Suicide in Asia
Causes and Prevention

Edited by Paul S.F. Yip

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Hong Kong University Press is honoured that Xu Bing, whose art explores the complex themes of language across cultures, has written the Press's name in his Square Word Calligraphy. This signals our commitment to cross-cultural thinking and the distinctive nature of our English-language books published in China.

"At first glance, Square Word Calligraphy appears to be nothing more unusual than Chinese characters, but in fact it is a new way of rendering English words in the format of a square so they resemble Chinese characters. Chinese viewers expect to be able to read Square word Calligraphy but cannot. Western viewers, however are surprised to find they can read it. Delight erupts when meaning is unexpectedly revealed."

— Britta Erickson, *The Art of Xu Bing*

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Contributors

Anne Chao (Taiwan)

Dr. Chao is a Professor in Institute of Statistics, National Tsing Hua University, Taiwan. Her research interests include biological/ecological statistics and applications to health-related sciences. She holds a Taiwan National Chair in Statistics and is currently an Associate Editor for the journals: *Biometrics, Journal of Agricultural, Biological and Ecological Statistics* and *Australian and New Zealand Journal of Statistics*.

Audrey Chia (Singapore)

Dr. Chia, MBBS Hons (Sydney), FRANZCO, is a medical practitioner who is interested in studying suicide in Singapore, and has been assisting Boon-Hock Chia in his research in suicide research and prevention. She coauthored with B.H. Chia in some publications on suicide prevention research.

Boon Hock Chia (Singapore)

Dr. Chia is a psychiatrist based in Singapore. He graduated from the University of Hong Kong (1961), and did his postgraduate training at the Maudsley Institute of Mental Health, London (1965-7). Returning to Singapore, he worked briefly at the Woodbridge Mental Hospital before setting up his private practice. His interest in suicidology began in 1967, and in 1981, he gained his Doctorate in Medicine with his thesis "Suicide in Singapore". In the 1990s, he spent two years in Sydney working with Community Health Services. Dr Chia has penned three

books on suicide: *Suicidal Behavior in Singapore*, *Too Young to Die*, and *Age of Despair*. Now semi-retired, he remains actively involved in suicide research, and spends his free time with his orchids, piano, golf and grandchildren.

C.K. Law (Hong Kong)

Dr. Law is a Postdoctoral Fellow of the HKJC Centre for Suicide Research and Prevention at the University of Hong Kong. He did his PhD on population studies in the University of Hong Kong. He is specializing in health economics and has received training from the World Health Organization (Geneva) on health promotion. He had also worked in the Hospital Authority of Hong Kong. He is conducting research studies on the socioeconomic cost of suicide, cost-benefit analysis and evaluation for suicide prevention strategies in Hong Kong.

David Lester (USA)

Dr. Lester is Professor of Psychology at the Richard Stockton College of New Jersey. Lester's scholarly research covers a broad range of issues in thanatology, resulting in the publication of 78 books and over 2,000 papers and reports, most of which focus on suicide.

P.C. Li (Taiwan)

Dr. Li is a Postdoctoral Fellow in National Tsing Hua University, Taiwan. His research interests are in the areas of public health, biostatistics and the use of capture-recapture experiment for improving surveillance and monitoring in public health areas.

K. Y. Liu (Hong Kong)

Dr. Liu is currently undertaking postdoctoral research in Columbia University on the social mechanisms of suicide. She had a bachelor degree from the University of Hong Kong and received her PhD in Sociology from the University of Oxford in 2007. She worked in the HKJC Centre for Suicide Research and Prevention at the University of Hong Kong and conducted research on suicidal behaviour among the general population in Hong Kong, deliberate self-harm patients presented to accident and emergency departments, and the epidemiology of suicide in Mainland China, Taiwan, and Hong Kong.

Manote Lotrakul (Thailand)

Dr. Lotrakul is an Associate Professor of psychiatry, department of psychiatry, Ramathibodi Hospital, Mahidol University, Bangkok. He obtained his medical degree from Chulalongkorn University and was trained in psychiatry at Somdet Chaopraya Institute of Psychiatry. He served as Editor-in-Chief of *Journal of the Psychiatric Association of Thailand* from 1996 through 2001. He currently serves as an executive committee of the Royal College of Psychiatrists of Thailand. His areas of clinical and research interests include mood disorders and suicide. He has various publications on these issues including the Royal College of Psychiatrists of Thailand's Clinical Practice Guidelines in suicide management and prevention.

B.C. Ben Park (South Korea)

Dr. Park is an Associate Professor in the Human Development and Family Studies program at Penn State DuBois. Dr. Park's scholarly effort focuses on suicide. In particular, his research on politically-motivated suicide has shed some light on the relationship between identity development and the logic in choosing such self-destructive behaviour.

Yoshitomo Takahashi (Japan)

Dr. Takahashi is a Professor of Division of Behavioral Sciences, National Defense Medical College Research Institute, Tokorozawa, Japan. He received his M.D. from Kanazawa University in 1979. He was given an opportunity by the Fulbright Commission to study suicide prevention under Professor Edwin Shneidman's guidance at University of California Los Angeles from 1987 to 1988. As a psychiatrist, he has conducted seminars on suicide prevention and published 20 books, about 300 journal articles and 120 book chapters on suicide prevention.

Lakshmi Vijayakumar (India)

Dr. Vijayakumar is the Head of the Department of Psychiatry, Voluntary Health Services, Adyar. She is also the founder of SNEHA, an NGO in Chennai for the prevention of suicide. She was Vice President of the International Association for Suicide Prevention (I.A.S.P.) for four years. She is a member of the WHO's International Network for Suicide Research and Prevention. She has various

publications and is the editor of the book titled "Suicide Prevention - Meeting the challenge together" published by Orient Longman.

