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Exploring the 'Silent Epidemic': The Phenomenon of Male Suicide in India

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Abstract

Male suicide in India has emerged as a critical area of inquiry due to its significant public health impact and the persistent gender disparities in suicide rates. Over recent decades, suicide rates in India have shown a rising trend, with men disproportionately affected, reflecting a global pattern where male suicide rates exceed those of females by a wide margin [1]. Despite the high incidence, male suicide remains underrecognized and underreported, often described as a "silent epidemic". Socio-cultural constructs of masculinity informed by traditional gender roles influence male psychology. Stigma and misconceptions surrounding mental health create a perfect storm of fragmentation and isolation, often resulting in self-harm. Combined with poverty and low social capital that inhibit ambition and mobility, men are expected to endure their mental illness in stoic silence and isolation. In contrast, women are encouraged to talk about their emotions and seek help for their psychological issues. This article examines the psychological and socio-economic determinants relevant to the evolving masculinity of India, which contributes to the suicide epidemic. It reviews the current attempts of psychiatric rehabilitation practices and examines existing policies that claim to address this problem.

Keywords: Masculinity; Anomic Suicide; Breadwinner; 498A; Copycat; Psychiatric Rehabilitation

Introduction

Suicide continues to be one of the leading causes of public health concerns in India, outranking sexually transmitted diseases, addiction, malaria, and maternal morbidity [2]. Male suicide rates have been up since the eighties [3], with a sharp increase in 2005 [4] before reaching its peak during COVID-19. 2020 saw the most significant rise in suicides in recent Indian history [5]. Presently, suicide is the leading cause of death of Indian men between the ages of 15 and 44 [6]. Often called a "silent epidemic" [7], male suicide is poorly understood as it is underreported [8].

In 2021, around 25% of male suicides globally occurred in India [9]. An analysis conducted by the International Institute for Population Sciences revealed that the suicide rate among Indian men is approximately 2.5 times greater than that among Indian women [10]. This pattern has been consistently observed over the past five decades, with recent data indicating an upward trend in these figures. In 2014, 8,129 males succumbed to suicide, and by 2022, this figure had increased to 122,724 [11]. A study published in The Lancet noted that, between 2014 and 2021, the incidence of suicides among Indian men surged by over one-third [10]. Furthermore, the study indicated that in 2021, the suicide mortality rate for married men was 24.3 per 100,000 individuals, which constitutes three times the rate of 8.4 recorded for women [10]; thus, this dire reality warrants serious attention.

In addition to focusing on numerical escalation, it is crucial to analyze the male suicide epidemic in India through an intersectional and biopsychosocial approach. Biological predispositions, such as neurochemical imbalances (e.g., serotonin dysregulation), interact with chronic socio-environmental stressors [12], including job insecurity, urban migration, and relationship dissolution [13]. Norms of masculinity in India typically valorize emotional stoicism and familial responsibility, which discourage individuals from seeking assistance and promote emotional suppression. This detrimental resilience, when combined with external stressors and insufficient coping strategies, heightens vulnerability to depression, substance abuse, and ultimately, suicidal ideation [14].

Scope and Objectives

In India's rapidly evolving landscape, young men navigate conflicting opportunities and Challenges [15]. Traditional norms and societal expectations—covering personal, family, and social spheres—often lead to severe mental health issues like emotional distress and untreated depression [16]. The rising rates of suicide among young to middle-aged men remain inadequately addressed, especially in urban impoverished communities, among agricultural workers, students, workers, and various religious groups [17]. Although the rise in male suicides has become more urgent due to alarming increases in reported data [18], it does not lessen the significance of female [19] and transgender suicides. Nevertheless, the increase in male suicide rates must be recognized. This article investigates the underlying tensions and examines the psychological, economic, societal, and cultural factors behind the rising male suicide rates. It emphasizes the importance of regional analysis to identify disparities in sex- and age-specific suicide data and advocates for a comprehensive scholarly approach to this critical issue.

This article also examines the psychiatric rehabilitation process in India, through structural and institutional shortcomings that contribute to an elevated risk of male suicide. The insufficiency in implementing workplace mental health frameworks, the deficiency of community-based mental health services in rural regions, and the slow enforcement of the provisions of the Mental Healthcare Act (2017)—notably those related to decriminalization and support—have collectively impeded preventive outreach initiatives [20]. By adopting an ecological systems approach, which considers the individual in conjunction with their relationships within family, workplace, society, and policy frameworks, this article proposes improved strategies for intervention.

Audience: The readership of this article may include clinicians, researchers, mental health advocates, and policymakers engaged in the formulation of guidelines for men's mental health. Additionally, prospective consumers seeking mental health counseling can find value in understanding the context, potential, and limitations of mental health policies and practices in India.

Historical trends in male suicide rates

The historical trends of male suicide rates in India show a troubling upward trajectory in recent decades, especially in the last sixty years. Data from the National Crime Records Bureau (NCRB) show a rise in male suicides from about 8,129 in 2014 to 118,979 in 2021, a 33.5% increase. This trend continued with over 122,000 suicides in 2022, highlighting the seriousness of the issue [10]. The male-to-female suicide ratio also increased from 2.5 times in 2021 to about 2.64 times in 2022, indicating a widening gap [10]. Age-specific data reveal important trends, with suicide rates for males aged 30-44 at 27 per 100,000 in 2021, up from previous years. Similarly, for males aged 18-29, rates rose from 20 per 100,000 in 2014 to 25 in 2021, showing a concerning increase among young men [10].

