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Remaining vigilant about COVID-19 and suicide

In The Lancet Psychiatry, Jane Pirkis and colleagues present the results of an interrupted time-series analysis of real-time data on suicides from 21 countries, including national data from ten countries as well as data from 25 regions across a further 11 countries. Their analysis suggests that, in the early months of the COVID-19 pandemic (April 1 to July 31, 2020), rates of suicide did not increase relative to modelled estimates of the number of suicides that would have occurred in this period without the pandemic. Additionally, the results indicated that suicide rates might have decreased in some areas. Pirkis and colleagues’ findings contribute to existing understanding of the associations between suicide and national disasters, including those caused by infectious diseases. These early data on suicide during the COVID-19 pandemic are consistent with the observation that national crises can be associated with a protective effect against suicide, perhaps due to greater social cohesion.

However, despite this initial snapshot, governments and services need to remain vigilant for a possible delayed increase in suicides as a result of the pandemic. Suicide can be a lagging indicator of psychosocial difficulties, influenced by medium-term and longer-term disruptions to civic life and the economy. Other work has shown that suicides can increase following economic recession, and such increases can be sustained for several years. Without counter-measures, ongoing reductions in economic activity can translate into individual financial and personal problems, such as job losses, reduced social status, housing instability, and relationship breakdowns. Alongside social isolation and disruption of normal routines, these factors can, in turn, increase the incidence of suicide through rises in mental health conditions such as depression as well as drug and alcohol misuse. Similar mechanisms might be relevant during the COVID-19 pandemic and its aftershocks.

In support, other research evidences this pattern of an initial decrease in suicide rates followed by an increase. In Japan, suicides declined early in the pandemic and subsequently increased by at least 10%. Women, and with less certainty, students, were more at risk. Complicating the picture in Japan was the concurrent death by suicide of a female celebrity and reporting of this event, which underscores the importance of responsible media reporting of suicides.

As we enter the second year of the COVID-19 pandemic, we need to understand more about the complex relationships between mental health, suicidal behaviour, and their underlying mechanisms. Improving how we identify high-risk populations and subgroups should also be part of the research agenda going forward. Monitoring proximal markers of suicide risk, such as recent self-harm and incidence of new mental illness, can provide early warning signs. More evidence on how risk is stratified by age, sex, and background risk factors (such as previous psychiatric conditions and self-harm), will be necessary to inform public health and policy in a more precise way. One promising approach is exemplified by the development of a simple scalable tool for the prediction of mortality and hospitalisation risk from COVID-19, QCOVID, which could potentially inform exposure mitigation and vaccine allocation in high-risk populations. Similarly, existing prediction tools for suicide can help to inform management decisions and to target interventions to those most at risk. Prediction models using probability scores anchored in research evidence can improve the consistency and transparency around clinical decision making and the allocation of resources. Such models can underscore the need for safety planning, and provide scalable population-based approaches for risk mitigation.

Reducing the global impact on mental health of the COVID-19 pandemic will involve continued monitoring alongside early intervention and investment into mental health services. Local, regional, and national strategies should not overlook at-risk groups, including those that might be hidden from view, such as people who are homeless, living in prison, or in abusive relationships. These strategies will be informed by consortia, such as the International COVID-19 Suicide Prevention Research Collaboration, allowing for ongoing surveillance, particularly of populations at higher risk. This collaboration can also lead to more consistent collection of high-quality suicide data across different countries. Pirkis and colleagues’ results are reassuring in that there has not been an initial clear increase in suicide deaths, but will need to be followed up across a wider set of countries over the next few years to investigate whether suicide will be one of the health-related aftershocks of the pandemic.
Racism is rife. Building on the Black Lives Matter movement, we comment on the need to accelerate racial justice among mental health researchers. Over the past decade, recognition of the importance of mental health in low-income and middle-income countries (LMICs) has grown. Although LMICs are an increasing focus, people from LMICs continue to be underrepresented in publications, grants, and project leadership. Achieving racial equity in research is paramount. In this Comment, we focus on the structures that create inequities between researchers in LMICs and those in high-income countries (HICs), which often fall along racial lines with White researchers, often from HICs, holding privileged positions relative to Black researchers, often from LMICs.

Colonial legacies have shaped the legal and political frameworks for health-care delivery and research in Africa and have laid the foundation for systemic racism in global mental health. Systemic racism is a pattern of racial inequality that runs through behaviours, institutions, norms, and economic structures, leading to policies and practices that disadvantage Black, Asian, and other minority ethnic populations (table). Systemic racism is often unintentional and addressing it requires us to reflect on assumptions of the status quo. For example, we see racism in teaching, through the use of case studies that report abuses of human rights drawn exclusively from LMICs, and through showing students models of cross-cultural research, which lack equitable partnership with Black, Asian, and other minority ethnic researchers in LMICs. An accumulation of these subtle discriminations can lead to so-called internalised racism: a feeling that, because of your race, you are less than others. This type of racism can lead to decreased confidence and unwillingness to speak up in class, claim authorship, ask for a mentor, or consider yourself to be an expert. Many of these systemic barriers can be more pronounced for people who are marginalised due to other aspects of their identity, such as gender, ethnicity, or sexual orientation.

Institutional racism is built into academic policies, processes, and hierarchies. A combination of funder requirements and reduced grant management capacity of LMIC institutions has led to more research grants being held by HIC institutions, with LMIC institutions as sub-awardees. This situation is perpetuated by LMIC institutions receiving flat-rate overheads (eg, <10%), whereas HIC institutions can negotiate rates of up to 60%. With this funding, HIC institutions can invest in their capacity without strengthening similar systems in LMICs. As a result of their institution’s greater capacity and power, investigators from HICs often head research projects, claim first and senior authorship, and lead publications from data collected by LMIC partners. Although some HIC collaborators have a valuable role as mentors for researchers in LMICs, this is not a substitute for having senior investigators from their home countries as role models.