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 "Definitions and deviations").

Suicide is a significant cause of death in many European Union countries, and there were approximately 55 000 such deaths in 2008. Rates of suicide were low in southern European countries – Greece, Cyprus, Italy, Malta, Spain and Portugal – as well as the United Kingdom, at less than eight deaths per 100 000 population (Figure 1.7.1). They were highest in the Baltic States and Central and Eastern Europe; in Lithuania, Hungary and Latvia, as well as Finland, there were more than 18 deaths per 100 000 population. There is more than a ten-fold difference between Lithuania and Greece, the countries with the lowest and high death rates.

In general, death rates from suicides are three-to-four times greater for men than for women across the European Union, except in those countries with the highest rates, where rates are up to six times greater (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, almost no progress has been observed among younger people.

Since 1994, suicide rates have decreased in many EU countries, with pronounced declines of 40% or more in Estonia, Latvia and Slovenia (Figure 1.7.2). Despite this progress, these three countries still have among the highest suicide rates in Europe. On the other hand, death rates from suicides have increased since 1994 in Malta, Iceland and Portugal, though rates in Malta and Portugal still remain below the EU average.

Following independence in 1990, suicide rates in Lithuania increased steadily, 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).

Suicide is often linked with depression and the abuse of alcohol and other substances. Early detection of these psycho-social problems in high-risk groups by families and health professionals must be part of suicide prevention campaigns, together with the provision of effective support and treatment. Many countries are promoting mental health and developing national strategies for prevention, focusing 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

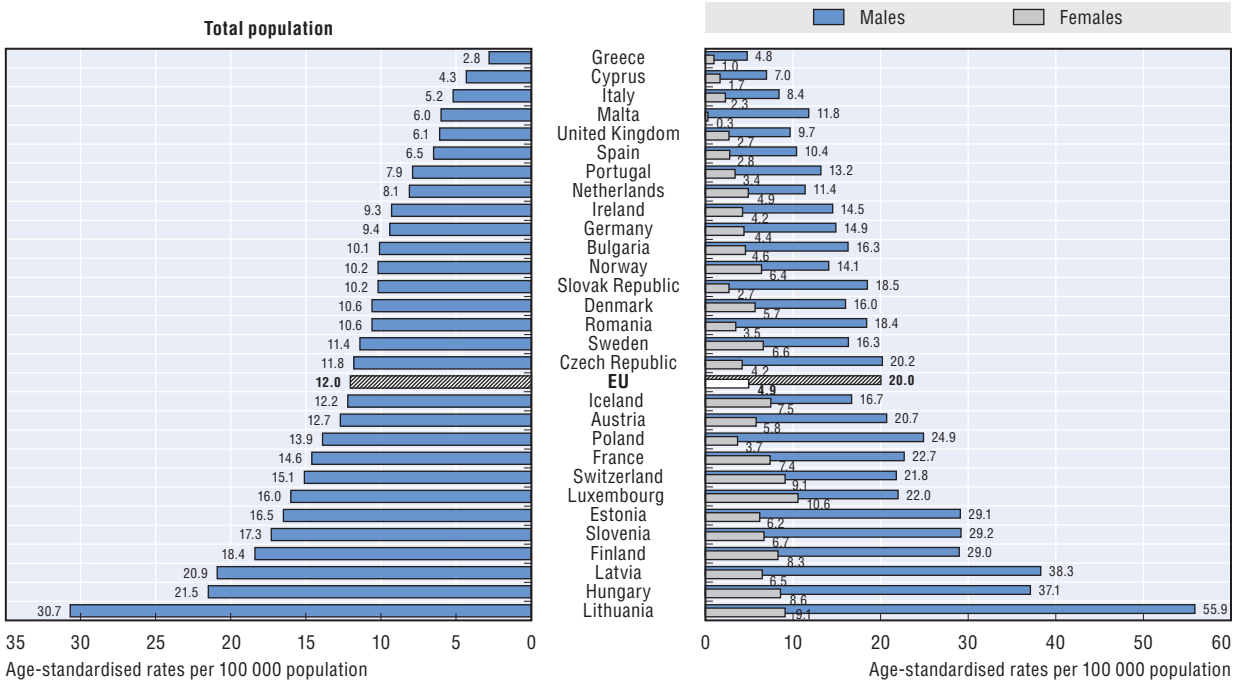
The World Health Organization defines "suicide" as an act deliberately initiated and performed by a person in the full knowledge or expectation of its fatal outcome. Comparability of suicide data between countries is affected by a number of reporting criteria, including how a person's intention of killing 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*.

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

Deaths from suicide are classified to ICD-10 codes X60-X84.

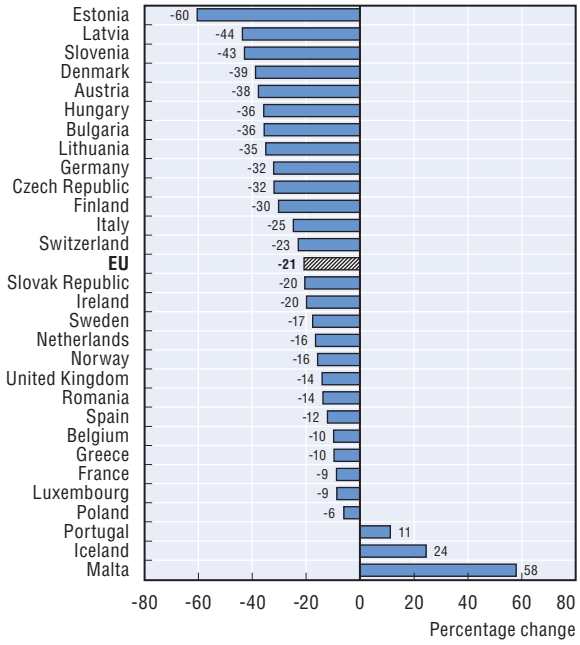
1.7.1. Suicide mortality rates, 2008 (or nearest year available)



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

StatLink http://dx.doi.org/10.1787/888932335761

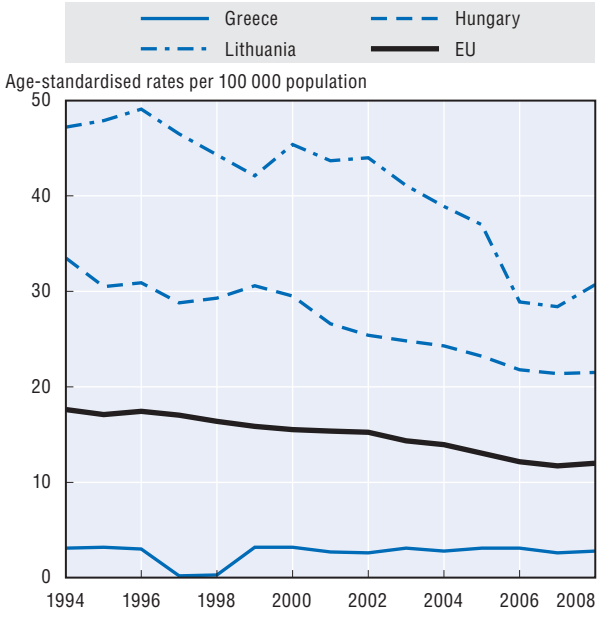
1.7.2. Change in suicide rates, 1994-2008 (or nearest year available)



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

StatLink http://dx.doi.org/10.1787/888932335780

1.7.3. Trends in suicide rates, selected EU countries, 1994-2008



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

StatLink http://dx.doi.org/10.1787/888932335799

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