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REVIEW ARTICLE

Causation in Suicide: Clinical, Legal and Policy Interfaces- Insights from an Interdisciplinary Roundtable

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ABSTRACT

Background: Suicide presents courts, legislators, and policymakers with one of the most structurally difficult causation problems in contemporary law. Its complexity, extensively documented in clinical and epidemiological research, exceeds what existing legal causal standards were designed to accommodate.

Aim: This article, written from the perspective of a legal practitioner engaged in interdisciplinary advocacy, examines the specific mechanisms by which legal and policy frameworks fail to engage adequately with the causal reality of suicide.

Methods: Drawing on discussions from an interdisciplinary roundtable convened in April 2026 and situating them within established legal principles from Indian and comparative jurisdictions, the article argues that reforms to causal standards in abetment prosecutions, investigative procedures, and preventive policy frameworks are both necessary and achievable.

Results: It identifies the structural deficiencies of existing legal doctrines, proximate causation, the novus actus interveniens doctrine, and the narrow construction of instigation under Section 306 IPC, and proposes a framework for interdisciplinary engagement as the necessary institutional infrastructure for just legal outcomes and evidence-based prevention policy.

Keywords: causation; suicide; legal attribution; abetment; policy reform; foreseeability; novus actus interveniens; Section 306 IPC; interdisciplinary; India; divergence

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INTRODUCTION

Suicide represents one of the most consequential and least tractable challenges in global public health. The World Health Organization estimates that over 700,000 people die by suicide each year, making it the fourth leading cause of death among individuals aged 15 to 29.1 Beyond the epidemiological scale, what makes suicide a peculiarly difficult subject for interdisciplinary analysis is the fundamental tension between how different professional systems understand causation. Clinical practice, legal reasoning, and policy design each operate under different epistemological assumptions, different evidentiary standards, and different consequential stakes. Clinicians understand suicide as the outcome of a complex, non-linear convergence of biological vulnerability, psychological distress, environmental stress, and proximate precipitants. Legal systems, by contrast, are institutionally compelled to assign responsibility to identifiable agents through the application of causal standards, proximate cause, substantial contribution, foreseeability, that are designed for simpler chains of events. Policy frameworks must operationalise interventions at scale, often reducing clinical complexity into measurable indicators and categorical risk factors. Each system, in fulfilling its own functions, necessarily simplifies a phenomenon whose explanatory richness defies simplification.

The limitations of legal causation standards become particularly acute in proceedings involving allegations of abetment of suicide, negligence in clinical care, and the framing of inquests and preventive policy. This article examines these limitations from the perspective of legal practice and advocacy, drawing on the clinical evidence base as an essential reference point. It focuses on the divergence between what the evidence base establishes about suicidal causation and what existing legal and policy frameworks are capable of recognising. It draws on discussions from an interdisciplinary roundtable convened in April 2026, and situates those discussions within established legal principles from Indian and comparative jurisdictions.

The article proceeds as follows. Section II surveys the clinical evidence base on suicidal causation, identifying those features of that evidence which are most significant for legal and policy analysis. Section III outlines the legal frameworks through which causation is attributed in cases involving suicide, with particular attention to Indian law and comparative common law principles. Section IV maps the principal points of divergence between legal doctrine and the clinical evidence. Section V considers system-level implications for investigation, regulatory governance, and judicial reasoning. Section VI proposes a framework for interdisciplinary integration. Sections VII and VIII address limitations and conclusions, respectively.

II. THE CLINICAL EVIDENCE BASE: IMPLICATIONS FOR LEGAL AND POLICY ANALYSIS

This section does not purport to provide a clinical account of suicidal causation. Rather, it identifies, from a legal and policy perspective, those features of the clinical and epidemiological literature that carry direct implications for how law and policy should be structured. Three such features are of particular significance.

First, the dominant models in the clinical literature including the stress-diathesis framework and multi-factor interpersonal theories- understand suicide as the outcome of a complex, non-linear convergence of biological vulnerability, psychological distress, environmental stress, and proximate precipitants. No single factor is identified as sufficient;

Rather, it is the interaction of multiple contributing elements, operating across different timescales and subject to individual variation, that produces lethal risk. The legal consequence of this finding is significant: no single act, however serious, can reliably be characterised as the cause of a suicidal outcome. The corollary, equally important for liability analysis, is that the removal or modification of any one contributing factor may be sufficient to interrupt the pathway to death, which has implications for both but-for causation and substantial contribution tests.

