

Suicide Prevention Among Marginalized Populations in India: A Clinical Social Work Perspective

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ABSTRACT: Suicide remains a significant public health concern in India, with marginalized populations facing disproportionately higher risks due to intersecting social, economic, and cultural vulnerabilities. Groups such as Scheduled Castes and Scheduled Tribes, LGBTQ+ individuals, migrant workers, women experiencing gender-based violence, and economically disadvantaged communities are particularly affected by systemic inequalities, social exclusion, and limited availability of mental health care. This paper adopts a public health lens to examine the social determinants contributing to suicidal behaviour among these populations, including poverty, discrimination, stigma, and lack of institutional support.

Drawing on a clinical social work perspective, the study highlights the critical role of psychosocial assessment, culturally sensitive counselling, crisis intervention, and community-based practices in suicide prevention. It also explores the gaps in existing mental health policies and programs in India, such as inadequate implementation of community mental health services and shortage of trained professionals. The paper argues for an integrated approach that combines clinical interventions with social justice and rights-based frameworks to address structural inequities. Strengthening the role of clinical social workers within multidisciplinary teams and expanding access to inclusive, community-oriented mental health services are essential for effective suicide prevention among marginalized populations in India.

KEYWORD: Suicide Prevention, Marginalized Populations, Clinical Social Work, Public Health Approach, Mental Health in India, Social Determinants, Caste and Inequality, Gender-Based Violence, LGBTQ+ Mental Health, Community Mental Health.

INTRODUCTION-

Understanding Marginalization in India-

Minority Communities and Processes of Marginalisation-

The term *minority* denotes groups that are **smaller in number relative to the majority population** however, it also encompasses issues of power, representation, and access to resources, rather than merely numerical strength.

- The concept extends beyond population size and includes social, cultural, economic, and political dimensions.
- Majority groups often benefit from greater visibility, influence, and institutional support, which can result in the neglect or exclusion of minority communities.
- As a consequence, minority groups may experience insecurity, marginalization, and limited access to opportunities, affecting their overall well-being.
- The Constitution of India seeks to **reduce disparities by guaranteeing Fundamental Rights that protect minority groups against discrimination and injustice.**
- The legislature, executive, and judiciary play a crucial role in upholding these rights and ensuring justice and equality.

Marginalised Communities in India

- Marginalised communities refer to groups that are socially excluded, disadvantaged, or treated as less significant within society.
- These groups often face systemic discrimination, social exclusion, and humiliation due to structural inequalities rather than merely their numerical minority.
- Marginalisation in India occurs along multiple axes, including caste, class, gender, religion, disability, and ethnicity.
- Women are considered a marginalised group due to persistent gender inequality, restricted access to opportunities, and social norms that limit their participation in various spheres of life.
- Scheduled Castes (SCs) experience marginalisation due to entrenched caste hierarchies, leading to social exclusion, economic deprivation, and restricted access to resources and opportunities.

Suicide Prevention Among Marginalized Populations in India: A Clinical Social Work Perspective

- Scheduled Tribes (STs) or Adivasis often face displacement, loss of land and livelihoods, and cultural marginalisation, particularly due to development projects and resource exploitation.
- Other marginalised groups include persons with disabilities and the elderly, who frequently encounter barriers to inclusion, accessibility, and social participation.

Socio-Economic Marginalisation of the Muslim Community-

Muslims are recognized as a minority community in India, not only in terms of population size but also due to their **comparative socio-economic disadvantages**. Over time, sections of the Muslim population have experienced **limited access to the benefits of economic development**, resulting in disparities across various social indicators. Access to Basic Amenities:

As reported in the *India Human Development Report (2011)*, the distribution of basic amenities such as housing, sanitation, electricity, and drinking water varies significantly across different communities, with Muslims often facing **relative deprivation in access to these essential services**.

Religious Community	Pucca House	Electricity	Tap Water
Hindu	65.4	75.2	43.7
Muslim	63.8	67.5	35.8
Christian	69.3	86.2	48.0
Sikh	91.3	96.0	49.3

Literacy Rate by Religion: Data from the *Census of India (2011)* illustrate the variation in literacy rates across religious communities, with figures presented as percentages.

All	Hindus	Muslims	Christians	Sikhs	Buddhists	Jains
74	63	57	74	67	71	86

Status of Muslim Participation in Public Employment: High-Level Committee Report under the Prime Minister, 2006 highlighted the status of Muslim representation in public sector employment. The following figures present their share in percentage terms.:

Population	IAS	IPS	IFS	Central Public Sector Unit	State PSU	Banks & RBI
13.5	3	4	1.8	3.3	10.8	2.2

Furthermore, Muslims face systemic discrimination and social exclusion arising from perceived differences in their customs and cultural practices.

Sachar Committee Report on the Socio-Economic Status of Muslims in India-

The Indian government recognized that the Muslim community was being relatively excluded from the process of socio-economic development. In response, a high-level committee was constituted in 2005.

Major Findings of the Committee

Muslim children aged 7–16 exhibit **lower average years of schooling in comparison to other socio-religious communities**.

The Committee dispelled the widespread belief that Muslim children are primarily educated in Madrasas, revealing that only **around 4% attend Madrasas**, whereas the majority are enrolled in **government (66%) and private (30%) schools**

Women: Domestic Violence and Economic Dependency

Domestic violence in India is strongly influenced by women's economic dependency, which traps them in abusive relationships by limiting financial autonomy and access to support systems. The National Family Health Survey (NFHS-5, 2019–21) indicates that nearly 30% of ever-married women aged 18–49 have experienced spousal violence. With economic dependence identified as a key barrier to leaving abusive situations.

Suicide Prevention Among Marginalized Populations in India: A Clinical Social Work Perspective

- **Financial Insecurity:** Evidence indicates that women with limited education and employment opportunities are at higher risk of domestic violence, whereas financial independence equips women with the resources to seek safety and autonomy.
- **Workforce Participation:** Despite high prevalence of abuse, according to the Periodic Labour Force Survey (PLFS) 2023, only 41.7% of Indian women aged 15 and above were actively participating in the workforce.”–24, and just 32% as per NFHS-5, underscoring systemic economic vulnerability.
- **Socioeconomic Factors:** Women from rural areas, nuclear families, lower-income classes, and marginalized caste groups face elevated rates of violence, often intensified by limited access to resources and legal literacy.
- **Cycle of Abuse:** Economic dependence reinforces power imbalances, enabling abusers to control financial resources and making it extremely difficult for victims to leave due to fear of destitution, social stigma, and isolation.
- This economic dimension of domestic violence is further compounded by entrenched patriarchal norms restricting women’s access to education and employment. Although the Protection of Women from Domestic Violence Act (PWDVA), 2005 establishes a legal framework, inconsistent enforcement undermines its effectiveness in tackling these structural economic barriers.

