaving an inpatient care facility. A comprehensive guide that lays out evidence-based best practices for care transitions, like the one The National Action Alliance for Suicide Prevention³² has put together, is a step in this direction.

Ideally, such guidelines should include recommendations for inpatient care providers for every step of the client's journey as they prepare to leave the facility, as well as once they leave. Care transition plans must be built in consultation with the client, tailored to their needs, and centring their agency. They must also take a collaborative approach with outpatient care providers, family, peer support, etc so that the client feels supported through the care transition. Outpatient providers should have protocols for communicating with the inpatient facility, for obtaining the requisite documents, for connecting with the client's loved ones, and for narrowing the transition gap. And, given the risks of suicide that many clients face just upon exiting facilities, outpatient care providers must actively reach out to clients once they leave, rather than leaving it to them to seek help. All of these steps can ultimately help prevent suicide.

“

“We need to reclaim the public narrative when it comes to suicide. The antidote to stigma is support groups that create safe supportive spaces and normalise the experience of suicide loss. As survivors of suicide loss, we don't move on from the loss, we move through it.”

– Dr. Nandini Murali

Our Framework

The Alliance for Suicide Prevention will use a framework to move towards a transformative, accessible suicide prevention ecosystem. The diagram shows ASP's funding and strategic support vision to build a broad base of stakeholders. Such collaboration can generate discourse to engage with a variety of institutions and policy.

1.

Via Funding and Direct Aid

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ASP will provide funding and strategic support for innovative suicide prevention interventions while connecting stakeholders to encourage exchange of ideas and potential collaborations.

2.

Dialogue

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The knowledge and dialogue generated by activists, service providers, and researchers will enable constructive, context-specific engagement and shape suicide prevention work with communities, public and private institutions, and policy.

3.

State and Civil Society

.....

The adoption of a rights-based, user-led suicide prevention approach by governmental, non-governmental institutions, enterprises, and communities will move us toward collaborations to support and intensify efforts and accountability for a vibrant suicide prevention ecosystem.

4.

Public

.....

Once the state and civil society drive rights-based, intersectional suicide prevention work, the foundation can be laid for approaches, services, and social safety nets that lead to inclusive suicide prevention services by dint of being accessible to all, irrespective of gender, sexual orientation, language, ability, age, class, caste, region, and religion.

How You Can Help Prevent Suicide



India's efforts towards suicide prevention are in their infancy, at best. What this means is that no matter where you sit in the ecosystem or what skills you bring to the table, you can play a role in preventing suicide.

Here's how you can participate.

If You Are A Funder

- **Educate yourself**

Take time to learn about and understand the public health approach to preventing suicide. Build an approach that is psychosocial, interdisciplinary, and intersectoral. You may refer to our references at the end of this report for additional reading on the subject.

- **Plug gaps in the system**

- Support nonprofits and projects working on suicide prevention; in particular, move beyond awareness building or breaking the stigma.

- Fund not just the development of suicide prevention services, but also the development and implementation of policies, strategies and plans to address the issue.

- Create awareness on suicide prevention, talking about myths related to suicide and breaking them down.

- **Take a long-term view**

Suicide reduction is a marathon, not a sprint. Any meaningful reduction in suicide rates will require incremental, sustained investments over a 5-7-year period.

- **Partner with other funders supporting suicide prevention efforts**

Mariwala Health Initiative is launching the Alliance for Suicide Prevention to work on this issue in a concerted, focused manner. Partner with us to join the collective effort to prevent suicide, taking an intersectional, rights-based, public health approach.

If You Work In Policy/Government

Much of this work falls within the ambit of the Ministry of Health.

- Create a National Policy on Suicide Prevention that has a public health, intersectoral, and psychosocial approach.

- Ensure adequate budgetary allocations for a concerted effort to work on suicide prevention.

- Improve data collection and reporting on deaths by suicide and attempts of suicide, as part of health reporting rather than crime reporting. This data should ideally be high quality, accessible to all, timely, and disaggregated, so that it can be used effectively to define and monitor the problem.

- Ensure provision of accessible services to all, especially marginalised groups. Involve a number of stakeholders in the conversation, including departments of health, social justice, home, education, and agriculture.

- Advocate for inter-departmental communication and collaboration, so that disparate priorities and interests can be accommodated for the best possible outcomes. For instance, the health department may want to reduce access to pesticides, while the agricultural ministry's mandate would be to increase farm productivity through the use of pesticides. Sensitising other departments about suicide prevention and bringing about an alignment in agendas is key to strengthening work on suicide prevention.

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“Of course, intersectionality is important—aspects including class, gender, sexuality, disability, etc. And there is a need to build a community, and access community support rather than individual support. For instance, when it comes to caste-based occupations of different kinds, we never consider them. We need to look at how a community comes forward to support its members. We need to look at caste-based aspects.”