Analysis of NCRB data shows that over a ten-year period, male students had a higher incidence of suicide than females across the country, especially in Rajasthan and Maharashtra [21]. This finding is reinforced by the urgency expressed by the Supreme Court of India, which, in a judgment dated 24th of March, 2025, issued a significant directive to establish a National Task Force under the chairmanship of Justice Ravindra Bhat, a former judge of the Supreme Court, along with various domain experts as members to deliberate on issues related to mental health concerns among students, the prevention of suicides in educational institutions, and to recommend preventive measures [22]. In the second meeting of the National Task Force, chaired by Justice (Retired) S. Ravindra Bhat, key areas of focus were delineated, including a) identifying predominant causes leading to student suicides, such as academic pressure, discrimination, financial burdens, and the stigma surrounding mental health; b) analyzing the effectiveness of existing student welfare and mental health regulations and policies; and c) proposing reforms to strengthen institutional frameworks and foster a supportive academic environment [23].

Regional variations in suicide statistics

India's suicide rates vary regionally due to socio-economic, cultural, and environmental factors. Maharashtra, Tamil Nadu, and Madhya Pradesh have the highest male suicides [24]. The male-to-female ratio differs across regions, with industrialized states showing higher rates [25]. The NCRB notes higher suicides in urbanizing, economically developing areas where stress increases [26,27]. Disparities also exist among demographic groups: suicide rates are higher among Christians than Hindus, with fluctuating rates among Scheduled Tribe populations depending on the region [28].

To address this public health crisis, understanding regional differences is essential for implementing effective interventions and policies. For example, farmer suicides make up about 10% of all suicides [29], mainly in states reliant on agriculture, highlighting the complex links among agricultural stress, economic hardship, and cultural beliefs. Maharashtra consistently reports a high number of farmer suicides [30]. Recent data indicate a persistent crisis, with 767 farmer suicides recorded in the first three months of 2025, averaging eight deaths per day [31]. Historically, farmer suicides in Maharashtra increased from 1997 to 2005, with one source reporting 28,911 suicides during that period [32]. The proportion of male farmer suicides to total male suicides in Maharashtra has also increased over time [33]. In 2022, out of 5,207 farmer/cultivator suicides nationally, 4,999 were male and 208 were female. Similarly, among 6,083 agricultural laborers who died by suicide, 5,472 were male and 611 were female [31].

Southern states such as Kerala, Karnataka, Andhra Pradesh, and Tamil Nadu generally report higher suicide rates, often

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exceeding 15 per 100,000 population [27]. More recent data from 2021 indicates that the Andaman and Nicobar Islands had the highest rate at 39.7%, followed by Sikkim (39.2%), Puducherry (31.8%), Telangana (26.9%), and Kerala (26.9%) [34]. These findings emphasize the need for tailored suicide prevention programs that consider each region's unique cultural and socio-economic realities.

Comparison with Global Suicide Rates

Globally, the suicide rates among Indian males reveal worrying trends aligned with international patterns [35]. In India, the male suicide rate is documented at 14.2 per 100,000, notably exceeding the global average of 12.3 per 100,000 reported in 2021 [36]. The gender disparity is particularly pronounced, with the suicide rate for Indian men being 2.5 times greater than that of women [10]. This discrepancy mirrors a global trend where men often constitute three-quarters of suicide fatalities across various nations, indicating a shared vulnerability among the male population [36]. For instance, in 2022, the suicide rate for American men was 22.9 per 100,000, which is nearly four times that of their female counterparts [37]. Similarly, in 2021, the suicide death rate for Canadian men was around 15 per 100,000, three times higher than the rate for women [38]. According to data from the European Alliance Against Depression, the suicide rate among males is approximately 10.2 per 100,000, with higher figures observed in Eastern Europe [39]. In East Asia, suicide rates among men differ; for example, in China, the rate was about 13.0 per 100,000 in 1999, while Hong Kong recorded a rate of 19.0 per 100,000 in 2009 [40]. Generally, East Asia has higher suicide rates compared to the West [40].

Lethality Methods and Comparative Data

Moreover, there are notable variations in suicide methods among different countries. In India, men tend to use more lethal and deliberate methods than women, leading to higher rates of completion [41]. Frequently employed lethal methods for men include hanging and pesticide poisoning, both known for their high fatality rates [42]. The incidence of suicides by hanging among males increased from 6.08 to 10.0 per 100,000 in recent years [43]. Pesticide poisoning, particularly with highly lethal substances such as aluminum phosphide, is prevalent in rural regions, exhibiting a case fatality rate that surpasses 70% [44-46]. Males are more inclined to employ organophosphate poisons, which possess elevated toxicity levels [47]. Conversely, women frequently opt for less lethal means, such as botanical toxins, resulting in diminished fatality rates [48]. Suicide attempts among men tend to be more deliberate, strategized, and discreet, reflecting a higher degree of lethal intention [49,50]. In contrast, while women's attempts are more frequent, they tend to exhibit lower lethality and an increased likelihood of rescue [51,52]. When compared globally, American men using firearms have a lethality rate ranging from about 75% to 90%, making them the deadliest method [53,54]. For Canadian men, hanging and firearms are commonly used and considered highly lethal methods [55]. Among European men, hanging and firearms are the most lethal, while poisoning remains less fatal yet is still common [39]. For East Asian men, firearms show the highest lethality rates (75-90%), with cutting methods having the lowest; pesticide poisoning is also significantly lethal in rural areas [56].

