# REPORT

# SPSS: Suicide Prevention and Support Services

भारतीय जन स्वास्थ्य प्रतिष्ठान
PUBLIC HEALTH FOUNDATION of INDIA
INJURY PREVENTION RESEARCH CENTRE
Public Health Foundation of India
Injury science for safer lives
mariwala health initiative

# REPORT
# SPSS: SUICIDE PREVENTION AND SUPPORT SERVICES

The writing of this report is a collaboration between Mariwala Health Initiative (MHI) and the Injury Prevention Research Centre at the Public Health Foundation of India (PHFI).


**MHI**

Priti Sridhar
Saisha M
Manali Jhinka Roy

**PHFI**

Prof. Rakhi Dandona
Dr. G Anil Kumar
Mohd. Akbar
Moutushi Majumder
Siva Prasad Dora
Dr. Neha Dhole
Prof. Lalit Dandona



**SPECIAL THANKS**

Amit Kumar Chetty
Ajay Prasad
Gina Sharma

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**CONTENT WARNING**

Mentions of suicide, self-harm, 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**

# DISCLAIMERS

This report uses the language of sex assigned at birth as identifiers for the survey population in a binary. We acknowledge that this may not reflect the gender identity of participants. The language of gender in this report is one reflective of a limited man-woman binary and may not encompass the full extent of gender identification and non-conformity that might be present in the surveyed population.

The phrase ‘committed suicide’ was used by some participants and has hence been featured in the report. However, it is crucial to note that attempting suicide is not a crime and has been decriminalised in India since the introduction of the Mental Healthcare Act (2017). Language used by participants has been maintained to reflect authenticity. Preferred language by others bereaved by suicide may be “died by suicide”.

This report contains findings related to the mode or method of suicide, with the overarching aim of guiding suicide prevention. To prevent harmful sensationalism of an already sensitive topic, we encourage this facet of suicide be read in context, and not highlighted in isolation. Please refer to the WHO’s media guidelines for reporting on suicide.

# FOREWORD / MHI

Based on a nationally representative sample, the findings of this report support what many in the suicide prevention space, as well as the larger mental health justice field, have long believed in and advocated for – systemic measures for suicide prevention need to be enacted from the ground up, and with a psychosocial approach. Several learnings from the present study, based on an existing data set, reaffirm this and point to crucial gaps in our understanding of suicide and the practice of its prevention.

The dominance of family, financial, and health reasons for suicide mortality points towards a failure of our social, economic, and public infrastructures at multiple levels. What is significant is also the extent of deaths falling under the 'reason unknown' category. The impact of wealth and class is made evident through the findings of the report – with not only higher overall mortality rates among those in the lower income quartiles, but also the higher preponderance of 'reasons unknown' for them. This brings forward the question of whose suicide deaths are allowed to be comprehensible, and in turn grievable, by our current data and care systems alike.

Similarly, the alarmingly high percentage of female suicide mortality attributed to family reasons (33%) is a painful reminder of the continuing nexus between patriarchal family structures and women's mental health. This connection has been highlighted in global literature on suicidality as well as lived experience advocates. It is highly likely

that instances of interpersonal violence, harassment, dowry deaths, and much more get obscured under the same label of 'family issues' in family members' accounts, and then further invisibilised in official reporting. We see the navigation of these dynamics in findings related to the "social reputation" reason given in decisions not to inform the police or media in the current report, all of which warrant further study and understanding.

The findings related to both income level and gender echo the need for an intersectional approach as supported by many practitioners and researchers in the field. They highlight the complex linkages between marginalisation and suicidality in the Indian context. For instance, contrary to Western research findings, marital status did not emerge to be a protective factor for people in the study — it was, in fact, the opposite for women's suicide deaths. This discrepancy can be understood only when one takes into account the patriarchal, caste-bound and heteronormative nature of marriage prevalent here.

Yet, while caste is a fundamental organising principle of Indian society, the current dataset does not explicitly provide this disaggregation. This is a limitation for this research. Based on MHI's work, while suicide impacts many groups, and there is a clear overlap between wealth indexes and caste, caste-based exclusion, atrocities, and marginalisation significantly shape experiences of distress, access to care, access to education, limiting access to livelihood, including access to finance and may increase the risk of suicide. The disproportionate number of suicide deaths among marginalised youth alerts us to the two-fold injustice of systemic oppression and the invisibilisation in popular discourse. This has far-reaching and long-term health consequences, both mentally and physically, that are liable to compound if not addressed. Future research and policy frameworks must prioritise caste-sensitive data collection to meaningfully address suicide prevention in India, and this requires participatory, equal and empowering research methodologies.

Similarly, a more comprehensive intersectional lens would also require researchers and practitioners to go beyond the dominant gender understanding to capture the stressors and suicidality among transgender and gender non-conforming populations, as they represent some of the most vulnerable communities in our country. Similarly, data needs to be collected to reflect the religion, caste, sexuality, disability and other demographic factors shaping the lived reality of people and consequently their mental health.

Findings in this report also prompt us to look further at the narrative of suicides being 'sudden' events, and thereby unpreventable, as many participants discussed chronic stressors and previous attempts of their loved ones. While many may look at such a finding and promote more awareness programs, gatekeeper training and so on, these also underscore the lack of intersectional/intersectoral services that frame a person's ultimate access to care, even if someone could "spot the signs", and call for the simultaneous redressal of such a lack of care and support systems that could lessen suicidal distress. Furthermore, there is a clear need to imagine suicide prevention measures beyond the family – we need to think of other structures and people that can serve as caregivers, especially when the family itself is the site causing and maintaining distress.

Addressing suicide also does not end at prevention – empathetic and effective postvention strategies are required to support those bereaved by suicide deaths. The report highlights the significant emotional distress, social disruption, financial stress and other challenges placed upon families in the wake of suicide deaths. The pressing need for support for children of the deceased presents itself in manifold ways – support for education and upbringing, but also for emotional support that others, the immediate grieving caregivers, may not be able to provide. The significant percentage of suicide deaths due to financial reasons and the high percentage of family members requiring financial and job support post suicide deaths together present a grim picture of the vicious cycle of impoverishment and suicidality.

The paradox of suicide reporting in India is such that it is a topic that is both misunderstood, individualised and easily sensationalised and highlighted in order to grab attention. This is even more true for certain deaths, as seen in the report data – deaths of farmers and young women get reported more frequently because they are deemed to be more “newsworthy”. Over half of the surveyed families did not support newspaper reporting for various reasons, and this number is important because insensitive and oversimplistic headlines about suicide deaths can impact the mental health and well-being of the bereaved families and reduce their ability to cope with the event. The media industry must recalibrate and re-commit to sensitive reporting ethics that prioritise the well-being of the affected people.

This report is important as it presents a cross-sectional, nation-wide picture of the complex nature of suicide deaths and hopefully brings us closer to effecting better prevention and postvention measures. We need more participatory, large-scale research that examines other crucial determinants of this phenomenon—such as caste, sexuality, gender beyond the binary, and disability—and how they co-constitute people’s daily lives while shaping the support networks that are (un)available to them. The facets explored in this report – of police reporting, newspaper coverage, and more also change based on the demographic
profile of the deceased. Addressing such determinants in the literature, so that the academics and policy makers in the suicide prevention space can incorporate a more nuanced understanding in their frameworks, remains a priority for MHI in all work going forward.

# FOREWORD / PHFI

Suicide is among the most pressing public health challenges of our time, claiming hundreds of thousands of lives globally each year and leaving families and communities grappling with profound grief and unanswered questions. In India, the burden of suicide deaths is among the highest in the world, cutting across regions, age groups, and social contexts. While national statistics offer essential insights into trends, patterns, and disparities, they often fail to capture the lived realities behind the numbers—the circumstances, pressures, and emotions that precede a life lost to suicide, and the devastation left behind for those who survive. Comprehensive, reliable, and context-specific evidence is essential to guide prevention strategies that are effective, equitable, and responsive to the needs of those most at risk.

This report brings together two complementary strands of evidence that are critical to shaping effective suicide prevention strategies. The first is a nationally representative survey of deaths that has systematically documented suicide mortality trends across India, providing a comprehensive and rigorous account of the scope and trajectory of the problem. It reveals not only the magnitude of suicide deaths but also the socio-demographic inequalities that persist, helping us identify populations at particular risk and where interventions must be prioritized.

The second, equally important strand, is a detailed sub-survey that goes beyond statistics to hear directly from the bereaved families. These narratives offer profound insight into the reasons, circumstances, and situations surrounding suicide. They remind us that behind every number is a human being—someone's daughter, son, parent, or friend—whose death reverberates across households and communities. Listening to families allows us to understand the interplay of social, economic, cultural, and psychological factors in ways that statistics alone cannot illuminate.

It also brings forward the voices of those left behind, whose needs for support, healing, and inclusion in prevention efforts are often overlooked. By bringing forward the perspectives of the bereaved, the report adds depth to statistical findings and contributes to a more holistic understanding of suicide in India.

Together, the findings of these surveys present an invaluable resource. They highlight the urgent need for multi-sectoral action: better mental health services that are accessible and affordable, policies that reduce social and economic stresses, community-based interventions that foster dialogue and resilience, and stronger systems for early identification and support for those at risk. At the same time, they call for compassion, empathy, and recognition that suicide prevention is not only the responsibility of health systems but of societies as a whole.

This report stands as both a mirror and a guide. It reflects the stark realities of suicide in India, while also offering direction for research, policy, and programmatic responses. Its strength lies in combining the rigor of large-scale epidemiological data with the humanity of personal accounts. In doing so, it underscores that effective prevention must be rooted not only in evidence but also in empathy.

We hope that the insights presented here will inform policymakers, researchers, practitioners, and communities in India and beyond. Most importantly, we hope they will inspire collective action—so that lives can be saved, suffering reduced, and families spared the lifelong impact of losing a loved one to suicide. The loss of life to suicide is both a public health tragedy and a call to action. Through evidence-based policies, coordinated programmes, and sustained commitment, India can make significant progress in reducing suicide mortality and supporting those most affected.

**Prof. Rakhi Dandona**

Director
Injury Prevention Research Centre
Public Health Foundation of India

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# BACKGROUND

Suicide is a serious global public health issue with an estimated 700 000 people dying by suicide every year globally.[1] The reduction in suicide mortality is included as an indicator in the Sustainable Development Goals (SDGs) target,[2] as well as in the World Health Organization's Mental Health Action Plan 2013–2020, now extended to 2030.[3]

India's contribution to global suicide deaths increased from 24.3% in 1990 to 32.9% in 2021 among females, and from 17.9% to 21.9% among males,[4] in the background of India having 18% of the global population. The Global Burden of Disease (GBD) Study estimated 185,000 suicide deaths in India in 2021, the highest number of suicide deaths globally. Suicide is the leading cause of death in the 15-39 years age group in India.[5,6] Importantly, suicide mortality rate among Indian females is twice the global rate (5.7 per 100,000 females). Based on current trends, India will not reach the SDG 2030 target of one-third reduction in suicide death rate.[5]

A comprehensive response to suicide prevention is critical to ensure that suicides do not continue to cost lives and affect many millions through the loss of loved ones or suicide attempts in India.

After several calls over many years, India released the National Suicide Prevention Strategy (NSPS) in November 2022 to address the significant burden of suicide deaths.[7]
While this is a welcome development, NSPS did not utilize fully the available epidemiological evidence on suicide deaths in a manner that could facilitate planning of effective interventions to enhance the desired outcomes.[7]
The official source for suicide deaths in India for policy making and monitoring are the National Crimes Record Bureau (NCRB) reports which is also the basis of the NSPS.[6] The NCRB report, in turn, is based on the First Information Report (FIR) completed by a police officer for suicide death case.[6, 8, 9]
The pre-tabulated format in the NCRB report significantly limits the understanding of suicide deaths and

related risk factors by age, sex, marital status and occupation to allow for meaningful interpretation for action.[5, 10-13] Our recent work by extrapolating the NCRB data for females at the population-level has highlighted the predominance of suicide deaths among the educated females and similar suicide death rate between the currently married and never married females, and variations in the reasons for and means of suicide at the state-level highlight the need for specific and multi-sectoral interventions to address these deaths.[13] Importantly, this analyses supports the importance of incorporating sociological insights into how the external social environment can matter to suicide and suicide prevention, which may help us better understand the complexity of suicide and determine how to effectively intervene.[13] Notably, the NCRB documented 170,924 deaths by suicide in 2022,[6] and is known to under-enumerate suicide deaths.[5, 14, 15]

Furthermore, families experiencing suicide loss often face a range of intense emotions, such as guilt, anger, and confusion, which can differ from reactions to other forms of death. Suicide bereavement is also associated with an increased risk of mental health issues, including depression and anxiety, and also of an increased risk of self-harm or suicide among those impacted by suicide. The need for research to plan effective postvention strategies for families bereaved by suicide is critical due to the unique complexities surrounding grief after a suicide death. Research in this area is vital to understanding the specific needs of these families, which can vary greatly depending on factors such as culture, family dynamics, the existing or continuing of the risk factors that led to suicide, and prior mental health history. Evidence-based postvention strategies can provide tailored support to help families navigate their grief while reducing the stigma and isolation often associated with suicide.

Furthermore, understanding the long-term effects of suicide bereavement can guide the development of interventions that not only address immediate emotional needs but also promote suicide prevention, resilience and healing over time. Additionally, research can inform best practices for professionals, such as counsellors, social workers, and healthcare providers, ensuring that they are equipped with the knowledge and skills necessary to offer compassionate, appropriate care. By prioritizing research in this field, society can better support bereaved families, help prevent further tragedies, and foster a more understanding and compassionate approach to suicide prevention and postvention.

However, there is a significant disparity in the availability of evidence on postvention strategies for families bereaved by suicide in low- and middle-income countries (LMICs) compared to high-income countries (HICs). In HICs, suicide postvention research is relatively more advanced, with studies that inform tailored interventions, community support models, and mental health care approaches for families affected by suicide. However, in LMICs, where resources for mental health services are often scarce, there is limited research on postvention strategies despite the growing burden of suicide in many of these countries. Several factors contribute to this gap.

In LMICs, mental health systems are often underfunded and understaffed, with a focus on addressing more immediate public health concerns. Additionally, stigma surrounding suicide may further hinder open discussion, research, and the provision of support for those left behind.

The poor knowledge about local customs, beliefs, and family dynamics in relation to suicide deaths makes it difficult to develop evidence-based postvention interventions that are relevant to those affected. Moreover, the limited research in LMICs often leaves health professionals unprepared to respond adequately to the unique challenges that suicide-bereaved families face, such as increased mental health risks and social isolation. Expanding research on suicide postvention in LMICs is crucial to developing strategies that can address the cultural, social, and economic barriers to care, ultimately helping to reduce the impact of suicide on families and communities. Without this focus, postvention efforts in LMICs remain inadequate compared to those in HICs.

# CONTEXT

The Public Health Foundation of India (PHFI) has recently completed a nationally representative survey covering 1 million population of all ages in 9 states – Assam, Gujarat, Haryana, Jharkhand, Kerala, Maharashtra, Odisha, Tamil Nadu, and Uttar Pradesh. The survey population was enumerated in 50 districts in these 9 states, and 29,273 deaths of all ages between 2019 and 2022 were captured to arrive at cause-specific mortality using verbal autopsy interviews.

**Figure 1** depicts the study design. Objective 1 for this project utilizes data from this national survey and an in-depth survey was undertaken prospectively towards objective 2 utilizing the suicide deaths captured in 3 of the 9 states from the national survey.

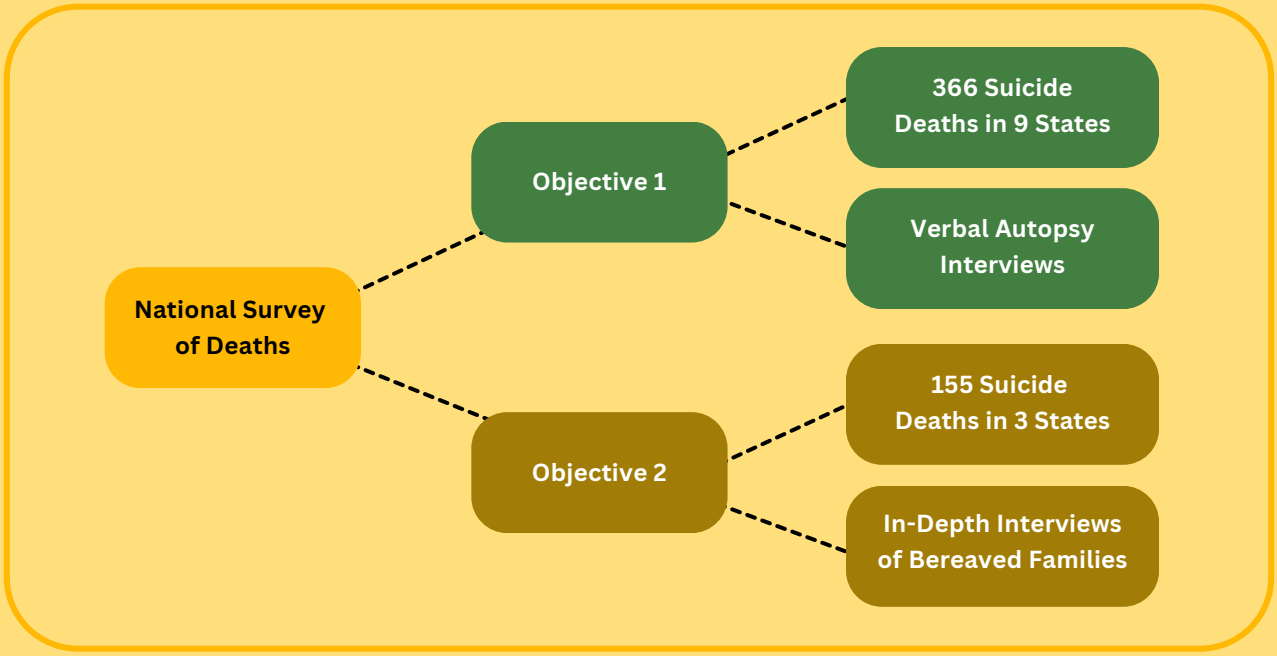



**Figure 1. Study design for objective 1 and objective 2**

# AIM & OBJECTIVES

The overarching aim of this project is to provide guidance in planning for suicide prevention and postvention strategies for the bereaved families utilizing the sample of suicide deaths captured in a nationally representative sample of deaths that occurred between 2019 and 2022.

### ■ Objective 1

The specific objectives from the **national survey of cause of death** are to:

- Estimate the suicide death rate in India between 2019 and 2022, by age, sex and urbanicity
- Assess the impact of COVID-19 pandemic on suicide death rate in India
- Explore the sex-disaggregated understanding of the reasons for suicide deaths by age and marital status
- Document the state-level variations in the means and reasons for suicide deaths

### ■ Objective 2

The specific objectives of the **in-depth study** are to:

- Assess state and sex variations in the reason(s) for suicide and signs of suicide risk in the deceased as identified by the bereaved family
- Understand history of self-harm in those who died by suicide
- Document the reasons for under-reporting of suicide deaths to the police
- Explore perspectives of the bereaved family on reporting of suicide death in the newspaper
- Identify the support needs of the bereaved families by taking into account the socio-demography of the deceased
- Assess perspectives of the bereaved family on reasons for suicide deaths in India

# METHODS

## Objective 1 : National Survey

### ■ Sampling Frame

Detailed sampling methods for the survey are reported previously, and methods relevant to this report are described.[16] Nine states as shown in **Figure 2** —Assam, Gujarat, Haryana, Jharkhand, Kerala, Maharashtra, Odisha, Tamil Nadu, and Uttar Pradesh—were selected as per the sampling criteria described elsewhere.[16]

The sample size for deaths was estimated 25,800 deaths for 1,000,000 population[16] sample based on the crude death rate for each of the sampled state and the assumed excess deaths in these sampled states during January 2020 to December 2021.

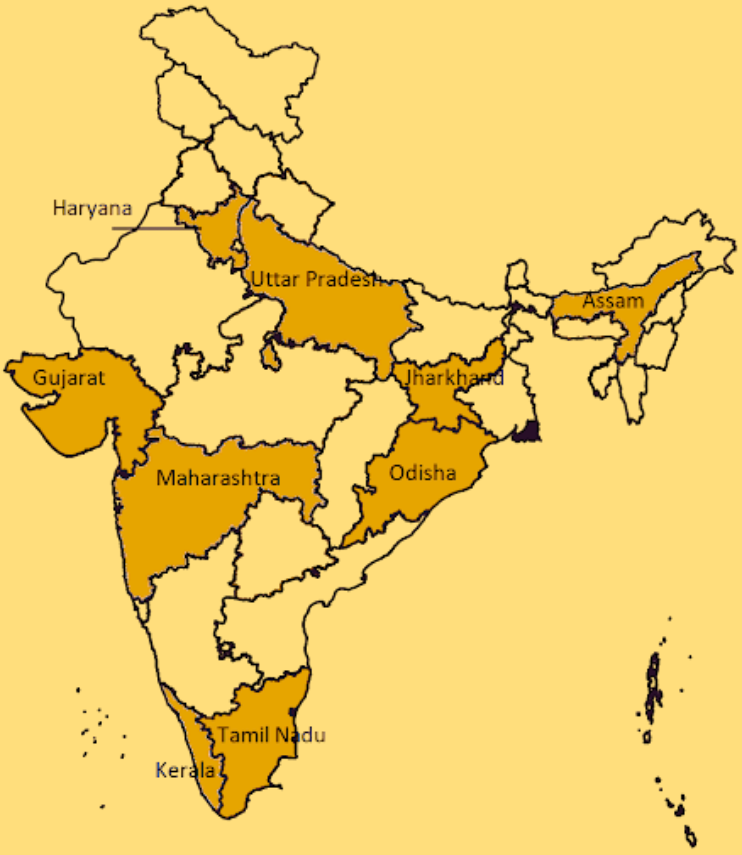



**Figure 2: States selected for the national survey**

Following the state selection, a multi-stage sampling procedure was used to select 1,000 clusters from 50 districts in the nine sampled states with the aim of having a sample representative of the population of India. The number of districts were distributed across the 9 sampled states based on the total population in these states. Four districts each were sampled in the states of Odisha, Kerala, Jharkhand, Assam and Haryana; 6 districts each in Gujarat and Tamil Nadu; 8 districts in Maharashtra; and 10 districts in Uttar Pradesh. The districts in each state were sampled randomly until a reasonable geographic spread was achieved within the state.[16] In the selected districts, we divided large villages into segments of 1,000 population each, and combined villages with smaller population with others to make a cluster size of 1,000 population each.

We then systematically selected the rural clusters from the villages with the first cluster sampled randomly, and similarly the urban clusters from the wards. All households in the sampled cluster were mapped and listed in a serpentine pattern starting from the north-east corner and ending in the opposite corner. A household was defined as people eating from the same kitchen. The survey population was enumerated in 50 districts in these 9 states, and 29,273 deaths of all ages between 2019 and 2022 were captured to arrive at cause-specific mortality using verbal autopsy interviews.

## Data Collection

Data collection was undertaken from January to August 2023. Trained interviewers documented the number of current usual residents, in-migration and out-migration, and deaths between January 2019 and December 2022 in all households during enumeration.

All households with at least one death between January 2019 and December 2022 were considered eligible for detailed survey. At least three attempts were made to reach all eligible households. Confidential interviews were undertaken in local language with the adult who was most knowledgeable about the deceased to ascertain the cause of death using the Population Health Metrics Research Consortium (PHMRC) verbal autopsy (VA) questionnaire.[17] The PHMRC VA questionnaire, which is in English, was translated into the local languages of the sampled states, and then back-translated into English to ensure accurate and relevant meaning and intent of the questions. Specific to this report, data were collected on socio-demography of the deceased, mode of suicide, and reasons for suicide. In the open narrative section, the respondent was asked to narrate the context of suicide in his/her own words which was documented in verbatim by the interviewer in the local language. The interview data were captured using Open Development Kit software in hand-held tablets.[18] Data entered were scrutinized using the internal consistency checks built in to detect and correct errors using the procedures standardized in the study for data quality. In addition, spot- and back-check techniques were adopted to assess and maintain the quality of interview data collected.

