Suicide statistics report

Latest statistics for the UK and Republic of Ireland

September 2019

SAMARITANS

Contents

There were 6,859 suicides in the UK and Republic of Ireland in 2018

Suicide statistics for the UK as a whole, England, Wales, Scotland, Northern Ireland and the Republic of Ireland are not routinely published together by any other organisation

Suicide statistics report

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Samaritans – working together to reduce suicide

- **Samaritans' vision is that fewer people die by suicide.**
- **Suicide is not inevitable; it is preventable.**
- **The causes of suicide are complex, but we know it is both a gender and an inequality issue.**
- **Behind every statistic is an individual with a family, and a community, devastated by their loss.**

Samaritans' strategy, *Working together to reduce suicide 2015-21*, outlines our commitment to reducing the number of people who die by suicide. To reduce suicide, we need to reach more people who may be at risk of taking their own lives. This can only be achieved by understanding which groups of individuals are more at risk of suicidal thoughts and behaviours.

This report pulls together data from national statistical agencies to provide an overview of the latest suicide rates and trends for the UK and Republic of Ireland.

Self-harm and suicide are increasing among young people and in this report we explore this issue in more detail. Reversing this worrying trend should be a priority for governments and is a key area of work for Samaritans.

The report also presents some of the key challenges with suicide statistics, which can be unreliable and slow to be released. Timely access to accurate statistics is vital so that we can fully understand who is at risk of suicide. In this report we take you on a journey to suicide statistics, from how the cause of death is established, through to what reported figures mean. Along the way we highlight key differences in the way countries produce suicide statistics, which influence how they are used and understood.

> We can choose to stand together in the face of a society which may often feel like a lonely and disconnected place, and we can choose to make a difference by making lives more liveable for those who struggle to cope. We believe we can do this because we know that people and organisations are stronger together.
>
> **Samaritans: Working together to reduce suicide** [1]

Recent trends in suicide

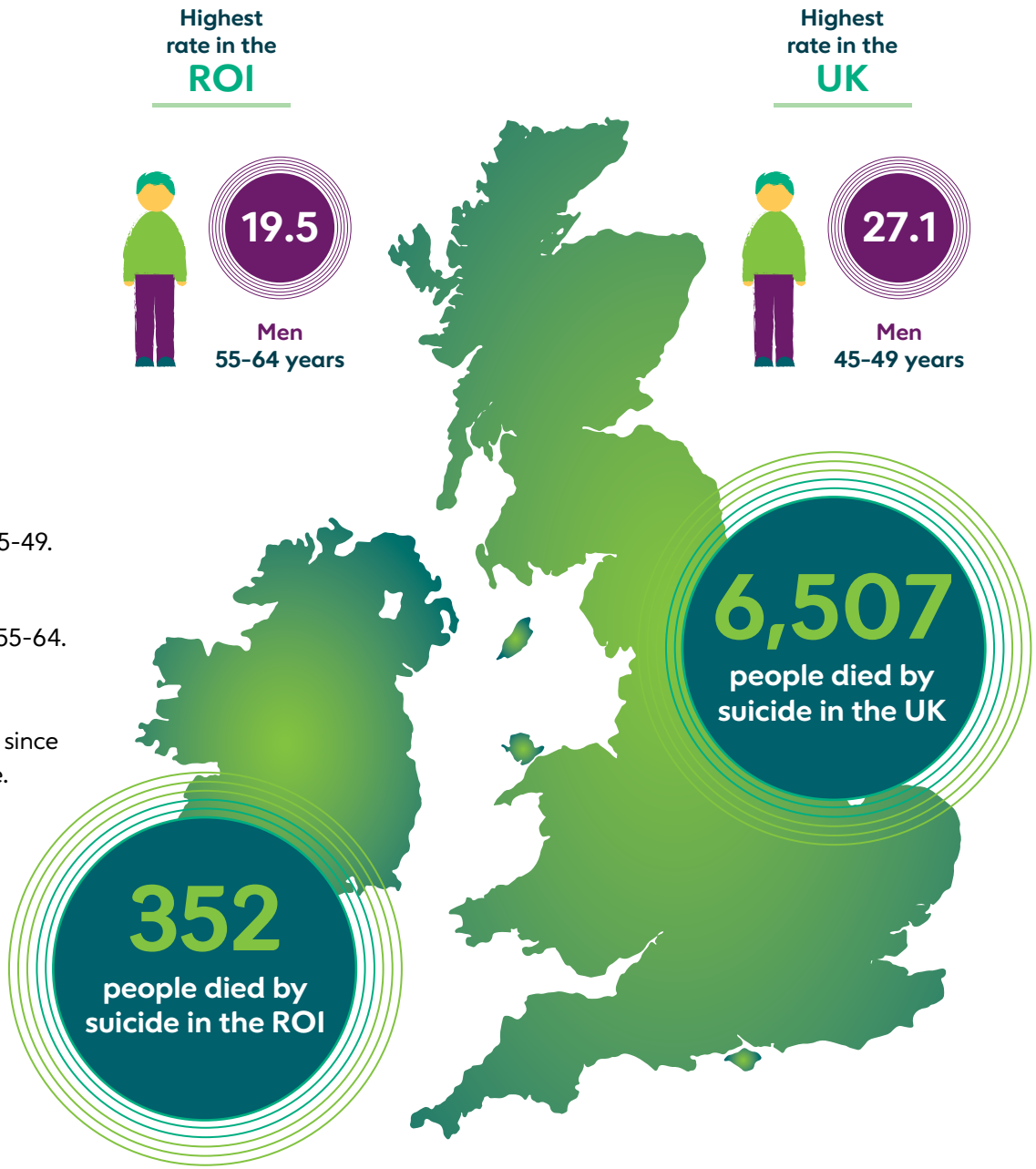
What are the recent trends?

