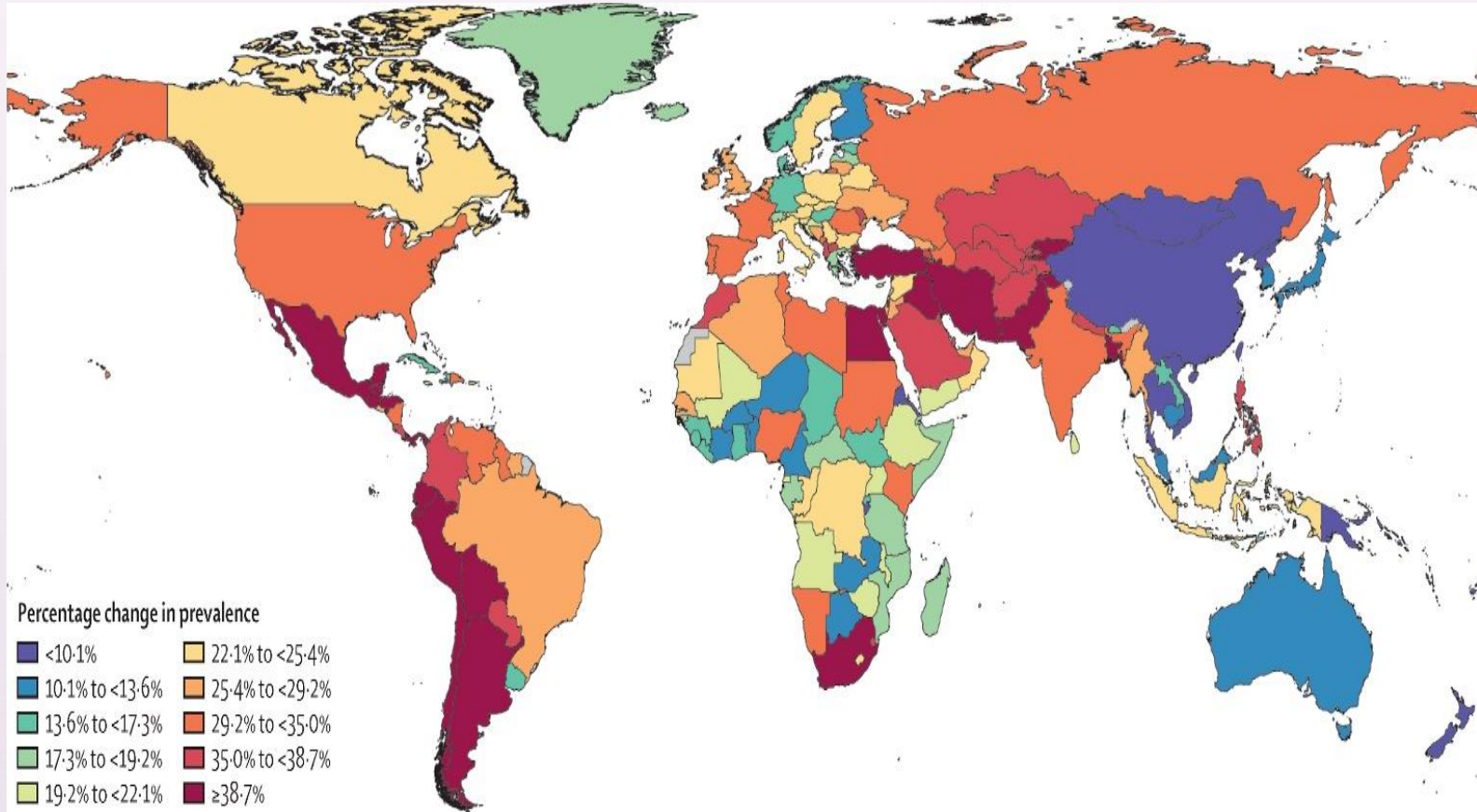
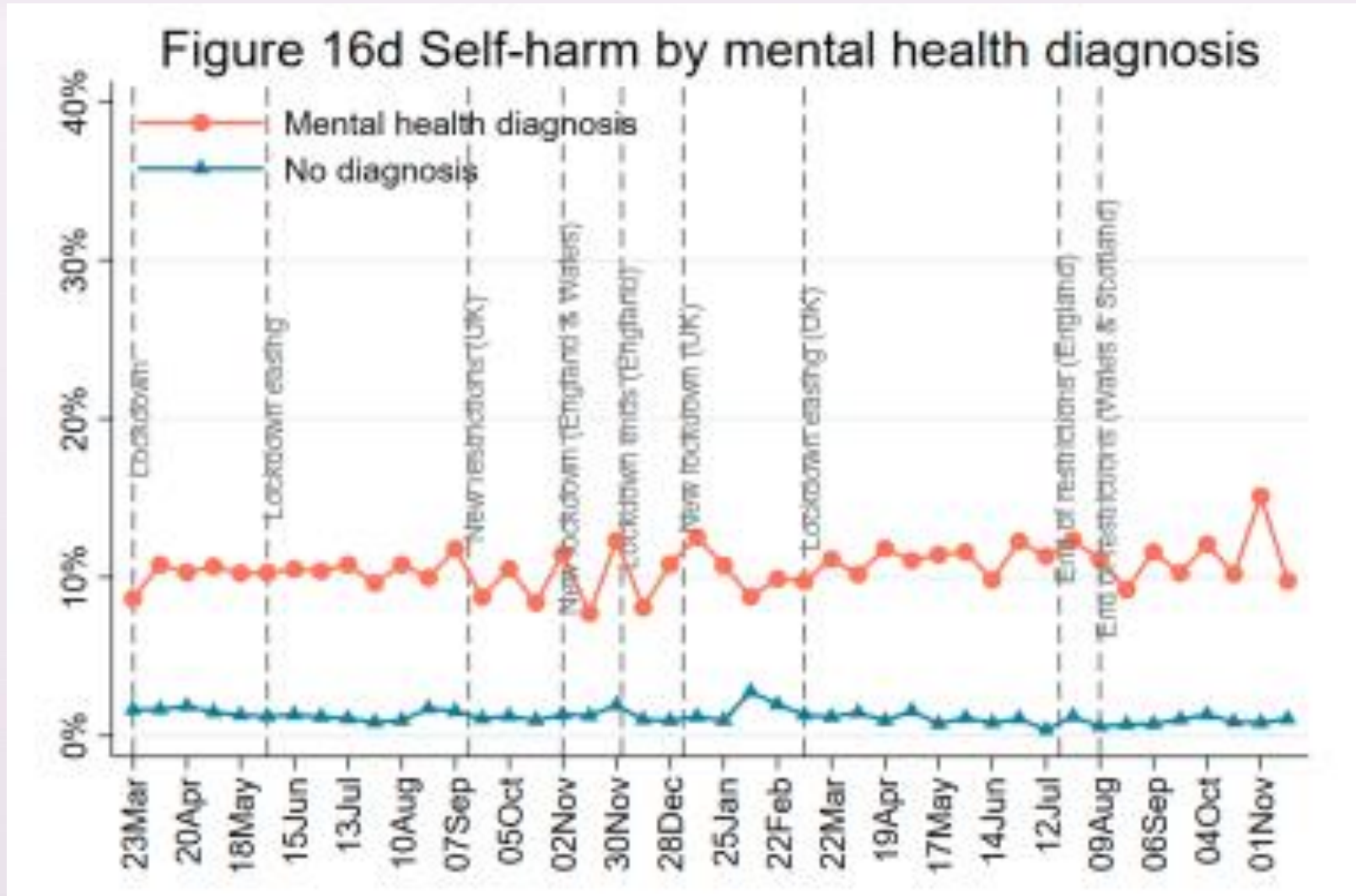