Paul S.F. Yip (Hong Kong)

Dr. Yip is the director of the HKJC Centre for Suicide Research and Prevention and a Professor of Social Work and Social Administration at the University of Hong Kong. He is a national representative of the Hong Kong SAR for the International Association of Suicide Prevention (IASP) and a fellow of the International Association of Suicide Research, a consultant for Beijing Suicide Prevention Service, a board member for Suicide Prevention Service (Hong Kong). His expertise is in population-health-related issues. His research interests include improving surveillance and monitoring of suicide statistics, adopting a public health approach to suicide prevention, understanding suicide differences between East and West and the effect of mass media reporting on suicide.

1

Introduction

Suicide has become a major public health issue throughout the world. Over a million people kill themselves every year, and more than half of these cases occur in Asia (WHO 2003). Suicide is especially a major concern in Asia due to its huge population and the relatively high suicide rate compared to that in Western countries. In response to the growing concern, the aim of this monograph is to provide an informative account of suicide in some Asian countries/societies to arouse more awareness of suicide in Asia so that more research and prevention efforts will be carried out.

Size and Magnitude of the Suicide Problem

Asia consists of more than half of the world's population and has considerable diversity in culture and socioeconomic development. The suicide rates are also very different: Japan and South Korea both have a high rate (about 25 per 100,000), Thailand has a relatively low rate (7 per 100,000), and Taiwan, China, Hong Kong, and Singapore are somewhere in between (15–18 per 100,000). However, it is the recent growth of suicide in these countries that is of particular concern. Suicide is the leading cause of death among young people (aged 15–24) in Hong Kong. South Korea and Japan. Taiwan have experienced nearly a threefold increase in suicide in the past decade. On the other hand, the suicide rate in Singapore has remained relatively steady. Thailand, a very religious country (Buddhism), used to have a low suicide rate (WHO 2003), but the rate has recently increased significantly. China and India are the two most populous countries in the world. It is estimated that about 250,000 and 100,000 people kill themselves every year in China and India, respectively. They have contributed to about 35% of total suicide deaths globally. Any suicide prevention effort in these countries would

produce significant impact on the reduction of suicide numbers on a global scale. Also, 90% of these suicide deaths in Mainland China occur in rural regions (Yip and Liu, 2007). Similarly, rural regions in India have a much higher rate than urban regions.

Questions to be Answered

The suicide methods used in these eight countries/societies are very different too. Many questions need to be answered which are relevant to suicide prevention. For example, about 60% died from pesticide poisoning in China, so would restricting access to pesticides reduce the suicide rate? How does the rapid rate of urbanization in China relating to suicides? Perhaps because of the ubiquity of high-rise buildings in Singapore and Hong Kong, about 40%–70% of suicide deaths in these cities are from jumping from high places. Can we do anything about this to restrict the means by barring/fencing the high place? How can we curb the number of deaths from poisoning through charcoal burning in Hong Kong, which has been growing rampantly since 1998? Is the number of Internet suicides (people get to know each other via internet and plan to commit suicide together) in Japan getting out of control? How does the increase in suicide in Thailand relate to the spread of the AIDS virus? What happened to the suicide rate in Taiwan, which has increased by 300% since 1993? What are the roles of the economic and political environments towards suicide? Is there a different suicide pattern for different races in the city-state, Singapore? Are there any differences between the suicides in South Korea and Japan? What about hidden work-related suicides in Japan? Do religious beliefs protect people in Thailand against suicide? In response to all these questions, this monograph, which consists of contributions by leading researchers from various disciplines such as psychiatry, psychology, suicidology, statistics, social and public policy, public health, sociology, and social medicine, represents an attempt to share our experiences in their respective societies. It is hoped that insights into these problems based on first-hand experience can fill some of the gaps in knowledge about suicide research in this part of the world. The information would be useful in formulating effective suicide prevention strategies.

Organization of This Book

Here, we address the topic of suicide in various societies in Asia. We provide valuable updated epidemiological data about suicidal behavior in the East and compare it to data from the West. We, the chapter authors, use different

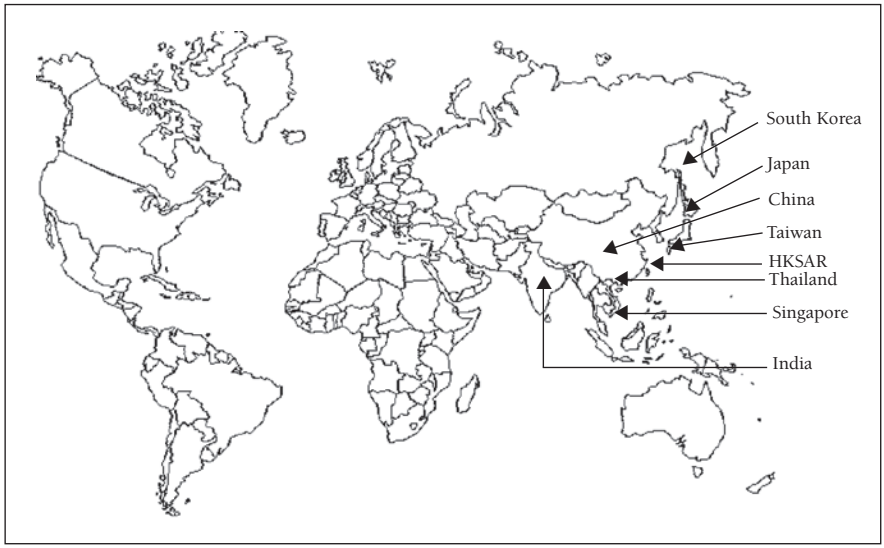

Figure 1 The locality of the right countries/societies in the book.

