RELATE
MALAYSIA

YOUTH SUICIDE
IN MALAYSIA

CHUA SOOK NING
VAISNAVI MOGAN

In collaboration with

IDEAS
INSTITUTE FOR DEMOCRACY AND ECONOMIC AFFAIRS

YOUTH SUICIDE
IN MALAYSIA

CHUA SOOK NING
VAISNAVI MOGAN

RELATE MALAYSIA

In collaboration with
IDEAS
INSTITUTE FOR DEMOCRACY AND ECONOMIC AFFAIRS

Suggested citation: Chua, S.N. & Rao, M.V. (2021). *Youth suicide in Malaysia*. Relate Mental Health Malaysia.

Contents

Executive Summary

This paper examines the status of youth suicides in Malaysia and provides policy recommendations for prevention.

Suicide remains a criminal act in Malaysia under Section 309 of the Penal Code, despite evidence showing that criminalization reduces help-seeking, hinders collection of accurate data, and the development and implementation of effective suicide prevention strategies.

Based on available public data, suicide is the leading cause of death among young people in Malaysia. The economic cost of these preventable deaths in Malaysia is estimated at RM 346.2 million in 2019.

Risk factors of suicide include age (youth), gender (men), psychological factors (e.g. depression, anxiety, stress, and interpersonal difficulties) and social factors (e.g. ethnicity and unemployment).

There is a lack of awareness about suicide and its risk factors in the general community in Malaysia. Unethical media reporting of suicides is an obstacle in correcting misconceptions and debunking the myths of suicide. Moreover there is a lack of evidence-based suicide campaigns. The criminalization of suicide has further hindered the development of a comprehensive suicide prevention strategy through social and public health interventions. The effectiveness of existing platforms for prevention of youth suicides remains unclear.

Some of the key recommendations proposed in this paper to address youth suicide in Malaysia are outlined below:

- The Ministry of Health should develop a comprehensive suicide prevention guideline specific to youths in collaboration with key stakeholders including Ministry of Education, Ministry of Human Resources, and Ministry of Women, Family and Community Development, as well as non-governmental organizations.

- The National Suicide Registry should be resumed and information on age, gender, ethnicity, state, and methods of suicide should be included.

- A comprehensive needs assessment on the availability and gaps in suicide prevention and treatment services should be conducted.

- Implement regulations to limit access to means of suicide, such as toxic substances.

- Assess the accessibility and effectiveness of existing mental health services available to youths, such as counselling in educational settings.

- Awareness campaigns should equip individuals with practical and useful resources. Regular evaluations of the effectiveness of programs should also be carried out.

- Guidelines for media reporting of suicides need to be developed in close collaboration with regional and national media as well as psychosocial experts (e.g. clinical psychologists, social workers) to increase “buy in” and implementation of the guidelines.

Introduction

In May 2019, a young 16-year old Malaysian girl asked her followers on Instagram to help her choose whether to L (live)/ D (die). When the majority of respondents on Instagram chose "D", she ended her life several hours later.[1] For a moment, Malaysians rallied together in outrage at this tragic event. Policymakers demanded a holistic public health approach across various ministries to improve youth mental health.[2] However, the outcry soon died down and little has been done since.

The World Health Organization (WHO) estimates that suicide is the leading cause of deaths globally among 15-30 year olds. In Malaysia, Befrienders, the national crisis hotline estimates that 41% (36% callers; 45% emails) of people reaching out for help are 30 years old and below.[3] There is an urgent need for Malaysia to view youth suicide as a social, economic and public health issue that requires a long-term, comprehensive strategy.

Impact of covid-19 health pandemic on suicide

In 2020, COVID-19 pandemic related movement control orders (MCO) resulted in an increase in mental health issues amongst Malaysians. A survey carried out by the Centre during the MCO period found that 48% and 45% of respondents reported high levels of anxiety and depression respectively. Not surprisingly, there has been a significant increase in the use of emotional support hotline services in the country. In 2020, 40% of callers between January to July expressed suicidal thoughts, compared to 34% in 2019.[4] According to the Ministry of Health, a total of 465 suicide attempt cases received treatment in Ministry of Health hospitals between January to June 2020.[5]

Between the start of the MCO (18th March 2020) to 30th October 2020, a total of 266 people have died by suicide, equivalent to around 30 suicides per month.[6] About 1 in 4 of these preventable deaths were adolescents between the ages of 15 and 18 years old. The reasons given for ending their lives included debt issues, family and marriage problems, relationship breakdowns, and work pressures.

In the context of the current pandemic, the rising number of suicides have become increasingly worrying. However, little practical efforts have been implemented to prevent suicides since the start of the pandemic. This paper will discuss the legal status of suicide in Malaysia, the risk factors associated with suicide and what can be done to reduce the suicide rates among youths in Malaysia.

Legal status of suicide in Malaysia

Criminalization of suicide

Section 309 of the Penal Code states "*Whoever attempts to commit suicide, and does any act towards the commission of such offence, shall be punished with imprisonment for a term which may extend to one year or with fine or with both".*

Although Malaysia's law against suicide was adopted from the British legal system, the UK decriminalized suicide in 1961 under the Suicide Act when the Parliament recognized that suicide is a result of psychological distress and not a sin or criminal offense.[7] Yet suicide remains a criminal act in Malaysia, despite clear evidence that criminalization of suicide reduces help-seeking, hinders collection of accurate data, and the development and implementation of effective suicide prevention strategies.[8] A review by the WHO concluded that the decriminalization of suicide often leads to lower suicide rates, as criminalization of suicide reduces help-seeking behavior.[9]

Case study 1

In August 2020, a 28-year-old man was fined RM 3000 (or serve a three-month sentence) for attempting to die by suicide.[10] Despite the defendant experiencing severe depression, the deputy public prosecutor urged the judge to teach the defendant a lesson because he "inconvenienced many parties". It was only after public outcry that the judge revised the sentence to a good behavior bond and advised the defendant to seek mental health care.

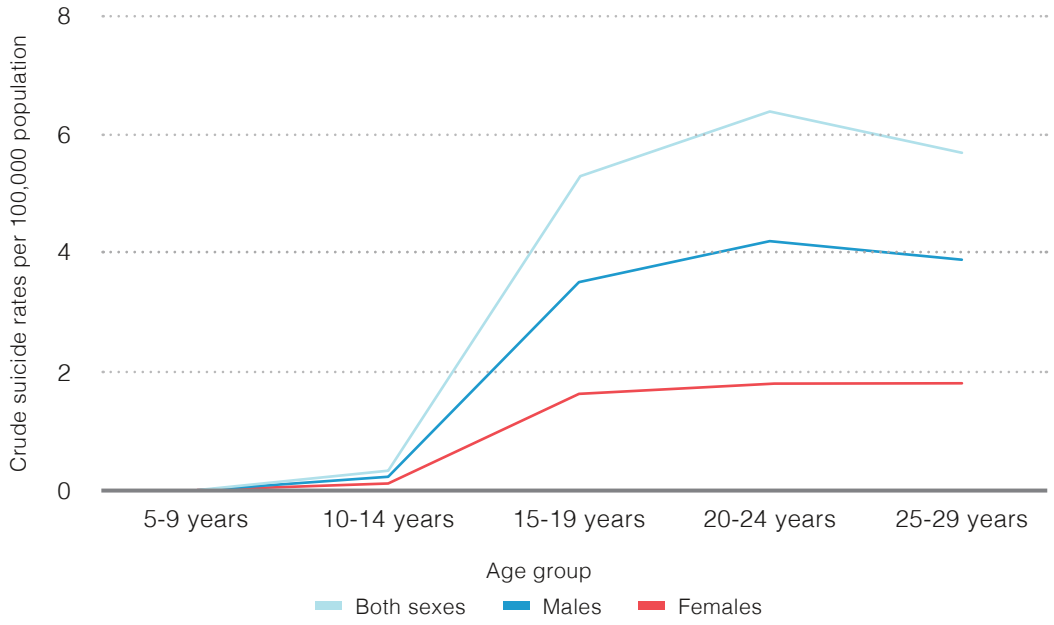
These cases often go unreported. Police statistics estimate that 10% of people who attempt to die by suicide are arrested and investigated under the Section 309 of the Penal code.[11] Those who are arrested but not charged are then released without any follow-up care through mental health services.

