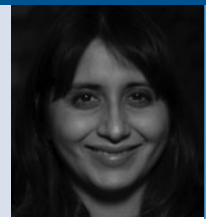


Editorial

Failure to tackle suicide inequalities
across Europe†

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**Summary**

In this issue, Lorant *et al.* confirm a social gradient in risk of suicide, across 15 European countries, over a period of marked social change. Understanding contextual and life-course factors, and acknowledging under-funding for mental health and failures to implement national mental health policies, may provide the reasons for these disparities.

Declaration of interest

None.

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It is estimated globally that one person dies every 40 seconds from suicide, with 804 000 suicides recorded worldwide in 2012.¹ This is likely to be an underestimate as suicide is a sensitive social and cultural issue, and in some jurisdictions is illegal.¹ Even where it is not illegal, suicide may be under-reported or misclassified.^{2–4} From a public health perspective, limiting access to means (such as to firearms and analgesics),^{5,6} prioritising the treatment of underlying mental disorders and alcohol/substance use,⁶ and the implementation of national suicide prevention programmes^{1,7} may be effective suicide prevention strategies.

The study by Lorant *et al.*⁸ confirms longstanding concerns about high suicide rates in some of the Nordic countries⁴ as well as in countries belonging to the former Soviet Union or Eastern Bloc,^{4,9} but also highlights the role of educational inequalities in fuelling differences in suicide rates. Notably, the authors found that over time, the association of an educational gradient for suicide risk in women has become more pronounced, whereas in men it has remained substantial and persistent.⁸ In particular, the findings of the study indicate that across the European countries included in the study, absolute and relative differences in suicide risk, between men with high levels of education versus men with low levels of education, remained large and consistent across both time periods (1991–1995 *v.* 2001–2005).

For women, there was evidence of absolute and relative educational inequalities for suicide risk apparent in the later period (2001–2005), particularly for women with lower levels of education residing in Finland, Norway, Lithuania, Belgium and Switzerland for having a higher risk of suicide compared with women with higher levels of education. Working age adults (those under the age of 65 years) with low levels of education, were more likely than those with higher education to die by suicide in the second period (2001–2005) versus the first (1991–1995). Across Europe, the elevated risk of suicide in Northern and Eastern European countries compared with Southern European countries also grew larger in 2001–2005 compared with 1991–1995. The association of the social gradient with suicide risk may also be greater in people resident in the European regions with the highest suicide risk.

We need to be cautious when interpreting these findings. Inter-country comparisons of suicide reporting are fraught with difficulties,³ particularly as suicide may be under-reported or misclassified.^{2,3} To try to take account of these issues, the authors conducted a number of sensitivity analyses and their subsequent findings remained broadly robust.

In interpreting the study findings, one also needs to be mindful of large changes in access to education across Europe. People in this study would have completed their education some years before death. In Europe and elsewhere there have been rapid post-war expansions in access to higher education, these shifts have been most notable for women. For example, in the UK only 10% of women born in 1946 had tertiary qualifications compared with 32% of women born in the UK in 1970.¹⁰ The emergence of an educational gradient for suicide in women could be because a lack of qualifications in the second time period had become more indicative of marginalisation in women (and therefore associated with a higher risk of suicide), or equally, may be a function of other factors differentially affecting men and women with lower education, such as labour market changes.¹¹ We will need further work assessing cohort effects and extending this work to later time points to understand these trends better.

The authors also highlight that their study did not cover the global financial crisis, which started in 2008. Across Europe, every 1% increase in unemployment is associated with a 0.79% rise in suicides in working age adults, with some evidence that this could be minimised through national programmes reintegrating people who have lost their jobs.¹² Suicide rates in men increased in Europe after the global financial crisis, with the largest increases noted in the countries with the largest job losses.¹³ The interplay of education, perhaps as a buffer to certain groups in times of high unemployment and economic recession,^{11,14} could be a future avenue for research.

The tragedy of this study's findings is that suicide is preventable,¹ but death by suicide has disproportionately greater effects among the most disadvantaged, as well as in citizens of certain regions within Europe, with larger inequalities apparent in 2001 compared with 1991, despite the adoption of country-level mental health policies over the same time period.^{1,9} These findings therefore indicate a failure across Europe in tackling disparities in suicide.

Further, this study spans a time when parts of Europe experienced seismic shifts in political and social systems, with the dissolution of the Soviet Union (1990/1991), and many of the countries formerly in the Eastern Bloc experiencing rapid social change. A recent review of these nations (including Estonia, Lithuania, Hungary and Poland, surveyed in the present study), indicated many of these countries had national mental health policies that focused on the delivery of community mental health services and improvements in patient psychiatric care and addressing mental health stigma.⁹ Because of a lack of political will, most of these policies have yet to be implemented.⁹ Many of these regions continue to rely on largely institutional-based psychiatric care, despite calls to promote deinstitutionalisation.¹⁵ As only

† See pp. 356–361, this issue.

one-third of people who complete suicide are in contact with secondary mental healthcare services in the year before their death,¹⁶ efforts to address suicide in these and other regions will have to retain a focus outside of mental healthcare provision, although undoubtedly mental health inequalities have been further exacerbated by chronic underinvestment.⁹

Suicide could also be seen as the tragic end-point in a chain of causation, resulting from an accumulation of adversities over the life course.^{17–19} The inequalities highlighted in this report broadly mirror those which have been described for other causes of death in these regions.^{14,20–22} Taken together, these findings support the notion that there may be other factors at play that are broader than traditional suicide ‘risk factors’. Lower education, income, socioeconomic position and job instability cluster in individuals.^{17,19} Education may also be indicative of an individual’s access to resources, their exposure to material deprivation¹⁴ and their access to social support and social networks. In times of high unemployment, education may act as a buffer against job instability and rapid social and economic upheaval.^{19,21} Education also captures life-course disadvantage because it is unlikely to change after early adulthood. Alcohol, substance misuse, mental disorders, poorer social networks and unemployment, which are all potential contributors for death by suicide,⁴ also follow strong educational gradients which trace back to childhood.¹⁹ In this life-course view, treating distal socioeconomic factors such as education may be as effective as targeting proximal psychiatric mental disorders²³ for the prevention of suicide. Despite the clear themes highlighted by this study, which seem to cross international borders across Europe, we still need further research from individual countries, as the interplay of country-specific socioeconomic context with systemic factors will differ.

In conclusion, much more needs to be done across nation states to tackle the educational inequalities that drive higher rates of suicide in disadvantaged groups across European regions. A broader view of the social determinants of health that addresses disadvantage over the life course,¹⁹ but with an eye to systemic factors and in particular the role of governments in financing and delivering mental healthcare policy, will contribute to suicide reduction in future.

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First received 25 Jan 2018, final revision 2 Mar 2018, accepted 28 Mar 2018

Funding

J.D.-M. has a Clinician Scientist Fellowship, funded by the Health Foundation working with the Academy of Medical Sciences. G.T. is supported by the National Institute for Health Research (NIHR) Collaboration for Leadership in Applied Health Research and Care South London at King’s College London National Health Service (NHS) Foundation Trust, and the NIHR Asset Global Health Unit award. The views expressed are those of the author(s) and not necessarily those of the NHS, the NIHR or the Department of Health. G.T. acknowledges financial support from the Department of Health via the NIHR Biomedical Research Centre and Dementia Unit awarded to South London and Maudsley NHS Foundation Trust in partnership with King’s College London and King’s College Hospital NHS Foundation Trust. G.T. is supported by the European Union Seventh Framework Programme (FP7/2007–2013) Emerald project.

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