3. METHODOLOGY

- A mixed-methods approach, combining qualitative and quantitative data, is recommended to thoroughly investigate the risk and protective factors influencing suicide among marginalized populations
- **Quantitative Component:** To measure prevalence, risk factors, and patterns.
- **Qualitative Component:** To explore lived experiences, social determinants, and coping mechanisms.

Rationale: Suicide among marginalized groups is influenced by socio-economic, cultural, and psychosocial factors that require both statistical and contextual understanding.

5.Social Determinants of Health (SDH) –

Social determinants of health (SDH) in India encompass the non-medical conditions in which individuals are born, grow, live, work, and age, which critically shape health outcomes and equity. These determinants account for 30–55% of overall health outcomes and include factors such as income and social protection, education, employment conditions, job security, food insecurity, housing, and access to affordable healthcare.

In India, SDH are strongly shaped by caste, gender, and poverty, resulting in deep disparities where marginalized groups, including Scheduled Castes (SCs) and Scheduled Tribes (STs), exhibit the poorest health indicators. Key policy priority areas include air pollution (both indoor and outdoor), child undernutrition, inadequate sanitation, precarious employment, and gender inequity—issues that persist despite overall progress in multidimensional poverty reduction.

Although India has implemented rights-based policies such as the Right to Education Act and the National Food Security Act to address these determinants, significant inequities persist across states, rural-urban settings, and socio-economic groups. Recent data indicate that while the Infant Mortality Rate (IMR) has declined from 58 per 1,000 live births in 2004–05 to 30 in 2019–21, disparities disproportionately affect women, lower-caste populations, and rural communities.

The World Health Organization (WHO) Commission on Social Determinants of Health has outlined key global targets to be achieved by 2040.

6. Role of Clinical Social Work –

A profession emerged from the understanding that providing material assistance alone cannot alleviate the suffering of recipients; effective support requires personal and social guidance to help individuals develop the skills to cope with their problems. The first major effort to formulate social work practice in a systematic fashion made by Mary Richmond in her book “Social Diagnosis”, and “What is Social Work” (1922), which is appreciated as landmark in Social Work education.

Social work is a professional practice aimed at strengthening the social functioning of individuals, families, groups, and communities, while promoting societal conditions that support their well-being (NASW, 2008).

Purpose of Social Work:

- To help individuals and groups identify, address, or mitigate problems arising from imbalances between themselves and their environment.
- To recognize potential areas of conflict or disequilibrium between individuals or groups and their environment, with the goal of preventing such issues.
- To identify, strengthen, and develop the inherent capacities and resources of individuals, groups, and communities, thereby promoting their overall well-being and social development.

Nature and Objectives of Clinical Social Work:

Clinical social work integrates core social work principles with an in-depth understanding of human behaviour and social

Suicide Prevention Among Marginalized Populations in India: A Clinical Social Work Perspective

environments, positioning practitioners to address individual, familial, and community-level psychosocial challenges effectively, positioning practitioners as essential contributors within the healthcare system. Clinical social workers provide support and interventions to individuals, families, and groups facing difficulties in their biopsychosocial functioning.

The objectives of clinical social work are both preventive and therapeutic. Interventions are diverse and may include individual psychotherapy, family therapy, group therapy, supportive or resource-based services, and advocacy within social systems to address environmental barriers that impact clients' well-being.

Role of Clinical Social Workers:

Clinical social workers deliver services to patients in inpatient settings, including clinical, de-addiction, neurological, and neurosurgical wards, as well as in their corresponding outpatient departments. These services encompass a comprehensive blend of independent psychosocial interventions and interdisciplinary. These approaches are executed at the individual, family, and group levels.

The primary focus of these interventions is the psychosocial assessment of patients and their families, followed by the formulation of a social diagnosis and the delivery of appropriate therapeutic interventions. This process involves systematic collection of information, documentation of case histories, home visits, collateral contacts, family education, and facilitation of group interactions with patients, detailed case history documentation, home visits, and collateral contacts, along with providing guidance and emotional support to distressed family members. Group-based interactions with patients are also conducted to enhance coping and social functioning.

Depending on the nature of the problem, family-centered casework services are offered. Clinical social workers actively engage significant others in the therapeutic process to strengthen support systems and improve treatment outcomes. Furthermore, the mobilization and effective utilization of family and community resources remain central to clinical social work practice, ensuring holistic care and the overall well-being of the patient.

Clinical Social Work and Child Psychiatry:

Clinical social work and child psychiatry in India share a long history of cooperation, with their collaboration emphasized in working with disturbed children, adolescents, and their families. Therapeutic interventions include group activities, individual counselling, and liaison with schools and child welfare agencies, delivered at both out-patient and in-patient levels.

While child guidance clinics were first introduced in India in 1937, services have historically been concentrated in metro cities, with many initiatives sustained by non-governmental organizations (NGOs) due to limited government policy focus. The multidisciplinary team approach is now standard, involving psychiatrists, psychologists, and psychiatric social workers who collaborate on assessment, treatment, and rehabilitation.

Despite the proven potential for these services to serve as models for developing countries, significant gaps remain in accessibility, with estimates suggesting that 90% of children with mental health disorders do not receive specialist services. The profession has evolved from early custodial models to modern strengths-based and community-oriented practices, supported by academic training programs like the M.Phil. in Psychiatric Social Work at institutes such as the Central Institute of Psychiatry (CIP) and the Institute of Psychiatry (IOP).

Family Clinical Centres-

Clinical social work services in family clinical centres primarily address **marital conflicts, family dysfunction, and interpersonal adjustment issues**. Interventions are conducted at both the individual and family levels.

Family members receiving services are encouraged to actively participate in **group sessions**, providing a supportive environment to explore concerns and develop practical solutions. Family-based therapeutic programmes, tailored to the **socio-economic and cultural context**, are delivered through the combined efforts of clinical social work professionals and trainees.