# National suicide prevention response to Covid pandemic

January 27, 2022

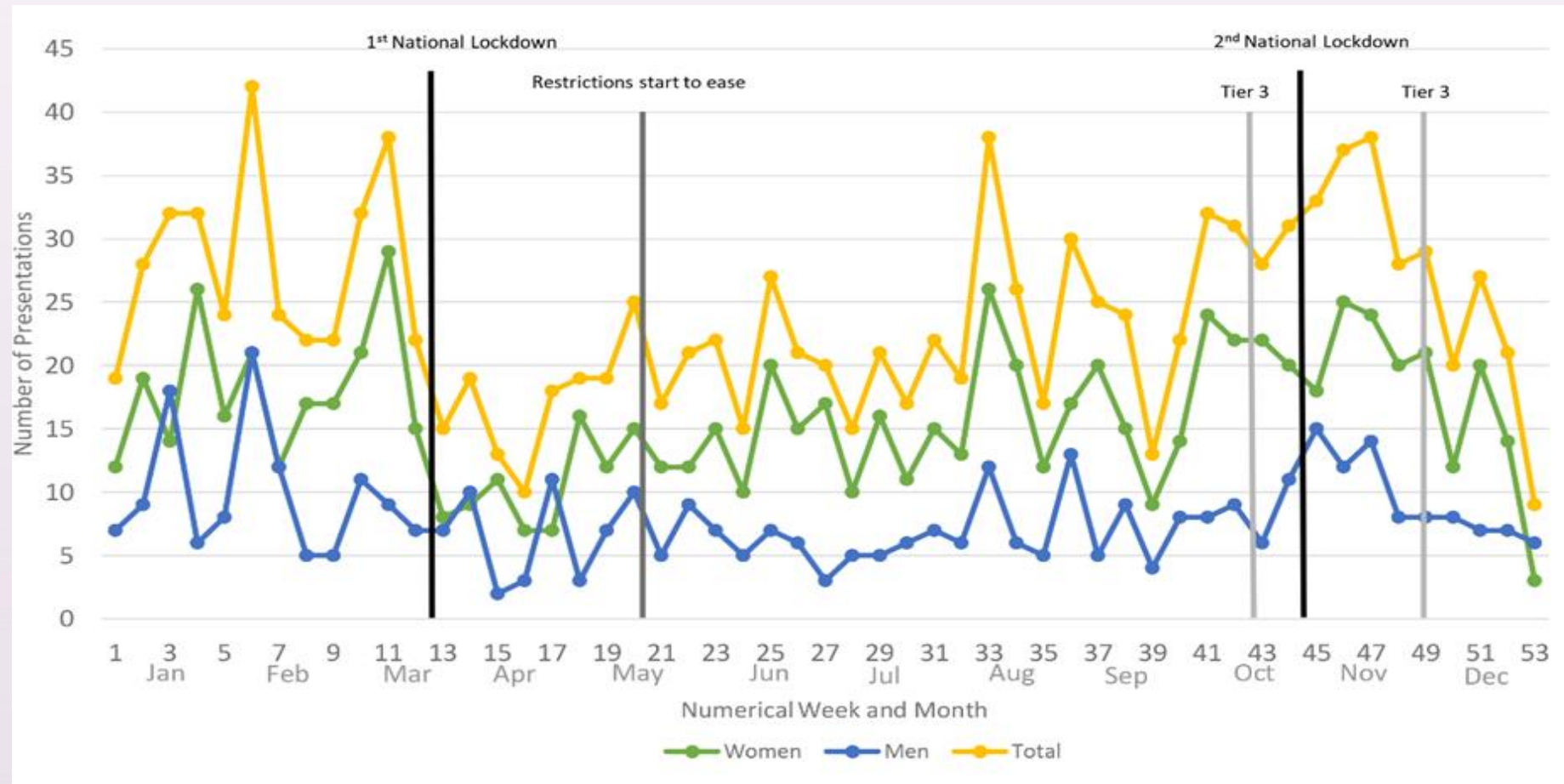
**Professor Louis Appleby**







## Total weekly self-harm presentations in 2020 to the Emergency Department in two Manchester hospitals



**228** patients  
presented to ED  
assessed

**47%** COVID-19-related  
factors

**Females** particularly  
affected



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

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



\* impacts on mental health influenced hospital

hospitals in Oxford whether the self-harm These factors were specific characteristics,

s were identified as s, N = 39/101,  $\chi^2$  = nt between the two and worsening distion and loneliness, utiple, often inter-

s presenting to hos- males were particu- , predominated has loneliness and sense reach out to others, n aide-memoire for