methodological approaches to the topic, based on our different professional backgrounds and academic disciplines, as well as on the different resources of information available. For each chapter, an overview of suicidality in the respective societies is given. A discussion of how the suicide behavior relates to social and cultural factors is explored, and some suicide prevention programs and/or efforts (if such exist) are reviewed. Eight countries/societies in this region are selected, which contain nearly 40% of the world's population. Each country/society is very different from the others in terms of its socioeconomic stages of development, religious beliefs, population size, gross national product (GNP), literacy rate, and suicide rate, etc., and so together they cover a diverse profile of Asia (Table 1). But they also provide a good representation of the countries/societies in this region.

The order of the chapters, which deal with different countries/societies, can be arranged alphabetically by country/society name. However, though this might be correct from a political perspective, the book as a whole would suffer from discontinuity as the chapters jumped from one society to another. Hence, we propose (as suggested by one of the reviewers), for the purpose of facilitating a meaningful understanding of the book, to arrange the chapter order in terms of the *geographical location* of the countries/societies, namely from north to south and from east to west within the Asian region (the order, therefore, is Japan, South Korea, Mainland China, Hong Kong, Taiwan, Thailand, Singapore, India). It is to be noted that some neighboring societies (which are geographically connected and culturally related in some way) are similar in terms of the suicidal behavior associated with social and cultural factors.

Table 1. A Socioeconomic Profile of the Eight Countries/Societies Chosen for the Monograph.

	China	Hong Kong	India	Japan	Singapore	South Korea	Taiwan	Thailand
Population	1,313,973,713 (July 2006 est.)	6,940,432 (July 2006 est.)	1,095,351,995 (July 2006 est.)	127,463,611 (July 2006 est.)	4,492,150 (July 2006 est.)	48,846,823 (July 2006 est.)	23,036,087	64,631,595
Population density(Pop per km²)	636	6,407	336	339	6,333	480	125	
Median age	*total:* 32.7 years *male:* 32.3 years *female:* 33.2 years	*total:* 40.7 years *male:* 40.4 years *female:* 40.9 years (2006 est.)	*total:* 24.9 years *male:* 24.9 years *female:* 24.9 years (2006 est.)	*total:* 42.9 years *male:* 41.1 years *female:* 44.7 years (2006 est.)	*total:* 37.3 years *male:* 36.9 years *female:* 37.6 years (2006 est.)	*total:* 35.2 years *male:* 34.2 years *female:* 36.3 years (2006 est.)	*total:* 34.6 years *male:* 34.1 years *female:* 35 years (2006 est.)	*total:* 31.9 years *male:* 31.1 years *female:* 32.8 years (2006 est.)
Population growth rate	0.59% (2006 est.)	0.59% (2006 est.)	1.38% (2006 est.)	0.02% (2006 est.)	1.42% (2006 est.)	0.42% (2006 est.)	0.61% (2006 est.)	0.68% (2006 est.)
Birth rate (births/1000 population)	13.25	7.29	22.01	9.37	9.34	10	12.56	13.87
Death rate (deaths/1000 population)	6.97	6.29	8.18	9.16	4.28	5.85	6.48	7.04
Marriage rate (per 1,000 population)	6.1 (2002)	6.0 (2004)	Not available	5.7 (2004)	6.4 (2004)	6.4 (2004)	5.8 (2004)	5.4 (2000)
Infant mortality rate(deaths/1000 live births)	*total:* 23.12 *male:* 20.6 *female:* 25.94	*total:* 2.95 *male:* 3.13 *female:* 2.75 (2006 est.)	*total:* 54.63 *male:* 55.18 *female:* 54.05 (2006 est.)	*total:* 3.24 *male:* 3.5 *female:* 2.97 (2006 est.)	*total:* 2.29 *male:* 2.5 *female:* 2.07 (2006 est.)	*total:* 6.29 *male:* 6.54 *female:* 5.75 (2006 est.)	*total:* 6.16 *male:* 6.97 *female:* 5.55 (2006 est.)	*total:* 19.49 *male:* 20.77 *female:* 18.15 (2006 est.)
Religion	Daoist (Taoist), Buddhist, Christian %–4%, Muslim 1%–2% *ote:* officially atheist (2002 est.)	eclectic mixture of local religions 90%, Christian 10%	Hindu 80.5%, Muslim 13.4%, Christian 2.3%, Sikh 1.9%, other 1.8%, unspecified 0.1% (2001 census)	observe both Shinto and Buddhist 84%, other 16% (including Christian 0.7%)	Buddhist 42.5%, Muslim 14.9%, Taoist 8.5%, Hindu 4%, Catholic 4.8%, other Christian 9.8%, other 0.7%, none 14.8% (2000 census)	no affiliation 46%, Christian 26%, Buddhist 26%, Confucianist 1%, other 1%	mixture of Buddhist, Confucian, and Taoist 93%, Christian 4.5%, other 2.5%	Buddhist 94.6%, Muslim 4.6%, Christian 0.7%, other 0.1% (2000 census)
Unemployment rate	20% (2005 est.)	5.5% (2005 est.)	8.9% (2005 est.)	4.4% (2005 est.)	3.1% (2005 est.)	3.7% (2005 est.)	4.1% (2005 est.)	1.8% (2005 est.)

