



Global EAP Challenges and Opportunities

Managing Suicide in India

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Not unlike the United States and other countries, suicide in India is truly a public and occupational health issue: In 2019, India represented nearly 20 percent of global suicide deaths¹. For over 25 years, India’s National Crime Report Bureau (NCRB) has recorded over 100,000 suicides annually, with 468 per day in 2022². Additional research indicates that for every suicide death in India, more than 200 presented with suicidality, and over 15 suicide attempts³. Given the increasing numbers of Indian immigrants and expatriates in the global economy, it is vital for EA professionals to understand the unique aspects of suicides in Indian culture and among Indians, so they can nuance their support for these clients.

Suicide in India versus the United States:

In order to contextualize these differences, some recent national data on suicide in India and the USA are compared below. Noting the percentage of male suicides is much higher than for women, as is the case for most countries, notable differences in both age and means used are present.

| | India 2022 ² | USA 2022 ^{4,5} |
|--------------------------------|--------------------------|-------------------------|
| Absolute number | 170,924 | 49,476 |
| Suicide rate per capita | 12.4 | 14.2 |
| Gender Male vs Female | 72% : 28% | 79% : 21% |
| Age distribution | Below 18: 6% | 10-24 years: 13% |
| | 18-29 years: 35% | 25-34 years: 18% |
| | 30-44 years: 32% | 35-44 years: 17% |
| | 45-59 years: 19% | 45-54 years: 16% |
| | 60+ years: 9% | 55+ years: 37% |
| Marital Status | Unmarried: 25% | Not Available |
| | Married: 67% | |
| | Widowed: 2% | |
| | Separated/Divorced: < 2% | |
| | Others/Unknown: 6% | |
| Method | Hanging: 58% | Firearms: 55% |
| | Poisoning: 25% | Suffocation: 25% |
| | Drowning: 5% | Poisoning: 12% |
| | Others: 12% | Others: 8% |

Age & Gender: In 2022, approximately 73 percent of Indian suicide decedents were younger than 45 years of age (compared to 48 percent in the USA). More than a third (43 percent) of the female Indian decedents were between 18-29 years. Suicide death rates in India are higher than expected for its Socio-demographic Index level*¹, especially for women⁶; with the suicide rate among younger Indian females being twice the global rate⁷. India’s National Mental Health Survey (NMHS) reveals the prevalence of suicidality among Indian women as 1.75 times that of men³. Younger age also appears to be a risk factor for Indians, and more so among Indian women.

Marital status: Unlike most Western suicide data⁸, wherein divorced and separated persons were more than twice as likely to commit suicide as married persons; two-thirds (67 percent) of the Indian decedents were married. Understanding and exploring the quality of the marital relationship, and integration with the family context will be important when working with at-risk Indian clients.

Means: Although firearms are the most common method in the USA⁴, this method accounted for less than 1 percent of the suicide deaths in India². Instead, hanging (as is common across many Asian countries)⁹, appears as the primary method. Safety planning and crisis watches for suicidal Indian clients may need to factor in a wider and more distinctive range of methods.

Challenges of Managing Suicidal Risk in India

A few long-established EA organizations in India, as well as a not-for-profit community-based crisis helpline consented to share their experiences with managing suicidal persons in India for this article. Given that these India-based EA providers followed similar best practices in suicide prevention and intervention (such as

¹* The Socio-demographic Index (SDI) is a number that measures a country’s or region’s development status on a scale of 0 to 1. The SDI is calculated by combining three indicators of fertility, mean education and distributed income per capita. It is a strong indicator of health outcomes and is used to estimate the comparative burden disease, injuries and risk factors in different countries.

awareness campaigns, peer/manager training, screening, triage, safety planning, etc), this article will highlight the some of the cultural challenges encountered in this area.

Insufficient data: India is a large country with wide heterogeneity in geography, culture, religious composition, and socio-economic development. The NMHS³ findings indicate these factors reveal variations that impact both suicidality behavior and death by suicide; and more state and community specific data is needed to inform and drive decision making. The NCRB’s annual publication² has been criticized for under-enumerating national levels of suicides^{10,11}, and attributing single, proximal, external factors as reasons for suicide, thus its research findings may not be representative of the general population.

Criminalization: Until India’s Mental Health Care Act¹⁴ was enacted in 2017, attempted suicide was a criminally punishable offence, with many hospitals delaying, refusing to treat, or even to admit suicidal people for fear of legal repercussions¹⁵. Despite the Act, attempted suicides continued to be recorded as medico-legal cases until December 2023 when the Indian Penal Code Section 309 was repealed. Thus, Indians may have lingering mistrust of police involvement with this condition, fearing investigations, punitive action, and stigma in dealing with courts.

