The intentional killing of oneself can be seen as evidence not only of personal breakdown, but also of a deterioration of the social context in which an individual lives. Suicide may be the end-point of a number of different contributing factors. It is more likely to occur during crisis periods associated with upheavals in personal relationships, through alcohol and drug abuse, unemployment, clinical depression and other forms of mental illness. Because of this, suicide is often used as a proxy indicator of the mental health status of a population. However, the number of suicides in certain countries may be underreported because of the stigma that is associated with the act, or because of data issues associated with reporting criteria (see "Definition and comparability").

Suicide is a significant cause of death in many EU member states, with approximately 60 000 such deaths in 2010. Rates of suicide were low in southern European countries – Cyprus, Greece, Italy, Malta, Portugal and Spain – as well as in the United Kingdom, at eight deaths or less per 100 000 population (Figure 1.7.1). They were highest in the Baltic States and Central Europe; in Estonia, Hungary, Latvia, Lithuania and Slovenia there were more than 17 deaths per 100 000 population. There is more than a ten-fold difference between Lithuania and Greece, the countries with the lowest and highest death rates.

Death rates from suicide are four-to-five times greater for men than for women across the European Union, although in those countries with the highest rates, male deaths are up to seven times as common (Figure 1.7.1). The gender gap is narrower for attempted suicides, reflecting the fact that women tend to use less fatal methods than men. Suicide is also related to age, with young people aged under 25 and elderly people especially at risk. While suicide rates among the latter have generally declined over the past two decades, little progress has been observed among younger people.

Since 1995, suicide rates have decreased in many countries, with pronounced declines of 40% or more in Bulgaria, Estonia and Latvia (Figure 1.7.2). Despite this progress, Estonia and Latvia still have among the highest suicide rates in Europe. On the other hand, death rates from suicides have increased since 1995 in Malta, Poland and Portugal, as well as Iceland, although rates in Iceland and Malta are dependent on small numbers. Iceland, Malta and Portugal still remain below the EU average. There is no strong evidence that national suicide rates have increased since the onset of the economic crisis.

Suicide rates in Lithuania increased steadily after 1990, especially among young men, peaking in 1996 (Figure 1.7.3). The high suicide rates in Lithuania have been associated with a wide range of factors including rapid socio-economic transition, increasing psychological and social insecurity and the absence of a national suicide prevention strategy. Similarly in Hungary, societal factors including employment and socio-economic circumstances, as well as individual demographic and clinical factors have been cited as determinants of suicide (Almasi *et al.*, 2009).

Mental health problems are rising in the European Union. The European Pact for Mental Health and Well-being, launched in 2008, recognised the prevention of depression and suicide as one of five priority areas. It called for action through improved training of mental health professionals, restricted access to potential means for suicide, measures to raise mental health awareness, measures to reduce risk factors for suicide such as excessive drinking, drug abuse and social exclusion, depression and stress, and provision of support mechanisms after suicide attempts and for those bereaved by suicide, such as emotional support helplines (EC, 2009b).