GDP per capital	$7,204 (2005 est.)	$37,400 (2006 est.)	$3,547 (2006 est.)	$32640 (2006 est.)	$28,368 (2006 est.)	$20,590 (2005 est.)	$27,500 (2005 est.)	$8,600 (2005 est.)
Total fertility rate (children born/woman)	1.73	0.95	2.73	1.4	1.06	1.27	1.57	1.64
Literacy (*definition:* age 15 and over can read and write/has attended school)	*total population:* 90.9% *male:* 95.1% *female:* 86.5%	*total population:* 93.5% *male:* 96.9% *female:* 89.6% (2002)	*total population:* 59.5% *male:* 70.2% *female:* 48.3% (2002)	*total population:* 99% *male:* 99% *female:* 99% (2003 est.)	*total population:* 92.5% *male:* 96.6% *female:* 88.6% (2002)	*total population:* 97.9% *male:* 99.2% *female:* 96.6% (2002)	*total population:* 96.1% *male:* NA% *female:* NA% (2003)	*total population:* 92.6% *male:* 94.9% *female:* 90.5% (2002)
Life expectancy	*total population:* 72.58 years *male:* 70.89 years *female:* 74.46 years	*total population:* 81.59 years *male:* 78.9 years *female:* 84.5 years (2006 est.)	*total population:* 64.71 years *male:* 63.9 years *female:* 65.57 years (2006 est.)	*total population:* 81.25 years *male:* 77.96 years *female:* 84.7 years (2006 est.)	*total population:* 81.71 years *male:* 79.13 years *female:* 84.49 years (2006 est.)	*total population:* 77.04 years *male:* 73.61 years *female:* 80.75 years (2006 est.)	*total population:* 77.43 years *male:* 74.67 years *female:* 80.47 years (2006 est.)	*total population:* 72.25 years *male:* 69.95 years *female:* 74.68 years (2006 est.)
% HIV/AIDS	0.1% (2003)	0.1% (2003 est.)	0.9% (2001 est.)	less than 0.1% (2003 est.)	0.2% (2003 est.)	less than 0.1% (2003 est.)	NA	1.5% (2003 est.)
Medical health facility	Hospitals: 320,000 Doctor: 1.39 billion Physicians: 1,892,000 (1 per 687 persons)	Doctors: 1.52 (number per 1,000 people) Hospitals: 53 Physicians: 10,884 (1 per 625 persons)	Hospitals: 239 Physicians: 555,000 (1 per 1,853 persons)	Hospitals: 33 physicians 260,500 (1 per 489 persons); dentists 91,783 (1 per 1,388 persons); nurses 1,096,967 (1 per 116 persons)	Hospitals: 38 Physicians: 78,592 (1 per 606 persons)	Hospitals: 11 Physicians: 6,292 (1 per 670 persons)	Hospitals: 29 Physicians: 32,390 (1 per 697 persons)	Hospitals: 60 Physicians: 18,531 (1 per 3,395 persons)
Homicide rate/Crime rate (per year per 100,000)	9.23	0.63 (2005)	3.72 (1999)	0.50 (2000)	1.01 (1999)	2.18 (2004)	8.49 (2001)	8.47 (2000)
Leading causes death [suicide] ranking	5th	7th	Not available	10th	6th	4th	9th	Not available
HDI	0.768(2004)	0.927(2004)	0.611(2006)	0.949(2004)	0.916(2004)	0.912(2006)	0.910(2003)	0.784(2004)
Suicide rate (per 100,000) (2003)	18.8	18.6	10.5	27	9.5	24.0	14.1	6.8
Gini coefficient	0.44(2002)	0.525(2006)	0.325(2000)	0.379(2000)	0.481(2000)	0.358(2000)	0.326 (2000)	0.511(2002)

Due to the sources of data and the professional background and interests of the chapter authors, the subjects dealt with in each chapter might differ, and sometimes this might be due to the unique profiles of suicide in different countries. Sometimes, only limited discussion on prevention in the eight societies is provided, which is due to early stages in its development. It is exactly the purpose of this monograph to highlight the issues in different countries/societies, hopefully stimulating the development of evidence-based suicide prevention strategies.

In the concluding chapter, a more detailed suicide prevention effort taken in Hong Kong is described for reference and reflections, and it is hoped that it can generate further discussion that will identify the culturally sensitive and best practice of suicide prevention for this region. We appreciate the sensitivity of the one-China policy. The term of societies, rather than country, is used to describe the suicide situations in the three societies, Taiwan, Hong Kong, and Mainland China. The concern of the suicide situations of the three societies is our ultimate concern.

We appreciate that there are a number of issues (including poverty, war, illiteracy, and natural disasters) that are going to be seen as higher priorities than suicide; however, as mental health has emerged as one of the main causes of death in the world, especially in regions of rapid transition, it is important to address this matter seriously, especially in those societies that have experienced a significant increase in the suicide rate in recent years. We make an impassioned plea for suicide prevention to be ranked as a major health priority in Asia.

Limitations

Only eight countries/societies are selected in the monograph from the 37 countries in the western Pacific region. Also, the problem of ascertaining suicide accurately in Asia provides an interesting contrast between those countries in which there is a coronial system of determining suicide, inherited from colonization and based on the British legal system (as in Hong Kong and Singapore), and those in which the suicide rate is estimated (e.g., China and India). If suicide prevention efforts are to be evaluated, then there has to be some way of ensuring that suicides are properly ascertained and monitored. However, to the best of the editor's knowledge, it is the best data that is available for the monograph's purpose. It is hoped that this monograph will provide the reader with a good understanding of the multifaceted and complex issues involved in suicide prevention in Asia.