Knowledge of and Access to Lethal Means: In India, ceiling fans and poisons (such as household products or insecticides) are easily available, and reducing access to these is difficult, or near impossible. The Press Council of India issued responsible media reporting guidelines¹⁶ in 2019, which cautioned against naming decedents, sensationalizing suicides and giving details of suicides undue mention as a constructive solution to assist in prevention. Unfortunately, these guidelines are not strictly followed as some Indian media outlets continue to explicitly report names of decedents, the method used, selectively reporting on suicides of certain population groups (such as students and farmers), and sensationalizing celebrity deaths, with harmful impacts.¹⁷

Insufficient Mental Health System supports: It is estimated that there are less than 1 mental health professionals per 100,000 people in India¹⁸. These inadequate mental health resources, especially in India’s rural areas create significant access and affordability barriers to services and treatment.



“Some individuals with means have access to a psychiatrist or other mental health professional or call their EAP and get a counselling session, but that is not the majority of people in India. The majority still struggle, wondering, ‘Should I spend money on a doctor or a therapist?’ That is still a big privilege for them.”
(Caroline Asirvatham)

“Mental health services can be expensive and unaffordable - part of the reason an EAPs have to step in to deal with suicide is because it becomes financially accessible.” (Mahua Bisht)

Online counselling platforms and mental health applications have certainly improved access to services, but they often have an exclusion criterion for suicidal clients. Most of the Indian states have non-government organizations (NGOs) providing suicide hotlines in local languages with trained volunteers. However, only a few are 365/24/7, nor are they always directly linked to emergency services.

“Because we are not a crisis line, we do recommend the national or local state crisis number. If that’s not there, then we do search for a NGO according to their preferences, such as 24/7 or in a certain language, male and female counsellors, LGBT affirming, non-religious or religious - and provide that referral.”
(Caroline Asirvatham)

Emergency Care: When a suicidal EA client seeks care, EA providers have historically struggled to identify and access helpful or trained emergency support.

“Since EAP is often telephonic, we may face the challenge of not being able to directly observe the client and their physical and environmental conditions...we may not know where they are calling from. We may not be able to reach emergency or public safety services. A lack of centralized emergency medical care for those at risk proves to be a common challenge across the country...” (Vani Reddy)

“...As a provider for clients in the UK and US, I can facilitate a police response or an ambulance in minutes. Even if I do not have an address, they can be located. In India, we do not have an adequate emergency service protocol, we do not have those systems and privileges. The police system does not have accurate addresses for every citizen. Thus, the responsibility to obtain the client’s address is on the clinician.”
(Caroline Asirvatham)

“Police support often depends on the whims of the local police administration. Some are interested to learn and others think it’s a ‘waste of time’ or ‘social policing’. We do not really have a second line of support. We work closely with child crisis helpline, which can send an ambulance. It starts and ends with me... At Iam, when I have to contact them, coverage may be partial or nonexistent, and they often speak a different language..” (Dr. Arun John)

More recently, in response to the increased prevalence and greater awareness of the acute need for suicide and crisis services, EA providers in India have engaged in outreach to public safety, coaching police personnel regionally and across state lines to better manage unfolding situations effectively and with community crisis resources to proactively build and coordinate support networks.

“We work through families, emergency contacts, or even neighbors in some situations. If we suspect a client has harmed themselves already, we must decide whether we need an ambulance to respond or if the police can check for us. It also depends on the particular state, whether the police are willing or able to respond. Most might be understanding, and even though suicide has been decriminalized, they may say ‘I’m going to register it as a police case.’ Because we have been providers here for a long time, we have developed a decent working relationship with local police, so we are able to communicate how important a particular welfare check is, that we’re really concerned about the individual’s mental health (so that they would hopefully not approach it as a negotiating or possible arrest situation). They will agree to do a welfare

check, see how the individual is doing, and if they are not doing fine, they will call the ambulance, and the hospital will admit them.” (Caroline Asirvatham)

Social Support: Family members are a key resource to help ensure a suicidal person is monitored for safety through the initial crisis, receives emotional support, adheres to any needed treatment, and subsequent care. As a collectivistic society, family members in India tend to be primary caregivers, who prefer to be meaningfully involved in all aspects of caregiving¹⁰. Today however, this is changing and fewer Indians live together with their family, or may not want to involve them in such issues.“

Procuring the client’s consent to inform the family members can be yet another challenge, as many times the clients are unwilling to inform their family.” (Vani Reddy)

This reluctance to share with families may be due to feelings of potential shame or stigma about being suicidal, the clients’ concerns about burdening others, and their uncertainty about others’ willingness or ability to support them.