## Method


Sites: **10** NHS regions

Population: **13** million

January – October 2020

The Lancet Regional Health - Europe 000 (2021) 100110

Contents lists available at ScienceDirect

 **The Lancet Regional Health - Europe**

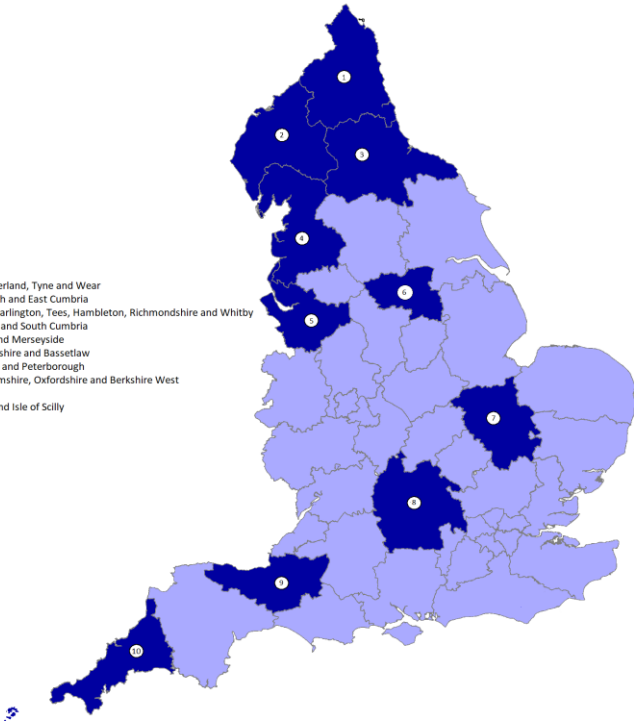
journal homepage: [www.elsevier.com/lanep](http://www.elsevier.com/lanep)

Research Paper

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

Louis Appleby<sup>a,\*</sup>, Nicola Richards<sup>a</sup>, Saied Ibrahim<sup>a</sup>, Pauline Turnbull<sup>a</sup>, Cathryn Rodway<sup>a</sup>, Nav Kapur<sup>a,b,c</sup>

<sup>a</sup> National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH), Centre for Mental Health and Safety, School of Health Sciences, University of Manchester, Manchester, United Kingdom  
<sup>b</sup> NIHR Greater Manchester Patient Safety Translational Research Centre, Manchester, United Kingdom  
<sup>c</sup> Greater Manchester Mental Health NHS Foundation Trust, Manchester, United Kingdom



**STP**

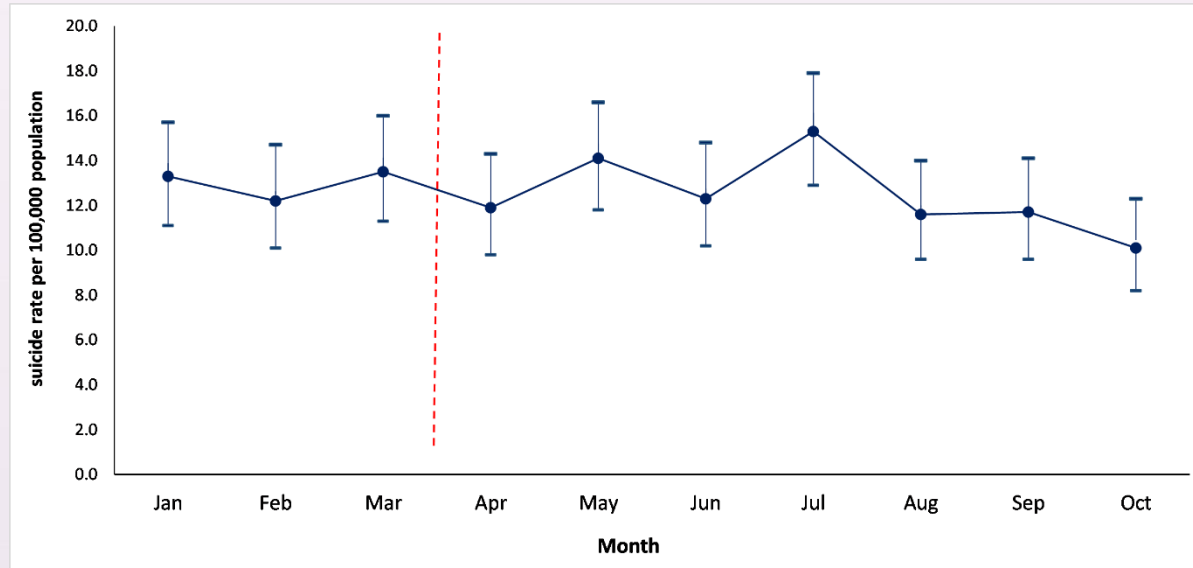
1. Northumberland, Tyne and Wear
2. West, North and East Cumbria
3. Durham, Darlington, Tees, Hambleton, Richmondshire and Whittby
4. Lancashire and South Cumbria
5. Cheshire and Merseyside
6. South Yorkshire and Bassettlaw
7. Cambridge and Peterborough
8. Buckinghamshire, Oxfordshire and Berkshire West
9. Somerset
10. Cornwall and Isle of Scilly

demical may lead to an increase in suicide. The incidence of suicide because of the delay of several weeks of surveillance" (RTS) of suspected suicides, in the hypothesis that the suicide rate rose after the first lockdown began, was 121.43 per month, 95% CI: 19% to 13%,  $p = 0.59$ . Incidence rate after lockdown began and were not raised during the 1-1.25) or the 5-month period after the comparison of the suicide rates after lockdown showed no difference. In the months after the first national lockdown, a number of caveats apply. These are likely to vary by population group or geographical area and it is needed before it can provide full national surveillance data.

Healthcare Quality Improvement Partnership (HQIP). The HQIP is led by the Royal College of Nursing, and National Voices, and in particular, to increase the impact that

