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EDITORIAL

Global suicide rates

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In spite of mixed trends, suicide remains a significant public health problem worldwide. In the 1970s and 1980s, suicide rates tended to rise in elderly men from North America and in younger men in Japan and several (mostly eastern) European countries, but were generally more stable for women. Furthermore, there were substantial (over 10-fold) differences in rates, between the highest ones from Hungary, Finland, Denmark, the former Soviet Union and Sri Lanka, and the lowest ones in South America or southern Europe.[1] Overall age-adjusted (on the world standard population) male mortality rates from suicide in Hungary or Sri Lanka were of the order of 50/100,000, i.e. higher than cardiovascular mortality rates in Japan or France.[2] A recent report from China estimated that 4% of deaths are due to suicide in the late 1990s.[3]

However, the aggregate figures hide variations that have occurred among sexes, age groups and regions.[4] In order to assess the actual magnitude of the problem and to implement effective measures to reduce suicide rates, research should be conducted to plot the changing trends in suicide in different countries, and to correlate these to known or likely risk and protective factors.

To contribute to the knowledge and quantification of the issue, trends have been updated in age-standardized mortality from suicide over the period 1965–98 in the European Union (EU), selected eastern European countries, the Russian Federation, the USA and Japan using the World Health Organization (WHO) database.[5] The main findings are given in *figure 1*. In the EU, overall age-standardized suicide mortality peaked at 16.1/100,000 men in 1980–84, and declined thereafter to 14.4/100,000 in 1995–98. In females, the fall was 29%, to reach 4.6/100,000 in 1995–98. Although mortality values were substantially higher than in the EU, a similar pattern of trends was observed in eastern European countries providing long-term data (Bulgaria, the Czech Republic, Hungary, Poland, Romania, and Slovakia). In contrast, mortality from suicide rose substantially in the Russian Federation, from 37.7/100,000 males in 1985–89 to 58.3 in 1995–98 (+55%), and from 8.5 to 9.5 (+12%) in females – as well as in most other countries of the former Soviet Union. In the USA and most other American countries, no consistent pattern was evident for males, but appreciable falls were observed in females (–25%). Downward trends were registered for Japan, until the early 1990s (minus 15% for men, minus 25% for women).

Although psychiatric conditions – mainly depression and its management – may have had some influence on several favourable trends in suicide rates,[6,7] the major determinants of the substantial variation in suicide rates across geographic areas and calendar periods should be related to economic, socio-cultural features and characteristics (including deprivation and unemployment, but also alcohol abuse) of various populations.[1,7,8] Some role may also have been played by reduced availability of methods of suicide, including gas detoxification and catalytic converters.[9]

In Russia and other countries of the former Soviet Union, substantial rises were observed in suicide mortality particularly for young males, whose rates reached 66/100,000 men aged 15 to 34 in the late 1990s. Suicide was therefore the major cause of death in young males.[10] The reasons for these rises are complex, but are likely to include widespread alcohol abuse as well as social deprivation.[10]

More important, recent trends in the Russian Federation contrast with the relatively favourable pattern of suicide mortality in other European countries and several other areas of the world, and indicate the importance and urgency of integrated medical, but mainly social, interventions – including control of alcohol abuse – in the prevention of suicide.

