Suicide

Suicide is a significant cause of death in many OECD countries, accounting for over 150 000 deaths in 2013. A complex set of reasons may explain why some people choose to attempt or commit suicide. A high proportion of people who have attempted or committed suicide are suffering from psychiatric disorders such as severe depression, bipolar disorder and schizophrenia. The social context in which an individual lives is also important. Low income, alcohol and drug abuse, unemployment and social isolation are all associated with higher rates of suicide.

Figure 3.12 shows that suicide rates in 2013 were lowest in Turkey, Greece, Mexico, Italy and Israel, at seven or fewer deaths per 100 000 population, although the number of suicides in certain countries may be under-reported because of the stigma associated with the act or data unreliability associated with reporting criteria (see "Definition and comparability"). Korea had the highest suicide rate with nearly 30 deaths per 100 000 population, followed by Japan, Hungary and Slovenia with nearly 20 deaths per 100 000 population. Mortality rates from suicide are three-to-four times greater for men than for women across OECD countries (Figure 3.12). In Poland and the Slovak Republic, men are seven times more likely to commit suicide than women. 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, less progress has been observed among younger people.

Since 1990, suicide rates have decreased by around 30% across OECD countries, with the rates being halved in countries such as Hungary and Finland (Figure 3.13). In Estonia, after an initial rise in the early 1990s, the rates have also fallen sharply. On the other hand, death rates from suicides have increased in Korea and Japan. In Japan, there was a sharp rise in the mid-to-late 1990s, coinciding with the Asian financial crisis, but rates have started to come down in recent years. In Korea, suicide rates rose steadily over the past two decades peaking around 2010, before starting to come down (Lim et al., 2014). Suicide is the number one cause of death among teenagers in Korea.

Suicide is often linked with depression and the abuse of alcohol and other substances. Early detection of these psychosocial problems in high-risk groups by families and health professionals is an important part of suicide prevention campaigns, together with the provision of effective support and treatment. Many countries are developing national strategies for prevention, focusing on at-risk groups. Mental health services in Korea lag behind those of other countries with fragmented support, focused largely around institutions, and insufficient or ineffective support services provided to those who remain in the community. Further efforts are also needed to remove the stigma associated with seeking care (OECD, 2014).

Previous studies have shown a strong link between adverse economic conditions and higher levels of suicide (Van Gool and Pearson, 2014). Suicide rates rose slightly at the start of the economic crisis in 2008-2009 in a number of countries, but this trend did not persist in most. In Greece, suicide rates were stable in 2009 and 2010, but have increased since 2011 (Figure 3.13). All countries need to continue monitoring developments closely in order to be able to respond quickly, including monitoring high-risk populations such as the unemployed and those with psychiatric disorders (see indicator "Mental health care" in Chapter 8).

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 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 2010 OECD population to remove variations arising from differences in age structures across countries and over time. The source is the *WHO Mortality Database*. Deaths from suicide are classified to ICD-10 codes X60-X84.

