

Suicide in India: a complex public health tragedy in need of a plan



Suicide is a major public health problem, with far-reaching socioeconomic, political, and emotional consequences. Southeast Asia accounts for roughly 40% of the estimated 800 000 annual suicide deaths globally,¹ and is the frontline for delivering on the aspirational Sustainable Development Goal (SDG) of a one-third reduction in the suicide death rate (SDR) by 2030.

In India, the official suicide rate for 2015 published by the National Crime Records Bureau (NCRB) of India was 10.6 per 100 000 population, similar to the global average of 11.4 per 100 000 population¹ and equating to 133 623 deaths registered as suicides.² However, the suicide statistics published by the NCRB are based on police reports and under-reporting and misclassification of suicide deaths is common.³

The paper by Rakhi Dandona and colleagues,⁴ reported in *The Lancet Public Health*, uses data from the Global Burden of Disease study to provide much needed estimations of SDRs across India from 1990 to 2016. Dandona and colleagues estimated the national age-standardised SDR for 2016 to be 17.9 per 100 000 population (14.7 per 100 000 among women and 21.2 per 100 000 among men), equating to an estimated 230 000 suicide deaths annually (100 000 more suicide deaths than recognised by the NCRB data).

Such sobering figures ought to be galvanising, yet coordination at the national level has been slow. Although there are substantially more suicide deaths in India each year than AIDS-related deaths (62 000 in 2016) and maternal deaths (45 000 in 2015) combined,^{5,6} suicide prevention has attracted considerably less public health attention. Nonetheless, a public health approach to suicide prevention is gaining momentum in India. A recent highlight has been the Mental Health Act 2017 through which there have been moves to decriminalise suicide. A pivotal next step will be to carry this momentum towards the development of a national suicide prevention plan. Such a national plan would indicate political commitment and give justified prominence to the issue of suicide prevention, attract resources, set strategic research and programme priorities, and provide guidance in mainstreaming suicide prevention across other health and social policies.

To support the process of developing suicide prevention plans for India, some lessons can be drawn out from the findings presented by Dandona and colleagues.⁴ Firstly, there is clearly an imperative to obtain better suicide mortality and suicide attempt data. Although a major undertaking, a comprehensive and reliable vital registration system is the ideal foundation of national health information systems. Surveillance of suicide attempts and self-harm cases presenting to health facilities would be beneficial,⁷ as would the continuous improvement of suicide research, so that policy makers have a greater understanding of this complex issue and what works and what doesn't.

Secondly, suicide prevention planning should address the substantial regional and state-level variation in suicide rates. India has an enormous and diverse population, with several states home to populations large enough to make it on their own into the top 20 most populous countries in the world. Although a national plan is important for political and strategic purposes, it is tailored state and community-level action plans that will be the key to implementing local suicide prevention priorities.

Thirdly, suicide prevention planning should give close consideration to trends by sex and age. Female suicide in India is exceptionally high by international standards and must be a core focus, and it is encouraging that female suicide rates have declined slightly since 1990.⁸ Nonetheless, the persistently high male suicide rates must also be addressed to have any hope of achieving the SDG target. To do so, there is a need for a broader perspective on male suicide that extends beyond the highly politicised issue of farmer suicide. Some strategies for addressing the risk factors associated with male suicide, such as addressing alcohol dependence,³ might also see benefits for reducing female suicide rates. Age is also a key factor for suicide prevention planning. The data presented by Dandona and colleagues⁴ indicate that youth and older age are key risk periods for women whereas young adulthood, middle age, and older age are key risk periods for men.

Finally, suicide prevention is not solely or even primarily the domain of mental health practitioners

Published Online
September 12, 2018
[http://dx.doi.org/10.1016/S2468-2667\(18\)30142-7](http://dx.doi.org/10.1016/S2468-2667(18)30142-7)
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For the **Mental Health Act 2017** see <http://www.prsindia.org/uploads/media/Mental%20Health/Mental%20Healthcare%20Act,%202017.pdf>

providing interventions for suicidal individuals. While not losing sight of the substantially heightened suicide risk for people with mental disorders, suicide is a complex and highly stigmatised issue in India, as it is elsewhere. Suicide prevention planning should be grounded in a broader public health approach framed around multisectoral collaboration and equal acknowledgement of the socioeconomic and cultural determinants of suicide and suicide prevention in India. Population-level approaches such as responsible media reporting of suicides and the central storage or removal of highly hazardous pesticides from agricultural practices should also feature prominently,^{9,10} as should selective interventions targeting at-risk sub-populations.¹¹

The new evidence provided by Dandona and colleagues should prompt the development of national and state-level suicide prevention planning, galvanising political and community will to address this complex public health tragedy.

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GA declares no competing interests. LV is a part of the India State-Level Disease Burden Initiative Suicide Collaborators.

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