1.7. Suicide

The intentional killing of oneself is 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 divorce, 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 under-estimated because of the stigma that is associated with the act, or because of data issues associated with reporting criteria (see "Definition and deviations").

Suicide is a significant cause of death in many OECD countries, and there were 140 000 such deaths in 2006. In 2006, there were fewest suicides in southern European countries (Greece, Italy and Spain) and in Mexico and the United Kingdom, at less than seven deaths per 100 000 population (Figure 1.7.1). They were highest in Korea, Hungary, Japan and Finland, at 18 or more deaths per 100 000 population. There is more than a seven-fold difference between Korea and Greece, the countries with the lowest and high death rates.

Since 1990, suicide rates have decreased in many OECD countries, with pronounced declines of 40% or more in Denmark, Luxembourg and Hungary (Figure 1.7.3). Despite this progress, Hungary still has one of the highest rates among OECD countries. On the other hand, death rates from suicides have increased the most since 1990 in Korea, Mexico and Japan, although in Mexico rates remain at low levels. In Korea and Japan, suicide rates now stand well above the OECD average (Figure 1.7.4). Male suicide rates in Korea almost tripled from 12 per 100 000 in 1990 to 32 in 2006, and suicide rates among women are the highest among OECD countries, at 13 per 100 000. Economic downturn, weakening social integration and the erosion of the traditional family support base for the elderly have all been implicated in Korea's recent increase in suicide rates (Kwon *et al.*, 2009).

In general, death rates from suicides are three to four times greater for men than for women across OECD countries (Figure 1.7.2), and this gender gap has been fairly stable over time. 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, almost no progress has been observed among younger people.

Since suicides are, in the vast majority of cases, linked with depression and alcohol and other substance abuse, the early detection of these psycho-social problems in high-risk groups by families, social workers and health professionals must be part of suicide prevention campaigns, together with the provision of effective support and treatment. With suicide receiving increasing attention worldwide, many countries are promoting mental health and developing national strategies for prevention, focussing on at-risk groups (Hawton and van Heeringen, 2009). In Finland and Iceland, suicide prevention programmes have been based on efforts to promote strong multisectoral collaboration and networking (NOMESCO, 2007).

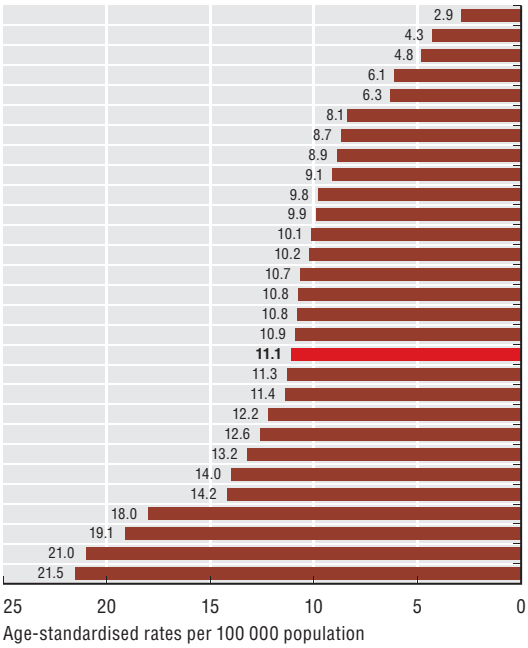
Definition and deviations

The World Health Organisation defines "suicide" as an act deliberately initiated and performed by a person in the full knowledge or expectation of its fatal outcome.