Drawing on their practice experience, clinical social workers have been instrumental in developing **indigenous models for understanding marital and family issues**. They have also contributed to designing **preventive, promotive, and therapeutic intervention frameworks** that are culturally sensitive and responsive to the needs of diverse family systems.

Services in rehabilitation and aftercare-

Rehabilitation constitutes a core component of practice. Clinical Social workers play a key role in addressing such as disability assessment, vocational rehabilitation, community reintegration, and resocialization.

Rehabilitation services for patients include post-treatment care and community reintegration for long-stay individuals, facilitation of employment opportunities for individuals with mental and neurological disabilities, social skills training programmes, sponsorship initiatives, and the promotion of self-help groups. These interventions aim to enhance independence, improve quality of life, and support successful reintegration into society.

Suicide Prevention Among Marginalized Populations in India: A Clinical Social Work Perspective

Neurological and neurosurgery services-

Clinical social work services are provided to patients with neurological illnesses and disabilities, with a focus on addressing their psychosocial and rehabilitative needs. These services include educating patients and their families, and applying casework and group work interventions to support individuals and families experiencing distress.

Special emphasis is placed on individuals with chronic disabilities, ensuring long-term support and care. Families are offered counselling and guidance regarding future planning, and are informed about available social security schemes and support resources. In addition, clinical social workers undertake regular home visits, coordinate with relevant agencies, and implement social and vocational rehabilitation interventions as required. These efforts aim to enhance the patient's quality of life and facilitate effective community reintegration.

7. Community Mental Health Programmes-

Community organization and social action are essential approaches for delivering, Mental health services are delivered across both rural and urban areas, with community participation and the promotion of mental health awareness serving as central components of clinical social work practice.

A workers actively engage in community-based care initiatives and play a pivotal role in capacity-building by training healthcare professionals and allied personnel. Additionally, involving local leaders and community stakeholders in the planning and implementation of mental health programmes enhances community ownership and improves the overall effectiveness of interventions.

8. Queerness and Mental Health in India-

Working with a queer community organization, we recruited participants through social media, dating apps (on which recruiters reached out to potential participants with study information),³ local influencers, and advertisements on LGBTQ+ groups and pages. We recruited broadly, cognizant of the potential bias stemming from the predominance of Hindu, upper-caste, gay men in many queer spaces in India (Shahani, 2020). Specifically, we aimed for representation across gender identities to mitigate overrepresentation of dominant groups and to help ensure a more inclusive sample that would better reflect the diversity within Mumbai's queer community. Interviews were conducted between October 2022 and May 2023 at a local community-based organization focused on LGBTQ+ advocacy, health, and research. Most interviews were in-person ($n = 24$); however, we offered an audio/video call option ($n = 11$) in case an in-person interview was uncomfortable or difficult. Prior to the interview, participants filled out a brief online questionnaire to provide demographic information and confirm that they met the study's eligibility criteria.

Demographics	Years	Count (n)
Age	18–24	10 (29%)
	25–34	18 (51%)
	35–45	7 (20%)
Gender identity	Cis-man	9 (26%)
	Cis-woman	7 (20%)
	Non-binary/agender	7 (20%)
	Transgender man	6 (17%)
	Transgender woman/Hijra/Kinnar ^a	6 (17%)
Sexual identity	Bisexual	5 (14%)
	Gay	9 (26%)
	Lesbian	5 (14%)
	Pansexual	2 (6%)
	Queer	4 (11%)
	Other	10 (29%)

Suicide Prevention Among Marginalized Populations in India: A Clinical Social Work Perspective

Demographics	Years	Count (n)
Outness	Out to all Out to some	19 (54%) 16 (46%)
Education	Completed 10 th std (high school)	2 (6%)
	Completed 12 th std (higher secondary school)	5 (14%)
	Graduate degree	15 (43%)
	Postgraduate degree or higher	13 (37%)
Monthly income	<10,000	9 (26%)
	10,000–30,000	14 (40%)
	30,000–50,000	7 (20%)
	>50,000	4 (11%)
	No response	1 (3%)
Social media platform use	Instagram	34 (97%)
	Facebook	29 (83%)
	WhatsApp	19 (54%)
	Twitter/X	9 (26%)
	Snapchat	6 (17%)

we sought to better understand disclosure among individuals with intersecting stigmas, specifically focusing on queer-identifying individuals in Mumbai, India, and how they navigate mental health disclosures on social media. We examined the reputational risks impacting their overall willingness to disclose, the benefits and risks of disclosure on social media, and the strategies around disclosure. With an eye toward extending frameworks for sensitive disclosure, we suggest three key factors that emerged as important throughout our findings: socio-cultural factors and willingness to disclose, perceived benefits of disclosure, and platform experience and platform spirit. Examining these elements through the lens of individuals with intersecting stigmas highlights unique challenges and considerations in the disclosure process. In discussing these three insights, we suggest how each one could further enhance frameworks for sensitive disclosure.

Socio-Cultural Factors and Willingness to Disclose-

First, the perceived risk of disclosure can be amplified by intersecting sources of stigma, making individuals particularly wary of disclosing at all. In our study, disclosures of mental health struggles are entangled with societal heteronormativity, which portrays queer identities as abnormal and in need of treatment. Participants expressed concerns that their family and/or community members would view their sexual/gender identity and mental health issues as interconnected pathologies. Indeed, [Dey \(2019\)](#) emphasizes how, “The colonial-era law, Section 377, perpetuated the stigmatization of LGBTQ identities by framing them as “unnatural” (p. 9). While India decriminalized consensual same-sex relations in 2018, **deep-rooted societal prejudice and marginalization remain significant challenges**. the lingering effects of this legal and cultural history continue to mark LGBTQ+ individuals as “non-natural.” This perception impacted participants’ willingness to disclose, as they did not want to be positioned at this stigmatized intersection.

Limitations and Future Work-

his study was based on in-depth interviews with 35 queer individuals residing in Mumbai. Efforts were made to ensure diversity by recruiting participants across a wide the full range of sexual orientations and gender identities. However, as highlighted earlier, a comprehensive understanding of disclosure strategies among individuals experiencing intersecting stigmas necessitates further research across diverse cultural contexts and marginalized populations.