# Suicide in England in the COVID-19 pandemic: early data from RTS

## 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

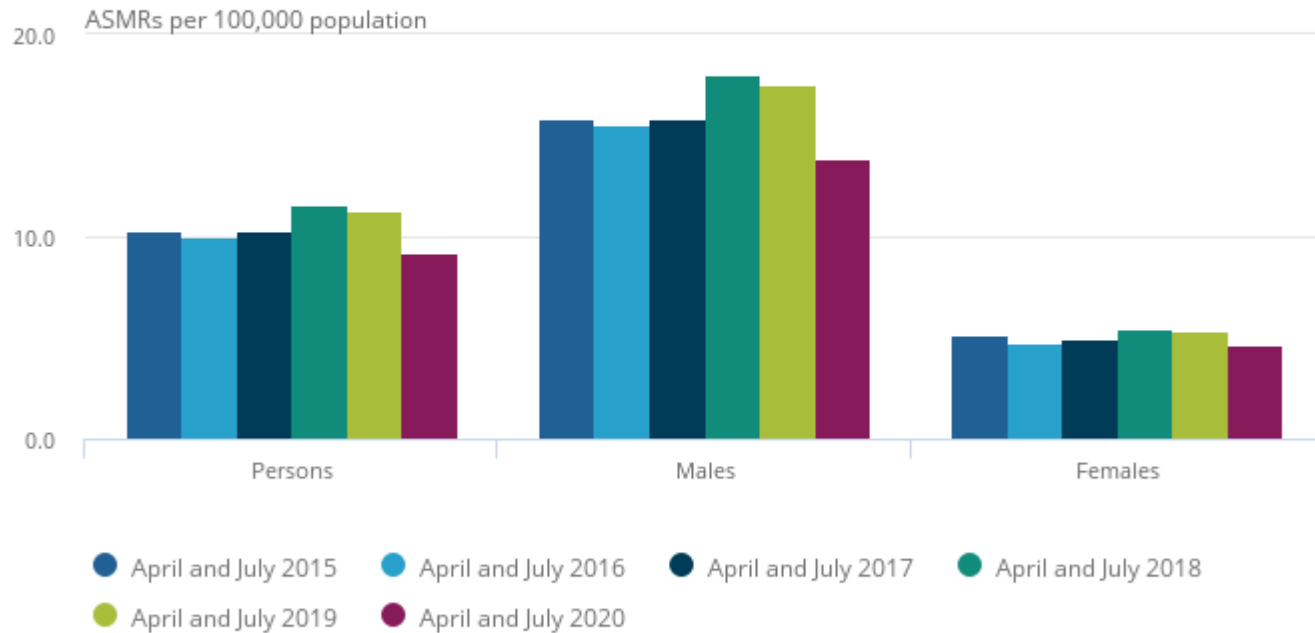
**RTS use is new** and further development is needed

May change with **economic adversity**



**Figure 1: The April to July 2020 suicide rate decreased significantly for males**

Age-standardised suicide rates by sex, England and Wales, deaths occurring between April and July, between 2015 and 2020

