Correspondence

https://doi.org/10.1038/s44220-023-00042-y

The coming global economic downturn and suicide: a call to action

Following the onset of the COVID-19 pandemic, there was no evidence of a worldwide increase in suicides[1], although data from low- and middle-income countries (LMICs) remain scarce[2]. This encouraging finding may be in part a result of enhanced labor market programs and income protection policies implemented in many countries, along with wider social and health care support. However, current economic forecasts present a new challenge. Extensive evidence, including studies of the 1930s Great Depression, 1997 Asian economic crisis and 2008 global financial crisis, shows that severe economic downturns and subsequent unemployment are often accompanied by increases in suicide rates, particularly in working-age males[3].

Today, there is general consensus that the world is entering a period of poor economic growth and that there is a substantial risk of a global recession. Stagflation and a potential recession will have wide-ranging and long-term impacts. Suicide risk may increase in groups shown to be at increased risk in previous downturns (i.e., working-age males), groups already experiencing negative mental

BOX 1

An approach to preventing suicide during the global economic downturn and possible coming recession

Guiding principles

- Economic downturns and recessions often disproportionately affect certain groups (such as working-age men)
- Impacts are likely to differ according to the unique aspects of the downturn (for example, groups already struggling during the pandemic, such as young people, may be at higher risk)
- Unemployment, economic vulnerability and lack of psychosocial supports drive increased suicides
- Accessing support is a challenge for many people

Economic measures

- Avoid austerity measures
- Promote and strengthen active labor market programs, including job creation and training; job search assistance; subsidized private and/or public sector employment
- Enhance economic protections for people at risk
- Prioritize funding for debt advice
- Ensure responsible debt and payment recovery in the public and private sectors

Public health

- Disseminate messaging about how to address mental health issues during a downturn
- Implement harm reduction strategies (such as, alcohol price controls)
- Enhance efforts to encourage healthy behaviors (for example, more sleep and exercise)
- Prioritize efforts to foster social cohesion (encouraging people to offer support to others in financial difficulty)
- Implement targeted gatekeeper training (such as in schools and workplaces)
- Ensure that messaging encourages help-seeking and is consistent with responsible media recommendations

Media

- Avoid sensationalized reporting of suicides that may be linked to a downturn and/or recession
- Avoid drawing a simplistic connection between economic hardship and suicide
- Provide stories of hope and recovery from psychosocial crisis
- Help educate the public about how to cope with effects of an economic downturn and/or recession
- Promote help-seeking and provide information about sources of help

Health and social care

- Alert services to the impact of financial stress on mental health and suicide
- Train front-line workers to recognize and respond to economic-downturn-related problems
- Provide front line workers with up-to-date information about available sources of debt, employment and therapeutic support to aid signposting
- Add further strategic mental healthcare funding
- Coordinate with voluntary sector agencies offering crisis support
- Offer system navigation supports

Data and research

- Facilitate strategic research and funding
- Monitor early/real-time data on suicide and self-harm for early detection of changes overall and in specific demographics, including young people
- Leverage alternative sources of data, such as crisis hotlines, chat and text data that may be useful proxies
- Use data gathered to evaluate the effectiveness of existing policies and to formulate updated evidence-based recommendations

health effects of the pandemic (young people, women, ethnic minorities, people with pre-existing mental health problems, healthcare and hospitality sector workers, people in other precarious job categories)[4] and children of financially and socially vulnerable parents. LMICs may be especially vulnerable to the effects of a weakening global economy given their greater pre-existing burden of suicide, less-resourced health and social protection systems, and highly precarious job markets.