Prevalence of suicide among Malaysian youths

There is a lack of comprehensive quality data on the prevalence of suicide in Malaysia. Official statistics are limited to the data published by the National Suicide Registry Malaysia (NSRM) which was active from 2007 to 2009. The statistics are likely to be an underestimate of the true rate of suicide, as suicides are often classified as "undetermined".[12] A death is ruled as a suicide only when there is abundantly clear evidence of the deceased's intention of suicide.[13-14] The true suicide rate is estimated to be approximately eight times higher than the rate of official certified suicides.

Based on the national suicide registry in Malaysia (NSRM) that was active from 2007 to 2009[15-17], the suicide rate was highest among individuals aged between 20 to 29 years. In lieu of local suicide statistics, the World Health Organization (WHO) Global Health Estimates published suicide estimates in Malaysia based on previous data collected by the NSRM, and the prevalence rates in other Asian countries.[18] The 2016 crude suicide rate per 100,000 population in Malaysia is 5.5 per 100,000, with a higher suicide rate among males (7.6) than females (3.1).[19] Figure 1 shows that the estimated crude suicide rate per 100,000 population by age group and sex. Based on the 2019 youth population in Malaysia of 9.31 million (ages between 15 to 29 years) and the gender specific crude suicide rate, 512 youths died by suicide in Malaysia (382 young males and 141 young females).[20]

Figure 1: Crude suicide rates (per 100,000 population) among youths in Malaysia by gender in 2016.[19]



The top five official causes of death reported by the Department of Statistics (DOS) in 2019 are listed below by gender.[21] Notably, the WHO estimated number of deaths by suicide of 382 young males and 141 young females in 2019 shows that suicide is indeed a leading cause of death among youths in Malaysia.[18]

Table 1a: Top five medically certified causes of death among 15 to 40 year olds males in 2019.[22]

	Number of deaths
Transport accidents	2160
Ischaemic heart diseases	729
Pneumonia	527
Cerebrovascular diseases	316
Accidental drowning and submersion	155

Table 1b: Top five medically certified causes of death among 15 to 40 year olds females in 2019.[22]

	Number of deaths
Transport accidents	292
Pneumonia	285
Breast cancer	190
Ischaemic heart diseases	144
Cerebrovascular diseases	134

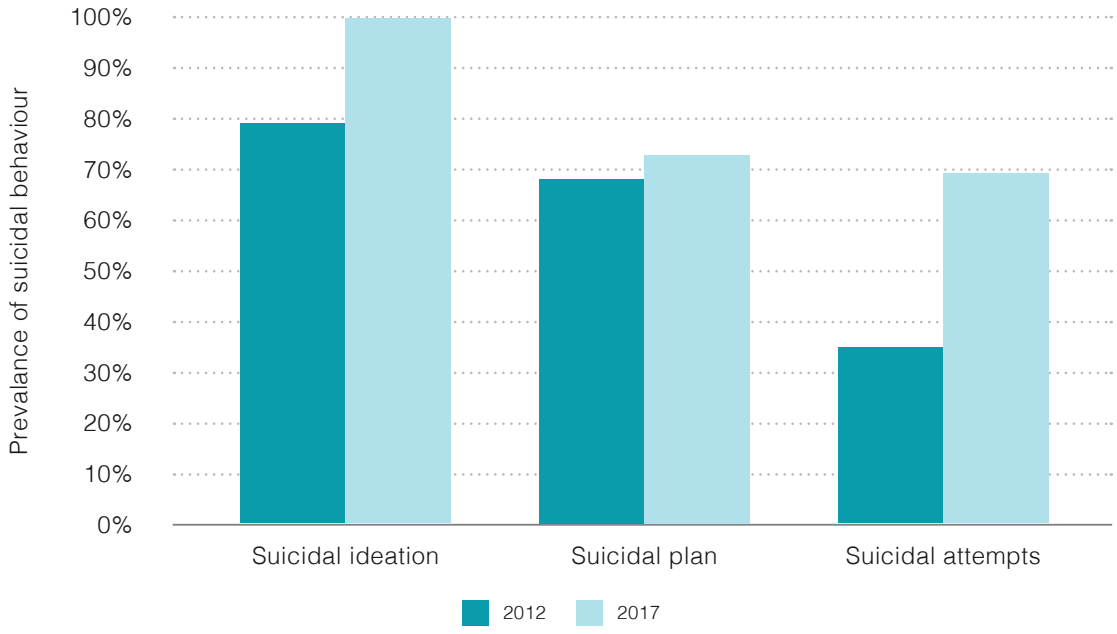
There is limited research about the methods of suicide among youths in Malaysia. A study based on the 2009 NRSM data found that among the 53 youths (ages 15 to 24 years) who died by suicide, the most common method of suicide were hanging (56.6%) and self-poisoning by pesticide (15.1%).[23]

Prevalence of suicidal behaviors among Malaysian youths

For every death by suicide, there are 10 to 20 more suicide attempts.[18,24] A nationally representative study of suicidal behaviors in Malaysia found that younger individuals were at the highest risk of any suicidal behaviors (ideation/thoughts, plans and attempts), with individuals between the ages of 16 to 24 years being 4.8 times more likely to attempt suicide compared to individuals who are 65 years and above.[25] This is consistent with a review of suicide attempts in Malaysia which found individuals between ages 20 and 30 years old reported the highest rate of suicide attempts.[24]

The 12-month prevalence of suicidal behaviour in adolescents (ages 13 to 17 years) also increased between 2012 and 2017 (see Figure 2). [26-27] In 2017, suicide attempts were highest among Malaysians of Indian ethnicity (17.9%) followed by ethnic Chinese (10.7%), others (other ethnic groups in Malaysia apart from the major ethnicities; 9.4%), Bumiputera Sarawak (9.4%), Bumiputera Sarawak (6.1%) and ethnic Malays (4.6%). The 12-month prevalence of suicide attempts was highest in Perak (9.3%), whilst the prevalence of suicidal ideation and plan was highest in WP Kuala Lumpur (13.2%) and Selangor (9.5%) respectively.

Figure 2: Adolescent Suicidal Behaviour in 2012 & 2017 [26-27]



Economic cost of suicide

The present value of lost earnings and tax revenue due to youth suicide in Malaysia is estimated to be RM 346.2 million in 2019.[28] The mean cost of a single youth suicide was estimated to be RM 676,165. The true economic cost is likely to be higher as this only accounts for the loss of economic productivity based on the number of years life lost (YLL) and the number of potential productive years of life lost (PYLL) suicide.

Risk factors & causes of youth suicide

Suicide is a complex phenomenon. It is rarely the outcome of one single factor but rather the result of an individual's interaction with a diverse range of demographic, psychological, environmental, familial and social factors.[29-30] Risk factors are characteristics that make an individual more likely to experience suicidal ideation. The following section discusses common suicide risk factors using the biopsychosocial model.

