Method

Sites: **10** STPs

Population: **13 million**

January – October 2020

Main results

January-March 2020 – **125.7** suicides

April-October 2020 – **121.3** suicides

No significant rise in individual months after lockdown began

Comparison of rates (2020 v 2019) showed no difference

Conclusions

Predicted large national rise has **not occurred in these areas**, despite evidence of greater distress.

Caveats apply –
Early overall data
Local impact may vary
Variation between groups
RTS use is new and further development is needed

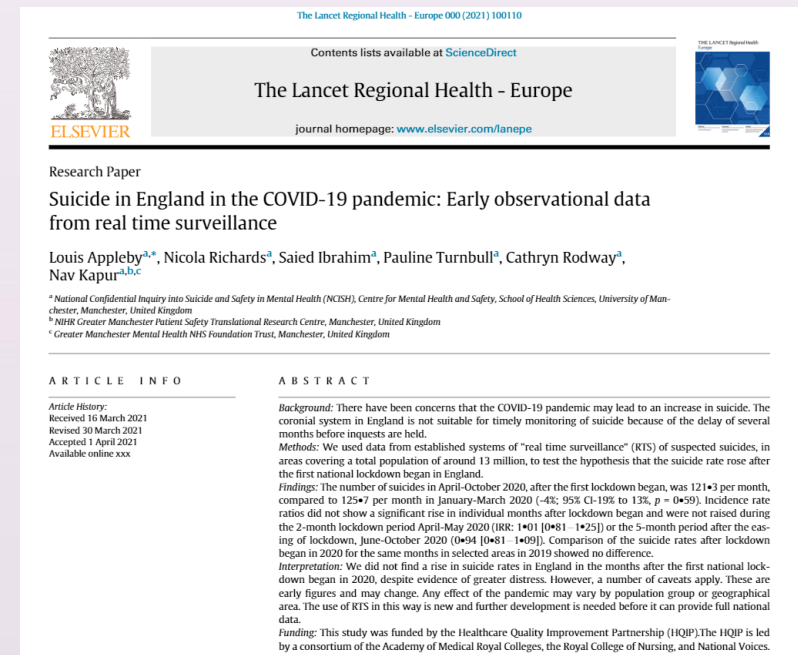May change with **economic adversity**

Reasons for no rise

Suicide rates **do not follow levels of mental disorder**

Increased vigilance and **support** from family, friends and neighbours

Reduced access to certain methods

Increase in **social coherence**

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Research Paper

Suicide in England in the COVID-19 pandemic: Early observational data from real time surveillance

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ABSTRACT

Background: There have been concerns that the COVID-19 pandemic may lead to an increase in suicide. The coronial system in England is not suitable for timely monitoring of suicide because of the delay of several months before inquests are held.
Methods: We used data from established systems of "real time surveillance" (RTS) of suspected suicides, in areas covering a total population of around 13 million, to test the hypothesis that the suicide rate rose after the first national lockdown began in England.
Findings: The number of suicides in April-October 2020, after the first lockdown began, was 121·3 per month, compared to 125·7 per month in January-March 2020 (-4%; 95% CI-19% to 13%, $p = 0·59$). Incidence rate ratios did not show a significant rise in individual months after lockdown began and were not raised during the 2-month lockdown period April-May 2020 (IRR: 1·01 [0·81 - 1·25]) or the 5-month period after the easing of lockdown, June-October 2020 (0·94 [0·81 - 1·09]). Comparison of the suicide rates after lockdown began in 2020 for the same months in selected areas in 2019 showed no difference.
Interpretation: We did not find a rise in suicide rates in England in the months after the first national lockdown began in 2020, despite evidence of greater distress. However, a number of caveats apply. These are early figures and may change. Any effect of the pandemic may vary by population group or geographical area. The use of RTS in this way is new and further development is needed before it can provide full national data.
Funding: This study was funded by the Healthcare Quality Improvement Partnership (HQIP).The HQIP is led by a consortium of the Academy of Medical Royal Colleges, the Royal College of Nursing, and National Voices. Its aim is to promote quality improvement in patient outcomes, and in particular, to increase the impact that

Suicide & Covid-19

During the early months of the pandemic there was limited evidence of an increase in suicide

This apparent lack of an increase, despite adverse changes in a number of risk factors, may be a result of the buffering effect of financial support measures and increased social cohesion