## Objective 2 : In-Depth Study

### Sampling Frame

Of the nine states that were considered in the above survey, three states which accounted for the most suicide death cases were considered for in-depth study – Uttar Pradesh, Maharashtra, and Tamil Nadu. A total of 53, 91, and 75 households were sampled for contact in Uttar Pradesh, Maharashtra, and Tamil Nadu, respectively.

### Data Collection

Data collection was undertaken from October 2024 to January 2025. Trained interviewers captured the following information in confidential semi-qualitaitve interviews:
Household and socio-demographic details – number of household members, occupation and marital status of the deceased, details of spouse if applicable.

- Suicide death related information - reason for suicide, self-harm and mental health history
- Support services – support and coping strategies utilised by the family, exploring level of communication, perception about suicide, and mental health of family members

Pilot testing of the in-depth interview questions was carried out in Haryana state of India and modifications made as necessary. The interview data were captured using Research Electronic Data Capture (REDCap) software in hand-held tablets.[19] Data entered were scrutinized using the internal consistency checks built in to detect and correct errors using the procedures standardised in the study for data quality. Three supervisors monitored the interviewers to standardise the data capture and maintain the quality of interview data collected.

## Considerations

Ethics approval for the study was obtained from the Institutional Review Board of PHFI. The proposed research was conducted according to the ethics guidelines issued by the Indian Council of Medical Research and the participants were treated as per the Declaration of Helsinki.

The participants were provided with Participant Information Sheet (PIS) detailing the purpose of the research, investigators involved, what is expected from the participants, benefit to the participant/society, compensation for injury, support needed as a result of participation, and contact of the site investigator and the Review Board for clarification or complaints.
The participants were informed that a decision not to take part in the research will have no impact on them. The PIS was developed in English, and was translated into local languages, and then back translated into English to check that the intended meaning was retained. The participants were administered the PIS in the language of their preference. The PIS was read out to the participants who were unable to read or write in the presence of a witness as selected by the participant.

After detailed explanation to the participants and answering their queries if any, they were requested to sign on the Informed Consent Form in the language of their preference. Those who cannot read or write were asked to put thumb impression.

The research staff had the necessary skills to ask questions sensitively, respond and provide appropriate immediate support when participants displayed any sign of distress.

A protocol for referral was established for the in-depth study. All participants, irrespective of the voiced need for mental health support, were provided with a list of mental health support services available in their district for in-person consultation, and also with the phone numbers of telephone helplines available in the state or country-wide. In case a participant was to be identified as needing more care, the protocol was in place for the field coordinator to call a senior mental health expert at the All India Institute of Medical Sciences (AIIMS, New Delhi) for telephonic consultation and guidance on the next steps.

# FINDINGS FROM THE NATIONAL SURVEY

## Participation

A total of 29,273 deaths between January 2019 to December 2022 were enumerated in 240,975 (87•1% participation rate) households with an average population of 1,002,098 in the national survey. Detailed interviews were available for 26,964 (92•1% participation rate) deaths including 11,093 (41•1%) female deaths and 19,303 (71•6%) deaths in rural areas.

## Suicide Deaths

A total of 366 (1•47%) suicide deaths were identified in the national survey. Distribution of suicide deaths among all deaths is shown in Table 1. The proportion of suicide deaths for both males and females varied significantly by age, marital status, and region among all deaths. The proportion of suicide deaths among all deaths 10 years of age or more was significantly higher in deaths in 15 to 29 years for both males and females, and in deaths of never married people for both males and females.

The proportion of male suicide deaths was higher in the states of Kerala (3.29%) and Maharashtra (2.83%) whereas the female suicide deaths were higher in Tamil Nadu (2.34%).

## Mean Age at Death

Considering both the sexes combined, the mean age at suicide death was estimated at 36 years, which was lower than the mean age at death irrespective of the other cause of death at 64 years.

The mean age at suicide death in India was similar in both urban and rural areas, at 36 years. Kerala had the highest mean age of suicide death (46 years) while it was the lowest in Jharkhand (26 years) as shown in **Figure 3.**

Across all the states, the mean age at suicide death was generally higher in the rural areas than in the urban areas, except in Jharkhand.

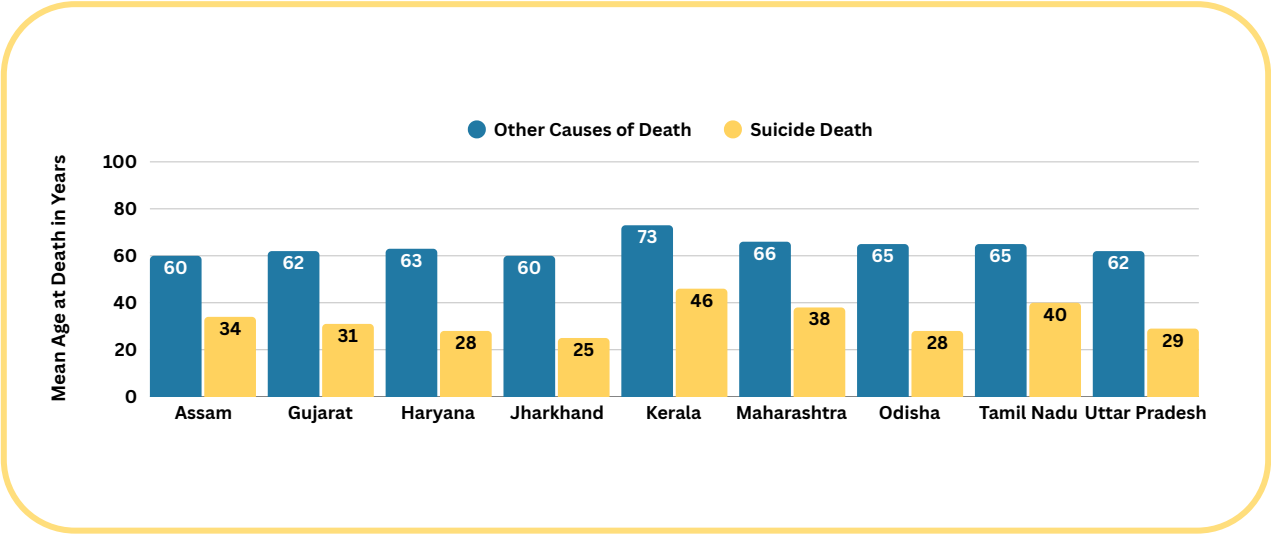



**Figure 3. Mean age at death for suicide death vs other causes of death for both sexes combined, by state**

| Table 1. Distribution of suicide deaths among deaths aged 10 or more years irrespective of the cause of death by select demographic characteristics | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | Male | | | Female | | |
| Variable | Variable category | All deaths aged 10 or more N=14,710 (% of N) | Suicide deaths (% of variable category) | Chi-square test of significance p-value | All deaths aged 10 or more N=10,166 (% of N) | Suicide deaths (% of variable category) | Chi-square test of significance p-value |
| Overall | | 14,710 (100) | 252 (1.71) | | 10,166 (100) | 114 (1.12) | |
| Age group (years) | 10-14 | 93 (0.6) | 6 (6.43) | <0.001 | 84 (0.8) | 2 (2.38) | <0.001 |
| | 15-19 | 206 (1.4) | 21 (10.19) | | 187 (1.8) | 24 (12.83) | |
| | 20-24 | 281 (1.9) | 22 (7.83) | | 207 (2.0) | 22 (10.63) | |
| | 25-29 | 389 (2.6) | 49 (12.60) | | 215 (2.1) | 28 (13.02) | |
| | 30-34 | 421 (2.9) | 19 (4.51) | | 167 (1.6) | 8 (4.79) | |
| | 35-39 | 576 (3.9) | 23 (3.99) | | 201 (2.0) | 8 (3.98) | |
| | 40-44 | 674 (4.6) | 22 (3.26) | | 263 (2.6) | 8 (3.04) | |
| | 45-49 | 883 (6.0) | 21 (2.38) | | 336 (3.5) | 3 (0.84) | |
| | 50-54 | 937 (6.4) | 19 (2.03) | | 465 (4.6) | 2 (0.43) | |
| | 55-59 | 1,069 (7.3) | 11 (1.03) | | 599 (5.9) | 1 (0.17) | |
| | 60 or more | 9,181 (62.4) | 39 (0.42) | | 7,422 (73.0) | 8 (0.11) | |
| Marital Status | Never Married | 1,177 (8.0) | 88 (7.48) | <0.001 | 494 (4.9) | 36 (7.29) | <0.001 |
| | Previously Married | 11,612 (78.9) | 156 (1.34) | | 5,255 (51.7) | 70 (1.33) | |
| | Currently Married | 1,921 (13.1) | 8 (0.42) | | 4,417 (43.5) | 8 (0.18) | |
| Wealth index quartile* | Quartile 1 | 3,592 (24.4) | 51 (1.42) | 0.080 | 2,297 (22.6) | 31 (1.35) | 0.511 |
| | Quartile 2 | 3,601 (24.5) | 67 (1.86) | | 2,543 (25.0) | 26 (1.02) | |
| | Quartile 3 | 3,724 (25.3) | 78 (2.09) | | 2,650 (26.1) | 32 (1.21) | |
| | Quartile 4 | 3,787 (25.8) | 56 (1.48) | | 2,671 (26.3) | 25 (0.94) | |
| Urbanicity | Urban | 4,413 (30.0) | 85 (1.93) | 0.192 | 2,941 (28.9) | 33 (1.12) | 0.997 |
| | Rural | 10,297 (70.0) | 167 (1.62) | | 7,225 (71.1) | 81 (1.12) | |

| | | Male | | | Female | | |
|---|---|---|---|---|---|---|---|
| Variable | Variable category | All deaths aged 10 or more N=14,710 (% of N) | Suicide deaths (% of variable category) | Chi-square test of significance p-value | All deaths aged 10 or more N=10,166 (% of N) | Suicide deaths (% of variable category) | Chi-square test of significance p-value |
| State | Assam | 1,304 (8.9) | 15 (1.15) | <0.001 | 821 (8.1) | 12 (1.46) | 0.001 |
| | Gujarat | 1,257 (8.6) | 14 (1.11) | | 834 (8.2) | 14 (1.68) | |
| | Haryana | 1,117 (7.6) | 11 (0.98) | | 616 (6.1) | 5 (0.81) | |
| | Jharkhand | 1,170 (8.0) | 8 (0.68) | | 802 (7.9) | 7 (0.87) | |
| | Kerala | 1,217 (8.3) | 40 (3.29) | | 1,014 (10.0) | 7 (0.69) | |
| | Maharashtra | 2,827 (19.2) | 80 (2.83) | | 1,835 (18.1) | 11 (0.60) | |
| | Odisha | 1,415 (9.6) | 6 (0.42) | | 1,119 (11.0) | 7 (0.63) | |
| | Tamil Nadu | 1,712 (11.6) | 51 (2.98) | | 1,068 (10.5) | 25 (2.34) | |
| | Uttar Pradesh | 2,691 (18.3) | 27 (1.00) | | 2,057 (20.2) | 26 (1.26) | |
| Region of India† | Central | 2,691 (18.3) | 27 (1.00) | <0.001 | 2,057 (20.2) | 26 (1.26) | 0.131 |
| | East | 2,585 (17.6) | 14 (0.54) | | 1,921 (18.9) | 14 (0.73) | |
| | West | 4,084 (27.8) | 94 (2.30) | | 2,669 (26.3) | 25 (0.94) | |
| | North-east | 1,304 (8.9) | 15 (1.15) | | 821 (8.1) | 12 (1.46) | |
| | North | 1,117 (7.6) | 11 (0.98) | | 616 (6.1) | 5 (0.81) | |
| | South | 2,929 (19.9) | 91 (3.11) | | 2,082 (20.5) | 32 (1.54) | |

*Data missing for 11 deaths

†North: Haryana, East: Jharkhand and Odisha; South: Kerala and Tamil Nadu; West: Gujarat and Maharashtra; Central: Uttar Pradesh; and North-east: Assam

The mean age at suicide death was lower for females (30 years) than for males (39 years) a pattern observed across most states **(Figure 4)**, with the largest age gap between male and female suicide deaths observed in Maharashtra (14 years) followed by Gujarat (10 years). Kerala had the highest mean age at suicide for both males (46 years) and females (43 years), while Jharkhand the lowest, particularly for females (20 years).

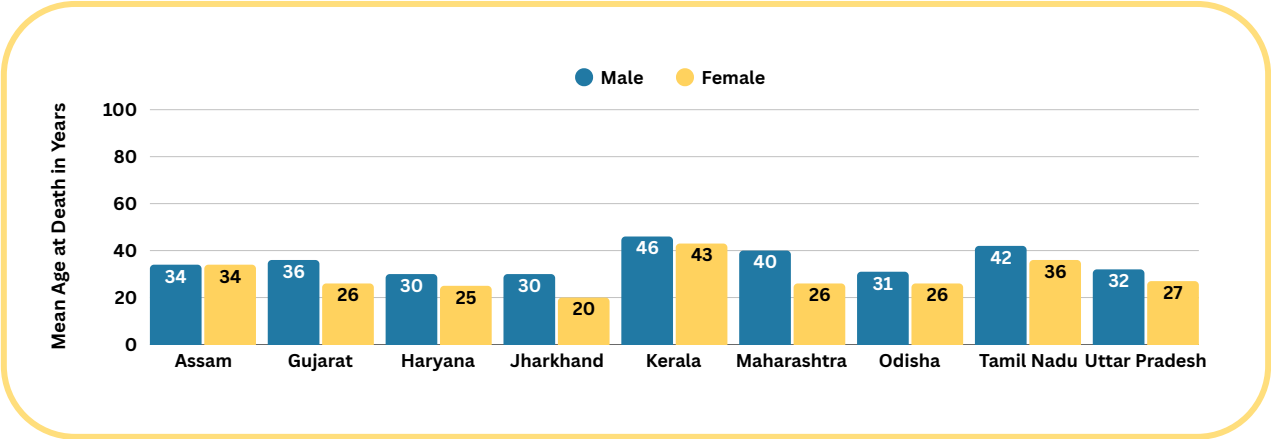



**Figure 4. Mean age at death for male and female suicide deaths, by state**

## Suicide Mortality Rate

The annualised suicide mortality rate for India was estimated at 10.0 (95% CI 7.4-12.7); this rate was higher for males (12.8 per 100,000 males) than for females (7.3 per 100,000 females) but this difference was not statistically significant **(Table 2)**. Rural areas (10.4, 95% CI 7.2-13.7) had a slightly higher suicide mortality rate than urban (9.23; 95% CI 4.6-13.9) but not statistically significant.

The highest suicide mortality rate was observed in the south region (19.6; 95% CI 11.4-27.8) followed by the west region (12.7; 95% CI 6.9-18.4).

Additionally, the suicide mortality rate was significantly higher during the COVID-19 period (17.7; 95% CI 14.3-21.1) compared to the pre-COVID-19 period (11.9; 95% CI 9.0-14.8) as shown in **Table 3.**

| Table 2. Annualised suicide mortality rate in India, 2019-2022 | | |
|---|---|---|
| | Variable category | Annualised adjusted suicide mortality rate (95% confidence interval) |
| Overall | | 10.0 (7.4-12.7) |
| Sex | Male | 12.8 (8.6-17.0) |
| | Female | 7.3 (4.1-10.4) |
| Urbanicity | Rural | 10.4 (7.2-13.7) |
| | Urban | 9.3 (4.6-13.9) |
| Region of India† | Central | 7.7 (2.3-13.0) |
| | East | 4.3 (0.3-8.4) |
| | West | 12.7 (6.9-18.4) |
| | North-east | 8.2 (0.5-15.8) |
| | North | 6.6 (0-14.6) |
| | South | 19.6 (11.4-27.8) |

*North: Haryana, East: Jharkhand and Odisha; South: Kerala and Tamil Nadu; West: Gujarat and Maharashtra; Central: Uttar Pradesh; and North-east: Assam

| Table 3. Adjusted suicide mortality rate in India based on COVID-19 pandemic | | | | |
|---|---|---|---|---|
| | | Annualised adjusted suicide mortality rate (95% confidence interval) | | |
| | | Pre- COVID-19 Period (January 2019 to March 2020) | Pre- COVID-19 Period (April 2020 to February 2022) | Pre- COVID-19 Period (March 2022 to December 2022) |
| Overall | | 11.9 (9.0-14.8) | 17.7 (14.3-21.1) | 9.0 (6.5-11.4) |
| Sex | Male | 14.3 (9.8-18.7) | 23.7 (18.1-29.3) | 10.7 (6.9-14.6) |
| | Female | 9.5 (5.9-13.2) | 11.5 (7.6-15.4) | 7.2 (4.1-10.3) |
| Urbanicity | Rural | 12.0 (8.56-15.5) | 18.8 (14.6-23.0) | 8.6 (5.7-11.5) |
| | Urban | 11.5 (6.3-16.7) | 15.6 (9.6-21.6) | 9.7 (5.0-14.4) |

| Table 3. Adjusted suicide mortality rate in India based on COVID-19 pandemic | | | | |
|---|---|---|---|---|
| | | Annualised adjusted suicide mortality rate (95% confidence interval) | | |
| | | Pre- COVID-19 Period (January 2019 to March 2020) | Pre- COVID-19 Period (April 2020 to February 2022) | Pre- COVID-19 Period (March 2022 to December 2022) |
| Region of India† | Central | 12.7 (5.1-20.3) | 12.0 (4.7-19.3) | 5.4 (0.6-10.2) |
| | East | 3.7 (0-7.7) | 6.6 (1.8-11.3) | 5.5 (0.7-10.2) |
| | West | 11.4 (4.8-17.9) | 27.3 (17.2-37.4) | 11.8 (5.2-18.4) |
| | North-east | 0 | 2.3 (0-6.7) | 2.5 (0-7.1) |
| | North | 10.2 (0-23.5) | 11.0 (0-24.7) | 4.9 (0-14.0) |
| | South | 22.4 (8.1-36.7) | 36.9 (18.7-55.0) | 18.9 (5.9-31.9) |

*North: Haryana, East: Jharkhand and Odisha; South: Kerala and Tamil Nadu; West: Gujarat and Maharashtra; Central: Uttar Pradesh; and North-east: Assam

## Age-specific Suicide Mortality Rate

The annualised age-specific suicide mortality rate for males and females are shown in **Figure 5**. The males age-specific suicide mortality rate was the highest in the 25-29 age group at 25.5 per 100,000 population and the lowest in the 10-14 age group at 3.0 per 100,000 population, with wide confidence intervals indicating substantial uncertainty in the estimates. On the other hand, the females age-specific suicide mortality rate was the highest in the 25-29 years (17.2 per 100,000 population) and 20-24 years (11.3 per 100,000 population)) age groups, and the lowest rates were observed in 10-14 years (0.9 per 100,000 population). The wide confidence intervals indicate considerable uncertainty in these estimates across the age groups.

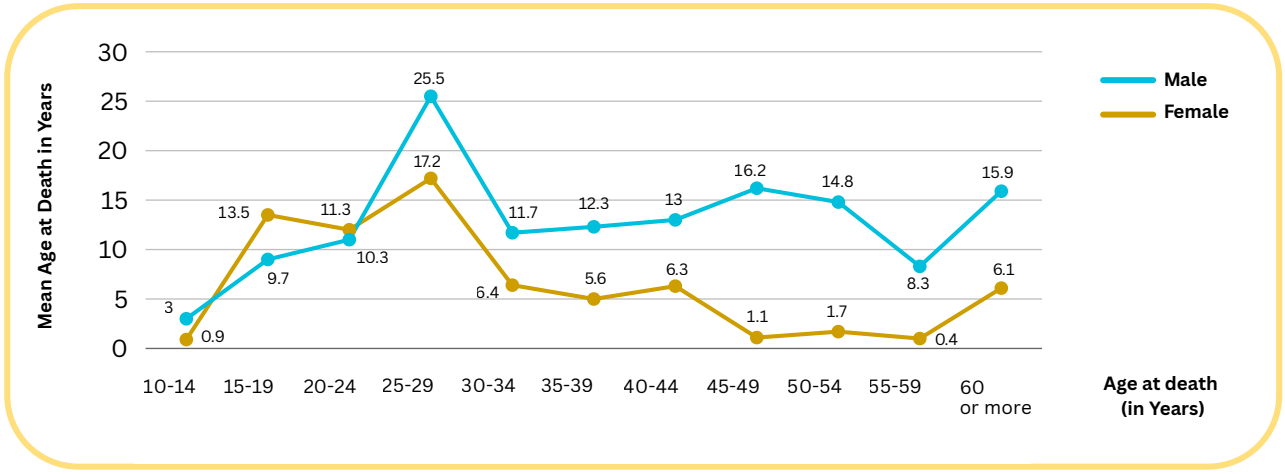



**Figure 5. Annualised age-specific suicide mortality rate in India, 2019-2022**

## Mode of Suicide

Considering both sexes combined, hanging accounted for 67.2% of all suicide deaths followed by poisoning (21.3%) and self-immolation (5.7%). Hanging accounted for 70.6% of male suicide deaths and 59.7% of all female suicide deaths **(Figure 6)**. The proportion of poisoning as the mode of death was similar for males (21.4%) and females (21.1%). Self-immolation was was reported only for female suicide deaths at 11.4%. State variations were seen in the mode of suicide **(Figure 6)**. Hanging was the most common mode of suicide across all states while poisoning was most frequent in Haryana (37.5%) and Gujarat (25.0%); whereas self-immolation was notably higher in Kerala (10.6%) and Uttar Pradesh (11.3%), while drowning and jumping were less commonly reported across states **(Figure 7)**.

