ORIGINAL PAPER

Impact of the economic crises on suicide in Italy: the moderating role of active labor market programs

Giorgio Mattei[1,2] · Barbara Pistoresi[3] · Roberto De Vogli[4]

Abstract

Purpose To analyze the association between unemployment and suicide in Italy during the years 1990–2014, with a peculiar focus on the great recession (GR) and the role played by social protection as buffering mechanism against the negative effect on health outcomes.

Methods Fixed effects panel regressions were used to assess the association between changes in unemployment rate and suicide rates. Additional models investigated the role of active labor market programs (ALMPs) as possible moderators of the association. Analyses were carried out for both males and females, stratified by age and region.

Results The negative time-trend displayed by suicide rate in Italy until 2007 was slowed down by changes in unemployment at the beginning of the GR, when this trend reversed and the rate of suicide started increasing. Male workers aged 25–64 and women aged 55–64 years were affected by both "normal" unemployment rate fluctuations as well as severe economic crises. Women aged 35–44 were only influenced by the latter. Men benefit from ALMPs mainly in Central Italy, while women did not benefit significantly from ALMPs.

Conclusions In Italy, economic downturns were associated with increased suicides mainly among men, while severe economic crises were associated with increased suicides among both men and women. ALMPs showed to be effective in moderating the association between unemployment and suicide among men aged 45–54 only in Central Italy. The overall small effectiveness of such programs may be due to lack of sufficient funding.

Keywords Economic crisis · Italy · Suicide · Active labor market programs · Fixed effects panel regression

✉ Barbara Pistoresi
barbara.pistoresi@unimore.it

Giorgio Mattei
giorgio.mattei@unimore.it

Roberto De Vogli
roberto.devogli@unipd.it

1   "Marco Biagi" Department of Economics and Marco Biagi
    Foundation, University of Modena and Reggio Emilia, Via J.
    Berengario, 51, 41121 Modena, Italy

2   Section of Psychiatry, Department of Biomedical, Metabolic
    and Neural Sciences, University of Modena and Reggio
    Emilia, via G. Campi, 287, 41125 Modena, Italy

3   Department of Economics, RECent, Center for Economic
    Research, University of Modena and Reggio Emila, Viale
    Berengario 51, 41121 Modena, Italy

4   Department of Social Psychology and Development
    and Human Rights Centre, University of Padova, Via
    Venezia, 12, 35131 Padova, Italy

Introduction

In 2008 the world was hit by the Great Recession (GR), the worst economic crisis since the 1929 Great Depression [1]. The GR began in 2007 in the United States to then affect the global economy and European countries such as Italy, though its effect showed to vary according to the country considered [2, 3].

In a previous study, Stuckler et al. [4] measured the impact of governmental policies as possible buffering mechanisms for the negative health effect of economic crises. They focused on the role of welfare and social safety nets, indicating that the relationship between suicide and economic fluctuations may vary according to level of expenditure in social protection, with particular reference to active labor market programs (ALMPs). According to these authors, recessions do not hurt per se; rather, it is the governments' choice to implement economic policies of stimulus or austerity (favoring or reducing social safety nets) that

matter the most for understanding the effect of economic downturns on population health. Specifically, austerity policies have a major detrimental effect on suicide, while public spending in ALMPs can be an effective buffering mechanism against negative health outcomes [5]. A case in point is Greece, where social and health indicators (all-cause mortality, cardiovascular mortality, homicides and crime, HIV and tuberculosis infections, anxiety and mood disorders, suicide, alcohol abuse, attendance of public healthcare services) worsened after the implementation of severe austerity measures [5].