Second, the clinical literature documents what has been described as the "suicidal state “- a transitional phase of acute psychological crisis in which the individual’s perceived options are profoundly constrained, and in which the capacity for reflective, autonomous decision-making is significantly diminished. This finding has direct implications for

the legal doctrine of novus actus interveniens. Courts that apply this doctrine to suicide cases by treating the deceased's act as the free and voluntary choice of a competent adult may be working from assumptions about autonomous volition that are inconsistent with the clinical evidence. Whether an individual in a suicidal state possesses the decision-making capacity that the law presupposes is a question that legal frameworks have not consistently engaged.

Third, clinical models recognise that the causal pathway to suicide may operate across extended periods, months, or years, during which vulnerability accumulates through sustained exposure to stressors such as relational abuse, financial coercion, institutional failure, or social marginalisation. This temporal dimension is poorly captured by legal frameworks that require a discernible proximate connection between identified conduct and a suicidal outcome. From a policy perspective, it also highlights the inadequacy of data collection frameworks such as those employed by the National Crime Records Bureau, which aggregate suicidal deaths under broad categorical headings without capturing the cumulative causal pathways that the evidence describes.

These three features of the clinical evidence base the non-linearity of causation, the constrained decision-making capacity of individuals in a suicidal crisis, and the extended temporal dimension of suicidal pathways are not peripheral observations. They are central findings of a well-developed research literature. The challenge this article addresses is that existing legal and policy frameworks are structurally ill-equipped to accommodate them.

III. LEGAL APPROACHES TO CAUSATION

Law must, by institutional necessity, make determinations of cause. Whether in criminal proceedings, civil liability, or inquest proceedings, the legal system requires that a causal relationship be established between a defendant's act or omission and a specified outcome. This requirement reflects not merely an epistemological claim but a normative one: legal responsibility must be assignable and bounded if it is to be just. In the common law tradition, causation is analysed in two stages: factual causation (the "but for" test) and legal causation (proximate or substantial cause). The "but for" test asks whether the harm would have occurred but for the defendant's act.[7] Legal causation then asks whether the defendant's contribution was sufficiently substantial and proximate to ground liability.8 Both stages present difficulties in the context of suicide, where multiple factors contribute to the outcome and where the act of the deceased is itself an intervening event. The doctrine of novus actus interveniens, a new intervening act that breaks the chain of causation, is particularly significant here.

In R v Kennedy (No 2), the House of Lords held that the free and informed act of an adult third party in self-administering a drug was sufficient to break the causal chain between the defendant's supply and the death.9 This reasoning has potential application to cases involving suicide: where the deceased exercised autonomous decision-making capacity, it may be argued that their act is a novus actus interveniens that severs the causal connection between any prior conduct of a defendant and the death. However, the doctrine does not apply where the antecedent conduct of the defendant substantially contributed to the undermining of the deceased's decision-making capacity.

The "thin skull" rule, established in R v Blaue, holds that a defendant must take the victim as they find them, including pre-existing vulnerabilities.10 In the context of suicide, this rule creates an interesting tension: it suggests that a defendant who acts upon a person of heightened vulnerability cannot escape liability by pointing to that vulnerability as a supervening cause. However, it also presupposes that the defendant's act was a cause at all, and it is precisely this initial causal connection that is most difficult to establish where suicide follows at a temporal remove from the impugned conduct.

Indian Legal Framework

In the Indian jurisdiction, the primary legal provision governing attribution in cases of suicide is Section 306 of the Indian Penal Code 1860, which criminalises abetment of suicide. Abetment, as defined under Sections 107–109 IPC, requires proof of instigation, conspiracy, or intentional facilitation. The courts have interpreted these elements to

require a direct and proximate connection between the accused's conduct and the deceased's decision to end their life, with a demonstrable mens rea.

The constitutional history of suicide in India reflects an evolving normative framework. In P Rathinam v Union of India, the Supreme Court read a right to die as implicit in the right to life under Article 21, effectively decriminalising attempted suicide. This was overturned in Gian Kaur v State of Punjab, where a larger constitutional bench held that the right to life does not encompass a right to die. The tension between these decisions reflects a broader jurisprudential uncertainty about autonomy, vulnerability, and the state's parents patriae obligations, a tension that has direct implications for how causation is approached in abetment cases.