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Conclusion and Reflections

Paul S.F. Yip

Suicide has become a worldwide public health concern. The situation is more serious in Asia in terms of the disability-adjusted life years (DALY) (*WHO* 2002). It is estimated that about 2.5% of loss of DALY is due to suicide and deliberate self-harm, and it is highest among different regions. We have selected eight countries/societies in the Asian region for our monograph, which, in total, cover nearly 50% of the world's population and more than 50% of suicides. For example, in China, the most highly populated country, it is estimated that more than 250,000 people commit suicide every year. Evidence suggests that men and women in rural areas are an important target group on which to focus in reducing the number of suicides in China (Yip et al. 2005a, 2008). A reduction in the number of suicides among men and women living in rural areas in China would have a significant worldwide impact. It is important that the cultural factors are better understood in order to formulate an effective suicide prevention program. For example, the pressure imposed on women relating to the one-child policy, a woman's status in China, and educational and employment opportunities are all important factors that could affect mental well-being. In addition, it is important to consider the power that the mass media has and its penetration into the community especially in Asian countries. The coverage of suicide news is always very explicit, graphical and sensational. A classic example is how information about poisoning by charcoal burning and its lethal effect spread throughout Hong Kong, the southern part of Guangzhou, Taiwan, and Japan. The leading cause of suicide in Taipei City in 2006 was charcoal burning; this was unheard of before the first case found in Hong Kong in 1997 (Liu et al., 2007; Yip and Lee, 2007).

It is gratifying that the Chinese government has become more receptive to recognizing the suicide problem. Limiting access to pesticides, especially in rural areas, and improving opportunities for education and quality of life (especially for women living in rural areas) seems to have led to a promising reduction in rates of suicide in China. However, suicide rates within urban regions (e.g., Beijing

and Shanghai) are lower than in city-states, such as Hong Kong and Singapore. Therefore, it is logical to deduce that improved living conditions and improved medical and health care within rural regions can induce a sense of hope among people; this would be conducive for countries with the highest rates of suicide.

India, the second most populated country after China, has also experienced increasing rates of suicide, especially among women and young people. A high suicide rate in females may be related to a high prevalence of women suffering from marriage problems, including conflicts with in-laws. Religion is very much alive and part of Indian culture, and it is advantageous if religion provides spiritual support to the people. We understand that changing a deep-rooted and colorful culture is not an easy task. Apparently, suicide rates would be reduced if the external environment can be changed, that is, eliminating arranged marriages and exam stress especially among the young people. If the suicide rates within these two countries can be reduced, it would have an important impact on the global disease burden of suicide. It is estimated that the suicide rate could be reduced by at least 20% if the number of suicides in China and India were reduced by only 10%, due to the effect of their large populations .

Japan and South Korea share very similar suicide patterns and have had high suicide rates since the Asian financial turmoil in 1997. Recently, both countries have launched a national strategy for suicide prevention. Long working hours and a culture of not seeking help (especially among men) are some of the major barriers to suicide prevention. Furthermore, the two countries are experiencing a rapid transition in the labor market; the life-long job arrangement has changed, and some people have experienced problems adjusting to this change. Enhancing the working environment and identifying those at risk within the workplace could be effective in reducing suicide rates of middle-age men in both countries. It is particularly relevant when work- related suicide in Japan is serious. Furthermore, a recent study (Chan et al. 2007) showed that enhancing mental health through awareness programs, teaching problem-solving skills, and making available vocational training and job opportunities will provide much needed help for the unemployed.

Thailand, a very religious country (Buddhism), has experienced a recent increase in the suicide rate. Although the rate is still low in comparison to that of some other countries, the increasing trend is worrying. Buddhism is a religion that condemns suicide; however, the religion has somehow been misunderstood by some believers who think that they will enjoy a second life after committing suicide. In fact, according to Buddhist teachings, an individual will be worse off than they are presently if they commit suicide. It is a kind of untimely death which would not be rewarded. Additionally, the poverty and the spread of HIV/AIDS within the central regions of Thailand and the high suicide rates among HIV and AIDS patients are also worrying. Economically, economically deprived

areas and high-risk groups should be areas of priority in the suicide prevention strategy in Thailand.

Taiwan has reached a historical high suicide rate that has increased by nearly 300% in the past ten years and shows no sign of slowing down. With a stagnant economy and unstable political conditions, suicide prevention may become even more difficult. There is a fear of job loss due to the poor economic conditions, and some manufacturing industries have been relocated to mainland China. Taiwan has also been seriously affected by the use of charcoal burning, which has become the leading cause of suicide in Taiwan; additionally, jumping to death from tall buildings in urban regions should be monitored carefully. Given such a high suicide rate and its rapid increasing trend, it is imperative that the Taiwan region need to address this issue with a matter of urgency. The method of charcoal burning poisoning death is of priority in restriction its accessibility.

In Singapore and Hong Kong, jumping from a high place is the leading method of suicide. The change of sovereignty in Hong Kong has not been shown to be directly linked to an increase in rates of suicide, although effective governance and an improving economic environment will definitely help make suicide prevention work easier. However, there are some serious problems currently facing Hong Kong. Marriage has been shown to be a protective factor, but fewer people are getting married. Within both countries, the increase in the proportion of people who have never married and divorced have had an adverse effect on suicide prevention effort. It is estimated more than 20% of the population would remain unmarried in the lifetime and the rate of divorce has increased ten times over the past two decades. The increase in divorce and domestic violence, and the disintegration of family support make it more difficult to utilize family resources to reduce the suicide rate in Hong Kong and other Asian cites that are experiencing similar problems.