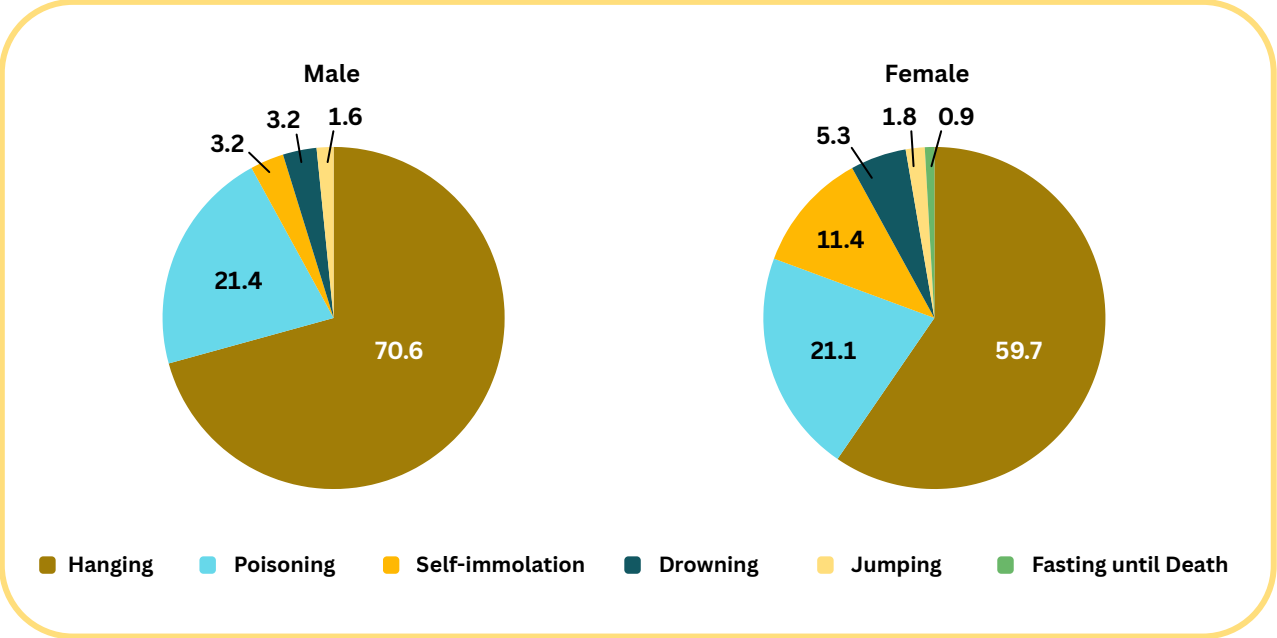



**Figure 6. Distribution of mode of suicide**

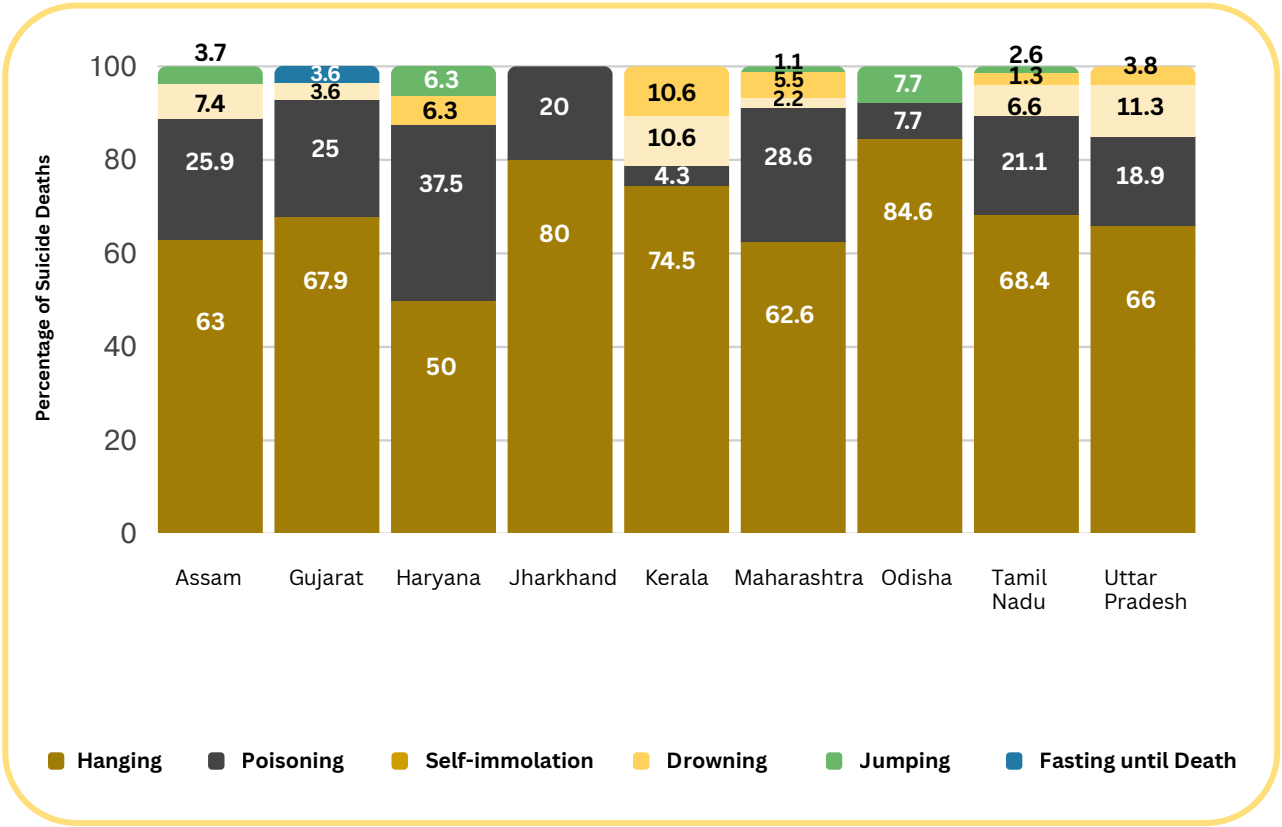



**Figure 7. Distribution of mode of suicide, by state**

## Reasons for Suicide Deaths

Among the 366 suicide deaths, a single reason was cited for 260 deaths (71.0%), two reasons for 22 deaths (6.0%), and no reason was given for 84 (23%) deaths. The reasons for suicide death varied across the states **(Figure 8)**, with family-related reason leading in Uttar Pradesh (38.6%), Tamil Nadu (35.8%), and Haryana (37.5%), while financial reason in Maharashtra (33.7%).

**Figure 9** shows the distribution of reasons for suicide for males and female suicide deaths. Health-related issues (25.3%) were reported for a quarter of male suicide deaths (25.3%) followed by family-related (22.3%) and financial-related reasons (18.0%). On the other hand, family-related reasons (33.3%) was the leading reason reported for female deaths followed by health-related reasons (23.4%). Overall, financial reasons were significantly more likely to be reported for males than female suicide deaths ($p<0.001$) whereas family-related reasons were more likely to be reported for females as compared with male suicide deaths ($p=0.03$). Importantly, reason for suicide not known was reported both for males (22%) and females (27.9%) suicide deaths but this difference was not statistically significant.

**Figures 10-12** shows the distribution of reasons for suicide by urbanicity, marital status, and wealth index for males. Among males, financial reasons were more significantly more likely to be reported in rural areas (27.5%) than in urban areas (12.9%; $p=0.009$) and for those married (29.8%) than never married (9.1%; $p<0.001$). Financial reasons for suicide were reported more commonly in wealth index quartile III (28.2%) and the proportion of reason unknown was the highest in the lowest wealth index quartile (33.3%) but these were not statistically significant. The sub-themes of each type of reason are shown in **Table 4** for males.

**Figures 13-15** shows the distribution of reasons for suicide urbanicity, marital status, and wealth index for females. For female deaths, family issues were significantly more likely to be reported for married females (44.9%) as compared with never married females (13.9%; $p=0.001$). Family issues were the leading reason across all wealth index quartiles, particularly in quartile II (42.3%) and the reason unknown was the highest in the lowest wealth index quartile (38.7%) though not statistically significant. The sub-themes of each type of reason are shown in **Table 5** for females.