Building on the existing literature, this study assesses the effect of ALMPs as moderator of the association between economic crises and suicide. No previous study we are aware of has yet investigated this relationship in Italy that, together with Greece, Portugal and Spain, was severely hit by the crisis, and experienced one of the fastest reductions in gross domestic product (GDP) in Europe [6]. Notably, the GR hit the Italian economy during a period of long-term difficulties coupled with a climate of political instability ultimately resulting in the postponement of crucial structural reforms (e.g., concerning labor market and retirement system), that made the country particularly vulnerable to a sovereign debt crisis [7]. Some studies showed that in the first years of the economic crisis, Italy experienced increased suicides and attempted suicides due to financial problems [8–11]. Also, in the same period, the following were noticeable: increased ischemic heart diseases and cardiovascular mortality [10, 12], increased nicotine consumption [13, 14], decreased prescription of expensive drugs, increased prescription of cheap drugs [15]. As far as alcohol consumption in concerned, an increase in binge drinking may have occurred, accompanied by an overall reduction in expenditure for alcoholics, possibly due to budget constraint [10, 14], and consistently with international literature [16, 17].

Although research has already shown that, as happened in the majority of EU-member states [18–20], the GR exerted a negative health effect in Italy, particularly increased suicides and poor mental health outcomes [8–11, 21], little is known about the role of welfare policies as buffering mechanisms. In a research letter published in the BMJ, De Vogli showed that the association between unemployment and suicides becomes weaker a higher levels of investment in social services across Italian regions [8]. The aim of the present research is to assess the role of ALMPs as moderators for the adverse health effects of the crisis. Using longitudinal secondary data concerning both males and females, stratified by age and region, we hypothesize that ALMPs are effective social buffering mechanisms able to mitigate the consequences of financial hardship on suicidal behavior.

We are aware that other indicators may be influenced by economic downturns, such as alcohol consumption, traffic fatalities, all-cause mortality and homicides [4, 22]; yet,

in the present study we focus specifically on the relation between unemployment and suicide, and the possible moderating effect played by social protection, since suicide may be considered a gross indicator of mental health within a population. In fact, though suicide is a multifactorial phenomenon, severe mental illnesses account up to the 74% of the population attributable risk of suicide [23], and in psychological autopsy studies the median proportion of suicides attributable to mental disorders was 91% [24]. Also, evidence concerning the moderating effect of social protection are particularly sound with respect to the impact of unemployment on suicide [4].

Methods

Study design and data collection

Health indicators were collected from the 'Health for All' (HFA) database (version: December 2017) powered by the Italian National Institute of Statistics (ISTAT), that can be freely downloaded at the following link: https://www.istat.it/it/archivio/14562. Since available data referred to years 1990–2014, the latter was considered as observation period of the study. Suicide rates obtained from HFA refer to the actual rates that are observed in the Italian population. In other words, they are not derived from a representative sample. Differently, unemployment rates (that were collected from the online database https://www.dati.istat.it, powered by ISTAT) are derived from a survey carried on quarterly by the Italian National Institute of Statistics, based on a sample made up of 250,000 families living in about 1400 municipalities (corresponding to a sample size of about 600,000 people, representative of the Italian population). More information concerning the survey may be found here: https://www.istat.it/it/archivio/8263.

Expenditure for ALMPs (per head, at current prices and adjusted for purchasing power parity, in US Dollars) was found on the Website of the Organization for Economic Co-operation and Development (https://data.oecd.org). ALMPs include "spending on public employment services and administration, labor market training, special programs for youth when in transition from school to work, labor market programs to provide or promote employment for unemployed and other people (excluding young and disabled people), and special programs for disabled people" [4].

The following Italian macro-regions were included in the analysis: North-East (Emilia-Romagna, Trentino, Veneto, Friuli Venezia-Giulia), North-West (Liguria, Lombardia, Piemonte, Valle d'Aosta), Central Italy (Lazio, Marche, Toscana e Umbria), South (Abruzzo, Basilicata, Calabria, Campania, Puglia, Molise), and Islands (Sicilia, Sardegna).