“...[Quoting family members’ reactions] Why would you even think this? You are unstable. You are the crazy one. If you believe in something good (religion), you should not be feeling this way, how ungrateful you are, your mind is fine, you are just making this up’ etc. So, we may also see a lot of religious trauma and accusations as negative family reactions...” (Caroline Asirvatham)

“When we do garner support from family members, we often hear them say ‘we are here for support’, but it’s not clear what that support means or entails. Families may be hesitant to acknowledge or discuss mental health concerns due to societal attitudes. Families may dismiss or deny that their family member could be having a mental health issue and brush it aside saying they are always temperamental or moody. They may keep asking the user repeatedly what is bothering them or share unhelpful opinions about what they think is the problem - rather than listening, providing empathy, or offering unconditional positive regard.” (Mahua Bisht)

Cultural Aspects of Stigma and Help Seeking: Mental health and suicide is highly stigmatized in India, and there is inadequate public awareness of it. In a 2015 survey¹¹, 66 percent of participants felt ‘suicide is sinful’, and 42 percent felt suicide attempters ‘should be punished’. Having an incurable illness and disability, financial difficulties, family problems, depression, etc. were considered appropriate reasons for suicide by respondents. Often, lack of mental health literacy and historical stigma associated with suicide may lead to negative attitudes towards seeking and receiving different kinds of help, which then impacts intervention effectiveness.

“In India, average EAP calls can be close to one and a half hours, because we spend a lot of time providing psychoeducation. Things like the impact of casteism, power hierarchies and religious traumas are still present here in India. So, we attempt to take a holistic approach of being trauma informed, understanding how certain religious, caste-based and wealth-based hierarchies, gender differences, and workplace power dynamics at work. Other issues include dowries, in-laws, parenting, and similar matters. Yes, clients may have a diagnosis, and then there is everything in between to consider, and if we do not acknowledge and try to address these, we are not going to be successful.” (Caroline Asirvatham)

“The religious and cultural stigma of suicide can lead to a lot of isolation for individuals suffering from this condition, making it both harder to identify and delaying help at the right time. The stigma also impacts public perception making psychoeducation challenging.” (Vani Reddy)

“We frequently encounter individuals and families who are just not supportive of nor willing to meet with a psychiatrist and this can result in inappropriate care for those at risk of suicide. This may stem from a lack of knowledge about the benefits of medications or the fear of becoming dependent on them.” (Mahua Bisht)

“Today, when we mention counselling, people are amenable. But the minute we say medications, they say, ‘No, do not put me on medications, or do not give me a referral for medications.’ Even if we do refer, they will often not go and see the doctor. If it is a minor, it’s very difficult when the parent says no to medications or even therapy: My child is ‘normal !’ ‘Why should my child talk to anybody? Why are you saying they should have an assessment?’” (Caroline Asirvatham)

Case Management and Client Confidentiality: While Indian employer representatives are generally supportive of EA services, their lack of understanding the concept of clients’ privacy which means they sometimes want to be over-involved at the expense of client confidentiality.

“They might want to be heavily involved in the clinical process, and it comes from the right intention. But the minute we say no to breaking confidentiality in all levels, they might feel less in control, very frustrated, and they do not understand the process of clinical counselling in the same way as we do. They start questioning about certain things and try to break confidentiality - ‘I can help so why are you not telling me?, especially when managers are engaged in the process.” (Caroline Asirvatham)

“Occasionally, those in the purchaser organization wants to get involved in the client’s care, and we understand that instinct, but it may not be the person’s preference, nor the client’s best interest. They say, ‘look it’s our employee and we really want to help.’ They ask for confidential data (not fully understanding the concept of consent and confidentiality) with the intention of offering support and assistance, but we must follow our confidentiality protocols and other norms. Sometimes when a client is posted in a remote factory or manufacturing setting, the only infrastructure available is the organization, so the organization gets involved, because the only supports around are created by that company whether that’s a hospital or stores, etc. There are variations in how much organizations want to be over-involved, and the EAP may not be able to escape disclosing general information to them because there is nothing available as support -- there is no family member or friend nearby.” (Mahua Bisht)

Historically, suicide prevention has been a low public health priority in India. However, in the last few years, progress at a national level has been made with the implementation of suicide prevention strategies and approaches, including:

- A national mental health toll-free telephone helpline – TeleMANAS was initiated in Oct 2022, and to date has logged over a billion calls¹⁹
- A first-ever National Suicide Prevention Strategy was launched in November 2022²⁰.
- The recent Bharatiya Nyaya Sanhita Act (2023) specifies when an attempted suicide can be a punishable offence.²¹
- A national centre (N-SPRITE), dedicated to suicide prevention training and research has been launched by the National Institute of Mental Health and Neurosciences in September 2024²².

Conclusion

Suicide has become increasingly recognized as a preventable global mental health problem. EAPs in India are becoming a valuable mental health resource for managing suicidal clients, and supporting their families and employers. They do so through awareness programs that build mental health and suicide literacy, thereby reducing stigma; free access to 24/7 helplines that screen for suicidality and other mental health concerns, providing crisis interventions that facilitate problem solving and coping to reduce distress, emergency and family support; offering consultation and collaborative engagement with organizational partners to ensure employees, families, and others receive the support and services they need to manage this condition.

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