# Mental Health and the COVID-19 Pandemic – A Global and National Perspective

Seminar School of Public Health, UCC
8th February 2022

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# Overview

- Global perspectives on mental health impacts of COVID-19
- Mental health impacts at population level and among priority groups
- COVID-19 and mental health impacts in Ireland
- Evidence based mental health interventions and mitigating factors
- The way forward – Preparedness in relation to mental health during Public Health Emergencies

# Acknowledgements


- National Suicide Research Foundation & School of Public Health, University College Cork
- International COVID-19 Suicide Prevention Research Collaboration (ICSPRC)
- Australian Institute for Suicide Research and Prevention, Griffith University, Brisbane
- Health Research Board Ireland
- National Office for Suicide Prevention Ireland


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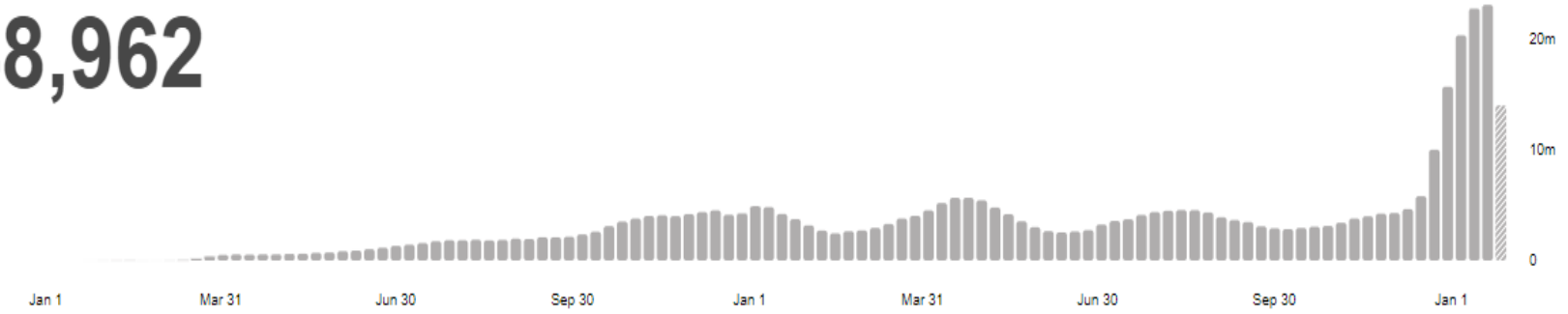
**Globally**, as of **5:30pm CET, 4 February 2022**, there have been **386,548,962 confirmed cases** of COVID-19, including **5,705,754 deaths**, reported to WHO. As of **7 February 2022**, a total of **10,045,314,770 vaccine doses** have been administered.

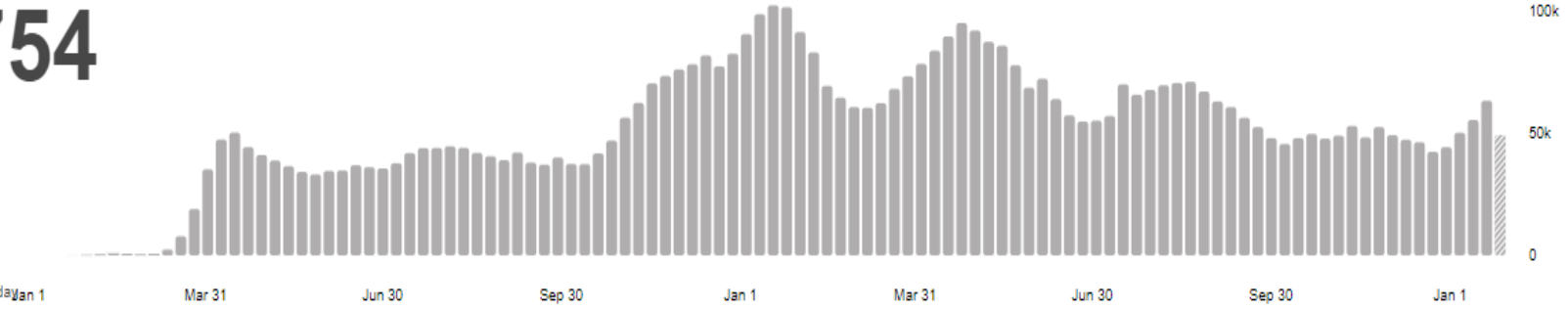
## Global Situation

Daily | Weekly

**386,548,962**
confirmed cases




**5,705,754**
deaths




Source: World Health Organization

Data may be incomplete for the current day or week.

# Global mental health challenges before COVID-19

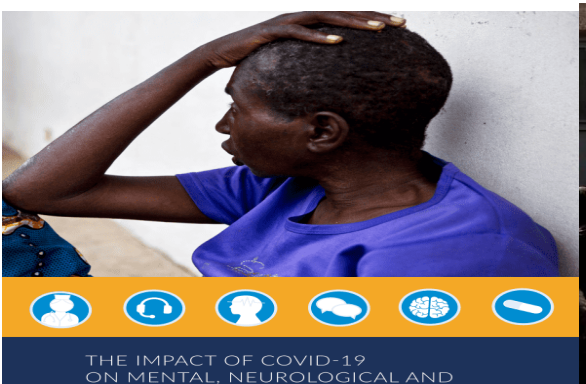
*Mental health issues are truly global. When it comes to mental health, all countries are developing countries. Lots to learn!*


*Mental health 'neglected issue' but key to achieving Global Goals*

# Global mental health challenges during COVID-19

*The United Nations has warned coronavirus could cause a global mental health crisis.*


*The COVID-19 pandemic has disrupted mental health services in 93% of countries at a time when they are most needed.*




# UN Sustainable Development Goals

Policy Brief:
**COVID-19 and the Need for Action on Mental Health**

13 MAY 2020

3 GOOD HEALTH AND WELL-BEING

Target

## 3.4

By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being

Indicators ▲

### 3.4.1

Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease

### 3.4.2

Suicide mortality rate

**The impact of COVID-19 on mental, neurological and substance use services:**

results of a rapid assessment

World Health Organization

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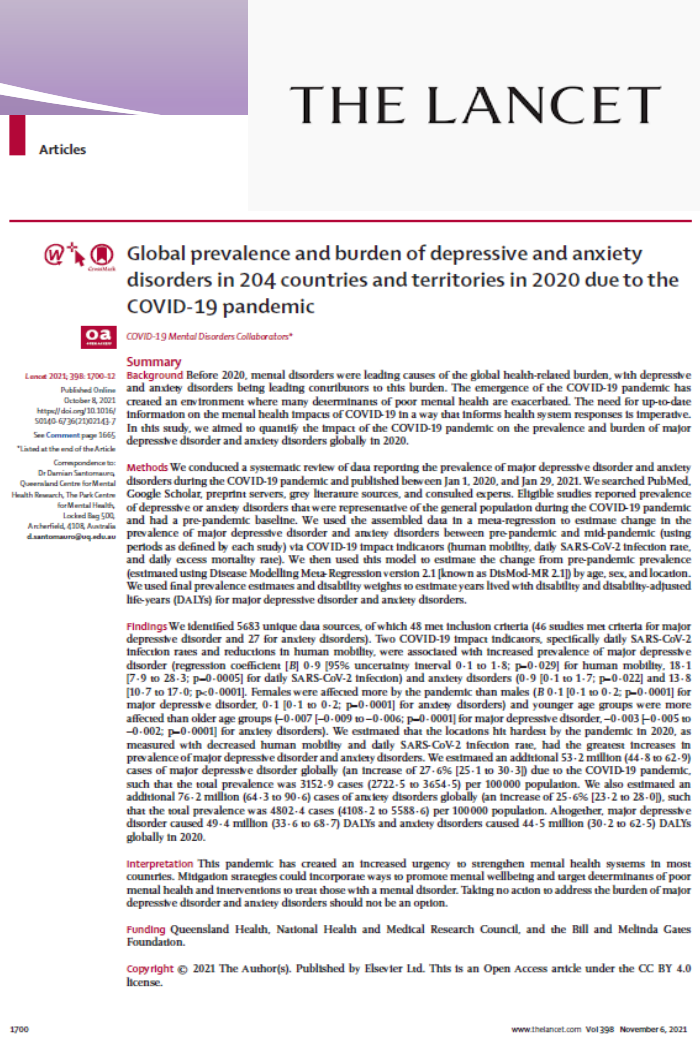
## Key question:

Will the COVID-19 Pandemic accelerate or delay achieving the SDG Target 3.4:
*By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and wellbeing?*

# Global prevalence of depressive and anxiety disorders during the COVID-19 pandemic

- Systematic review (48 studies) of data reporting the prevalence of major depressive disorder and anxiety disorders during the COVID-19 pandemic and published between Jan 2020, and Jan 2021.

- Studies examining the prevalence of depressive or anxiety disorders that were representative of the general population during the COVID-19 pandemic and had a pre-pandemic baseline.



THE LANCET

Articles

Global prevalence and burden of depressive and anxiety disorders in 204 countries and territories in 2020 due to the COVID-19 pandemic

COVID-19 Mental Disorders Collaborators*

Lancet 2021; 398: 1700–12
Published Online October 8, 2021
https://doi.org/10.1016/S0140-6736(21)02143-7
See Comment page 1665
*Listed at the end of the Article

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**Summary**

**Background** Before 2020, mental disorders were leading causes of the global health-related burden, with depressive and anxiety disorders being leading contributors to this burden. The emergence of the COVID-19 pandemic has created an environment where many determinants of poor mental health are exacerbated. The need for up-to-date information on the mental health impacts of COVID-19 in a way that informs health system responses is imperative. In this study, we aimed to quantify the impact of the COVID-19 pandemic on the prevalence and burden of major depressive disorder and anxiety disorders globally in 2020.