The study’s focus on mental health and queerness as intersecting stigmas may limit the generalizability of the findings to other forms of stigma. Stigmas that are not medicalized or are perceived as resulting from “personal choices” (such as criminal behaviour or substance use) may shape disclosure dynamics in distinct ways. Future research should examine how varying types of stigmata—

Suicide Prevention Among Marginalized Populations in India: A Clinical Social Work Perspective

particularly those linked to perceived personal responsibility or social circumstances—intersect and influence disclosure processes, thereby enriching existing theoretical frameworks.

Although not directly central to intersectional stigma, future studies may also investigate how the concept of “platform culture” varies across different social media environments and how these differences influence disclosure practices. Several factors may shape users’ perceptions of platform culture, including evolving platform policies, shifting community norms, and public controversies involving the platform or its parent organization. Importantly, user experiences of the same platform can differ significantly depending on whom they follow, their geographic location, the language of interaction, and the level of content moderation and governance. While this study focused on centralized social media platforms, disclosure practices may differ on platforms with community-based moderation, such as Reddit, or on decentralized platforms utilizing federated protocols (Chandrasekharan et al., 2022; Ermoshina & Musiani, 2022).

9. Caste and Inequality-

Caste inequality in India remains deeply entrenched, with wealth and economic outcomes closely mirroring caste hierarchies despite constitutional safeguards. Research indicates that **upper castes (Forward Castes)** are over-represented in the top wealth deciles, owning **63% of the total household wealth** in 2012, while individuals from Scheduled Castes (SC) and Scheduled Tribes (ST) continue to be concentrated in the lowest wealth deciles, owning only **8% of total wealth**. This disparity is driven by historical land ownership patterns, limited access to education, and persistent discrimination in employment and resource distribution.

Economic and social metrics reveal a stark divide between caste groups, where **Forward Castes** have significantly higher average incomes, asset indices, and education levels compared to **SC/ST communities**. For instance, **Forward Castes** report an annual household income of **₹167,013** and **11.5 years of education**, whereas **SCs** report **₹89,356** and **6.7 years of education**. This "ordinal polarisation" ensures that **lower-caste groups** face systemic barriers in securing high-paying jobs and quality education, perpetuating a cycle of poverty and social exclusion.

Government initiatives and legal frameworks have been implemented to address these disparities. Policy measures, such as reservations in education and employment, the Scheduled Castes and Scheduled Tribes (Prevention of Atrocities) Act, 1989, and financial initiatives like the National Scheduled Castes Finance and Development Corporation play a crucial role in protecting rights and advancing the socio-economic development of marginalized communities. Nevertheless, caste-based discrimination persists in both urban and rural areas, often intertwined with class dynamics, continuing to drive political polarization and social fragmentation, and impeding India’s progress toward economic equality.

10. Policy Context-

Mental health in India has evolved from a stigmatized taboo to a recognized national priority, driven by progressive legislation, digital innovation, and shifting social attitudes, particularly among youth. While approximately 15% of Indians face mental health problems with a treatment gap of 70–90%, the government has implemented key frameworks like the Mental Healthcare Act (2017), which decriminalized suicide and guaranteed the right to care, and the National Tele Mental Health Programme (Tele MANAS), launched in October 2022 to provide free, 24×7 counselling.

- **National Mental Health Programme (NMHP, 1982):** One of the first in the developing world, it integrated mental health into general healthcare via the District Mental Health Programme (DMHP) covering 767 districts.
- **Mental Healthcare Act (2017):** A landmark rights-based law ensuring affordable care, patient consent, and dignity, aligning with the UN Convention on the Rights of Persons with Disabilities.
- **National Suicide Prevention Strategy (2022):** Aims to reduce suicide mortality by 10% by 2030 through early detection and crisis helplines.
- **Tele MANAS:** As of February 2025, this digital initiative handled over 1.8 million calls in 20 languages, serving as a scalable model for community-based care.

Despite these advancements, significant challenges persist, including a severe shortage of mental health professionals (0.75 psychiatrists per 100,000 people versus the WHO recommendation of 3), minimal funding (only 1.05% of the health budget), and persistent stigma in rural areas. The narrative is changing, with Millennials and Gen-Zs increasingly normalizing therapy, yet affordability and accessibility remain critical barriers for the majority of the population.

Modern Understanding and Freud’s Influence-

The 20th century marked a paradigm shift in India's mental health by moving from biological explanations to psychological exploration through Sigmund Freud's psychoanalysis, which introduced talk therapy as a revolutionary treatment. This era transformed psychiatry to address unconscious emotions and experiences, contrasting with earlier views that attributed mental illness to supernatural forces or purely physical causes. The post-war era ushered in the biomedical phase of psychiatry, characterized by the development of:

- **The Biomedical Phase:** Post-war decades introduced Electroconvulsive Therapy (ECT), psychosurgery, and psychopharmacology with drugs like Lithium, Valium, and Prozac, though this led to an overreliance on medication.

Suicide Prevention Among Marginalized Populations in India: A Clinical Social Work Perspective

- **Psychogenic Perspective:** Freud's theories proposed that mental disorders stem from psychological processes rather than just brain pathology, emphasizing unconscious determinism and early childhood experiences.
- **Global Integration:** India's mental hygiene movement in the 1930s aligned with global trends, incorporating Freudian notions on neuroses and sexual abstinence into local discourse.
- **Legacy:** While the biomedical approach revolutionized treatment for chronic disorders, it also highlighted an imbalance in neglecting psychosocial dimensions, a gap that persists in India's current infrastructure.

Mental Health in India: Current Scenario-

The National Mental Health Survey (NMHS) 2015–16, conducted by NIMHANS on behalf of the Ministry of Health and Family Welfare, estimated that 10.56% of adults in India suffered from current mental morbidity, with a lifetime prevalence of 13.67%. The survey covered 34,802 individuals across 12 states, revealing that nearly 15% of the adult population requires treatment for one or more mental health disorders, yet a massive treatment gap of 84.5% exists due to stigma, lack of awareness, and a shortage of professionals.

Prevalence and Patterns:

- **Substance Use Dominance:** Mental and behavioral problems due to psychoactive substance use were the most prevalent disorder at 22.44%, followed by mood disorders (5.61%) and neurotic/stress-related disorders (3.70%).
- **Demographic Disparities:** Prevalence was higher among males (lifetime: 16.75% vs. 10.8% for females), urban metro residents (19.33% lifetime vs. 12.28% in rural areas), and individuals with lower education or income.
- **Regional Variation:** Lifetime morbidity ranged from 8.1% in Assam to 19.9% in Manipur, while suicide risk varied from 2.2% in Chhattisgarh to 12.5% in Kerala.

