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Editorial





Engagement With Death Registration and Cause-of-Death Reporting to Strengthen Suicide Statistics

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Suicide mortality rate is an indicator for Target 3.4 of the Sustainable Development Goals (SDGs). The number of deaths by suicide globally was estimated at 703,000 by the World Health Organization and at 759,000 by the Global Burden of Disease Study in 2019 (Institute for Health Metrics and Evaluation [IHME], 2024; World Health Organization, 2021). These numbers are "estimates" because of the lack of availability and the poor quality of data on suicide deaths in many countries. Monitoring many of the SDGs, including suicide mortality rate, depends on the availability of continuous and detailed mortality statistics by age, sex, and cause of death that only civil registration systems can provide (Mills et al., 2017). With three quarters of global suicide deaths occurring in low- and middle-income countries and with the majority of these countries having poor-quality mortality data, the implications for tracking suicide mortality are significant (Mikkelsen et al. 2023; Snowdon & Choi, 2020).

It is estimated that only around 80 countries have good-quality vital registration data that can be used directly to estimate suicide mortality rates (World Health Organization, 2021, 2023). In many countries, deaths that are considered unnatural or suspicious, such as suicides, homicides, road traffic injuries, and drowning, are investigated within the medicolegal death investigation (MLDI) system, a separate system connected to the civil registration system (Joos et al., 2021). The MLDI systems generally fall within one of three types: medical examiner, coroner, or police-/law-enforcement-led systems. The current quality of the cause-of-death statistics on deaths investigated within MLDI systems globally further limits an effective public health response, as incomplete and inaccurate statistics minimize the burden of unnatural deaths and do not provide policy-makers with the information necessary for targeted prevention measures (Joos et al., 2021; Rockett et al., 2011; Tait & Carpenter, 2016). Therefore, the issue of poor-quality mortality data is not unique to suicide, although the extent of under-reporting and misclassification could be a larger issue for suicide deaths as compared with many other causes of death given the sensitivity of suicide and the illegality of suicidal behavior in some countries (Arya et al., 2020; Bertuccio et al., 2024; Connolly & Cullen, 1995; Moradinazar et al., 2019; Thomas et al., 2013; Tøllefsen et al., 2012; Vichi et al., 2010; Williams et al., 2010).

Calls have been made to strengthen the civil registration systems for better-quality vital statistics and also specifically to improve the quality of injury mortality data (Bhalla et al., 2010; Boerma, 2014; Iaych & Khayesi, 2020; Mahapatra et al., 2007) and to strengthen MLDI systems so as to address under-reporting and unspecified reporting of unnatural deaths (França et al., 2011; Hanzlick, 2007; Mavroforou & Michalodimitrakis, 2002; Serra et al., 2017). Suicide researchers are uniquely placed to play a vital role in improving cause-of-death statistics for all deaths by advocating for policy changes and collaborating with relevant stakeholders to enhance all-cause mortality statistics, which in turn would also improve suicide statistics. We highlight the potential opportunities in this regard.

Administrative data, mostly collected by the police, are the primary data available with which to understand, prevent, and respond to suicide in many less developed

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countries (IHME, 2024; World Health Organization, 2021). Administrative data, for the most part, are collected by governments primarily for administrative purposes and not necessarily for use in research. To enable the outcome of improved suicide death statistics, a collaborative partnership between suicide researchers and police is needed, by highlighting how the data collected by the police contribute to the understanding and prevention of suicide deaths. Institutionalized dialogue that engages suicide researchers as the data users and police as the data producers can improve the production process of statistics, enhance data quality, and promote a better alignment between which statistics are needed or wanted and which are available. Such a dialogue can contribute to increased availability of robust statistics to improve programs and policies for suicide prevention and also to encourage communication about how to collect and use such data effectively. This collaboration can also be utilized to improve the quality of cause-of-death documentation by medical examiners, coroners, and other professionals involved in MLDI death investigations in order to develop protocols for identifying and documenting suicide cases (Joos et al., 2021). Quality improvement programs can help standardize procedures, increase the accuracy of cause-of-death determinations, and reduce under-reporting in the MLDI systems (Joos et al., 2021).