Support needs to continue

Important to note

- Proactive suicide prevention measures are critical to mitigate long-term negative impacts
- Impact may change over time and vary by subgroups
- Data limited to high/upper-middle income countries
- There are some suggestions from newspaper reports that the pandemic is having an adverse effect in economically poorer nations

https://bit.ly/3d9t9pm

Results

Suicide numbers remained **unchanged** or **declined**

Articles

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

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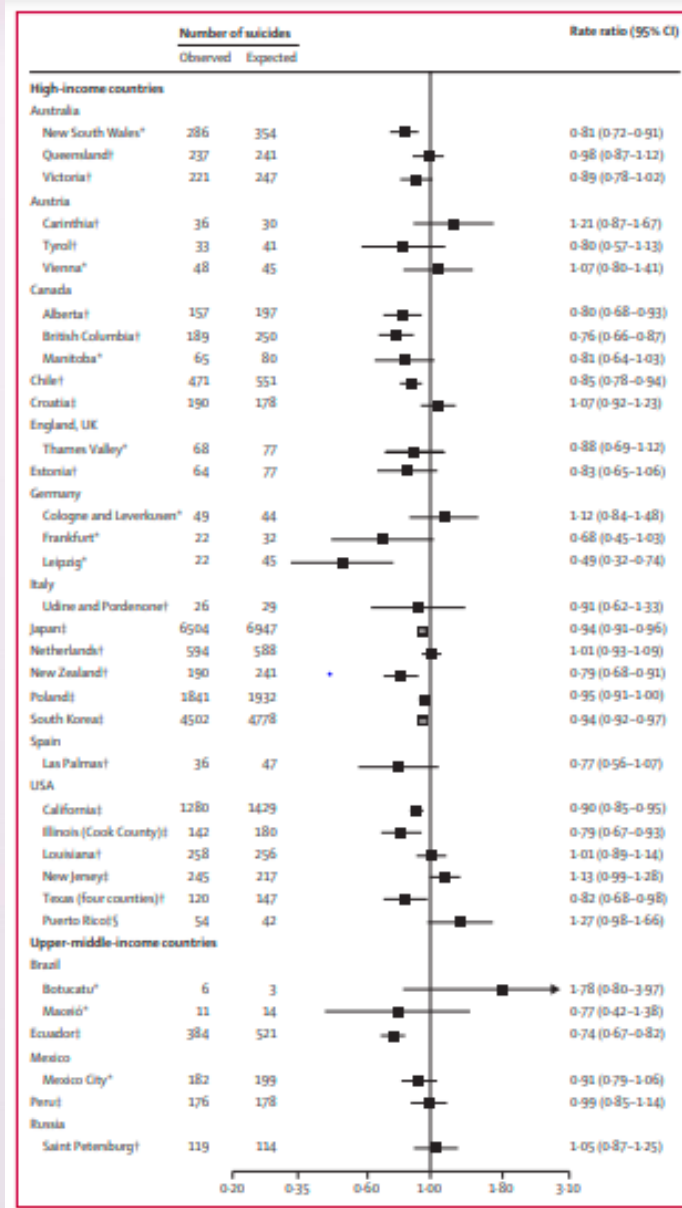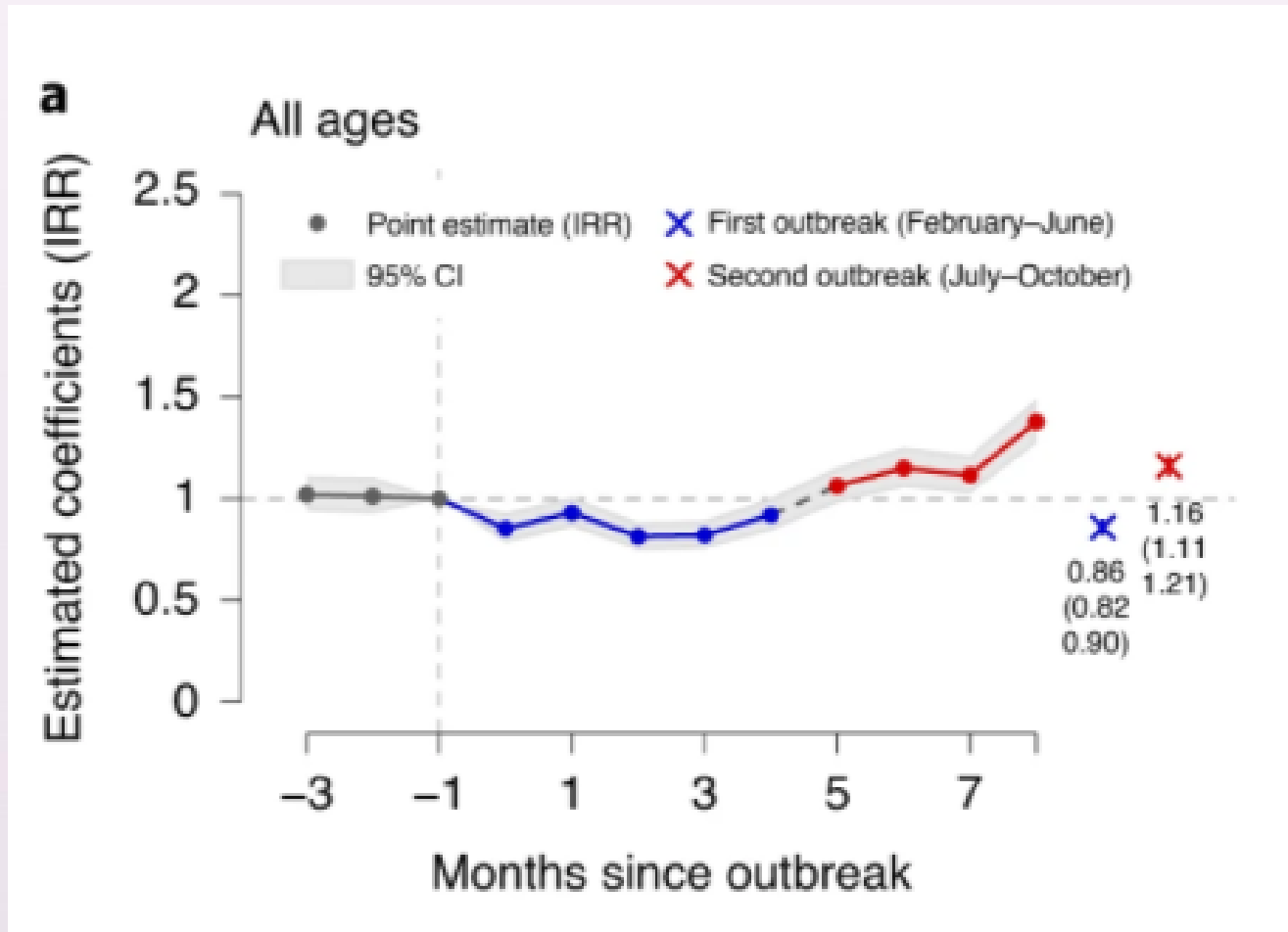
UCL social survey: COVID stress
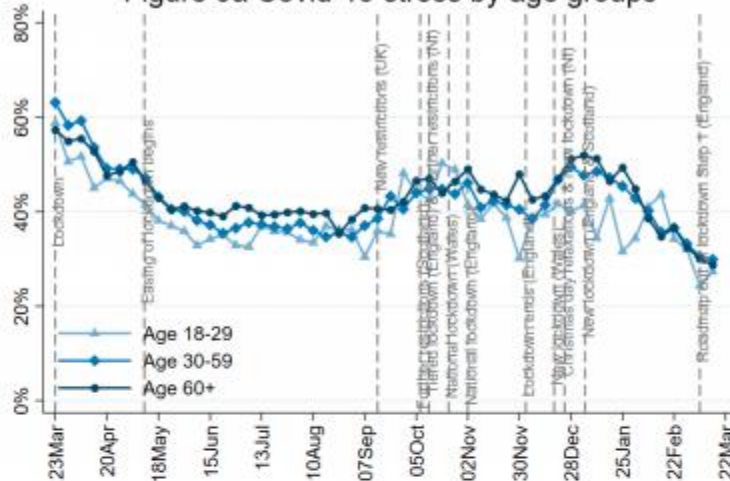