Systemic Gaps and Resources:

- **Treatment Gap:** While nearly 150 million Indians need mental health care, less than 30 million are seeking it, with 70% to 92% of those with disorders receiving no proper treatment.
- **Resource Shortage:** India has only 0.75 psychiatrists per 100,000 people, falling significantly short of the WHO recommendation of 3 per 100,000.
- **Budget Allocation:** Most state governments allocate less than 1% of their budget to mental health, despite the high burden of disease.

The NMHS serves as the first comprehensive national-level epidemiologic survey in India, establishing a baseline for future policy and highlighting the urgent need for increased investment and the implementation of **NMHS 2** to address emerging concerns and measure broader mental wellness beyond psychiatric disorders.

Treatment Gaps and Challenges

Despite increasing awareness, India continues to experience a substantial treatment gap, with an estimated 70% to 90% of individuals with mental disorders lacking access to formal care. This gap arises from multiple factors, including:

- Persistent stigma and socio-cultural taboos
- Limited awareness and inadequate early detection and diagnosis
- Insufficient infrastructure and a shortage of trained mental health professionals

The Indian Journal of Psychiatry reports that India has approximately 0.75 psychiatrists per 100,000 population, significantly below the WHO-recommended 3 per 100,000. Investment in mental health infrastructure, funding, and research continues to be limited and services are largely concentrated in urban areas, restricting access for rural populations. Structural inequalities related to class, caste, education, and income further exacerbate disparities in care. Additionally, evolving socio-economic conditions—including post-liberalization work culture, digital overexposure, and the COVID-19 pandemic—have contributed to rising levels of anxiety, depression, and burnout across different population groups.

Government Policies and Institutional Initiatives

India was among the first developing countries to launch a dedicated mental health program, officially implementing the National Mental Health Programme (NMHP) in August 1982 to integrate mental healthcare into the general health system. This landmark initiative was designed to make mental health services accessible, affordable, and inclusive, addressing a critical treatment gap where over 90% of affected individuals received no care due to a shortage of professionals and social stigma.

The program was launched by the Ministry of Health and Family Welfare in response to WHO recommendations and the need to decentralize care beyond urban centres. Its core strategy involved three primary objectives: ensuring accessibility of minimum mental healthcare for all, integrating mental health services into general primary care, and promoting community involvement to reduce stigma.

- **District Mental Health Programme (DMHP):** Introduced in 1996 as the operational arm of NMHP to deliver services at the district level, expanding to nearly 770 districts by 2025.

Suicide Prevention Among Marginalized Populations in India: A Clinical Social Work Perspective

- **Manpower Development:** Launched in 2009 to address the severe shortage of psychiatrists and train primary healthcare workers in basic psychiatric skills.
- **Modernization and Upgradation:** Revised in 2003 to include the modernization of state mental hospitals and the upgradation of psychiatry departments in medical colleges.
- **Legal and Policy Framework:** Strengthened by the National Mental Health Policy (2014) and the Mental Healthcare Act (2017), which legally guaranteed the right to mental healthcare and protected the rights of patients.
- **Digital Initiatives:** Enhanced by newer programs like the Tele-MANAS national helpline to provide 24/7 tele-counselling and reach remote areas.

Rights of Persons with Disabilities (RPwD) Act, 2016-

Replacing the 1995 legislation, the RPwD Act broadened the definition of disability to explicitly include mental illness, aligning India's legal framework with the UN Convention on the Rights of Persons with Disabilities (UNCRPD). The Act emphasizes the protection of rights, dignity, and non-discrimination for individuals with psychosocial disabilities.

Mental Healthcare Act (MHCA), 2017

The MHCA (2017) represents a landmark reform in India's mental health legislation:

- Guarantees the right to affordable, accessible, and quality mental healthcare.
- Decriminalizes suicide, recognizing it as a mental health issue.
- Stipulates informed consent, confidentiality, and community-based rehabilitation.

This legislation positions India among a select group of countries with a rights-based mental health framework.

National Health Policy, 2017

The policy identifies mental health as a national priority and advocates for its integration into primary healthcare. Initiatives such as the Ayushman Bharat Health and Wellness Centres are expanding access to essential mental health services, including basic medications, counselling, and referral support, at the grassroots level.

National Suicide Prevention Strategy, 2022

Launched by the Ministry of Health and Family Welfare, the strategy aims to reduce suicide mortality by 10% by 2030. Its core focus areas include:

- Early detection and school-based mental health screening.
- 24×7 crisis helplines.
- Community-based interventions targeting high-risk populations such as students, farmers, and youth.

Digital Mental Health Initiatives: Tele-MANAS

India has entered a digital phase in mental healthcare with the Tele-MANAS (Tele Mental Health Assistance and Networking Across States) programme, launched in October 2022. This initiative provides free, round-the-clock support via multilingual toll-free helplines.

As of February 2025:

- Over 1.8 million calls have been handled.
- 53 Tele-MANAS centres, 23 mentoring institutions, and 5 regional hubs are operational.
- A mobile app (launched 2024) provides self-care tools, stress management resources, and tele-consultation services.

The World Health Organization recognizes Tele-MANAS as a scalable and inclusive model for community-based mental healthcare. The programme also integrates previous services, such as the KIRAN Helpline, to ensure streamlined support delivery.

Capacity Building and Workforce Development

To address the shortage of mental health professionals, India has established:

- 25 Centres of Excellence and 47 postgraduate training departments in mental health.
- Digital training platforms, including iGOT-Diksha, to equip doctors, nurses, and community health workers with skills for early identification and management of mental health conditions.

Economic Survey 2024–25: Mental Health as Human Capital

Recognizing mental health as central to individual well-being and national development, the Economic Survey 2024–25 reports that approximately 10.6% of adults in India experience mental disorders, with treatment gaps ranging from 70% to 92%. Urban metropolitan areas report higher prevalence (13.5%) than rural (6.9%) and urban non-metropolitan areas (4.3%).

