1.6. Suicide

Suicide is a significant cause of death in many OECD countries, and accounted for over 150 000 deaths in 2011. There is a complex set of reasons why some people choose to attempt or commit suicide, with multiple risk factors that can predispose a person to attempt to take their own life. Over 90% of people who have attempted or committed suicide have been diagnosed with psychiatric disorders such as severe depression, bipolar disorder and schizophrenia (Nock et al., 2008). The social context in which an individual lives is also important. Low income, alcohol and drug abuse, unemployment and unmarried status are all associated with higher rates of suicide (Qin et al., 2003; Crump et al., 2013).

Figure 1.6.1 shows that suicide rates were lowest in Greece, Turkey, Mexico, Brazil and Italy, at six or fewer deaths per 100 000 population. In Korea, Hungary, the Russian Federation and Japan, on the other hand, suicide is responsible for more than 20 deaths per 100 000 population. There is a tenfold difference between Korea and Greece, the two countries with the highest and lowest suicide rates. 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").

Death rates from suicide are four times greater for men than for women across OECD countries. In Greece and Poland, men are at least seven times more likely to commit suicide than women. The gender gap in those two countries has widened in recent years. While in Luxembourg and the Netherlands the gender gap is smaller, male suicide rates are still twice those of females.

Since 1990, suicide rates have decreased by more than 20% across OECD countries, with pronounced declines of over 40% in some countries such as Hungary (Figure 1.6.2). In Estonia, rates fell by nearly 50% over the 20-year period, but not before rising substantially in the mid-1990s. Death rates from suicides have increased in countries such as 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 remained stable since then. Suicide rates also rose sharply at this time in Korea and, unlike in Japan, have continued to increase. It is now the fourth leading cause of death in Korea (Jeon, 2011). Mental health services in Korea lag behind those of other countries with fragmented support, focused largely around institutions, with insufficient or ineffective support provided to those who remain in the community. Further efforts are also needed to remove the stigma associated with seeking care (OECD, forthcoming).

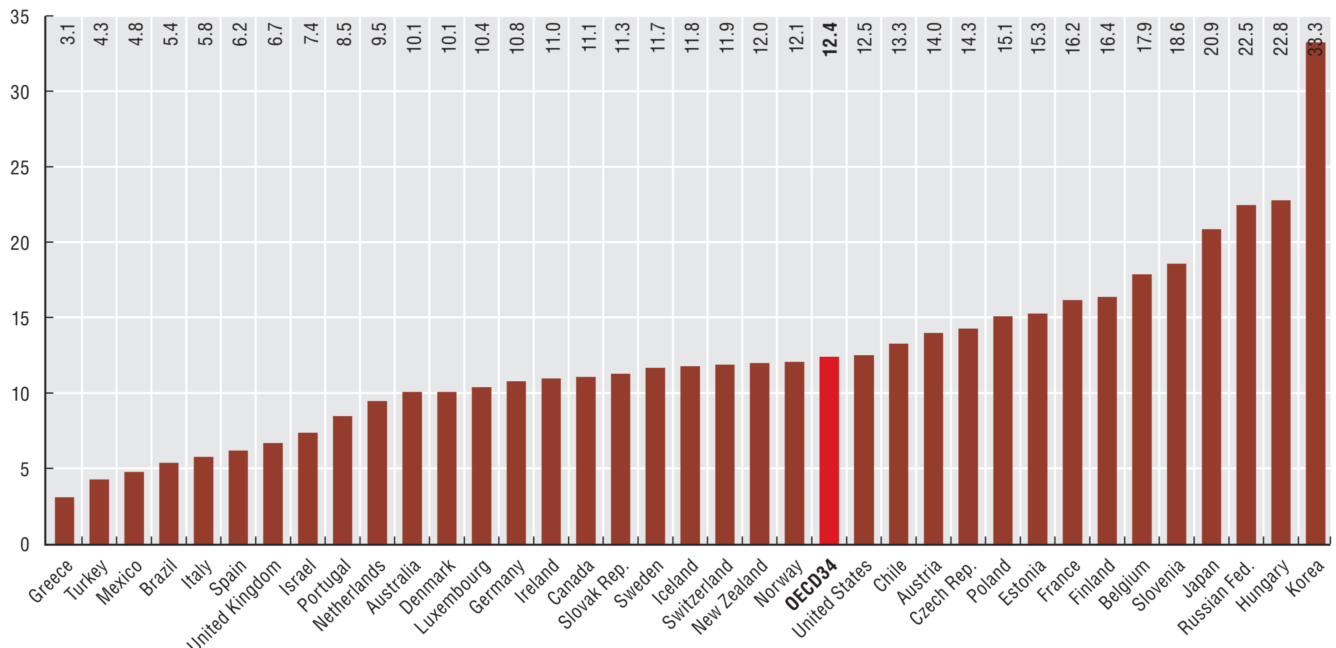
Previous studies have shown a strong link between adverse economic conditions and higher levels of suicide (Ceccherini-Nelli et al., 2011; Classen and Dunn, 2012; Zivin et al., 2011). Figure 1.6.2 shows suicide rates for a number of countries that have been hard hit by the recent economic crisis. Suicide rates rose slightly at the start of the economic crisis in a number of countries such as Ireland but more recent data suggest that this trend did not persist. In Greece, overall suicide rates were stable in 2009 and 2010, despite worsening economic conditions. There is a need for countries 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 5.8 for further information).

