Perspective

Suicide Prevention Policy in India: Reflections by Mental Health Professionals

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Abstract

The National Suicide Prevention Strategy was launched by India on November 21, 2022. It was the first step toward making suicide prevention a public health priority with the aim of a 10% reduction in suicide mortality by 2030. The present article incorporates the reflections by mental health professionals in India by emphasizing on the sociocultural contexts, diversity, the training of the professionals, ethical dilemmas, the need for early intervention, and risk assessment along with a more comprehensive method of implementation of the policy.

Keywords: Ethics, mental health, mental health professionals, public health, suicide, training

Introduction

The Ministry of Health and Family Welfare, Government of India, unveiled the "National Suicide Prevention Strategy" (NSPS) in November 2022.[1] It is India's first initiative in this arena, with time-sensitive action plans and cross-sectoral collaboration to reduce suicide mortality by 10% by 2030. The policy is consistent with the World Health Organization's South East Asia Region Suicide Prevention policy.[2] Following its release, the NSPS was well received and evaluated.[2-4] In this essay, we describe opinions from many sectors of mental health and consider the next steps.

Historical Antecedents

The United Nations issued "Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies" after consulting with a number of experts and receiving technical assistance from World Health Organization (WHO).[5] The statement emphasized the need of inter-sectoral collaboration, inter-disciplinary methods, and ongoing assessment and review, as well as crucial features as a means of boosting the success of suicide prevention programs. The WHO[6] established components and methods for establishing a suicide prevention plan in 2012. WHO (2014)[7] highlighted the influence of culture and religion in suicide and issued the first suicide prevention report. In 2017, the International Association for Suicide Prevention[8] established a special interest group to develop effective suicide prevention techniques.

Developments Across the World

We reviewed the policies of the UK, USA, France, and Australia[9] and the highlights are as follows:

France

The "ALGOS" program in France focused on high-risk populations and trained all health-care professionals during their medical education and it was highly effective in reducing suicide.

UK

The first program was launched in 2002 and thereafter it has been regularly updated. The policy in the UK includes specific

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measures directed at each population group in schools and workplaces to reduce stigma and improve access to care and support for bereaved persons.

Australia

The Australian program is based on the whole systems approach for promotion, prevention, and early intervention with clear guidelines for at-risk groups with unique follow-up support for attempts as well as ensuring high standards in mental health-care services.

USA

The policy in the USA includes integration of mental health care into primary health-care services, provision of help through telemedicine, expanding the scope of insurance to include mental health-care costs, peer support, and stigma reduction, and special programs for high-risk groups such as older adults and specific ethnic groups.

India

Despite having a long tradition of suicidology,[10] the clear formulation of policy for suicide prevention was delayed. Meanwhile, we observe that other countries have gained several years of experience and have evolved strategies that have greater relevance and efficacy to their populations. To make up for the lost time, our policy has borrowed some elements of their learning, such as manpower development. Suicide is preventable and the causes are constantly changing.[11,12] It would have been helpful for NSPS to have an element of responsiveness to changes and data as they become available so that the policy became dynamic rather than static.

The Context

According to WHO (2023)[13] estimates, more than 1 lakh lives are lost every year to suicide in India. There has been a 3-year increase from 10.2 to 12/100,000 population as per the NSPS document. The most common reasons for suicide are illness and family problems. The National Mental Health Survey conducted by NIMHANS (2016),[14] shows a high prevalence of mental morbidity in urban metropolitan areas; mental disorders are closely linked to both causation and consequences of several non-communicable disorders. The survey also states that nearly one in 40 and one in 20 persons suffer from past and current depression, respectively; 0.9% of the survey population were at high risk of suicide; and nearly 50% of persons with major depressive disorders reported difficulties in carrying out their daily activities.

The goal of suicide prevention is to lower the risk of suicide and attempt to avoid it at the individual, interpersonal, social, and societal levels. Suicide impacts individuals, families, and communities. Therefore, strategies at all societal levels are necessary to prevent suicide: including preventative measures that make people aware of the warning signals, encouraging resilience, and a commitment to social change. In that sense, the NSPS is a good beginning, as we shall see below.