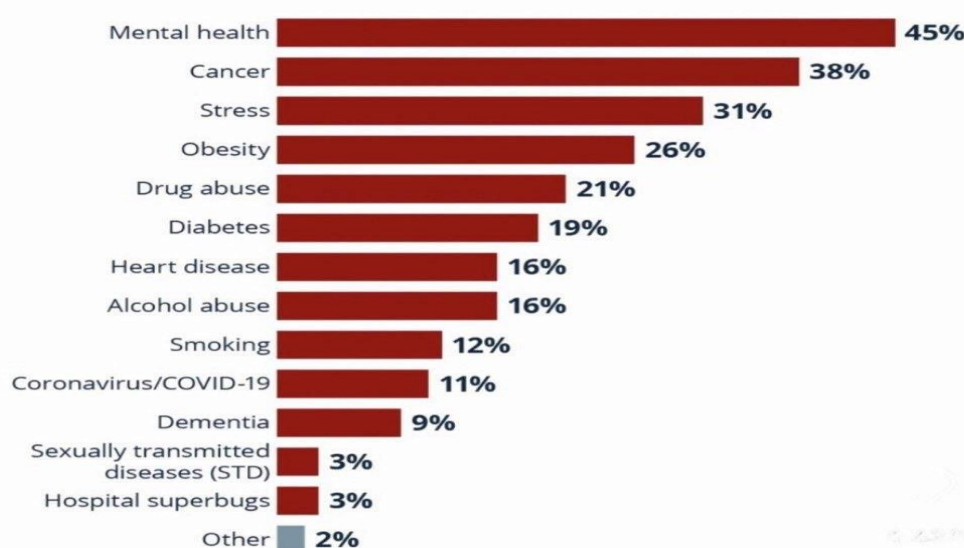
Drawing on the NCERT Mental Health and Well-being of School Students Survey, the report highlights rising mental health concerns among adolescents, exacerbated by the COVID-19 pandemic: 11% reported anxiety, 14% intense emotional distress, and 43% frequent mood fluctuations.

Suicide Prevention Among Marginalized Populations in India: A Clinical Social Work Perspective

At the macroeconomic level, the Survey notes that mental health disorders result in significant productivity losses due to absenteeism, reduced work efficiency, disability, and higher healthcare costs. Poverty and economic vulnerability further exacerbate psychological distress, as adverse living conditions, financial insecurity, and limited upward mobility increase mental health risks. The Survey also highlights innovative state-level programmes promoting mental health and well-being, particularly among children and adolescents. These initiatives complement national programmes, fostering a decentralized and comprehensive approach to mental healthcare in India.

Mental Health Is Now the World's Top Health Concern.

Mental health has overtaken cancer as the world's most cited health concern in a global Ipsos survey, rising from 27% in 2018 to 45% in 2024 by respondents in 31 countries.



The **Economic Survey 2024–25** explicitly links mental well-being to India's economic future, identifying it as a critical driver of productivity and national growth. The survey highlights that **mental health disorders cause significant productivity losses** through absenteeism, reduced output, disability, and increased healthcare costs, noting that these issues drag down the economy more broadly than physical health problems. By recognizing mental health as a core component of human capital, India demonstrates a shift from a predominantly curative model toward a preventive, community-oriented approach to care. Despite progressive frameworks such as the Mental Healthcare Act (2017), the National Mental Health Programme (NMHP), and the District Mental Health Programme (DMHP), substantial gaps in implementation and service delivery persist.

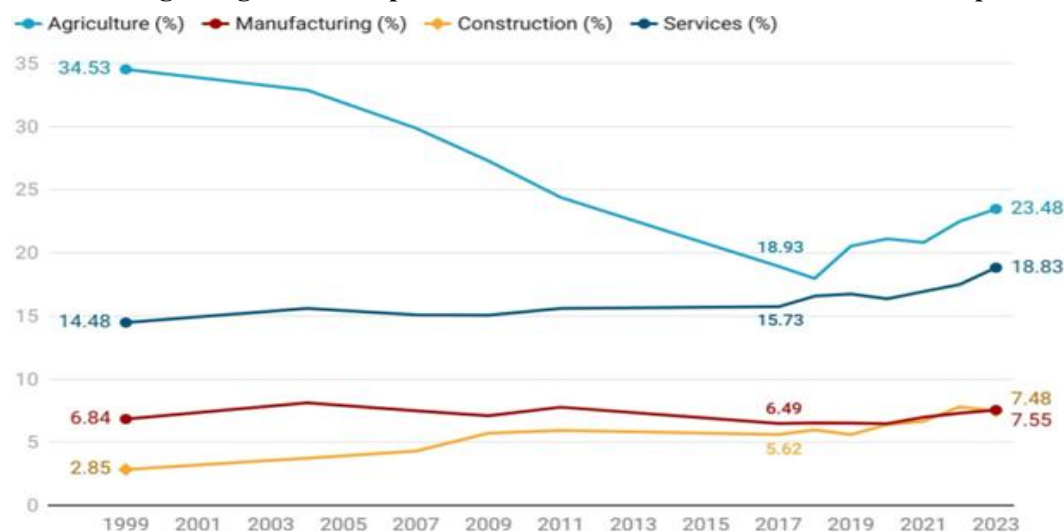
- **Youth Mental Health:** The survey emphasizes that the mental well-being of the youth, central to India's demographic dividend, is vital for future economic ambitions, citing rising issues among children and adolescents linked to internet and social media overuse.
- **Workplace and Lifestyle:** It identifies hostile work cultures, excessive working hours, unhealthy diets, and lack of physical activity as major contributors to poor mental health that hinder economic progress.
- **Policy Gap:** While the survey calls for a paradigm shift towards early intervention and holistic policies, critics note a divergence between this recognition and actual budget allocations, with mental health funding remaining at just over 1% of the Ministry of Health's budget for FY 2025–26.

11. Challenges-

Workforce participation by sector-

Workforce participation by sector refers to the distribution of employed individuals across different sectors of the economy.

Suicide Prevention Among Marginalized Populations in India: A Clinical Social Work Perspective



Beginning in the late 1980s, India experienced significant **structural transformation**, reflected in shifting sectoral contributions to Gross Domestic Product (GDP). The share of agriculture declined from **36% in 1980–81 to 16% in 2023–24**, while the services sector expanded from **38% to 50%** during the same period. In contrast, the contribution of manufacturing has remained relatively stable within the range of **13–17%**, with a slight decline observed since 2010, whereas the construction sector has maintained a consistent share of **18–21%**. These trends indicate that India's economic growth has been largely **service-led**.

