GUIDELINES FOR

SUICIDE PREVENTION PROGRAMMES FOR YOUTHS

PREFACE

These Guidelines for Suicide Prevention Programmes offer guidance, direction and structure for initiatives aimed at safeguarding our youth. By adopting a comprehensive and systemic approach to suicide prevention, incorporating evidence-based strategies across various intervention levels, we can significantly enhance our abilities to protect young lives.

We urge organisations and stakeholders to take action: Integrate these guidelines into your existing programmes, and carefully assess whether your efforts address the diverse needs of different intervention levels. Together, we can make a substantial impact on preventing youth suicide and ensuring a safer, brighter future for our young population.

SECTION 1:

INTRODUCTION

- Suicide is the leading cause of death for youth aged 10 to 29 years old[1] in Singapore.
- In 2021, there were 378 suicides, of which 112 were residents aged 10-29 years old.[2]
- The number of suicides for those aged in their 20s is one of the highest as compared to other age groups.[3]
- Suicide is multi-faceted and results from a complex interplay of biological, psychological, social and cultural risk factors, in combination with a lack of protective factors. However, it is preventable with timely and evidence-based intervention.[4]
- Thus, a multi-pronged approach to suicide prevention and intervention is necessary.[5]
- This is achieved through partnering different ministries, organisations and agencies, so as to involve all levels of intervention (universal prevention, selective prevention and indicated prevention), after taking into account the risk, protective and threshold factors of suicide.[6]

1 "Suicide Facts and Figures," Samaritans of Singapore (SOS), accessed March 21, 2022, https://www.sos.org.sg/learn-about-suicide/quick-facts.

2 Immigration & Checkpoints Authority Singapore, "Report on Registration of Births and Deaths 2021," accessed May 12, 2023, https://www.ica.gov.sg/docs/default-source/ica/stats/annual-bd-statistics/stats_2021_annual_rbd_report.pdf.

3 Yan Han Goh, "Youth Suicides Still a Concern, with 94 Cases Last Year and in 2018," The Straits Times, March 21, 2022, https://www.straitstimes.com/singapore/number-of-suicides-in-2019-did-not-decline-compared-with-2018-youth-suicides-still-a.

4 Eva Dumon and Gwendolyn Portzky, General Guidelines on Suicide Prevention (EUREGENAS Project), 2014.

5 "Suicide Prevention | Quality Standards," National Institute of Health and Care Excellence (NICE) (NICE), March 21, 2022, https://www.nice.org.uk/guidance/qs189.

6 Dumon and Portzky, General Guidelines on Suicide Prevention (EUREGENAS Project); "Suicide," World Health Organisation (WHO), accessed August 18, 2021, https://www.who.int/news-room/fact-sheets/detail/suicide; "Public Health Action for Prevention of Suicide | A Framework," World Health Organisation (WHO), accessed March 21, 2022, https://apps.who.int/iris/bitstream/handle/10665/75166/9789241503570_eng.pdf.

SECTION 2:
UNDERSTANDING SUICIDE

Risk factors, protective factors and threshold factors[7]

7 "Public Health Action for Prevention of Suicide | A Framework"; Dumon and Portzky, General Guidelines on Suicide Prevention (EUREGENAS Project).

Risk factors increase the likelihood that an individual will consider, attempt, or die by suicide.

- Previous suicidal attempts
- Mental health conditions/illnesses (e.g. mood disorder, substance use disorder)
- Major physical or chronic illness that disrupts daily activity (e.g. medical conditions causing chronic pain)
- Early negative life experiences such as adverse childhood experiences (e.g. losing a parent at an early age, experience of trauma or abuse, exposure to bullying)
- Personal characteristics (e.g. hopelessness, aggressive tendencies, impulsiveness)
- Financial, relationship, legal or criminal problems

Protective factors decrease the likelihood that an individual will consider, attempt, or die by suicide.