Exploring Social Factors

Celebrity and Media

Research shows that media coverage of real suicides—whether in newspapers, on TV, or through films and literature—can impact suicidal behavior [57]. A copycat suicide occurs when someone attempts to take their own life after being influenced by another person's suicide, often copying the method used [58]. Reports on celebrity suicides are 14.3 times more likely to trigger a copycat effect compared to reports that do not focus on them [59]. Sensational stories that glorify the deceased, oversimplify the reasons for suicide, or reveal the method of suicide can raise the overall suicide rate [58].

The recent suicide of 34-year-old Bengaluru-based software engineer Atul Subhash on December 9, 2024, was accompanied by a video and notes that ignited widespread debate concerning the issue of men's mental health [60]. Atul left a placard that read "Justice is Due," along with a detailed 24-page note and an 81-minute video in which he blamed his marriage and divorce struggles on his death [60]. Several incidents following Atul's case can be classified as copycat suicides [59], in which men have taken their own lives due to troubled marriages and accusations of harassment against their wives and in-laws. Examples include the Tata Consultancy Manager suicide case [61] and the Mumbai hotel suicide case, in which a senior executive named his wife and her aunt in his suicide note for alleged abetment [62].

Suicide Contagion

Suicide contagion, a phenomenon extensively documented in psychological research [63], refers to the propensity for media reporting to trigger vulnerable individuals [64]. The Werther effect suggests that sensationalized or detailed reporting of suicides, particularly those involving public figures or traumatic narratives, is correlated with an increase in suicidal behavior among viewers [65,66]. This underscores the ethical imperative for Indian media platforms to adhere to WHO guidelines on suicide reporting, thereby ensuring dignity, accuracy, and discretion, while also integrating helpline information as a standard practice in reporting [67]. The aforementioned instances involving Atul Subhash and the subsequent suicides provide insight into the phenomenon of suicide contagion, which may lead to a Werther effect.

Masculinity and Suicide

Men are statistically more likely to die by suicide than women [68]. But, discussing "men" or "masculinity" as a uniform group is

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particularly challenging. Likewise, emphasizing "true" gendered insights over other frameworks like socioeconomic discourse proves difficult. From this viewpoint, suicide highlights another tragic outcome of social. Framing suicide in connection with social class, racial and gender equality, corrupt political leaders, abusive partners, or structural problems tends to cast men in a less favorable light, which might be seen as accusatory. As a result, the prevalent discussions surrounding mental health and suicide have gradually confined the issue of "men's issues" to the recognition of the lower likelihood of men seeking professional help, often culminating in the discussion at that juncture [69].

Research [70] shows that men face a restricted range of options regarding self-identity, relationships, and the capacity for happiness [71,72]. Boys are initially instructed to suppress their emotions from ages three to five through a "boy code" that incentivizes toughness [73] while utilizing shame to enforce a prohibition against emotional expression or vulnerability- a condition termed gender-straitjacketing [73]. Theory contends that cultural gender-role expectations restrict males' available responses when confronted with stress, crisis, or loss, thereby elevating their susceptibility to self-endangering or self-harming behaviors [70]. While men are capable of experiencing a wide array of emotions, their ability to express these feelings is curtailed by the prevailing social norms surrounding masculinity. Men who are conditioned during childhood to perceive expressions of certain emotions, such as sadness or anxiety, as indicative of weakness, while regarding the expression of anger as more masculine, are likely to conceal their emotional distress. Researchers discovered that certain participants found a secure means of expressing their socially prohibited emotions by confiding in females, be they partners, sisters, or friends, while simultaneously maintaining a public facade of masculinity [74].

The concept of hegemonic masculinity [75] is particularly relevant in this context reinforcing dominance, control, and stoicism as ideals of masculinity while penalizing emotional expression, ultimately exacerbating psychological risk. However, when the concealment of emotions is no longer a viable option during significant life crises, such as the death of a loved one, men are more susceptible to committing suicide rather than articulating their emotions. In some instances, suicide is perceived as a 'macho thing' to do instead of seeking assistance for their distress. Consequently, suicide becomes a manifestation of masculinity through acts of violence directed towards oneself. It is thus interpreted as an extension of the inclination to convey emotions through violence, in alignment with the concept of the triad of men's violence [76], which encompasses violence directed at other men, women, and oneself. Furthermore, Kaufman [76] draws a comparison between men and pressure cookers, stating that in the absence of safe outlets for emotional expression, emotions are transformed into anger and hostility, which is partially directed at other men, partially at women, and at times directed towards oneself [76].