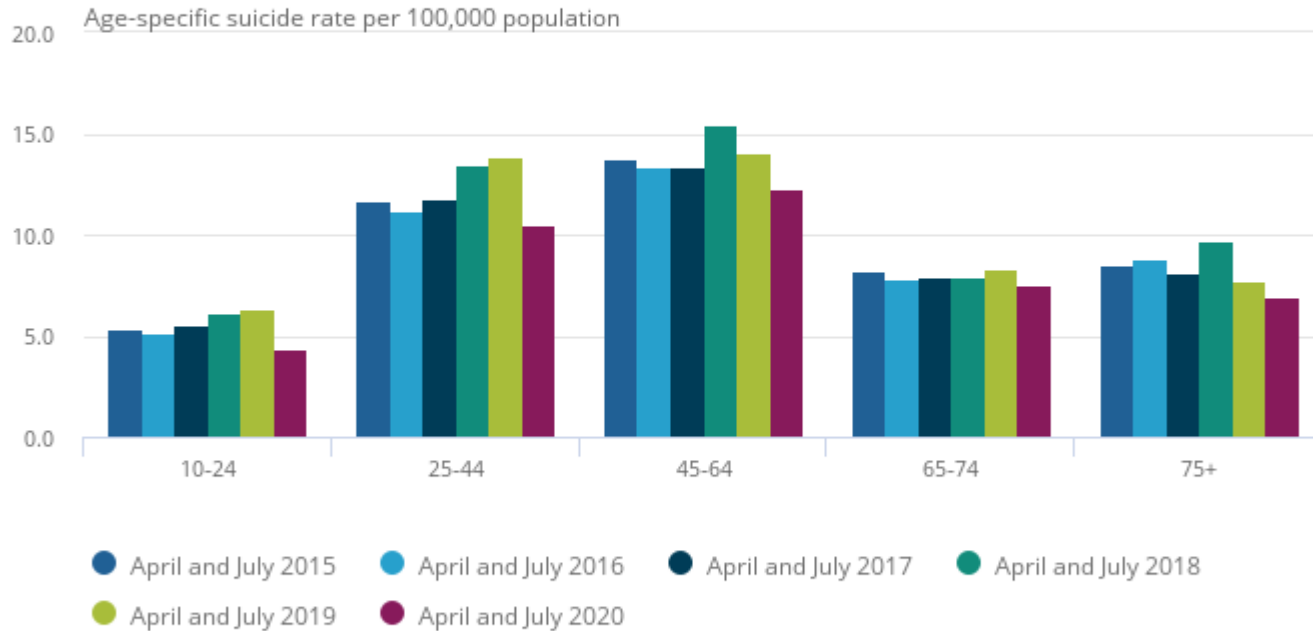


**Source: Office for National Statistics - Deaths from suicide that occurred in England and Wales**

# Suicide in the Covid-19 pandemic: early data from ONS

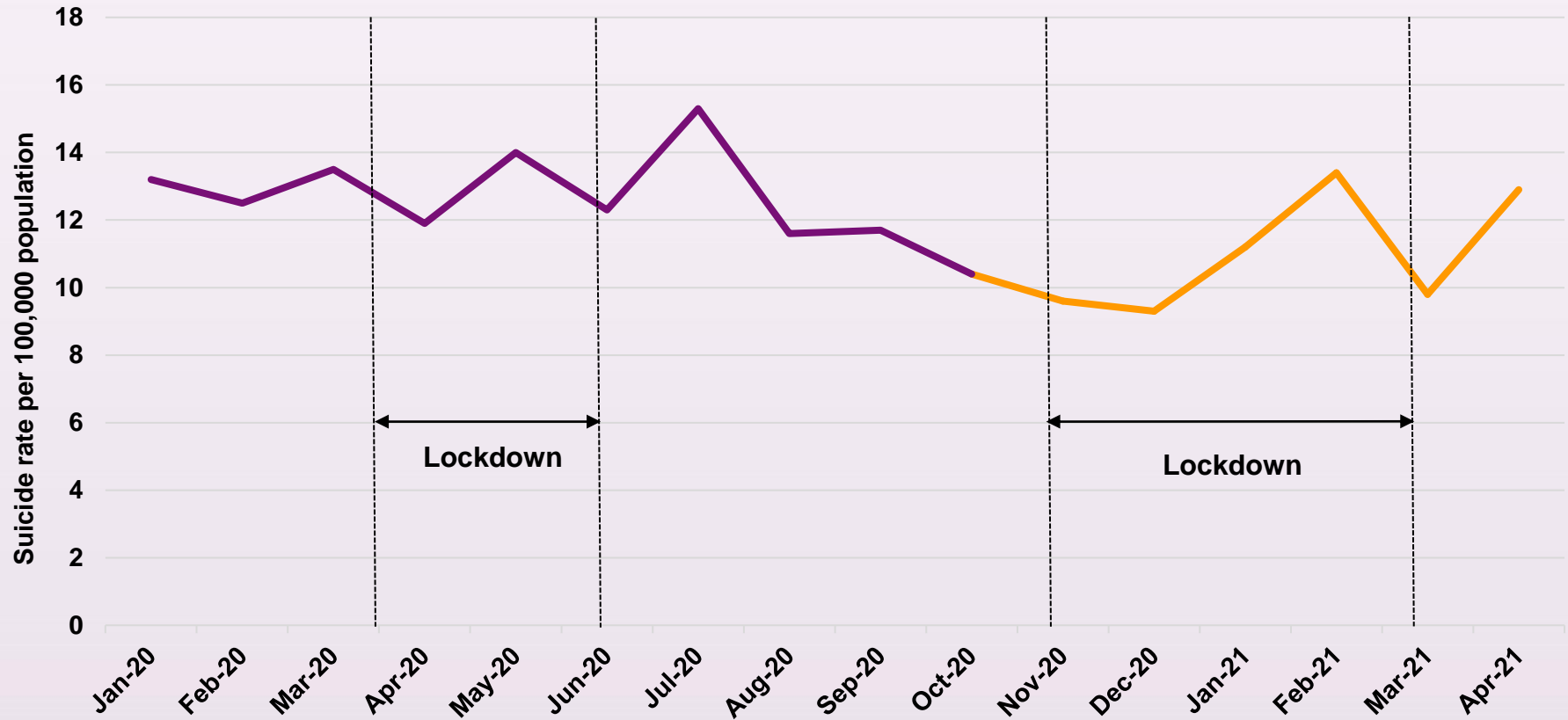
**Figure 3: There was a statistically significant decrease in the age-specific suicide rate for all persons aged 10 to 24 years and 25 to 44 years**

Age-specific suicide rates for broad age groups, England and Wales, deaths occurring between April and July, between 2015 and 2020



**Source: Office for National Statistics - Deaths from suicide that occurred in England and Wales**

# Suicide in England in the COVID-19 pandemic: RTS updated to 2021



Suicide rates using “real-time surveillance” data in 10 participating STPs

## Reasons for no rise

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

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

Increase in **social cohesion**

Sense of **short-term crisis**

**Economic** protections

**Reduced access** to certain methods

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journal homepage: [www.elsevier.com/lanep](http://www.elsevier.com/lanep)

Research Paper

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

Louis Appleby<sup>a,\*</sup>, Nicola Richards<sup>a</sup>, Saied Ibrahim<sup>a</sup>, Pauline Turnbull<sup>a</sup>, Cathryn Rodway<sup>a</sup>, Nav Kapur<sup>a,b,c</sup>

<sup>a</sup> National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH), Centre for Mental Health and Safety, School of Health Sciences, University of Manchester, Manchester, United Kingdom  
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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.

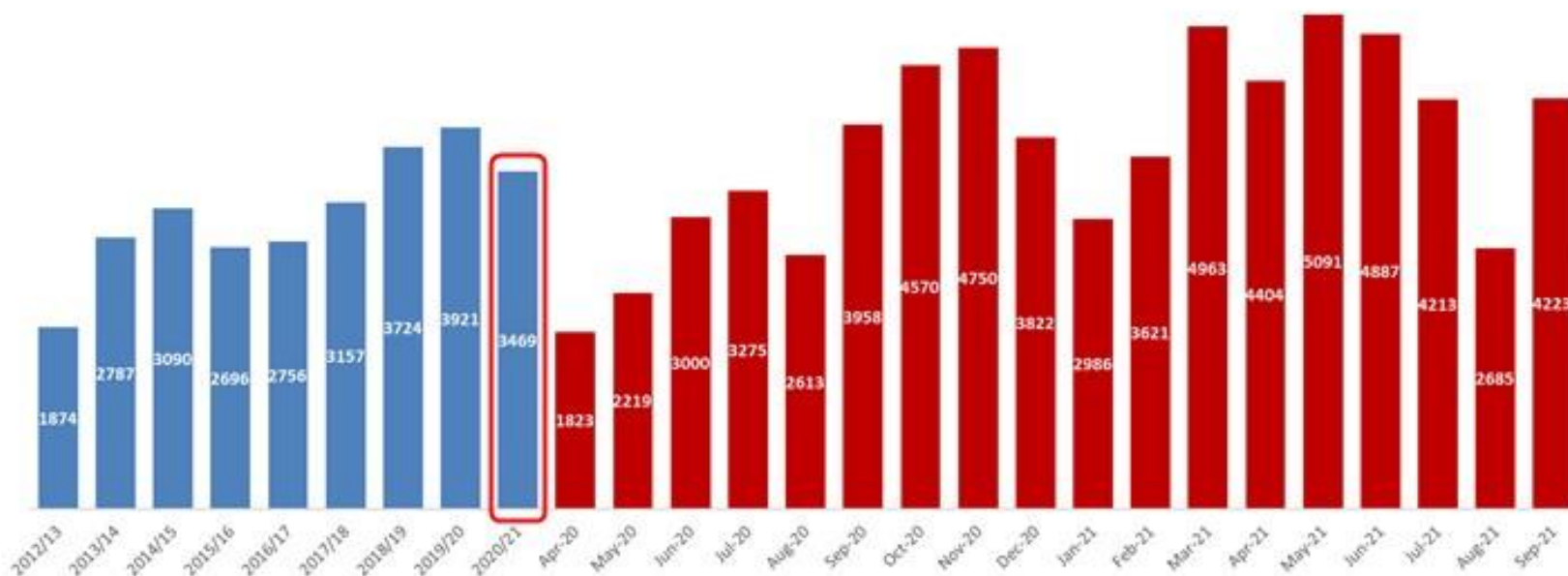
**Findings:** The number of suicides in April-October 2020, after the first lockdown began, was 121•3 per month, compared to 125•7 per month in January-March 2020 (-4%; 95% CI-19% to 13%,  $p = 0•59$ ). Incidence rate ratios did not show a significant rise in individual months after lockdown began and 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