- Positive self-image
- Adequate problem-solving and conflict resolution skills
- Help-seeking behaviour
- Strong connections to family
- Community and social support
- Reasons for living (e.g. personal convictions about life and death, core values, aspirations or responsibilities)

Threshold factors (moderating factors) may increase or decrease the risk of suicidal behaviour.

What increases the risk of suicidal behaviour:

- Exposure to suicidal behaviours
- Family history of suicide
- Access to lethal means of suicide
- Stigma associated with help-seeking behaviour
- Media coverage of suicidal behaviours including suicides involving celebrities, may lead to an increase in suicidal behaviours[8]

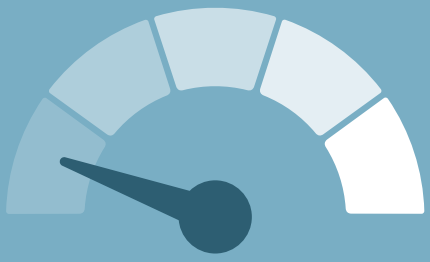
What decreases the risk of suicidal behaviour:

- Personal, social, cultural, religious beliefs that discourage suicide
- Knowledge and attitudes about the healthcare system and sources of help in the community
- Access to health care, especially mental health care support
- Quality of connection to existing support system
- Participation in suicide prevention programmes

8 BMJ, "Media Reports of Celebrity Suicide Linked to Increased Suicide Rates," accessed March 21, 2022, https://www.bmj.com/company/newsroom/media-reports-of-celebrity-suicide-linked-to-increased-suicide-rates/.

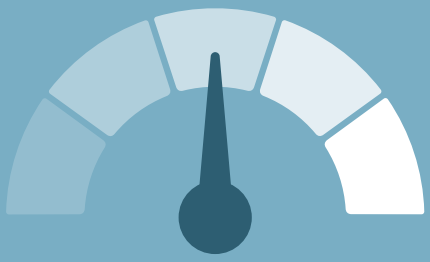
Risk level of suicide

There is no exact objective measure of suicidal risk, but in general, risk can be classified as low, moderate or high.



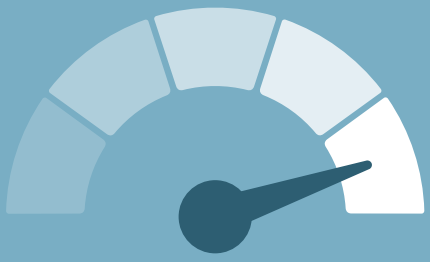
Low risk

Individuals who display some warning signs of suicide or express passive thoughts of killing themselves, but have no intention or plan to act on these thoughts. They also have more supportive resources.