**Methods** We conducted a systematic review of data reporting the prevalence of major depressive disorder and anxiety disorders during the COVID-19 pandemic and published between Jan 1, 2020, and Jan 29, 2021. We searched PubMed, Google Scholar, preprint servers, grey literature sources, and consulted experts. Eligible studies reported prevalence of depressive or anxiety disorders that were representative of the general population during the COVID-19 pandemic and had a pre-pandemic baseline. We used the assembled data in a meta-regression to estimate change in the prevalence of major depressive disorder and anxiety disorders between pre-pandemic and mid-pandemic (using periods as defined by each study) via COVID-19 impact indicators (human mobility, daily SARS-CoV-2 infection rate, and daily excess mortality rate). We then used this model to estimate the change from pre-pandemic prevalence (estimated using Disease Modelling Meta-Regression version 2.1 [known as DisMod-MR 2.1]) by age, sex, and location. We used final prevalence estimates and disability weights to estimate years lived with disability and disability-adjusted life-years (DALYs) for major depressive disorder and anxiety disorders.

**Findings** We identified 5683 unique data sources, of which 48 met inclusion criteria (46 studies met criteria for major depressive disorder and 27 for anxiety disorders). Two COVID-19 impact indicators, specifically daily SARS-CoV-2 infection rates and reductions in human mobility, were associated with increased prevalence of major depressive disorder (regression coefficient [*B*] 0·9 [95% uncertainty interval 0·1 to 1·8; p=0·029] for human mobility, 18·1 [7·9 to 28·3; p=0·0005] for daily SARS-CoV-2 infection) and anxiety disorders (0·9 [0·1 to 1·7; p=0·022] and 13·8 [10·7 to 17·0; p<0·0001]. Females were affected more by the pandemic than males (*B* 0·1 [0·1 to 0·2; p=0·0001] for major depressive disorder, 0·1 [0·1 to 0·2; p=0·0001] for anxiety disorders) and younger age groups were more affected than older age groups (–0·007 [–0·009 to –0·006; p=0·0001] for major depressive disorder, –0·003 [–0·005 to –0·002; p=0·0001] for anxiety disorders). We estimated that the locations hit hardest by the pandemic in 2020, as measured with decreased human mobility and daily SARS-CoV-2 infection rate, had the greatest increases in prevalence of major depressive disorder and anxiety disorders. We estimated an additional 53·2 million (44·8 to 62·9) cases of major depressive disorder globally (an increase of 27·6% [25·1 to 30·3]) due to the COVID-19 pandemic, such that the total prevalence was 3152·9 cases (2722·5 to 3654·5) per 100 000 population. We also estimated an additional 76·2 million (64·3 to 90·6) cases of anxiety disorders globally (an increase of 25·6% [23·2 to 28·0]), such that the total prevalence was 4802·4 cases (4108·2 to 5588·6) per 100 000 population. Altogether, major depressive disorder caused 49·4 million (33·6 to 68·7) DALYs and anxiety disorders caused 44·5 million (30·2 to 62·5) DALYs globally in 2020.

**Interpretation** This pandemic has created an increased urgency to strengthen mental health systems in most countries. Mitigation strategies could incorporate ways to promote mental wellbeing and target determinants of poor mental health and interventions to treat those with a mental disorder. Taking no action to address the burden of major depressive disorder and anxiety disorders should not be an option.

**Funding** Queensland Health, National Health and Medical Research Council, and the Bill and Melinda Gates Foundation.

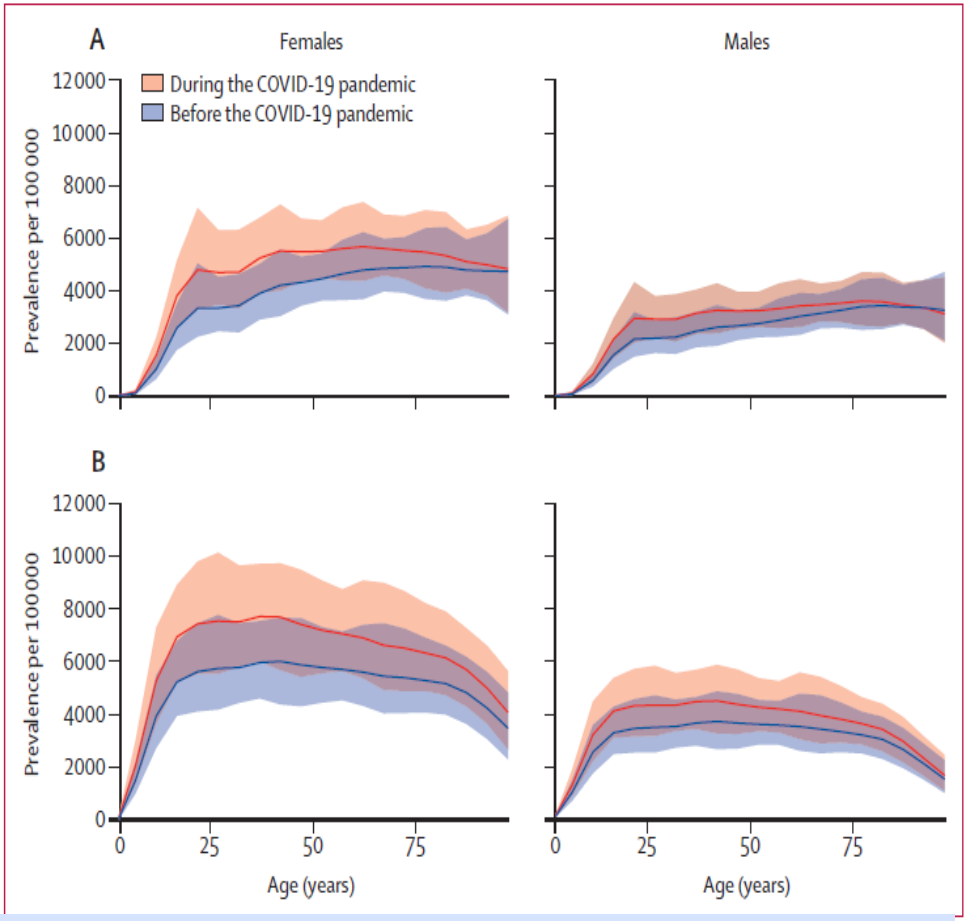




*COVID-19 Mental Disorders Collaborators*

# Global prevalence of depressive and anxiety disorders during the COVID-19 pandemic

- Significant increases in the prevalence of major depressive disorders (A) and anxiety disorders (B) during the first months of COVID-19.
- Human mobility and daily SARS-CoV-2 infection rate were significantly associated with the change in major depressive disorder and anxiety disorder prevalence.
- For both disorders, females were affected more than males, and younger age groups were affected more than older age groups.

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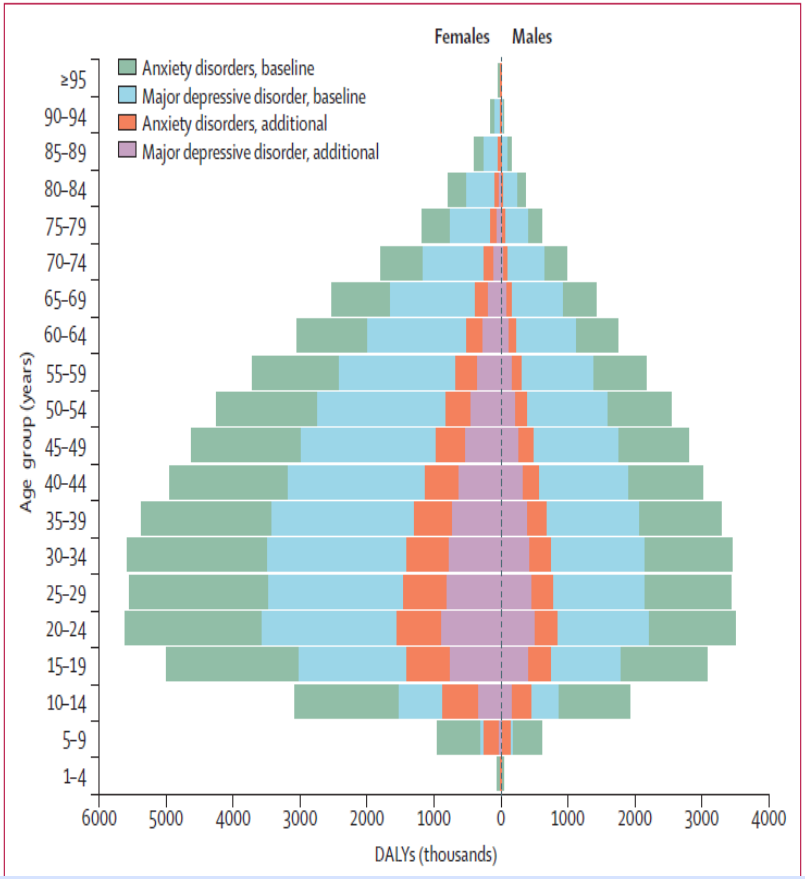
# Magnitude of the pandemic's impact on major depressive disorders and anxiety disorders

- An estimated additional 53·2 million cases of major depressive disorder globally in 2020 due to the effects of COVID-19; new cases: 682·4 per 100 000 population (+ 27·6%).
- An estimated additional 76·2 million cases of anxiety disorders in 2020 due to the COVID-19 pandemic; new cases: 977·5 per 100 000 (+ 25.6%).
- Interrelatedness between depression and anxiety.