The conventional male gender role, characterized by values such as the pursuit of success, power, emotional control, fearlessness, and self-reliance [72], sets the foundation for male gender role strain [77]. Feelings of inadequacy arising from failure to meet these gender role ideals are exacerbated by the associated expectations, which include the avoidance of perceived weakness, the unacceptability of emotions other than anger, and prohibitions against dependency or seeking assistance. Notably, men who are victims of violence inflicted by another man are also more likely to contemplate suicide [72]; furthermore, research indicated that, among older participants, masculinity was correlated with lower suicidal thoughts; however, more traditional gender role attitudes were associated with increased suicidal thoughts [78].

Marriage and 498A

Furthermore, challenges associated with marriage frequently emerge as significant contributors to male suicides, representing approximately 3.28% of these incidents among men [79]. Experiences of failed marriages or unresolved issues frequently converge with economic pressures, heightening stress and fostering feelings of helplessness [80]. These pressures are further exacerbated by the prevailing societal expectation for men to assume the role of 'breadwinners,' which can be particularly burdensome during economic downturns or personal financial difficulties [81]. Additionally, in the context of marriages in India, men often find themselves at a disadvantage because matrimonial laws are not gender- neutral [82]. Numerous issues and reasons necessitate attention, including gender-based legislation in India, such as Sections 85 and 86 of the Bharatiya Nyaya Sanhita (BNS), formerly known as Section 498A of the Indian Penal Code. Furthermore, men encounter various challenges within the Domestic Violence Act of the Domestic Violence Act of BNS. The rising incidence of suicides can also be linked to the misuse of these laws [60].

The desperation leading men in India to contemplate suicide is illustrated by the Supreme Court's refusal to entertain a Public Interest Litigation seeking the establishment of guidelines to address incidents of suicide among married men subjected to domestic violence, as well as the formation of a "National Commission for Men" to protect their interests. A bench comprising Justices Surya Kant and Dipankar Datta was appointed to safeguard their interests [83]. However, the bench, comprising the same justices, showed reluctance to consider the matter. The justices raised concerns about the intent behind such a motion, stating, "You just want to portray a one-sided picture. Can you give us the data of young girls dying soon after marriage? Nobody wants to commit suicide; it depends on the facts of an individual case," as the bench noted." The bench also informed the petitioner, "If you expect us to hold that these husbands have committed suicide due to harassment by their wives, you are sadly mistaken". The apex court was evaluating a plea that referenced data from the National Crime Record Bureau (NCRB, 2021), which indicated that 164,033 individuals died by suicide across the nation that

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year, of which 81,063 were married men and 28,680 were married women, as stated in the petition [83].

Impact of Job Loss and Other Socio-economic Factors

The socio-economic environment in India significantly influences male suicide rates, linking financial stability, occupational stress, and mental health. Economic insecurity and job loss has become a major trigger for suicide. According to allostatic load theory [84], prolonged exposure to economic uncertainty alters neuroendocrine function, which heightens emotional dysregulation and hopelessness—key precursors to suicidal thoughts. Biological stress responses among marginalized groups, such as higher cortisol levels, are rarely studied in Indian suicide research but could be a promising area for future mixed-methods studies. The link between economic hardship and mental health issues is clear; research shows that job loss and financial strain are strongly connected to a higher risk of suicide among men. Financial loss and unemployment emerged as major factors during the COVID-19 pandemic [84].

For instance, there has been a 170.7% increase in the suicide rate among daily wage earners from 2014 to 2021 nearly tripling from 2014 to 2021 [10]. These workers are among the lowest-income groups and lack a stable, ongoing income. They reflect the broader economic challenges experienced by workers in a rapidly industrializing economy, where traditional job structures are evolving, often leading to unstable work conditions that exacerbate stress and anxiety. Within this group, suicide deaths among men rose by 170.7% between 2014 and 2021, with a suicide death rate (SDR) of 34.6 per 100,000 for men compared to 13.1 for women. In 2021, during the post-COVID-19 period, daily wage workers faced even greater risk, with male suicide cases tripling from 13,944 in 2014 to 37,751 in 2021 [85]. Thus, unemployment remains a significant factor; in 2021, the total number of unemployed men in India had a high SDR of 48.2 [10].

This phenomenon can be attributed to two primary factors: first, the increased privatization of the economy following the governmental changes after 2014 [86]; and second, the impact of the Covid-19 pandemic, which struck India in 2019, resulting in reverse migration, job losses, and the closure of numerous sectors due to pandemic-related restrictions [87]. In contrast, countries with robust social support systems generally report lower suicide rates among men, emphasizing the protective advantages of economic stability and access to mental health resources [88].