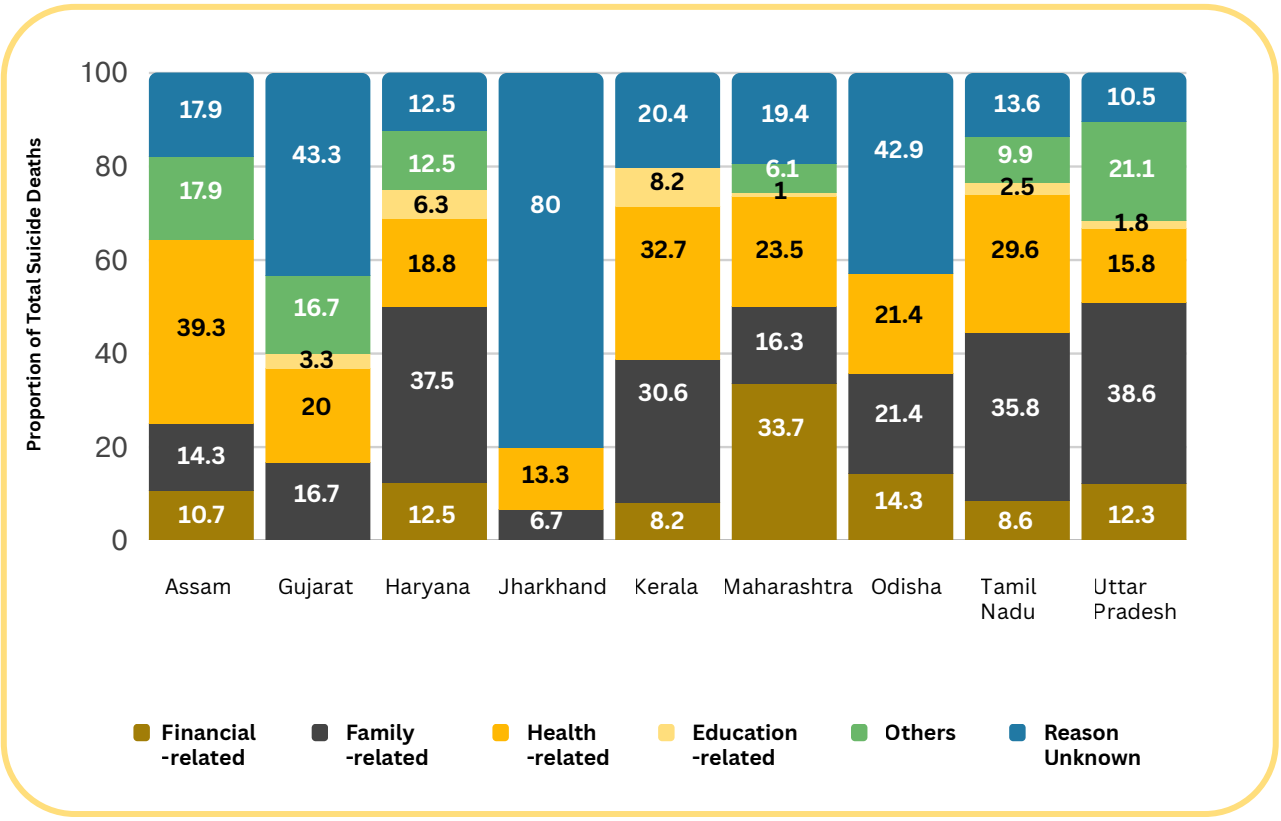



**Figure 8. Distribution of reasons for suicide death, by state**

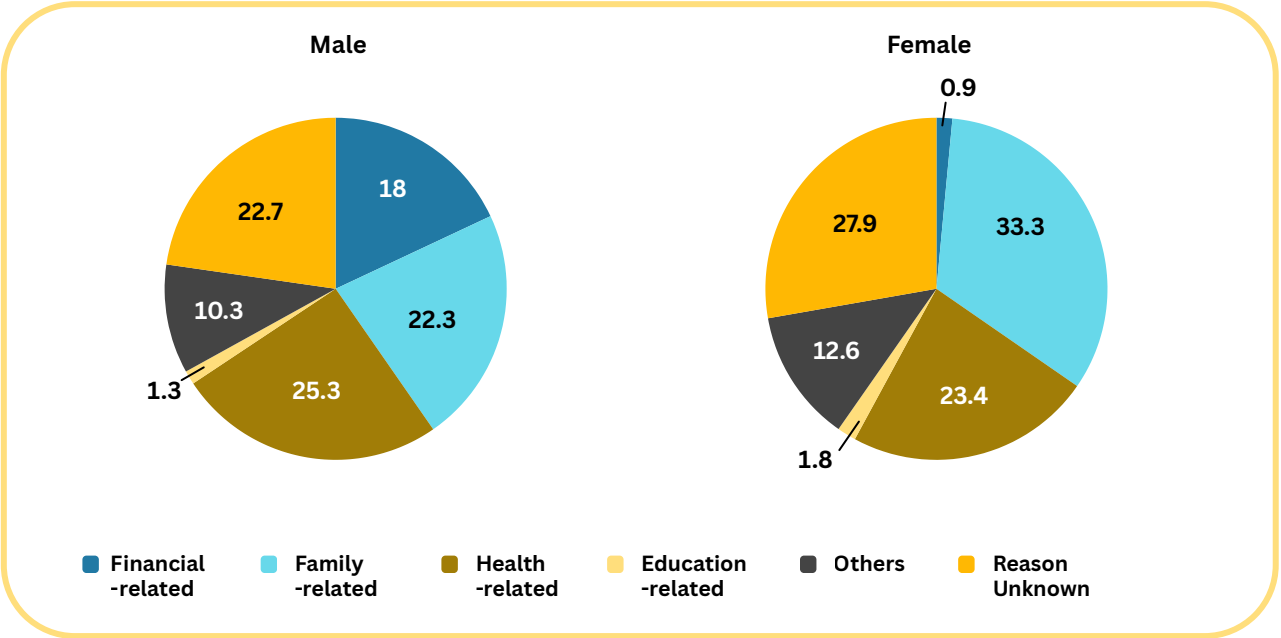



**Figure 9. Distribution of reasons for suicide death**

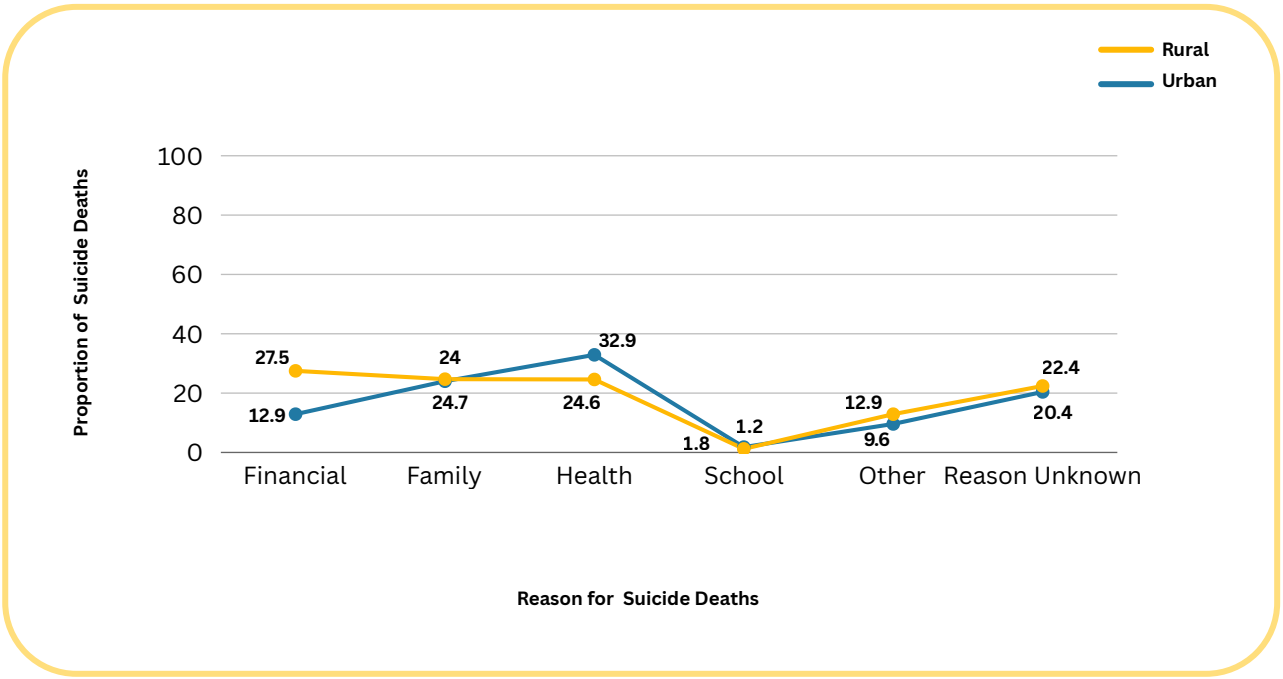



**Figure 10. Distribution of reasons for male suicide deaths by urbaniticity**

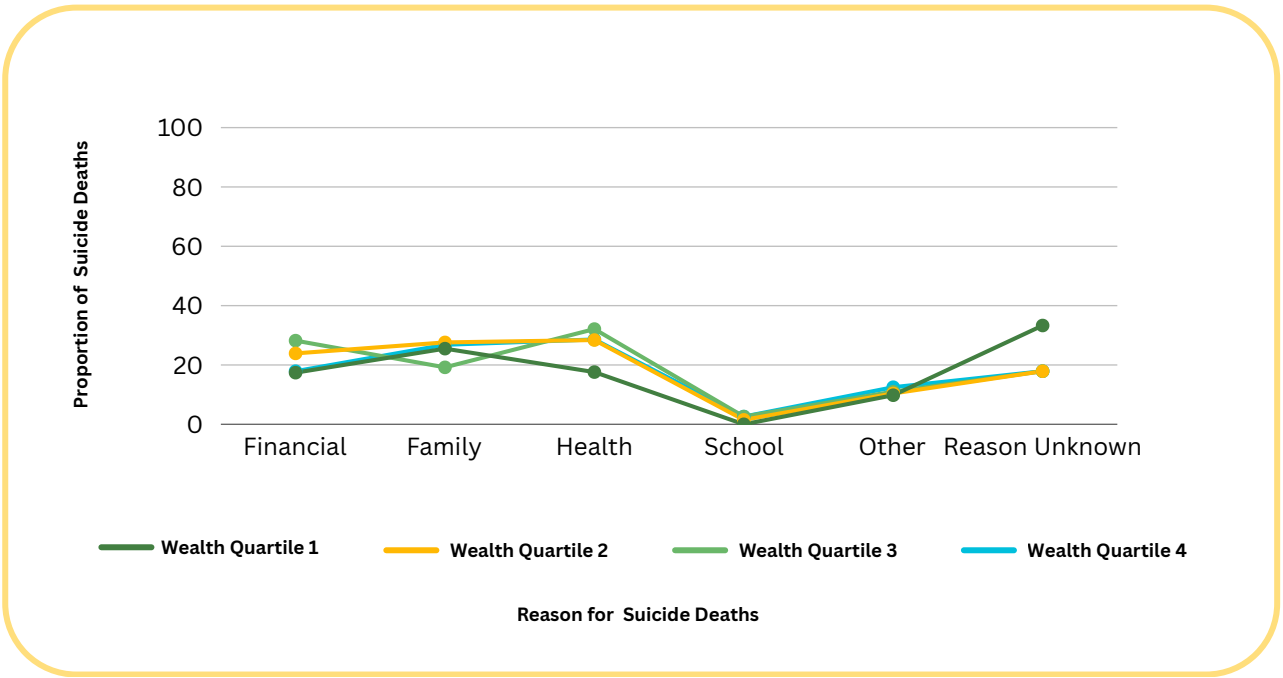



**Figure 11. Distribution of reasons for male suicide deaths by wealth index quartile**

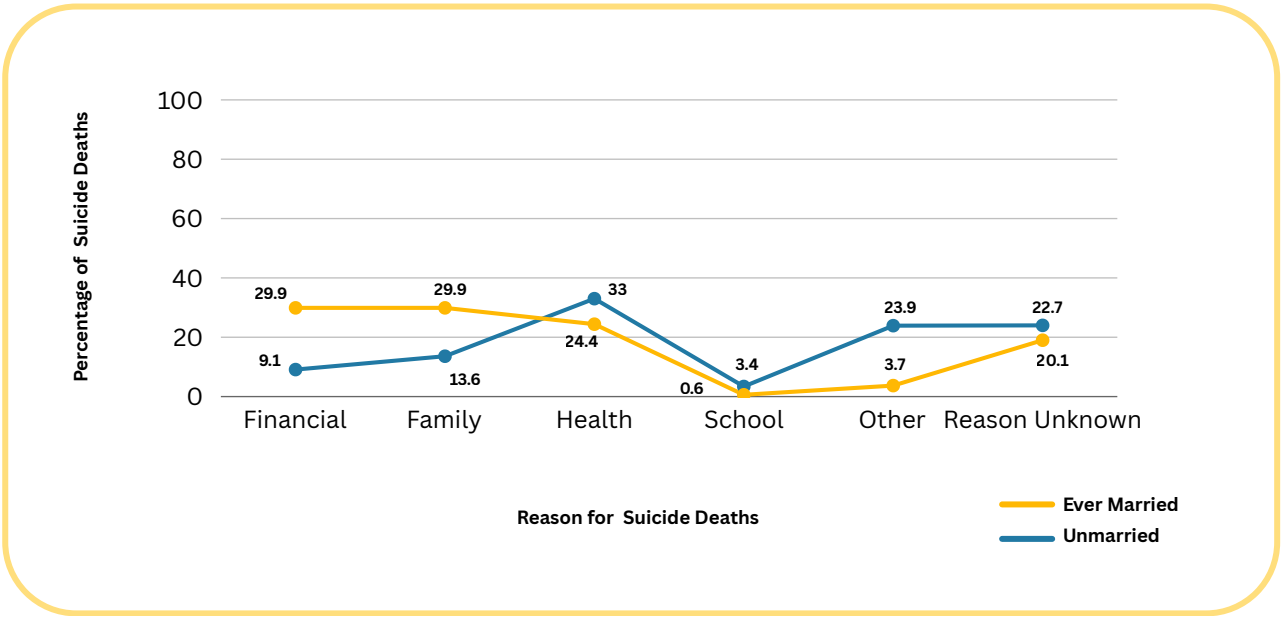



**Figure 12. Distribution of reasons for male suicide deaths by marital status**

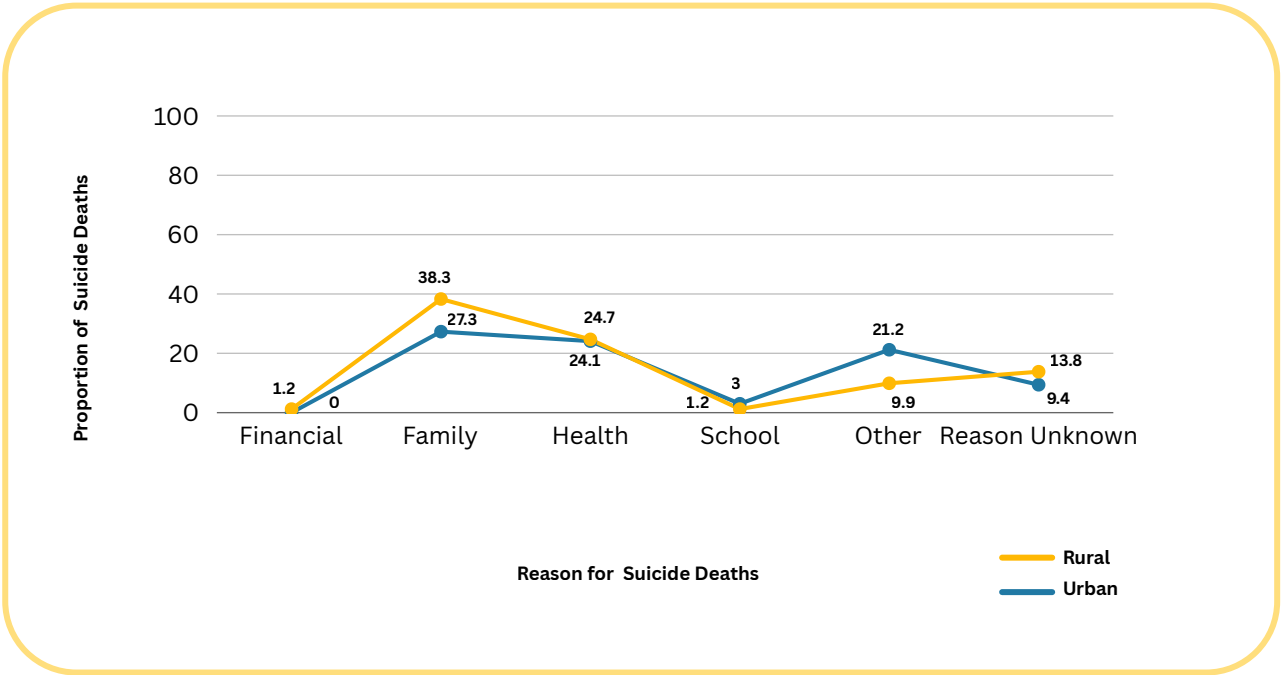



**Figure 13. Distribution of reasons for female suicide deaths by urbanicity**

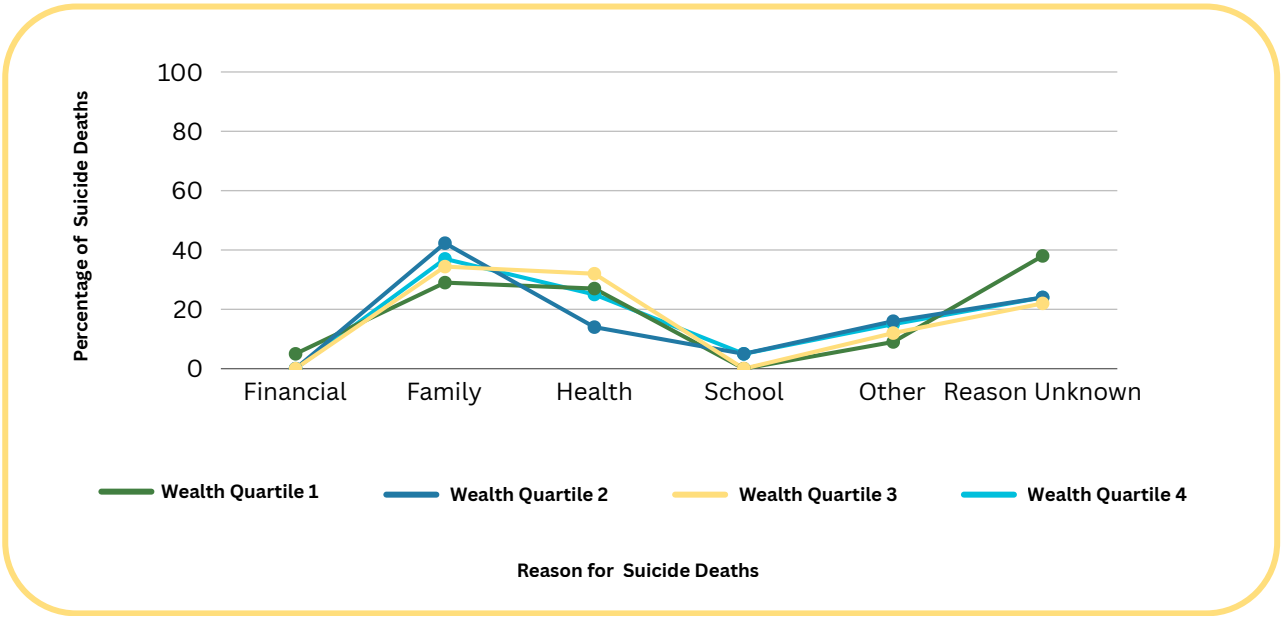



**Figure 14. Distribution of reasons for female suicide deaths by wealth index quartile**

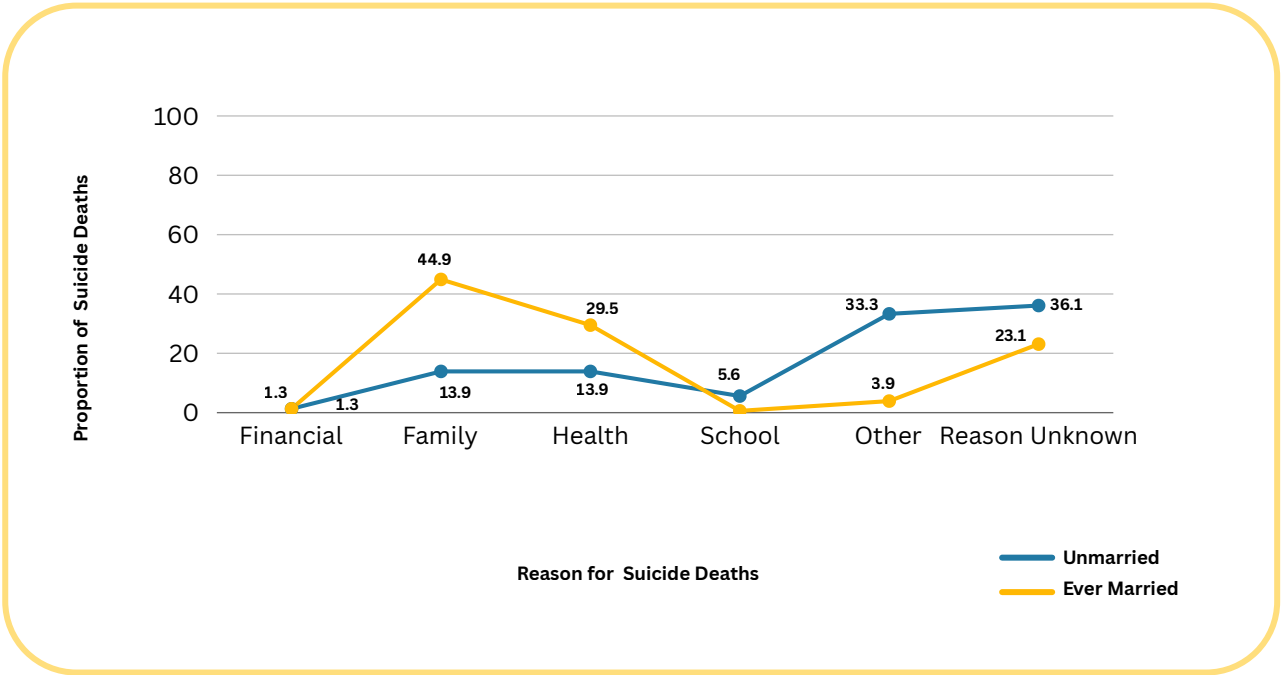



**Figure 15. Distribution of reasons for female suicide deaths by marital status**

**Table 4. List of sub-themes under each major theme for male suicide deaths by marital status and wealth index quartile**

| Theme/sub-theme of reason | Marital Status | | Wealth index quartile | | | |
|---|---|---|---|---|---|---|
| | Unmarried | Ever Married | I | II | III | IV |
| **Financial** | • Loss of money / income<br>• Loss of job/ business<br>• Lack of money | • Debt<br>• Loss of job /business<br>• Loss of money<br>• Financial cheating<br>• Agricultural loss | • Loss of job /business<br>• Loss of money / income<br>• Financial cheating /scam<br>• Agricultural loss | • Debt<br>• Loss of job /business<br>• Loss of money<br>• Agricultural loss | • Loss of job /business<br>• Loss of money<br>• Financial cheating /scam<br>• Agricultural loss | • Debt<br>• Loss of job /business<br>• Loss of money<br>• Lack of money<br>• Agricultural loss |
| **Family** | • Quarrel with parents<br>• Family discord | • Quarrel with spouse<br>• Quarrel with parents<br>• Harassment by mother-in-law<br>• Family discord | • Quarrel with spouse<br>• Quarrel with parents<br>• Family discord | • Quarrel with spouse<br>• Quarrel with parents<br>• Harassment by mother-in-law<br>• Family discord | • Quarrel with spouse<br>• Quarrel with parents<br>• Family discord | |
| **Health** | • Chronic physical illness<br>• Chronic mental health issues<br>• Alcohol addiction<br>• Depression<br>• Depression - COVID-19<br>• COVID-19<br>• Depression - job | • Chronic physical illness<br>• Chronic mental health issues<br>• Alcohol addiction<br>• Depression<br>• Depression - COVID-19<br>• Depression - job | • Chronic mental health issues<br>• Alcohol addiction<br>• Depression | • Chronic physical illness<br>• Chronic mental health issues<br>• Depression<br>• Depression - COVID-19<br>• Depression - job | • Chronic physical illness<br>• Chronic mental health issues<br>• Alcohol addiction<br>• Depression<br>• Depression - COVID-19<br>• Depression - job | |
| **School** | • Change of school/ college | • Unable to appear in exam | | • Change of school/ college | • Unable to appear in exam<br>• Change of school/college | |
| **Other** | • Love affair / Failure in love affair / Not allowed to marry the person of choice | • Harassment by a boy/ Black-mail | • Harassment by a boy/ Black-mail | • Love affair / Failure in love affair / Not allowed to marry the person of choice | • Love affair/ Failure in love affair/ Not allowed to marry the person of choice | |

**Table 4. List of sub-themes under each major theme for male suicide deaths by marital status and wealth index quartile**

| Theme/sub-theme of reason | Marital Status | | Wealth index quartile | | | |
|---|---|---|---|---|---|---|
| | Unmarried | Ever Married | I | II | III | IV |
| **Other** | • Love affair/ Failure in love affair/ Not allowed to marry the person of choice<br>• Quarrel<br>• Unhappy with his name, postponed of marriage due to COVID<br>• Black magic | • Harassment by a boy/ Blackmail<br>• Love affair / Failure in love affair / Not allowed to marry the person of choice<br>• Black magic | • Harassment by a boy/ Blackmail<br>• Love affair/ Failure in love affair/ Not allowed to marry the person of choice | • Love affair/ Failure in love affair/ Not allowed to marry the person of choice<br>• Quarrel<br>• Black magic | • Love affair/ Failure in love affair/ Not allowed to marry the person of choice<br>• Love affair/ Failure in love affair/ Not allowed to marry the person of choice | |

**Table 5. List of sub-themes under each major theme for female suicide deaths by marital status and wealth index quartile**

| Theme/sub-theme of reason | Marital Status | | Wealth index quartile | | | |
|---|---|---|---|---|---|---|
| | Unmarried | Ever Married | I | II | III | IV |
| **Financial** | | | • Loss of money/ income | | | |
| **Family** | • Family discord<br>• Domestic violence | • Quarrel with spouse<br>• Quarrel with parents<br>• Family discord<br>• Domestic violence | • Quarrel with spouse<br>• Family discord | • Quarrel with spouse<br>• Family discord | • Quarrel with spouse<br>• Family discord<br>• Domestic violence | • Quarrel with spouse<br>• Quarrel with parents<br>• Family discord |
| **Health** | • Chronic physical illness | • Chronic physical illness | • Chronic mental health | • Chronic mental health issues | • Chronic physical illness | • Chronic physical illness |

**Table 5. List of sub-themes under each major theme for female suicide deaths by marital status and wealth index quartile**

| Theme/sub-theme of reason | Marital Status | | Wealth index quartile | | | |
|---|---|---|---|---|---|---|
| | Unmarried | Ever Married | I | II | III | IV |
| **Health** | • Chronic mental health issues<br>• Depression | • Chronic mental health issues<br>• Depression<br>• Depression -COVID-19 | • Depression<br>• Depression -COVID-19 | • Depression | • Chronic mental health issues<br>• Depression | • Chronic mental health issues<br>• Depression |
| **School** | • Fail/poor score in exam | | | • Fail/poor score in exam | | • Fail/ poor score in exam |
| **Other** | • Harassment by a boy/ Black-mail<br>• Love affair/ Failure in love affair/ Not allowed to marry the person of choice<br>• Black magic | • Harassment by a boy/ Black-mail<br>• Love affair/ Failure in love affair/ Not allowed to marry the person of choice | | • Harassment by a boy/ Black-mail<br>• Love affair/ Failure in love affair/ Not allowed to marry the person of choice | • Love affair/ Failure in love affair/ Not allowed to marry the person of choice<br>• Black magic | • Harassment by a boy/ Black-mail<br>• Black magic |

# MAJOR TAKEAWAYS FROM THE NATIONAL SURVEY

## Magnitude of suicide deaths in India

- On an average, those dying by suicide in India were dying 28 years younger than those dying due to other causes of death. Variations in the mean age at suicide death were seen by sex, urbanicity, and by state.

- Suicide mortality rate continues to be high in India estimated at 10 per 100,000 population in this study. Though the suicide death rate in India is similar to the UK (9.4) and is lower than Australia (12.3) and the USA (15.5),[4] the rate translates into a much larger number of suicide deaths in India (198,300) than in UK (6,500), Australia (3,300), and USA (51,800) as India is the most populous country globally. This is why it is urgent to address suicide prevention effectively in India.

- Suicide mortality rate was higher in males than females but not statistically significant. A higher suicide mortality rate was documented in the southern region, which needs further in-depth exploration.

- Suicide deaths are reported to be the leading cause of death in 15-39 years age group for India.[5] This is reinforced in this study with the young economically productive population having the highest proportion of suicide deaths. Implications of these deaths are clear not only in terms of social implications but significant economic implications for the country.

- A significant increase is documented in suicide mortality rate during COVID-19 pandemic as compared with the pre- and post-pandemic periods in this study. Though the suicide mortality rate has returned to the pre-pandemic period, improved understanding is needed to reduce the chances of such increase again due to another unforeseen health or other event.

## Gendered Context of Suicide Deaths in India

- Suicide deaths in India are not gender-neutral. The pattern and magnitude of suicide deaths in India reflect deep-rooted gender inequalities, social norms, and structural disadvantages.

- Globally, suicide mortality rate is higher in males than females, which is also true for India. However, the difference in the mortality rate between males and females in India is much narrower as also documented in this study. Importantly, Indian females have twice the suicide mortality rate than the global average for females.[5] Recent work has also shown that suicide death rate among never married females is similar to that among currently married females.[13] Therefore, suicide prevention in India will need to address these deaths both in males and females to effectively reduce the number of people dying by suicide.

- The reasons reported for suicide deaths by families further highlight the gendered context of suicide deaths. Financial reasons were significantly more likely to be reported as a reason for suicide among males whereas family-related reasons were significantly more likely to be reported as a reason for suicide among females. Alcohol abuse was cited as an important contributor to suicide deaths in males in two states, which led to family issues including child abuse/neglect, domestic violence, and loss of income, and eventually suicide. Broadly:

  - Male suicide deaths are linked to economic stress and pressures of being the "provider".

  - Females face heightened risk due to domestic violence, early marriage, and lack of autonomy.

- The experience of isolation, lack of support, and abuse in females in unpaid care work (home duties) may contribute to suicidal distress that is often reported as family issues, and is invisible in policy discourse.

- Hanging was the most common mode of suicide for both males (70%) and females (60%) followed by poisoning (males: 21% and females: 21%). However, 11% of females also died of self-immolation as compared with only 3% of males. This mode of suicide with household fuel sources (kerosene, gas cylinders) are more accessible to females, especially those working in domestic spaces, and warrants further studies/action.

## Implications for Suicide Prevention

- Recognising and addressing the age and gendered drivers of suicide is essential for effective and equitable suicide prevention strategies.
- With hanging being the predominant mode of suicide, access to which cannot be restricted as in case with pesticides, addressing the risk factors is the pathway to reduce suicide deaths in India.
- The reasons reported for suicide deaths highlight the need for public health approach to suicide prevention, which needs to be inter-sectoral.[20-22]
- The reasons reported for suicide deaths highlight the need for public health approach to suicide prevention, which needs to be inter-sectoral.
    - Address economic and livelihood insecurities.
    - Strengthen protection against domestic violence and dowry-related abuse.
    - Invest in education, economic empowerment, and legal support for at-risk females.
    - Improve access to mental health services.
- Reasons for suicide death was not known in 28% of female and 23% of male suicide deaths, and this proportion was significantly higher in Jharkhand, Gujarat, and Odisha, and among deaths in the lowest wealth quartile. Not knowing the possible reason for suicide has major implications for suicide prevention for these sub-group of populations. It also highlights the vulnerability which is hidden from the family, friends, loved ones, and those in their lives that can affect implementation of gate-keeping approach to identify potential risks to save lives.

# FINDINGS FROM THE IN-DEPTH STUDY

## Participation

In-depth data were available for 155 (70.5%) of the 220 suicide deaths in the states of Uttar Pradesh, Maharashtra and Tamil Nadu **(Table 6)**. For the 65 deaths wherein, in-depth interviews could not be undertaken, 6 (9.2%) households had migrated, 36 (55.4%) were not available for interview, and 23 (35.4%) refused to participate.

**Table 6. Distribution of suicide deaths by select demographic characteristics from Maharashtra, Tamil Nadu and Uttar Pradesh**

| Variable | Variable Category | Maharashtra N= 67 (% of N) | Tamil Nadu N= 52 (% of N) | Uttar Pradesh N=36 (% of N) |
|---|---|---|---|---|
| Age group (years) | 10-14 | 3 (4.5) | 1 (1.9) | 0 |
| | 15-19 | 3 (4.5) | 5 (9.6) | 4 (11.1) |
| | 20-24 | 7 (10.4) | 6 (11.5) | 9 (25.0) |
| | 25-29 | 9 (13.4) | 11 (21.2) | 7 (19.4) |
| | 30-34 | 7 (10.4) | 6 (11.5) | 5 (13.9) |
| | 35-39 | 9 (13.4) | 1 (1.9) | 3 (8.3) |
| | 40-44 | 7 (10.4) | 4 (7.7) | 4 (11.1) |

| Table 6. Distribution of suicide deaths by select demographic characteristics from Maharashtra, Tamil Nadu and Uttar Pradesh | | | | |
|---|---|---|---|---|
| **Variable** | **Variable Category** | **Maharashtra N= 67 (% of N)** | **Tamil Nadu N= 52 (% of N)** | **Uttar Pradesh N=36 (% of N)** |
| Age group (years) | 45-49 | 1 (1.5) | 4 (7.7) | 3 (8.3) |
| | 50-54 | 9 (13.4) | 3 (5.8) | 0 |
| | 55-59 | 2 (3.0) | 0 | 1 (2.8) |
| | 60 or more | 10 (14.9) | 11 (21.2) | 0 |
| Sex | Male | 59 (88.1) | 35 (67.3) | 17 (47.2) |
| | Female | 8 (11.9) | 17 (332.7) | 19 (52.8) |
| Marital status | Never married | 19 (28.4) | 18 (34.6) | 7 (19.4) |
| | Ever married | 48 (71.6) | 34 (65.4) | 29 (80.6) |
| Wealth index quartile | Quartile 1 | 13 (19.4) | 16 (30.8) | 10 (27.8) |
| | Quartile 2 | 12 (17.9) | 16 (30.8) | 7 (19.4) |
| | Quartile 3 | 20 (29.9) | 16 (30.8) | 10 (27.8) |
| | Quartile 4 | 22 (32.8) | 4 (7.7) | 9 (25.0) |
| Urbanicity | Urban | 10 (14.9) | 24 (46.2) | 1 (2.8) |
| | Rural | 57 (85.1) | 28 (53.8) | 35 (97.2) |
| Year of Death | 2019 | 13 (19.4) | 9 (17.3) | 12 (33.3) |
| | 2020 | 13 (19.4) | 15 (28.8) | 7 (19.4) |
| | 2021 | 17 (25.4) | 13 (25.0) | 8 (22.2) |
| | 2022 | 24 (35.8) | 15 (28.8) | 9 (25.0) |
| Mode of Suicide | Hanging | 40 (59.7) | 38 (73.1) | 23 (63.9) |
| | Pesticide | 14 (20.9) | 6 (11.5) | 7 (19.4) |
| | Other poison | 7 (10.4) | 5 (9.6) | 2 (5.6) |
| | Self-immolation | 1 (1.5) | 3 (5.8) | 2 (5.6) |
| | Drowning | 5 (7.5) | 0 | 2 (5.6) |

## Police Case Registration

Of 155 suicide deaths, police case was registered for 104 (67.1%; 95% CI 59.3-74.1) deaths. The police case registration coverage for suicide deaths was significantly higher in Maharashtra (85.1%) compared to Tamil Nadu (53.9%) and Uttar Pradesh (52.8%).

## Cases Registered by Socio-demography

The coverage of police case registration was 68.5% (95% CI 59.2-76.5) for male suicide deaths and 63.6% (95% CI 48.2-76.7) for female suicide deaths **(Table 7)**. Police case registration for both male and female suicide deaths was higher in urban areas (80.0% for both) compared to rural areas (65.5% for males and 58.8% for females). Male suicide deaths registration varied significantly by state with 88% registered in Maharashtra and only 29% in Uttar Pradesh.

**Table 7. Distribution of police case registration for suicide death by select socio-demographic characteristics for male and female deaths**

| | | Male suicide deaths | | | Female suicide deaths | | |
|---|---|---|---|---|---|---|---|
| Variable | Variable category | Number | Coverage of police case registration of suicide death (% of variable category) | Chi-square test of significance p-value | Number | Coverage of police case registration of suicide death (% of variable category) | Chi-square test of significance p-value |
| Overall | | 111 | 76 (68.5) | | 44 | 28 (63.6) | |
| Age group (years) | 10-19 | 8 | 5 (62.5) | 0.803 | 6 | 4 (66.7) | 0.337 |
| | 20-29 | 30 | 20 (66.7) | | 22 | 12 (54.6) | |
| | 30-39 | 20 | 16 (80.0) | | 8 | 7 (87.5) | |
| | 40-49 | 19 | 13 (68.4) | | 5 | 4 (80.0) | |
| | 50 or more | 34 | 22 (64.7) | | 3 | 1 (33.3) | |
| Marital Status | Never Married | 32 | 23 (71.9) | 0.623 | 12 | 7 (58.3) | 0.654 |
| | Ever Married | 79 | 53 (67.1) | | 32 | 21 (65.6) | |

| Table 7. Distribution of police case registration for suicide death by select socio-demographic characteristics for male and female deaths | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | Male suicide deaths | | | Female suicide deaths | | |
| Variable | Variable category | Number | Coverage of police case registration of suicide death (% of variable category) | Chi-square test of significance p-value | Number | Coverage of police case registration of suicide death (% of variable category) | Chi-square test of significance p-value |
| Wealth index quartile* | Quartile 1 | 25 | 15 (60.0) | 0.679 | 14 | 8 (57.1) | 0.880 |
| | Quartile 2 | 28 | 19 (67.9) | | 7 | 5 (71.4) | |
| | Quartile 3 | 33 | 23 (69.7) | | 13 | 9 (69.2) | |
| | Quartile 4 | 25 | 19 (76.0) | | 10 | 6 (60.0) | |
| Urbanicity | Never Married | 25 | 20 (80.0) | 0.159 | 10 | 8 (80.0) | 0.221 |
| | Ever Married | 86 | 56 (65.1) | | 34 | 20 (58.8) | |
| Year of death | 2019 | 24 | 20 (83.3) | 0.176 | 10 | 9 (90.0) | 0.143 |
| | 2020 | 27 | 15 (55.6) | | 8 | 3 (37.5) | |
| | 2021 | 28 | 18 (64.3) | | 10 | 6 (60.0) | |
| | 2022 | 32 | 23 (71.9) | | 16 | 10 (62.5) | |
| State | Maharashtra | 59 | 52 (88.1) | <0.001 | 8 | 5 (62.5) | 0.433 |
| | Tamil Nadu | 35 | 19 (54.3) | | 17 | 9 (52.9) | |
| | Uttar Pradesh | 17 | 5 (29.4) | | 19 | 14 (73.7) | |

The significantly higher police case registration in Maharashtra could be attributed to two reasons:

- Presence of Police Patil – The position of Police Patil in Maharashtra is a government-appointed position responsible for mediating between the local community and the police officer in charge of the police station for a particular area. The Police Patil oversees the village law-and-order cases in the area to maintain public peace, and facilitates registering of police cases as needed.

- A higher proportion of farmer suicide deaths in the state are reported to the police for the family to claim compensation for death from the state government.

## Who Registered the Police Case?

Among the suicide deaths that were registered with the police, hospital authority was more likely to have registered the police case for male deaths (in the medico-legal register) and family was more likely to register the case for female deaths **(Table 8)**.

Considering the data by state, hospitals overwhelmingly registered the police case in Tamil Nadu (89.3%) and a variety of sources were documented for the suicide deaths in Maharashtra **(Figure 16)**.