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. Mathers et al. (2005) have provided a general assessment of the coverage, completeness and reliability of data on causes of death.

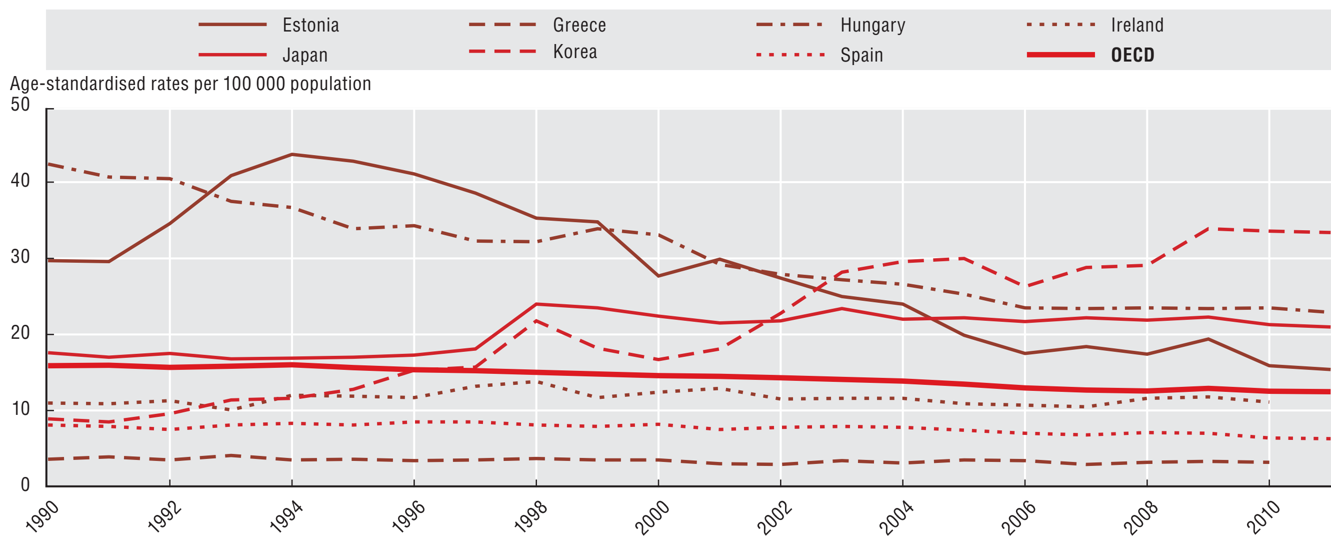
1.6.1. Suicide mortality rates, 2011 (or nearest year)



Source: *OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.*

StatLink http://dx.doi.org/10.1787/888932916211

1.6.2. Trends in suicide rates, selected OECD countries, 1990-2011



Source: *OECD Health Statistics 2013, http://dx.doi.org/10.1787/health-data-en.*

StatLink http://dx.doi.org/10.1787/888932916230

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