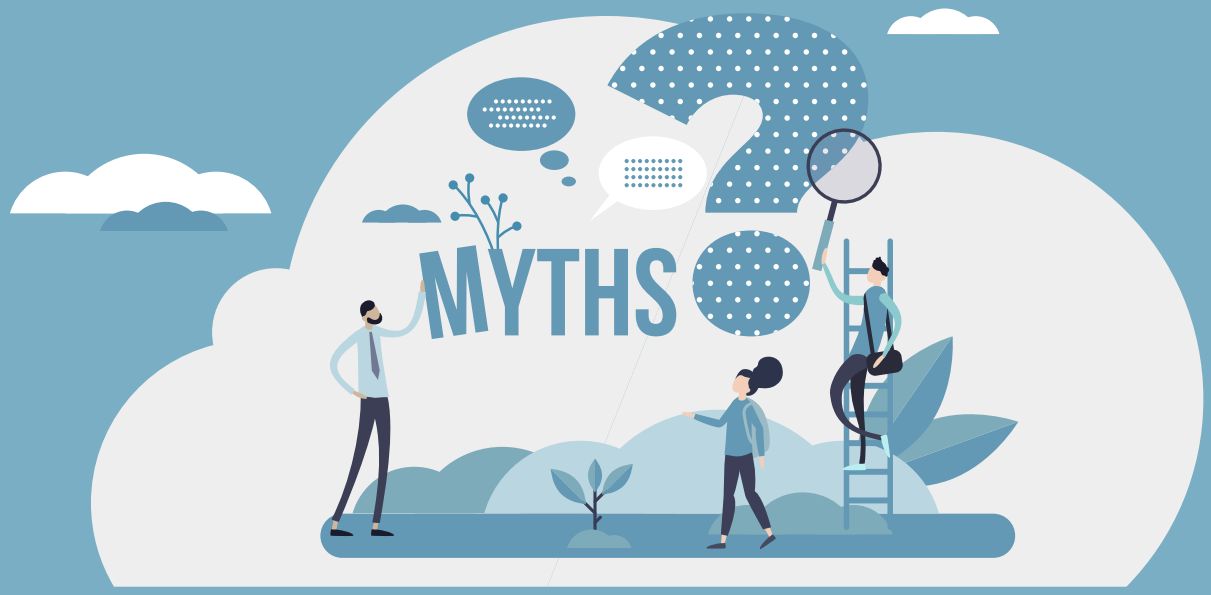
Moderate risk

Individuals expressing suicidal ideation or behaviour with intention or desire to die.



High risk

Individuals who have voiced the intention to engage in a suicidal act, with a concrete plan, and have access to the lethal means needed to carry out the act.



Addressing myths of suicide[9]

MYTH 1

Suicide cannot be prevented

Most people who have suicidal ideations can be ambivalent about death. They often fluctuate between wanting to live and wanting to die.

MYTH 2

There are no warning signs to suicide[10]

Those contemplating suicide would often have communicated their intention. These signs may not always be direct or explicit as individuals fear being judged by those around them. The fact that you may not spot these warning signs doesn't mean they don't exist. It is therefore crucial to know some of the common warning signs and risk factors.

9 Dumon and Portzky, General Guidelines on Suicide Prevention (EUREGENAS Project); "10 Myths and Facts About Suicide," Samaritans of Singapore (SOS), accessed August 18, 2021, https://www.sos.org.sg/blog/10-myths-and-facts-about-suicide.

10 "Suicide Warning Signs: Here's Where to Start," Samaritans of Singapore (SOS), accessed March 21, 2022, https://www.sos.org.sg/blog/suicide-warning-sign-here-where-to-start.

MYTH 3

Suicide is caused by depression

It is often assumed that depression is the cause of all suicides, but suicide is often due to the interaction of a myriad of factors and life circumstances. Depression may be one of the many stressors an individual is struggling with, but someone who is not depressed can still be suicidal.

MYTH 4

Suicidal people are moody and sad

Suicide does not have a definitive appearance. Sometimes, a person who has decided to on plans to suicide can become uncharacteristically relieved and calm. It is important to take note of unusual emotional and behavioural changes in those around us.

MYTH 5

Talking about suicide encourages suicidal behaviour

Talking or asking about suicidal thoughts and plans does not increase suicidal intent or hopelessness. On the contrary, it may be a relief for suicidal individuals to communicate and verbalise their struggle. Talking about suicide can potentially save a life by encouraging help seeking.

MYTH 6

Suicide is an impulsive act

Some suicides could be due to an act of impulse, but there are also suicidal individuals who have contemplated and deliberated on their suicidal plans over some time.

MYTH 7

Suicidal people want to die

Suicidal individuals often contemplated suicide because they could be in a situation of helplessness and despair. They are unable to see any hopes or future while in that situation, and suicide seems like the best solution out of their pain and suffering, rather than wanting to die per se.

MYTH 8

People who talk about suicide will not do it

The majority of suicide attempters and people who died from suicide had communicated to someone that they want to die, or that life is not worth living.
It's possible that someone might share about suicidal ideations as a call for help. It is important to take any expression of suicidal thoughts seriously and encourage the person to seek help.

MYTH 9

Suicide is a normal reaction to an abnormal situation

Suicide is not a normal reaction to extreme stressors in life. Suicide is an extreme and maladaptive reaction to stressful situations or negative life events, which may occur in people's lifetime. These stressors can possibly be dealt with in more adaptive ways, such as problem solving or changing the perception of events.