Common Challenges

There are some common challenges for the countries included in this monograph, namely an incomplete or inaccurate monitoring and surveillance system for suicide death, especially in those countries that do not have a reliable and complete death registration system (e.g., India, China). It makes any evaluation program difficult, if not impossible, if we cannot establish accurate, baseline, suicide information.

Also, an increase in suicide rates among teenagers; relatively high suicide rates among older adults for both men and women; and a high case-fatality rate among suicide attempters due to the lethal methods used in these countries (e.g., pesticides in China and India, jumping in Hong Kong and Singapore, and hanging

in South Korea and Japan) pose real challenges for suicide prevention in Asia. All these methods are easily available and highly effective. Community support and participation in preventing suicides in Asia is not only desirable but essential if there is any chance to succeed. However, some of the programs that have been set up for suicide prevention are not conducted in an organized, integrated, or holistic manner. The commitment and resources from the governments of these countries is still relatively low compared to developed Western countries. Furthermore, resources for health and medical services are inadequate to provide the necessary psychological treatment and services for depressed individuals. Additionally, stigmatization exists towards the mentally ill, and the help-seeking behavior among the needy is poor. At the same time, the estimated loss of labor productivity due to suicide is high; this is partly due to the increasing rate of suicide among the young and middle aged (Yip et al. 2005b, 2008).

A Public Health Approach to Suicide Prevention

The burden of suicide in Asian countries can no longer be ignored. Suicides have a significant impact on economic growth and development. Unfortunately, the majority of suicidal people are reluctant to seek help from health care professionals, probably because of many cultural factors: suicide is still seen as a taboo subject that is not widely discussed in the community; stigma towards treatment; limited availability of treatment; and uncertainty about treatment effectiveness. Suicide has traditionally been viewed as a mental health issue that is addressed primarily through clinical intervention, especially the treatment of depression. However, it has been suggested that the role of mental illness within suicide is not as significant as it is in the West (Phillips et al. 2002; Yip et al. 2005a, b). Also, it is known that approximately two-thirds of all people who commit suicide did not receive any specialist psychiatric care in the year before their death (CSRP 2005). The World Health Organization (WHO) and many national suicide prevention strategies (for example, those in the USA, Australia, Ireland, New Zealand, and the UK) have proposed a public health approach aimed at dealing with suicide prevention, rather than treating it as a medical problem only.

The public health approach involves three layers of intervention: universal, selective, and *indicative* (Table 1). This public health approach acknowledges the importance of both high-risk and population-based strategies of suicide prevention, and requires a multi-sector effort to tackle the problem at multiple levels: in the community (*universal* strategies), among specific population subgroups (*selective* strategies), and among those at a particularly high risk of suicidal behavior (*indicative* strategies).

Table 1. Universal, Selective, and Indicative Preventive Interventions.

Strategy	Definition	Examples
Universal	For everyone in a population	Public education programs about the dangers of substance abuse
Selective	For target subgroups at particular risk of suicide	Programs for the children of parents with manic depressive illness or victims of physical sexual abuse, unemployed
Indicative	For specific individuals who, at examination, have a risk factor or condition that puts them at a very high risk	Programs for people who already have had suicidal ideation or have made previous attempts

The public health approach is particularly apt for suicide prevention in Asian countries. Flooding is a common problem in Asia, and it can be used as a useful metaphor for suicide prevention. When a flood occurs, rescue teams work hard to save those affected, focusing attention mainly on the victims who are swept downstream. Indeed, this is very important, otherwise lives will be lost. However, in the long term, it is important that the causes of the flood (e.g., upstream conditions such as deforestation, over-cultivation, pollution, etc.) are ascertained in order to prevent further flooding. What lies "upstream" of the increasing number of suicides is often a malfunctioning and disconnected society. A disconnected community, the breakdown of the traditional family support system, and a stressful and uncaring community culture, unhealthy working practices are important correlates of suicidality in the respective communities.

By virtue of its systematic approach to prevent illness, disability, and premature death, the public health strategy provides a strong framework for creating an effective and concerted effort to prevent suicide. In other words, public health interventions not only tackle the "downstream" problems, but also aim to improve the "upstream" conditions. The Rose Theorem states that a large number of people exposed to a low risk may generate more cases than a small number of people who are exposed to a high risk (Rose 1992). The proverb "an ounce of prevention is better than an ounce of cure" echoes the idea behind this insight. Figure 1 further illustrates this philosophy: by reducing the suicidal risk of the population at large (shifting the distribution of the suicidal risk of the whole population to the left), fewer people will have a very high risk of suicide (reduction in the area under the "danger zone"). Hence, a partnership among mental health professionals and different sectors of the community should target the larger populations before any "symptoms" appear, and the risk of suicide becomes imminent.