Highlights of the National Suicide Prevention Strategy

The NSPS proposes immediate, intermediate, and long-term strategies. The priority areas include reducing easy access to suicide modes, strengthening health-care systems to prevent suicide, sensitization through media, and strengthening suicide surveillance. It exhorts the government to phase out hazardous pesticides; increase post-graduate seats in the field of mental health and introduce short-term training in mental health to non-specialist doctors and others to increase access to services. Thus, it envisions a complete package of mental health promotion, prevention, and intervention at all levels. Such actions will eventually result in the mitigation of suicide.

Social Determinants in Suicide

The WHO[7] has emphasized that social, economic, and physical environments influence mental health and illness. These determinants not only predispose the individual to common mental disorders but also to the risk of suicide, to adverse life events, interpersonal difficulties, family quarrels, and issues related to gender.[15-19] Therefore, it has urged the need for environmental, structural, and local interventions across the life course of individuals at risk.

Risk factors across and throughout the lifespan that are located in systems, social and cultural norms have been studied by Vijayakumar *et al*. (2022).[20] These complexities and vulnerabilities of everyday life that are embedded in social and cultural contexts predispose a person to suicide. For example, in a scoping study, younger women were at a higher risk of suicide[21] and reported being tortured by the family of procreation.[22] Multiple family factors have also been studied.[23] Such studies only highlight the lack of robust data on gender differences, especially among non-binary gender groups, given their risk of being stigmatized by exclusionary and discriminating structures.[24] Dandona *et al*. (2017).[25] found personal or social reasons as the foremost cause of suicide that range from individual-focused causes to life-diminishing cultural norms that apply to only “certain groups” of people. Cultural and societal norms disadvantage the already vulnerable groups – such as women, gender non-binary groups, disabled, and those below the poverty line. These pose enormous risks for suicide.

Jacob[26] recommends addressing gender justice in the context of a patriarchal society, which is supported by cultural and religious biases against girls and women. The author highlights the role of economic systems and related structural violence, subtle cultural sanctions and beliefs, capitalist philosophy and increased social isolation, and political perspectives that blame and other issues pertaining to suicide. The tendency to provide quick-fix partial solutions or responses is unlikely to be sustained and the problems persist in the long term. When individuals operate from a mindset based on a scarcity ideology, they operate from fear and exclude self and others,

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causing more distress and discrimination.[26] Not only are the social, cultural, and systemic factors inter-related, but they are also intersectional and complex-leading to partial and untenable solutions. Several authors argue for the need for a multi-sectoral,[24,26,27] multi-dimensional, multi-phased, and multi-departmental[28] collaborations,[28] comprehensive,[17,25] and holistic[24] approach to dealing with suicide at the national level. However, it is imperative to take into account the prevailing social and cultural factors[21,22,26,29] and interrupt them.[26]

In that regard, the NSPS has done well in clearly enumerating the different departments of government tasked with implementing changes in social, familial, educational, justice, and related sectors. The policy acknowledges the role of environmental factors in mental health in general and suicide in particular. Further, it has roped in the concerned sectors and departments and set out a plan for collaborative action. This, according to us, is a strength of the policy. However, the means to monitor and enforce the plan are not clearly set out in the policy.

The policy has also mentioned the inclusion of "non-government organizations, including faith-based organizations." These entities are heterogenous and often function outside and independently of the formal health-care system. Therefore, on-field practicalities of their inclusion need further study and elucidation.

Training of Mental Health Professionals

The NSPS recommends manpower development on a large scale. Our concern is that this manpower should be of suitable quality, in addition to the stated requirement of large numbers. Quality assurance in mental health at the level of provision itself is essential in our country. This is because there is widespread ignorance about mental health and the average Indian is unable to judge for themselves about the quality, safety, and cost of mental health interventions on offer. Another issue is that mental health professionals (MHPs) frequently encounter situations that call for ethically wise decision-making. This decision-making skill is imperative in suicide risk assessment and prevention and is impacted by the training and ethical proficiency of the professional. The four principles of ethical reasoning in health care as recognized to be autonomy, justice, beneficence, non-maleficence, and fidelity often help in ethical decision-making.[30-32] Competency in ethical decision-making should be a mandatory part of the training of persons dealing with mental health and suicide prevention.