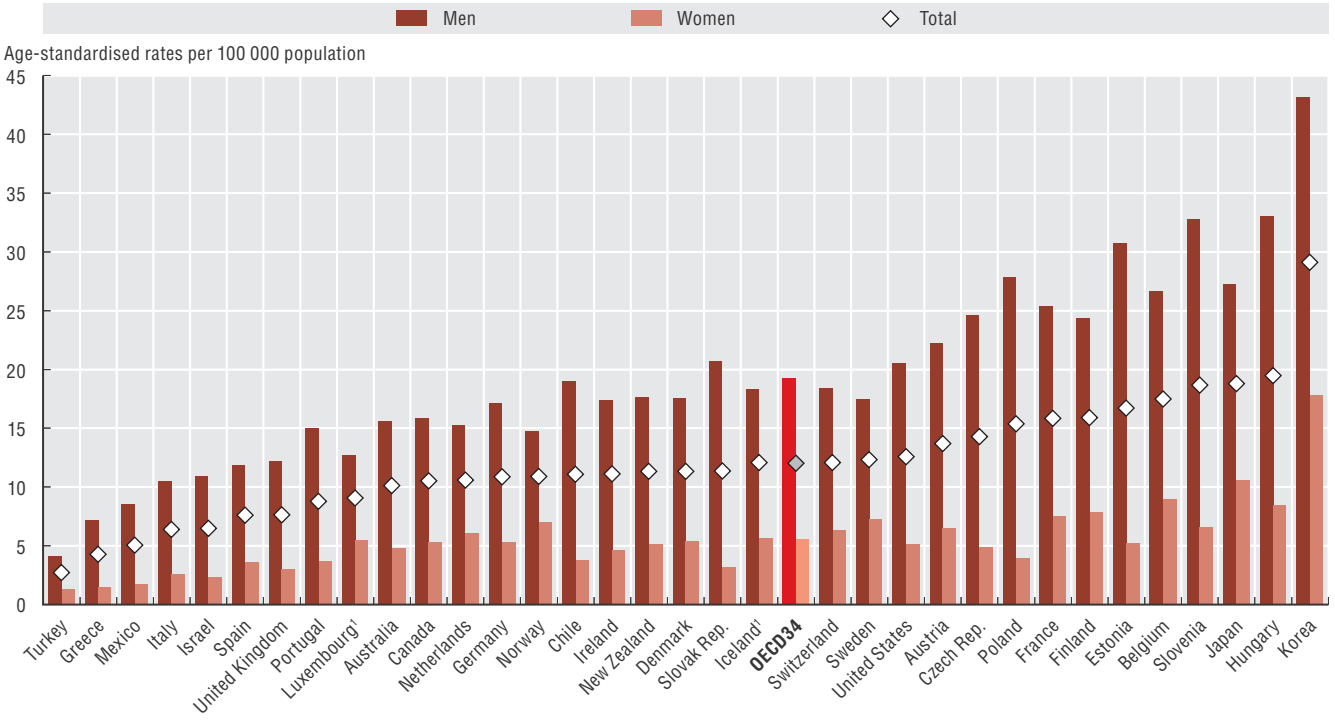
References

Lim, D. et al. (2014), "Trends in the Leading Causes of Death in Korea, 1983-2012", *Journal of Korean Medical Science*, Vol. 29, No. 12, pp. 1597-1603.

OECD (2014), *Making Mental Health Count: The Social and Economic costs of Neglecting Mental Health Care*, OECD Publishing, Paris, *http://dx.doi.org/10.1787/9789264208445-en*.

Van Gool, K. and M. Pearson (2014), "Health, Austerity and Economic Crisis: Assessing the Short-term Impact in OECD Countries", *OECD Health Working Papers,* No. 76, OECD Publishing, Paris, *http://dx.doi.org/10.1787/5jxx71lt1zg6-en*.

3.12. Suicide, 2013 (or nearest year)

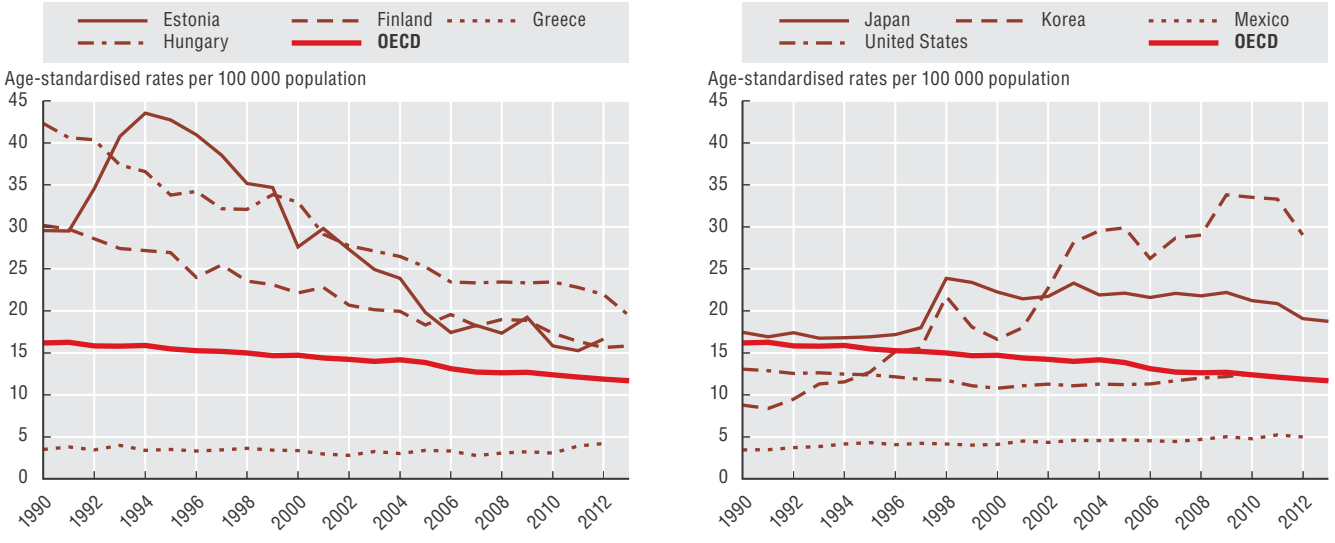


1. Three-year average.

Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en.

StatLink http://dx.doi.org/10.1787/888933280778

3.13. Trends in suicide, selected OECD countries, 1990-2013



Source: OECD Health Statistics 2015, http://dx.doi.org/10.1787/health-data-en.

StatLink http://dx.doi.org/10.1787/888933280778

Information on data for Israel: *http://oe.cd/israel-disclaimer*