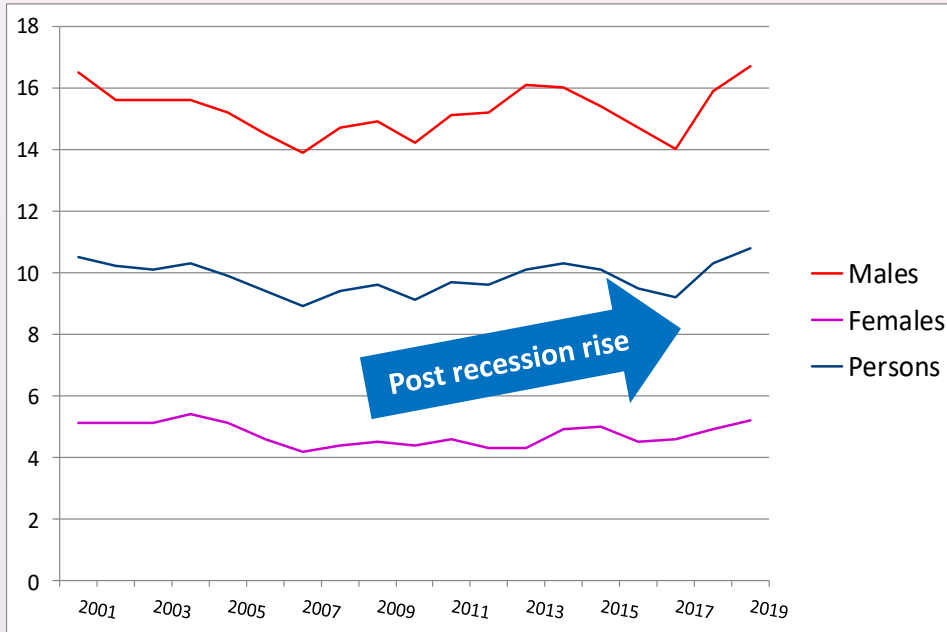
## Referral timeseries and Covid-19 impact

Referrals received per 100,000 population (age 0-18)





# Future risks: economic stress



Source: ONS, England



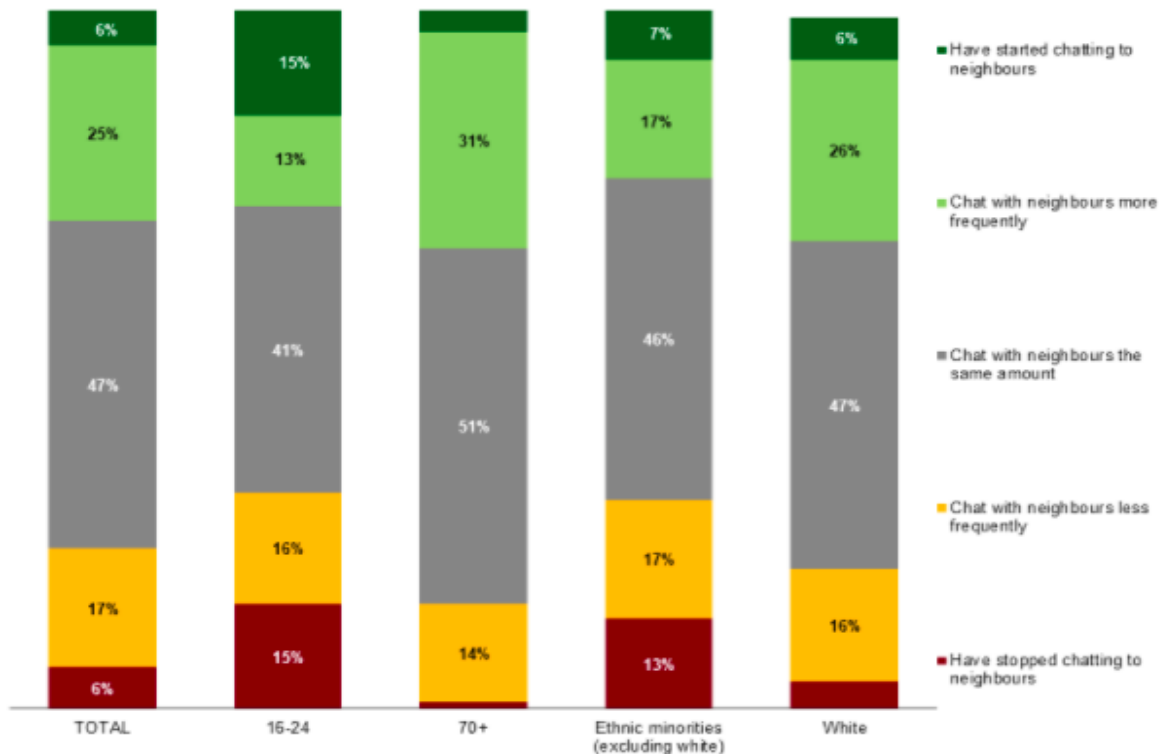
HM Government Coronavirus

## Coronavirus Job Retention Scheme

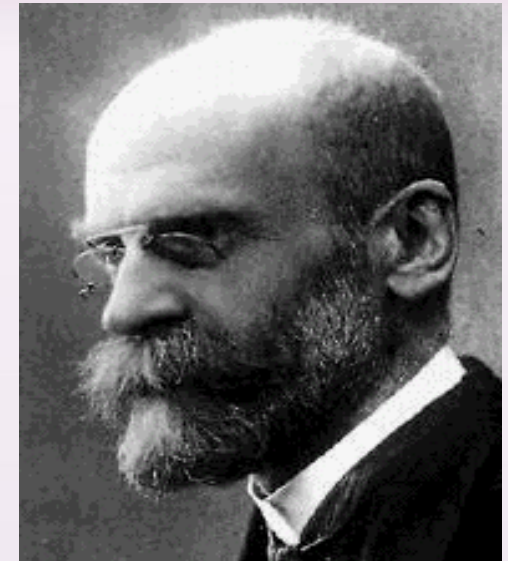
Claim up to 80%  
Up to £2,500 per person

