

FINDINGS FROM THE SUICIDE AND SELF-HARM OBSERVATORY DURING THE COVID-19 PANDEMIC

The Suicide and Self-Harm Observatory (SSHO)

The process of verification, registration and classification of external causes of death, including suicides in Ireland usually involves several months and, in some cases, up to two years due to the requirement of a Coroner's inquest and the involvement of An Garda Síochána, pathologists, and Vital Statistics Registrars.¹ Having access to a real-time surveillance system, the outputs of which can be measured against Central Statistics Office data once published, will assist in early identification of emerging suicide and self-harm clusters, a timely response to people affected by suicide and self-harm, and verification of anecdotal evidence and public statements on suicide and self-harm that are disseminated via media outlets, including social media.

The methods and procedures of the Observatory meet international best-practice criteria for real-time surveillance of suicide mortality data and align with existing systems such as the Thames Valley Real-Time Surveillance System Buckinghamshire, Berkshire & Oxfordshire, United Kingdom;² the interim Queensland Suicide Register, Queensland, Australia;³ the Victorian Suicide Register, Victoria, Australia,⁴ and the Coronial Suspected Suicide Data Sharing Service, New Zealand.^{5,6}

The SSHO has been developed with the main aim to obtain minimal data on suspected suicide cases from the Coroners, the HSE Patient Mortality Register and the NSHRI on a real-time basis. Information collected by the SSHO:

- Increases the capacity for early intervention in instances where emerging suicide and self-harm clusters are identified.
- Facilitates implementation or activation of local plans to respond to emerging clusters.
- Assists with optimising resource allocation and location by means of spatial analysis.
- Informs health service responses in geographical areas with recurring clusters.
- Provides up-to-date data in relation to locations where people frequently take their lives.

A systematic approach is applied to the data collection process. An encrypted Masterfile database is stored within the NSRF, UCC. Access to the database is restricted to the PhD researcher and Principal Investigator of the project, who possess a unique identifier that permits access to the database. Evidence-based screening criteria are applied to ensure that only cases that meet the criteria for suspected suicide are recorded in the database. An additional encrypted data file exists and is used by the NSRF, UCC for research purposes. Confidentiality is strictly maintained, and all information extracted from the master database and input into the data file is coded to ensure anonymity. No personal information is detailed in this data file that could expose the identity of the deceased or their next of kin.

Telephone communication is deemed the most secure method of contact to gather data from the data sources as it ensures data is protected and avoids potential interception of emails containing sensitive information. In instances where telephone communication is deemed unsuitable or inefficient due to capacity related issues, onsite data collection is conducted. This active surveillance method ensures regular, routine, and reliable data collection. Data collection is conducted by the PhD researcher in the Cork region, while HSE Resource Officers for Suicide Prevention (ROSPs) will undertake this task in their respective localities and maintain their relevant database. Data will be routinely provided by the ROSPs to the PhD Researcher for inclusion in the Masterfile.

In order to maintain real-time surveillance data on all cases of suspected suicide in the locality, the PhD Researcher (in Cork) or the ROSP (elsewhere) contact the office of the Coroner via phone or alternatively conduct onsite visits on a fortnightly basis. Data that is available prior to coronial inquest is collected and recorded in the database, based on the following core variables:

Abiding by the Coroners Act 1962, information provided by the Coroners will under no circumstances be used to communicate with any individual related to a suspected suicide case until after an inquest has been held.

The SSHO fulfils both national and international objectives based on the need for real-time suicide mortality data, including Ireland's National Strategy to Reduce Suicide 2015-2020 'Connecting for Life', objective 7.2: Improve access to timely and high-quality data on suicide; the World Health Organisation Collaborating Centre work programme agreement to facilitate real-time suicide data and the United Nations Sustainable Development Goal 3, target 2.4 to reduce by one third premature mortality from noncommunicable diseases through prevention, treatment and promotion of mental health and well-being by 2030, of which suicide mortality rate is an indicator.

