

Prevention of Suicide in Singapore

Boon Hock Chia, ¹MD, Audrey Chia, ¹MBBS

Suicide prevention is an important public health issue.¹ In Singapore where the suicide rate has been relatively stable at 9.8 to 13 per 100,000 over the last 5 decades, roughly 350 to 400 people kill themselves each year.²

The impetus to suicide is influenced by a combination of factors including the individual's personality traits and coping mechanisms, concurrent life events and stressors, existing family and community support networks, availability of professional mental and physical healthcare, and the presence of government support and intervention programmes.³ The common emotional key, however, is an overwhelming sense of psychological or physical suffering, hopelessness and an inability to find a solution to their problems such that death becomes a viable alternative.⁴

Studies have shown that the rates of suicide in Singapore are higher in older Chinese males, younger Indian males/females, those who are widowed or divorced and the unemployed.³ The reasons for suicide vary with age. Younger cases of suicide (<25 years) are more likely to be associated with poor family relationships (parental-child discontent/sibling rivalry), boy-girl relationships and academic stress.^{5,6} In adult cases (25 to 59 years), factors such as employment, debt, marital problems, legal problems and mental illness become more prevalent while in elderly cases (>60 years), the primary reasons include physical illness, bereavement and fear of becoming a burden to their families.⁷

The success of any suicide programme must thus be multifaceted with personal, familial, job, social, community, medical and mental-health components. In the acute stage, there needs to be an effective crisis intervention with longer term of follow-up and support to reduce future risk. There is also a need to have general mental wellness programmes to reduce the risk of overall suicide risk in the general population.

The role of crisis intervention programmes is to provide help and support for persons-at-risk and their families when the suicide risk is greatest. In Singapore, this includes the 24-hour phone services such as those provided by the Samaritans of Singapore and by various drug and gambling helplines. Other front line workers include school counsellors/teachers, police/ civil defence staff, social

workers, medical professionals (general practitioners and accident/emergency staff) and mental health professionals (psychologists, nurse consultants and psychiatrists). These people need to receive adequate training to recognise, assess and evaluate suicide risk, be able to defuse any imminent suicide threat, and be aware of the help and services that should be activated to ensure that a person-at-risk receives the help he or she requires.⁸ These people should also require continued support for themselves to address any emotional stress and to prevent psychological burnout.

Mental healthcare professionals play an important role in supporting a person in crisis either with counselling and/or medication, and helping to manage any mental/psychiatric problems. Mentally ill subjects (e.g. those suffering from major depression, bipolar disorder, schizophrenia, obsessive compulsive disorder and panic disorder) have a higher risk of suicide. The risk is even greater in those with repeated suicide attempts or who require hospitalisation for a mental health condition.⁹ Each patient should have a thorough assessment and receive appropriate/effective treatment ideally with newer medications with fewer side effects so as to improve the outcome and compliance. Careful discharge planning with proper follow-up to ensure compliance to medication is also important, and family and community members should be actively involved in the patient's aftercare.

Special care should be paid to the needs of suicide survivors (i.e. parent, spouse, sibling, child, colleague, friend, teacher, counsellor, and mental and physical healthcare professionals) who are often psychologically affected by the suicide. Mental health service may be needed to help them to overcome shame, grief and guilt and to move on with their lives.¹⁰⁻¹²

Mental healthcare professionals can also play a greater role as advocates to suicide prevention by raising suicide awareness, educating the public, dispelling myths and erasing taboos, and in supporting various community mental health programmes.

Community/government programmes can be designed to target areas of concern, and also to improve the mental health of the entire population. In the younger population, the emphasis should be to improve the relationships between

¹Chia Clinic

Address for Correspondence: Dr Chia Boon Hock, #06-47 Tanglin Shopping Center, 19 Tanglin Road, Singapore 247909.

Email: chiaboanhock@gmail.com

family members, promote good parenting skills, to teach children appropriate life skills so that they are able to cope with adversity and failure and to recognise the impact of academic stress has on children. In adults, programmes could target unemployment (e.g. through job retraining and recruitment programmes), good financial education to ensure good money management skills, and to provide support/counselling services for those in debt or faced with sudden cash flow problems. Measures should be taken to curb the activities of illegal money-lenders (e.g. loan sharks). Support groups for alcoholism, drug abuse and gambling addictions are useful to address the special needs of these individuals. For the elderly, it is important to ensure that there is good, affordable healthcare, adequate pain management and a better understanding of their physical and psychological needs.