Biological factors

Age

Young people are more vulnerable to suicide as adolescence is a critical developmental period of transitioning from childhood to adulthood, and is characterised by the pursuit of greater independence, formation of new social interactions and greater academic pressures. This period of life is associated with frequent changes and transitions in various domains at the same time, and feelings of uncertainty.[31-32] This can include transitioning to college, independent living, as well as entering new relationships, whilst coping with the expectations of society and family.

Gender

Females are more likely to attempt suicide and have suicidal thoughts, while males are more likely to die from suicide.[33-35] The risk of suicide in both boys and girls peak during mid adolescents. For young females, the risk drops significantly after age 18 years. For young males however, there is only a slight decrease in late adolescence.[19] This can be attributed to the differences in problem-solving strategies between both genders. Females are more likely to consult peers and readily accept help, whereas males place higher value on independence and decisiveness.[36] Specific risk factors for suicide in females can include eating disorders, post-traumatic stress disorder, being a victim of domestic violence, interpersonal problems and depressive symptoms. For males, this can include hopelessness, parental separation or divorce, suicidal behaviour of peers, and access to means.[37]

Psychological factors

Interpersonal issues

Although mental health problems are often cited as a reason for suicide, there are significant cross-cultural differences in suicide patterns.[38] In Western cultures, more than 80% of deaths by suicide are associated with mental illness, but in contrast, fewer than 65% of deaths by suicide in East Asian cultures are associated with mental health conditions.[39] A recent systematic review of deaths by suicide in Malaysia found that suicide in Malaysia is strongly associated with interpersonal problems.[40] For instance, 94% of patients who were hospitalized after a suicide attempt in 2004 at Hospital Kuala Lumpur reported significant interpersonal conflict in the six-month period leading to the suicide attempt.[41] A review of suicide attempts in Malaysia from

1969 to 2011 found that 46% of individuals who attempted suicide identified interpersonal conflict (at home and at work) as the main reason for suicide.[24]

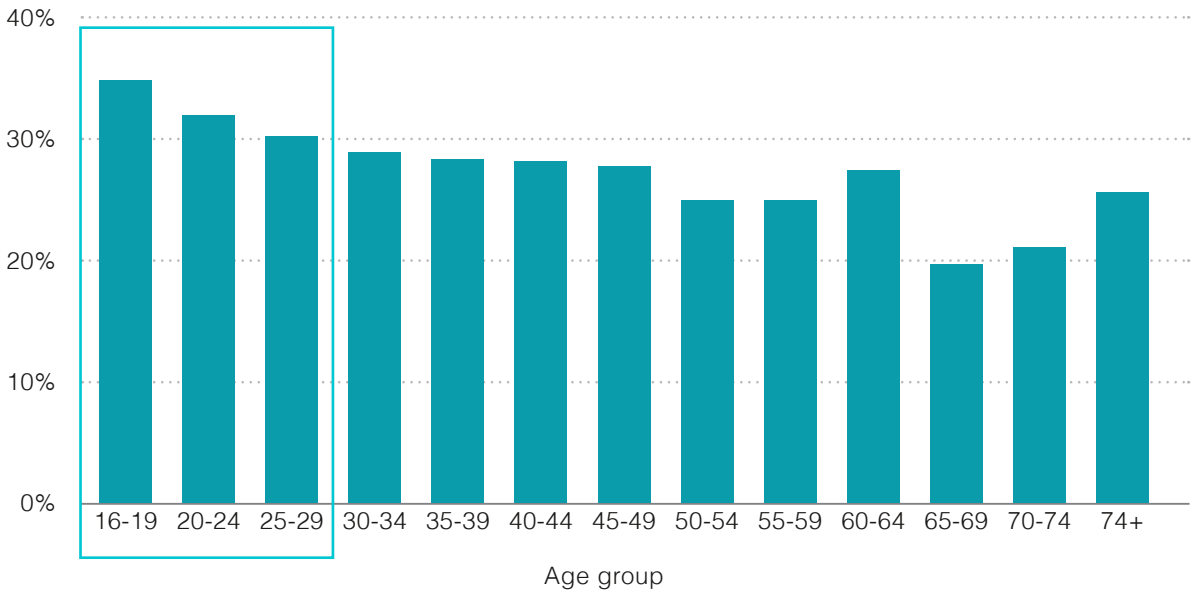
This is consistent with a growing body of research that found negative life events is a greater risk factor for suicidal behaviours among Asians than mental health conditions, especially among youths and those who reside in rural regions.[42-44] In particular, interpersonal conflict such as quarreling with family members or a partner is associated with immediate risk of a suicide attempt.[45]

Depression, anxiety & stress

Apart from interpersonal conflict, depression, stress and anxiety are still the most common factors associated with suicide and suicide ideation (thoughts of suicide).[24,46]

According to the 2015 National Health and Morbidity Survey, the highest 12-month prevalence of mental health problems (depression and anxiety) are among young people between the ages of 16 and 29 years (Figure 3).[47]

Figure 3: Prevalence of mental health problems by age in 2015 [48]



The high prevalence of mental health problems in young people between the ages of 16 to 29 years needs to be addressed through mental health interventions to reduce risk of suicide within this population.

Social factors

Ethnicity

The highest rate of suicide attempts has consistently been reported among Malaysians of Indian ethnicity, followed by Chinese and Malays.[49] It was reported that the most common causes for suicide among the Malaysian Indian population are interpersonal issues and socioeconomic conditions.[23] In general, poverty is associated with unemployment, alcoholism, social crimes, stress, and poor physical health.[50]

Unemployment

Unemployment can result in a two to three-fold increase in the risk of suicide.[51] A longitudinal analysis of unemployment and suicide found that unemployment increases the risk of suicide by about 20% to 30%. Unemployment among young people can have long-term consequences on job stability and income as unemployment affects confidence and resilience in response to negative life events.

In 2018, the Ministry of Education (MOE) in Malaysia reported that 57,000 of 173,000 graduates remained unemployed after six months of job searching.[51] According to a recent report by ISEAS-Yusof Ishak Institute, the rate of unemployment has increased among 20 to 25 year olds specifically in urban areas and among young Indians.[52] Male youth unemployment was notably high in Sabah while female unemployment remained high across the country. The causal risk of unemployment on suicide is especially important to address now, as Malaysia enters into economic recession.[53]

Media

The Internet and social media have evolved at a rapid rate in the last two decades. Social media specifically is a relatively new form of digital social interaction that has transformed the way individuals communicate and interact with other individuals and groups. It has become a fundamental part of people's lives, more so among the younger generation. Research shows an association between increased screen time and worse mental health in young people,[54] such that internet addiction increases the risk of suicide attempts.[55]

Understanding the specific risks associated with different digital activities among youth in Malaysia can inform specific targeted interventions. Despite the various risks associated with excessive use of the internet and social media, the online presence of young people can also be leveraged positively to facilitate suicide prevention through digital campaigns.

Summary of risk factors

Understanding the risk factors for suicide associated with youths is the first step in identifying vulnerable groups within this population, to design appropriate and targeted prevention strategies.

Table 2: The biopsychosocial risk factors of suicide

Category	Risk factors
Biological	• Gender (male for death by suicide and female for suicide attempts and ideation)
Psychological	• Depression, anxiety & stress • Hopelessness • Lack of peer and parental connectedness • Interpersonal problems • Academic issues • Sexual abuse • Substance abuse • Bullying
Social	• Ethnicity (Malaysian of Indian ethnicity) • Unemployment rate • Media

The factors discussed above suggests the need for youth suicide prevention to go beyond psychological services. Education and awareness of how social factors and cultural values can affect the way individuals experience life and view death is necessary. Prevention strategies need to adopt a social and public health approach that promotes a holistic (individual, family, community and health systems) approach to interventions.