While the National Medical Commission has established the basic and minimum training requirements, this is applicable to medical professionals only. The NSPS envisages large-scale sensitization and training of paramedical professionals (psychologists and social workers) and ancillary workers (teachers, multipurpose workers, etc). Currently, the training curriculum for nonmedical professionals is not uniform and licensing requirements are not adequately enforced. Among paramedical professionals and ancillary workers, there is heterogeneity in training and practice to such an extent that even a reasonable classification of their services is not possible. People seek these services more readily, more often and as the first point of contact; rather than medical services. The NSPS has not elucidated how it plans to standardize, assure quality, and regulate these services. The eventual success of any "prevention" policy rests on the performance at the first point of contact. Therefore, this needed to be given greater consideration in the policy.

Way Forward

A dynamic policy in step with the developments around the world as well as relevant to the culture and needs of India is required. We need more and higher quality data about mental health in general and suicide in particular, to be able to formulate such a policy. One agenda would be to study the implementation, barriers, and impact of the current policy. This goes beyond suicide surveillance and extends into the study of service delivery and effectiveness.

A policy on suicide prevention must take into account the systemic and structural factors as well as cultural norms that disenfranchise groups or individuals. This policy has rightly taken these factors into account, but a greater depth is required for such a vast country like India with cultural diversity rooted in ancient traditions. Unless we interrupt disempowering systems and cultural norms, we will not be able to consciously generate the full spectrum responses.[16] To do this, we need to source the universal values for human and planetary transformation, shift and transform unworkable norms, and generate results across the lifespan and across systems, contexts, sectors, and structures. One way to begin this process and make such interventions sustainable is to scaffold these values from early childhood and adolescence.[17] Early childhood care centers and schools are the best places to guide students and offer well-being interventions.

There is a need for trained professionals for early identification and intervention among children, parents, and teachers, who are impacted by social, environmental, and physical stressors, and challenge unworkable systems and cultural norms. A safe and nurturing workspace that embraces diversity and fosters competencies are essential for expressing abilities and working productively and fruitfully. MHPs can make impactful interventions at the micro and macrolevels through holistic strategies for mental health screening and biopsychosocial-spiritual interventions.

The improving and upgrading of an effective strategy for establishing an electronic registry for suicide as emphasized by the WHO is important. A standardized and updated training program and assessment in mental health curriculum across the length and breadth of the country, with sufficient inter-departmental learning, skilled faculty, research opportunities, and community exposure with varying cultural norms along with the specific emphasis on

maintaining the ethical standards of training are required. It is essential to have boundaries, along with stringent licensing requirements for MHPs to reduce compromising on the mental health of individuals. Alongside these, suitable guidelines, laws, and regulations need to be brought in to ensure quality and safety.

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Conclusion

The first steps of the suicide prevention policy launch are definitely positive and appreciable steps toward handling and management of suicide in India. The focus is toward raising awareness about suicide and identification of the early signs and symptoms, along with reducing social stigma about help-seeking behavior. The policy has made a good beginning. Its momentum can be sustained by having a greater depth of reach, more nuance to account for the heterogeneity of problems and solutions, better benchmarks and safety features, and the inclusion of all stakeholders with accountability.

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Conflicts of interest

There are no conflicts of interest.