**Table 8. Distribution of who registered the police case**

| | Both sexes combined deaths (N=104) | Male suicide deaths (N=76) | Female suicide deaths (N=28) |
|---|---|---|---|
| Who registered with the police? | Number of suicide deaths registered with police | Number of suicide deaths registered with police | Number of suicide deaths registered with police |
| Family member) | 37 (35.6) | 23 (30.3) | 14 (50.0) |
| Village member | 12 (11.5) | 10 (13.2) | 2 (7.1) |
| Hospital authority | 40 (38.5) | 80 (42.1) | 8 (28.6) |
| Police | 9 (8.7) | 8 (10.5) | 1 (3.6) |
| Don't know | 6 (5.8) | 3 (4.0) | 3 (10.7) |

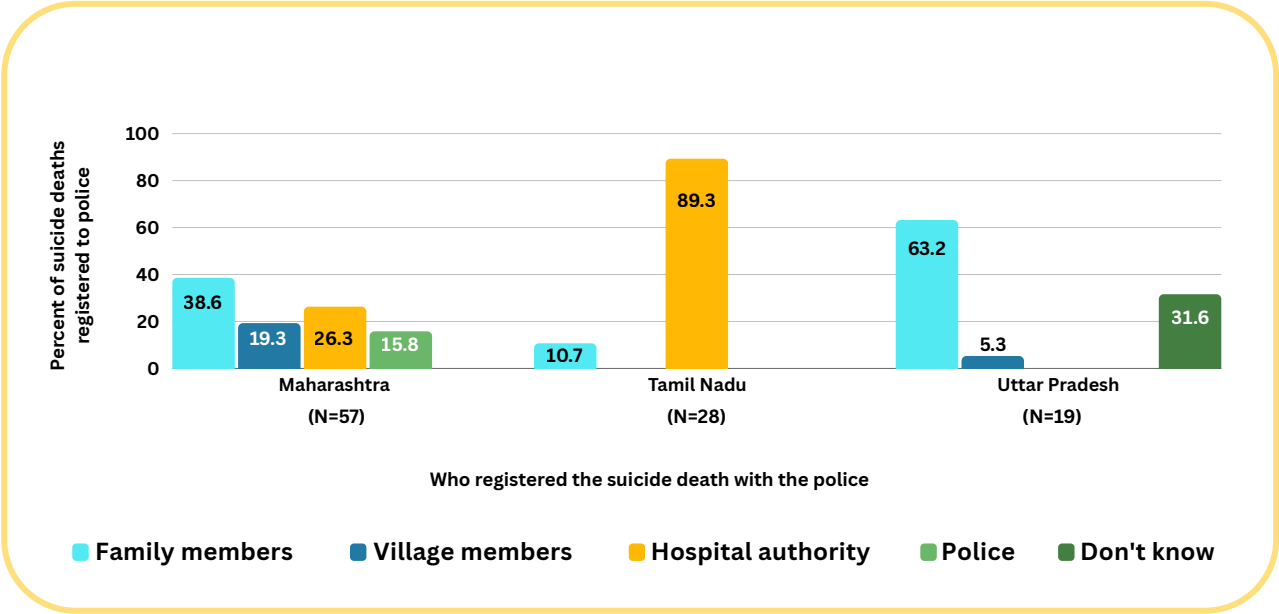



**Figure 16. Distribution of who registered the police case by state**

## Cases Registered and Then Withdrawn

It came to light that six police cases were registered and then withdrawn, the reasons for which are indicated in **Table 9** as verbatim provided by the respondents. Four of these six cases were for female suicide deaths, and all the six suicide deaths were in married people. Money was involved in five of these six cases.

| Table 9. Verbatims translated for cases registered and then withdrawn |
|---|
| **Female suicide deaths** |
| ***Deceased: 26 years/female/married***<br>*Husband was the respondent. As per him, there was not any issue in the family. She had kept all her jewellery in her maternal house and a day before death. He had asked her to bring back all jewellery from her maternal house. Her brother gave all the ornaments to him. The day in which she died no one was at home – he had gone for duty and the mother-in-law to a nearby village. The mother-in-law, who returned home in about 30 minutes, found her dead. She called the neighbour and him. He came immediately and called the police and his wife's brother. But her brother registered a case against him for dowry and harassment. He had to run away for a few days and was arrested by the police later. Police released him on the condition to provide INR 10 lacs within 20 days as his wife's family demanded this amount. This was later reduced to 8 lacs, which he gave. Later the case was withdrawn.* |
| ***Deceased: 32 years/female/married***<br>*Husband was the respondent. The deceased was married at 16 years and had her first baby at 17 years. Four children- out of which the elder daughter who is 15 years was married this year. He said that the deceased got back from her maternal home two days ago. They had a normal conversation the next morning wherein he has asked her to make "Sharbat" and then he went to the agricultural field. She was cooking and then she set herself on fire. She was taken to the public hospital in Rasoolbad from where they referred to Kanpur. Doctor said 50% burns and there is less chance of survival. She expired the next morning. Police case was registered but was withdrawn after INR 50,000 cash was given to wife's family through mediation by the village leader and police.* |
| ***Deceased: 22 years/female/married***<br>*Father-in-law was the respondent. She had an 8-month-old girl child. Her husband was staying in Surat at the time of her death. Respondents for interview were sister-in-law, mother-in-law, and father-in law. According to them, she was very happy with her family life. Before her death she had a video call with her husband, sister and mother. That night, all the family members went to sleep on the terrace after dinner and the deceased was alone in her room. When the family saw her in the morning, they called the police and broke the door to enter the room.Brother of the deceased filed complaint against them as he believed that his sister could not have taken her own life. Police called her father-in-law twice to police station but did not arrest him. Then both the families reached an agreement and the case was dropped. Police also seized her mobile for investigation based on her brother's request but did not find anything.* |
| ***Deceased: 25 years/female/married***<br>*Mother-in-law was the respondent. As per the respondent, the husband of the deceased had two wives. The deceased's firstborn, a baby boy, was stillborn. The second child was a girl, who is 12-years-old now and third child was also a stillborn boy. Her uterus was removed after the third delivery. The family wanted a male child. The deceased herself convinced her husband for second marriage because she was unable to give birth anymore. Initially the days were spent well. Eventually, discord happened between both wives as the second wife gave birth to two boy children. The deceased died by suicide. Her brother registered a case against her husband and his family members. Later the two families reached an agreement and the case was dropped. Between interaction, both parents-in-law repeatedly said that the deceased was mentally unstable.* |

| Table 9. Verbatims translated for cases registered and then withdrawn |
| --- |
| **Male suicide deaths** |
| ***Deceased: 45 years/male/married***<br><br>*Mother-in-law was the respondent. As per the respondent, the husband of the deceased had two wives. The deceased's firstborn, a baby boy, was stillborn. The second child was a girl, who is 12-years-old now and third child was also a stillborn boy. Her uterus was removed after the third delivery. The family wanted a male child. The deceased herself convinced her husband for second marriage because she was unable to give birth anymore. Initially the days were spent well. Eventually, discord happened between both wives as the second wife gave birth to two boy children. The deceased died by suicide. Her brother registered a case against her husband and his family members. Later the two families reached an agreement and the case was dropped. Between interaction, both parents-in-law repeatedly said that the deceased was mentally unstable.* |
| ***Deceased: 30 years/male/married***<br><br>*Mother was the respondent. Deceased had been married for two years and had an 11-month-old baby. The reason for his death is that his wife was asking him to stay away from his family. Wife's parents used to incite against him due to which there was constant quarrel between them. Hence the deceased drank insecticide and he fell down while walking on the road.People nearby took him to the government hospital and called his family. He was alive at that time and family shifted him to the government hospital in Nanded. The wife came to the hospital and he asked her, "Why are you seeing me now? All this happened because of you." He then died around 6-7pm. His family filed a case against his wife in the police station. It was said that the wife's family paid INR 2 lacs to the lawyer and closed the case. The wife did not even come to bury his body.* |

## Cases Not Registered With the Police

Among the 51 suicide death cases that were not registered with the police, the main reasons cited were related to police for both male and female suicide deaths **(Figure 17)**. The other reasons were compromise between the affected, village community did not allow to register. Importantly, to prevent damage to social reputation was reported as a reason only for females. With some probing, the team understood that the village head, at times, preferred case not to be registered to avoid spending their own time in visiting police station and courts given that the death occurred under their administration. Some variations were documented by state in the reasons for not registering the case with the police **(Figure 18)**.

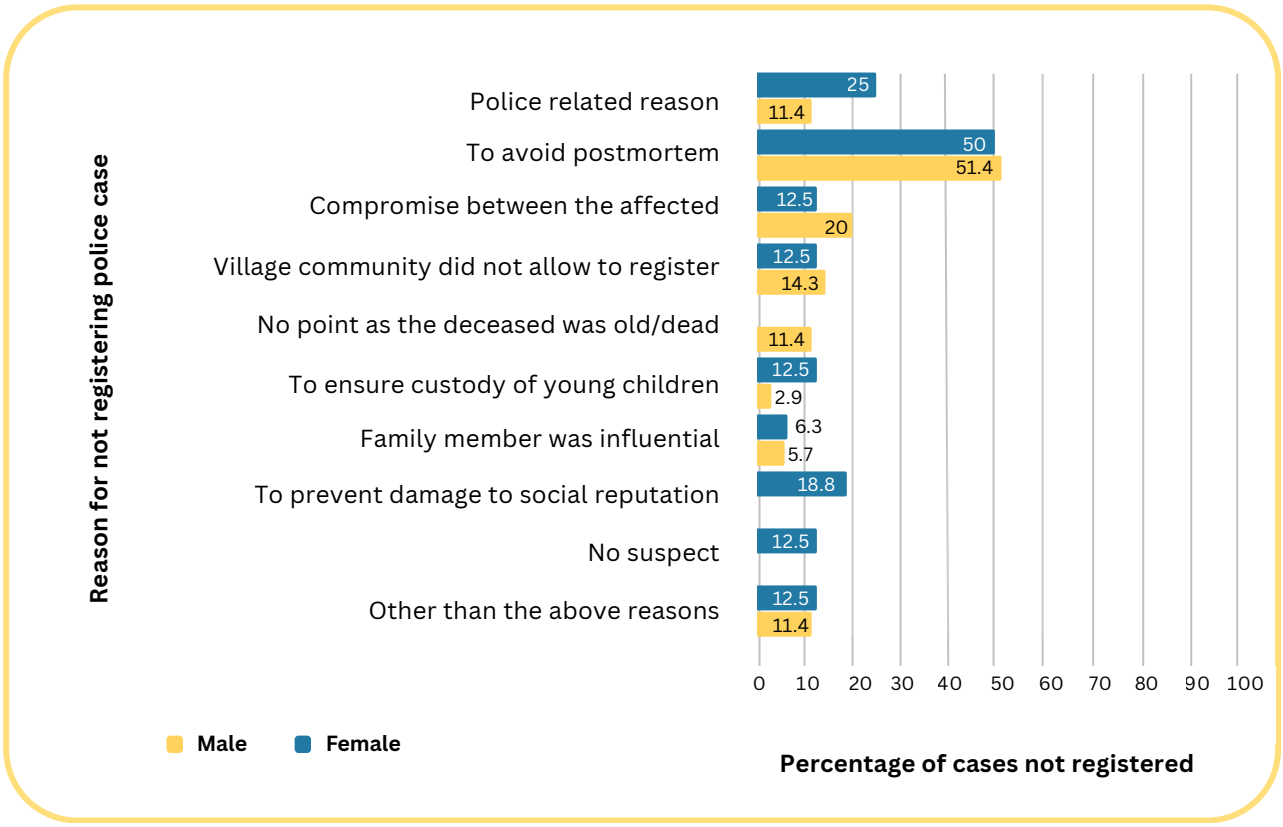



**Figure 17. Reasons for not registering police case (not mutually exclusive)**

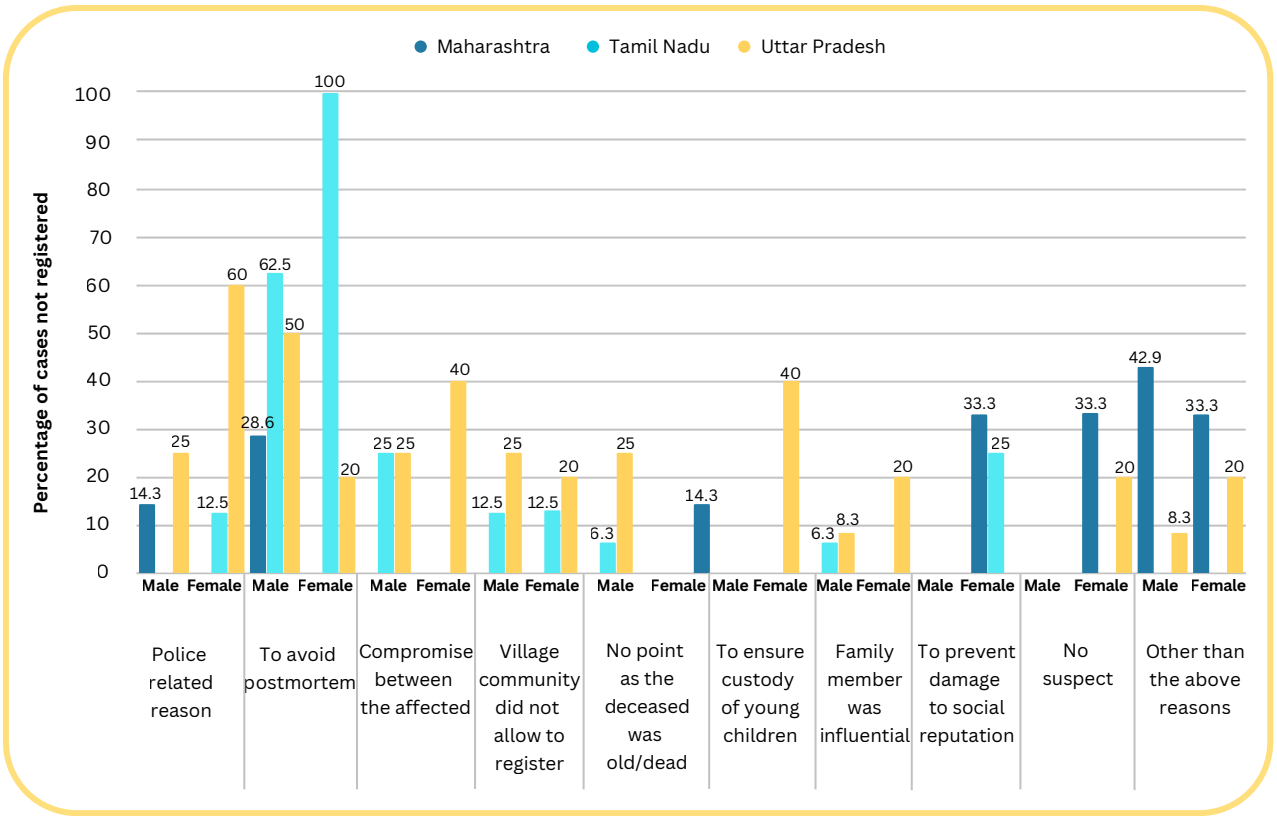



**Figure 18. Reasons for not registering police case by state (not mutually exclusive)**

## Newspaper Reporting of Suicide Death

Newspaper and/or other media coverage of suicide death was reported for 62 deaths, of which 61 (98.4%) were reported in a newspaper. The newspaper coverage of suicide death was estimated at 39.4% (95% CI: 31.9-47.3%), 37.8% (95% CI: 29.2-47.3%), and 43.2% (95% CI: 29.1-58.4%) for both sexes combined, male and female suicide deaths, respectively. For both sexes combined, Tamil Nadu state had the lowest newspaper coverage at 28.8% (95% CI: 18.1-42.6%) compared to Uttar Pradesh (47.2%; 95% CI: 31.6-63.4%) and Maharashtra (43.3%; 95% CI: 31.9-55.4%).

**Table 10** documents the newspaper coverage of suicide deaths by a variety of socio-demographic characteristics for male and female suicide deaths. The states of Maharashtra and Uttar Pradesh had the highest newspaper coverage for males (44.1%; 95% CI: 31.9-57.0%) and females (52.6%; 95% CI: 30.5-73.7%) suicide deaths, respectively. More newspaper coverage was noted for urban suicide deaths for both males (44.0%; 95% CI: 26.1-63.6%) and females (60.0%; 95% CI: 29.0-84.6%) compared to rural deaths, but the differences were not statistically significant. The coverage was higher if the deceased was either salaried or a farmer for both sexes.

| Table 10. Newspaper coverage of suicide death by select socio-demography of the deceased | | | | | |
|---|---|---|---|---|---|
| Variable | Variable category | Male suicide deaths | | Female suicide deaths | |
| | | Number | Coverage of newspaper reporting of suicide death (% of variable category) | Number | Coverage of newspaper reporting of suicide death (% of variable category) |
| Overall | | 111 | 37.8 (29.2-47.3) | 44 | 43.2 (29.1-58.4) |
| Age group (years) | 10-19 | 8 | 12.5 (1.7-54.3) | 6 | 66.7 (25.9-92.0) |
| | 20-29 | 30 | 40.0 (24.2-58.3) | 22 | 36.4 (18.9-58.3) |
| | 30-39 | 20 | 45.0 (25.1-66.6) | 8 | 50.0 (19.4-80.6) |
| | 40-49 | 19 | 31.6 (14.8-55.1) | 5 | 40.0 (9.6-80.8) |
| | 50 or more | 34 | 41.2 (26.0-58.3) | 3 | 33.3 (4.1-85.5) |
| Marital Status | Never Married | 32 | 34.4 (20.0-52.3) | 12 | 50.0 (23.8-76.2) |
| | Previously Married | 79 | 39.2 (29.0-50.5) | 32 | 40.6 (24.9-58.6) |
| Wealth index quartile* | Quartile 1 | 25 | 36.0 (19.8-56.2) | 14 | 35.7 (15.3-63.1) |
| | Quartile 2 | 28 | 28.6 (14.9-47.8) | 7 | 57.1 (22.2-86.2) |
| | Quartile 3 | 33 | 36.4 (21.8-53.9) | 13 | 38.5 (16.5-66.4) |
| | Quartile 4 | 25 | 52.0 (32.9-70.5) | 10 | 50.0 (21.8-78.2) |
| Occupation | Home duties | 9 | 33.3 (11.0-67.0) | 23 | 39.1 (21.4-60.3) |
| | Labourer | 36 | 16.7 (7.6-32.7) | 4 | 0 |
| | Farmer | 24 | 54.2 (34.4-72.7) | 4 | 50.0 (11.7-88.3) |
| | Salaried | 18 | 61.1 (37.6-80.4) | 3 | 66.7 (14.5-95.9) |
| | Business/self-employed | 12 | 33.3 (12.9-62.7) | 0 | - |
| | Student | 12 | 41.7 (18.3-69.5) | 10 | 60.0 (29.0-84.6) |
| Urbanicity | Urban | 25 | 44.0 (26.1-63.6) | 10 | 60.0 (29.0-84.6) |
| | Rural | 86 | 36.0 (26.5-46.8) | 34 | 38.2 (23.3-55.8) |

**Table 10. Newspaper coverage of suicide death by select socio-demography of the deceased**

| Variable | Variable category | Male suicide deaths | | Female suicide deaths | |
|---|---|---|---|---|---|
| | | Number | Coverage of newspaper reporting of suicide death (% of variable category) | Number | Coverage of newspaper reporting of suicide death (% of variable category) |
| State | Maharashtra | 59 | 44.1 (31.9-57.0) | 8 | 37.5 (12.1-72.4) |
| | Tamil Nadu | 35 | 25.7 (13.9-42.7) | 17 | 35.3 (16.4-60.3) |
| | Uttar Pradesh | 17 | 41.2 (20.9-65.0) | 19 | 52.6 (30.5-73.7) |
| Police case registered | Yes | 76 | 50.0 (38.5-61.5) | 28 | 60.7 (41.1-77.4) |
| | No | 35 | 11.4 (4.2-27.5) | 16 | 12.5 (2.8-41.7) |

A total of 104 suicide deaths were registered with the police for both sexes combined. The newspaper coverage was significantly higher (4.5 times) for the suicide deaths registered with the police (55, 52.9%) compared with those not registered (6, 11.8%). Half of the male deaths ($p<0.001$) and 61% of female deaths ($p=0.017$) received newspaper coverage among the suicide deaths that were registered with the police.

## Opinion on Reporting in the Newspaper

For the 61 suicide deaths reported in newspapers, 30 (49.2%; 95% CI: 36.7-61.8%) survivors did not support the news being reported in the newspaper, 19 (31.1%; 95% CI: 20.6-44.0%) supported the newspaper coverage, while 12 (19.7%) declined to answer the question. Majority of the respondents from Tamil Nadu opposed the newspaper coverage (80%) whereas Uttar Pradesh had the highest support for the reporting (58.8%; p=0.007). This support was nearly twice in the rural areas (38.6%) as compared to the urban areas (11.8%) though not statistically significant (p=0.109). A higher proportion of respondents supported the newspaper coverage of females (42.1%) than male deaths (26.2%) though not statistically significant (p=0.324).

Of the 19 respondents who supported the newspaper coverage, 4 (21.1%) mentioned that the news had to be accurate and 3 (15.8%) mentioned that the newspaper should have sought their permission before reporting. Support for newspaper reporting by the socio-demography of the females and male suicide deaths is shown in **Figures 19 and 20,** respectively. Support for newspaper reporting of female suicide deaths varied significantly across states (p<0.001) with all in Tamil Nadu opposed to media coverage while 70% in Uttar Pradesh

Support was over three times higher in rural areas (53.9%) compared to urban areas (16.7%; p=0.058), and support for reporting of deaths of ever-married females (53.9%) was higher than that for never-married females (16.7%), though not statistically significant (p=0.309).

For male suicide deaths, state-wise differences in support were not statistically significant (p=0.097). However, no survivors in Tamil Nadu supported media coverage, while 42.9% in Uttar Pradesh supported it. The survivor support was the lowest among the wealth quartile 1 (11.1%), and higher for ever-married (32.3%) compared to never-married males (9.1%), though not statistically significant (p=0.318).