Case study 2

Subang Jaya Community wellness program

YB Michelle Ng (ADUN Subang Jaya) launched a mental health community program called SJ Care Warriors, with the aim to equip members of the community with the skills to build self-resiliency and to support others.[56]

> *This is not just a suicide prevention task force but also an initiative to empower youths to build resilience by maintaining a healthy mental state. The wisdom is to know that it is okay to be sad and what they can do when faced with adversity, stress and rejection without hurting themselves.* Michelle Ng [56]

1. A one-day programme for university students was developed in collaboration with local psychologists and counsellors to cultivate four essential positive competencies namely creativity, appreciation, empathy, and strength. In each session, the trainer first illustrates the concept of the competency with examples. Students are then guided to apply scientifically tested methods to develop the competency. Preliminary analysis shows that the programme is effective in nurturing the four competencies. As of November 2020, 120 university students have been trained.

2. A two-day suicide gatekeeper program for community leaders was developed in collaboration with local clinical psychologists and psychiatrists. This teaches community leaders to identify warning signs of suicide and how to help people in distress. This gatekeeper program relies on a task shifting approach of training the lay person to identify warning signs of suicide. As of November 2020, 90 community leaders have been trained.

> *"Our vision is, once the two programmes stabilise, if another community wants it, they can implement it,"* said Ng. *"The question is how to get communities interested and how do we have that kind of support system of resources and professionals to facilitate the programmes? That's the long-term vision."*[57]

The effective components for the program should be identified through evaluation and monitoring of outcomes. This will facilitate the adaptation of the blueprint to the unique needs of other communities.

Case study 3

Singapore - decriminalization of suicide

Initiative

In January 1 2020, attempted suicide was decriminalized in Singapore. The Penal Code Reform Committee (PCRC) 2018 report recommended that "treatment (rather than prosecution) is the appropriate response to persons who are so distressed that they attempt suicide….the PCRC recommends that attempted suicide should no longer be a crime and amendments should be made to other legislation to ensure that responders have the necessary powers to intervene to ensure persons who require help get the help they need."[58]

A multi-prong approach to suicide prevention was developed to support the decriminalization of suicide. The government focused on (1) building mental resilience, (2) encouraging help seeking and early identification, (3) supporting at risk groups, and (4) providing crisis support. Importantly, there was greater investment for mental health resources and consistent evaluation of the effectiveness of the programs.[59] The Singapore MOH spends on average 3% of the total MOH expenditure on mental health.[60-61]

Results

After the decriminalization of suicide, there were 166 deaths by suicide from January to September 2020, a decline from 304 deaths by suicide during the same period in 2019.[62] Initial evidence suggests that decriminalization of suicide in combination with a national suicide network improved population mental health and decreases suicide rates.

Challenges of suicide prevention in Malaysia

Lack of comprehensive suicide prevention strategy for youth

The MOH has acknowledged the concerning rise of suicide among youths in Malaysia, supports the decriminalisation of suicide and is working to increase community mental health support.[63-64] A comprehensive suicide prevention strategy for youths needs to be developed, and mechanisms have to be put in place to monitor and assess strategy implementation and outcomes to ensure the effectiveness of the strategy across multiple sectors. Based on the WHO's public health suicide prevention strategy, we have highlighted three key areas below for strategic action for immediate implementation in Malaysia (see Table 3 for full list of recommendations).

Monitor and improve data quality. The NSRM was active from 2007 to 2009. The government recently announced that they will resume the suicide registry in 2021.[65] While this is a good step forward to develop an effective suicide prevention plan, the limitations discussed in the NSRM 2009 report need to be addressed to ensure that the data collected is reliable and valid.

a. The NSRM under-records the prevalence of suicides as it only registers deaths certified by a registered medical practitioner. About 45% of deaths in Malaysia are non-certified (which includes suicides or "sudden deaths"). Although the law mandates "sudden death" cases to be fully investigated, the discretion still lies with the attending police officer.

b. The NSRM only registers cases that have clear evidence (beyond reasonable doubt) for intent of suicide, and excludes cases where intent was unclear. While the assumption that all sudden deaths with unclear intentions are suicides will lead to an over-reporting of the prevalence of suicides; the opposite assumption that only sudden deaths with clear intentions are suicides will equally distort the true suicide rate. Past research estimated that there is a high likelihood that the majority of cases with unclear intent are suicides and should be included in the registry. There should be a clear standardized assessment to help determine which deaths with unclear intent should be considered as suicide.[66]

c. The NSRM needs the resources to develop an effective system of quality data collection. The NSRM committee highlighted the lack of resources in human resources (staffing in forensics, mental health services, research fellows), funding, and support from authorities.

Unethical media reporting on suicide

The media coverage in Malaysia on suicide rely on sensational headlines and pictures of real suicides.[67] Despite the 2013 MOH guidelines for media reporting on suicide, these guidelines have not been implemented or followed by Malaysia media outlets. This is concerning, as sensationalised media coverage about suicide is a risk factor for copycat suicides.[68] Media blackouts or an increased quality of reporting have been associated with a decrease in suicidal behaviour. Past studies have found that guidelines need to be developed in close collaboration with regional and national media as well as psychosocial experts (e.g. psychologists, social workers) in order to

increase "buy in" and implementation of the guidelines.[9,69] This requires journalist training and education around suicide and mental health during guideline development and dissemination. In addition, it is essential that resources are invested in ongoing monitoring of adherence, training of journalists and evaluation of guideline effectiveness as part of a national comprehensive suicide strategy.

Lack of evidence based suicide prevention campaigns

While suicide prevention public awareness campaigns are held occasionally, there is little data on the effectiveness of such campaigns. At its best, a public campaign will raise awareness and decrease stigma. At its worst, it will normalize suicide and increase suicidal intentions.[67] A review of public health campaigns in the U.S. concluded that successful campaigns adhere to a set of best practices:

a. Evaluation strategies for campaign development and outcome assessments have to be incorporated into the campaign.

b. Campaign development should account for different protective and risk factors associated with diverse demographic groups (target and non-target groups) when developing the campaign message as these groups may respond differently to the campaign message.