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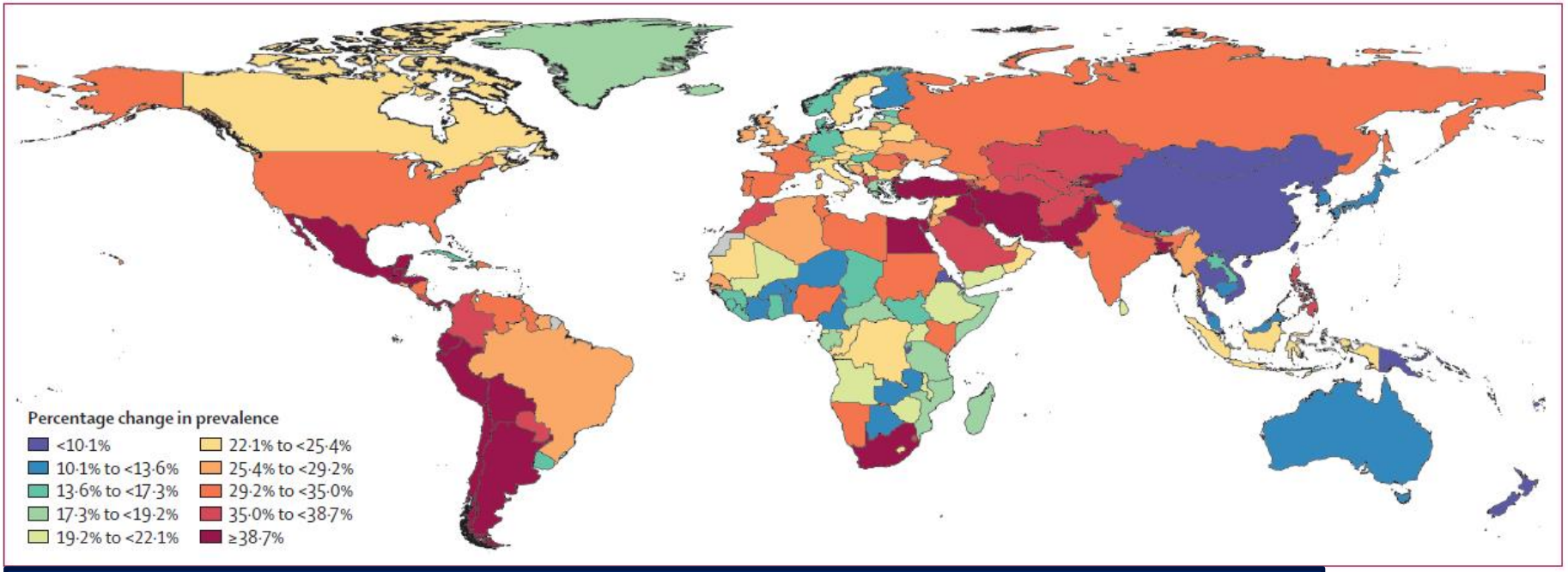
# Change in prevalence of major depressive disorder during the COVID-19 pandemic - 2020




Global trend – Countries affected by greater prevalence of COVID-19 had higher prevalence of major depressive disorder

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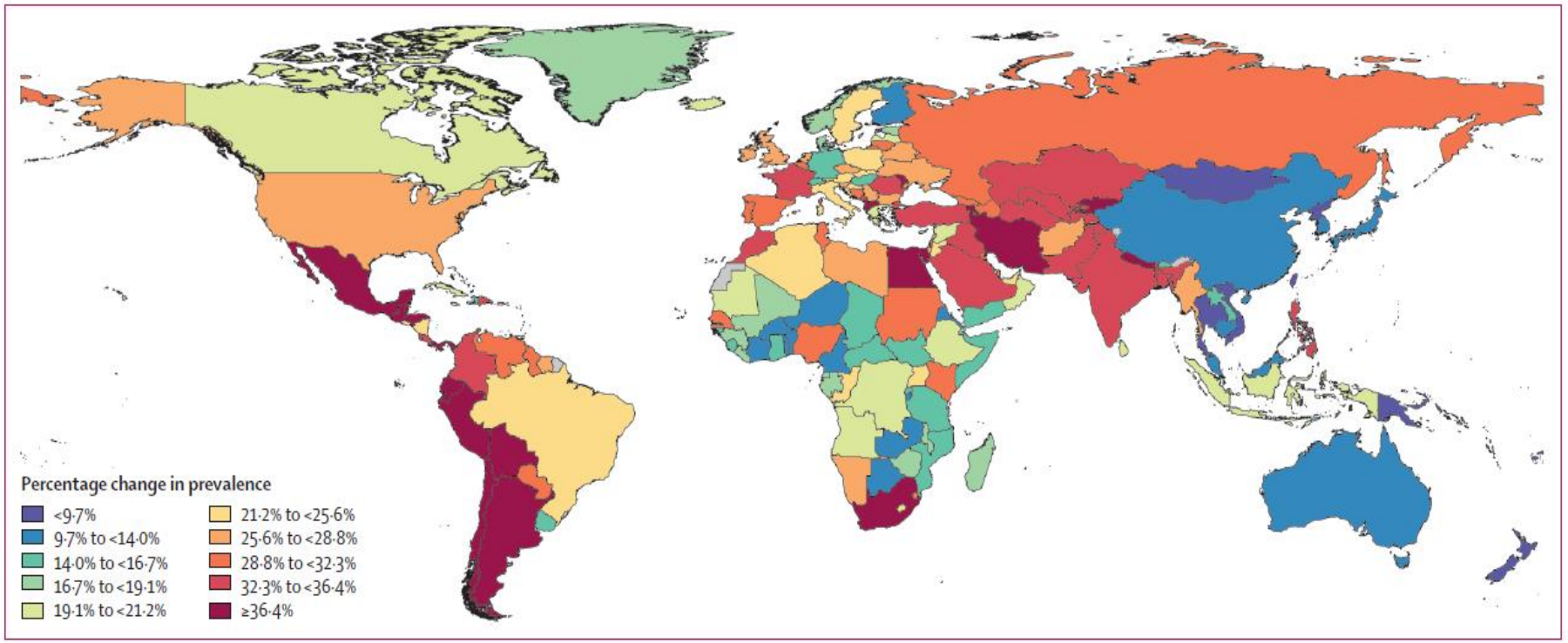
# Change in prevalence of anxiety disorders during the COVID-19 pandemic - 2020




Global trend – Countries affected by greater prevalence of COVID-19 had higher prevalence of anxiety disorders

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# COVID-19 and Mental Health - Gender differences

**Negative mental health impacts**

**Women:**

- High rate of maternal and neonatal complications in COVID-19 positive pregnant women
- In creased domestic violence
- Increased violence against children
- Increased psychosomatic ill health
- Increased levels of depression and anxiety

**Men:**

- COVID-19-specific fear/anxiety/worry/PTSD
- Suicidal ideation
- Sleep problems

➢ Increased alcohol consumption for both men and women

**Potential protective factors**

**Women:**

- More likely to adhere to COVID related Public Health guidelines
- More likely to ask for support from family, friends and mental health professionals

**Men:**

- Increased levels of physical activity

*Tibubos et al, 2021*

# Domestic Violence during COVID-19

Review addressing intimate partner violence in 11 Western and South European countries during COVID 19 incl. baseline data.

- Increase in domestic violence in 6 countries: Austria, Belgium, France, Ireland, Spain and UK
- Decrease in domestic violence in 2 countries: Italy and Portugal
- No change in 2 countries: The Netherlands and Switzerland

**Example France:** 30% increase in reported cases of domestic violence in 2020; 8% increase in female deaths related to domestic violence


*European Journal of Public Health*, Vol. 31, No. 5, 1067–1072

doi:10.1093/eurpub/ckab093 Advance Access published on 18 August 2021

## Intimate partner violence during the COVID-19 pandemic in Western and Southern European countries

Julia Brink[1], Patricia Cullen [2,3,4], Kristen Beek[2], Sanne A.E. Peters[1,3,5]

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Netherlands
2 School of Population Health, UNSW, Sydney, Australia
3 The George Institute for Global Health, UNSW, Sydney, Austral
4 Ngarruwan Ngadju: First Peoples Health and Wellbeing Researc
Australia
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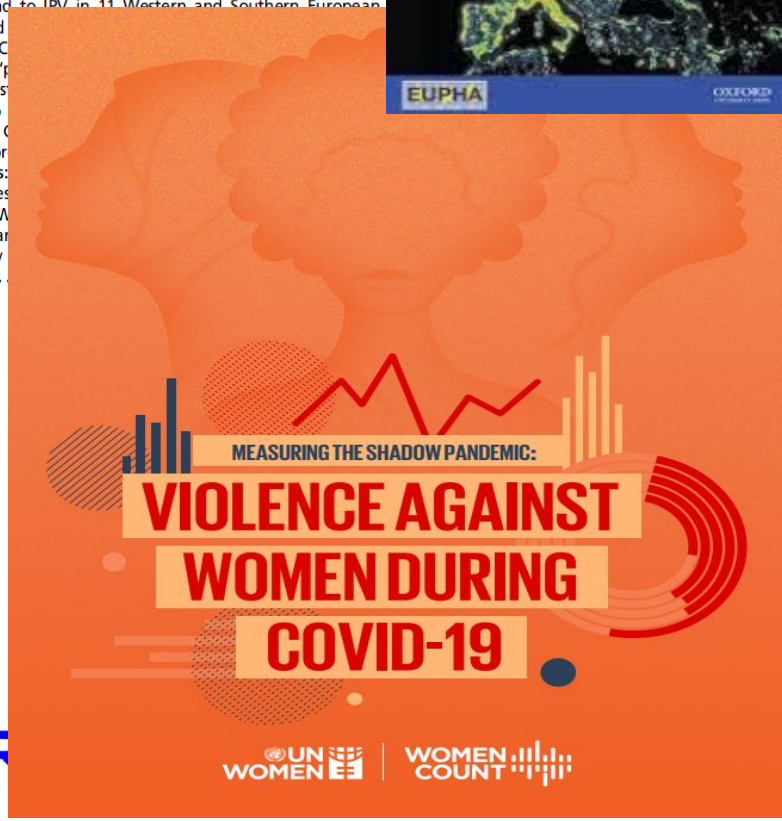
Medical Center Utrecht, Heidelberglaan 100, 3584 CX Utrecht, The
75 68099, e-mail: speters@georgeinstitute.org.uk