The once-thriving diamond markets of Surat, a city in Gujarat, India, have experienced an unprecedented slowdown, leading to factory closures and job losses for numerous diamond workers. Within a mere 18-month period, 71 diamond workers took their own lives [89]. Furthermore, this trend is mirrored in numerous recent cases of male suicides reported in various newspapers. For instance, on March 4, 2025, it was reported that a 30-year-old software engineer from Bengaluru allegedly took his own life by jumping from the 12th-floor corridor of his apartment complex [90], having suffered losses in his startup. Similarly, on March 13, 2024, it was reported that a 25-year-old employee of a multinational company died by suicide in Matunga, Mumbai, as a result of workplace pressure. He jumped off the 9th floor of his apartment [91].

Anomic Suicide

These instances exemplify Durkheim's concept of "anomic suicide," which is associated with social and economic disruptions that impede individuals' capacity to integrate and achieve stability within society. In scenarios where sudden change renders individuals unable to recalibrate, particularly within India's urban job markets, suicide may manifest as a tragic response to ongoing structural dislocation [92]. One notable case occurred in 2025, in which a 50-year-old senior manager, overseeing a team of software engineers in a multinational consulting and outsourcing firm, tragically jumped to his death from the sixth floor of his office building [93] in New Town, Kolkata, attributed to work-related pressure.

Another case reported on October 2, 2024, involved two suicides [94] within a span of two days: one individual, a banker, and another, a businessman, both succumbed to suicide after jumping off Mumbai's Atal Setu and the Mumbai Trans-Harbour Link, respectively, due to stress arising from business and work-related pressures. Thus, it can be inferred that in India, a higher suicide rate is observed among males in states characterized by elevated levels of unemployment [43].

Exploring Individual Causes

Role of mental health stigma in male suicides

According to the WHO, men account for 75 % of all suicides internationally [95]. More than 90% of Individuals who die by suicide struggle with their mental health. Researchers estimate that up to 60% of Individuals who die by suicide have major depression [96,97]. Multiple studies provide robust clinical assessments using standardized diagnostic tools (e.g., ICD-10, MINI, SCAN) to identify psychiatric disorders prevalent among Indian men who attempt suicide, such as depression, substance use, and adjustment disorders [98]. Assessments show that:

i. Major depressive episodes are common among suicide attempters, with studies indicating that 27.56% of attempted suicide cases involve major depressive disorder. Depression, often coupled with hopelessness, is a leading cause of suicidal behavior [99,100].

ii. Individuals with schizophrenia face a 20-50 times higher lifetime suicide risk than the general population, with about 9-13% dying by suicide [101]. Male gender is identified as a risk factor for suicide among patients with schizophrenia. [102].

iii. Bipolar disorder is also a significant psychiatric risk factor, often leading to episodic mental illness that can impair

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daily functioning and increase suicide risk [103].

The stigma associated with mental health issues significantly exacerbates the challenges faced by men in India, contributing to the elevated suicide rates within this demographic. Indian men are expected to be stoic, strong, and emotionally unflinching, often hearing phrases like "Mard ko rona nahi chahiye" (men shouldn't cry) [104]. This fosters an emotional lockdown where displaying vulnerability is seen as weakness, leading to suppression of emotions and mental health issues. Stigma around mental health prevents men from seeking professional help, feeling it implies defeat or instability.

Additionally, the pressure to conform to conventional gender roles generates an environment where discussing mental health may be construed as an admission of weakness. Men are less likely to disclose suicidal thoughts or access professional support compared to women and often seek help only when prompted by women [105]. This delay in seeking help can exacerbate mental health conditions and increase suicide risk. Fathers who suppress their emotions often pass these behaviors to their sons, perpetuating a cycle of emotional restraint. Movies and social media can reinforce "macho-man" images, influencing younger generations (Gen-Z) to internalize these harmful stereotypes [106], making them unsure of themselves in interpersonal conflicts and vulnerable to peer pressure involving substance use. This reluctance contributes to underreporting, which subsequently leads to the underdiagnosis and inadequate treatment of mental health issues among men.

Loneliness

Psychosocial stress and social isolation are acknowledged as major risk factors [107,108], beyond just psychiatric disorders. In studies of South India, factors like persistent stress, chronic pain, living alone, and recent breakup experiences were closely associated with suicide [109]. Family problems were the most common cause of suicide from 2012 to 2021, increasing from 25.6% to 33.2%. Marital and domestic problems accounted for 37.3% of suicides, while incurable diseases contributed to 29% [110]. The rise of commodified relationships within a profit-oriented economy has led many urban men to feel deeply isolated, alienated, and worthless [111]. In countries like India, these issues are often exacerbated by the desire for expensive status symbols and household goods, which is compounded by the absence of spousal support [112]. The loss of stable employment and the sudden drop in family income coincided with an increase in suicides among men, as indicated by NCRB data following the COVID-19 pandemic [10]. Rising feelings of loneliness and isolation, coupled with inadequate support networks, hinder the development of meaningful social connections.

Addiction and Suicide Risk

Addiction in India is linked to rising male suicides, driven by social, economic, and psychological factors. Research shows alcohol and substance use increase suicide risk among men [113], acting as coping tools and impulsivity triggers. Alcohol-related disorders and drug abuse are strong predictors of suicide, particularly in men aged 31-75 years [114]. Data from a scientific analysis of NCRB reports indicates that, between 1995 and 2021, the proportion of male suicides related to addiction increased from 1.14% to 8.64% [115]. The pressures that push individuals toward substance abuse are deeply tied to societal norms [116]. Many men, feeling inadequate due to their provider roles, turn to alcohol and drugs to escape financial and emotional stress [117].