Figure 9a Covid-19 stress by age groups

Figure 9b Covid-19 stress by living arrangement

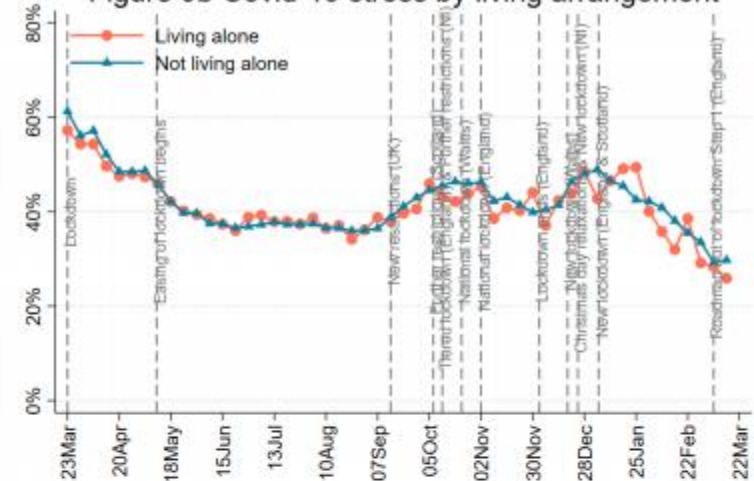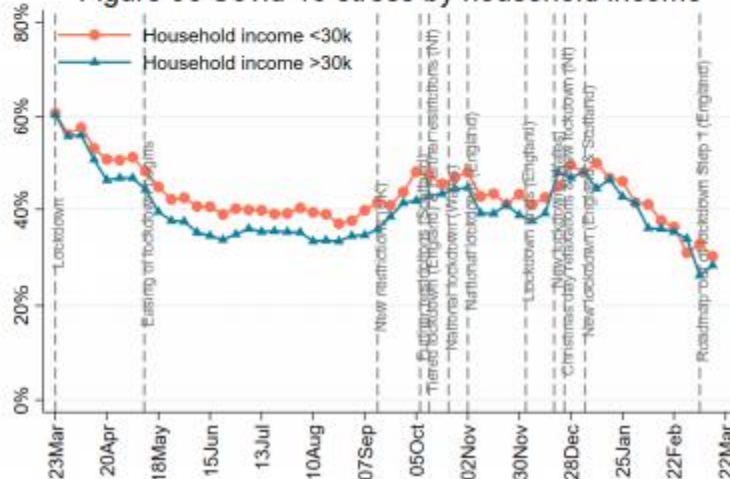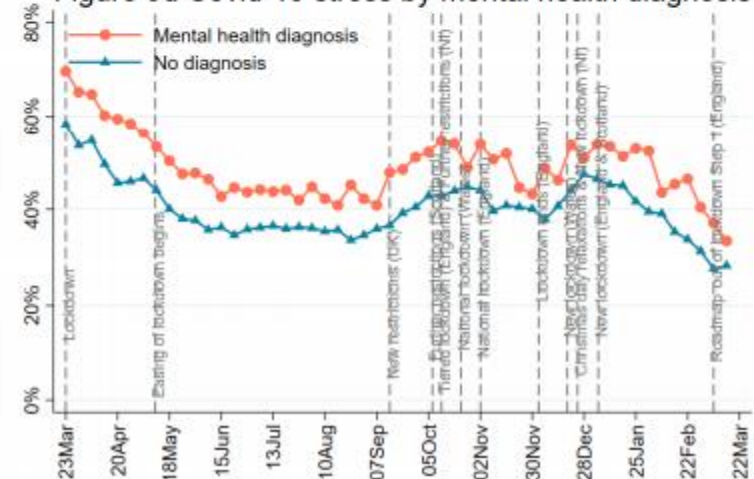Figure 9c Covid-19 stress by household income