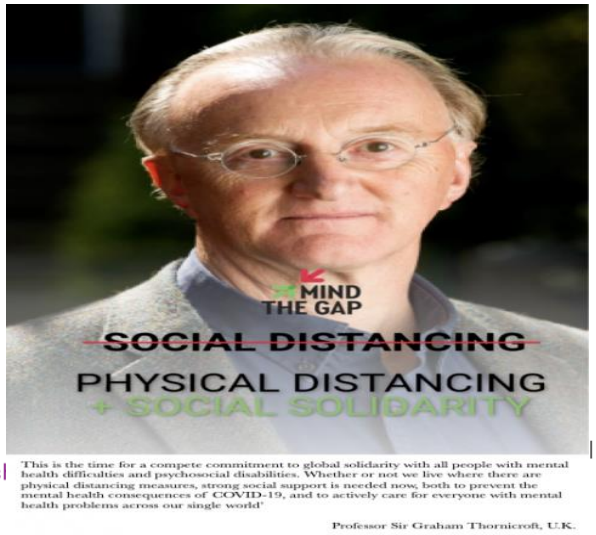

**Background:** Intimate partner violence (IPV) is a significant
Disasters are linked to increased IPV, but little is known about
the COVID-19 pandemic. This review maps the IPV reporting
and respond to IPV in 11 Western and Southern European
articles and
'Covid' or 'C
lence' and 'p
reports (Aus
showed no
(Germany).
(seven), mor
**Conclusions:**
19 measures
countries. W
pandemic ar
the efficacy



# Delayed response to mental health needs during COVID-19

*'Alongside the sometimes severe or fatal physical consequences of the SARS-CoV-2 virus, there is a threat far less often discussed: the mental health implications of COVID-19. The true breadth and depth of the mental health impacts are only now becoming clear'*

*(Graham Thornicroft, December 2020)*

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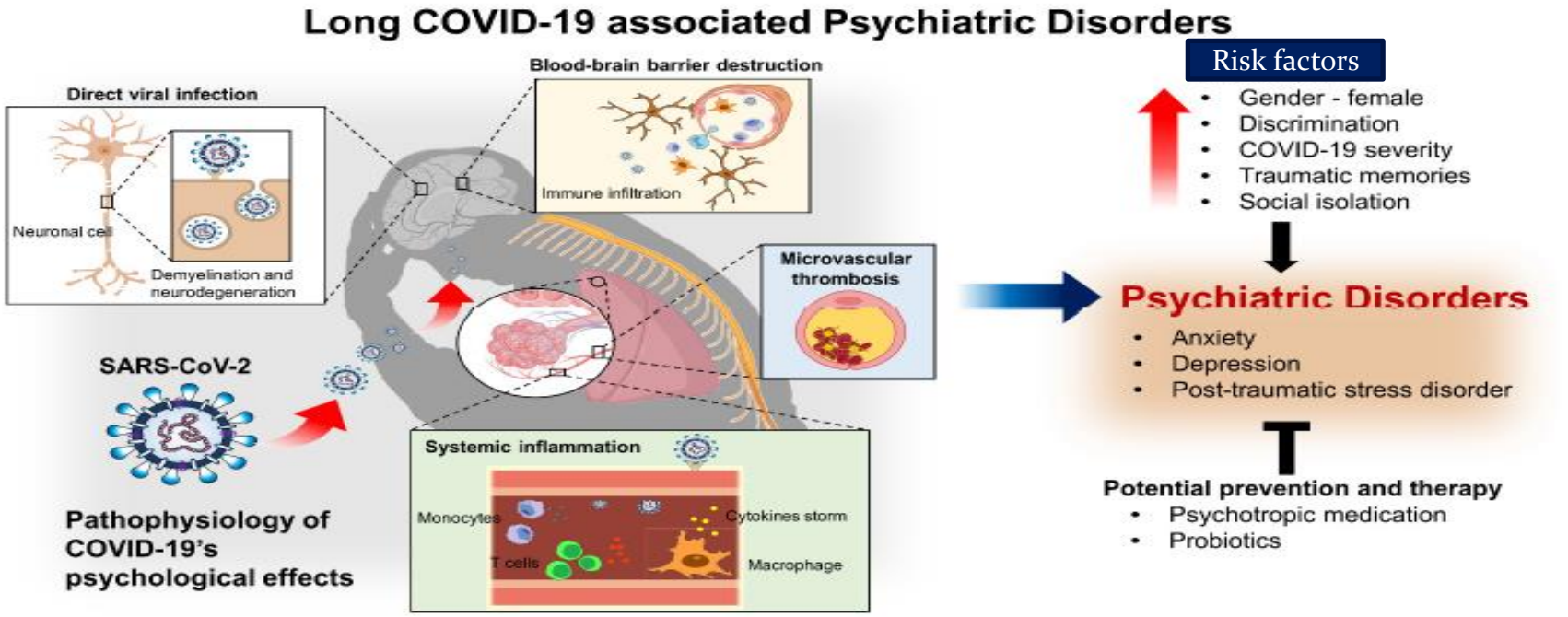
# Long Covid and associated psychiatric disorders




Increased risk of mental health conditions after COVID-19 among people with pre-existing mental health symptoms/conditions;
Inconsistent findings on direct impacts of COVID-19 on neuropsychiatric  nd psychiatric disorders *(Thye et al, 2021; Schou  et al, 2021)*

# Further risk factors associated with mental health symptoms during the COVID-19 pandemic

- Stress on health and social care staff and frontline workers and loss of colleagues, in particular Doctors, Nurses, Priests

- Economic impact / recession

- Bereavement / complicated grief

- Averse impacts of limited access to mental health care among people with pre-existing mental health conditions

- Interrupted education

- Media reporting and misinformation leading to increased anxiety

# Mental health promotion and Intervention in Occupational Settings - MENTUPP

Stakeholder survey on views and experiences concerning the impacts of COVID-19 on mental health of SME employees in the health, construction and ICT sector

- 146 experts from nine countries invited (Delphi study)
- In total, 65 experts responded to the survey

77% job stress and burnout have increased

52% capacity for SMEs to promote mental wellbeing have reduced

48% level of stigma has stayed the same

69% levels of depression, anxiety, and/or suicidal behaviour have increased

48% capacity of managers to support employee mental health have decreased

17% level of stigma has increased

This project has received funding from the European Union's H2020 research and innovation programme under grant agreement No 848137. The material presented and views expressed here are the responsibility of the author(s) only. The EU Commission takes no responsibility for any use made of the information set out.

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# How do mental health impacts relate to suicidal behaviour at global level?

# Can we rely on the media?

**CORONAVIRUS LOCKDOWN COULD LEAD TO SPIKE IN SUICIDES AS HUNDREDS STRUGGLE TO ACCESS HELP**

**The silent COVID-19 death toll: Far more Australians will kill themselves because of coronavirus lockdown than those who die of the virus,**

**‘The Anglosphere is committing suicide': US, UK, Australia, New Zealand and Canada are allowing Covid to destroy individual rights**

# Suicide trends during the first wave of COVID-19 - Real-time suicide data

- 21 Countries/regions included with data on suicide between January 2019 and July 2020; high and middle income countries
- Rate ratios (RRs) and 95% CIs based on the observed versus expected numbers of suicides showed no significant change in suicide rates in 9 countries and a decrease in 12 countries during the first 5 months of COVID-19



## Suicide trends in the early months of the COVID-19 pandemic: an interrupted time-series analysis of preliminary data from 21 countries

*Jane Pirkis, Ann John, Sangsoo Shin, Marcos DelPozo-Banos, Vikas Arya, Pablo Analuisa-Aguilar, Louis Appleby, Ella Arensman, Jason Bantjes, Anna Baran, Jose M Bertolote, Guilherme Borges, Petrana Brečić, Eric Caine, Giulio Castelpietra, Shu-Sen Chang, David Colchester, David Crompton, Marko Curkovic, Eberhard A Deisenhammer, Chengan Du, Jeremy Dwyer, Annette Erlangsen, Jeremy S Faust, Sarah Fortune, Andrew Garrett, Devin George, Rebekka Gerstner, Renske Gilissen, Madelyn Gould, Keith Hawton, Joseph Kanter, Navneet Kapur, Murad Khan, Olivia J Kirtley, Duleeka Knipe, Kairi Kolves, Stuart Leske, Kedar Marahatta, Ellenor Mittendorfer-Rutz, Nikolay Neznanov, Thomas Niederkrotenthaler, Emma Nielsen, Merete Nordentoft, Herwig Oberlerchner, Rory C O'Connor, Melissa Pearson, Michael R Phillips, Steve Platt, Paul L Plener, Georg Psota, Ping Qin, Daniel Radeloff, Christa Rados, Andreas Reif, Christine Reif-Leonhard, Vsevolod Rozanov, Christiane Schlang, Barbara Schneider, Natalia Semenova, Mark Sinyor, Ellen Townsend, Michiko Ueda, Lakshmi Vijayakumar, Roger T Webb, Manjula Weerasinghe, Gil Zalsman, David Gunnell*, Matthew J Spittal**

### Summary

**Background** The COVID-19 pandemic is having profound mental health consequences for many people. Concerns have been expressed that, at their most extreme, these consequences could manifest as increased suicide rates. We aimed to assess the early effect of the COVID-19 pandemic on suicide rates around the world.

**Methods** We sourced real-time suicide data from countries or areas within countries through a systematic internet search and recourse to our networks and the published literature. Between Sept 1 and Nov 1, 2020, we searched the official websites of these countries' ministries of health, police agencies, and government-run statistics agencies or equivalents, using the translated search terms "suicide" and "cause of death", before broadening the search in an attempt to identify data through other public sources. Data were included from a given country or area if they came from an official government source and were available at a monthly level from at least Jan 1, 2019, to July 31, 2020. Our internet searches were restricted to countries with more than 3 million residents for pragmatic reasons, but we relaxed this rule for countries identified through the literature and our networks. Areas within countries could also be included with populations of less than 3 million. We used an interrupted time-series analysis to model the trend in monthly suicides before COVID-19 (from at least Jan 1, 2019, to March 31, 2020) in each country or area within a country, comparing the expected number of suicides derived from the model with the observed number of suicides in the early months of the pandemic (from April 1 to July 31, 2020, in the primary analysis).