A collaborative partnership with the police can also be utilized to address the perception of criminality and its impact on suicide reporting in the community. Police reporting of suicide in crime statistics contributes to the perception that suicide is an offense and reinforces stigma in the community (Utyasheva et al., 2022). Decriminalization is not only about removing the legality but also about increasing public awareness of why police investigation is undertaken for suspicious deaths, improving sensitivity in handling of suicide deaths by police, and enhancing the understanding of the police and relevant stakeholders about suicide and its prevention (Lew et al., 2022; Utyasheva et al., 2022). Changing the perception of criminality will place both the survivors and the police in a better position to report suicide, thereby improving the robustness of suicide data, which can facilitate an enabling environment for suicide prevention.

Suicide researchers can draw attention to the contribution that the health sector can make in strengthening civil registration and vital statistics systems and in increasing death registration coverage. Detailed and accurate hospital death certificates are a key component of a strong vital statistics system (AbouZahr et al., 2018; Lucero et al., 2018; Mahapatra et al., 2007; Maharjan et al., 2015; Miki et al., 2018). Many times, *brought in dead* or *dead on arrival* is mentioned as the cause of death for individuals who are found dead or die before reaching a hospital, including those who die by suicide. This results in an undercount of suicide deaths (Parmar et al., 2022; Yokobori et al., 2020). A medical certificate of the cause of death should be completed by a physician documenting medical opinion on the injuries (physical determination of cause and manner of death) and medical conditions that ultimately led to death (World Health Organization, 2024). Suicide researchers should advocate for key information recorded by the health sector on the occurrence and circumstances of death, including cause of death, to be harnessed by the civil registration agencies in order to increase the notification and official registration of suicide deaths. Some countries such as Bangladesh, China, Peru, and Sri Lanka have succeeded in improving cause-of-death data for hospital deaths (Hazard et al., 2017; Miki et al., 2018; Mikkelsen et al., 2021; Qi et al., 2021). However, this does not address the information gap in the cause of death, as the majority of deaths in most countries occur outside of hospitals. To address this gap, some countries have included verbal autopsy interviews (interviews with those with most knowledge about the disease or the context of death to estimate the likely cause of death) in routine civil registration and vital statistics systems to obtain a general picture of the causes of death at the population level (Mapoma et al., 2021; Mikkelsen et al., 2021; Qi et al., 2021; Reeve et al., 2021), and some have adopted this as part of community surveillance (Alam et al., 2014; Gelaye et al., 2018; Hazard et al., 2018; Streatfield et al. 2014). Verbal autopsies provide a strategy for documenting the cause of death for deaths that are not otherwise certified (Leitao et al., 2013; Serina et al., 2015).

Much has been written about the need for responsible reporting of suicide deaths in the media and about the implications of irresponsible media reporting on suicide rates (Chen et al., 2023; Gunnell & Biddle, 2020; Lai et al., 2021; Niederkrotenthaler et al., 2020; Niederkrotenthaler et al., 2012; Oyetunji et al., 2021; Shamla et al., 2023). On the other hand, the media is also a partner in raising public awareness and stakeholder engagement for suicide prevention (Jenkin et al., 2020; Kirchner & Niederkrotenthaler, 2024; Ng et al., 2021). Suicide researchers can further partner with the media to raise public awareness about the need to report suicide deaths in a responsible fashion to enable a better understanding for the prevention of suicides, and to encourage communities to register all deaths irrespective of age, sex, and cause of death with the civil registration and vital statistics systems. Community awareness regarding complete and accurate vital statistics as the foundation for improving population health is imperative in addressing the gaps in death registration coverage.

To conclude, the public health significance of suicides can be undermined if attempts are not made to integrate

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suicide deaths within the existing systems of death notification and assignment of cause of death (Adair et al., 2021; Dandona, 2022). With such an integration, attempts at improving the timeliness, completeness, and accuracy of vital statistics will also enhance the availability and quality of suicide statistics. Suicide researchers can enable this outcome through collaboration with relevant stakeholders to re-engineer the death registration processes and build information- and data-sharing into civil registration and vital statistics systems for suicide deaths.

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