Data management and econometric framework

We estimated a panel regression with fixed effects by OLS. The specification is:

$$Y_{i,t} = \beta_1 X_t + \beta_2 X_{i,t} + \beta_3 \text{ time} + \beta_4 \text{ crises} + \beta_5 P_t + \alpha_i + u_{i,t},$$

where $i = 1, \ldots, 20$ is the cross-sectional dimension of the panel representing the 20 Italian regions while $t = 1, \ldots, 24$ is the time dimension of the panel that ranges from 1990 to 2014. $Y_{i,t}$ is the regional suicide rate for males and females, crude and age-standardized (i.e., 15–24, 25–34, 35–44, 45–54, 55–64, 65–74 years old). $X_{i,t}$ is the change in regional unemployment rate, X_t is the change in national unemployment rate. P_t represents the growth rate of national expenditure for ALMPs on annual basis. $\alpha_{i,t} = \alpha_1, \ldots, \alpha_n$ are the fixed effects capturing unobservable regional heterogeneity. Time describes the trend in the suicide rate, while crisis is a dummy equal to 1 in the period of the GR (i.e., 2008–2014 and 2010–2014, depending on the model run) and 0 otherwise; $u_{i,t}$ are the residuals.

Ethics

All data were anonymous and aggregated at the origin, therefore Ethics Committee approval was not necessary. The guidelines governing research from the Declaration of Helsinki were followed.

Results

Our analysis confirmed the well-known relation between economic crises and suicides, and pointed out a significant, though small effect of ALMPs on mental health outcomes, confined to Central Italy.

In particular, Table 1 shows a decreasing trend in the past decades for the regional suicide rates (until 2007), indicated by the negative and significant coefficient of the time trend in all the specifications. This trend was slowed down by the unemployment changes, in particular during economic crises. The fixed effect models with the national unemployment rate were more robust than pooled regressions with regional unemployment rates (columns 1–2 vs. column 5, males and females), suggesting that for the suicide behavior the national dimension of the labor market may be more relevant than the local one. Every 1% rise in unemployment rate changes was associated with a 0.05% rise in suicide rate (column 2). The dummy crisis 2008–2014 was not statistically significant in the male specification, while it describes the same negative time-trend among females at the 5% significance level (column 2, males and females). The link between the changes in the national unemployment and suicides rates becomes not significant when the dummy crisis 2010–2014 is included (columns 3–4, males and females). Note that this dummy shows a positive and highly significant relation with suicide rates (1% significance level). This suggests that the GR induced with some lags an increase in the Italian suicide rate around the 0.16% for males and around 0.047% for females. At this level of aggregation of the data, the main negative effects on the suicide rates of the financial crisis and deep recession are confined in the period 2010–2014.

Table 2 shows the effects of rises in unemployment rate on suicides by age group and sex. Unemployment affects people of working age population, who are more directly affected by labor market dynamics, than retired people and the young. Working age men were more affected by the crisis 2010–2014 than women (columns 3–5, males and females). A 1% rise in male unemployment at ages 35–44 years was associated with a 0.19% rise in suicide rate, at ages 45–54 with a 0.25% rise and finally at ages 54–65 with a 0.31% rise (columns 3–5, males). For females, at age 33–44 the marginal effect was 0.10%, while at age 54–65 is 0.12% (columns 3 and 5, females). The 24–35 age group and the 45–55 age group in male population were also affected by business cycle fluctuations in normal time; in other words, unemployment rate changes induced suicide rate changes in the same direction. In particular, a 1% increase in unemployment rate induced a 0.05% rise in the suicide rate.

Table 3 shows in which Italian macro-regions the investment in ALMPs reduced the effects of unemployment and crisis on suicides. In Central Italy, a 1% increase in the expenditure for ALMPs was associated with a 0.45% decrease in suicide rate among men aged 45–54 (in bold, in the Table 3). Notably, females did not benefit significantly from ALMPs (columns 1–6, females).

