Suicide Prevention in India

More than 700,000 people die by suicide each year – one every 40 seconds. 77% of these deaths take place in low- and middle-income countries.

CONTENT WARNING

Mentions of suicide, self-harm, caste-based discrimination, gender-based violence, depression, and heterosexism.

Why does Suicide occur?

50% of suicide in India is not attributable to mental illness.

Suicide is commonly seen as an individual's problem or "weakness". In fact, it is caused by a complex range of factors, including social, cultural and economic issues. For example, issues such as a lack of housing, unemployment, lack of access to healthcare, forced marriage can contribute to distress that may lead to suicidal thoughts.

For every death by suicide, there are about 60 people impacted due to the loss of a loved one, and more than 20 who attempt suicide. India lost over 150,000 people to suicide in 2020 alone – a number greater than those who died due to Covid-19. Despite this, conversations around suicide are conspicuously absent from public and development discourse, and when it is spoken about, it is still seen as an individual issue rather than a social one.

Category	Examples
Interpersonal Conflict	parental concern, familial conflict, relationship issues
Occupational Conflict	unemployment, debt, work-life concerns, academic concerns
Self and Identity	discrimination, sex & sexuality, abandonment, loss of personhood, emotional distress, grief & loss, sexual & reproductive issues
Violence	long-term abuse, emotional abuse, violence against women, domestic violence, physical violence, sexual violence, substance abuse, alcohol addiction, over medication
Inclusion	living conditions, referrals to other services, mental health information
Psychosis Syndrome	schizophrenia, paranoia, interpersonal conflict
Anxiety Syndrome	generalized anxiety, panic disorder, phobias, social anxiety, OCD, PTSD
Mood Syndrome	sub-clinical depression, major depression, bipolar

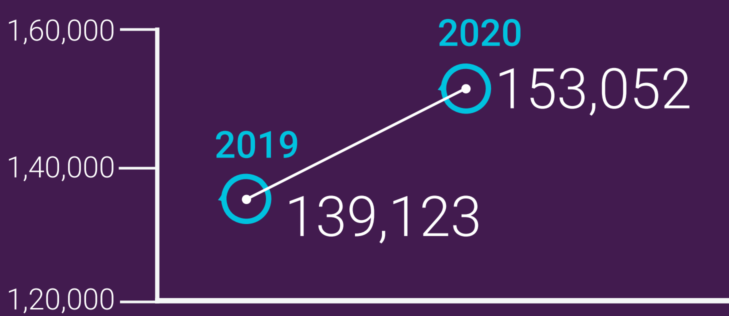
SCALE OF THE ISSUE

Every
40 SECONDS
one person takes their life globally.

Every
3 SECONDS
someone attempts suicide in India.

18%
of global population lives in India, however India accounts for

24 - 37%
of global deaths by suicide.



Deaths by suicide have been increasing in India since 1990, and have
JUMPED 10% IN 2020
alone, to over 1,50,000 deaths.

Young adults are taking their own lives in alarmingly high numbers, constituting a public health crisis.

Approaches to Suicide Prevention

SYSTEMIC:
While suicide is a global problem across multiple age groups, ethnicities and communities, the numbers tilt disproportionately towards the marginalised. Rates of suicide amongst Dalits, Adivasis and Christians in India are significantly higher than the national average. Hence, conversations and interventions on suicide prevention must acknowledge the range of social, economic, and/or political factors that can lead a person to consider suicide.

PSYCHOSOCIAL:
The sociocultural environment a person lives in continuously influences their mental and emotional state. For example, in India, a staggering 34% of suicides, especially amongst young women are attributed to "family issues", indicating that distress and violence in homes contribute heavily to the stress people experience that may lead them to attempt suicide. Hence, it is important to provide social support such as anti-violence measures, legal aid, livelihood opprtunities, healthcare access, etc that addresses the root causes of such distress not only to individuals experiencing suicidal ideation, but to communities and populations at large, as this can help prevent suicide as well.