SECTION 3:
INTERVENTION[11]

11 Dumon and Portzky, General Guidelines on Suicide Prevention (EUREGENAS Project).

Recognising different intervention levels

Suicide prevention strategies can be categorised into three levels of intervention, namely: universal prevention, selective prevention and indicated prevention.

An effective suicide prevention programme needs to take a multi-pronged and multi-sectorial approach, targeting strategies at all three intervention levels.

Universal Prevention

- Targets the general population.
- Examples are mental health promotion and education, raising awareness, fighting stigma and developing support networks.

Selective Prevention

- Targets the vulnerable populations in the "moderate risk" level of suicide. Examples of vulnerable populations include suicide loss survivors, individuals who had experienced trauma, adverse childhood events or adverse life experiences.
- Examples are conducting gatekeeper training, providing helplines and online help, as well as programmes for vulnerable groups.

Indicated Prevention

- Targets suicidal individuals and high risk population.
- Examples are intervention for suicidal individuals and mental health treatment.

	Intervention Levels		
Strategies	**Universal Prevention**	**Selective Prevention**	**Indicated Prevention**
Mental Health Promotion and Building Mental Resilience	●	●	
Early Identification and Encourage Help Seeking	●	●	
Programmes for Vulnerable Groups		●	
Programmes for Highest Risk Groups			●
Crisis Support			●
Helplines and Online Support		●	●
Apps and Chatbots		●	●

SECTION 3.1:
MENTAL HEALTH PROMOTION AND BUILDING MENTAL RESILIENCE (UNIVERSAL PREVENTION)[12]

12 Dumon and Portzky; "Public Health Action for Prevention of Suicide | A Framework."

Enhancing protective factors at individual level

Aims to develop personal skills, self-esteem, coping strategies, problem solving skills. To increase capacity to cope with stressors in life, emotional resilience and reducing vulnerability to mental health problems.

- **Schools' efforts to strengthen students' mental health**

  These include helping students learn about healthy mindsets, habits and skills to strengthen their mental health and be resilient in the face of challenges.

  This is achieved through teaching of such competencies in the Mental Health Education under MOE's refreshed Character and Citizenship Education (CCE) curriculum, which are further practised and internalised through school experiences such as co-curricular activities (CCAs) and camps in schools.

- **Online self-help tools**

  These are a form of e-mental health, making use of information and computer technology to promote positive mental health and provide resources to individuals with possible mental health difficulties.

  Some examples include informative websites such as MindSG (MindSG.gov.sg) or other websites listed on page 33 which provides brief mental health assessments and suggest suitable resources, chat websites, mobile apps and chatbots.

Enhancing protective factors at community levels

Aims to increase social inclusion and cohesion through the following approaches:

Raising mental health awareness and literacy

- Run public and media campaigns (e.g. HPB's It's OKAY to Reach Out campaign and NCSS' Beyond the Label campaign) to spread awareness about mental health and suicide.
- Equip the public with knowledge and skills to improve mental well-being, spot warning signs of mental illness and suicide and access the right care and support when needed.
- Adopt a scientific approach supported by literature to guide the processes of such campaigns.
- Share messages about how suicide can be prevented, portray options and solutions, and provide helpful resources.
- Do not make broad assumptions about the causes of suicide based on a single or limited set of risk factors, as suicidal behaviour is complex and multifaceted.

Reducing stigma

- Stigma remains a major barrier to suicide prevention efforts.
- De-stigmatisation of mental illness and suicide is of paramount importance.
- Mental illness and suicide should not be a taboo or unapproachable topic.
- Increasing mental health literacy in the wider community would reduce discrimination, shame and burden of help-seeking.

Improving media reports and portrayal of suicide[13]

- Studies have shown that media reports on suicide have an impact on suicidal behaviours.
- For example, reports on suicide method or suicide of celebrity, can lead to imitative suicidal behaviours.
- Samaritans of Singapore (SOS) has developed guidelines for media reporting on suicide, to raise awareness on journalists' role in the prevention of suicide, as well as to improve the quality of media reporting on suicidal behaviour.