**Findings** We sourced data from 21 countries (16 high-income and five upper-middle-income countries), including whole-country data in ten countries and data for various areas in 11 countries). Rate ratios (RRs) and 95% CIs based on the observed versus expected numbers of suicides showed no evidence of a significant increase in risk of suicide since the pandemic began in any country or area. There was statistical evidence of a decrease in suicide compared with the expected number in 12 countries or areas: New South Wales, Australia (RR 0·81 [95% CI 0·72–0·91]); Alberta, Canada (0·80 [0·68–0·93]); British Columbia, Canada (0·76 [0·66–0·87]); Chile (0·85 [0·78–0·94]); Leipzig, Germany (0·49 [0·32–0·74]); Japan (0·94 [0·91–0·96]); New Zealand (0·79 [0·68–0·91]); South Korea (0·94 [0·92–0·97]); California, USA (0·90 [0·85–0·95]); Illinois (Cook County), USA (0·79 [0·67–0·93]); Texas (four counties), USA (0·82 [0·68–0·98]); and Ecuador (0·74 [0·67–0·82]).

**Interpretation** This is the first study to examine suicides occurring in the context of the COVID-19 pandemic in multiple countries. In high-income and upper-middle-income countries, suicide numbers have remained largely unchanged or declined in the early months of the pandemic compared with the expected levels based on the pre-pandemic period. We need to remain vigilant and be poised to respond if the situation changes as the longer-term mental health and economic effects of the pandemic unfold.

**Funding** None.



*Lancet Psychiatry* 2021; 8: 579–88

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See Comment page 552

*Joint last authors

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### Introduction

The COVID-19 pandemic has had profound mental health consequences[1] and there are concerns that it could lead to increases in suicide rates.[2] However, few studies have examined the effects of previous widespread disease outbreaks on suicide. Two systematic reviews collectively



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# Implications and mitigating factors

- Policy responses to prevent the spread of COVID-19 need to balance the benefits of physical distancing, school and workplace closures, and other restrictions against the possible adverse impact of these measures on population mental health and suicide.

- The absence of an increase in suicide rates during the first months of the COVID-19 pandemic provide some reassurance (at least for high-income and upper-middle-income countries) that COVID-19 risk mitigation measures have not led to population-level increases in suicide rates.

- Many countries put in place additional mental health supports and financial safety nets, both of which might have buffered any early adverse effects of the pandemic.

# Vigilance in terms of long term impacts

- There is a need to ensure that efforts that might have kept suicide rates down until now are continued, and to remain vigilant as the longer-term mental health and economic consequences of the pandemic unfold.

- There are some concerning signals that the pandemic might be adversely affecting suicide rates in low-income and lower-middle-income countries.

- Recent real-time suicide data from a number of countries indicate that suicide rates return to levels of the pre-Covid period or increasing trend in a number of countries since October 2020, including Japan, The Netherlands, Austria.

# Mental health impacts of COVID-19 in Ireland


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# Status of COVID-19 and Omicron in Ireland as of today

WORLD / COUNTRIES / IRELAND

Last updated: February 08, 2022, 09:53 GMT

Ireland

Coronavirus Cases:

**1,221,082**

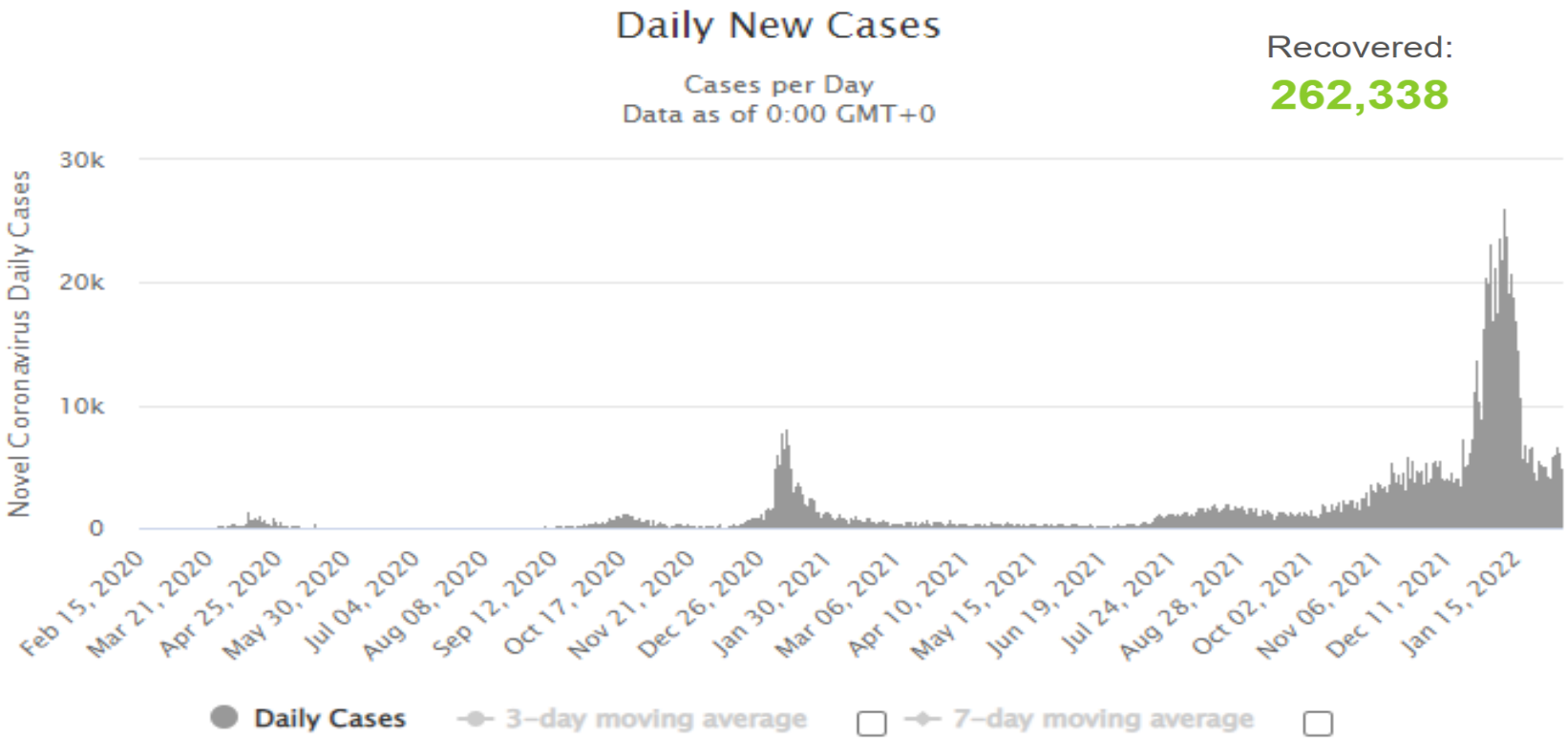
Deaths:

**6,228**

Recovered:

**262,338**

## Daily New Cases in Ireland

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# Mental health impacts of COVID-19 at population level in Ireland – Symptoms of depression, anxiety and suicidal ideation

**National Household Survey with estimated sample size of 1,000 participants 18+ at each time-point**

- Time-point 1: May - June 2020
- Time-point 2: July 2020
- Time-point 3: September 2020
- Time-point 4: April 2021

HRB Open Research

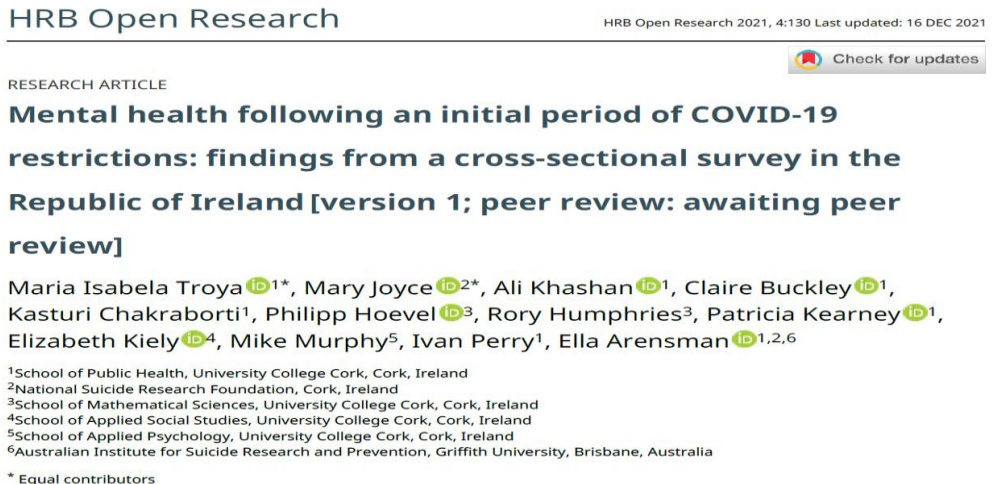
HRB Open Research 2020, 3:49 Last updated: 29 SEP 2020

Check for updates

STUDY PROTOCOL

**Covid-19 Estimating the burden of symptomatic disease in the community and the impact of public health measures on physical, mental and social wellbeing: a study protocol [version 1; peer review: 2 approved]**

M. Isabela Troya[1,2], Ali Khashan[1], Patricia Kearney[1], Ella Arensman[1-3], Philipp Hoevel[4], Claire Buckley[1], Margaret Fitzgerald[5], Rory Humphries[4], Elizabeth Kiely[6], Kieran Mulchrone[4], Mike Murphy[7], Lois O'Connor[5], Joan O'Donnell[5], Eilis O'Reilly[1], Micheal O'Riordain[4,8], Mary Spillane[4], Sebastian Wieczorek[4], Ivan J Perry[1]