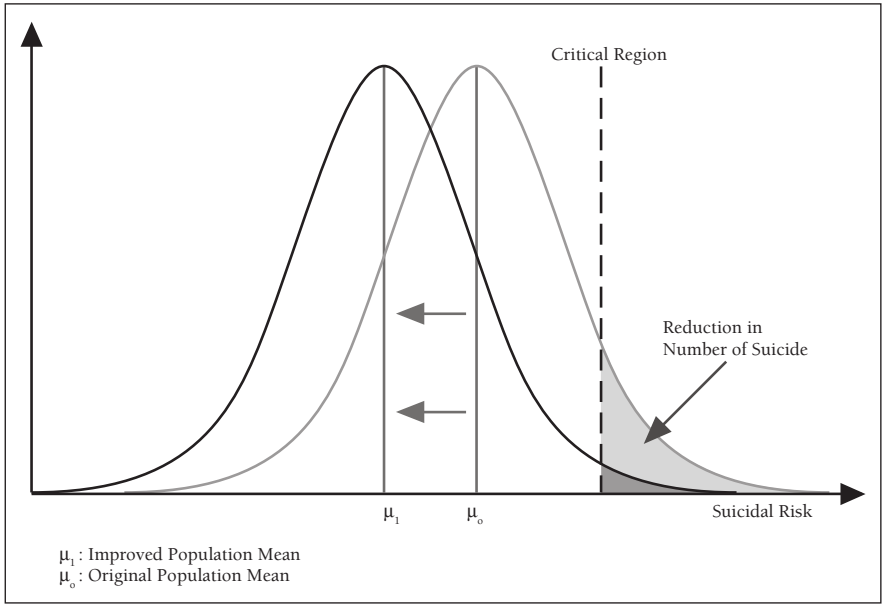

Figure 1 A schematic representation of the Rose Theorem (Rose 1992) and Yip (2005)

On the basis of rigorous calculations, Lewis et al. (1997) have shown that high-risk (indicative) strategies would only have a modest effect on suicide rates within a population, even if effective interventions were developed, and the UK government's target for suicide reduction was more likely to be achieved using population-based strategies that aimed at actively reducing risk among the whole population. Furthermore, research has shown that suicide can be the tragic endpoint of the interplay of a wide range of factors, including biological, genetic, social, cultural, psychological, and behavioral factors. For these reasons, it is imperative that multiple avenues and the three approaches of intervention should be considered together for suicide prevention and intervention. As the eminent psychiatrist Keith Hawton (Centre for Suicide Research, University of Oxford, UK) put it: "Suicide rates are unlikely to decline as long as we confine our prevention efforts only to those who are at immediate risk of attempting suicide." (Yip 2005)

The Hong Kong Experience: Some Initiatives and Reflections

Hong Kong has demonstrated some unique examples of suicide prevention that would be of interest and relevance to other countries. We strongly believe that one size does not fit all. The differences in the strategies being adopted in different

countries are related to the different stages of economic development that countries have reached. The importance of the availability of resources for suicide prevention cannot be understated. There is always cost involved for any suicide prevention effort, but the potential benefit for preventing suicide will outweigh its cost. There are some important ingredients from suicide prevention strategies in Hong Kong that can be applied to other countries. One example is government commitment: it is important to have support from the government to do any suicide prevention work in the community. Raising awareness of the importance of mental health can be more cost-effective if the government is willing to come on board and provide help. Support from the government cannot be taken for granted. In some situations, mental health and suicide prevention is not high on their list of priorities and will not be given the requested support. However, schools and other government departments and agencies can be effective mediums through which to communicate the message across the community. The Hong Kong Jockey Club Centre for Suicide Research and Prevention (CSRP) at The University of Hong Kong was established in 2002 and is supported by the Chief Executive Community Fund that provides resources for projects which can provide direct benefit to the community. The centre was set up during a time of increased suicide rates in the community, and the government was under pressure to do something. An international advisory committee that consisted of esteemed suicide research scholars was set up and is chaired by the Secretary of Justice (Ms Elsie Leung, a senior government official) at the time.

We have also managed to build channels to communicate our opinion that mass media reporting on suicide is an issue of great importance. The rapid spread of suicide by poisoning through charcoal burning is very much related to the sensational and overwhelmingly detailed description of the method to the community (Liu et al. 2006; Chan et al. 2005; Yip et al. 2006).

The nongovernmental organizations (NGOs) that are working on suicide prevention in Hong Kong have formed an alliance so that each stakeholder can be better informed about the latest knowledge and developments. Despite some differences in expectations and logistics among suicide prevention agencies, communication in the community has been improved and expanded. The CSRP has also actively participated in providing training to frontline individuals, such as teachers, social workers, and insurance agents. The CSRP's website on depression, entitled "Little Prince is Depressed" (www.depression.edu.hk), has won the Silver Innovation award (*Asian Wall Street Journal*) and the Hong Kong-based best ten meritorious awards for its innovation and creativity in reaching out to the public and destigmatizing depression. This effort can be seen as part of the universal intervention program for the community.

A community project for suicide prevention has been launched by the Hong Kong Police Force in one of the districts on Hong Kong Island. The stakeholders

in the community, including many Government departments, for example, housing department, social work department, schools, district office, police, and hospitals, are part of the community task force. One of the objectives is to raise awareness of the problem of suicide in the community, thereby improving the connectedness among stakeholders who seek to further improve the care provided for suicide-attempt survivors. The project is inspired by a successful community-based suicide prevention effort on Cheung Chau Island, which is a popular getaway destination in Hong Kong. After a local visitor committed suicide by burning charcoal in a holiday flat in 1998, the island became a notoriously popular place to commit suicide. To tackle the problem, local representatives of the island initiated a joint effort to prevent further suicides; this involved a partnership among community members, the police, and mental health care professionals. In the two years since the program was implemented, suicide rates have decreased substantially. This example illustrates the effectiveness of a timely in-person crisis intervention and community-based gate keeping in preventing suicide, and has strengthened the belief that suicide is preventable. Prevention needs the involvement of the whole community, including volunteers. Implementing a neighborhood watch scheme and strengthening the community network seem to be promising measures that can prevent suicide at the community level (Wong et al. 2008; Knox et al. 2003).