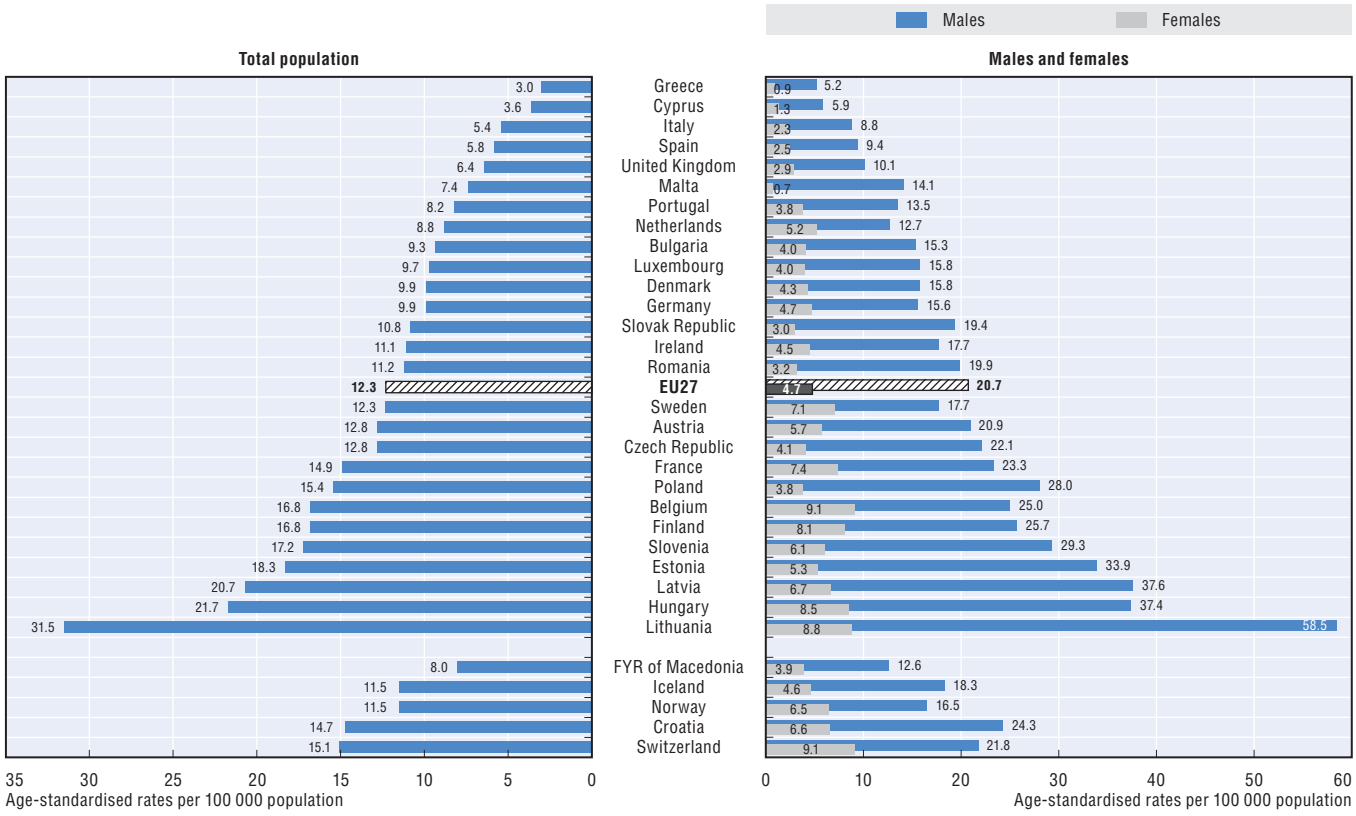
Definition and comparability

The World Health Organization defines "suicide" as an act deliberately initiated and performed by a person in the full knowledge or expectation of its fatal outcome. Comparability of suicide data between countries is affected by a number of reporting criteria, including how a person's intention of killing themselves is ascertained, who is responsible for completing the death certificate, whether a forensic investigation is carried out, and the provisions for confidentiality of the cause of death. Caution is required therefore in interpreting variations across countries.

Mortality rates are based on numbers of deaths registered in a country in a year divided by the size of the corresponding population. The rates have been directly age-standardised to the WHO European standard population to remove variations arising from differences in age structures across countries and over time. The source is the *Eurostat Statistics Database*.

Deaths from suicide are classified to ICD-10 Codes X60-X84. Mathers *et al.* (2005) have provided a general assessment of the coverage, completeness and reliability of data on causes of death.

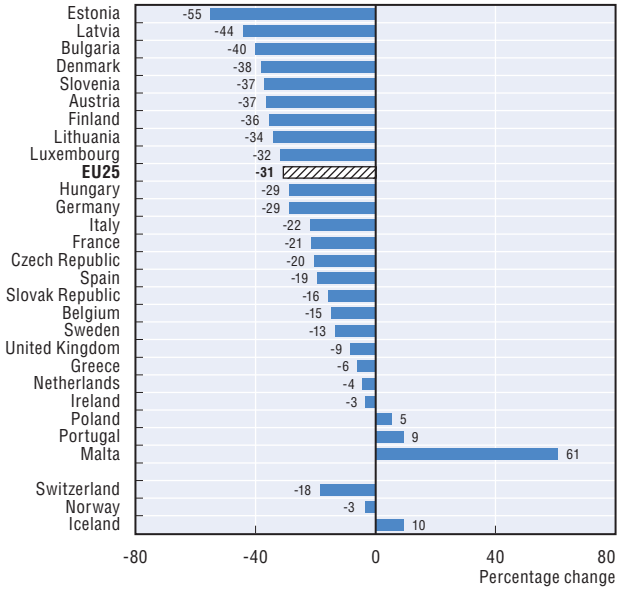
1.7.1. Suicide mortality rates, 2010 (or nearest year)



Source: Eurostat Statistics Database. Data are age-standardised to the WHO European standard population.

StatLink http://dx.doi.org/10.1787/888932703259

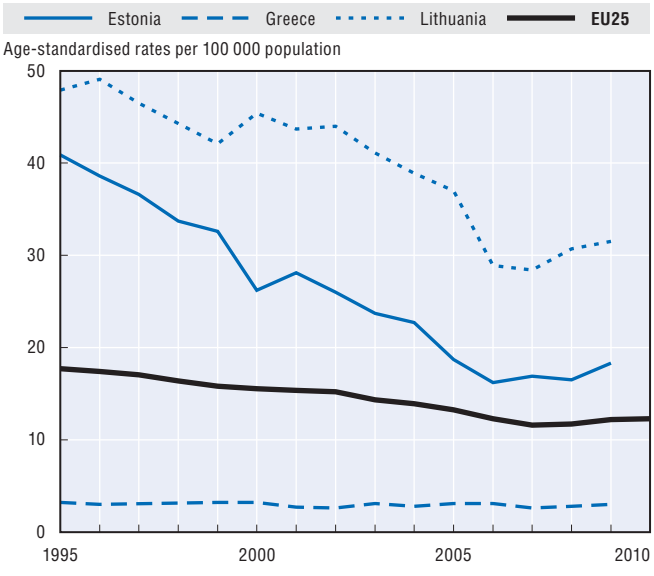
1.7.2. Change in suicide rates, 1995-2010 (or nearest year)



Source: Eurostat Statistics Database. Data are age-standardised to the WHO European standard population.

StatLink http://dx.doi.org/10.1787/888932703278

1.7.3. Trends in suicide rates, selected European countries, 1995-2010



Source: Eurostat Statistics Database. Data are age-standardised to the WHO European standard population.

StatLink http://dx.doi.org/10.1787/888932703297