SUICIDES

The intentional killing of oneself can be 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, 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.

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 is an important 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, focussing on at-risk groups. In Germany, as well as Finland and Iceland, suicide prevention programmes have been based on efforts to promote strong multisectoral collaboration and networking.

Overview

Suicide is a significant cause of death in many OECD countries, with almost 150 000 such deaths in 2010. Rates were lowest in southern European countries (Greece, Italy and Spain) and in Mexico and Israel, at six or less deaths per 100 000 population. Suicides rates were highest in Korea, Hungary, the Russian Federation and Japan, at more than 20 deaths per 100 000 population.

In general, death rates from suicide are three-to-four times greater for men than for women across OECD countries, and this gender gap has been fairly stable over time. The exception is Korea, where women are much more likely to take their own lives than in other OECD countries. 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 in many OECD countries, with declines of 40% or more in Denmark, Estonia, Hungary, Finland and Austria. On the other hand, suicide rates have increased in Korea, Chile, Mexico, the Russian Federation, Japan and Poland, although in Mexico rates remain at low levels. In Korea, rates have increased sharply and are well above the OECD average.

Male suicide rates in Korea more than doubled from 19 per 100 000 in 1995 to 50 in 2010, and rates among women are the highest in the OECD, at 21 per 100 000. Between 2006 and 2010, the number of persons treated for depression and bipolar disease in Korea rose sharply (increases of 17 and 29 per cent respectively), with those in low socioeconomic groups more likely to be affected. The 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.

Definition

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. Data on suicide rates are based on official registers of causes of death.

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 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.

Comparability

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. 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. Caution is required therefore in interpreting variations across countries.

Sources

- OECD (2012), *OECD Health Statistics*, OECD Publishing.

Further information

Analytical publications

- OECD (2011), *Mental Health and Work: Evidence, Challenges and Policy Directions*, OECD Publishing.
- OECD (2011), *Health at a Glance: OECD Indicators*, OECD Publishing.
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Online databases

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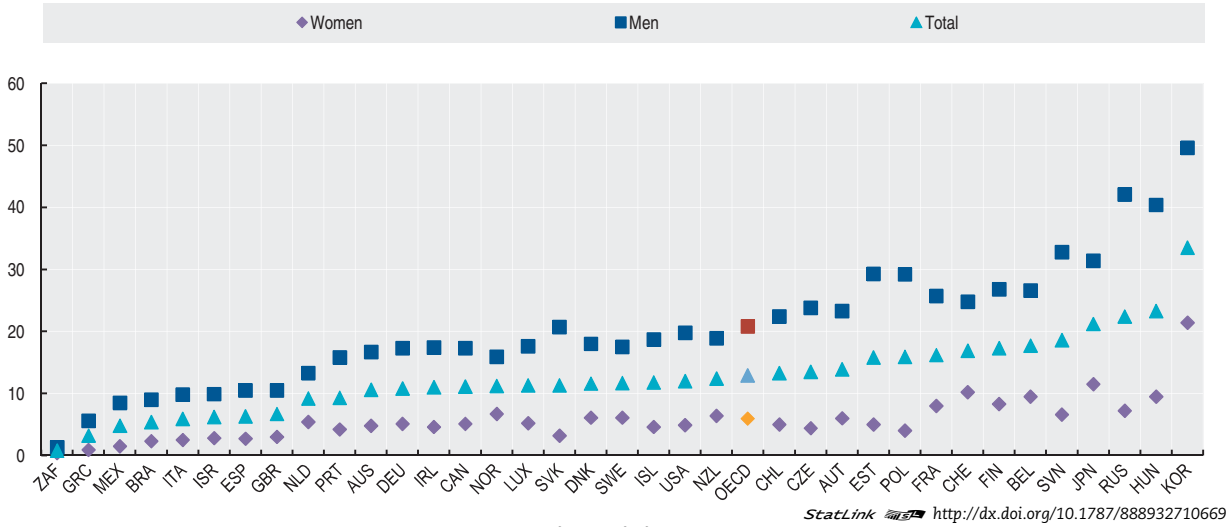
Suicide rates by gender

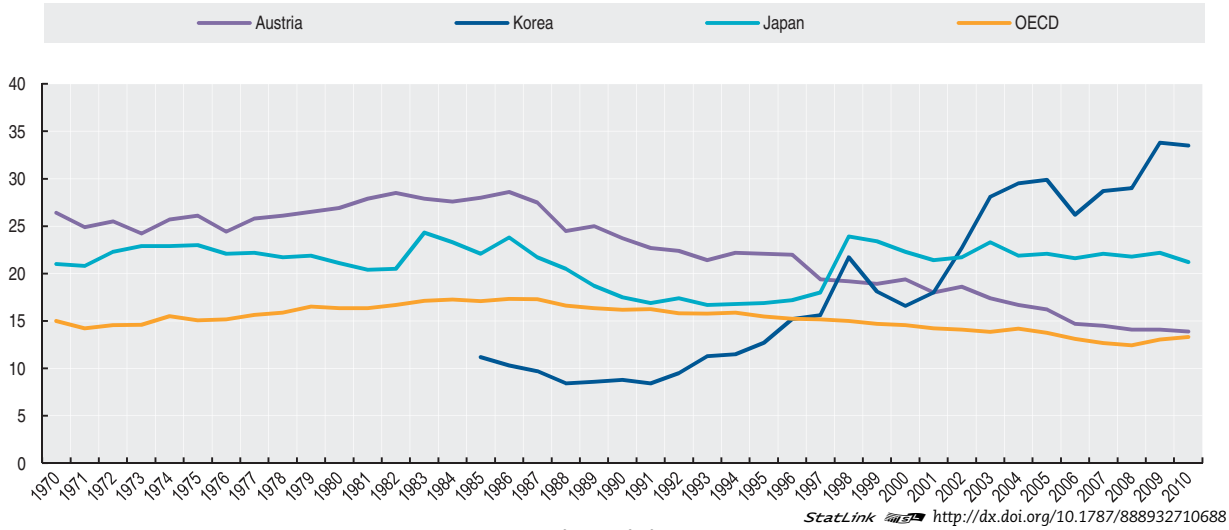
Age-standardised per 100 000 persons, 2010 or latest available year



StatLink http://dx.doi.org/10.1787/888932710669

Trends in suicide rates

Per 100 000 persons

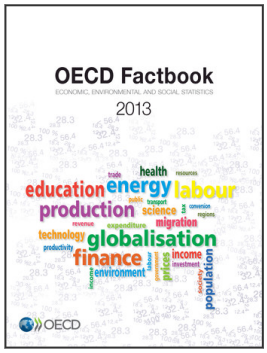


StatLink http://dx.doi.org/10.1787/888932710688

Change in suicide rates

Percentage, 1990-2010 or latest available period

StatLink http://dx.doi.org/10.1787/888932710707



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