Other community-based suicide prevention efforts have been implemented in the last few years: the CARElink service in the police department and Greenpasture in the public hospital system, which are tailored to provide counseling and support services to the police force, and medical and health workers, respectively.

Regarding selective intervention, there is a special program for pathological gamblers and mental illness. Additional efforts and resources from the government have been channeled to those districts where higher suicide rates are found. Consideration is also being given to youth mentoring programs for young people with suicidal risk in the community (e.g. Peter Lee's Youth Mentoring Program). Training is also provided for medical doctors and allied health care workers in order to raise their awareness and enhance their competence to deal with suicidal patients.

Regarding indicative strategies, which are especially helpful for those who have deliberately self-harmed, efforts have been made in accident and emergency (A&E) departments to enhance the treatment protocol and discharge plan because a significant proportion of suicide reattempts are admitted to A&E departments. It has been shown that making use of existing community resources to enhance drug compliance, family acceptance, and employment opportunities is crucial for reducing suicidality among people with mental illness (Yim et al. 2004). The police have implemented training programs so that frontline staff are better able to deal with deliberate self-harm and domestic violence calls.

Our psychological autopsy study (Chen et al. 2006) and prevalence study (Liu et al. 2006) suggest that the important risk factors are psychiatric problems; unemployment; unmanageable debts; poor social problem-solving skills; and being separated, divorced, widowed, or never married. Depression is an important risk factor for suicidal behavior. However, having good coping skills, a strong family, and a strong social support system, and being socially connected and responsible to one's family make people more resilient to adverse life situations. These findings suggest that if suicide prevention efforts only make use of medical and health care professionals, the effect on suicide reduction would be limited. Suicide prevention efforts need to tackle multiple causes of suicide and suicidal behavior by addressing all possible avenues. Such efforts may include enhancing mental health education, empowering families to function better, improving the community network, and, more specifically, restricting access to the means of committing suicide.

The need for an effective suicide prevention program in Hong Kong is clear. However, one of the most challenging concerns in offering a suicide prevention program is the lack of objective evidence on the effectiveness of such a program. Policymakers and stakeholders often do not have adequate information on what makes an effective prevention program. Evaluation is very important, and it is essential for directing the use of scarce resources as well as for constantly improving services. Therefore, there is an urgent need to develop local skills through rigorous evaluation. It is also important to make evaluation a necessary, rather than auxiliary or optional, component of local prevention efforts. A measure of the effectiveness of suicide prevention efforts is the reduction in the level of suicidal behavior in the community.

We are appealing to the governments in this region to develop a universal approach that prioritizes suicide as one of the leading problems in the community which need to be addressed. This includes providing funding and logistical support for suicide research and prevention. Additionally, the mass media plays an influential part in suicide prevention. It is a two-edged sword that, if not managed correctly, will make vulnerable people follow suit by romanticizing suicide as a way to resolve problems. International efforts are being made by the WHO and other organizations that are trying to work in partnership with the media to get them to participate in suicide prevention work.

People are sometimes skeptical of the effectiveness of restricting access to the means of committing suicide; however, research does suggest that this is an evidence-based suicide prevention effort (Liu et al. 2007). By restricting such access, we are buying time, which allows more opportunities for intervention.

Regarding the selective approach, there are certain groups who are at high risk of suicide: women living in rural China, the unemployed, those who suffer from mental illness, and those experiencing family violence and divorce. It might be worthwhile to consider certain programs, and some tailor-made programs

might be more effective in helping those in high-risk groups. For a selective program to work, it might be necessary to procure additional resources to do the work properly; however, it is important to be able to make use of community resources. For example, with community support, this relatively high-risk group (e.g., ex-mental health patients) can be reintegrated into the community more successfully which has been shown to be significant in reducing the suicide risk among the ex-mental health patients. (Yim et al. 2004)

Regarding indicative intervention, which is especially helpful for those who have made previous suicide attempts, it is important that the management of existing health care systems be improved for these groups. Suicide risk among recently discharged mental health patients is particularly high, and the treatment protocol for those who have deliberately self-harmed and have been admitted to hospital needs to be carefully monitored. Research also shows that for people who have made a previous suicide attempt, their suicidal risk increases by 60%–300%; therefore, we need to try and understand their needs better so that more effective services can be provided to them.

National Suicide Prevention Strategy: Are We Ready?

National Suicide Prevention Strategy has been launched by many different countries: the USA, England, Scotland, Australia, New Zealand, Finland, and Norway. They have developed comprehensive national suicide prevention strategies that incorporate a public health approach. National strategies for suicide prevention in these countries share a number of common elements, including the use of educational settings as sites of intervention; attempts to change the portrayal of suicidal behavior and mental illness in the media; efforts to increase and improve the detection and treatment of depression and other mental illness; an emphasis on reducing the stigma associated with help-seeking behaviors; strategies designed to improve access to services; promotion of effective preventive efforts with rigorous evaluation; and efforts to reduce access to the means of suicide. In learning from other countries, Hong Kong should place great value on implementing a similar public health approach; however, the Hong Kong government has yet to endorse a national strategy campaign.

Indeed, suicide is everyone's business. Not all suicides are preventable, but we certainly can make a difference. The suicide problem in Asia is huge. The cost is high. Every year, more than 500,000 people die from suicide in this part of the world. Increased research and prevention in this region will not only reduce the suicide rate in Asia, but the information and evidence will be of benefit to the West as well. Despite limited resources, we can make a contribution. Suicide is not only a problem in Asia and the stakes are high, so let us spare no effort in combating the rise of this tragedy.

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