This coping mechanism often worsens mental health, impairs decision-making, and increases impulsivity, raising suicide risks [118]. The stigma around mental health also prevents many men from seeking help, isolating them further [119]. The expectation that men should be stoic and self-reliant discourages open discussion about mental health issues, worsening their substance use problems [120,121]. Significantly, research has demonstrated that men frequently seek mental health support only when encouraged by loved ones [122], indicating a hesitance to proactively confront personal difficulties. This hesitance must also be understood within the framework of help-negation theory, which posits that individuals experiencing profound psychological distress are paradoxically less inclined to seek assistance [123]. Suicide prevention initiatives must, therefore, prioritize gatekeeper training programs—targeting spouses, co-workers, and community leaders—to facilitate early identification and intervention for high-risk males [124,125].

Addressing the Crisis: Psychiatric Rehabilitation and Male Suicide Survivors in India

"Psychiatric rehabilitation is regarded as a collaborative endeavor focused on functional recovery and reintegration into the community [126,127]. Norms of masculinity influence how men express emotions and seek assistance, thereby affecting their risk of suicide [128,129]. While research documents the prevalence of psychiatric morbidity and social stressors among individuals who have attempted suicide, there is limited integration of gender-specific factors such as masculinity norms, stigma, and help-seeking behaviors that uniquely impact Indian men [127,128]. Furthermore, the interaction between sociocultural determinants, psychiatric disorders, and suicide risk remains inadequately explored, with conflicting viewpoints on the relative influence of mental illness versus social stressors [129]. This gap hampers the development of effective, contextually appropriate rehabilitation strategies and contributes to ongoing challenges in suicide prevention [130]. The consequences of this deficiency in knowledge include inadequate clinical training, insufficient community support, and persistent stigma, all of which impede recovery [131]."

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Background

Historically, psychiatric rehabilitation in India has progressed from ancient practices to contemporary, rights-based methods. Early care existed in India, with mental hospitals dating back to the 11th century. During British rule, asylums were introduced, initially serving custodial purposes. Occupational therapy emerged in the early 20th century at institutions like the Central Institute of Psychiatry, Ranchi, and Kilpauk Mental Hospital, focusing on work therapy [132]. After independence, reforms emphasized training mental health personnel, highlighted by the 1946 Bhore Committee [133,134]. The establishment of the All-India Institute of Mental Health (now NIMHANS) in 1954 marked a key milestone in psychiatric rehabilitation [135].

Modern laws, such as the Mental Healthcare Act 2017, decriminalized suicide, secured mental health rights, and mandated rehabilitation facilities, including halfway homes [136]. The Act also ensures free treatment for suicide attempters and access to rehabilitation services. Additionally, the Rights of Persons with Disabilities Act 2016 (RPWD Act) recognizes mental illness as a disability, offering social protections such as income tax reductions, travel concessions, and employment programs [137].

Existing Interventions

Psychiatric rehabilitation in India involves efforts from communities, hospitals, and NGOs. Building effective support networks requires collaboration between mental health professionals, community and religious leaders, and policymakers [138]. Currently, various intervention types exist; for instance, community-based approaches are widely recognized for improving mental health care, with a growing focus on reducing hospitalizations [139]. Yet, stigma persists, often portraying mental illness as "a cause without a home," which hampers recognition and treatment. In India, only 10% of those with mental health issues seek professional help [140]. These programs aim to reintegrate individuals into their communities and are vital in resource-limited areas [141]. They include home services, community outreach, and peer support, such as the Suicide Prevention and Implementation Research Initiative (SPIRIT), which trains youth and communities, and iOutlive!, targeting urban youth [142]. Hospital-based rehabilitation at centers like NIMHANS and the Central Institute of Psychiatry offers day care, vocational training, and multidisciplinary care. Additionally, NGO-led initiatives by organizations like SCARF [143], The Banyan, and Shraddha Rehabilitation Center deliver essential services, including halfway homes, supported employment, and psychosocial support, often bridging gaps in government provision and promoting social recovery and inclusion [144].

The aforementioned programs are adapted based on ongoing evaluations such as the RE-AIM framework (Reach, Effectiveness, Adoption, Implementation, and Maintenance) to enhance their relevance and effectiveness. However, while most suicide prevention efforts in India mainly concentrate on raising awareness, there is limited data on their long-term success [145]. Furthermore, support groups specifically for men experiencing mental health issues or affected by suicide are almost nonexistent.

Best Practices and Innovative Approaches

Effective suicide prevention strategies for Indian men blend traditional approaches with modern innovations. Peer Support Models involve individuals with lived experience supporting others, fostering hope and a sense of community [146]. Peer-led initiatives, particularly in high-risk environments like prisons, have proven effective in addressing mental health concerns and lowering suicide risk [147]. Digital tools, such as mobile apps and online platforms, are emerging to overcome challenges like stigma and limited access [148]. These platforms offer psychoeducation, safety planning, and helpline connections. India's helplines [149], including KIRAN—a free, 24/7 mental health support line launched in September 2020—provide screening, crisis assistance, and referrals.