Figure 9d Covid-19 stress by mental health diagnosis

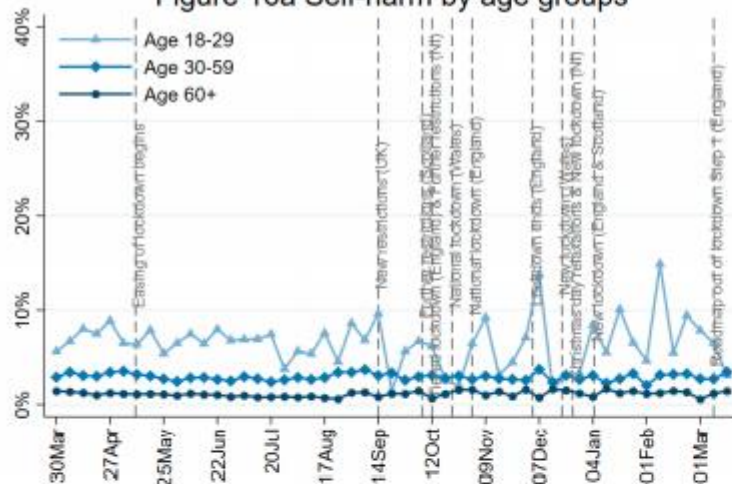Figure 16a Self-harm by age groups
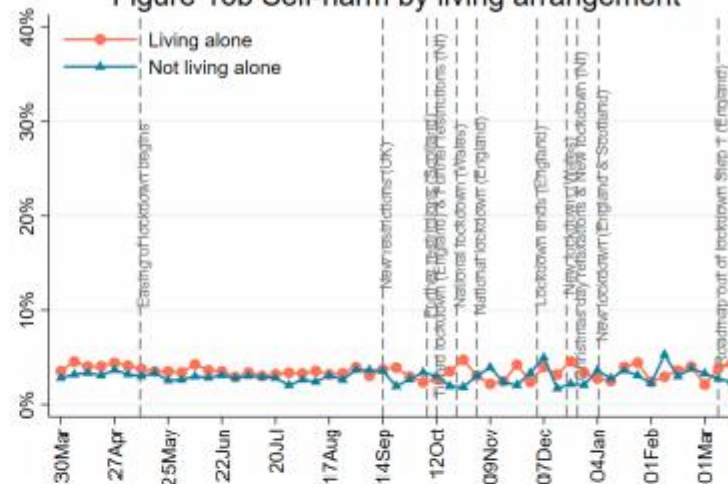