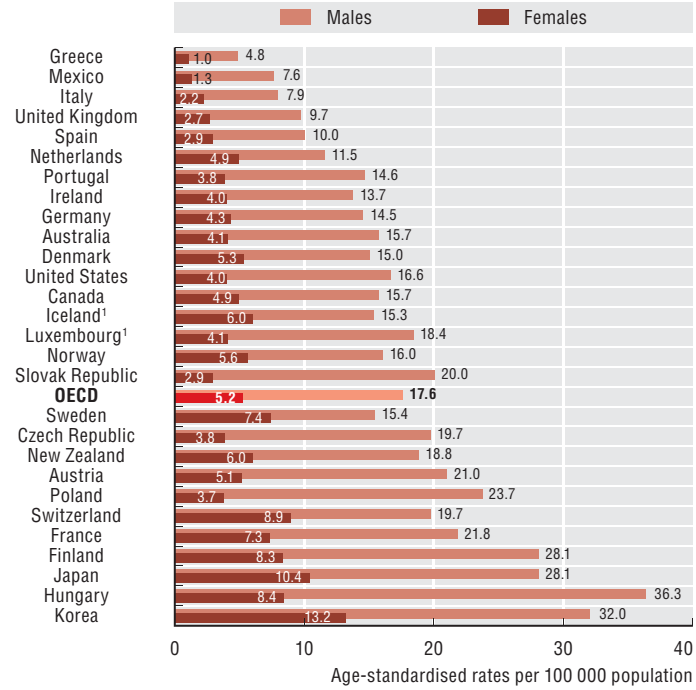
Mortality rates are based on the crude number of deaths according to selected causes in the WHO Mortality Database. Mathers *et al.* (2005) have provided a general assessment of the coverage, completeness and reliability of WHO data on causes of death. Mortality rates have been age-standardised to the 1980 OECD population, to remove variations arising from differences in age structures across countries and over time within each country.

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.

1.7.1 Suicide, mortality rates, total population, 2006 (or latest year available)

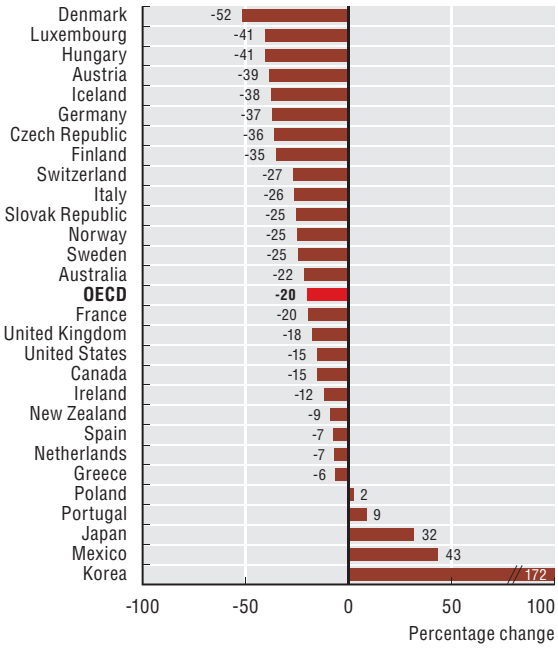


1.7.2 Suicide, mortality rates, males and females, 2006 (or latest year available)

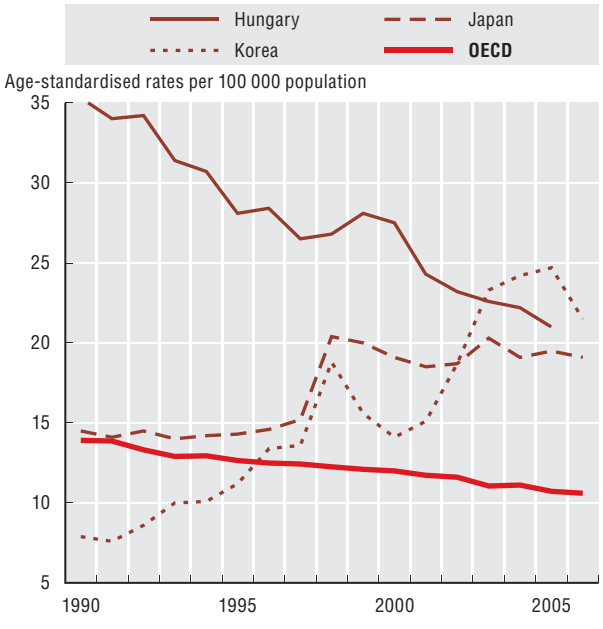


1. Three-year average.

1.7.3 Change in suicide rates, 1990-2006 (or nearest year)



1.7.4 Trends in suicide rates, selected OECD countries, 1990-2006



Source: OECD Health Data 2009. The raw mortality data have been extracted from the WHO Mortality Database, and age-standardised to the 1980 OECD population.

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