**GET HELP | PROTECT YOUR BUSINESS | SAVE JOBS**

**Figure 6.5: Changes in frequency of chats with neighbours between wave 1 and wave 2 (gross change)**

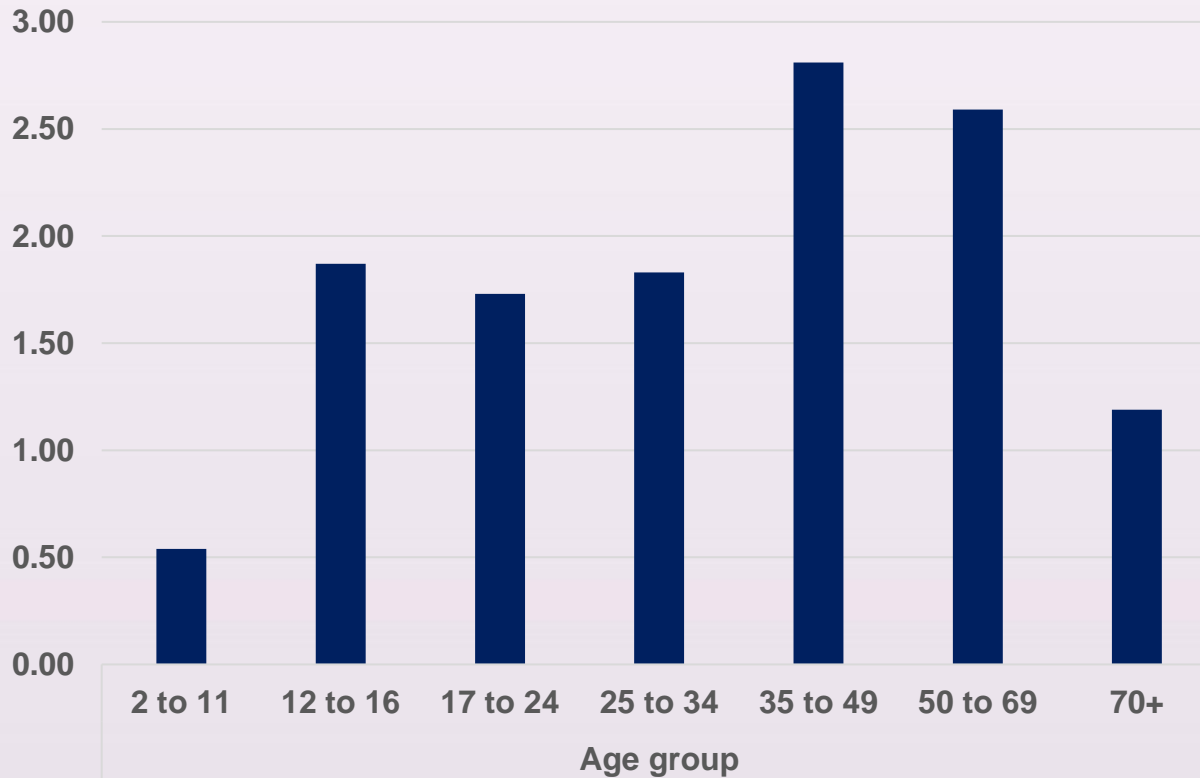


All respondents excluding don't know and refused responses (2,804); 16-24 (194); 70+ (471); Ethnic minorities (excluding white) (307); White (2,457).



- Volunteering
- Contact with neighbours
- Asking for help

Estimated % of people living in private households with self-reported long COVID of any duration, UK: four week period ending 6 Dec 2021



- Overall **1.96%**
- **Higher** in females, deprived areas, occupations (teaching, health & social care), people with disability

Figure 5 Depression and anxiety

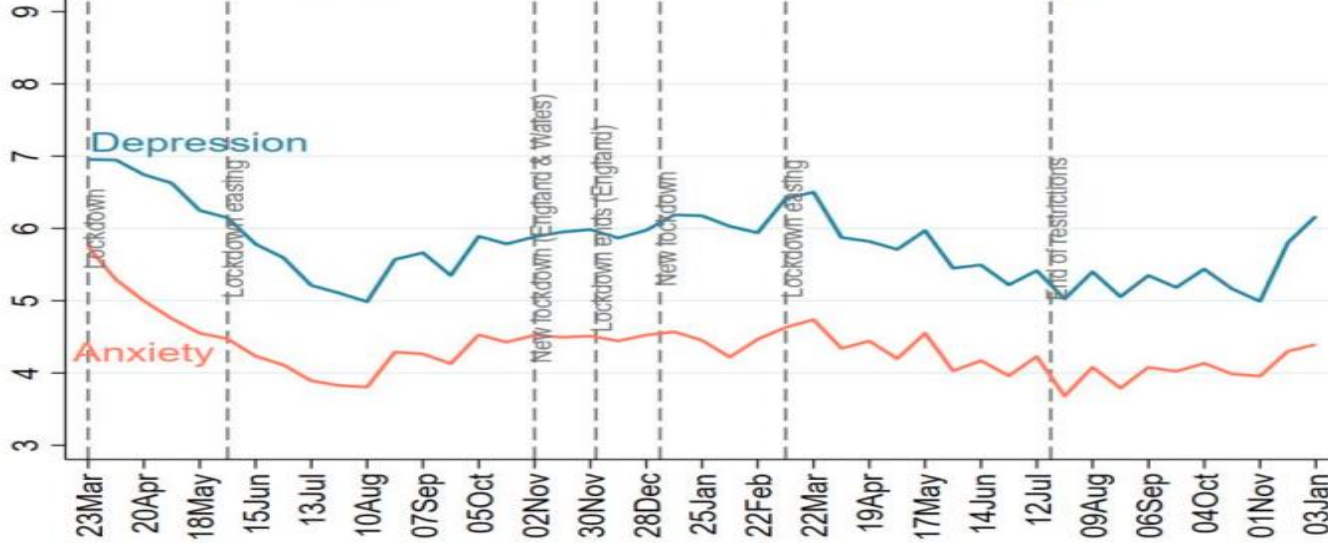
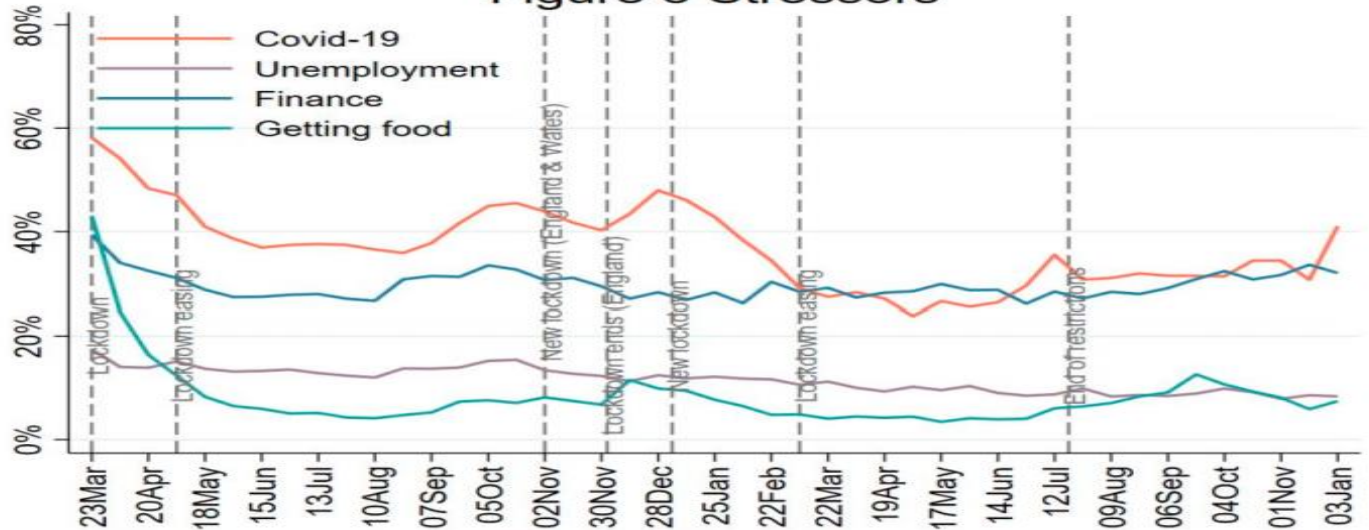