Alcohol use has also consistently been implicated in the precipitating suicidal behaviour through disinhibition, impulsiveness and impaired judgment. Programmes for suicide prevention should take into account drinking habits and promote responsible drinking behaviour.¹³ Other groups who require special help are those suffering from anorexia nervosa,¹⁴ and Acquired Immunodeficiency Disease (AIDS),¹⁵ and those with sexual preferences which deviate from the norm (e.g. homosexual or transsexual).³

Government initiatives can also help by limiting the access to and the availability of various means of suicide. Laws set in place for control of certain medication (e.g. barbiturate), illicit drugs, some poisons (e.g. caustic soda) and firearms have limited suicide by these means. Unfortunately, there are other methods such as jumping, hanging and drowning which are more difficult to prevent, and in Singapore where over 80% of the population live in high-rise apartments, it is thus not surprising that jumping accounts for 72% of all the suicides.¹⁶ Some thought, however, could be placed in the design of high-rise buildings so that there is no general access to higher floors, less open spaces or corridors, and more building features to break the falls from upper floors.

The media can also play an important role in suicide prevention by educating the public about suicide: the reasons why people commit suicide, how and when to seek help, and to introduce and promote community mental wellness programmes. The media should, however, avoid the temptation to sensationalise any suicide as this can precipitate copycat suicides, or teach people how to commit suicide by providing details of suicide methods. There are guidelines on how suicides should be reported if in doubt.^{17,18}

In summary, although the suicide rate in Singapore is relatively low compared to other countries, there is still room for improvement. Suicide prevention is multifaceted and needs to be tailored to address the different needs of

each community over time. It starts with an understanding of suicide statistics, the unique reasons and methods of suicides, mental and physical healthcare availability, media reporting and the development of strategies based on this knowledge.¹⁹ Also importantly is to realise that suicide risk can change, and continued re-assessment of the existing suicide prevention strategies and development of new strategies will be required over time.

REFERENCES

1. Yip SFP. Introduction. In: Yip PSF, editor. *Suicide in Asia: Causes and Prevention*. Hong Kong: Hong Kong University Press, 2008.
2. Chia BH, Chia A, Ng WY, Tai BC. Suicide trends in Singapore 1955-2004. *Arch Suicide Res* 2010;14:276-83.
3. Chia BH, Chia A. Singapore. In: Yip PSF, editor. *Suicide in Asia: Causes and Prevention*. Hong Kong: Hong Kong University Press, 2008.
4. Chia BH, Chia A, Tai BC. Suicide letters in Singapore. *Arch Suicide Res* 2008;12:74-81.
5. Chia BH. *Too young to die: An Asian perspective on youth suicide*. Singapore: Times Books International, 1999.
6. Loh C, Tai BC, Ng WY, Chia A, Chia BH. Suicide in young Singaporeans aged 10-24 years between 2000 to 2004. *Arch Suicide Res* 2012;16:174-82.
7. Chia BH. *Age of despair: a study of elderly suicide in Singapore*. Singapore: Times Books International, 2001.
8. Chia BH, Chia A. Suicide in Singapore. *The Singapore family Physician*, 2010;36:26-9.
9. Thong JY, Su AHC, Chan YH, Chia BH. Suicide in psychiatric patients: case-control study in Singapore. *Aust N Z J Psychiatry* 2008;42:509-19.
10. Dyregrov K, Plyhn E, Dierserud G. *After the Suicide – Helping the Bereaved to Find a Path from Grief to Recovery*. London: Jessica Kingsley Publisher, 2012.
11. Chia BH. *Suicide in Singapore*. MD thesis. University of Singapore, 1978.
12. Chia BH. *Suicidal behaviour in Singapore*. Tokyo: Southeast Asian Medical Information Center, 1981.
13. Pompili M, Serafini G, Innamorati M, Dominici G, Ferracuti S, Kotzalidis GD, et al. Suicidal behavior and alcohol abuse. *In J Environ Res Public Health* 2010;7:1392-431.
14. Joiner T. *Myths about suicide*. USA: First Harvard University Press, 2011.
15. Lotrakul M. Thailand. In: Yip PSF, editor. *Suicide in Asia: Causes and Prevention*. Hong Kong: Hong Kong University Press, 2008.
16. Chia BH, Chia A, Ng WY, Tai BC. Suicide methods in Singapore, 2000-2004: Types and associations. *Suicide Life Threat Behav* 2011;41:574-83.
17. Pirkis J, Blood RW, Beautrais A, Burger P, Skehan J. Media guideline on reporting of suicide. *Crisis* 2006;21:82-7.
18. Tor PC, Ng BY, Ang YG. The Media and Suicide. *Ann Acad Medicine* 2008;37:797-9.
19. Chia BH. Suicide prevention in Singapore. In: Wasserman D and Wasserman C, editors. *Oxford Textbook of Suicidology and Suicide Prevention*. Oxford: Oxford University Press, 2009.