The Mental Healthcare Act 2017 marked a significant legislative shift. Section 115 provides that any person who attempts suicide shall be presumed to be under severe stress and shall not be tried and punished under the Indian Penal Code. This provision reflects a clinical orientation in the legislative framework, one that treats the suicidal act as a symptom of distress rather than a volitional criminal act. In doing so, it implicitly acknowledges the clinical model of causation, even as Section 306 IPC continues to impose criminal liability on third parties through a framework that requires linear causal attribution.

The MHCA 2017 did not, however, resolve the underlying legislative incoherence. As commentators have noted, the Act achieved only a partial decriminalisation: Section 309 IPC remained formally on the statute book, and the presumption of severe stress established by Section 115 MHCA operated as a shield from prosecution rather than as a repeal of the offence itself. The Law Commission of India had twice recommended the repeal of Section 309 in 1971 and again in 2008, and the IPC (Amendment) Bill 1978 was passed by the Rajya Sabha but lapsed before the Lok Sabha could act on it. This legislative history of incremental and incomplete reform is itself evidence of the structural difficulty of accommodating clinical understandings of suicidal causation within a framework of penal law.

The legislative position has been further altered by the Bharatiya Nyaya Sanhita 2023, which came into force on 1 July 2024 and replaced the Indian Penal Code. Under Section 226 of the BNS 2023, attempted suicide is now a punishable offence only where the attempt is directed at compelling or restraining a public servant in the performance of official duties. In

all other cases, attempted suicide is no longer a criminal offence under the principal penal code. Abetment of suicide is retained as an offence under Section 108 of the BNS 2023 in materially similar terms to the former Section 306 IPC. The reform accordingly removes one dimension of the penal response to suicide while leaving intact the doctrinal framework that most directly implicates legal causation analysis in third-party liability cases.

In Common Cause v Union of India, the Supreme Court recognised the right to die with dignity in the context of passive euthanasia and advance directives. While distinct from suicide in the strict sense, this decision has broader implications for how the legal system understands the relationship between autonomy, clinical vulnerability, and the attribution of responsibility for a person's death.

In comparative law, the English Court of Appeal's decision in R v Wallace addressed causation in a case where the victim of a serious assault later travelled to Belgium for assisted dying. The court held that the question of causation required an assessment of whether the defendant's initial act remained an operating and substantial cause of death at the time of the assisted death, notwithstanding the intervening autonomous choice of the deceased. This reasoning is instructive for abetment cases, suggesting that temporal distance and intervening volition do not automatically sever the causal chain.

IV. POINTS OF DIVERGENCE: WHERE LEGAL DOCTRINE FAILS THE EVIDENCE

The clinical evidence surveyed in the preceding section establishes a picture of suicidal causation that legal doctrine is poorly equipped to accommodate. This section identifies the principal points of structural mismatch between the causal requirements of legal proceedings and what the evidence base establishes. The distortions that result are not incidental. They produce systematically unjust outcomes: liability imposed where causation is genuinely contested, and liability

denied where cumulative institutional or relational conduct is causatively significant.

The first major tension concerns the question of linearity. The evidence establishes that suicide results from a non-linear convergence of factors across multiple domains and timescales. Legal causation, however, is fundamentally a linear concept: it traces a causal chain from act to consequence, identifying which links in that chain are legally relevant.19 When courts apply this framework to suicide, they tend to focus on the most proximate precipitant, the final trigger, and to underweight the distal vulnerability factors that, from a clinical perspective, were equally constitutive of the outcome.

A second tension concerns the role of individual volition. Legal frameworks, particularly in the criminal law, place significant normative weight on autonomous choice as a factor that can interrupt causal chains. As noted in Section II, the clinical evidence indicates that the suicidal state is characterised by significant constraints on autonomous decision-making. The legal attribution of full volitional choice to a person in such a state may therefore be evidentially unsupported, yet the doctrine of novus actus interveniens invites precisely this attribution.