Now is the time to act to prevent a rise in suicides. We call for a strategic approach combining economic, public health and frontline service measures with responsible media coverage and timely suicide surveillance (Box 1). A lack of economic and psychosocial support, along with challenges accessing available services, are crucial drivers of suicide and self-harm during economic downturns[3,5,6]. Cross-sectoral mitigation efforts must therefore address these gaps. Such efforts should acknowledge real and perceived tensions that decision-makers face when trying to optimize both macroeconomic and health policies. A major challenge facing governments is that increased spending and income protection policies implemented during the pandemic may now be less feasible in an environment where governments are cautious about stimulating further inflationary pressures. Indeed, contractionary monetary policies enacted by central banks to stem inflation often reduce aggregate demand and can increase unemployment. In parallel, some governments may become tempted to shift toward an austerity approach; however, such measures can worsen mental health and suicide risk[7]. Broad investment in active labor market programs could be an alternative. For every US$10 per person invested in labor market programs during European recessions in 1970–2007, the impact of rising unemployment on suicide was reduced by 0.04% (ref. 6).

'Wellbeing budgets', which broadly consider the implications of public spending and promote spending that can help make people's lives worthwhile, may also prove helpful. Actions to strengthen social welfare should include strategic spending (e.g., targeted income protection; social safety nets; debt relief; and mental health and family support programs aimed at high-risk groups and income sectors). Such actions must be targeted to avoid excess spending and associated inflationary effects that might perpetuate a global financial downturn and inadvertently increase suicides. Challenges and solutions may emerge differently in LMIC settings, where social protection schemes have less reach and where there can be greater reliance on family-based welfare. Notably, conditional cash transfers targeted at low-income families in Brazil demonstrated a 56% reduction in suicide risk amongst beneficiaries versus non-beneficiaries[8].

In tandem with economic and public health measures, healthcare systems must enhance early detection of, and intervention for, people for whom the economic downturn leads to poor mental health and health risk behaviors (such as substance misuse). Frontline clinical staff, including those in primary care, should routinely enquire about the impact of unemployment, debt and cost of living pressures on mental health, suicide risk and substance misuse and direct patients to appropriate support services. Governments must focus on capacity-building within both traditional and nontraditional mental health and social services (such as online interventions or social prescribing)[9].

Important lessons can be learned from suicide research on community responses to the COVID-19 pandemic. In particular, near real-time surveillance of rates of suicidal behavior is essential for a rapid response, optimally targeted policies and evaluation of their effect. If suicide data are unavailable, proxies such as crisis hotline data or incidence of self-harm may be useful to track changing trends in suicidality in at-risk groups[10]. A data-driven policy response must be paired with robust media communication that aims to counter messaging promoting and normalizing a cultural expectation that suicide is a way to cope with economic hardship.

Economic downturn places populations at risk for suicide, and this is already occurring with a potential global recession on the horizon. Yet a rise in suicides is not inevitable. Now is the time to act to meet the challenge head-on. Recognizing urgent and long-term risks, the comprehensive, strategic, cross-sectoral approach we outline here should be implemented as rapidly as possible across the globe to prevent increases in suicides.

Mark Sinyor[1,2] ✉, Keith Hawton[3,4], Louis Appleby[5], Gregory Armstrong[6], Michiko Ueda[7,8], David Gunnell[9,10], Navneet Kapur[11,12], Shu-Sen Chang[13], Ella Arensman[14,15], Rory C. O'Connor[16], Ann John[17], Duleeka Knipe[10,18], Michael R. Phillips[19,20], Jane Pirkis[21], Rakhi Dandona[22,23], Lai Fong Chan[24], Jason Bantjes[25], Guilherme Borges[26], Richard McKeon[27] & Thomas Niederkrotenthaler[28,29]