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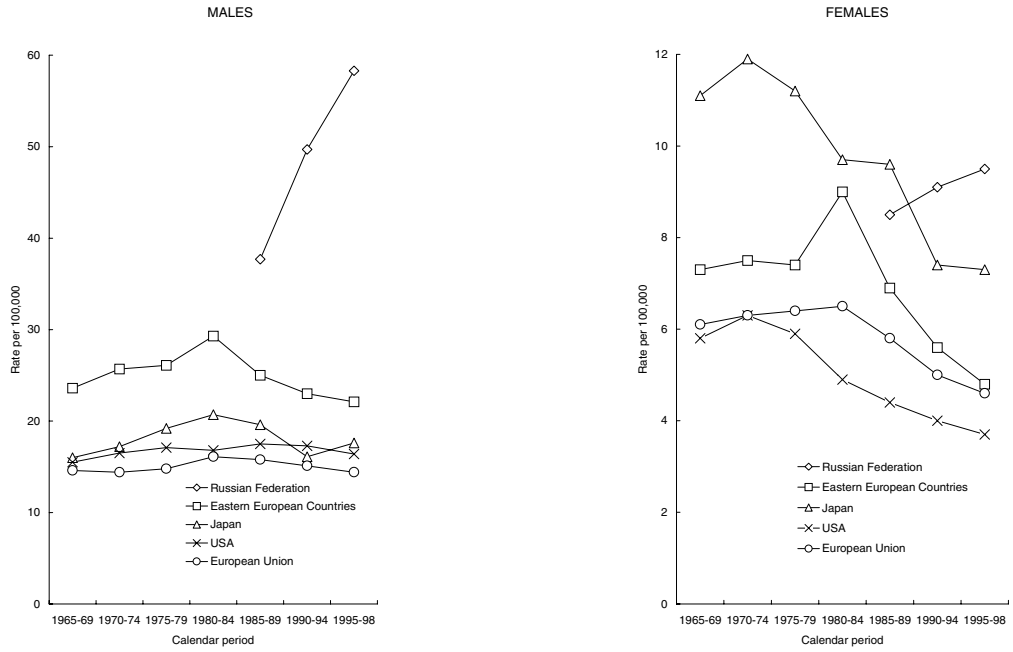

Figure 1 Trends in overall age-adjusted (world standard) death certification rates per 100,000 males (left) and females (right) from suicide in European Union, six eastern European countries (Bulgaria, Czech Republic, Hungary, Poland, Romania and Slovakia), Russian Federation (period 1985–1998), United States, and Japan, 1965–1998

6 Geddes J. Suicide and homicide by people with mental illness. Br Med J 1999;318:1225-6.
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8 Hawton K. A national target for reducing suicide. Br Med J 1998;317:156-7.
9 Kendall RE. Catalytic converters and prevention of suicide. Lancet 1998;352:1525.
10 Shkolnikov V, McKee M, Leon DA. Changes in life expectancy in Russia in the mid-1990s. Lancet 2001;357:917-21.

NOTE
RECTIFICATION THREE FIGURES

We regret that a technical problem during printing meant that the shading in three figures in the last edition of the journal was not reproduced appropriately making the information difficult to visualise. Below and on the inside of the backflap we have reproduced the figures with this problem corrected.

Eur J Public Health 2003;13:4–10 (page 7, figure 1)
Kaltiala-Heino R, Kautiainen S, Virtanen SM, Rimpelä A, Rimpelä M. Has the adolescents' weight concern increased over 20 years?

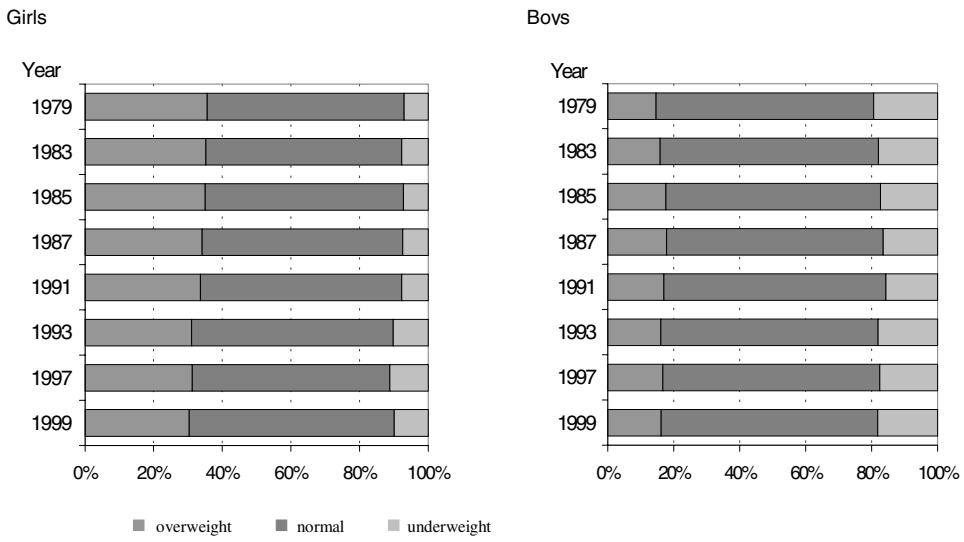

Figure 1 Age-standardized distributions of perceived weight (%) for girls and boys over the period 1979–1999