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HRB Open Research 2021, 4:130 Last updated: 16 DEC 2021

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RESEARCH ARTICLE

**Mental health following an initial period of COVID-19 restrictions: findings from a cross-sectional survey in the Republic of Ireland [version 1; peer review: awaiting peer review]**

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# Depression and Anxiety symptoms

Waves 1 and 2 combined

- More than a quarter of participants (27.7%, *n* =549) reported symptoms of depression and anxiety in the last 2 weeks

- Poisson regression analysis indicated significantly greater risk of reporting depression and anxiety in:
  - Females vs males: RR 1.60 (1.37 – 1.87)
  - Individuals who had been employed and had experienced a *change* in their employment status: RR 1.50 (1.24 - 1.82)
  - Individuals cocooning because of a health condition: RR 1.34 (1.08 – 1.66) and individuals who were self-isolating: RR 1.25 (1.03 – 1.51)
  - 'Moderate' or 'Heavy' alcohol consumers versus 'Occasional'/ None drinkers: RR 1.27 (1.09 – 1.47)

# Thoughts of Self-harm and/or Suicide

Waves 1 and 2 combined

- 3.8% (*n* = 74) participants reported suicidal/self-harm thoughts in the previous two weeks
- There was an increase in the number of participants reporting suicidal thoughts from wave 1 (3.3%, *n* = 32) to 2 (4.2%, *n* = 42). Similar between waves 2 and 3 (4.2%, *n* = 39).
- Those at increased risk of self-harm/suicidal thoughts:
  - Young people aged 18-29 years: RR 3.41 (1.86 – 6.22)
  - Individuals in the two lowest annual income categories
    - <€19,999: RR 2.84 (1.34 – 6.04)
    - €20,000-€29,999: RR 2.22 (1.03 – 4.80)

| **Suicidal Ideation** | **Wave 1**<br>Frequency (%)<br>*N* = 32 | **Wave 2**<br>Frequency (%)<br>*N* = 42 | **Wave 3**<br>Frequency (%)<br>*N* = 48 | **Wave 4**<br>Frequency (%)<br>*N* = 37 |
|---|---|---|---|---|
| **Gender** | | | | |
| Male | 15 (47%) | 15 (36%) | 24 (50%) | 20 (54%) |
| Female | 16 (50%) | 26 (62%) | 24 (50%) | 17 (46%) |
| Other | 1 (3%) | 1 (2%) | ~ | ~ |
| **Age Group** | | | | |
| 18-29 years | 14 (47%) | 18 (44%) | 10 (21%) | 12 (34%) |
| 30-39 years | 3 (10%) | 5 (12%) | 8 (17%) | 5 (14%) |
| 40-49 years | 4 (13%) | 6 (15%) | 10 (21%) | 6 (17%) |
| 50-59 years | 5 (17%) | 2 (5%) | 8 (17%) | 5 (14%) |
| 60-69 years | 3 (10%) | 7 (17%) | 10 (21%) | 2 (6%) |
| 70 years + | 1 (3%) | 3 (7%) | 2 (4%) | 5 (14%) |

# Domestic Violence

<u>Waves 2 and 3 combined</u>

- 4.4% (*n* = 74) participants reported domestic violence

- Males comprised more than a third of those reporting domestic violence (37.8%, *n* = 28)

- Associations noted between domestic violence and mental health symptoms:
  - Anxiety and depression: OR 5.89 (3.36 – 10.35)
  - Thoughts of self-harm and/or suicide: OR 3.34 (1.46 – 7.64)


- Similar levels of mental health symptoms (anxiety & depression) reported in international studies (e.g. *O'Connor et al, 2020)*
- Young people at increased risk self-harm/suicidal thoughts
- Being over 70 year not associated with poorer mental health outcomes in Ireland, despite this being reported in other countries (e.g. The Netherlands).
- Higher rates of self-harm and/or suicidal thoughts reported in UK study which increased over time during the COVID-19 pandemic (8.2% - 9.8%; *O'Connor et al, 2020)*
- Mental health symptoms reported in Ireland (incl. thoughts of self-harm) is not paralleled with an increase in hospital presenting self-harm during the same period
- Relatively high levels of domestic violence reported among men.

# Implications

- Possible bias due to relatively low response rates
- Possible protective factors:
  - Mental health support services and helplines – Increased uptake
  - Change to online availability/ text based services and telemedicine
  - 2nd National Suicide Prevention Strategy – *Connecting for Life* 2015-2024
  - "In it together"
- Increased support service capacity required for victims of domestic violence and service provision for men experiencing domestic abuse
- Increased risk of suicidal behaviour in year following pandemic *(Zortea et al., 2020).* Need for ongoing monitoring and provision of support services.

# How do mental health impacts relate to suicidal behaviour in Ireland?

# Suicide mortality figures for Ireland based on CSO Vital Statistics Releases

| Both sexes | Suicide | | | |
|---|---|---|---|---|
| Year | Number | Rate per 100,000 | Late Registered | Revised |
| 2011 | 554 | 12.1 | 23 | 577 |
| 2012 | 541 | 11.8 | 39 | 580 |
| 2013 | 487 | 10.6 | 60 | 547 |
| 2014 | 486 | 10.5 | 83 | 569 |
| 2015 | 425 | 9.1 | 70 | 495 |
| 2016 | 437 | 9.2 | 87 | 524 |
| 2017 | 383 | 8 | 117 | 500 |
| 2018 | 437 | 9 | | |
| 2019 | 390 | 7.9 | | |
| 2020 | 340 | 6.8 | | |

- No up to date suicide figures due to delays in accessing information on late registered suicide deaths
- Need for accurate real-time suicide mortality data

2011-2019 based on year of occurrence; 2020 based on year of registration

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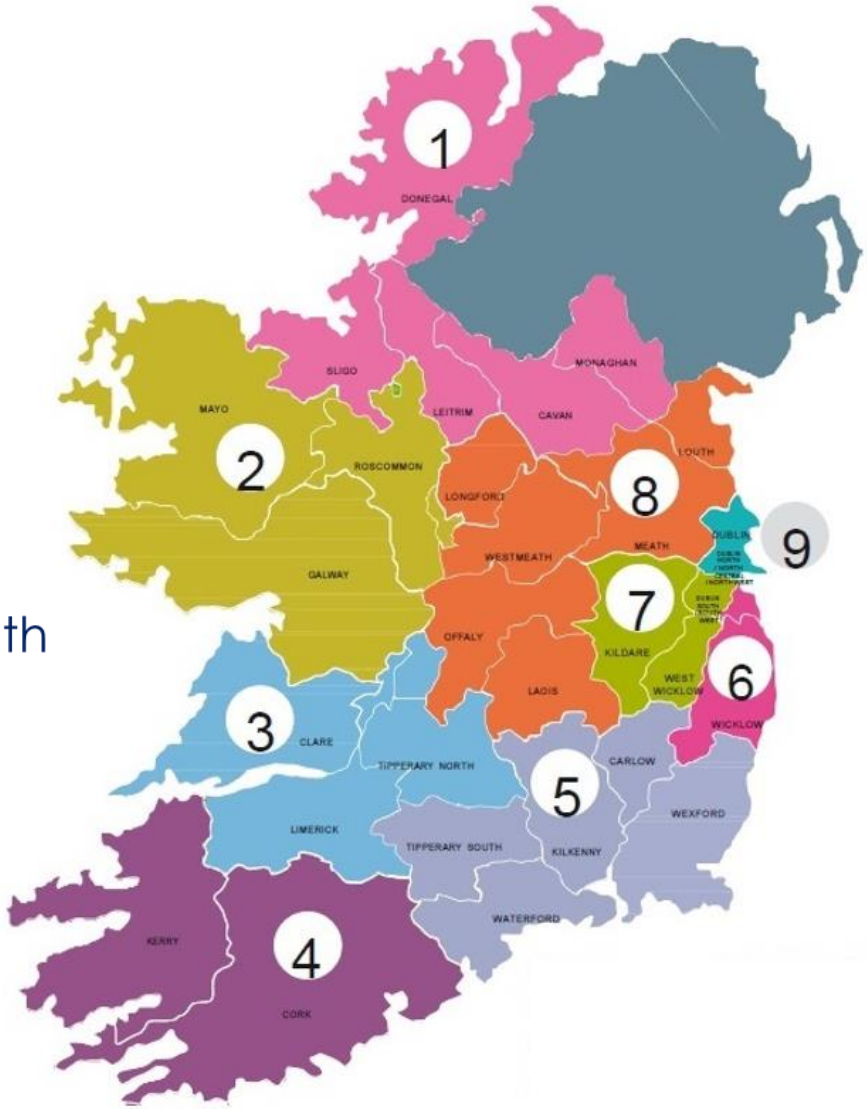
# Suicide and Self-Harm Observatory

- The SSHO started as a pilot study in County Cork in 2019 involving all Coroners

- **Suspected suicide** (before completion of Coronial inquest); access to data from Coroner's service on a fortnightly basis; 16 core data items

HSE Community Health Organisation 4; Counties Cork and Kerry



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**BRIEFING – OFFICE OF THE CHIEF MEDICIAL OFFICER**

**SUICIDE TRENDS DURING THE FIRST MONTHS OF THE COVID-19 PANDEMIC**

**Studies reviewed by the International COVID-19 Suicide Prevention Research Collaboration**

Members of the International COVID-19 Suicide Prevention Research Collaboration (ICSPRC) are monitoring trends in suicide, based on available data, including real-time suicide mortality data at international level.

Based on published data on suicidal ideation, self-harm, suicide and suspected suicide obtained during the first months of the COVID-19 pandemic (March-August 2020), there does not appear to be a significant increase in suicide in high-income countries. There are some suggestions that the trends may differ in low- and middle-income countries but it is not possible to be definitive about this due to the paucity of data from these countries. The absence of a significant increase in suicide in high-income countries may be associated with protective factors, as well as the implementation of national suicide prevention strategies, with all high-income countries involved currently implementing their second national strategy (WHO, 2018).