- *Jyotsna Siddharth*

If You Work in the Media

- Follow suicide reporting guidelines by Press Council of India and WHO.³³
- Recognise and acknowledge that unethical, sensational reporting of suicide can actually lead to higher rates of deaths by suicide.
- Ensure that through your reporting, you are discouraging readers from wanting to know every detail of the death, respecting the rights of the deceased and the bereaved.
- Write about suicide more comprehensively, so that the context, structural issues at play, and other factors are a part of the story; educate yourself about using non-stigmatising language.
- Respect the privacy of the bereaved; use language that is compassionate towards the individual, their family, and the issue of suicide prevention.

If You Work At A Nonprofit Or Civil Society Organisation

- Evaluate what systems act as stressors to the communities that you work in, and have conversations about this. For instance, some education systems might believe that online schooling is the best way to provide an education, without recognising that such an approach adversely impacts families without access to technology or digital literacy.
- Build capacity to provide crisis support. For instance, organisations that work on gender-based violence must have protocols on how to talk to someone who may have suicidal ideation because of the trauma that they have experienced.
- Advocate with local, state, and the central government to prioritise suicide prevention and implement both the National Mental Health Policy, 2014 and the National Health Policy, 2017. Participate in the process of law reform and strategic litigation to demand government action.
- Finally, as outlined in the National Health Policy, 2017, work towards creating a network of community members to provide support to those with suicidal ideation and those affected by suicide.

Finally

Normalise having conversations about suicide prevention with friends, within families, and at workplaces. If someone you know initiates a conversation on suicide, move from resilience building to understanding the stressors that that person is experiencing; provide the support that they are seeking; understand that their agency is paramount; and, ensure confidentiality of the conversation.

At Mariwala Health Initiative, we are committed to changing the conversation around and working concertedly on suicide prevention. In our work on funding mental health, we have seen that suicide

prevention is a much-neglected and misunderstood area. Thus, we are launching the Alliance for Suicide Prevention—a collaborative effort that aims to work on this issue in a focused manner, in line with an intersectional, intersectoral, and rights-based approach.

If you are an activist, mediaperson, funder, nonprofit, academic institution, researcher, or mental health professional, partner with us as we grow the Alliance for Suicide Prevention. Please write to us at asp@mariwalahealthinitiative.org to learn more about how you can be a part of this collective effort.

Glossary

Indicated Prevention: Indicated prevention strategies focus on specific vulnerable individuals within the population e.g. those who have survived a suicide attempt.

Lived Experience: Lived experience is a self-expression of an individual's experiences and the knowledge gained through those experiences. In the context of suicide, lived experience refers to the experiences of people who have themselves survived suicide attempts, suicidal ideation, and/or self-harm; along with those bereaved due to the loss of a loved one to suicide.

Means Restriction: Techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm.

Psychosocial Approach: Mental health counselling or a programme intervention should account for one's emotional and psychological vulnerabilities, feelings of isolation and exclusion, and everyday struggles with accessing education and employment. This approach avoids a narrow perspective that views a person with mental illness from a biological and medical lens and instead, really attempts to 'see' one as a sum of the myriad emotions and experiences of their daily lives.

Public Health Approach: The focus of public health is on the health, safety, and well-being of entire populations. A unique aspect of the approach is that it strives to provide the maximum benefit for the largest number of people. The public health approach also emphasises input from diverse sectors including health, education, social services, justice, policy, and the private sector. Collective action on the part of these stakeholders can help in addressing problems like suicide.

Selective Prevention: Selective prevention strategies target vulnerable groups within a population based on characteristics such as age, sex, occupational status, or family history. While individuals may not currently express suicidal ideation, they may be at an elevated level of biological, psychological, or socioeconomic risk.

Self-harm: A preoccupation with deliberately hurting oneself without conscious suicidal intent, often resulting in damage to body tissue.

Suicidal Ideation: Suicidal ideation, also known as suicidal thoughts or ideas, is a broad term used to describe a range of contemplations, wishes, and preoccupations with death and suicide.

Suicide: Suicide is the act of deliberately killing oneself.

Suicide Attempt: Suicide attempt is used to mean any non-fatal suicidal behaviour. It refers to intentional self-inflicted injury or self-harm, which may or may not have a fatal intent or outcome.

Suicide Attempt Survivors: Suicide attempt survivors are individuals who have survived a prior suicide attempt.

Universal Prevention: Universal prevention strategies are designed to reach an entire population in an effort to maximise health and minimise suicide risk by removing barriers to care and increasing access to help, strengthening protective processes such as social support, and altering the physical environment.

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