Figure 8 Stressors

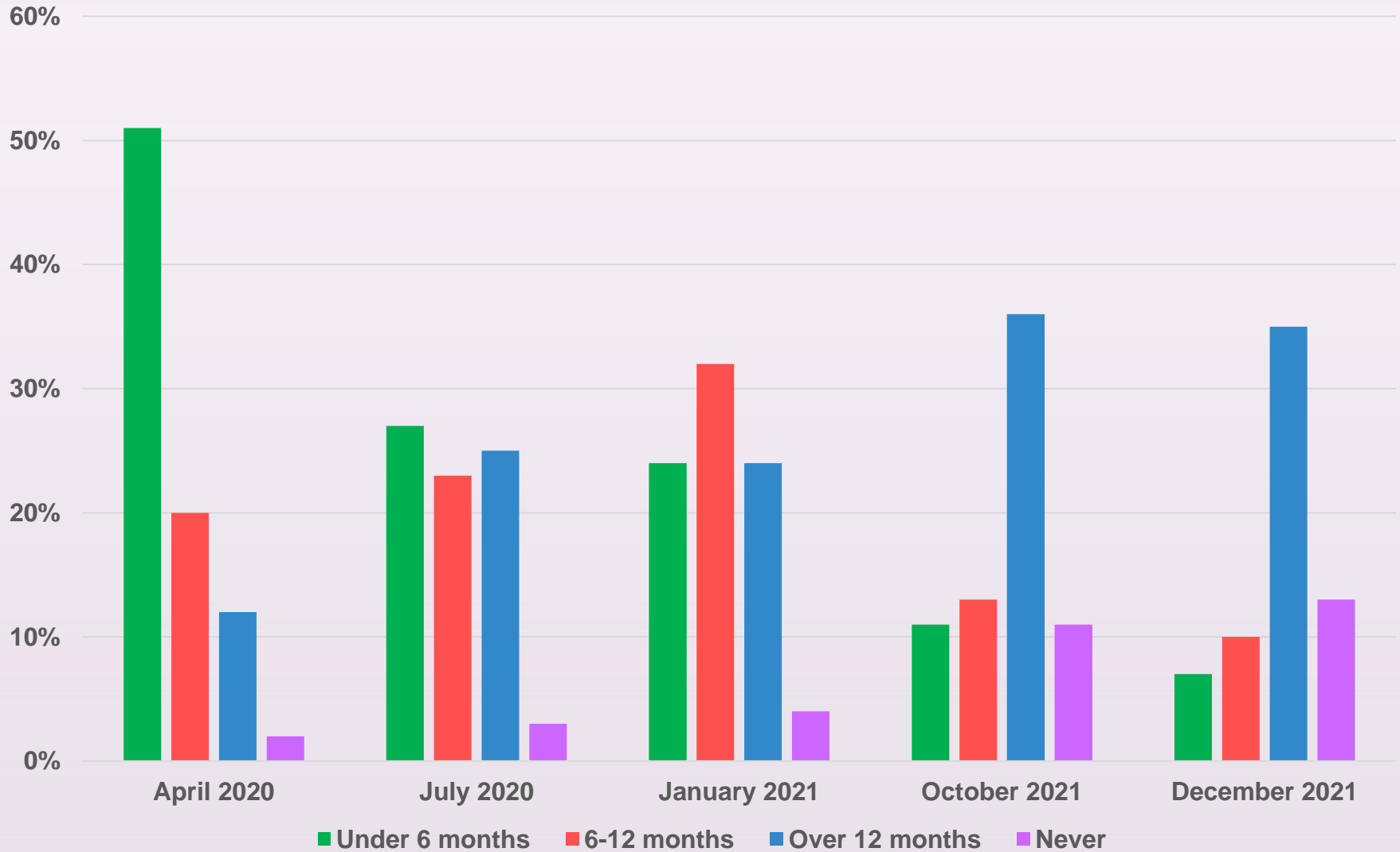


## Percentage of adults very or somewhat worried about the effect of COVID-19 on their life right now





# When will life return to normal?



- **Pandemic has had significant impact on mental health**
- **This has not so far translated into rise in suicide or self-harm**
- **Future risks: economic adversity, isolation & illness, young people & MH patients**
- **Suicide prevention: economic protections, MH care & support, media coverage, social attitudes**
- **Recovery from pandemic means also addressing pre-Covid risk**