Brief interventions and follow-ups, which are short, cost-efficient strategies within healthcare settings, can greatly reduce repeated suicide attempts [150]. Finally, restricting access to common means, such as pesticides, remains a vital public health focus. Centralized pesticide storage has shown significant reductions in pesticide-related suicides in pilot projects [151].

Barriers and Challenges

Despite advancements, significant barriers hinder psychiatric rehabilitation and suicide prevention for Indian men. Stigma and cultural norms intensify societal pressure on men to hide emotions and appear strong, leading to reluctance in seeking help due to fear of judgment or being labeled weak [152]. This cultural environment makes mental health issues "unspoken problem" among Indian men. The root causes include a lack of awareness and education, as many men fail to identify their symptoms as mental health issues, and overall ignorance persists about mental health [153]. Additionally, government funding is critically inadequate. The Indian government's annual budget for mental health is insufficient. With a population of 1.408 billion, the estimated government spending per person is approximately US$0.00355, or about INR 0.29 [154]. This limited funding obstructs access to care; consequently, men's mental health challenges, such as suicidal thoughts, often remain unaddressed [155].

The shortage of qualified professionals and limited services, especially in rural areas with long distances to tertiary care, compounds the problem. The healthcare infrastructure faces constraints, with only 0.075 psychiatrists, 0.069 psychologists, and 0.065 psychiatric social workers per 100,000 people [156]. Rehabilitation programs are scarce, inadequate, and often costly [157]. Economic constraints also pose a barrier; the high out-of-pocket costs of mental health care push many families into poverty, deterring treatment seeking, particularly among daily

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wage earners [158]. Furthermore, official suicide data reported by agencies like the National Crime Records Bureau (NCRB) is frequently underestimated due to social stigma and legal risks [159]. The report on Global Burden of Disease indicates significantly higher actual rates, particularly for women and various age groups, highlighting gaps in data surveillance and reporting [160].

Policy Recommendations and Implications

The Government of India has launched several national programs, notably the National Mental Health Program (NMHP), to improve mental health services. This program aims to deliver essential mental health services to individuals facing mental health challenges, focusing on early detection, treatment, and short-term care for those in need [161]. Districts eligible for support under this initiative must have general hospitals with at least 200 beds, a psychiatrist, a clinical psychologist, and trained community health workers [162]. To bolster the national mental health strategy, the central government has set up start centers that act as hubs for mental health resources, including the National Tele Mental Health Programme (Tele MANAS) and the District Mental Health Programme (DMHP). These initiatives integrate mental health services into primary healthcare and improve facilities like Ayushman Arogya Mandirs, thereby increasing access to diagnosis and treatment of mental health disorders [163].

Furthermore, a total of INR 620 million has been designated for 19 other government-sanctioned institutions to implement district mental health initiatives effectively [164]. In addition, the Rashtriya Swasthya Bima Yojana offers insurance coverage for individuals living below the poverty line. This policy provides an annual insurance amount of INR 30,000 per household, thus facilitating access to cashless hospitalization treatment for a range of illnesses, including mental health disorders [165].

National Suicide Prevention Strategy (NSPS)

Although the Mental Health Care Act of 2017 has decriminalized suicide, a national suicide prevention policy is still lacking. However, on November 21, 2022, the National Suicide Prevention Strategy was launched, aiming to reduce suicide mortality by 10% nationwide by 2030 [166]. A pertinent question is why the government refers to it as a strategy rather than a policy. In the United Kingdom, there is a distinction between policy and strategy in suicide prevention. In India, it is essential to clearly differentiate between strategy and policy as well. A strategy involves broad, long-term planning aimed at achieving organizational or societal goals, while a policy consists of rules or guidelines that govern specific actions to ensure consistency in decision-making [167]. Strategy outlines the what and why, whereas policy provides formal guidelines that detail the principles, rules, and procedures for specific activities, focusing on the how and when of achieving objectives, thus establishing a framework for decision-making and execution. In the absence of a coherent policy, a strategy may be rendered ineffective, suggesting that the policymakers in India have not sufficiently engaged their analytical faculties. A significant limitation of the National Suicide Prevention Strategy (NSPS) is its omission of approaches to mitigate male suicide, which constitutes a substantial proportion of gender-specific suicides [168].

The NSPS anticipates achieving a 10% reduction in suicide mortality by 2025 through the establishment of an effective surveillance mechanism. It also aims to implement suicide prevention services through the District Mental Health Program in all jurisdictions by 2027 and to incorporate a mental well-being curriculum in all educational institutions by 2030 [169]. However, these ambitious targets remain largely unfulfilled, as many state governments in India have yet to enact the Mental Health Care Act of 2017, nor have state councils been established. Moreover, the financial allocation to health, particularly mental health, remains exceedingly inadequate [170].