Providing mental health support and services in the community

- Beyond mental health services and support in the schools and medical setting, it would be beneficial to provide similar support and services in the community for those who may need support beyond these institutional settings.

13 "Media Guidelines: Reporting and Portrayal of Suicide," Samaritans of Singapore (SOS), accessed March 21, 2022, https://www.sos.org.sg/media/media-guidelines.

- Agency for Integrated Care (AIC), together with the Ministry of Health (MOH), have been working with social service agencies to provide community mental health programmes for youth, namely Youth Community Outreach Team (CREST-Youth) and Youth Community Intervention Team (YIT). Visit here for the full listing of services.

- CREST-Youth increases awareness of mental health and promotes early identification by organising outreach events for the youth population, as well as those in their circles of support. The team involves parents and peers in the recovery journeys through youth-for-youth initiatives. The team is also the community node linking youths and their families to appropriate health and social support networks.

- YIT increases awareness of mental wellness through targeted outreach to youth at risk of mental health issues. It provides assessment, therapeutic intervention and case management while engaging youth for ongoing monitoring and support. The team facilitates the formation of supportive relationship with family and peers, and works actively with other youth agencies, schools and community partners to provide holistic case management for the youths and their families.

Developing support networks in schools and community[14]

- All schools have a peer support structures in place where students look out for each others' well-being, encourage early help-seeking and alert a trusted adult if their peer is in danger of hurting themselves or others. Teachers are also trained to identify signs of distress and are being provided with enhanced professional development in mental health literacy to recognise early signs of mental health issues. Teachers also provide timely support and make referrals to School Counsellors for further assessment and interventions when necessary.

14 "Social and Emotional Learning," Ministry of Education (MOE), accessed March 21, 2022, http://www.moe.gov.sg/programmes/social-and-emotional-learning; "Our Services," Samaritans of Singapore (SOS), accessed March 21, 2022, https://www.sos.org.sg/about/our-services; "PleaseStay Movement | Youth Suicide Prevention Singapore," PleaseStay Movement, accessed March 21, 2022, https://www.pleasestaymovement.com; "REACH," Institute of Mental Health (IMH), accessed March 21, 2022, https://www.chat.mentalhealth.sg/.

- HPB provides additional mental well-being programmes to schools on topics such as stress coping, managing emotions, change and transitions. HPB also provides resources to Educators to keep them informed on mental health topics and ways to better support students.

- Increase public access to information on mental health and prevention of suicide (please refer to Recommended Helplines/Resources below).

- SOS support network: This includes services such as 24-hour hotline, email, text messaging, crisis support, specialist counselling and support group. Shared workflow and tightened handshakes have been established amongst SOS, Ministries, Institutions and fellow Social Service Agencies (SSAs) to facilitate cross-referrals.

- PleaseStay movement: an advocacy group calling for unity and support to prevent suicide among young people.

- CHAT from IMH is a community team located in Orchard. It is dedicated to promote awareness of mental illness, access to mental health resources and provide confidential mental health check for youths aged between 16 and 30 years old.

- Response, Early intervention and Assessment in Community mental Health (REACH) is a community-based mental healthcare service for students with emotional, social or behavioural issues. REACH's multidisciplinary members work closely with schools to provide assessments and interventions for students in need.

SECTION 3.2:
EARLY IDENTIFICATION AND ENCOURAGING HELP SEEKING (SELECTIVE PREVENTION)[15]

15 Dumon and Portzky, General Guidelines on Suicide Prevention (EUREGENAS Project); Pam Oliver, “Evaluation of the Suicide Prevention Gatekeeper Training Programmes,” 2015.

Gatekeeper training[16]

- Gatekeepers are individuals who have frequent contact with others in their communities.