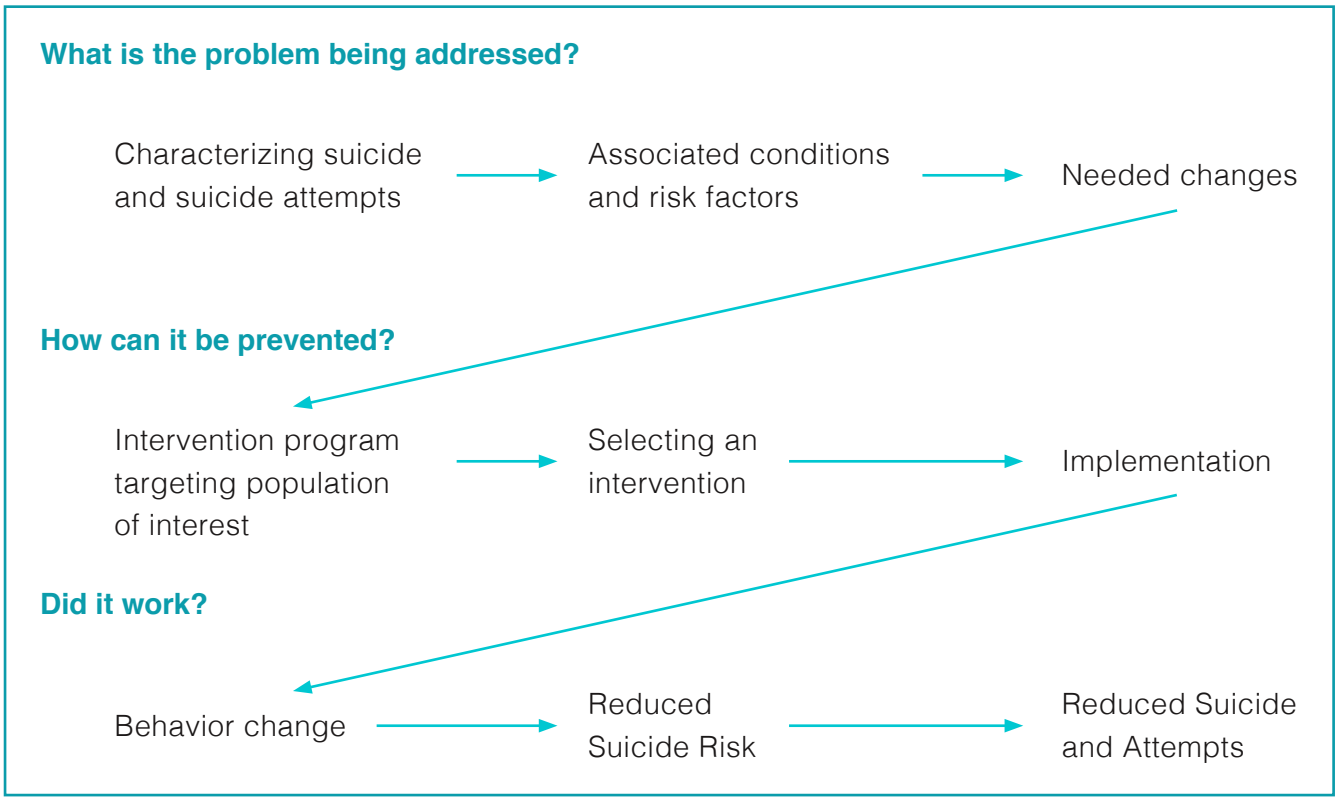
c. Focus on the most effective campaign messages by pre-testing campaign materials with diverse groups of the population.

d. Avoid using approaches that glorify or increase the recognition of individual cases of suicide.

e. Provide realistic helpful solutions that will most likely be adopted by the target population.

A three step phased approach for suicide prevention (developed by the CDC) [70] is described in Figure 4. In the first phase (planning), the problem to be addressed is examined, as well as the informational needs of the target audience. The second phase (implementation) is carried out only after key issues are identified: "*the intended audience; the knowledge (awareness), attitudes, and behavior that ought to change; the past performance of a similar intervention; the assumed theory of change; the most realistic approach; and the resources available to campaign developers.*" In the final phase (evaluation), campaign developers must assess the success of the implementation and the campaign, and identify affected outcomes (both positive and negative).

Figure 4: A three step phased approach for suicide prevention (developed by the CDC) [70]



In addition, the Blackdog Institute in Australia also found that short-term campaigns and standalone campaigns are not successful in effecting positive change.[71] To develop a successful suicide prevention public awareness campaign, Blackdog Institute recommends that:

1. All campaigns should include an evaluation to determine their effect across a range of measures (help-seeking attitudes and help-seeking behaviours, lowered suicide attempts and suicide). These should include longer-term outcomes and the use of a strong research design along with impacts on subgroups.

2. Invest in research to understand the effect of campaigns as a whole and individual components and mechanisms of action.

3. Invest in and promote campaigns that go beyond awareness raising and include components that are likely to have a positive impact on behaviour change.

4. Embed effective campaigns within multicomponent suicide prevention strategies that incorporate service-level augmentation at the state and community level.

Case study 4

Australia - The #Chatsafe Project[72]

Initiative

Young people have a large online presence, predominantly through social media platforms, which they use to communicate about suicide. To facilitate safe communications about suicide on the Internet, #chatsafe guidelines were developed by a group of Australian researchers to implement on a national social media campaign. In order to maximize the reach of the suicide campaign to target audience, the campaign was co-designed with young people to understand appropriate strategies for dissemination and engagement with the guidelines. The key recommendations and strategies identified by young people for the #chatsafe campaign included:

1. **Agency and self-care.** Young people highlighted the need for campaign content not be prescriptive. Self-care methods that equip them with tools to act as their own mental health champions, and campaigns that promoted privacy of communication preferred.
2. **Stories of hope and recovery.** Real stories of young people's recovery can help normalize & validate challenges whilst modeling adaptive behavior and providing a sense of community.
3. **Active support.** Young people wanted their immediate support system, (i.e.: friends) to be equipped with the knowledge and skill to support them.
4. **Self - awareness.** Young people reported that they wanted their peers to reach out only if they were able to provide support without causing distress to themselves, acknowledging that it may be beyond the capability of their peers to support at-risk friends.
5. **Multicultural perspectives, diversity and visibility.** They highlighted the importance of feeling represented in the campaign. Young people identify in many ways and have intersectional identities. Seeing a diverse range of young people visibly represented in all content, whilst avoiding tokenism was necessary. They acknowledge that there are unique needs in different communities that need to be addressed in a respectful and meaningful manner, through culturally based and community generated content.

Lessons for Malaysia

This case study highlights the value of engaging the target populations at risk of (i.e. young people) when designing prevention campaigns to ensure maximum reach and effectiveness. In a Malaysian context, national social media campaigns can be created by the government in collaboration with existing mental health NGOs working with youth in the country. For example, Mindakami raises awareness on mental health by providing a safe, online platform for mental health discussion, with a focus on young people. Channeling resources to existing platforms that have experience creating content specifically for young people can be a more effective and cost efficient approach. Workshops such as the #chatsafe project

can be carried out in collaboration with local researchers, to have a deeper understanding of the needs of young people in Malaysia to inform the design of suicide prevention campaign content. As exemplified in the case study above, young people need to be able to relate to the campaign content and feel visibly represented. For a multicultural country like Malaysia with a range of identities, representation and cultural sensitivity is crucial.

Effectiveness of existing services

Educational services such as schools and universities can play an important role in identifying at risk youth and delivering appropriate interventions to prevent suicides, specifically through counselling services. Counselling services have been established in Malaysian schools and universities with the aim to support social and emotional needs since the 1960s. It is compulsory for all national secondary schools to be staffed with at least one school counsellor.

However, uptake of counselling services are low.[73] Students are more willing to seek counselling for assistance on schoolwork or career related matters, but are reluctant to use the services for emotional and mental health support. Reasons for low help-seeking behaviors include a lack of willingness to disclose personal problems due to cultural values, a difficulty in expressing their feelings and emotions, and the view that counselling is not helpful.The perception of the role of counselling services can be ambiguous, as counselling services are often seen as a platform to deal with the so-called “problematic students” as part of the school disciplinary system.

Gender and language differences between student and counsellor may be a deterrent to effective counselling services.[74] Sensitivity to the student’s cultural background is vital in counselling as family culture shapes the way individuals define themselves and communicate with their environment.

On an individual level, self- reliance is one of the most common barriers to seeking help when faced with stressful life events. Malaysian university students reported that they perceive their emotional problems as minor and could be solved without assistance. Self-reliance can be considered a protective factor for mental wellbeing,[75] however, individuals who are highly self-reliant are more likely to feel depressed and experience suicidal thoughts, and less likely to seek treatment.[76]

Counselling services in schools can be a valuable platform to leverage and implement suicide prevention strategies, however, there is a need to assess the current effectiveness of these platforms. A more collaborative approach between counsellors, school community, and parents, can provide a more effective and holistic support system for students.[77]

Key policy recommendations

Based on the risk factors and challenges discussed above, outlined below are policy recommendations to improve youth suicide prevention in Malaysia.