However, the distribution of employment across sectors presents a contrasting picture. As of 2023–24, agriculture continues to employ approximately **40% of the workforce**, making it the largest source of employment. The services sector accounts for about **32% of employment**, while manufacturing and construction employ **13% and 14%**, respectively. This disparity highlights that, although the services sector has driven economic growth, its **capacity to generate employment has not kept pace with its contribution to GDP**, reflecting structural imbalances within the economy.

Sectoral Contribution to Growth and Employment –

International comparisons indicate that India's structural transformation is characterized by a significant lag in moving labour from agriculture to high-productivity non-agricultural sectors. While the service sector dominates GDP at approximately 55–60% and the industrial sector contributes around 25–30%, the agricultural sector still employs roughly 45–46% of the workforce despite generating only 16–20% of GDP.

- **Mismatch in Productivity:** Unlike typical development patterns where labor moves to manufacturing, India's non-agricultural transition has largely shifted workers into low value-added construction rather than high-productivity manufacturing or modern services.
- **Informality and Slow Growth:** The process of pulling workers out of the informal sector has been notably slower than pulling them out of agriculture, creating a vicious cycle of low productivity and precarious livelihoods.
- **Employment Gap:** To sustain economic growth and meet rising demand, India needs to create 7.85 million non-agriculture sector jobs annually until 2030, a target that current growth patterns struggle to meet due to the capital-intensive nature of modern industries.

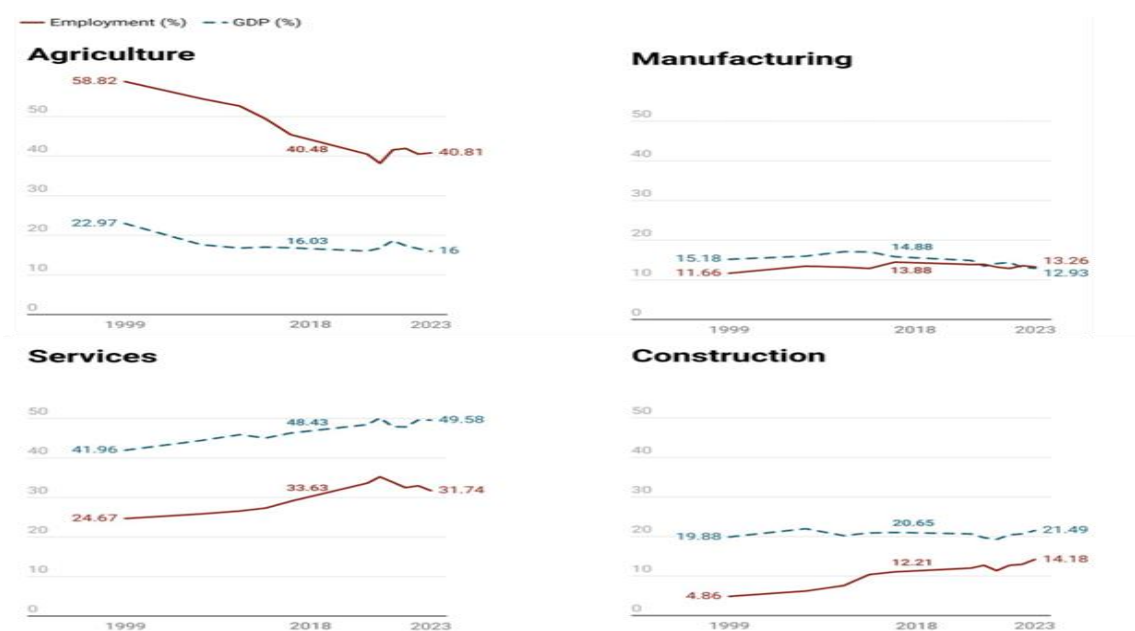
sector	GDP Contribution	Workforce Share	Key Observation
Primary (Agriculture)	16–20%	45–46%	Highest employment but lowest productivity; laggard in growth.
Secondary (Industry)	25–30%	27–30%	Stagnant employment share; transition often leads to construction.

Suicide Prevention Among Marginalized Populations in India: A Clinical Social Work Perspective

Tertiary (Services)	55–60%	27–30%	Largest GDP contributor but employs fewer workers; high skill
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This divergence highlights a unique Kuznets process where India has achieved high service-sector growth without a corresponding rise in formal, high-value employment, unlike many other developing economies that experienced robust manufacturing-led job creation.

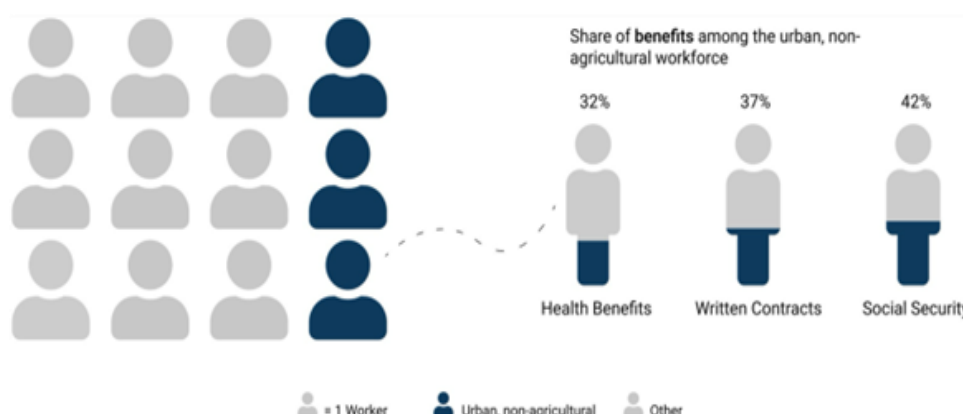
In summary, although overall workforce participation has improved, sectoral distribution remains imbalanced, reflecting persistent structural challenges in India's economy.