- Examples are primary healthcare professionals such as general practitioners (GPs), emergency healthcare providers, counsellors, teachers, youth workers, religious leaders, community leaders and peer supporters.

  - Training gatekeepers on suicide prevention can help to improve their skills, knowledge, attitudes and confidence in dealing with suicidal individuals in the community.

  - Gatekeepers are trained to recognise warning signs of mental distress and symptoms of depression, understand risk factors for suicide, ask appropriate questions to check for suicide risk, and refer to appropriate services and resources.

There are established gatekeeper training programmes, such as Applied Suicide Intervention Skills Training (ASSIST) workshop and Question, Persuade, Refer (QPR) Online training, to equip gatekeepers with skills on suicide first aid. SOS also conducts skills-based Gatekeepers Intervention Skills Workshops (GISW).

16 Oliver, "Evaluation of the Suicide Prevention Gatekeeper Training Programmes."

Vulnerable Groups (Selective Prevention)[17]

- Be aware of vulnerable groups who are at a higher risk of developing suicidal ideations, and they may require tailored intervention.

- Examples are suicide loss survivors, individuals who have experienced trauma, adverse childhood events or adverse life experiences.

- This is not an exhaustive list of vulnerable groups, and the purpose of highlighting this is not to stereotype them, but to bring out awareness of their potentially higher risk.

- Suicide loss survivors

  - Individuals who suffered loss of loved ones by suicide are at a higher risk of developing physical and mental illness, as well as suicidal behaviour.

  - It is important to set up networks and support services for the bereaved.

- Immigrants

  - It is important to have diversity consideration for the immigrant groups.

  - Information and support should be available to people who do not speak or read English and sensitive to cultural differences.

17 Dumon and Portzky, General Guidelines on Suicide Prevention (EUREGENAS Project).

- Individuals who have experienced trauma, adverse childhood events or adverse life experiences.
    - Prior experiences of trauma and adverse childhood events are associated with a heightened risk of suicide.
    - Trauma can negatively impact individuals' ability to cope and manage stress.
    - Trauma-informed care takes into account the history of adverse experiences and focuses on the strengths and challenges that have resulted from the trauma.

SECTION 3.3:
HIGH RISK GROUPS (INDICATED PREVENTION)[18]

18 Dumon and Portzky, General Guidelines on Suicide Prevention (EUREGENAS Project).

The high risk groups for suicide include suicide attempters and individuals with mental health conditions, and there should be targeted interventions to help them

Suicide attempters

- A history of suicide attempts is a strong predictor of future suicidal behaviours.
- Suicide attempts are much more common than suicides, with a ratio of 1 suicide to every 25 suicidal attempts.[19]
- Effective postvention support is very important to mitigate risk.
- These can include regular follow-up calls and contact to closely monitor their moods and behaviours.

Individuals with mental health conditions or illnesses

- About 90% of individuals who die by suicide meet the criteria for a mental health condition, but up to 80% of these cases can be untreated.
- People with mental health conditions, such as major depression, alcohol and substance use disorders, schizophrenia, bipolar disorders, eating disorders and anxiety disorders show an increased risk for suicide.

19 World Health Organization. Global Health Estimates 2016: Disease burden by Cause, Age, Sex, by Country and by Region, 2000–2016. (2018).

- For youths, psychotherapy such as CBT (Cognitive Behavioural Therapy) can be effective in treating many mental health conditions.

- In more severe cases, prescription of psychopharmaceutical medication can be helpful.

- Caution needs to be taken on the use of antidepressants with youth, and it should be only be prescribed by a psychiatrist or psychiatric trained medical practitioner.

Restriction to lethal methods

- Restricting access to lethal methods is one of the most effective ways in reducing suicide rates.

  - Restricting access to jump sites (e.g. locking of window grills)

  - Restricting access to medications and drugs

  - Restricting access to poisons and chemicals (e.g. pesticides, bleach)

  - Restricting access to sharp weapons (e.g. knives)

Targeted Interventions

- Individuals who possess high risk of suicide, with severe symptoms of mental health conditions, require specialist services in a tertiary care setting, for example at the Institute of Mental Health (IMH), where a comprehensive suicide risk assessment as well as assessment of their mental health conditions are conducted.