Figure 16b Self-harm by living arrangement
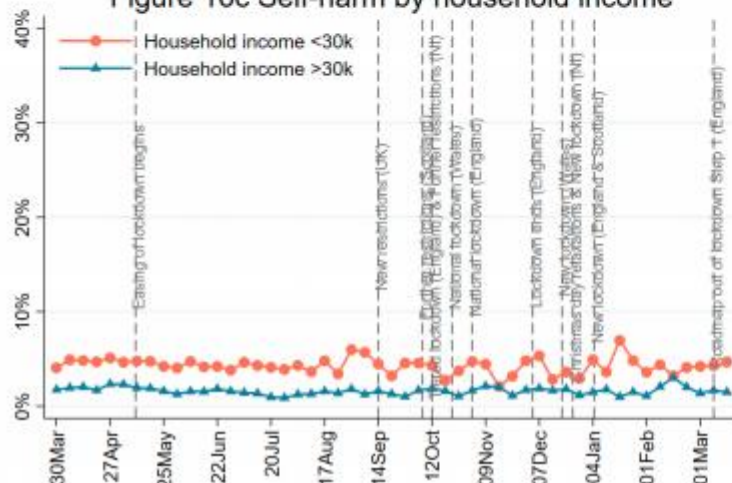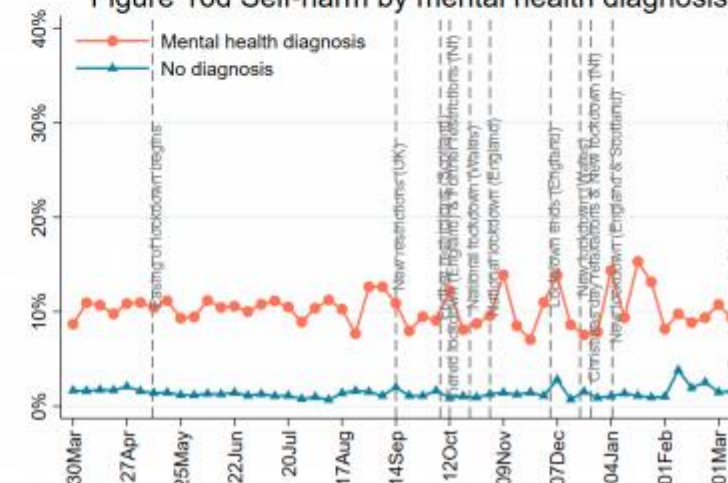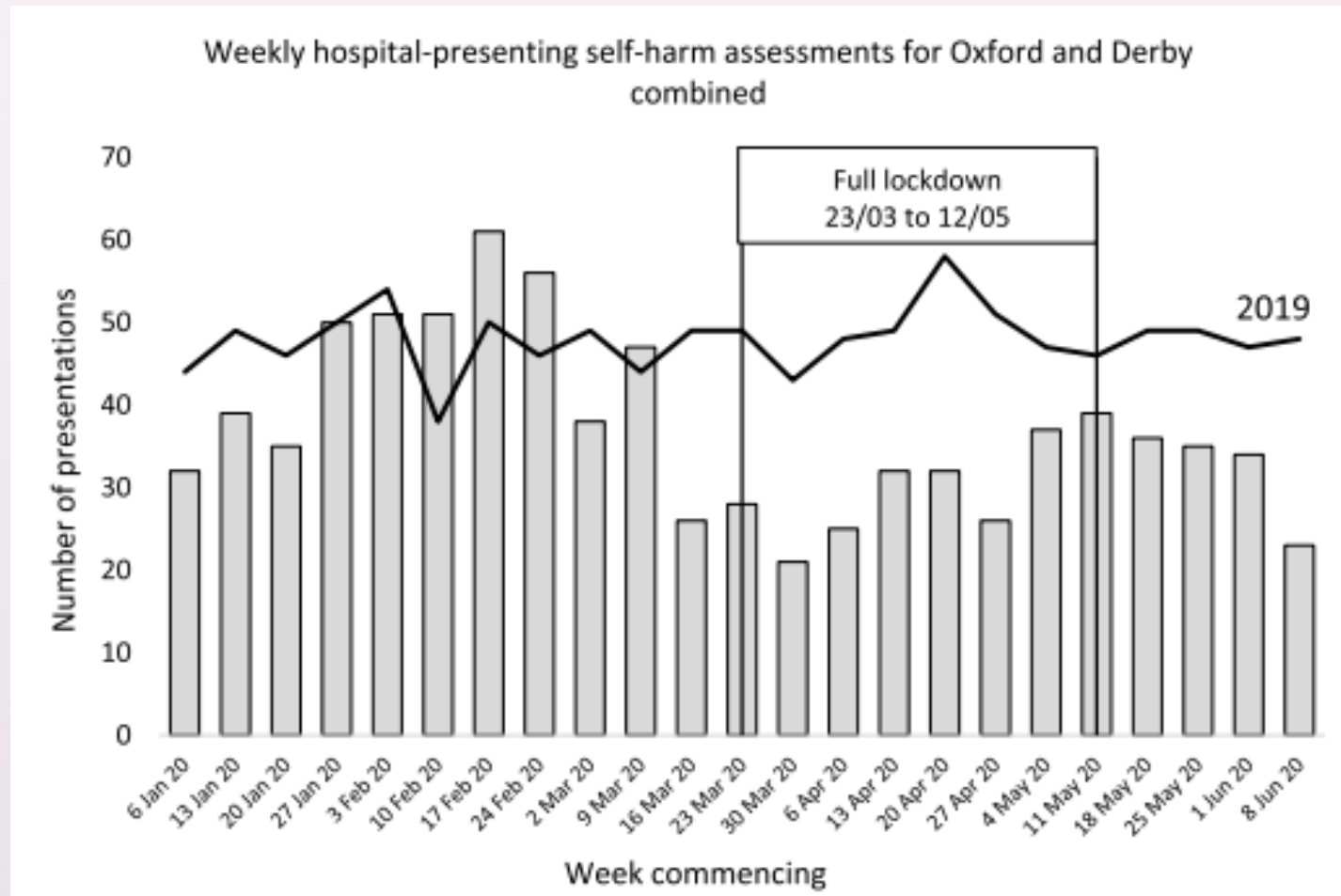
Figure 16c Self-harm by household income