Current Government Initiatives

At the Mental Health Congress in New Delhi on World Mental Health Day, India's Union Health Minister, Shri J. P. Nadda, stated, "The primary challenge we face is combating the stigma associated with mental health. Generally, individuals maintain a markedly negative perception of mental health. Thus, it is imperative to advance along the path of responsive mental health initiatives, which will contribute to diminishing disparities over time" [171]. This remark underscores the critical issues connected to the pertinent legislation. Since health is a state responsibility, the primary duty of implementing this act falls to the individual state governments. To ensure these frameworks are effective, measures are established to maintain minimum care standards consistently.

The Mental Healthcare Act of 2017 marks an important step forward for India in protecting the rights of people with mental illness, though it also has some limitations, as discussed. It guarantees the right to mental healthcare, which encompasses free treatment, the right to reside within the community, and access to mental health services. Additionally, the act prohibits solitary confinement for those with mental illnesses and encourages steps to combat discrimination against them. It further supports the establishment of advance directives, allowing individuals to specify their preferred treatment options, and requires all healthcare and clinical facilities to adhere to these standards.

Recently, the Government of India released the UMMEED (Understand, Motivate, Manage, Empathize, Empower, Develop) guidelines. These guidelines aim to provide schools with directions to enhance sensitivity, understanding, and support when self-harm is reported. They also outline a plan of action for schools, which includes establishing wellness teams, fostering a positive school environment, building capacity among stakeholders-such as teachers, non-teaching staff, students, parents, and the community- responding promptly to students at risk, and evaluating the actions taken by the school [172].

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National Task Force on Mental Health and Well-being of Medical Students (2024)

In response to the concerning suicide rates among medical students in India, the Government of India formed a National Task Force dedicated to their mental health and well-being. Chaired by Dr. Suresh Bada Math, a Professor of Forensic Psychiatry at Nimhan's in Bengaluru, this task force has created a detailed report of 153 pages divided into 12 chapters, which serves as a vital tool for addressing the issue of student suicides. Published in 2024, the report presents universal strategies aimed at improving the welfare and well-being of students and faculty in medical colleges [173]. The primary challenge remains the effective implementation of the report's recommendations to ensure meaningful outcomes.

The National Task Force on Student Suicides has been created to address mental health challenges faced by students and to reduce the rising suicide rates in higher educational institutions. This initiative was ordered by the Supreme Court on March 24, 2025, during a hearing on a petition from the families of two students who took their own lives, contesting a Delhi High Court decision that rejected their plea for a First Information Report (FIR) on the fatalities [174]. The task force, chaired by former Supreme Court Justice S. Ravindra Bhatt, has begun its meetings. It aims to review mental health in higher education and suggest strategies for preventing suicide.

Proposed Strategies for Improvement

India has implemented comprehensive suicide prevention efforts, like decriminalizing suicide via the National Mental Health Program [175]. Strategies to improve male suicide prevention include increasing community engagement, integrating mental health services into primary healthcare, and targeting high-risk groups.

- **Community Engagement**: Building community resilience and support for suicide prevention, including destigmatization, is vital. This involves empowering community members, recovered service users, and families to share knowledge about social protection and support rehabilitation. Emphasizing community involvement in shaping policies, programs, and research is crucial, as initiatives risk irrelevance if communities see them as unrelated [176]. Advocating for broader policies, like integrating mental health into primary healthcare—especially in India, where service use is low—can help. Promoting mental health education in schools and partnerships also aids in reducing stigma around male help-seeking for suicide [177].

- **Workforce Development:** There is an urgent need to train more mental health professionals and community health workers, including gatekeeper skills, crisis management, and culturally appropriate psychosocial support [178]. Enhancing counseling services in schools and empowering male students and their parents can improve emotional health. Training teachers and administrators is also vital. Establishing Men's Resource Groups may foster safe discussions on mental health and suicide. Supporting groups for families and friends of male suicide survivors are equally important [179].

- **Research and Data Improvement:** Further research is needed to understand gender-specific suicide risks in India, especially for under-researched groups like transgender people. Improving data collection is crucial for prevention. Raising awareness about male-focused suicide research is vital. Key inquiries include: What prevents men from seeking help? What barriers inhibit their expression of negative emotions? What coping strategies do they utilize to manage stress? Exploring these questions can facilitate the creation of effective interventions, which should be continually evaluated and refined to remain well-informed.

- **Integration of Services:** Mental health services should be integrated into general healthcare systems, including primary healthcare settings, to enhance accessibility and facilitate early intervention. Collaborating with community stakeholders is essential for all these endeavors.

Conclusion

An inclusive agenda is critical to effectively combat the challenges presented by the mounting male suicide crisis in India. Only about one-half of men who die by suicide in India have a recorded mental health diagnosis, so it is urgent to address the larger social, economic, and cultural contexts that are influential in men's mental health [180]. Next steps could include creating a favored social environment for men to express emotional vulnerability, launching mental health programs for specific populations, such as daily wage earners and unemployed males, while reducing financial instability. Overcoming societal barriers that hinder men from seeking help, increasing mental health awareness, providing effective psychiatric support, and utilizing advanced technologies like AI are critical steps. Developing a more inclusive mental health system that understands the specific challenges men face can significantly improve their mental well-being. Supporting men's mental health is not a matter of charity; it is a vital step toward building a healthier, more inclusive society.

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