- Some of these individuals might require inpatient care to keep them safe from their acute conditions.

- When their conditions improve and they can be discharged, a clear safety plan, which is a written list delineating warning signs, coping strategies, sources of support, emergency contacts, is created with these individuals.

- Family members or caregivers are also briefed on the safety plan, taught to keep the environment safe and given instructions on what to do in times where is high risk of suicide.

- These individuals will continue to be closely and regularly followed up in outpatient services and receive interventions such as psychotherapy and psychopharmaceutical medication for their mental health conditions.

Improving Suicide Prevention Programmes

- Working with individuals with lived experience of suicide on programmes/guidelines.

- Monitoring and evaluation of programmes through feedback and pre-post results.

- Research will help to improve the field of suicide prevention

  - Epidemiology of suicides and suicide attempts

  - Risk and protective factors of suicidal behaviours

  - The neurobiology of suicidal behaviour

  - Effectiveness of prevention strategies and actions

SECTION 4:

RECOMMENDED HELPLINES/RESOURCES TO INCLUDE IN SUICIDE PREVENTION PROGRAMMES:

Crisis Support (24hr)

- IMH Mental Health Helpline 6389 2222
- SOS 1-767(Helpline)
  9151 1767 (Care Text)

Other Helplines

- Tinkle Friend Helpline 1800-274 4788
- TOUCH Youth Intervention 1800-377-2252
- Silver Ribbon 6386 1928
- SAMH 1800-283-7019

Online Platforms and Resources

- Institute of Mental Health
  www.imh.com.sg/wellness
- Please Stay Movement
  www.pleasestaymovement.com/support-for-youths
- Mindline.sg
  www.mindline.sg
- MindSG
  mindSG.gov.sg
- Otrlistens
  www.otrlistens.net
- Samaritans of Singapore (SOS)
  www.sos.org.sg
- Chat
  https://www.imh.com.sg/CHAT/Get-Help/Pages/default.aspx

Apps and Chatbots (for general mental health support)

- Jason Foundation A Friend Asks
- Woebot
- Wysa

SECTION 5:

STANDARDISED GLOSSARY OF SUICIDE TERMS[20]

20 Dumon and Portzky, General Guidelines on Suicide Prevention (EUREGENAS Project).

Gatekeepers:

Individuals who have frequent contact with others in their communities, for example, mental healthcare professionals, primary healthcare professionals such as general practitioners (GPs), emergency healthcare providers, counsellors, teachers, youth workers, religious leaders, community leaders. They may be trained to identify individuals at risk of suicide and refer them to treatment, help resources or supporting services as needed.

Mental Health:

Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community. In this positive sense, mental health is the foundation for individual well-being and the effective functioning of a community (WHO, 2010).

Mental (health) condition/ disorder / psychiatric disorder / mental illness:

A mental (health) condition or disorder or psychiatric disorder is a diagnosable illness characterised by alterations in thinking, mood, or behaviour (or some combination thereof) associated with distress that significantly interferes with an individual's cognitive, emotional or social abilities.

Mental health problem:

Diminished cognitive, social or emotional abilities but not to the extent that the criteria for a mental disorder are met.

Non-fatal suicidal behaviour:

A non-habitual act with non-fatal outcome that the individual, expecting to, or taking the risk, to die or to inflict bodily harm, initiated and carried out with the purpose of bringing about wanted changes (De Leo et al., 2004). Non-fatal suicidal behaviour can include attempted suicide, deliberate self-harm and deliberate self-poisoning, with or without injuries.

Postvention:

A strategy or approach that is implemented after a crisis or traumatic event has occurred.

Prevention:

A strategy or approach that reduces the likelihood of risk of onset or delays the onset of adverse health problems or reduces the harm resulting from conditions or behaviors.