Table 3: Policy recommendations to improve youth suicide prevention (table adapted from WHO)[9]

Areas of strategic action	Lead stakeholders	Malaysian context
Engage key stakeholders	• Ministry of Health (MOH) as lead, or other coordinating health body to engage with other relevant ministries. • MOH to engage with non-governmental organisations as well as research organisations and think tanks. • MOH to engage with the relevant target population, youth.	• MOH has published a brief guide on suicide prevention in 2013. However, there is no comprehensive updated suicide prevention guideline available particularly for youth. We recommended MOH to identify and engage with key stakeholders, including other ministries such as MOE, Ministry of Human Resources, and Ministry of Women, Family and Community Development, as well as non-government organisations. • Collaborate with MOE to leverage and improve the effectiveness of existing youth mental health support services in educational settings. • Relevant ministries should further engage research organisations and/or think tanks to support the assessment and identification policy gaps for suicide prevention. • The MOH should engage with youth organisations such as Majlis Belia Malaysia, community and religious youth organizations to ensure the viewpoint of the target population is taken into account during the development of prevention strategies.
Reduce access to means	• Legal and judicial system, policy-makers, agriculture, transportation	• The two most common method of suicide among youth in Malaysia are intentional self-harm and intentional self-poisoning. Regulations to limit access to means of suicide such as toxic substances should be explored.[23]
Conduct surveillance and improve data quality	• MOH, Bureau of Statistics, community mental health organizations, and other formal and informal health systems to collect data	• The government announced that the National Suicide Registry of Malaysia will be resumed in 2021.[65] The National Suicide Registry should include information on age, sex, ethnicity, state and methods of suicide. Begin identification of representative locations for development of models.

Raise awareness	• All sectors, with leadership from the MOH and the media.	• Awareness raising campaigns should aim to engage the community to ask, listen and encourage action. The MOH's "Let's talk Minda Sihat" campaign attempts to raise awareness by encouraging these steps, however it fails to provide clear resources to support action.[77] • The community needs to be equipped with clear resources on all stages of the process. Evaluation of the programs should be carried out periodically by assessing the awareness of its presence, message or involvement in the community.[78-79]
Engage the media	• Media and MOH in partnership	• Sensationalized media stories about suicide is a risk factor for suicide. Media blackouts or better reporting quality have been associated with decreased suicidal behaviour.[80] • Guidelines for media reporting should be strengthened and enforced in close collaboration with regional and national media as well as psychosocial experts (e.g. psychologists, social workers) in order to increase "buy in" and implementation of the guidelines.
Mobilize the health system and train health workers	• Formal and informal health systems, education sector	• A suicide prevention gatekeeper training program such as C.A.R.E can be rolled out nationally educators and health workers. Gatekeeper training alone is insufficient to lower suicide rates and should be done in combination with other programs such as targetting stigma and limiting means to suicide.[80]
Change attitudes and beliefs	• Media, health services sector, education sector, community organizations • Legal and judicial system, policy-makers.	• Successful public awareness campaigns have several key features in common. Namely, the information presented must be evidence-based; pre-tested with the target population; portray helpful options; and not further stigmatizing youths. Refer to Figure 4 for further recommendations of campaign elements.[81] • The decriminalization of suicide to ensure a support-and-treat approach or individuals with suicidal behaviours, within the national legal system and community.

Conduct evaluation and research	• Relevant community health services, education sector and MOH	• In addition to the NRSM, we recommend a comprehensive needs assessment on the availability and gaps in suicide prevention and treatment services. Expand existing research, assigning resources to inform and evaluate efforts to prevent suicide at state and/or national level.
Build on existing suicides prevention guidelines to develop and implement a comprehensive national suicide prevention strategy for youths.	• MOH	• There is no national youth suicide prevention strategy for Malaysia. A national suicide prevention strategy for youths needs to be developed to serve as a rallying point, even if data and resources are not yet available. • Mechanisms have to be put in place to monitor and assess strategy implementation and outcomes to ensure the effectiveness of the strategy across multiple sectors.

Summary

Suicide is a leading cause of death among youths in Malaysia and is a serious public health issue that must be addressed immediately. It is estimated that 382 young men and 141 young women ended their lives by suicide in 2019. These preventable deaths are estimated to cost RM 346.2 million in lost economic income and tax revenue. Suicide remains a criminal act in Malaysia, despite evidence that criminalization of suicide reduces help-seeking, hinders collection of accurate data, and the development and implementation of effective suicide prevention strategies.

To date, there is no comprehensive suicide prevention strategy for youths. Beside the direct loss of young lives, youth suicides can also have disruptive psychosocial and negative socioeconomic effects on society. There needs to be improved coordination and collaboration across ministries, organisations and sectors to develop a national strategy. We recommend three initial steps to developing a comprehensive suicide prevention strategy in Malaysia. Firstly, there needs to be more funding and resources allocated to the development and maintenance of a surveillance system to monitor suicide and suicide attempts in Malaysia. Secondly, there needs to be responsible reporting of suicide by media in Malaysia. Thirdly, effective public awareness campaigns are needed to raise awareness, encourage help-seeking and reduce the stigma associated with seeking help for suicidal ideation. Decision makers need to take urgent action to address youth suicide due to the immense personal, social and economic costs of suicide to Malaysian society.

References

1. Fullerton, J. (2019, May 15). Teenage girl kills herself 'after Instagram poll' in Malaysia: Police investigating after she asked her followers to choose death or life and 69% voted for death. The Guardian. https://www.theguardian.com/world/2019/may/15/teenage-girl-kills-herself-after-instagram-poll-in-malaysia

2. Hassan, H. (2019, May 16). Malaysian police investigate case of teen who committed suicide after Instagram poll. The Strait Times. https://www.straitstimes.com/asia/se-asia/malaysianpolice-investigate-case-of-teen-who-committedsuicide-after-instagram-poll

3. Pillay, S. (2017, May 28). Suicide on the rise among Malaysian youth. New Straits Times. https://www.nst.com.my/news/exclusive/2017/05/243354/suiciderise-among-malaysian-youth-committedsuicide-after-instagram-poll

4. The Sun Daily. (2020). Effect of Covid-19 on mental health. Retrieved from https://www.thesundaily.my/local/effect-of-covid-19-on-mental-health-LF4205937

5. CodeBlue. (2020). Government Psychosocial Hotlines Received 12,000 Calls During Pandemic: Minister. https://codeblue.galencentre.org/2020/09/10/government-psychosocial-hotlines-received-12000-calls-during-pandemic-minister/

6. Daily Express. (2020). 266 commit suicide during movement restrictions (one everyday). https://www.dailyexpress.com.my/news/161783/266-commit-suicide-during-movement-restrictions-one-everyday-/

7. Low, W.L. (2020, November). The Pandemic: A Greater Call for the Reformation of the Law on Attempted Suicide? Relate Insights 2020/03. Relate Mental Health Malaysia. https://relate.com.my/the-pandemic-a-greater-call-for-the-reformationof-the-law-on-attempted-suicide/

8. Vijayakumar, L. (2017). Challenges and opportunities in suicide prevention in South-East Asia. WHO South-East Asia Journal of Public Health, 6(1), 30.