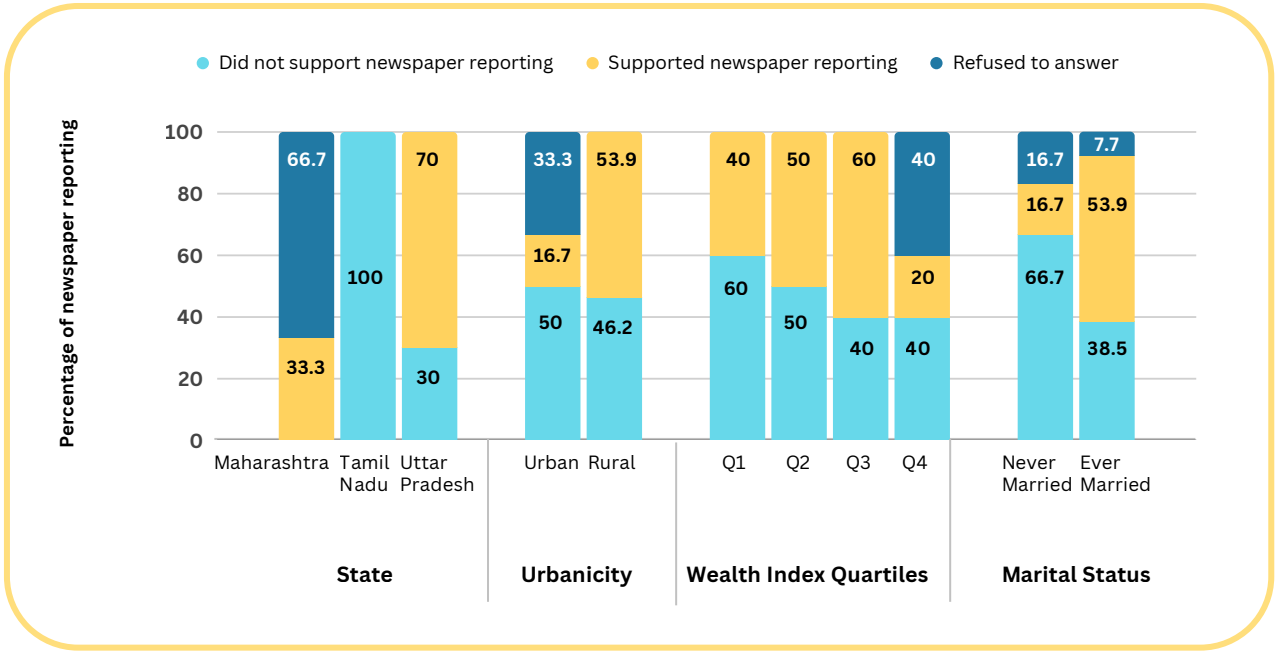



**Figure 19. Distribution of survivors' preferences for newspaper reporting of female suicide deaths in their household based on socio-demography of the deceased**

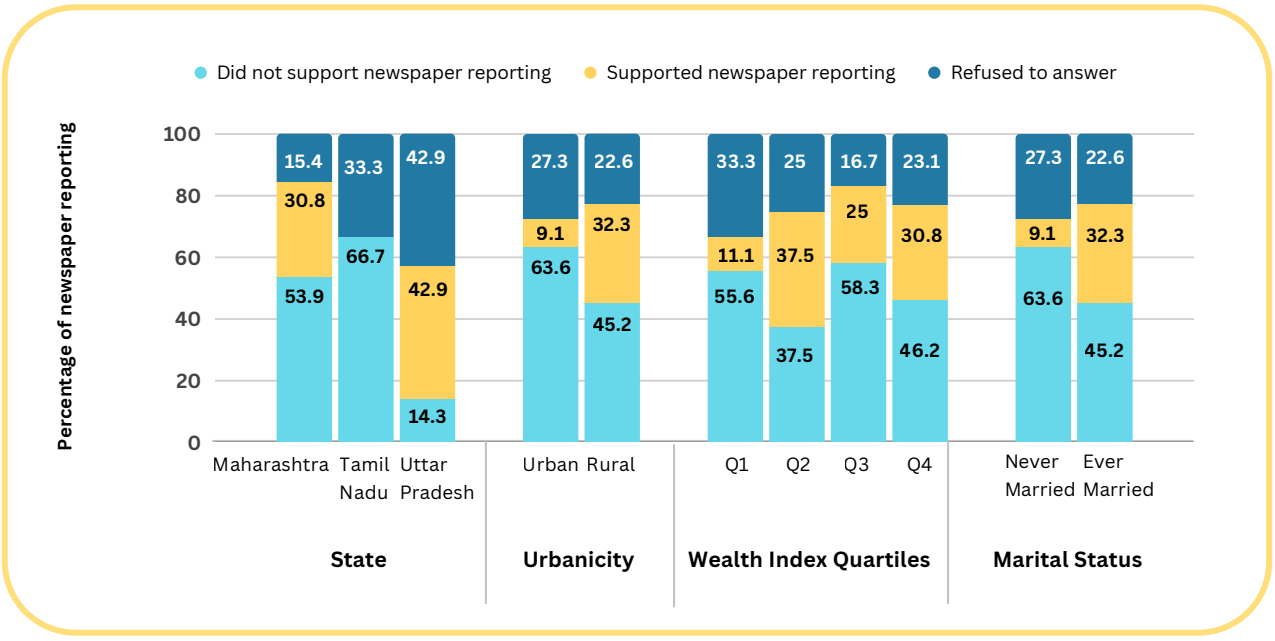



**Figure 20. Distribution of survivors' preferences for newspaper reporting of male suicide deaths in their household based on socio-demography of the deceased**

**Table 11** documents the reasons for the survivors supporting or opposing the newspaper coverage of their household member's suicide death, along with exemplary quotes from them. The survivors predominately supported reporting to increase public awareness for suicide prevention (65%) followed by availing benefits from the government through the newspaper coverage (10%). Avoidance of defamation through the news report was also cited as a reason for support for a suicide death of a married female. In this case, the deceased's husband said that because the newspaper published the accurate reason of his wife's suicide as her extramarital affair, this reporting prevented his family from being defamed or accused of suicide abetment. Majority of the survivors who opposed the coverage reported that they were simply not interested in media reporting (60.7%), felt distressed on reading or knowing about the news (14.3%), did not like being defamed by the news (7.1%), did not think the newspaper reporting was accurate (3.6%), and felt the news stigmatized them (3.6%). We also found a report of suggested misreporting by a media person for a suicide by drowning of a 26-year-old female in Uttar Pradesh. The media person suggested to the deceased's husband to change his narrative for the newspaper reporting from suicide death to unintentional drowning death during bathing to claim USD 5,840 under a government scheme. Two households in Uttar Pradesh showed the newspaper report to the study team, and both reports had the deceased's name and photograph.

**Table 11. Reasons given by survivors for supporting and opposing the newspaper coverage of suicide death. Reasons are not mutually exclusive**

| Reasons for Supporting | Reasons for Opposing |
|---|---|
| **To increase public awareness about suicide**<br>• "We wanted people to know and people should not take such steps." ***(22-year-old female, Uttar Pradesh, Respondent: Father-in-law)***<br>• "People know the suicide death with reason so no one can attempt." ***(32-year-old male, Maharashtra, Respondent: Father-in-law)*** | **Not interested in media reporting**<br>• "We didn't like it." ***(60-year-old female, Tamil Nadu, Respondent: Father-in-law)***<br>• "It should not have come, we thought it was not good." ***(55-year-old male, Maharashtra, Respondent: Father-in-law)***<br>• "No hope of getting any support from the government." ***(42-year-old female, Uttar Pradesh)***<br>• "News about suicide by itself should not be published." ***(58-year-old male, Maharashtra, Respondent: Son)*** |
| **Likelihood of benefit from the government as result of the case coverage**<br>• "People know the suicide death with reason so farmer can claim the yojana (government support scheme)." ***(43-year-old male, Maharashtra, Respondent: Wife)*** | **Felt distress on reading the news**<br>• "Family suffers and gets troubled, memories come back." ***(23-year-old male, Maharashtra, Respondent: Brother)***<br>• "Hearing or seeing it's disturbing my family members." ***(52-year-old male, Tamil Nadu, Respondent: Wife)*** |
| **To avoid defamation through the news report**<br>• "My wife's nature was not good. She had an affair with my brother-in-law. To avoid the defamation that we killed her, I think that it was important for the correct news should be published in the media." ***(26-year-old female, Uttar Pradesh, Respondent: Husband)*** | **Defamation due to reporting**<br>• "We were defamed intentionally by reporting that we had killed our daughter-in-law. We did nothing." ***(31-year-old female, Uttar Pradesh, Respondent: Father-in-law)*** |
| **To support reducing suicide-related stigma**<br>• "The information was given in the paper because the people and the government should know that the farmer committed suicide (sic)...The family was stigmatized, the stigma should be removed from the society, suicide awareness program should be conducted in the village. By doing this, others should not be stigmatized." ***(63-year-old male, Maharashtra, Respondent: Son)*** | **Stigma**<br>• "We didn't like that, fearing that the life of other girl child may be affected." ***(19-year-old female, Tamil Nadu, Respondent: Sister)***<br>• The deceased was accused of stealing a mobile phone. The family did not read the news themselves but were informed about it by other people. "They felt very bad and sad. It was observed that they were talking about it in the village and at work place that your son had stolen a kind of stigma." ***(13-year-old boy, Maharashtra, Respondent: Mother)*** |

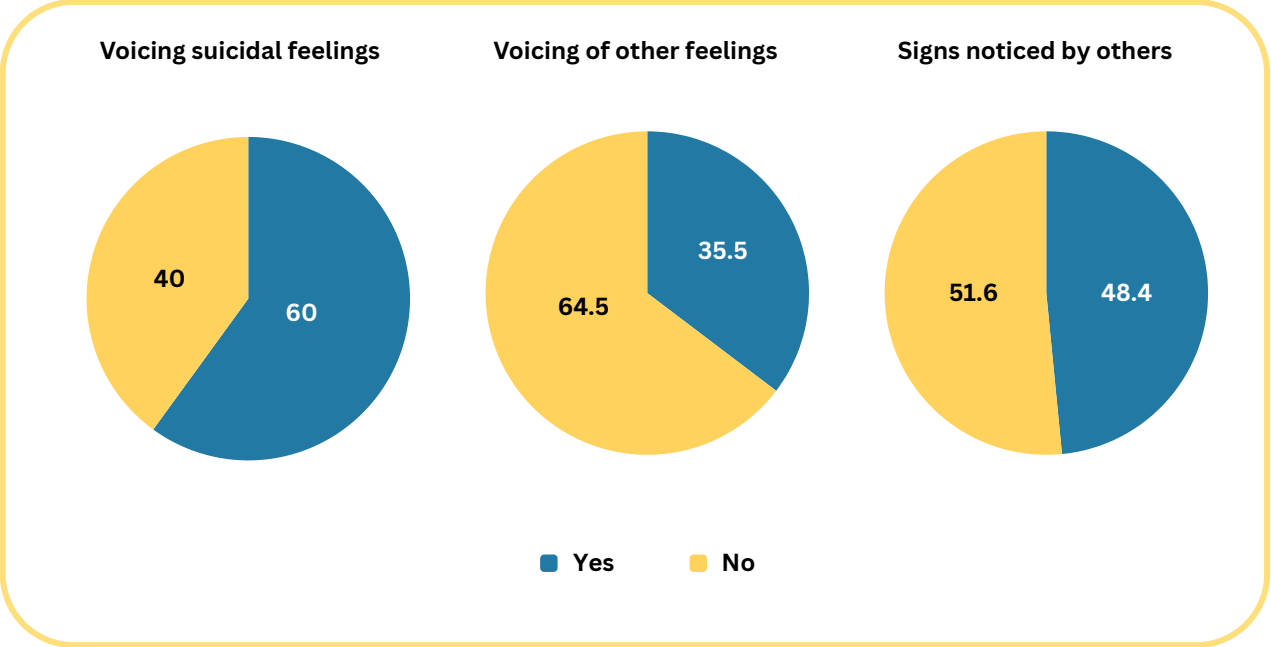



**Figure 21. Distribution of reported possible signs of suicide/self-harm for both sexes combined**

## Recognising Signs of Possible Suicide/Self -Harm

Overall for both sexes combined, 93 (60%) deceased had voiced suicidal feelings, 55 (35.5%) had voiced other feelings, and for 75 (48.4%) some signs were noticeable **(Figure 21).** For males who died by suicide, 66 (59.5%) had voiced suicidal feelings, 43 (38.7%) had voiced other feelings, and for 63 (57.3%) some signs were noticeable.

These proportions for female suicide deaths were 64.3%, 27.3% and 27.3%, respectively. Some patterns emerged in the type of feelings and signs between males and females **(Figure 22)**. Guilt/shame or anger was voiced relatively more by males under voicing of suicidal feelings than females; males also voiced feeling extremely sad or anxious more than females under voicing of other feelings whereas females voiced more unbearable emotional pain. Signs were noticed more for male deaths than females.

## History of Self-Harm Attempt

History of at least one self-harm attempt episode was reported for 16 (10.3%; 95% CI 5.4-16.2) suicide deaths for both sexes combined, 10.8% (95% CI 6.2-18.1) for males and 9.1% (95% CI 3.4-22.0) for female suicide deaths. In total, 34 episodes of self-harm attempt were reported for 16 suicide deaths, with the episodes ranging from 1 to 3. **Tables 11 and 12** provide the duration gap between the self-harm attempts and suicide death for male and female deaths, respectively. It also provides the details of place for each episode of self-harm attempt and also of suicide death. What is striking is that irrespective of the number of self-harm episodes for both males and females, there was very minimal variation in the reason, place, or mode of self-harm attempt/suicide. The gap between episodes of self-harm attempt, and between self-harm attempt and suicide was not much for most cases.

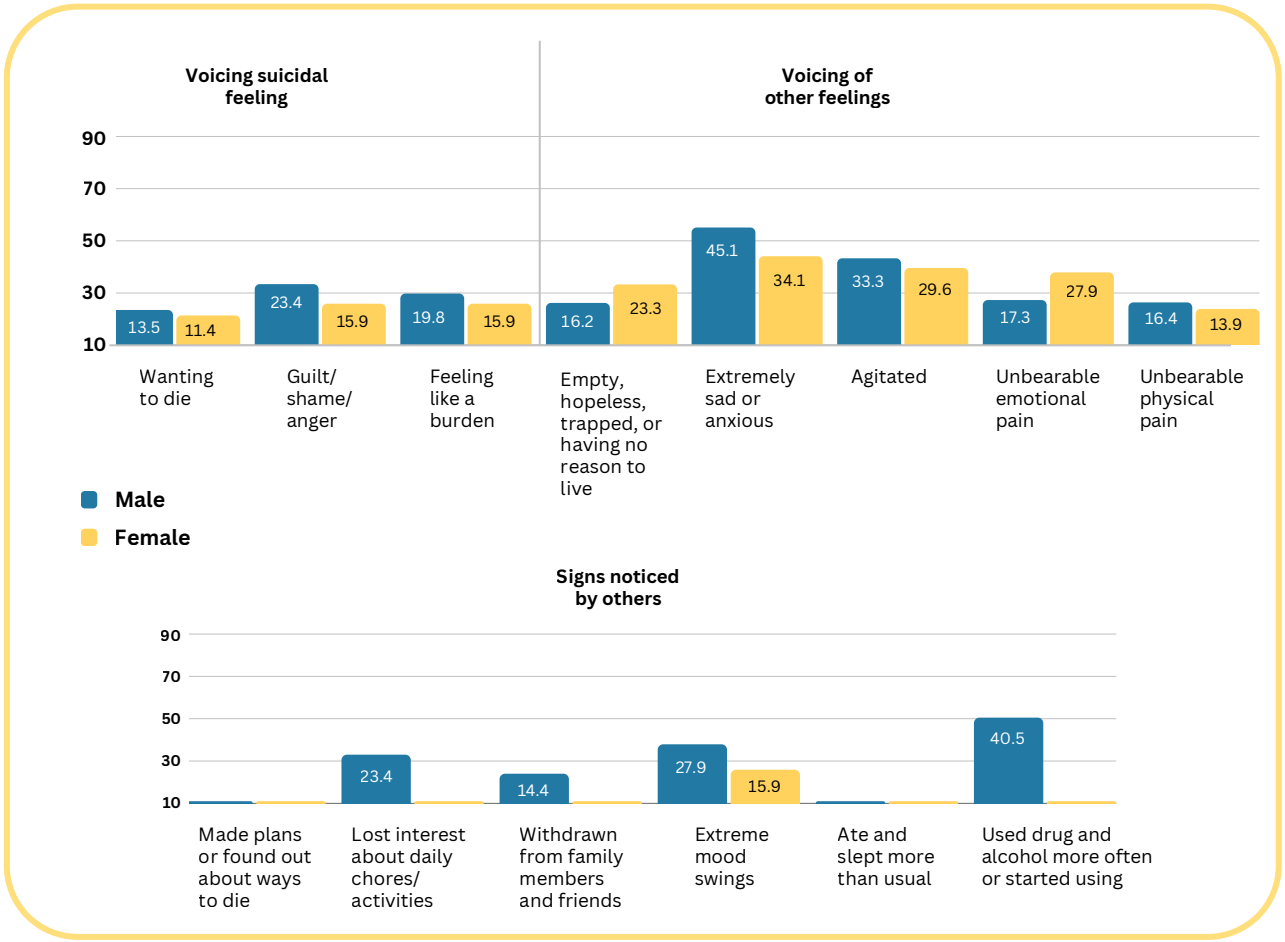



**Figure 22. Distribution of reported signs of suicide/self-harm reported for male and female suicide deaths**

Table 12. Patterns in suicide attempts including gaps between episodes, mode, place, and reasons for suicide in male suicide deaths. All cases were of currently married males except one who was previously married (*)

| Age at death (years) | Number of self-harm attempts | Gap between episodes (in years) | | Gap between last suicide attempt episode & death (in years) | Mode of self-harm attempt by episode and death | | | | Place of self-harm attempt by episode & death | | | | Reason(s) of self-harm attempt by episode and death | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | | 1-2 | 2-3 | | 1 | 2 | 3 | Death | 1 | 2 | 3 | Death | 1 | 2 | 3 | Death |
| 46 | 1 | | | 2 | Hanging | | | Hanging | Farm | | | Farm | | | | Family & Health |
| 51 | 1 | | | 2 | Hanging | | | Hanging | Farm | | | Farm | | | | |
| 70 | 1 | | | 1 | Poisoning | | | Pesticide | Home | | | Home | Financial Health | | | Financial Health |
| 34 | 2 | 0 | | 1 | Poisoning | Poisoning | | Poisoning | Home | Home | | Home | Health | Health | | Health |
| 66 | 2 | 0 | | 8 | Hanging | Hanging | | Hanging | Home | Home | | Home | Substance abuse | Substance abuse | | Substance Abuse |
| 55 | 2 | 6 | | 6 | Hanging | Hanging | | Hanging | Home | School | | Home | Don't Know | Don't Know | | Don't Know |
| 38 | 3 | 2 | 2 | 12 | Hanging | Hanging | | Hanging | Home | Home | Home | Home | Substance abuse | Don't Know | Don't Know | Substance Abuse |
| 32 | 3 | 0 | 1 | 0 | Hanging | Hanging | Poisoning | Hanging | Home | Home | Home | Home | Family | Family | Family | Family |
| 40 | 3 | 22 | 0 | 3 | Hanging | Hanging | Hanging | Hanging | Home | Home | Home | Home | - | - | - | Financial Help & Substance Abuse |
| | | | | | | | | | | | | | | | | |
| 47 | 3 | 1 | 0 | 1 | Jumping | | Jumping | Hanging | Road | Farm | Road | Home | Substance Abuse | Substance Abuse | Substance Abuse | Substance Abuse |
| 25 | 3 | 0 | 0 | 0 | Hanging | Poisoning | Hanging | Hanging | Home | Home | Home | Home | Family & Brother's Accident | Family & Substance abuse & Brother's Accident | Family & Substance abuse & Brother's Accident | Family & Substance Abuse & Brother's Accident |
| | | | | | | | | | | | | | | | | |
| 81* | 3 | 1 | 1 | 0 | Hanging | Hanging | Hanging | Hanging | Home | Home | Home | Home | Financial & Health | Financial & Health | Financial & Health | Financial & Health |

| Table 13. Patterns in suicide attempts including gaps between episodes, mode, place, and reasons for suicide in female suicide deaths | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Age at death (in years) | Number of self-harm attempts | Gap between episodes (in years) | | Gap between last suicide attempt episode & death (in years) | Mode of self-harm attempt by episode & death | | | | Place of self-harm attempt by episode & death | | | | Reason(s) of self-harm attempt by episode & death | | | |
| | | 1-2 | 2-3 | | 1 | 2 | 3 | Death | 1 | 2 | 3 | Death | 1 | 2 | 3 | Death |
| 22 | 1 | | | 2 | Hanging | | | Hanging | Home | | | Home | Health | | | Health |
| 30 | 1 | | | 4 | Poisoning | | | Poisoning | Home | | | Home | Family | | | Family |
| 74* | 3 | 0 | 2 | 1 | Hanging | Hanging | Hanging | Hanging | Home | Home | Home | Home | Health | | | Health |
| 26** | 2 | Don't know | | Don't know | Hanging | Hanging | | Hanging | Home | Home | | Home | Health | Health | | Health |

*Previously married; **Unmarried

## Issues Faced by the Family due to Suicide Death

The average time gap between the suicide death and the current interview to document needs was 3.4 years, which should be taken into context for interpretation of these findings. Some sex-related differences were noticed in the reported issues faced by the families following the suicide death **(Table 14)**. The most common issues reported was emotional distress/grief by families of both male (91.0%) and female (74.4%) suicide deaths. A higher proportion of families with male suicide deaths (82.9%) reported financial difficulties compared to the families with female suicide deaths (58.1%). Families of both males and female suicide deaths reported similar levels of disruption to daily life and impact on children, however, stigma in speaking with others was relatively higher for female suicide deaths (51.2%) compared to male suicide deaths (43.2%). In general, the stress of providing care, losing support, and raising children were reported as significant issues, especially by the families impacted by male suicide deaths.

**Table 14. Distribution of issues faced by family due to suicide death**

| Issues faced by families (% of N) | Male suicide deaths N=111 (% of N) | Female suicide deaths N=43 (% of N) |
|---|---|---|
| Emotional distress or grief | 101 (91.0) | 32 (74.4) |
| Financial issues | 92 (82.9) | 25 (58.1) |
| Stigma to talk with others | 48 (43.2) | 22 (51.2) |
| Impact on children or dependents | 74 (66.7) | 29 (67.4) |
| Disruption of daily life | 69 (62.2) | 29 (67.4) |
| Health-related issues (physical or mental) | 67 (60.4) | 24 (55.8) |
| Strained family relationships | 48 (43.2) | 19 (44.2) |
| Loss of other household/family support | 90 (81.1) | 30 (69.8) |
| Burden of caring for children after this death | 66 (59.5) | 23 (53.5) |

- Data missing for 1 case

## Current Needs of the Bereaved Families

The pattern of current needs of the bereaved families was similar for male and female suicide deaths **(Figure 23)**. All types of supports were essentially money-related ranging from support for children, job, financial and pension.

The most pressing current need was support for children irrespective of the sex of the deceased, which was predominately for education support.

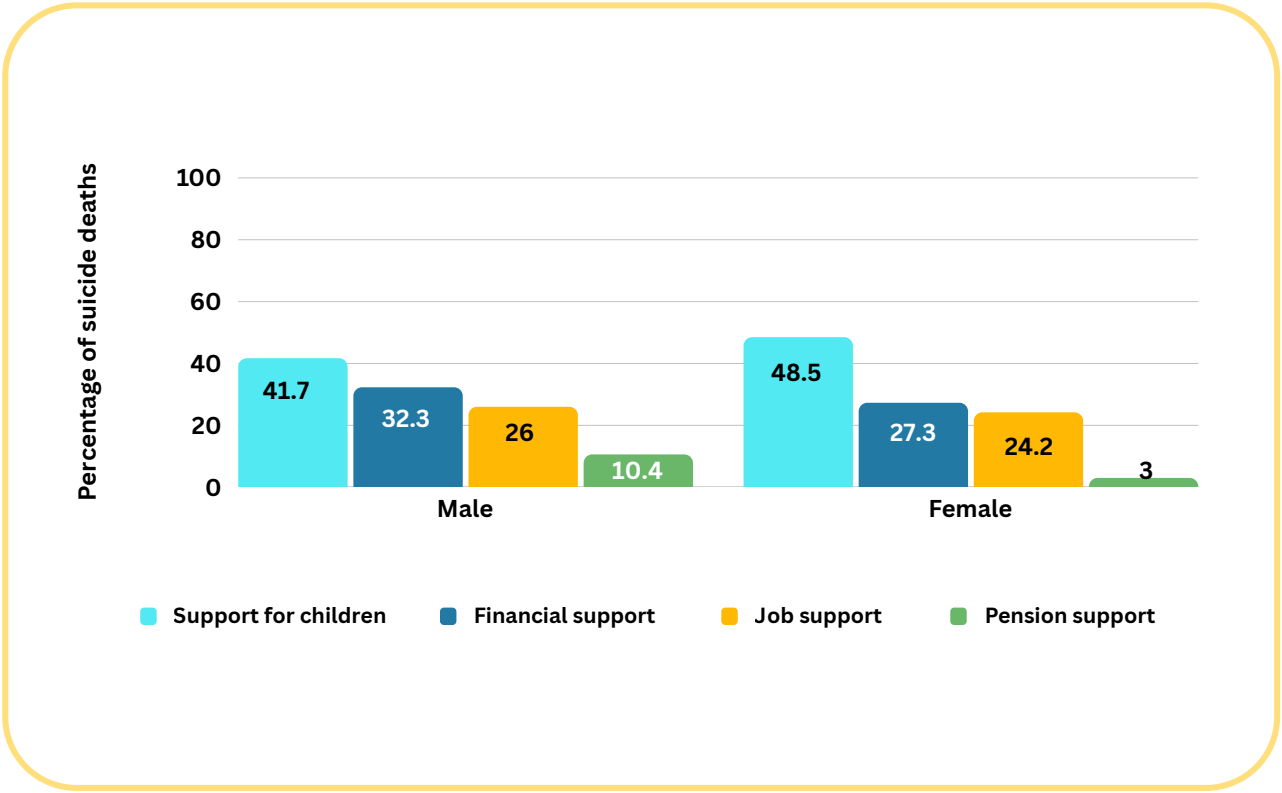



**Figure 23. Type of support currently needed by families post suicide death**

## Support Need by State

Variation was seen in the proportion of type of support families currently needed by state **(Figure 24)**. Over half of the families in Maharashtra needed child support as compared with one-third in Tamil Nadu and 40% in Uttar Pradesh. Job support need was the highest in Tamil Nadu (51%) with significantly less proportion in the other two states. This was also true to pension support. Some variations were seen in the type of support needed by socio-demography of the deceased within the states **(Figure 25)**. Job and pension support was cited as a need more in the urban areas than in the rural areas in Maharashtra and Tamil Nadu, the families affected by suicide of homemakers had the highest need for child support whereas those impacted by salaried individuals' suicides had the highest demand for job support with pension support being the least required across occupations.