Acknowledges vulnerable groups

Includes care givers

Aims to promote mental health

Aims to reduce suicide and attempt to suicide

Emphasizes the need for increased resources

INTERSECTIONAL:

Individuals may experience privilege and marginalisation on multiple levels, such as gender, race, class, caste, sexual identity, religion, sexual orientation, and ability. For example, while Indian youth are overall vulnerable to suicide, those belonging to marginalised castes and religions (Dalits, Christians, and Adivasis) have higher rates of suicide than the national average. Recognising these intersections is key to ensuring that conversations and interventions can account for the fullness of people's lived experiences.

COMMUNITY-BASED:

An expert-led approach to suicide based on western contexts may not account for the cultural contexts and issues leading to death by suicide, as well as healthcare support required in India. In a low-resource setting like India, community-based interventions are more likely to be effective, as they reach the person who is most in need, and are culturally appropriate and cost-effective. Communities best understand their own unique stressors and risk factors, and are best placed to support their members.

RIGHTS-BASED:

Addressing inequality by supporting people in securing social services, labour rights, children's rights, right to housing, among others, can contribute to reducing the incidence of suicide. For example, LMICs such as Indonesia have seen success in reducing suicides significantly through conditional cash transfer programs that help people access health and education services.

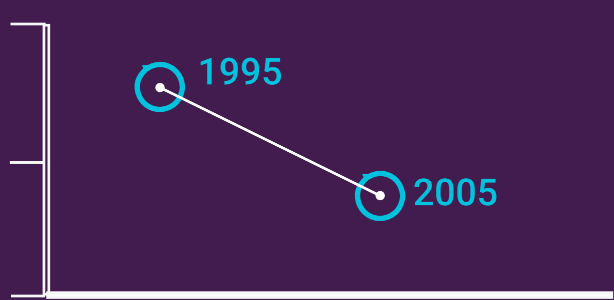
INTERSECTORAL:

Beyond the provision of mental healthcare services, there is a need for intersectoral 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, education and employment.

PUBLIC HEALTH APPROACH:

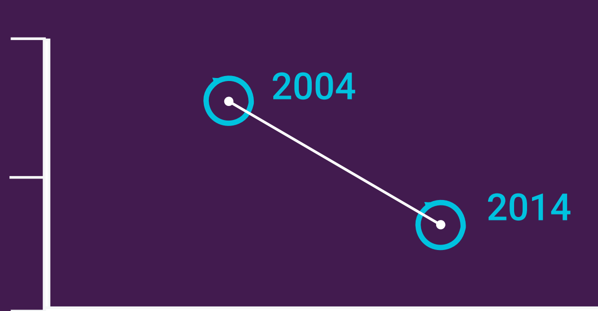
A public health approach attempts to prevent or reduce a particular illness or social problem in a population by identifying risk factors, and then targeting policies and programmes to address the underlying risk factors. It is designed to provide the maximum benefit at a population level, through intersectoral collaboration.

Effective Suicide Prevention interventions in LMICs



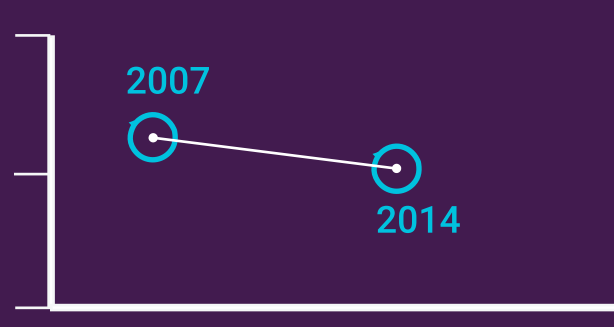
UNIVERSAL INTERVENTION:
Means Restriction

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, most commonly with pesticides.