Discussion

Following the GR, suicide rate started increasing in Italy, possibly due to insufficient public expenditure in social protection. In fact, while an average expenditure of 190 USD per head in ALMPs is able to mitigate the relation between unemployment and suicide [4], between 1990 and 2013 the average expenditure in Italy for such programs was 125 USD. Our results vary according to regional differences however, consistently with available literature [25, 26]. In particular, we found that ALMPs are able to exert their buffering mechanisms against the negative health effects of the crisis in Central Italy, but not in the rest of the country. This regional heterogeneity may be explained by large regional differences in terms of the proportion of unemployed people who attend Job Centers, higher in the South

Table 1 Suicide rate, unemployment and economic crisis

	M					F				
	(1)	(2)	(3)	(4)	(5) Pooled OLS	(1)	(2)	(3)	(4)	(5) Pooled OLS
Constant	−1.441** (0.134)	1.433** (0.045)	1.481** (0.057)	1.485** (0.056)	1.48*** (0.14)	0.439** (0.011)	0.431** (0.028)	0.451** (0.013)	0.452** (0.014)	0.45*** (0.034)
Time	−0.014** (0.003)	−0.014** (0.0031)	−0.019** (0.004)	−0.019** (0.005)	−0.019** (0.004)	−0.006** (0.000)	−0.005** (0.001)	−0.007** (0.001)	−0.008** (0.001)	−0.008** (0.001)
Crisis 2008–2014		−0.040 (0.046)					−0.042* (0.019)			
Crisis 2010–2014			0.160** (0.038)	0.174** (0.033)	0.162** (0.033)			0.047* (0.020)	0.048* (0.018)	0.044* (0.018)
Δ national unemployment rate	0.047** (0.010)	0.055** (0.013)	0.019 (0.013)			0.010 (0.006)	0.019** (0.005)	0.002 (0.007)		
Δ regional unemployment rate				0.009 (0.0053)	0.019* (0.007)				0.002 (0.002)	0.005 (0.003)
LSDV R^2	0.794	0.795	0.801	0.801	0.051	0.567	0.083	0.573	0.574	0.083

Fixed effects and pooled estimation (OLS). Dependent variable: regional suicide rates for males and females

Number of observations = 480; (.) robust standard errors, HAC; * and ** denote 5% and 1% significance level. Fixed effects estimation in columns 1–4, pooled estimation column 5. The null hypothesis: the groups have a common intercept, i.e., fixed effects equal to zero, is always rejected with p values = 0

Table 2 Suicide rate, unemployment and economic crisis

Age group and sex	M						F					
	15–24	25–34	35–44	45–54	55–64	65–74	15–24	25–34	35–44	45–54	55–64	65–74
Constant	0.918**	1.266**	1.362**	1.518**	2.057**	2.723	0.200**	0.323**	0.396**	0.450**	0.726**	0.791**
	(0.063)	(0.043)	(0.109)	(0.098)	(0.069)	(0.136)	(0.0124)	(0.020)	(0.020)	(0.032)	(0.021)	(0.034)
Time	−0.020**	−0.019**	−0.019**	−0.014	−0.037**	−0.050	−0.003**	−0.006**	−0.005**	−0.001	−0.017**	−0.017**
	(0.018)	(0.003)	(0.008)	(0.007)	(0.005)	(0.011)	(0.000)	(0.001)	(0.001)	(0.002)	(0.001)	(0.003)
Crisis 2010–2014	0.118	0.119	0.194*	0.254**	0.315**	0.189	0.025	−0.016	0.102*	0.051	0.124*	0.090
	(0.085)	(0.094)	(0.091)	(0.068)	(0.075)	(0.125)	(0.027)	(0.029)	(0.044)	(0.040)	(0.049)	(0.114)
Δ national unemployment rate	−0.000	0.0467	0.021	0.058*	0.044	0.005	0.009	0.006	−0.018	0.014	0.004	0.000
	(0.018)	(0.024)	(0.029)	(0.023)	(0.028)	(0.042)	(0.010)	(0.008)	(0.017)	(0.018)	(0.022)	(0.033)
LSDV $R2$	0.327	0.315	0.438	0.463	0.541	0.512	0.062	0.157	0.177	0.219	0.208	0.186

Fixed effects and pooled estimation (OLS). Dependent variable: regional suicide rates by age group and sex