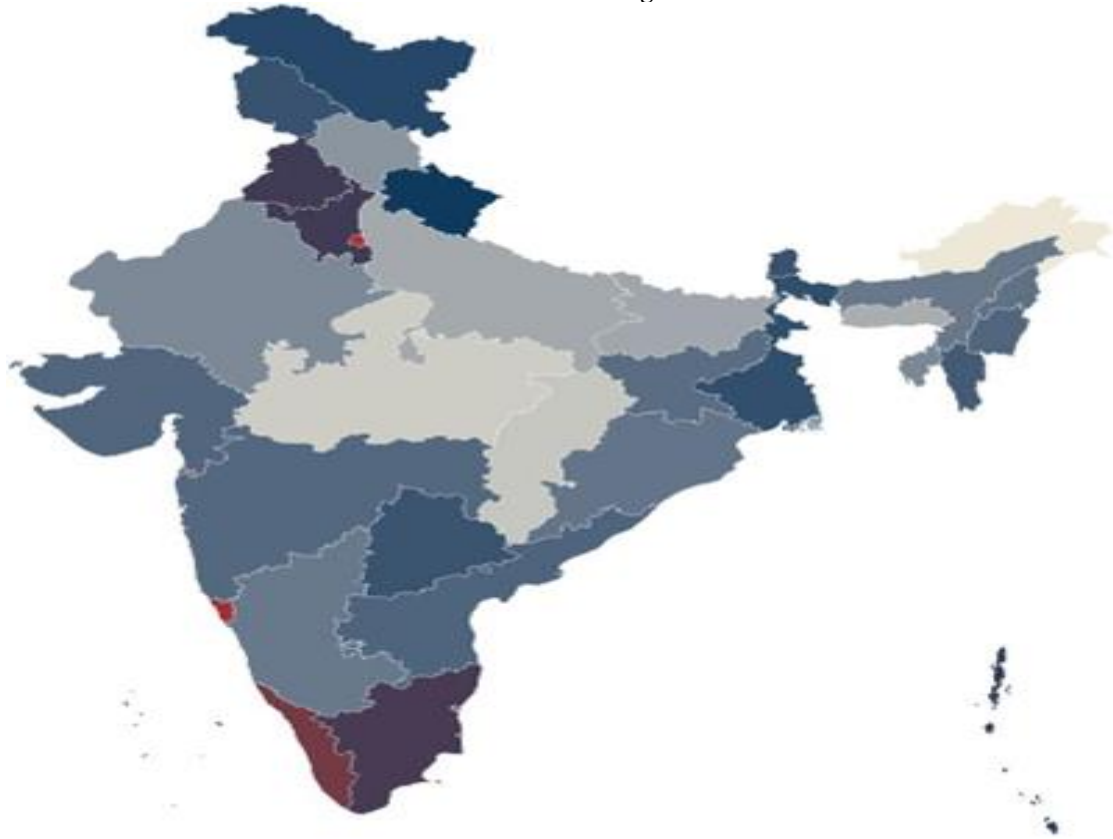
Workforce Formalisation and Social Security-

The share of workers with formal employment contracts, health benefits, and social security coverage remains low in India, highlighting the pervasive informality of the labour market.

The rapid growth of the gig economy may further increase informal work arrangements. Although digital platforms provide opportunities for flexible work outside traditional employment structures—especially for women with caregiving responsibilities—gig workers frequently lack adequate social protection and benefits.



State-wise Distribution of the Non-Agricultural Workforce-



Migration, Regional Development, and the Future of Work in India-

Internal migration in India is predominantly driven by regional development disparities, with the 2011 Census recording 21 crore migrants where 88% were intra-state and 12% were inter-state. While marriage accounts for 51% of female intra-state migration, work and employment remain the primary driver for inter-state mobility, particularly for males. Recent studies indicate that employment-related factors, such as job loss, continue to be the dominant cause of migration even in the post-pandemic period. The future of work is increasingly shaped by a North-South demographic divide, where southern states face population greying and labour shortages due to early fertility transitions, while northern regions possess a youth bulge. Consequently, labour mobility is shifting southward to fill these vacancies, with circular migration emerging as a key trend rather than permanent settlement. This flow is critical for reaping the demographic dividend and achieving regionally balanced development, as remittances from the south can fuel growth in the poorer north.

Challenges persist regarding the vulnerability of migrant workers, who often face low wages, poor working conditions, and limited access to social security in the informal sector. Although remittances reached over \$111 billion in 2022, making India the largest recipient globally, the benefits are often unevenly distributed, exacerbating economic inequality. Future strategies must focus on skill development, regional infrastructure investment to create "counter-magnet cities," and coordinated welfare schemes to protect migrant rights and reduce the need for survival-based migration.

12. RECOMMENDATIONS

The Ministry of Health and Family Welfare, in collaboration with public health institutions and Asia India Mental Health, is **implementing an innovative community mental health development initiative** aimed at strengthening the District Mental Health Programme (DMHP) and **enhancing access to essential community-based mental health services**.

This initiative presents a **strategic opportunity to address persistent challenges in mental healthcare delivery in India**. It recognizes that a uniform model of care is insufficient for a diverse country and emphasizes the importance of **context-specific, locally adapted approaches co-developed with communities**.

Moreover, **targeted, competency-based training programmes** are crucial for cultivating local leadership and workforce capacity, thereby ensuring the **effective provision of culturally sensitive, high-quality community mental health services**.

13. Conclusion-

Suicide among marginalized populations in India is deeply rooted in **structural inequalities, social exclusion, and systemic disadvantage**, rather than merely individual vulnerability. Marginalisation, as a process, pushes individuals and communities to the periphery of society, exposing them to **discrimination, economic deprivation, and limited access to essential resources and**

Suicide Prevention Among Marginalized Populations in India: A Clinical Social Work Perspective

opportunities. Groups including women, persons with disabilities, the elderly, Scheduled Castes, Scheduled Tribes, Muslims, and Adivasis continue to experience multiple, intersecting forms of marginalization, increasing their psychosocial distress and overall vulnerability

Clinical social work assumes a critical role by delivering holistic, culturally sensitive, and rights-based interventions that address both individual needs and structural barriers. Through advocacy, community engagement, and psychosocial support, clinical social workers contribute to promoting equity, dignity, and social inclusion.

India's evolving mental health landscape reflects a broader societal transformation—from stigma and neglect to **greater awareness, policy reform, and innovation.** By integrating traditional knowledge systems with modern mental healthcare approaches and expanding digital and community-based services, India has the potential to build a **more just, accessible, and responsive mental health system.**

Ultimately, prioritizing mental well-being is not only essential for improving individual health outcomes but also for fostering a **just, resilient, and empathetic society**, where no group is left behind.

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