Third, there is a temporal dimension to the divergence. Legal causation typically requires a discernible temporal and causal connection between conduct and consequence. Clinical models recognise that the path to suicide may traverse extended periods of time, involving multiple episodes of vulnerability, partial recovery, and renewed crisis. Legal frameworks are not well-equipped to reason across this extended temporal horizon, particularly where the impugned conduct, say, a pattern of harassment, institutional failure, or relational abuse, operated cumulatively over months or years before producing the outcome.

Fourth, the question of foreseeability, a central element in both tort and criminal causation, is particularly contested. Courts have generally required that the relevant harm be reasonably foreseeable to the defendant. In the context of suicide, this raises the question of whether and to what extent a defendant ought to have known of the deceased's vulnerability. Clinical knowledge of risk factors and warning signs is extensive and well-documented,23 but it is not uniformly distributed across the lay population. Courts must therefore make judgments about what a reasonable person in the defendant's position ought to have known, and those judgments will be heavily influenced by assumptions about the predictability of suicidal behaviour that may be clinically contested.

In the Indian context, the judicial interpretation of "instigation" under Section 306 IPC has given rise to a body of difficulties. Courts have at times construed instigation narrowly, requiring active encouragement or a direct and proximate connection, while the clinical literature suggests that passive withdrawal of support, financial coercion, or sustained emotional abuse may be equally causative of a suicidal outcome even in the absence of explicit instigation.

V. SYSTEM-LEVEL IMPLICATIONS

The divergence between the clinical evidence base and existing legal causal standards does not remain at the level of abstract theory. It produces concrete and consequential effects at the system level, across investigation, institutional governance, and judicial reasoning.

Investigative Systems

Coroners' inquests and equivalent investigative proceedings are designed to establish the cause of death and, in some jurisdictions, to identify systemic lessons for prevention. However, the causal frameworks available to investigators are typically legal or quasi-legal in nature, requiring the identification of a cause of death that is formulated in terms of identifiable acts or omissions. This creates pressure towards oversimplification: the investigator must select a cause from a complex field of contributing factors, and that selection will inevitably reflect the categories available within the investigative framework rather than the full clinical picture.

In India, the National Crime Records Bureau collects data on suicides under broad categorical headings family problems, illness, financial difficulties, that aggregate vastly different clinical and social profiles into homogeneous categories. This data is then used to shape preventive policy. The epistemological

limitations of those categories, rooted in legal and administrative rather than clinical frameworks, constrain the quality and specificity of the policy responses that can be derived from them.

The inadequacy of the policy framework is most starkly illustrated by recent empirical evidence on the consequences of decriminalisation itself. A study examining suicide mortality data across 35 Indian states from 2001 to 2020 found that the enactment of the Mental Healthcare Act 2017 was not associated with any significant overall reduction in suicide mortality. More troublingly, in less developed states characterised by weaker health infrastructure and limited access to mental health services suicide mortality increased by approximately 1.9 times in the years following the Act's enactment. This finding does not vitiate the normative case for decriminalisation, which remains sound; but it powerfully illustrates that legislative reform, without accompanying investment in service delivery and mental health infrastructure, cannot of itself address the structural conditions that give rise to suicidal outcomes. India accounts for approximately 28 per cent of global suicides despite comprising 18 per cent of the world's population, a disproportion that will not be addressed by statutory reclassification alone.

Institutional Governance and Legal Duty of Care

Clinical institutions, hospitals, psychiatric facilities, and community health programmes, operate under legal duties of care that require them to anticipate and prevent foreseeable harm. When suicide follows a period of clinical contact, institutions face potential liability under both civil negligence law and, in some jurisdictions, criminal law. The legal standard of care applied in such proceedings is typically constructed around measurable risk indicators and documented assessments. This standard is not derived from the clinical literature on best practice; it is derived from what courts, operating under proximate causation frameworks, have determined to be a legally defensible response to foreseeable risk. From a policy perspective, this creates a structural misalignment: the legal standard may incentivise documentation-focused compliance over the kind of holistic relational engagement that the evidence suggests is clinically effective in reducing suicidal risk.

The policy concern here is not merely that legal standards may distort institutional practice — it is that the legal standard itself may be inadequate as a proxy for harm prevention. If the clinical evidence identifies relational continuity, crisis planning, and early intervention as the most effective preventive measures, and if the legal standard rewards documentation and risk categorisation instead, then the legal framework is not merely failing to prevent harm: it may be affirmatively structuring institutional responses away from what works. This is a legal and policy problem of the first order, and it calls for legislative attention to the design of duty-of-care standards in mental health and suicide prevention contexts.