Figure 16d Self-harm by mental health diagnosis

Weekly hospital-presenting self-harm assessments for Oxford and Derby combined

228 patients presented to ED assessed

46.9% COVID-19-related factors

Females particularly affected

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Self-harm and the COVID-19 pandemic: A study of factors contributing to self-harm during lockdown restrictions

COVID-19-related factors identified as influencing self-harm, by gender

Factors influencing Self-harm	Males (N=39)	Females (N=68)	Total (N=107)
Overall mental health problems	11	22	33
Mental health/worsening of mental health	5	15	20
Loss/reduction of supports for mental health problems	7	10	17
Isolation /Loneliness	14	17	31
Lack/reduced contact	9	14	23
Lack/ reduced contact with family	5	10	15
Reduced contact with social network	4	6	10
Disruption to normal routine	6	14	20
Entrapment	5	13	18
Interpersonal conflict	3	9	12
Employment (including loss/furloughed)	9*	3	12
Fear of COVID infection	3	7	10
Self becoming infected	2	3	5
Self infecting others	0	2	2
Others becoming infected	2	3	5
Accommodation/housing	3	4	7
Education/ training	1	6	7
Financial	5*	1	6
General concerns about impact of Covid	0	5	5
Substance misuse	2	2	4
Alcohol	2	2	4
Drugs	1	0	1
Domestic abuse (actual/threatened)	0	3	3
Bereavement due to Covid	0	1	1
Other	2	2	4

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