The relatively reassuring picture in high-income countries should be interpreted with caution as patterns may change over time. We know that many of the risk factors for suicide are being heightened by the pandemic, and the outcomes of this are unclear as of yet. The economic consequences of the pandemic are of concern, and steps need to be taken to ensure appropriate safety nets are in place for people facing financial hardship because of the risk this poses for suicidal behaviour. We also know that levels of community distress remain high compared to pre-pandemic levels, and that appropriate services must be made available for people in crisis and those facing mental health problems (Gunnell et al, 2020: Niederkrotenthaler et al., 2020).

**Summary of studies addressing the IMPACT of COVID-19 on suicidal ideation, self-harm and suicide**

*Suicidal ideation*

Four studies that examined the impact of COVID-19 on suicidal thoughts showed either a reduction or no change in presentations to health/mental health services or self-reported suicidal thoughts. Smalley et al. (2020) reported a fall in ED visits for suicidal thoughts in Midwest USA, as well as a fall in the proportion of total visits for suicidal thoughts. Hernández-Calle et al. (2020) reported a decrease in psychiatric emergency department visits due to suicidal ideation in Spain during March and April 2020 in comparison to the same period in 2019. While Titov et al., (2020) found evidence of increased contact volume to a national digital mental health service in Australia and increased anxiety and levels of concerns about COVID-19, which increased with age. There was no evidence that the percentage of contacts with suicidal thoughts/plans increased. Sade et al. (2020) examined suicidal thoughts among pregnant women before (3.0%) and during the first months of the pandemic (8.6%), finding no significant change.

*Self-harm and suicide*

The majority of available studies reported a decrease in self-harm/suicide attempts during the first months of the COVID-19 pandemic. However, two studies reported an increase. Pignon et al. (2020) reported a 54.8% decrease in overall psychiatric emergency consultations and a 42.6% decrease in self-harm/suicide attempts during the first 4 weeks of the lockdown in France compared to the same period in 2019. Gonçalves-Pinho et al. (2020) identified a significant reduction in presentations of suicidal and intentional self-inflicted injury to a psychiatric ED emergency department in Portugal between March 19th and May 2nd 2020 (47.2%), following a similar decrease in the same period of 2019.

Real-time data based on cases of suspected suicide, collected by the Suicide and Self-Harm Observatory (SSHO) in County Cork, Ireland, did not indicate a significant increase during the first months of COVID-19, in 2020, in comparison to data from the same period in 2019.

*Arensman et al, 2020*

## No visible increase in suicides in pandemic

The long-term economic impact of Covid-19 is of most concern, as job losses and financial hardship frequently contribute to suicide, say Mary Joyce, Ella Arensman, and Eve Griffin

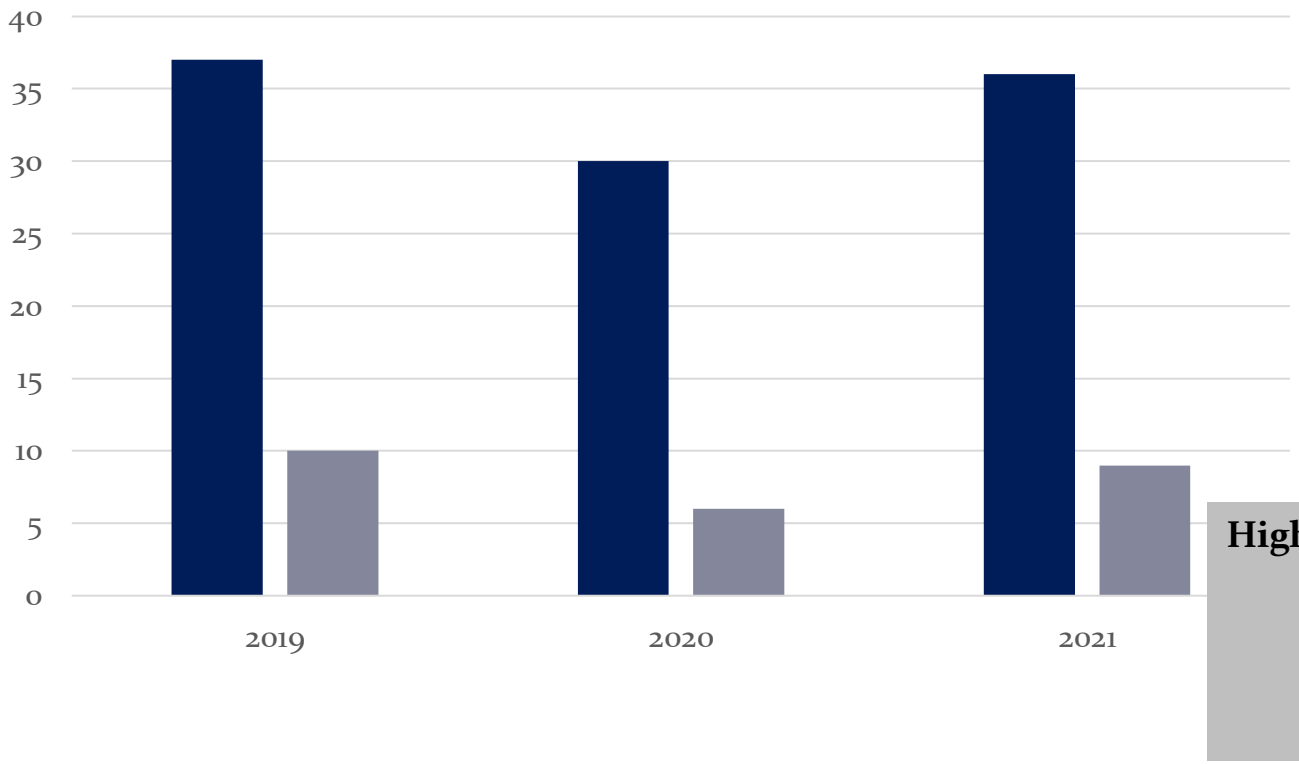
Irish Examiner 30 Apr 2021

A convoy of 50 vehicles from all sectors of the emergency services taking part in a drive-by on the streets of Kinsale, Co Cork, in aid of Pieta House's Darkness into Light fundraiser last year, which was curtailed because of Covid-19. During the pandemic, appropriate services should also be prioritised for known 'at-risk' groups and for those with known mental health difficulties.

Since the onset of the Covid-19 pandemic in early 2020, there has been concern and much debate about the impact of the pandemic on mental health and wellbeing of individuals. We hear many discussions referring to the 'real'

# But, we have to remain vigilant while the real-time suicide data for 2021 in County Cork indicates a slight increase

## Suicide rates in County Cork by gender 2019-2021




**Highest rate of suicide:**

♂ Men aged 45-49

♀ Women aged 40-44

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NCG National Centre for Geocomputation An tIonad Náisiúnta Geoiriomhaireachta

Maynooth University National University of Ireland Maynooth

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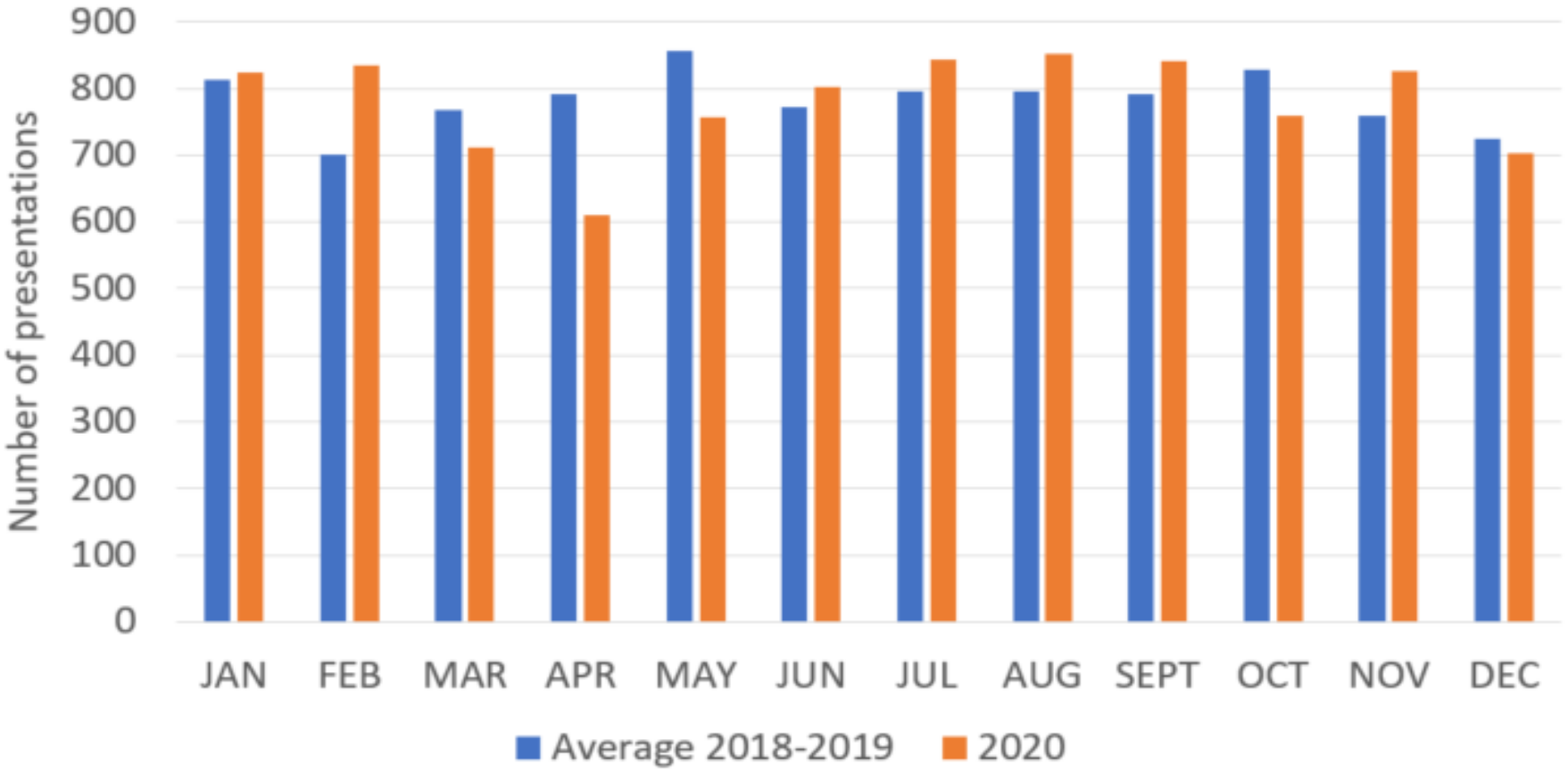
Connecting for Life