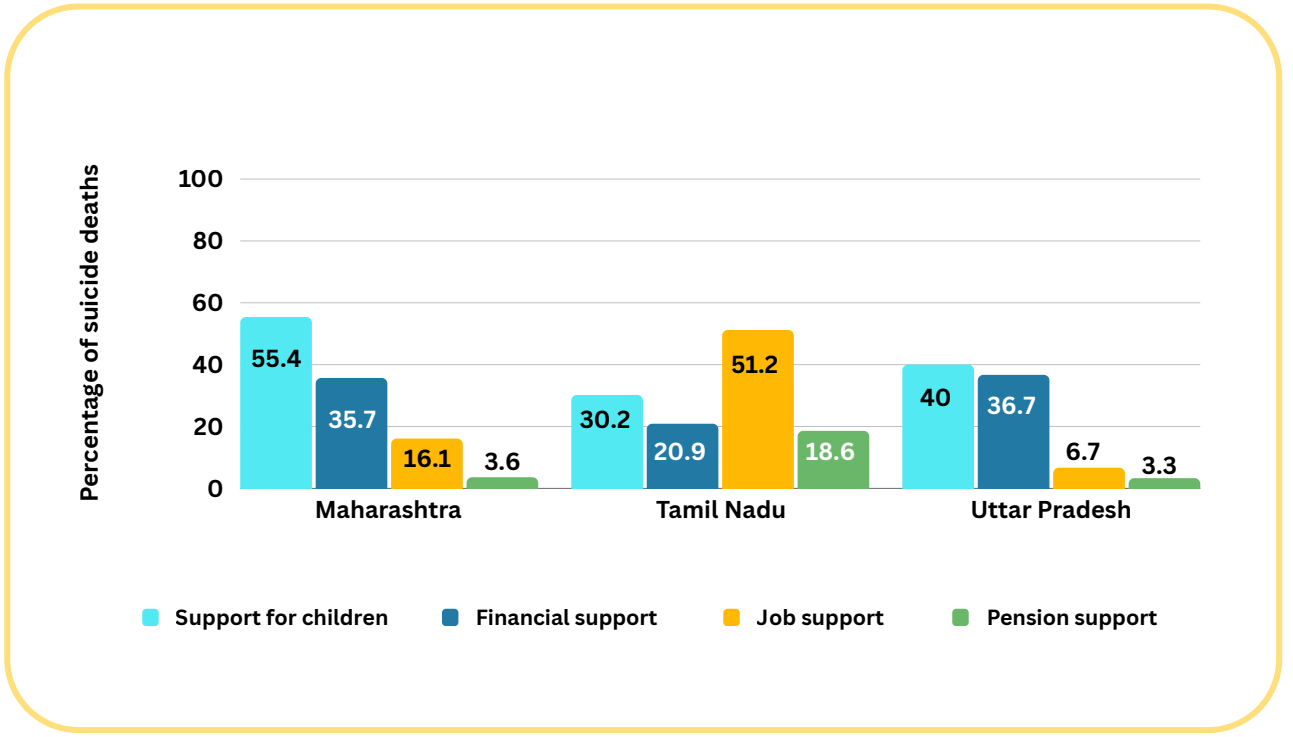



**Figure 24. Type of support currently needed by families post suicide death by state**

Maharashtra

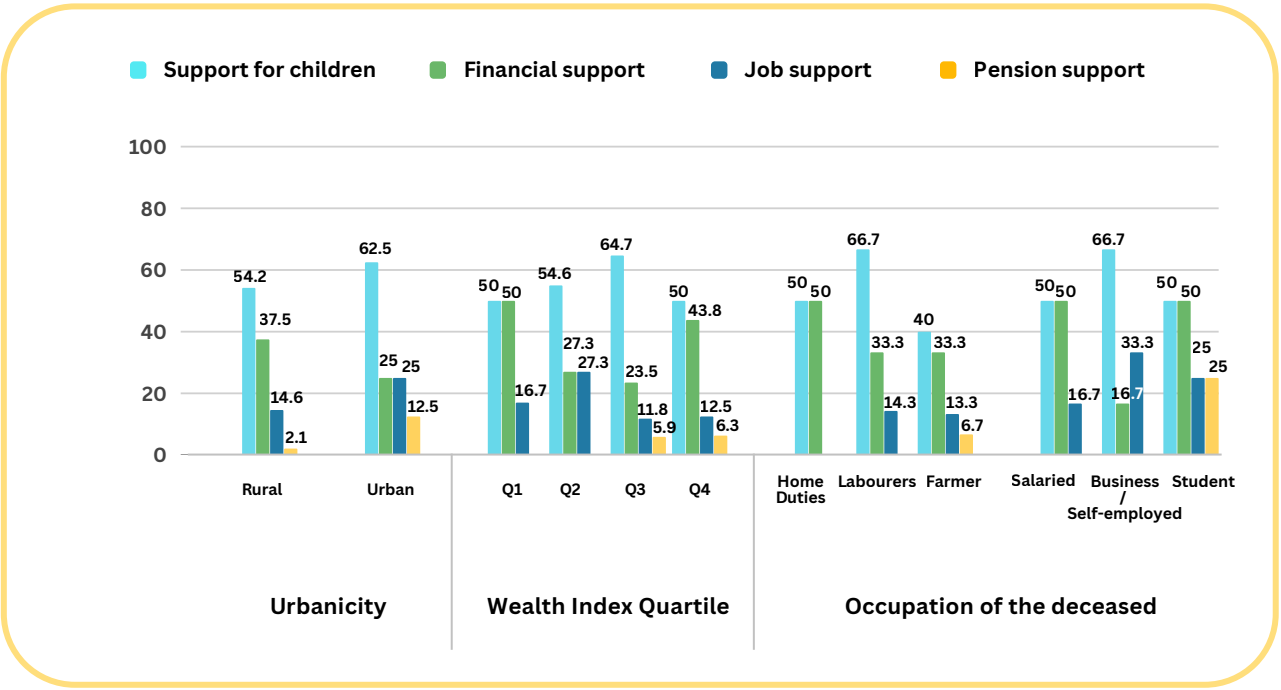
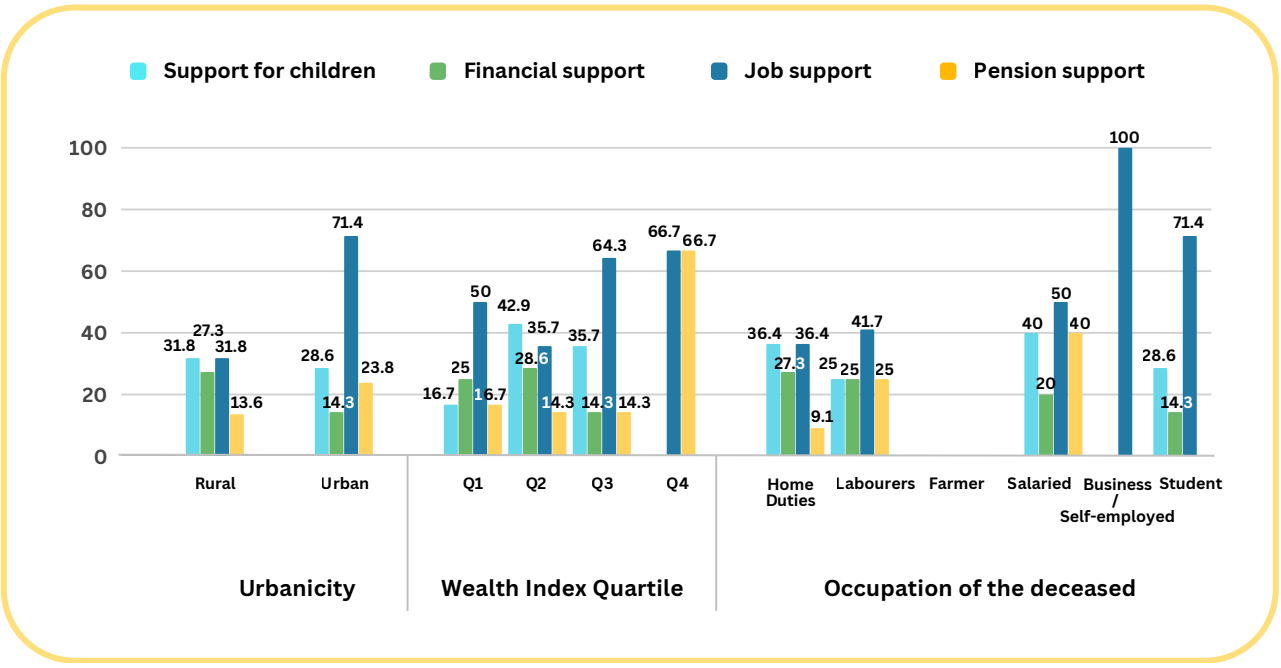
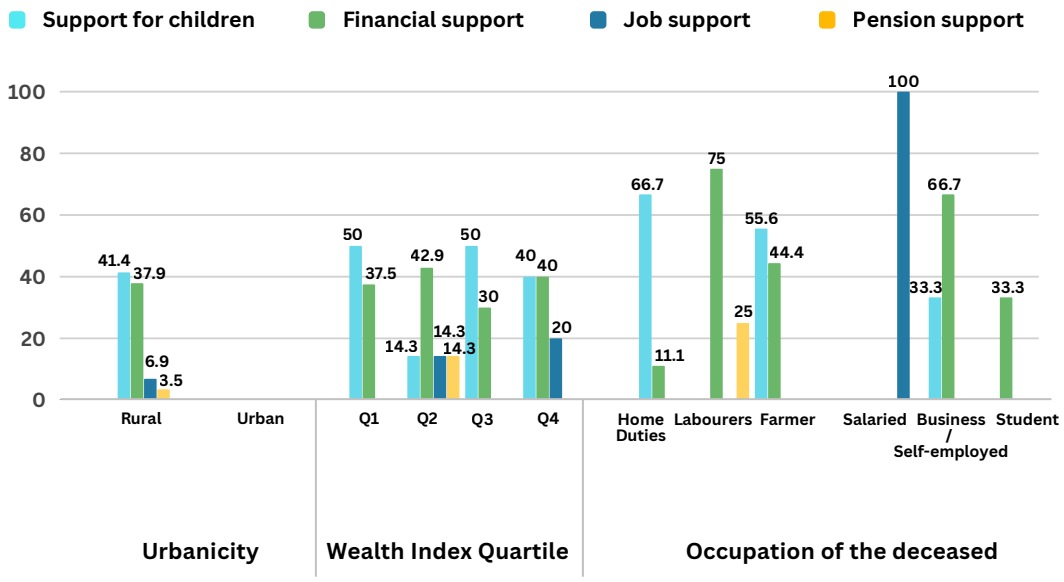



**Figure 25. Type of support currently needed by families post suicide death by socio-demography of the deceased for each state (Maharashtra)**

Tamil Nadu



## Uttar Pradesh



## Support Need for Orphaned Children

One issue that came to light was support needed for children orphaned by suicide. This was first brough to the attention during the pilot study in Haryana (case included below). The related verbatims are showcased in **Table 15**.

The team alsolearnt that a few families were informed locally (in village) that orphan scheme is not available for them because the death was suicide (as against a natural cause of death).

**Table 15. Verbatims indicating support needed for orphaned children**

| |
|---|
| ***Deceased: 28 years/male/married and 24/female/married; Haryana*** |
| *Sister of deceased was the respondents. Both parents died by suicide within a span of six months. The father, employed as a security guard, lost his entire monthly salary to an ATM fraud and, devastated by the loss, died by suicide. Six months later, his wife—struggling with depression following his death—also died by suicide. Their 4-year-old child has been orphaned and is being cared for by elderly grandparents who survive on a modest pension of just ₹3,000 per month.* |
| ***Deceased: 21 years/female/married; Uttar Pradesh*** |
| *Father-in-law of deceased was the respondent. The father of her children re-married and has not visited them for the past 1.5 years. On occasion, he sends a small amount—₹1,000 to ₹2,000 per month—but the children remain largely unsupported. The family is in urgent need of financial assistance and caregiving support.* |
| ***Deceased: 30 years/male/married; Maharashtra*** |
| *Mother of deceased was the respondent. The deceased, a 30-year-old, died by suicide in 2022. He had been married for six years and was engaged in various forms of employment. On the day of the incident, he died by suicide in a nearby field at around 3:00 PM. It was also reported that the deceased had left his wife two years prior and had returned to his parent's home. Following his death, his two children have been cared for by their elderly grandparents. The deceased's mother appeared visibly distressed during the visit. It was noted that the children—currently studying in Classes 3 and 5—need both emotional and financial support, particularly for their education.* |
| ***Deceased: 45 years/male/married/Maharashtra*** |
| *Son of deceased was the respondent. The deceased, died by suicide in 2022.. According to the deceased's children, their mother had passed away when they were very young. Since then, the family's condition deteriorated significantly. The father, deeply affected by his wife's death in 2017, showed signs of depression but did not receive any medical treatment due to financial hardship. He often stayed away from home, taking up odd jobs, and rarely returned to the house. He occasionally consumed alcohol. The deceased left behind two sons. After their mother's death, they were taken in by their aunt, a widow without children of her own. The elder son completed Class 12 but was forced to discontinue his education to take care of the household. The younger son, who was studying in Class 9, failed and had to drop out as he couldn't afford the examination fees. The children now live in a structurally weak house and are in urgent need of financial support to continue their education and secure employment. Their current situation remains vulnerable, and without their aunt's care, they would have been left completely unsupported.* |

## Alcohol as a Risk Factor

Assessment of alcohol use as a risk factor was not included in the original interview tool. However, "alcohol use as a reason for suicide" was mentioned in pilot interviews in Tamil Nadu. We, therefore, added this as a question for Tamil Nadu and Maharashtra. Alcohol use as a reason for suicide was reported by families only for males in both the states, 58.8% in Maharashtra and 40.4% in Tamil Nadu **(Table 16)**. Alcohol use was reported significantly more for ever married males, in those belonging to lower wealth index quartiles in both the states; the distribution was nearly similar in rural and urban areas.

**Table 16: Distribution of alcohol use among deceased by select socio-demographic characteristics for male suicide deaths**

| | | Tamil Nadu | | | Maharashtra | | |
|---|---|---|---|---|---|---|---|
| Variable | Variable category | Number of suicide deaths | Percent of alcohol use (% of variable category) | Chi-square test of significance p-value | Number of suicide deaths | Percent of alcohol use (% of variable category) | Chi-square test of significance p-value |
| Overall | | 52 | 21 (40.4) | | 67 | 34 (58.8) | |
| Age group (years) | 10-19 | 6 | 0 | 0.132 | 5 | 0 | 0.057 |
| | 20-29 | 17 | 6 (35.3) | | 17 | 6 (35.3) | |
| | 30-39 | 8 | 4 (50.0) | | 13 | 8 (61.5) | |
| | 40-49 | 6 | 2 (33.3) | | 11 | 7 (53.6) | |
| | 50 or more | 15 | 9 (60.0) | | 21 | 13 (61.9) | |
| Marital Status | Never Married | 18 | 4 (22.2) | 0.052 | 19 | 5(28.3) | 0.012 |
| | Ever Married | 34 | 17 (50.0) | | 48 | 29 (60.4) | |
| Wealth index quartile* | Quartile 1 | 16 | 5 (31.3) | 0.444 | 13 | 8 (61.5) | 0.302 |
| | Quartile 2 | 16 | 9 (56.3) | | 12 | 8 (66.7) | |
| | Quartile 3 | 16 | 6 (37.5) | | 20 | 10 (50.0) | |
| | Quartile 4 | 4 | 1 (25.0) | | 22 | 8 (36.4) | |

| Table 16: Distribution of alcohol use among deceased by select socio-demographic characteristics for male suicide deaths | | | | | | | |
|---|---|---|---|---|---|---|---|
| | | Tamil Nadu | | | Maharashtra | | |
| Variable | Variable category | Number of suicide deaths | Percent of alcohol use (% of variable category) | Chi-square test of significance p-value | Number of suicide deaths | Percent of alcohol use (% of variable category) | Chi-square test of significance p-value |
| Urbanicity | Urban | 24 | 10 (41.7) | 0.862 | 10 | 6 (60.0) | 0.526 |
| | Rural | 28 | 11 (39.3) | | 57 | 28 (49.1) | |
| Occupation | Home duties | 15 | 2 (13.3) | 0.001 | 4 | 2 (50.0) | 0.026 |
| | Labourer | 14 | 9 (64.3) | | 22 | 13 (59.1) | |
| | Farmer | 0 | | | 19 | 12 (63.2) | |
| | Salaried | 12 | 8 (66.7) | | 6 | 3 (50.0) | |
| | Business/ self-employed | 3 | 2 (66.7) | | 6 | 4 (66.7) | |
| | Student | 8 | 0 | | 10 | 0 | |

## Verbatims Documenting Alcohol Use

**Table 17** showcases how the alcohol use was reported by the respondents in the interviews. In all interviews, the respondents conveyed that alcohol had a major role to play, either directly or as a facilitator.

| Table 17. Alcohol use verbatims from Maharashtra and Tamil Nadu |
|---|
| **Maharashtra** |
| ***Deceased: 40 years/male/married***<br>*Son of deceased was the respondent. Deceased, a 40-year-old, died by suicide in 2022. He had previously made three suicide attempts. He had a history of alcohol dependence and often expressed suicidal intent during periods of domestic conflict. If he did not have money for alcohol, he used to ask people. Following a serious accident in 2018 that left him with a leg fracture, he experienced chronic pain and increased his alcohol consumption. He was also under financial stress, with debts amounting to approximately ₹4–5 lakhs.* |
| ***Deceased: 41 years/male/married***<br>*Son of deceased was the respondent. The deceased died by suicide on 2019 at home, when no one else was present. His grandmother and neighbours discovered the incident and informed the police. He was taken to a Government Hospital where he was declared dead. He supported the family through agricultural work. In 2017, he had purchased a car worth ₹6.5 lakh, and he still had an outstanding loan of ₹2.8 lakh at the time of his death. According to family and neighbours, he had been under financial stress and showed signs of depression for the past four years. He also reportedly consumed alcohol and frequently had conflicts with his spouse, which led her to temporarily move to her mother's house.* |
| ***Deceased: 40 years/male/married***<br>*Wife of deceased was the respondent. The deceased was self-employed and worked by grazing goats and sheep daily. He was married with two children. According to his wife, he had a pattern of returning home in the evening and consuming alcohol, which often led to arguments between them. On days that he did not drink, family life was peaceful. On the day of the incident, he followed his usual routine of grazing animals. Around 4:00 pm, he called his wife, and told her, "From today, you will only feed the goats and sheep," and then disconnected the call. She did not anticipate that he would harm himself. Sometime later, neighbours discovered that he had died by suicide in the sheep hut. He was taken immediately to Government Hospital where he was declared dead. The household atmosphere had reportedly been tensed for a long time due to his habitual alcohol use, which was perceived as the primary factor contributing to his death. Following his death, wife experienced social stigma, with neighbours and the community distancing themselves. She strongly believes that alcoholism must be addressed first to prevent others from facing similar tragedies. She advocated for suicide awareness programs in the village to reduce stigma and promote mental health.* |

| Table 17. Alcohol use verbatims from Maharashtra and Tamil Nadu |
|---|
| **Maharashtra** |
| ***Deceased: 38 years/male/married***<br>*Wife of deceased was the respondent. According to the deceased's wife, he died by suicide by at home. He was not taken to the hospital as he was found deceased at the scene. The deceased had a long history of alcohol dependence, having started drinking at the age of 20–21. He was reportedly addicted to alcohol and would behave very differently under its influence. When sober, he was described as kind and gentle. However, under the influence of alcohol, his behavior changed significantly, often leading to conflict and distress within the family. Family members shared that the deceased had made multiple suicide attempts since 2005, often as a reaction when things did not go his way. In previous instances, he was always saved by family members, and his demands would often be met afterwards. He was described as stubborn and emotionally volatile, particularly when intoxicated. He worked in a furniture shop. On the day of his death, the family was in shock and unable to take immediate action beyond informing neighbors. The deceased left behind his wife, three daughters, retired father, and elderly parents. The family is in a severe financial crisis. The wife has expressed the urgent need for employment to support her children's education and the household. Although the exact trigger for the suicide was not clear, family members strongly believe that chronic alcohol addiction and unresolved emotional distress were major contributing factors.* |
| ***Deceased: 36 years/male/married***<br>*Wife of deceased was the respondent. During Diwali of 2019, he died by suicide. Since he had drunk alcohol regularly and was asleep, the family members did not try to wake him up. After that, when he started vomiting, his wife and neighbors took him to the hospital. He was admitted for four days. Although they spent about 1,50,000 to 2,00,000 rupees, but they could not save him. He used to work and provide all the financial support at home, but he had a habit of drinking alcohol. He used to drink a lot of alcohol every day. His wife now works in someone else's farm and they have two children. It was very bad with the children; the father was gone. The wife does not talk about her husband in front of the children because the children would cry. They need money for their education and for their daily life. He had no worries and suddenly committed suicide by drinking alcohol.* |
| **Tamil Nadu** |
| ***Deceased: 56 years/male/married***<br>*Daughter of deceased was the respondent. The deceased had discontinued his coconut water business due to financial difficulties and was struggling with alcohol addiction. For about 10 days, he stayed at home without going to work, consuming alcohol heavily. During this period, he became increasingly depressed due to a large debt burden. On the 11th day, late at night, he died by suicide in front of his house. Villagers discovered him and gathered to perform his last rites without informing the police or taking him to a government hospital. The deceased is survived by his wife, two married daughters, and one son. The family is now facing serious financial hardship, struggling to manage the existing debt. His wife has expressed urgent need for financial assistance to settle the outstanding debts and to support the family, as they have no other support system.* |

| Table 17. Alcohol use verbatims from Maharashtra and Tamil Nadu |
|---|
| **Tamil Nadu** |
| ***Deceased: 35 years/male/unmarried***<br>*Father of deceased was the respondent. The deceased was a mason with two brothers and two sisters. One brother lives in Chennai, while the others reside with their parents. The deceased struggled with chronic alcohol addiction, frequently drinking and engaging in conflicts with his parents. He was also influenced by a negative peer group. He had previously attempted suicide twice, both times being saved after admission to a government hospital. These incidents were reported to the police. Tragically, on a subsequent occasion, he consumed rat poison and was admitted again to the government hospital. Despite medical treatment, he was declared dead on the third day. The deceased's parents have since appealed to the government to ban local liquor shops, blaming alcohol availability for their son's death, and urged measures to prevent similar tragedies. The family has also requested financial assistance to cope with their loss and associated expenses.* |
| ***Deceased: 25 years/male/married***<br>*Wife of deceased was the respondent. The deceased lived with his wife and two sons. Following the accidental death of his co-brother, with whom he was very close, the deceased fell into deep depression. Struggling with grief, he began drinking heavily and was unable to continue working regularly. In 2022, he made multiple suicide attempts—but was saved each time. Eventually, in a state of emotional distress, he made a video call to his wife, during which he stated that no one was to blame for his actions and informed her that he was going to die by suicide. His body was taken to the government hospital, where a post-mortem was conducted following a police complaint. The deceased's wife has since requested employment assistance to support the family and educational support for her children, as they are now in financial hardship following his death.* |
| ***Deceased: 50 years/male/ married***<br>*Wife of deceased was the respondent. The deceased had bad association and chronic drinking and ganja habit. Deceased died by suicide at home as his wife got angry and went to her mother's house. He attempted suicide 3 times already. He tried, but he could not give up his habit of alcohol and ganja. Deceased has 1 son and 1 daughter. Deceased's mother and wife look after the children. Deceased's wife asks for help for her children's education.* |
| ***Deceased: 32 years/male/married***<br>*Wife of deceased was the respondent. The deceased had an incessant drinking habit. He also had a habit of ganja. Every day he got drunk and quarrelled at home. He had attempted suicide 3 times. One day in 2020, he came home drunk and died by suicide in the toilet. Deceased had no other issue and died of total intoxication.* |

## Interviewer Observations

The interview teams noted that alcohol was relatively easily available in Tamil Nadu and Maharashtra. They noted that both foreign and country liquor were widely available through numerous licensed wine shops in Tamil Nadu. Alcohol consumption in rural areas was often seen to begin early in the day. While in the sampled clusters along national highways in Maharashtra, the team reported high density of wine shops and restaurant-bars. Several of these establishments were offering discounts, making alcohol more accessible and affordable. In rural areas, they found both the Indian-made foreign liquor and country liquor easily available. The proliferation of wine shops in the region was notable, with new outlets emerging frequently and with little regulation.