9. World Health Organization. (2014). Preventing suicide: A global imperative. https://www.who.int/mental_health/suicide-prevention/world_report_2014/en/

10. Court fines man who survived suicide bid RM3,000. (2020, August 04). Malaymail. https://www.malaymail.com/news/malaysia/2020/08/04/court-fines-manwho-survived-suicide-bid-rm3000/1891010

11. Shah, A. (2018, August 26). [Exclusive] Over 2,000 suicide cases in the past four years (NSTTV). New Strait Times. https://www.nst.com.my/news/exclusive/2018/08/404930/exclusive-over-2000-suicide-cases-past-four-years-nsttv

12. Maniam, T. (1995). Suicide and undetermined violent deaths in Malaysia, 1966-1990: Evidence for the misclassification of suicide statistics. Asia Pacific Journal of Public Health, 8(3), 181-185.

13. National Suicide Registry Malaysia (NSRM). (2009). Annual report 2008. https://www.crc.gov.my/wp-content/uploads/documents/report/NSRM_report_2008.pdf

14. Ministry of Health Malaysia. (2014). Guideline on suicide risk management in hospitals. https://www.moh.gov.my/index.php/file_manager/dl_i

15. National Suicide Registry Malaysia (NSRM). (2008). Preliminary report July – December 2007. https://www.crc.gov.my/wp-content/uploads/documents/report/nsrm.pdf

16. National Suicide Registry Malaysia (NSRM). (2009). Annual report 2008. https://www.crc.gov.my/wp-content/uploads/documents/report/NSRM_report_2008.pdf

17. National Suicide Registry Malaysia (NSRM). (2010). Annual report 2009. https://www.crc.gov.my/wp-content/uploads/documents/report/NSRM_report_2009.pdf

18. World Health Organization. (n.d.) Mental health and substance use. https://www.who.int/mental_health/prevention/suicide/estimates/en/

19. World Health Organization. (n.d.) Crude suicide rates (per 100000 population). https://www.who.int/data/gho/data/indicators/indicator-details/GHO/crude-suicide-rates-(per-100-000-population)

20. Department of Statistics Malaysia. (n.d.) Population quick info. http://pqi.stats.gov.my/result.

21. Department of Statistics Malaysia. (2020). Cause of death 2019. https://newss.statistics.gov.my/newss-portalx/ep/epFreeDownloadContentSearch.seam?cid=489944

22. Department of Statistics Malaysia. (2019). Cause of death 2018. https://newss.statistics.gov.my/newss-portalx/ep/epFreeDownloadContentSearch.seam?cid=365416

23. Bahar, N., Ismail, W. S. W., Hussain, N., Haniff, J., Bujang, M. A., Hamid, A. M., ... & Ali, N. H. (2015). Suicide among the youth in M alaysia: What do we know?. Asia-Pacific Psychiatry, 7(2), 223-229.

24. Sinniah, A., Maniam, T., Oei, T. P., & Subramaniam, P. (2014). Suicide attempts in Malaysia from the year 1969 to 2011. The Scientific World Journal, 2014.

25. Maniam, T., Marhani, M., Firdaus, M., Kadir, A. B., Mazni, M. J., Azizul, A., ... & Jasvindar, K. (2014). Risk factors for suicidal ideation, plans and attempts in Malaysia—Results of an epidemiological survey. Comprehensive Psychiatry, 55, S121-S125.

26. Institute of Public Health. (2011). National health and morbidity survey 2012. http://iku.moh.gov.my/nhms-2012

27. Institute of Public Health. (2017). National health and morbidity survey 2017. http://iku.moh.gov.my/nhms-2017

28. Chua, S.N. (2021, January). Economic cost of youth suicide in Malaysia. Relate Insights 2021/02. Relate Mental Health Malaysia. https://relate.com.my/economic-cost-of-youth-suicide-in-malaysia/

29. Evans, E., Hawton, K., & Rodham, K. (2004). Factors associated with suicidal phenomena in adolescents: a systematic review of population-based studies. Clinical Psychology Review, 24(8), 957-979.

30. Michail, M. (n.d.). Understanding the complexity of suicidal behaviour. https://www.birmingham.ac.uk/research/perspective/understanding-the-complexity-of-suicide.aspx

31. Bilsen, J. (2018). Suicide and youth: risk factors. Frontiers in psychiatry, 9, 540.

32. Arnett, J. J. (1998). Learning to stand alone: The contemporary American transition to adulthood in cultural and historical context. Human Development, 41, 295–315.

33. Befrienders Worldwide [webpage on the Internet]. Suicide statistics; 2016. Available from: http://www.befrienders.org/suicide-statistics. Accessed October 5, 2016.

34. Grøholt, B., Ekeberg, Ø., Wichstrøm, L., & Haldorsen, T. (1999). Sex differences in adolescent suicides in Norway, 1990–1992. Suicide and Life-Threatening Behavior, 29(4), 295-308.

35. Lewinsohn, P. M., Rohde, P., Seeley, J. R., & Baldwin, C. L. (2001). Gender differences in suicide attempts from adolescence to young adulthood. Journal of the American Academy of Child & Adolescent Psychiatry, 40(4), 427-434.

36. Murphy, G. E. (1998). Why women are less likely than men to commit suicide. Comprehensive psychiatry, 39(4), 165-175.

37. Wunderlich, U., Bronisch, T., Wittchen, H. U., & Carter, R. (2001). Gender differences in adolescents and young adults with suicidal behaviour. Acta Psychiatrica Scandinavica, 104(5), 332-339.

38. Snowdon, J. (2018). Differences between patterns of suicide in East Asia and the West. The importance of sociocultural factors. Asian Journal of Psychiatry, 37, 106-111.

39. Knipe, D., Williams, A. J., Hannam-Swain, S., Upton, S., Brown, K., Bandara, P., ... & Kapur, N. (2019). Psychiatric morbidity and suicidal behaviour in low-and middle-income countries: A systematic review and meta-analysis. PLoS Medicine, 16(10), e1002905.

40. Armitage, C. J., Panagioti, M., Rahim, W. A., Rowe, R., & O'Connor, R. C. (2015). Completed suicides and self-harm in Malaysia: a systematic review. General Hospital Psychiatry, 37(2), 153-165.

41. Hamidin, A., & Maniam, T. (2011). Life events and parasuicides in hospital Kuala Lumpur, Malaysia. Malaysian Journal of Medicine and Health Sciences, 7(2), 45-52.

42. Tong, Y., & Phillips, M. R. (2010). Cohort-specific risk of suicide for different mental disorders in China. The British Journal of Psychiatry, 196(6), 467-473.

43. Tong, Y., Phillips, M. R., & Yin, Y. (2018). Prevalence of psychiatric diagnoses in individuals who die by suicide or attempt suicide in China based on independent structured diagnostic interviews with different informants. Journal of Psychiatric Research, 98, 30-38.

44. Liu, B. P., Zhang, J., Chu, J., Qiu, H. M., Jia, C. X., & Hennessy, D. A. (2019). Negative life events as triggers on suicide attempt in rural China: a case-crossover study. Psychiatry Research, 276, 100-106.

45. Abdul Aziz, F., Abd Razak, M., Ahmad, N., Awaluddin, S., Lodz, N., & Sooryanarayana, R. et al. (2019). Factors Associated With Suicidal Attempt Among School-Going Adolescents in Malaysia. Asia Pacific Journal Of Public Health, 31(8_suppl), 73S-79S.

46. Ibrahim, N., Amit, N., & Suen, M. (2014). Psychological Factors as Predictors of Suicidal Ideation among Adolescents in Malaysia. Plos ONE, 9(10), e110670.

47. Institute of Public Health. (2015). National health and morbidity survey 2015. http://iku.moh.gov.my/nhms-2015

48. Sinniah, A., Maniam, T., Sidi, H., & Oei, T. (2014). Suicide ideation and intent in Malaysia: A review of the literature. Comprehensive Psychiatry, 55(1), 95-100.