Judicial Reasoning

Courts adjudicating cases involving suicide whether in abetment prosecutions, civil negligence claims, or constitutional challenges must reason about causation without consistent access to expert clinical frameworks. The adversarial system may introduce competing expert accounts, but the court's ultimate assessment of causation will be shaped by the doctrinal framework available to it. Where that framework is poorly equipped to handle multi-factorial, non-linear causation, the outcomes may be systematically unjust, either imposing liability where clinical causation is contested, or failing to impose it where it is established.

VI. TOWARDS INTERDISCIPLINARY INTEGRATION

The foregoing analysis suggests that the divergence between clinical and legal models of causation is not merely a conceptual inconvenience but a structural problem with practical consequences. The question, then, is how that divergence might be addressed without collapsing the legitimate institutional differences that give each framework its utility.

The first step towards integration is epistemic: each domain must develop a working understanding of the causal frameworks deployed by the others. Clinicians involved in medico-legal contexts as expert witnesses, as authors of risk assessments used in legal proceedings, or as members of serious

case review panels require structured exposure to legal causal standards and their application. Lawyers and adjudicators, conversely, require access to clinical literature on suicide and training in the interpretation of risk assessments that goes beyond a superficial understanding of categorical risk factors.

The second step is structural: interdisciplinary dialogue requires institutional forums in which it can occur on a sustained and systematic basis. Ad hoc expert testimony within adversarial proceedings is an inadequate substitute for structured cross-disciplinary collaboration. Roundtable processes, of the kind that generated the discussions informing this article, represent one model for such collaboration. Others include multi-disciplinary panels for serious case reviews, clinical-legal liaison roles within prosecution and public health agencies, and interdisciplinary modules within professional training programmes for lawyers, clinicians, and investigators.

The third step involves legal reform. Several specific reforms would reduce the structural mismatch between legal and clinical causal frameworks. These include the adoption of a cumulative causation standard in abetment cases — recognising that sustained courses of conduct may be causative even without a single identifiable act of instigation; the development of judicially accepted expert consensus guidance on clinical risk assessment; and legislative provision for clinical advisors in inquest and investigative proceedings.

The fourth step concerns data and evidence. As the National Mental Health Survey of India has documented, the epidemiology of suicide in India reflects patterns of distress that are deeply embedded in social structures, caste, gender, occupational precarity, and agrarian crisis that are only partially captured by existing legal and administrative categories.[34] The development of more clinically and sociologically informed data collection frameworks, aligned with legal investigative purposes, would improve both the quality of preventive policy and the evidentiary basis available to courts.

India's first National Suicide Prevention Strategy, released by the Ministry of Health and Family Welfare in November 2022, represents a tentative step towards the integrated framework this article has argued for. Drawing on the WHO's recommended multisectoral approach, the Strategy sets a goal of reducing suicide mortality by 10 per cent by 2030 and identifies multiple ministries and stakeholder bodies as responsible for implementation. It is notable, however, that the Strategy addresses policy targets and service delivery mechanisms without attending to the reform of legal causal standards that would support those targets. A prevention strategy that identifies social structure, agricultural distress, and economic precarity as significant contributors to suicidal outcomes cannot achieve its stated goals while courts and investigative bodies continue to operate under causal frameworks that require a single proximate cause and underweight distal structural contributors.

The international normative framework provides further resources for this analysis. The WHO's policy brief on the health aspects of decriminalisation of suicide makes explicit that criminalisation deters help-seeking, perpetuates stigma, and fails to recognise the social determinants of suicidal distress. The joint WHO and United Nations Office of the High Commissioner for Human Rights guidance on mental health, human rights, and legislation articulates the international standards against which domestic legal frameworks should be assessed, emphasising that rights-based protections must be embedded in legislative design and not confined to clinical guidelines. Comparative legislative models, including the New South Wales Suicide Prevention Legislation Discussion Paper of 2024, which proposes a statutory framework integrating duty-of-care obligations with population-level prevention architecture demonstrate that the alignment of legal accountability and public health in this domain is practically achievable and not merely aspirational.