Number of observations=480; (.) robust standard errors, HAC; * and ** denote 5% and 1% significance level. The null hypothesis: the groups have a common intercept, i.e., fixed effects equal to zero, is always rejected with p values=0

than in the North-East of the country (79.7% of long-term unemployed vs 67.2%, respectively [25]). In Central Italy, where ALMPs proved to be effective mechanisms against the negative mental health outcomes of the crises, up to the 73.1% of long-term unemployed attend Job Centers [25]. Furthermore, although austerity measures were implemented after the onset of the GR in all regions, the reduction in social expenditure per capita from 2000 to 2014 was lower in Central Italy (− 12.7%), when compared to the Northern (− 33.7%) and the Southern (− 26.7) Italian regions [26].

Our findings have important public policy implications. They suggest the need to increase public spending for ALMPs up to 190 USD per head per year, paying specific attention to regional inequalities. Stronger investment in ALMPs may positively affect mental health outcomes and, since they include vocational rehabilitation programs (VRPs), they may also facilitate recovery from psychiatric disorders.

Certainly, we do not think that adequate funding in ALMPs and VRPs alone can be sufficient to prevent suicides and mental health disorders due to financial crises. In order to improve the effectiveness and efficiency of VRPs, it may be helpful to strengthen the liaison between psychiatric services and occupational health professionals [27–29]. Moreover, specific clinical interventions such as psychoeducation group interventions may be also needed to provide users and families with information about psychiatric disorders, available treatments, access to psychiatric services, and coping strategies against workplace stress [29].

The present research helped identify vulnerable groups. In particular, women seem more vulnerable to severe economic downturns, while men may be affected by both financial cycle fluctuations as well as severe economic crises, with differences according to age [21, 30]. One strength of our study is the fact that it includes data concerning the GR and the following years of severe economic crisis, therefore representing an attempt to complete the epidemiological analysis provided by other research [4, 31]. Other strengths are represented by the methodology adopted, as well as having included data on social protection, namely ALMPs. Also, we collected regional suicide rates.

Despite this, the present study has several limitations. First, for its observational nature, no conclusion can be drawn with respect to causality. Also, given its ecological design, the fact that some associations were noticeable at population level does not necessary mean that the same associations are present at individual level. Yet, our findings are consistent with available literature pointing out an association between economic hardship and health outcomes, moderated by social protection. Second, since data were already collected and aggregated at the origin, their quality was not assessable. Yet, we believe that having derived them from two major agencies, the Italian Institute of Statistics and the

Table 3 Suicide rate, unemployment rate and expenditure for active labor market programs (ALMPs)