49. Morris, P., & Maniam, T. (2001). Ethnicity and Suicidal Behaviour in Malaysia: A Review of the Literature. Transcultural Psychiatry, 38(1), 51-63.

50. Blakely, T. (2003). Unemployment and suicide. Evidence for a causal association?. Journal Of Epidemiology & Community Health, 57(8), 594-600.

51. Ministry of Education Malaysia Higher Education. (2018). Graduate tracer study (SKPG) 2018.

52. ISEAS - Yusof Ishak Insititute. (2020). Unemployment among Malaysia's Youth: Structural Trends and Current Challenges. Retrieved from https://www.iseas.edu.sg/wp-content/uploads/2020/05/ISEAS_Perspective_2020_65.pdf

53. The Malaysian Reserve. (2020). Malaysia officially in recession. https://themalaysianreserve.com/2020/11/13/malaysia-officially-in-recession/

54. Stiglic, N., & Viner, R. M. (2019). Effects of screentime on the health and well-being of children and adolescents: a systematic review of reviews. BMJ open, 9(1), e023191.

55. Sedgwick, R., Epstein, S., Dutta, R., & Ougrin, D. (2019). Social media, internet use and suicide attempts in adolescents. Current Opinion in Psychiatry, 32(6), 534.

56. Hassandarvish, M. (2019). Subang Jaya-based SJ care warriors train community to address mental health issues. https://www.malaymail.com/news/life/2019/05/23/subang-jaya-based-sj-care-warriors-train-community-to-address-mental-health/1755760

57. Wong, L.Z. (2019). SJ care warriors aim to remove stigma of mental health among youths. https://www.thestar.com.my/lifestyle/family/2019/10/08/sj-care-warriors-community-based-programme-destigmatise-mental-health-problems

58. Minister for Home Affairs and Minister for Law. (2018). Penal code review committee report. https://www.mha.gov.sg/docs/default-source/defaultdocument-library/penal-code-review-committee-report3d9709ea6f13421b92d3ef8af69a4ad0.pdf

59. Ministry of Health Singapore. (2020). Multi-pronged approach to suicide prevention and intervention in Singapore. https://www.moh.gov.sg/newshighlights/details/multi-pronged-approach-tosuicide-prevention-and-intervention-in-singapore

60. Ministry of Health Singapore. (2020). Breakdown andrationale of funds allocated for suicide preventionservices on annual basis. https://www.moh.gov.sg/news-highlights/details/breakdown-and-rationaleof-funds-allocated-for-suicide-prevention-serviceson-annual-basis/

61. Ministry of Health Singapore. (2019). Percentage of spending on mental health diabetes and ageing versus total health care spending in 2018 against amount budgeted for 2019. https://www.moh.gov.sg/news-highlights/details/percentage-ofspending-on-mental-health-diabetes-and-ageingversus-total-healthcare-spending-in-2018-againstamount-budgeted-for-2019/

62. Strait Times. (2020). Parliament: Number of suicide deaths down this year after its decriminalisation. https://www.straitstimes.com/singapore/politics/parliament-number-of-deaths-from-suicide-decreased-this-year-following-its

63. The New Strait Times. (2019). Suicide rate on the rise, particularly among youth. https://www.nst.com.my/news/nation/2019/09/520301/suicide-rate-rise-

64. Malay Mail. (2020). Health Ministry records 465 attempted suicide cases from Jan-June this year. https://www.malaymail.com/news/malaysia/2020/09/10/health-ministry-records-465-attempted-suicide-cases-from-jan-june-this-year/1901996

65. Yeoh, H. (2020, Dec 4). My parliamentary question on National Suicide Registry Malaysia and mental health data/cases. [Tweet]. Twitter. https://twitter.com/hannahyeoh/status/1334713270335283204

66. Linsley, K. R., Schapira, K., & Kelly, T. P. (2001). Open verdict v. suicide–importance to research. The British Journal of Psychiatry, 178(5), 465-468.

67. Johari, M. A., Shukri, M. Z. M., Abd, M. A. S., Karim, M. H. H. I., Khazali, A. K., Nasarudin, A. A., ... & Razali, S. (2017). Perception of media in reporting suicide cases in Malaysia. Akademia Baru. Journal of Advanced Research in Social and Behavioural Sciences, 7(1), 59-67.

68. Wang, X. (2012). Media guidelines for the responsible reporting of suicide. Crisis.

69. Niederkrotenthaler, T., & Sonneck, G. (2007). Assessing the impact of media guidelines for reporting on suicides in Austria: interrupted time series analysis. Australian & New Zealand Journal of Psychiatry, 41(5), 419-428.

70. Stone, D.M., Holland, K.M., Bartholow, B., Crosby, A.E., Davis, S., and Wilkins, N. (2017). Preventing Suicide: A Technical Package of Policies, Programs, and Practices. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

71. Deady, M., Harvey, S.B., Tye, M., Boydell, K., Petrie, K., Yip, D., Lavender, I. & Christensen, H. (2020). Suicide awareness campaigns: are they a valid prevention strategy? The Black Dog Institute.

72. Thorn, P., Hill, N., Lamblin, M., Teh, Z., Battersby-Coulter, R., & Rice, S. et al. (2020). Developing a Suicide Prevention Social Media Campaign With Young People (The #Chatsafe Project): Co-Design Approach. JMIR Mental Health, 7(5), e17520. doi: 10.2196/17520

73. Chai, M. S. (2000). Fears of psychological treatment and attitudes toward seeking professional help among students. Unpublished Masters Thesis University Putra Malaysia

74. Low, S. K., Kok, J. K., & Lee, M. N. (2011). Cultural Sensitivity in Counselling for Youth Development [Paper presentation]. https://www.researchgate.net/publication/264713726_Cultural_Sensitivity_in_Counselling_for_Youth_Development

75. Tran, K. K., Wong, Y. J., Cokley, K. O., Brownson, C., Drum, D., Awad, G., & Wang, M. C. (2015). Suicidal Asian American college students' perceptions of protective factors: A qualitative study. Death studies, 39(8), 500-507.

76. Labouliere, C. D., Kleinman, M., & Gould, M. S. (2015). When self-reliance is not safe: associations between reduced help-seeking and subsequent mental health symptoms in suicidal adolescents. International journal of environmental research and public health, 12(4), 3741-3755.

77. Low, S. K., Kok, J. K., & Lee, M. N. (2013). A holistic approach to school-based counselling and guidance services in Malaysia. School Psychology International, 34(2), 190-201.

78. R U OK? Foundation. R U OK? Submission to Productivity Commission Inquiry into Mental Health April 2019. Melbourne: Australian Government Productivity Commission; 2019

79. Mok, K., Donovan, R., Hocking, B., Maher, B., Lewis, R., & Pirkis, J. (2016). Stimulating community action for suicide prevention: findings on the effectiveness of the Australian RU OK? Campaign. International Journal of Mental Health Promotion, 18(4), 213-221.

80. Ross, A. M., & Bassilios, B. (2019). Australian RU OK? Day campaign: improving helping beliefs, intentions and behaviours. International journal of mental health systems, 13(1), 1-12.

81. Zalsman, G., Hawton, K., Wasserman, D., van Heeringen, K., Arensman, E., Sarchiapone, M., ... & Purebl, G. (2016). Suicide prevention strategies revisited: 10-year systematic review. The Lancet Psychiatry, 3(7), 646-659.

Relate Mental Health Malaysia
www.relate.com.my
A non-profit registered in Malaysia no. 201701036955 (1251126-M)

Follow us on

relatemalaysia @relatemalaysia