[1]Department of Psychiatry, Sunnybrook Health Sciences Centre, Toronto, Ontario, Canada. [2]Department of Psychiatry, University of Toronto, Toronto, Ontario, Canada. [3]Centre for Suicide Research, Department of Psychiatry, University of Oxford, Warneford Hospital, Oxford, UK. [4]Oxford Health NHS Foundation Trust, Oxford, UK. [5]Division of Psychology and Mental Health, School of Medicine, University of Manchester, Manchester, UK. [6]Nossal Institute for Global Health, Melbourne School of Population and Global Health, The University of Melbourne, Parkville, Victoria, Australia. [7]Department of Public Administration and International Affairs, Syracuse University, Syracuse, NY, USA. [8]Center for Policy Research, Maxwell School of Citizenship and Public Affairs, Syracuse, NY, USA. [9]National Institute of Health and Care Research Biomedical Research Centre, University Hospitals Bristol and Weston NHS Foundation Trust, University of Bristol, Bristol, UK. [10]Population Health Sciences, Bristol Medical School, University of Bristol, Bristol, UK. [11]Centre for Mental Health and Safety and National Institute for Health Research (NIHR) Patient Safety Translational Research Centre, University of Manchester, Manchester, UK. [12]Greater Manchester Mental Health NHS Foundation Trust, Manchester, UK. [13]Institute of Health Behaviors and Community Sciences, College of Public Health, National Taiwan University, Taipei, Taiwan. [14]School of Public Health, National Suicide Research Foundation, University College Cork, Cork, Ireland. [15]Australian Institute for Suicide Research and Prevention, School of Applied Psychology, Griffith University, Brisbane, Queensland, Australia. [16]Suicidal Behaviour Research Lab, School of Health and Wellbeing, University of Glasgow, Glasgow, Scotland. [17]Population Data Science, Swansea University Medical School, Swansea, UK. [18]South Asian Clinical Toxicology Research Collaboration, Faculty of Medicine, University of Peradeniya, Peradeniya, Sri Lanka. [19]Suicide Research and Prevention Center, Shanghai Mental Health Center, Shanghai Jiao Tong University School of Medicine, Shanghai, China. [20]Departments of Psychiatry and Epidemiology, Columbia University, New York, NY, USA. [21]Centre for Mental Health, Melbourne School of Population and Global Health, University of Melbourne, Melbourne, Victoria, Australia. [22]Public Health Foundation of India, Gurugram, India. [23]Institute for Health Metrics and Evaluation, University of Washington, Seattle, WA, USA. [24]Department

of Psychiatry, Faculty of Medicine, National University of Malaysia, Kuala Lumpur, Malaysia. [25]Alcohol, Tobacco and Other Drug Research Unit, South African Medical Research Council, Cape Town, South Africa. [26]Department of Global Mental Health, Instituto Nacional de Psiquiatría Ramon de la Fuente Muñiz, Mexico City, Mexico. [27]Division of Prevention, Traumatic Stress, and Special Programs, Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration, Rockville, MD, USA. [28]Unit Suicide Research and Mental Health Promotion, Department of Social and Preventive Medicine, Centre for Public Health, Medical University of Vienna, Vienna, Austria. [29]Wiener Werkstaette for Suicide Research, Vienna, Austria.
e-mail: mark.sinyor@sunnybrook.ca

Published online: 18 April 2023

References

1. Pirkis, J. et al. *eClinicalMedicine* **51**, 101573 (2022).
2. Knipe, D. et al. *PLoS Glob. Public Health* **2**, e0000282 (2022).
3. Gunnell, D. & Chang, S.-S. in *The International Handbook of Suicide Prevention: Research, Policy and Practice* (eds O'Connor, R. & Pirkis, J.) 284–300 (Wiley, 2016).
4. OECD. https://go.nature.com/3Zabt1q (2022).
5. Barnes, M. C. et al. *BMJ Open* **6**, e010131 (2016).
6. Stuckler, D., Basu, S., Suhrcke, M., Coutts, A. & McKee, M. *Lancet* **374**, 315–323 (2009).
7. Stuckler, D. & Basu, S. *The Body Economic: Why Austerity Kills* (Basic Books, 2013).
8. Machado, D. B. et al. *PLoS Med.* **19**, e1004000 (2022).
9. Zangani, C. et al. *JMIR Ment. Health* **9**, e38600 (2022).
10. Liu, G. Y. et al. *Arch. Suicide Res.* https://doi.org/10.1080/13811118.2022.2114867 (2022).

Competing interests

The authors declare no competing interests.