Age group by sex	M						F					
	15–24	25–34	35–44	45–54	55–64	65–74	15–24	25–34	35–44	45–54	55–64	65–74
Constant	0.835** (0.050)	1.21** (0.057)	1.308** (0.104)	1.523** (0.102)	1.995** (0.057)	2.680** (0.103)	0.207** (0.021)	0.309** (0.023)	0.389** (0.027)	0.437** (0.034)	1.995** (0.057)	0.758** (0.040)
Δ national unemployment rate	0.014 (0.022)	0.057* (0.023)	0.031 (0.029)	0.057* (0.025)	0.056** (0.025)	0.013 (0.040)	0.009 (0.011)	0.009 (0.009)	−0.017 (0.016)	0.016 (0.017)	0.056* (0.025)	0.006 (0.032)
Crisis 2010–2014	0.071 (0.077)	0.088 (0.088)	0.163 (0.087)	0.257** (0.072)	0.280** (0.067)	0.165 (0.096)	0.029 (0.031)	−0.025 (0.033)	0.099* (0.041)	0.044 (0.040)	0.279** (0.067)	0.071 (0.111)
Time	−0.015** (0.015)	−0.016** (0.004)	−0.016 (0.008)	−0.015 (0.008)	−0.033** (0.005)	−0.048** (0.008)	−0.004* (0.001)	−0.005* (0.002)	−0.005* (0.002)	−0.001 (0.003)	−0.033** (0.005)	−0.015** (0.003)
ΔLog ALMPs—North-East	0.267* (0.099)	0.300 (0.234)	0.243 (0.302)	−0.038 (0.191)	0.671 (0.551)	0.722 (0.367)	−0.017 (0.072)	−0.001 (0.089)	−0.041 (0.069)	−0.028 (0.107)	0.671 (0.549)	0.549 (0.269)
ΔLog ALMPs—North-West	1.309 (1.07)	0.881 (0.474)	1.100 (0.776)	0.593 (0.479)	0.456 (0.42)	2.282 (1.498)	−0.171 (0.174)	0.175 (0.122)	0.164 (0.230)	−0.146 (0.137)	0.456 (0.418)	0.315 (0.297)
ΔLog ALMPs—Central Italy	−0.168 (0.155)	−0.073 (0.178)	0.313 (0.282)	**−0.449*** **(0.172)**	0.274 (0.384)	−0.422 (0.326)	−0.014 (0.15)	0.021 (0.095)	0.037 (0.131)	0.227 (0.125)	0.274 (0.389)	−0.085 (0.166)
ΔLog ALMPs—South	0.39 (0.28)	0.298* (0.138)	−0.142 (0.229)	−0.126 (0.200)	0.408 (0.375)	−1.15* (0.538)	−0.006 (0.102)	0.063 (0.087)	−0.023 (0.072)	0.112 (0.123)	0.408 (0.291)	0.053 (0.207)
Δlog ALMPs—Islands	0.303* (0.11)	−0.139 (0.081)	−0.034 (0.159)	−0.102 (0.350)	−0.723 (0.455)	0.590 (0.614)	0.095* (0.037)	0.179 (0.073)	0.088 (0.087)	0.246** (0.048)	−0.72 (0.131)	0.044 (0.083)
LSDV R^2	0.36	0.32	0.45	0.47	0.55	0.54	0.06	0.16	0.18	0.22	0.55	0.20

Fixed effects and pooled estimation (OLS). Dependent variable: regional suicide rates by age group and sex

Number of observations = 480; (.) robust standard errors, HAC; * , ** denote 5% and 1% significance level. The null hypothesis: the groups have a common intercept, i.e., fixed effects equal to zero, is always rejected with p values = 0

The bold coefficient indicates that ALMPs were able to mitigate the impact of economic crises on mental health only in Central Italy

Organization for Economic Co-operation and Development, reliably guarantee their quality. The observational period of our study represents a third limit. In fact, having considered data for years 1990–2014 may reduce the generalizability of our findings to longer periods. Yet, we collected all available data in a panel dataset that made it possible to increase the degrees of freedom of our analysis. A fourth limitation is that only the 'Italian case' was addressed; in other words, the present study lacks a European perspective. Yet, other studies are available in literature, providing such perspective [4, 11, 32]. Also, since differences exist in Mediterranean countries and North-Europe countries, concerning welfare, epidemiology of psychiatric disorders (namely suicidal behavior) and welfare, it is possible that an aggregated perspective fails to recognize such differences, that we tried to highlight with our analysis. Fifth, it was pointed out that the variables in levels (e.g., suicide rates, unemployment rates) may be non-stationary unit root processes, making them unfit for the regression analysis with ordinary least square methods [31]. To reduce this problem we used in the regressions stationary variables, i.e., I(0), that is the changes in unemployment rate and the first difference of the expenditure in ALMPs (i.e., the growth rate of the variables). Moreover, we regressed the suicide rate on a time trend because this variable is possibly trend stationary.

Conclusions

In Italy, periods of economic fluctuations are associated with increased suicides among men, while severe economic downturns are associated with increased suicides among both men and women. Such association is moderated by social protection measures, namely ALMPs that display macro-regional differences and a different protective potential. In particular, in Central Italy ALMPs were able to moderate the association between unemployment and suicide among men aged 45–54. The overall small effectiveness of such programs may be due to lack of sufficient funding.

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