Protective factors (for suicidal behaviour):

Factors that make it less likely that individuals will develop suicidal thoughts and/or attempt suicide. Protective factors may encompass biological, psychological or social factors in the individual, family and environment.

Risk assessment:

The process of quantifying the probability of an individual harming himself or others.

Risk factors (for suicidal behaviour):

Those factors that make it more likely that individuals will develop suicidal thoughts and/or attempt suicide. Risk factors may encompass biological, psychological or social factors in the individual, family and environment.

Self-destructive behavior/deliberate self-harm/self-injury:

The various methods by which individuals injure themselves, such as self-cutting, self-battering, taking overdoses or exhibiting deliberate recklessness.

Suicidal ideation and behaviours:

A complex process that can range from suicidal thoughts, thorough planning of suicide, to attempting suicide and ending in suicide. Suicidal behaviour is the consequence of interacting biological, genetic, psychological, social, environmental and situational factors (Hawton and van Heeringen, 2009).

Suicidal intent:

Subjective expectation and desire for a self-destructive act to end in death.

Suicide (or ‘fatal suicidal behaviour’):

An act with a fatal outcome which the deceased, knowing or expecting a potentially fatal outcome, has initiated and carried out with the purpose of bringing about wanted changes (De Leo et al., 2004).

Suicide attempt survivors:

Individuals who have survived a prior suicide attempt.

Suicide risk:

The degree of danger to self an individual faces based on the absence or presence of suicidal behaviors and factors associated with the likelihood of suicide.

Suicide (loss) survivors:

Family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide. Sometimes the term ‘suicide survivors’ is also used to mean suicide attempt survivors.

Suicide warning signs:

Indications that an individual is at risk for suicide.

Guidelines for Suicide Prevention Partnerships[21]

Recognising that the complex and multi-faceted nature of suicide necessarily means that different organizations with their own expertise domain have to collaborate in suicide prevention efforts.

- The different ministries and organisations should be able to cover all levels of intervention (universal prevention, selective prevention and indicated prevention), after taking into account the risk, protective and threshold factors of suicide.
- This could consist of a core group and a wider network of representatives.
- There should be a clear identified leadership for the partnership.
- Ensure the partnership has clear terms of reference, based on a shared understanding that suicide can be prevented.
- Ministries and organisations include MOH, MOE, MCCY, MSF, MHA, HPB, IMH, HSA, SAF, and the State Courts.[22]
- Research is also conducted by MOH, IMH, HSA, SOS and the courts.[22]

21 "Creating a Partnership Memorandum of Understanding," Suicide Prevention Resource Center, accessed October 12, 2023, https://sprc.org/online-library/creating-a-partnership-memorandum-of-understanding

22 "Multi-Agency Research Group to Study Suicides among Children, Youth," TODAYonline, February 24, 2017, accessed March 21, 2022, https://www.todayonline.com/singapore/multi-agency-research-group-study-suicides-among-children-youth.

Multi-agency suicide prevention partnerships should have clear governance and accountability structures, such that the lead organization ensures that the representatives of the group can make decisions and commit resources on behalf of their organization (NICE standards).

- Lead agencies should ensure that representatives on the group can make decisions and commit resources on behalf of their organisation.

- Lead agencies should ensure that representatives on the group are experts in their field, as well as possess basic understanding, skills and knowledge in the area of suicide and suicide prevention.

Lead organization should ensure that people with personal experience of suicide attempt, suicidal thoughts and feelings, or a suicide bereavement are supported to be involved in the partnership.

- The quality of the strategies proposed can be improved with inputs from people who have personal experience with the subject matter of suicide.

- Group representatives should have skills and knowledge in line with the self-harm and suicide prevention frameworks.

- Group representatives should create a partnership Memorandum of Understanding (MOU) to accomplish the common goals and outcomes of suicide prevention.[23]

23 "Creating a Partnership Memorandum of Understanding," Suicide Prevention Resource Center, accessed October 12, 2023, https://sprc.org/online-library/creating-a-partnership-memorandum-of-understanding

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