## Knowledge about Reasons for Suicide Deaths in India

We asked the respondents about their perspective on what were the top reasons for suicide in India. They were given a list of potential reasons and were asked to rank the reasons from 1 to 8. Interestingly, the respondents in Tamil Nadu were able to rank the reasons from 1 to 8 whereas the respondents in Maharashtra and Uttar Pradesh predominantly ranked from 1 to 3 **(Figures 26 to 29)**.

The top three reasons given by the respondents from the household of deceased never married males and females were similar, with money-related, mental health and family-related reasons ranked top 3 **(Figures 26 and 27).** On the other hand, the top reason given by the respondents from the household of deceased ever married males was overwhelmingly was money-related followed by domestic violence, property-related and mental health reasons **(Figure 28)**. The top reason given by the respondents from the household of deceased ever married females was overwhelmingly mental health related followed by family-related reasons **(Figure 29)**.

| | Reasons for Suicide deaths | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Money-related | Property-related | Mental Health-related | Other Health Reasons | Marriage-related | Family Problems Other than Marriage | Exam-related | Domestic Violence |
| Maharashtra (N=9) | 1 | 2 | 4 | | | | | 3 |
| | 1 | | | | 2 | | | |
| | | | | | | 1 | | |
| | | | | 1 | | | | |
| | 2 | | 1 | | 4 | | | 3 |
| | 1 | | | | | | | |
| | 1 | | 3 | | | | | |
| | 2 | | | | | | | 1 |
| | 2 | | 1 | | | | 3 | |
| Tamil Nadu (N=11) | 4 | 5 | 1 | 3 | 2 | | 6 | |
| | 2 | 6 | 1 | 7 | 3 | 4 | 8 | 5 |
| | 4 | 5 | 1 | 6 | 3 | 2 | 8 | 7 |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| | 5 | 6 | 2 | 1 | 4 | 3 | 7 | 8 |
| | 1 | 8 | 4 | 7 | 2 | 6 | 5 | 3 |

| | Reasons for Suicide deaths | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Money-related | Property-related | Mental Health-related | Other Health Reasons | Marriage-related | Family Problems Other than Marriage | Exam-related | Domestic Violence |
| Tamil Nadu (N=11) | 4 | 5 | 1 | 6 | 7 | 3 | 2 | 8 |
| | 1 | 2 | 3 | 4 | 8 | 7 | 6 | 5 |
| | 2 | 7 | 3 | 5 | 6 | 4 | 1 | 8 |
| | 1 | 2 | 3 | 8 | 5 | 4 | 6 | 7 |
| | 4 | 2 | 1 | 3 | 7 | 2 | 6 | 8 |
| Uttar Pradesh (N=4) | | | | | | 1 | 2 | |
| | 4 | | 1 | | | 2 | 3 | |
| | | 2 | | | 1 | | | |
| | 1 | | | 3 | | | | 2 |

**Figure 26. Heat map showing the ranking of reasons for suicide deaths in India from 1 to 8, as indicated by the families of never married male suicide deaths in the study. A total of 8 respondents could not rank the reasons, and are not included in below**

| | Reasons for Suicide deaths | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Money-related | Property-related | Mental Health-related | Other Health Reasons | Marriage-related | Family Problems Other than Marriage | Exam-related | Domestic Violence |
| Maharashtra (N=2) | 2 | | | | | 1 | | 3 |
| | 2 | | 1 | | | | | |
| Tamil Nadu (N=7) | 1 | 7 | 3 | 8 | 5 | 6 | 2 | 4 |
| | 5 | 6 | 1 | 3 | 7 | 2 | 4 | 8 |
| | 1 | 2 | 5 | 6 | 3 | 7 | 4 | 8 |
| | 1 | 5 | 2 | 7 | 4 | 3 | 8 | 6 |
| | 4 | 5 | 1 | 2 | 6 | 3 | 7 | 8 |
| | 4 | 5 | 2 | 6 | 7 | 3 | 1 | 8 |
| | 4 | 5 | 2 | 3 | 7 | 1 | 6 | 8 |
| Uttar Pradesh (N=1) | 1 | | | | | 2 | 3 | |

**Figure 27. Heat map showing the ranking of reasons for suicide deaths in India from 1 to 8, as indicated by the families of never married female suicide deaths in the study. A total of 2 respondents could not rank the reasons, and are not included in below**

| | Reasons for Suicide deaths | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Money-related | Property-related | Mental Health-related | Other Health Reasons | Marriage-related | Family Problems Other than Marriage | Exam-related | Domestic Violence |
| Maharashtra (N=35) | 1 | | 2 | | | 1 | | |
| | 1 | 2 | 3 | | 4 | | | |
| | 1 | | | | | | | |
| | 3 | | 1 | | | | | 2 |
| | 2 | | 1 | | | | | 3 |
| | 1 | | 2 | | | | | 3 |
| | 1 | | | | | | | 2 |
| | 1 | | 2 | | | 3 | | |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| | 1 | | | | | | | |
| | 1 | | | | | | | |
| | 1 | 3 | | | | 4 | | 2 |
| | 1 | | | | | | | 2 |
| | 1 | 2 | 3 | | | | | |
| | 1 | 2 | | | | | | |
| | 1 | 2 | | | | | | |

| | Reasons for Suicide deaths | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Money-related | Property-related | Mental Health-related | Other Health Reasons | Marriage-related | Family Problems Other than Marriage | Exam-related | Domestic Violence |
| Maharashtra (N=25) | 1 | | | | | | | |
| | 1 | | 3 | | | | | 2 |
| | 2 | | 1 | | | | | |
| | 1 | | | 2 | | | | |
| | | 1 | | | 2 | | | |
| | 1 | 3 | | | | | | 2 |
| | 1 | | | | 2 | 3 | 4 | |
| | 1 | | 2 | | | | | |
| | 1 | | | | | | | |
| | | 3 | 1 | 2 | | | | |
| | | | 3 | | 1 | 4 | | 2 |
| | 1 | | 3 | | | | | 2 |
| | 1 | | | | | | | 2 |
| | 1 | | | | | | 2 | |
| | 1 | 2 | | | | | | 3 |
| | 1 | | | | | | | |

| | Reasons for Suicide deaths | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Money-related | Property-related | Mental Health-related | Other Health Reasons | Marriage-related | Family Problems Other than Marriage | Exam-related | Domestic Violence |
| Maharashtra (N=35) | 1 | | | 2 | | | 3 | 4 |
| | 1 | 2 | 3 | 4 | | | 5 | |
| | 1 | | 2 | | | | | |
| Tamil Nadu (N=24) | 3 | 5 | 1 | 2 | 4 | 6 | 7 | 8 |
| | 1 | 6 | 2 | 4 | 5 | 7 | 3 | 8 |
| | 1 | 5 | 2 | 3 | 6 | 4 | 7 | 8 |
| | 1 | 8 | 2 | 3 | 4 | 5 | 6 | 7 |
| | 1 | 2 | 4 | 3 | 5 | 6 | 7 | 8 |
| | 4 | 5 | 3 | 6 | 7 | 1 | 2 | 8 |
| | 1 | 8 | 5 | 2 | 6 | 7 | 4 | 3 |
| | 3 | 4 | 1 | 2 | 5 | 6 | 8 | 7 |
| | 1 | 2 | 3 | 5 | 7 | 4 | 6 | 8 |
| | 1 | 5 | 2 | 3 | 7 | 4 | 6 | 8 |
| | 3 | 4 | 1 | 5 | 6 | 2 | 7 | 8 |
| | 3 | 4 | 2 | 1 | 6 | 5 | 7 | 8 |
| | 1 | 2 | 4 | 3 | 5 | 6 | 8 | 7 |

| | Reasons for Suicide deaths | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Money-related | Property-related | Mental Health-related | Other Health Reasons | Marriage-related | Family Problems Other than Marriage | Exam-related | Domestic Violence |
| Tamil Nadu (N=24) | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| | 4 | 5 | 2 | 1 | 6 | 3 | 7 | 8 |
| | 1 | 2 | 3 | 4 | 5 | 7 | 8 | 6 |
| | 2 | 5 | 1 | 4 | 6 | 3 | 7 | 8 |
| | 1 | 4 | 3 | 5 | 6 | 7 | 2 | 8 |
| | 4 | 5 | 1 | 2 | 7 | 3 | 6 | 8 |
| | 1 | 2 | 4 | 5 | 7 | 3 | 6 | 8 |
| | 4 | 3 | 1 | 2 | 5 | 6 | 7 | 8 |
| | 1 | 5 | 4 | 3 | 6 | 2 | 7 | 8 |
| | 4 | 5 | 1 | 3 | 6 | 2 | 7 | 8 |
| | 1 | 2 | 3 | 7 | 4 | 5 | 8 | 6 |
| Uttar Pradesh (N=12) | | | | | | | 1 | |
| | | | 1 | 2 | | | | |
| | | 1 | | | 2 | | | 3 |
| | | | 1 | | 2 | | | |
| | 1 | | | | | | | 2 |

| | Reasons for Suicide deaths | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Money-related | Property-related | Mental Health-related | Other Health Reasons | Marriage-related | Family Problems Other than Marriage | Exam-related | Domestic Violence |
| Uttar Pradesh (N=12) | 1 | 2 | | | | 3 | | |
| | 1 | 4 | 2 | 8 | 6 | 5 | 3 | 4 |
| | 2 | | | | | 1 | | 3 |
| | | 1 | | 2 | | | | 3 |
| | 3 | | 1 | | | | | 2 |
| | 3 | 2 | | | | 1 | | 0 |
| | 1 | | 2 | | | 3 | 5 | 4 |

**Figure 28. Heat map showing the ranking of reasons for suicide deaths in India from 1 to 8, as indicated by the families of ever married male suicide deaths in the study. A total of 8 respondents could not rank the reasons, and are not included in below**

| | Reasons for Suicide deaths | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Money-related | Property-related | Mental Health-related | Other Health Reasons | Marriage-related | Family Problems Other than Marriage | Exam-related | Domestic Violence |
| Maharashtra (N=5) | 1 | | | | | | | 1 |
| | 1 | | | | | 2 | 3 | |
| | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 |
| | | | 1 | | | | | |
| | 2 | | 1 | | | | | |
| Tamil Nadu (N=10) | 4 | 3 | 1 | 5 | 7 | 2 | 6 | 8 |
| | 4 | 5 | 1 | 2 | 8 | 3 | 7 | 6 |
| | 5 | 6 | 1 | 2 | 4 | 3 | | |
| | 3 | 4 | 1 | 5 | 6 | 2 | 8 | 7 |
| | 4 | 5 | 1 | 2 | 7 | 3 | 6 | 8 |
| | 1 | 2 | 4 | 3 | 6 | 5 | 7 | 8 |
| | 3 | 4 | 1 | 5 | 7 | 2 | 6 | 8 |
| | 2 | 4 | 1 | 6 | 7 | 3 | 5 | 8 |
| | 4 | 5 | 1 | 3 | 6 | 2 | 7 | 8 |
| | 1 | 3 | 4 | 5 | 2 | 7 | 8 | 6 |

| | Reasons for Suicide deaths | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Money-related | Property-related | Mental Health-related | Other Health Reasons | Marriage-related | Family Problems Other than Marriage | Exam-related | Domestic Violence |
| Uttar Pradesh (N=15) | | | 1 | | 2 | | | |
| | | | | 2 | | 1 | | |
| | 3 | 2 | | | | 1 | | |
| | | | | | | 1 | | |
| | | | | | | | | |
| | 1 | | | | | | | 2 |
| | | | 3 | | | 2 | | 1 |
| | | | 1 | 5 | 4 | 3 | | 2 |
| | 3 | | | | | 1 | | 2 |
| | | 3 | 2 | | | | | 1 |
| | 1 | 2 | | | | | | 3 |
| | 1 | | | 3 | | | | 2 |
| | 2 | 1 | 3 | | 4 | | | |
| | 2 | 1 | | 3 | | | | |
| | 1 | | | | 2 | 4 | 3 | 4 |

**Figure 29. Heat map showing the ranking of reasons for suicide deaths in India from 1 to 8, as indicated by the families of ever married female suicide deaths in the study. A total of 1 respondent could not rank the reasons, and are not included in below**

# MAJOR TAKEAWAYS FROM IN-DEPTH STUDY

## Addressing Under-reporting of Suicide Deaths in Police Data

- Suicide deaths are documented as unnatural deaths by the police, and these are reported annually in the National Crimes Report Bureau (NCRB). The numbers reported in the NCRB reports are the official source of the number of suicide deaths in India.[6]
- Under-reporting of injury deaths (such as suicide, road accident) in the police data is known for various reasons.[10, 14, 23]
- Nearly 3 in 10 suicide deaths were not reported to police in this study. The police case reporting of suicide deaths to varied by age, sex, state and urbanicity.
- Maharashtra had the highest reporting to police, perhaps, due to presence of police- facilitator at the local level and government compensation schemes related to farmer suicide deaths.
- Majority of those who did not report the death to police cited police-related reasons, predominantly related to avoiding post-mortem.
- Reasons for not reporting the suicide death to police varied by state and sex of the deceased. This highlights the need for local socio-cultural understanding of these reasons to specifically address improved reporting of suicide deaths to the police. This is necessary to capture the burden of suicide deaths more robustly in India.

## Newspaper Coverage of Suicide Deaths

- Two in five suicide deaths were reported in newspaper, with variations seen across the states. It is previously reported that suicide reporting is considered "newsworthy" in India.[24]

- Coverage in newspapers was 3 times higher if a police case was registered for the suicide death. This reflects the symbiotic relationship between the police and crime reporters.

- Male deceased farmers and salaried employees outnumbered female deceased (who are engaged more in home duties) and hence received more newspaper coverage. However, a higher coverage of female deaths in 10-19 years age group was reported whereas a suicide death in this age group for male was reported the least.

    - The journalists in India have expressed that, "suicide among younger people and females were generally more newsworthy, as they were presumed to generate greater reader empathy and curiosity." [24]

    - The reporting in newspaper is influenced by the prevailing gendered assumptions in the Indian context about livelihood and financial responsibilities as males' domain. The topic of farmers' suicides has also been determined as newsworthy by media professionals as "farmer suicides are highly politicised and attract a lot of attention," thus affecting the amount of news coverage.[24]

- Notably, nearly half of the survivors opposed the newspaper coverage and one-third supported it.

    - The survivors may be at a greater risk of suicide themselves after the loss, which is why the WHO guidelines recommend that journalists exercise caution when interviewing bereaved family members, friends, and relatives.[25]

    - Survivors who supported coverage in the newspaper believed that it helped with creating awareness for suicide prevention.

    - Survivors who opposed coverage in the newspaper were not interested in reading about death in their family in the media, and were worried about impact on family members, in particular on children and girls.

    - Incorporating lived experience voices in media reporting is important to ensure that the emotional, social, and personal realities of those affected are taken care of.

## Signs for At-risk Behaviour

- 3 in 5 people who died by suicide in this study had voiced suicidal feelings, and some signs were observed by the others in half of these deaths. These findings have major implications for depending predominately on gate-keeping in suicide prevention. Effort is needed to put in place relevant primary and secondary prevention strategies that can respond to the primary stressors for suicide.

- Gendered context in the feelings/signs displayed by the deceased was evident.
  - Guilt/shame or anger was voiced relatively more by males than females.
  - Males also voiced feeling extremely sad or anxious more than females whereas females voiced more unbearable emotional pain.
  - Signs such as lost interest in daily chores, substance abuse, and extreme mood swings were noticed more for males than females who died by suicide.

## Previous Suicide Attempt

- Previous suicide attempt is known as a strong risk factor for suicide globally.

- In this study, at least one suicide attempt was reported for 10% of the suicide deaths with no sex difference. This proportion will have to be seen in the context of under-reporting of suicide attempts and poor knowledge of such attempt in the family.

- The most striking finding here is this is the consistency in the reason, mode and place of suicide attempt and suicide across most cases. These findings also have major implications for gate-keeping in suicide prevention.

## Support Need for the Survivors

- All types of support needed by the families were essentially financial ranging from support for children, job, and pension. The most pressing current need was support for children irrespective of the sex of the deceased, which was predominately for education support.
- The families affected by suicide of females had the highest need for child support whereas those impacted by salaried individuals' suicides had the highest demand for job support.
- Some children had become orphan due to suicide of both the parents, or because of one parent dying by suicide and other not available for children.
  - The team also learnt that a few families were informed locally (in village) that orphan scheme is not available for these children because the parent died of suicide (as against a natural cause of death).
- State and urbanicity variations were seen in the type of support needed.

## Implications for suicide prevention

- Collaboration, cooperation and co-designing with the police of efforts to address barriers in the community to improve documentation of suicide deaths in police records is needed. This is necessary as police records continue to be the primary official source of suicide deaths in India.
- State contextualization and ownership of the interventions is needed. Both, health and police, are state subjects and hence the action will need to be driven at the state-level for meaningful reduction in suicide deaths.
- Children are the centre of needs identified in the households impacted by suicide. Examining multi-sectoral approach to support the bereaved households irrespective of the occupation of the deceased (farmers) is the need of the hour. Linkages are needed with education and child health programmes, and employment and pension programmes.
- Gate-keeping to identify those at risk is recommended for suicide prevention. With the consistency seen in previous suicide attempts

and many voicing suicidal feelings, further exploration is needed into practical aspects of what this may mean in real-life context, in particular at the family-level at home, to prevent suicide. This further understanding will have to take gender into context.

- Newspaper reporting of suicide deaths impacts the affected families. Further work can benefit from insights into how this impact can be negated while highlighting suicide prevention and avoiding distress to those affected.

# ADVOCACY RECOMMENDATIONS

In this section, we make recommendations based on the study findings and our interactions with the respondents that we were unable to fully capture in the report.

## In the Community

- A good proportion of potential respondents initially did not want to participate in the in-depth study as they did not want to recollect what had happened and because the person who has died will not return. However, when the team informed them about the magnitude of suicide deaths in India and that it affected mostly young people, they were surprised as they had no idea of the extent of the problem. This information changed their hesitation to willingness to participate in the study mainly to help with suicide prevention in the others.

- We asked people to rank eight possible reasons for suicide death in India from 1 to 8, with 1 being the most important reason as per them. Interestingly, most respondents were able to list reasons based on why suicide death happened in their family, and seemed less aware of the other reasons as to why people die by suicide in India.

- We had not planned to document the role of alcohol in suicide in our study until this was raised in pilot studies in Tamil Nadu and Maharashtra. The verbatims in these states documented how alcohol abuse led to domestic violence, child abuse, loss of income, anger, etc. and was narrated as reason for suicide for males.

**Recommendation 1:**

Advocacy efforts for suicide prevention in the community in India should focus on the following to get bottom-up support for suicide prevention:

- inform about the magnitude of suicide deaths;
- highlight that suicide deaths are an issue both in males and females, in 15-39 years age group, and in a variety of people and not only in farmers or students;
- should highlight the potential causes of suicide deaths in India separately for males and females; and clearly establish link between domestic violence and suicide in females (as has been established for alcohol abuse and suicide in males).

**Recommendation 2:**

Support networks for suicide attempt survivors and bereaved families towards advocacy to humanize the issue and influence policies with real-life stories.

## With the Police

- Police is the primary source of data capture for suicide deaths, and these data are available in the NCRB reports. However, police are not collecting these data with the aim of suicide prevention but as reporting of unnatural death.
- Avoiding post-mortem was a major theme in addition to harassment by police for not reporting of suicide deaths to them.

**Recommendation 3:** Advocacy efforts are needed with the police with the aim to collaborate with them for suicide prevention and mitigating impact on the bereaved families. These efforts should specifically target:

- Improved understanding in the police about how suicide data collected by them is used towards suicide prevention.
- Increased awareness about what community feels about post-mortem and interaction with them.
- Impact on bereaved families that they could be cognizant of in their interactions.

### With the Government

- Both, the reasons for suicide deaths and the needs of the bereaved families, point to the urgent need of multi-sectoral actions beyond only mental health needs.
- Respondents highlighted varying levels of involvement of the village leaders in decision-making to report suicide death to police, and in support to bereaved families.
- Some village leaders were very vocal with the study team about the need to act on suicide prevention.

**Recommendation 4:** Advocacy efforts are needed with the police with the aim to collaborate with them for suicide prevention and mitigating impact on the bereaved families. These efforts should specifically target:

- The reasons for suicide deaths which indicate the need for multi-sectoral actions;
- Financial needs of the impacted families as many of those who die by suicide are in the young and productive age group;
- Long-term impact on children of suicide death of a parent;
- Address misconceptions of access to government programs for families affected by suicide.

# STRENGTHS & LIMITATIONS OF THE STUDY

The major strength of this study is that it is a representative sample of deaths in India between 2019 and 2022, which is a value-add as this population is typically not covered in routine service coverage surveys. The last nationally representative survey of deaths in India was undertaken for deaths in years 1998 to 2014.

Many times, semi-structured qualitative interviews are undertaken in non-representative sample which often has limited generalizability since participants may not represent broader populations or cultural contexts. The strength of the semi-structured qualitative interview sample in this study was that it was drawn from a nationally representative sample of suicide deaths, and hence the findings are more generalisable at the broader population level. Furthermore, survivors willing to participate may differ systematically from those who decline. In the national survey, we had excellent participation at 90%, and the participation was 70% in the semi-structured qualitative interviews.

The semi-structured qualitative interviews with suicide attempt survivors can generate deep insights, but there are important limitations to acknowledge. Survivors may have difficulty accurately recalling thoughts, emotions, or circumstances around the event. Revisiting painful experiences may lead to incomplete or inconsistent narratives. They may underreport stigmatized experiences (e.g., substance use, family conflict) or shape responses to appear more socially acceptable. The interpretive limitations that have to be acknowledged, which include subjectivity in the analysis, context-dependency as the risk factors described may be deeply shaped by cultural, social, or personal contexts. Also, focus on individual narratives, while valuable, these may overlook structural or systemic risk factors (e.g., healthcare access, socioeconomic inequality). We attempted to mitigate these limitations by having more than one researcher analyse transcripts to increase reliability of thematic coding, and have attempted to situate findings within cultural, systemic, and socioeconomic contexts, not just individual experiences.

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