The interdisciplinary roundtable process has demonstrated the value of sustained, structured cross-domain conversation. It has also revealed that the obstacles to integration are as much institutional and cultural as they are conceptual. Clinicians and lawyers inhabit different professional cultures, with different languages, different standards of evidence, and different conceptions of what constitutes an

adequate explanation. Overcoming those differences requires not merely goodwill but institutional investment in shared forums, shared vocabularies, and shared accountability mechanisms.

Roundtable Discussion: Principal Observations

The interdisciplinary roundtable convened in April 2026 surfaced a range of observations that illustrate the systemic character of the problem this article addresses. Several recurring themes emerged across the discussion, spanning vulnerability, institutional failure, clinical understanding, prevention, and the respective roles of the media, the judiciary, and government.

Youth, Education, and Social Pressure

Participants consistently identified youth as a disproportionately vulnerable population. The pressure-cooker environment created by competitive entrance examinations particularly those governing admission to institutions of national repute such as the IITs and IIMs was identified as a context in which educational structures designed to cultivate human capital have themselves become a proximate stressor. The aspiration of prestige attached by families to such institutions generates a gap between the public symbol of achievement and the private experience of competition, workload, and financial burden. It was noted that faculty members within these institutions are themselves subject to mounting pressure, as universities leverage student performance for institutional ranking purposes — creating a cascade of institutional stress. The associated costs of elite education were flagged as a compounding financial stressor. Participants further observed that Indian parents' tendency to evaluate children primarily through academic performance produces dynamics in which examination failure carries disproportionate psychological consequences and that this burden falls with particular harshness on young women, who face social shame in circumstances where male peers experience no comparable sanction. The growing phenomenon of romantic rejection as a precipitating factor among Generation Z was also raised as an emerging concern. It was noted, with some dark humour, that, at the present rate of education-related suicides, one might be tempted to say that restricting access to education itself would be a more effective intervention. The Supreme Court's cognisance of suicide among secondary school students in cases such as those of Sukhdeva Saha and Amit Kumar was cited as a significant judicial acknowledgement of the scale of the phenomenon. Mandatory counselling infrastructure in schools, along the model developed under the CBSE framework, and the establishment of counselling facilities in proximity to rather than within educational institutions, to preserve student confidentiality, were both recommended.

Clinical Understanding and the Multi-Factorial Nature of Causation. Participants emphasised that internal biological predispositions and external circumstantial pressures are equally constitutive of suicidal risk, and that the persistence of the biological-tendency dimension as a causal substrate calls for treatment-oriented rather than punitive responses. Psychologists and neuro-psychiatrists reported success in explaining biological factors to patients without diagnostic labelling, reducing stigma while improving engagement. It was observed that therapy, medication, and a supportive social environment together constitute the most reliable pathway to recovery. Crucially, participants noted that the multi-factorial character of suicidal causation, far from complicating intervention, actually multiplies the points at which an effective intervention may be introduced. In rural areas in particular, where the contributors to suicidal risk are multiple and mutually reinforcing, including family conflict, substance abuse, financial distress, dowry-related pressures, and educational deprivation, this multiplicity of factors correspondingly opens up a wider range of intervention opportunities.

Data, Stigma, and Structural Blind Spots

The National Crime Records Bureau data was characterised as capturing only the surface of the phenomenon, with complex and cumulative causal pathways flattened into administrative categories. Participants observed that Bihar's combination of the country's lowest literacy rates and its lowest reported suicide rates constitutes an empirical observation that resists easy interpretation but demands serious policy attention. Social stigma was identified as a structural barrier: the differential

response to examination failure for male and female students was highlighted as a systemic injustice, and the broader reluctance of individuals and families to seek help, reinforced by the cultural construction of suicide as shameful, continues to suppress both reporting and help-seeking.

Media, Awareness, and Civil Society

Media narratives were identified as a structural distortion that redirects public attention away from root causes. However, the media's positive potential was also acknowledged: making helpline numbers accessible through search results and other information channels could meaningfully extend the reach of crisis support. The SNEHA organisation's successful intervention, which resulted in the curtailment of television scenes normalising female self-immolation, was cited as a concrete example of the media's susceptibility to rights-based advocacy. Participants concluded that media sensitisation must be a deliberate policy objective, not an afterthought. Awareness at the community level was consistently identified as a prerequisite for early identification and timely intervention.