SELECTIVE INTERVENTION:
Intervention for vulnerable groups

Student suicides in India peak every year around the time of 10th and 12th grade exam results. In 2004, the Indian state of Tamil Nadu passed a state government order allowing students to re-attempt exams that they failed to secure the minimum pass percentage in, in their first attempt.



UNIVERSAL INTERVENTION:
Access to health care

In 2007, the Indonesian government introduced a conditional cash transfer programme, Programme Keluarga Harapan (PKH). The programme was designed to improve poor households' health and education through a cash transfer, conditional on their participation in health and education services.

SELECTIVE INTERVENTION: Intervention for vulnerable groups and Crisis helplines

The Trevor Project works to prevent suicide amongst LGBTQ youth through its 5 key programmes: Crisis support (phone, text and chat helplines), peer support, research, education and public awareness, and advocacy.

HOW YOU CAN HELP PREVENT SUICIDE

FUNDERS:

1. Learn about a psychosocial, interdisciplinary and public health approach to suicide.
2. Fund not just awareness and stigma reduction but also service delivery programs focused on the psychosocial and structural root causes of suicide, as well as policy development and implementation.
3. Take a long-term view. Any meaningful reduction in suicide rates will require incremental, sustained investments over a 5 to 7-year period.

POLICYMAKERS/GOVERNMENT MINISTRIES:

1. Create a National Policy on Suicide Prevention that has a public health, intersectoral, and psychosocial approach.
2. Ensure adequate budgetary allocations for a concerted effort to work on suicide prevention.
3. Improve data collection, data quality and accessibility, and reporting on deaths by suicide and attempts of suicide, as part of health reporting.
4. 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.
5. Advocate for inter-departmental communication and collaboration, so that disparate priorities and interests can be accommodated for the best possible outcomes. Sensitising other departments about suicide prevention and bringing about an alignment in agendas is key to strengthening work on suicide prevention.

MEDIA:

1. Follow suicide reporting guidelines by WHO.
2. Recognise and acknowledge that unethical, sensational reporting of suicide can actually lead to higher rates of deaths by suicide.
3. Ensure that your reporting is compassionate, respecting the rights and privacy of the deceased and the bereaved, and through it, you discourage readers from wanting to know every detail of the death.
4. 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.

NON-PROFITS AND CIVIL SOCIETY ORGANISATIONS:

1. Evaluate what systems act as stressors to the communities that you work in, and have conversations about this.
2. Build capacity to provide crisis support within existing work.
3. Advocate with local, state, and the central government to prioritise suicide prevention and create and implement policies. Participate in law reform and strategic litigation to demand government action.
4. Work towards creating a network of community members to provide support to those with suicidal ideation and those affected by suicide.

Alliance for Suicide Prevention

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, media person, funder, non-profit, academic institution, researcher, or mental health professional, partner with us as we grow the Alliance for Suicide Prevention. Please visit **www.mhi.org.in/asp** write to us at **asp@mariwalahealthinitiative.org** to learn more about how you can be a part of this collective effort.

In the case of material being triggering or upsetting, you can reach out to **iCALL at (+91) 9152987821** or **icall@tiss.edu**

Published:
April 2022

mhi.org.in

/ mariwalahealth
/ mariwalahealth
/ mariwalahealth
/ mariwalahealth

Grande Palladium, 8th floor,
175, CST Road, Kalina, Santa Cruz (E,)
Mumbai, Maharashtra 400098

022 6648 0500
asp@mariwalahealthinitiative.org

About Mariwala Health Initiative

Mariwala Health Initiative (MHI) is a personal philanthropy of Mr. Harsh Mariwala, chairman of Marico Limited. MHI exclusively works on mental health and is a grant making, advocacy and capacity building agency. MHI focuses on making mental health accessible to marginalised persons and communities by fostering an environment of accessible, affirmative, rights-based and user-centric mental health care. At MHI, mental health is viewed as a spectrum and that people with lived experiences must be situated at the core of any capacity building work, or intervention.