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Complete data on suspected suicide cases has been made available by the Cork County Coroners in real-time for inclusion in the SSHO. Data on all cases of suspected suicide that occurred in County Cork between January 2019 – December 2020 have been collated by the system. Based on a yearly comparison, no significant increase has been observed between 2019 (n=53) and 2020 (n=40), despite the onset of the pandemic and the government implementation of restriction measures in Ireland in March 2020. The gender ratio of deaths by suspected suicide was consistent overall, with men accounting for four of every five deaths by suspected suicide during both years of observation. The high-risk age bracket of 45-49 years-old remained unchanged across both years. In 2020, half of all deaths by suspected suicide in County Cork took place at the home residence of the individual (50%), a reduction from 2019 (59%). The Observatory did not identify a change in methods involved in suspected suicides comparing 2019 and 2020.

International comparison

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

Based on published data on suicide obtained during the first months of the COVID-19 pandemic: January – July 2020, there does not appear to be a significant increase in suicide in high-income countries.¹⁰ 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), showed no evidence of a significant increase in risk of suicide since the pandemic began in any country or area. In 12 of these countries, there was evidence of a decrease in suicide, comparing the expected to the observed suicide data.

The relatively reassuring picture in high- and upper-middle-income countries during the first wave of the COVID-19 pandemic should be interpreted with caution as patterns may change over time, and therefore vigilance and ongoing monitoring of suicide is a key priority. 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.^{11,12}

References

1. Corcoran P, Arensman E. A Study of the Irish System of Recording Suicide Deaths. *Crisis*. 2010; 31(4):174-82.
2. Fahie H, Sharma N, Colchester D. *Thames Valley Real – Time Suicide Surveillance System Resource Pack*. Available from: <https://www.nspa.org.uk/wp-content/uploads/2017/10/Thames-Valley-Real-Time-Suicide-for-website-FINAL-with-links.pdf> [Accessed 5th March 2021].
3. Leske S, Kölves, K, Crompton D, Arensman E, de Leo D. Real-time suicide mortality data from police reports in Queensland, Australia, during the Covid-19 pandemic: an interrupted time-series analysis. *The Lancet Psychiatry*. 2020; 8(1):58-63.
4. Sutherland G, Milner A, Dwyer J, Bugeja L, Woodward A, Robinson J, Pirkis J. Implementation and evaluation of the Victorian Suicide Register. *Australian and New Zealand Journal of Public Health*. 2018; 42: 296–302.
5. Clinical Advisory Services Aotearoa. *Coronial Suspected Suicide Data Sharing Service (CDS) Explanatory Notes*. Available from: <https://www.casa.org.nz/resources/public/39-cds-explanatory-notes/file> [Accessed 5th March 2021].
6. Benson R, et al. Real-time surveillance of suicide mortality data: recommendations for international best-practice criteria. 2021, In progress.
7. Department of Health. *Connecting for Life, Ireland’s National Strategy to Reduce Suicide 2015-2020*. Dublin, Ireland: Department of Health; 2015.
8. Department of Health. *Sharing the Vision: A Mental Health Policy for Everyone*. Dublin, Ireland: Department of Health; 2020.
9. United Nations. *Transforming our world: the 2030 Agenda for Sustainable Development*. United Nations, New York; 2015
10. Pirkis J, John A, Shin S, DelPozo-Banos M, Arya V, Analuisa-Aguilar P, Appleby L, Arensman E, Bantjes J, Baran A, Bertolote JM. Suicide trends in the early months of the COVID-19 pandemic: an interrupted time-series analysis of preliminary data from 21 countries. *The Lancet Psychiatry*. 2021 Apr 13.
11. Gunnell D, Appleby L, Arensman E, Hawton K, John A, Kapur N, Khan M, O’Connor RC, Pirkis J, Caine ED, Chan LF. Suicide risk and prevention during the COVID-19 pandemic. *The Lancet Psychiatry*. 2020; 7: 468–71.
12. Niederkrotenthaler T, Gunnell D, Arensman E, Pirkis J, Appleby L, Hawton K, John A, Kapur N, Khan M, O’Connor RC, Platt S. Suicide research, prevention, and COVID-19. *Crisis*. 2020; 41: 321–330.

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