Institutional Responsibility and Prevention Architecture

Several demonstrable success stories were noted: the restriction of access to harmful pesticides and fertilisers has been associated with meaningful reductions in farmer suicides in certain States, and legislative action to curtail online gambling has reduced associated deaths. Post-crisis counselling extended not only to survivors but equally to the families and immediate social networks of those who have died was identified as a neglected dimension of current policy. The mental health of parents was raised as a systemic variable: where parental mental health needs go unmet, children's distress goes unrecognised. Participants advocated for expanded governmental support for awareness camps, community programmes, and civil society organisations. For juvenile populations in institutional care, the question of responsibility for minor offending was raised, and the introduction of drop-in centres where attendance forms a bail condition and is oriented towards recreational engagement was identified as a promising experimental model.

Government, Judiciary, and the Path Forward

Adequate governmental funding for preventive schemes was identified as a persistent institutional bottleneck. Participants noted that the judiciary has exercised, and must continue to exercise, its constitutional authority to compel transparency and accountability from executive and administrative bodies. The consensus view was that all tiers of government central, state, and local must coordinate their efforts in an organised and sustained manner. Suicide represents a loss of human capital to the State, and governments bear a corresponding obligation of care. Participants concluded that coherent, coordinated action at the intersection of policy, judicial precedent and public administration directed by the principle that multiple points of intervention exist across a complex causal field offers a realistic and evidence-grounded path towards meaningful reduction in suicide mortality.

VII. LIMITATIONS

This article is a conceptual synthesis rather than an empirical study. It does not report on the outcomes of specific cases, the results of clinical trials, or the findings of systematic surveys. Its conclusions are accordingly subject to the limitations inherent in any conceptual analysis: they cannot be verified against data, and they may reflect selective engagement with the available literature. While the article draws on established clinical and legal frameworks, the full complexity of each domain exceeds what can be adequately represented in a single article of this scope. The article addresses legal frameworks primarily with reference to Indian law and English common law. Other common law and civil law jurisdictions have developed their own approaches to causation in the context of suicide, and comparative analysis across a broader range of jurisdictions may reveal insights not captured here. Similarly, the clinical literature on suicide is extensive and continues to evolve; the frameworks described here reflect dominant models at the time of writing but should not be taken as exhaustive.

Finally, it should be noted that the discussions informing this article arose from a single roundtable

event. The diversity of perspectives represented at that event is acknowledged, but it cannot substitute for the kind of sustained, systematic empirical research, longitudinal studies, institutional audits, legislative impact assessments, that would be required to test the policy recommendations advanced here.

VIII. CONCLUSION

Suicide defies the kind of linear causal narrative that both popular understanding and legal doctrine tend to demand. The clinical and epidemiological evidence establishes, with considerable consistency, that it is the product of a dynamic and non-linear interaction between vulnerability, stress, transitional disruption, and acute psychological crisis. These features mean that any legal account of causation which focuses on a single proximate act ether of the deceased, a defendant, or a negligent institution is likely to be both evidentially inadequate and normatively unjust.

Legal systems are not insensitive to complexity. The thin skull rule, the doctrine of cumulative causation in certain civil contexts, and the evolving jurisprudence on foreseeability all provide some resources for engaging with multi-factorial causation. But these resources remain underdeveloped in the specific context of suicide, and their application is inconsistent across jurisdictions and proceedings. The result is a body of law that is simultaneously over-inclusive imposing liability on actors who made marginal contributions to a complex causal field and under-inclusive, failing to respond to systemic and institutional failures that are causally constitutive of suicidal outcomes.

The path forward lies not in replacing legal causal analysis with clinical analysis, nor in treating clinical models as legally irrelevant. It lies in the development of shared frameworks that preserve the institutional integrity of each domain while creating structured mechanisms for cross-domain understanding. The Bombay High Court's early recognition in Maruti Shripati Dubal of the need to engage with psychiatric evidence in evaluating the voluntariness of suicidal conduct was a step in this direction. More recent legislative developments under the Mental Healthcare Act 2017 reflect a clinical turn in Indian statutory policy. The task now is to translate these partial convergences into a coherent and institutionally embedded framework for interdisciplinary engagement.

Roundtable processes, interdisciplinary training, clinical advisory roles in investigative proceedings, and reform of causal standards in abetment prosecutions are among the practical steps through which this framework can be realised. The scale of suicide as a public health and justice challenge demands nothing less.

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