# Monthly self-harm presentations to 25 hospitals in Ireland during 2018-2019 and 2020 – National Self-Harm Registry Ireland

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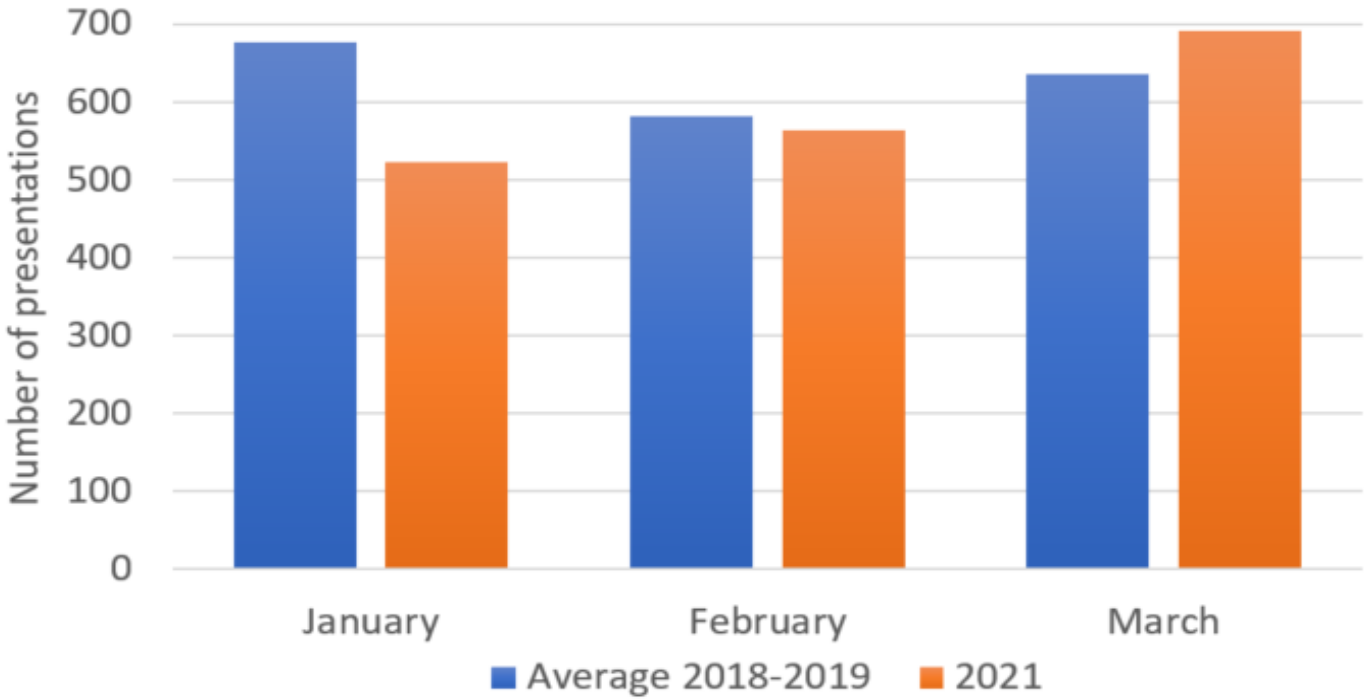
# Monthly self-harm presentations to 18 hospitals during January-March 2018-2019 and 2021 - National Self-Harm Registry Ireland




The overall rate ratio (RR) for self-harm rate in the first 3 months of 2021 was equal or similar to the rate in 2018-2019.

The date indicates a possible stepped increase in self-harm for 2021.

(*Corcoran et al, 2021)*

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# Recommended actions

- Prioritise access to real-time suicide mortality data and ongoing monitoring in order to examine changes in trends of suicide and self-harm during subsequent waves of COVID-19 and to improved preparedness of adapted mental health promotion programmes, capacity of mental health services

- Expand and strengthen interdisciplinary collaboration in mental health and suicide prevention research

- Prioritise evaluation and enhancement of new ways of working to conduct assessments and deliver mental health services to people presenting with self-harm and suicide risk, including new care pathways, remote consultation, and increased use of telemedicine and digital interventions.

- Pro-active communication and dissemination of surveillance and research outcomes relating to impacts of COVID-19 on suicide and self-harm to prevent misinformation in the media and to strengthen proactive suicide prevention/mitigating measures


Target

**3.4**

By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being

Indicators

**3.4.1**

Mortality rate attributed to cardiovascular disease, cancer, diabetes or chronic respiratory disease

**3.4.2**

Suicide mortality rate

# Key question:

Will the COVID-19 Pandemic accelerate or delay achieving the SDG Target 3.4:

*By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and wellbeing?*

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# *People who attempt suicide don't want to die, what they want is a different life*


*Bermans et al, 2009; Scoliers et al, 2009; Rasumussen et al, 2016; Bermans et al, 2017*

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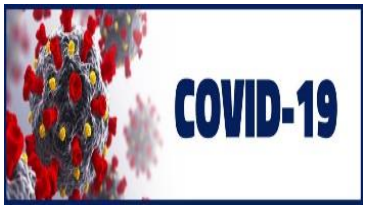


World Health Organization

## Mental health and psychosocial considerations during the COVID-19 outbreak

**18 March 2020**

In January 2020 the World Health Organization (WHO) declared the outbreak of a new coronavirus disease, COVID-19, to be a Public Health Emergency of International Concern. WHO stated that there is a high risk of COVID-19 spreading to other countries around the world. In March 2020, WHO made the assessment that COVID-19 can be characterized as a pandemic.

WHO and public health authorities around the world are acting to contain the COVID-19 outbreak. However, this time of crisis is generating stress throughout the population. The considerations presented in this document have been developed by the WHO Department of Mental Health and Substance Use as a series of messages that can be used in communications to support mental and psychosocial well-being in different target groups during the outbreak.

### Messages for the general population

1. COVID-19 has and is likely to affect people from many countries, in many geographical locations. When referring to people with COVID-19, do not attach the disease to any particular ethnicity or nationality. Be empathetic to all those who are affected, in and from any country. People who are affected by COVID-19 have not done anything wrong, and they deserve our support, compassion and kindness.

2. Do not refer to people with the disease as "COVID-19 cases", "victims" "COVID-19 families" or "the diseased". They are "people who have COVID-19", "people who are being treated for COVID-19", or "people who are recovering from COVID-19", and after recovering from COVID-19 their life will go on with their jobs, families and loved ones. It is important to separate a person from having an identity defined by COVID-19, in order to reduce stigma.

**Policy Brief: COVID-19 and the Need for Action on Mental Health**

13 MAY 2020


EDITORIALS

Trends in suicide during the covid-19 pandemic

Prevention must be prioritised while we wait for a clearer picture

Ann John, Jane Pirkis, David Gunnell, Louis Appleby, Jacqui Morrissey

Preventive action

Editorial

Suicide Research, Prevention, and COVID-19

Global Response and the Establishment ational Research Collaboration

otenthaler, David Gunnell, Ella Arensman, Jane Pirkis, Louis Appleby, n John, Nav Kapur, Murad Khan, Rory C. O'Connor, Steve Platt, and COVID-19 Suicide Prevention Research Collaboration

THE LANCET Psychiatry

Comment

Suicide risk and prevention during the COVID-19 pandemic

The mental health effects of the coronavirus disease 2019 (COVID-19) pandemic might be profound and there are suggestions that suicide rates will rise, not inevitable. Suicide is likely to become g concern as the pandemic spreads and n effects on the general population, the vulnerable groups. Preventing suicide ls urgent consideration. The response on, but extend beyond, general mental nd practices.

me evidence that deaths by suicide he USA during the 1918–19 influenza among older people in Hong Kong 03 severe acute respiratory syndrome ic.3 The current context is different and e-ranging interdisciplinary response that the pandemic might heighten risk and dge about effective suicide prevention key. Selective, indicated, and universal re required (figure).

verse effects of the pandemic on people ness, and on population mental health ht be exacerbated by fear, self-isolation,

People in suicidal crises require special attention. Some might not seek help, fearing that services are overwhelmed and that attending face-to-face appointments might put them at risk. Others may seek help from voluntary sector crisis helplines which might be stretched beyond capacity due to surges in calls and reductions in volunteers. Mental health services should develop clear remote assessment and care pathways for people who are suicidal, and staff training to support new ways of working. Helplines will require support to maintain or increase their volunteer workforce, and offer more flexible methods of working. Digital training resources would enable those who have not previously worked with people who are suicidal to take active roles in mental health services and helplines. Evidence-based online interventions and applications should be made available to support people who are suicidal.[3]

Loss of employment and financial stressors are well-recognised risk factors for suicide.[4] Governments should provide financial safety nets (eg, food, housing, and unemployment supports). Consideration must be given not only to individuals' current situations but also their futures. For example, many young people have

*Lancet Psychiatry* 2020
Published Online
April 21, 2020
https://doi.org/10.1016/
S2215-0366(20)30171-1

For the **Royal College of Psychiatrists guidance** see https://www.rcpsych.ac.uk/about-us/responding-to-covid-19/responding-to-covid-19-guidance-for-clinicians

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