References

1. National Suicide Prevention Strategy.pdf [Internet]. Available from: https://main.mohfw.gov.in/sites/default/files/National%20Suicide%20Prevention%20Strategy.pdf. [Last accessed on 2023 Jun 21].
2. Regional Strategy on Preventing Suicide, First WHO Report on Suicide Prevention (News Release). World Health Organization: Media Center; 2017. Available from: http://www.who.int/mediacentre/news/releases/2014/suicide-preventionreport/en/. [Last accessed on 2014 Sep 04].
3. Ransing R, Arafat SM, Menon V, Kar SK. National suicide prevention strategy of India: Implementation challenges and the way forward. Lancet Psychiatry 2023;10:163-5.
4. Singh OP. National suicide prevention strategy of India: Great leap forward in field of mental health. Indian J Psychiatry 2023;65:1-2.
5. Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies. New York: United Nations, Department for Policy Coordination and Sustainable Development; 1996.
6. World Health Organization. Public Health Action for Prevention of Suicide. A Framework. Geneva: World Health Organization; 2012.
7. World Health Organization. Social Determinants of Mental Health. Geneva: World Health Organization and Calouste Gulbenkian Foundation; 2014.
8. Development of effective National Suicide Prevention Strategy and Practice. Special Interest Group. International Association for Suicide Prevention; 2017.
9. World Health Organization. National suicide prevention strategies: progress, examples and indicators [Internet]. World Health Organization; 2018. v, p. 64. Available from: https://apps.who.int/iris/handle/10665/279765. [Last accessed on 2023 Jun 21].
10. Vijayakumar L. Indian research on suicide. Indian J Psychiatry 2010;52:S291-6.
11. Thippaiah SM, Nanjappa MS, Math SB. Suicide in India: A preventable epidemic. Indian J Med Res 2019;150:324-7.
12. Menon V, Cherian AV, Vijayakumar L. Rising incidence and changing demographics of suicide in India: Time to recalibrate prevention policies? Asian J Psychiatr 2022;69:102983.
13. World Health Organization. Suicide India. Geneva: World Health Organization; 2023.
14. Gautham MS, Gururaj G, Varghese M, Benegal V, Rao GN, Kokane A, *et al.* The national mental health survey of India (2016): Prevalence, socio-demographic correlates and treatment gap of mental morbidity. Int J Soc Psychiatry 2020;66:361-72.
15. Prasad J, Abraham VJ, Minz S, Abraham S, Joseph A, Muliyil JP, *et al.* Rates and factors associated with suicide in Kaniyambadi block, Tamil Nadu, South India, 2000-2002. Int J Soc Psychiatry 2006;52:65-71.
16. Jacob KS, Jayakaran R, Manoranjitham SD. Suicide in India. Br J Psychiatry 2006;188:86.
17. Aggarwal S. Suicide in India. Br Med Bull 2015;114:127-34.
18. Mythri SV, Ebenezer JA. Suicide in India: Distinct epidemiological patterns and implications. Indian J Psychol Med 2016;38:493-8.
19. Kumar A, Srivastava M, Srivastava M, Saroj RK. Study of prevalence and psychosocial determinants of deliberate self-harm in students. Res Highl 2017;4:136-43.
20. Vijayakumar L, Chandra PS, Kumar MS, Pathare S, Banerjee D, Goswami T, *et al.* The national suicide prevention strategy in India: Context and considerations for urgent action. Lancet Psychiatry 2022;9:160-8.
21. Ramesh P, Taylor PJ, McPhillips R, Raman R, Robinson C. A scoping review of gender differences in suicide in India. Front Psychiatry 2022;13:884657.
22. Batra AK. Burn mortality: Recent trends and sociocultural determinants in rural India. Burns 2003;29:270-5.
23. Mathew A, Saradamma R, Krishnapillai V, Muthubeevi SB. Exploring the family factors associated with suicide attempts among adolescents and young adults: A qualitative study. Indian J Psychol Med 2021;43:113-8.
24. Rego A, Ramamurthy C, Menezes C. When death seems suddenly appealing, defeated by the long, hard struggle to stay alive. Int J Soc Work Hum Serv Pract 2017;5:53-7.
25. Dandona R, Bertozzi-Villa A, Kumar GA, Dandona L. Lessons from a decade of suicide surveillance in India: Who, why and how? Int J Epidemiol 2017;46:983-93.
26. Jacob KS. Suicide in india: Part perceptions, partial insights, and inadequate solutions. Natl Med J India 2017;30:155-8.
27. Sharma M. Radical Transformational Leadership: Strategic Action for Change Agents. California: North Atlantic Books; 2017.
28. Armstrong G, Vijayakumar L. Suicide in India: A complex public health tragedy in need of a plan. Lancet Public Health 2018;3:e459-60.
29. Swain PK, Tripathy MR, Priyadarshini S, Acharya SK. Forecasting suicide rates in India: An empirical exposition. PLoS One 2021;16:e0255342.
30. Arya V, Page A, River J, Armstrong G, Mayer P. Trends and socio-economic determinants of suicide in India: 2001-2013. Soc Psychiatry Psychiatr Epidemiol 2018;53:269-78.
31. Beauchamp TL, Childress JF. Principles of Biomedical Ethics. Oxford: Oxford University Press; 1979.
32. Kitchener KS. Intuition, critical evaluation, and ethical principles: The foundation for ethical decisions in counseling psychology. The Counseling Psychologist 1984;12:43-55.