Key facts from 2018:

- There were 6,859 suicides in the UK and Republic of Ireland.
- 6,507 suicides were registered in the UK and 352 occurred in the Republic of Ireland.
- The suicide rate in Scotland is the highest in the UK – where men aged 35-44 have the highest suicide rate.
- The highest suicide rate in the UK, and England, is among men aged 45-49.
- The highest suicide rate in Wales is among men aged 40-44.
- The highest suicide rate in the Republic of Ireland is among men aged 55-64.

Key trends from 2018:

- There has been a significant increase in suicide in the UK, the first time since 2013 – this appears to be driven by an increase in the male suicide rate.
- In the UK, suicide rates among young people have been increasing in recent years. The suicide rate for young females is now at its highest rate on record.
- In the UK men remain three times more likely to take their own lives than women, and in the Republic of Ireland four times more likely.
- Suicide has continued to fall in both males and females in the Republic of Ireland.



What do the trends tell us?

It is worrying to see a significant increase in suicide in the UK, for both men and women. Although, the overall increase seems to be driven by the rise in male suicide.

The continued decline in suicide rates in the Republic of Ireland is encouraging.

Men remain around three times more likely to take their own lives than women in the UK, and four times in the Republic of Ireland. Middle aged-men are still at greatest risk of suicide overall. Our previous research has shown that there are unique factors affecting middle-aged men. Now this knowledge needs to translate into actionable ways to target this group.

In the UK, suicide rates increased in women aged 45-49 years. Over the past 2 years, the female suicide rates also appear to be increasing in Wales. This also shows that more evidence is needed to understand why women take their own life, and why rates are increasing.

It is also particularly concerning that suicide in young people is increasing in the UK. Suicide is complex and it is rarely caused by one thing. However, we know that some risk factors – such as self-harm and academic pressures – are particularly common among young people.

Suicide is not inevitable - it is preventable. Monitoring trends and changing suicide rates is key to understanding who is most at risk and what we can do to prevent suicide.

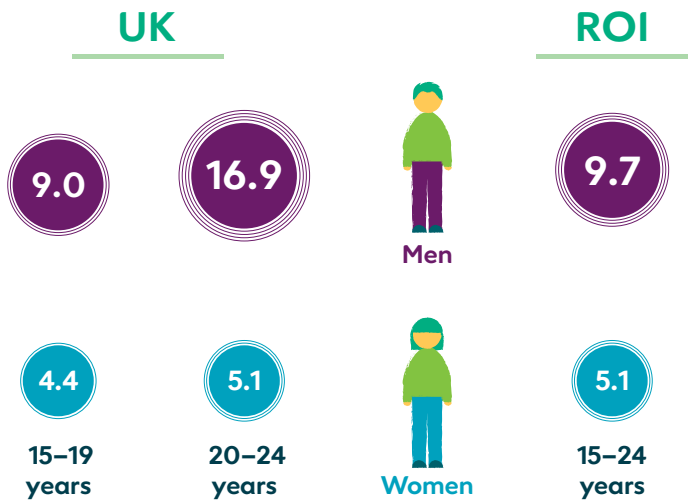
Impact of changes to coroners practices in England and Wales on 2018 data - In July 2018 the standard of proof used by coroners to determine whether a death was caused by suicide were lowered. The lowering of the standard of proof may mean that more deaths are registered as suicides (for further information see p.32).

SAMARITANS Focus on young people

Suicide is the biggest killer of young people[2]. In 2018, 759 young people took their own life in the UK and Republic of Ireland. Every single one of these deaths is a tragedy that devastates families, friends and communities.

Three quarters of deaths among young people are male, and rates are highest in men aged 20-24.

Suicide rates per 100,000, for young people in 2018



* 'Young people' refers to those aged 15-24 years. Data and evidence provided within this section are aligned to this age range as closely as possible. However, data is collated from multiple sources where age brackets and definitions may differ, and therefore will not necessarily always match the age range exactly.

Notes about data: Data source – Office for National Statistics (ONS) and Central Statistics Office (CSO). Data for the Republic of Ireland for 2017 and 2018 is provisional.

Trends in suicide among young people in the UK and ROI

In the UK, suicide rates increased for all groups of young people in 2018. Suicide rates among men aged 20-24 had been decreasing, but this year there was a significant increase of 30%.

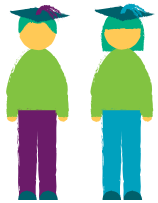
In the Republic of Ireland, suicide rates have been decreasing among young people since 2011.

Suicide rate per 100,000 for young people in the UK 2004-2018

Focus on young people...

Why do young people take their own life?

Suicide is complex and is rarely caused by one thing. It usually follows a combination of adverse childhood experiences, stressors in early life and recent events[3]. Research shows that bereavement, abuse, neglect, self-harm, mental or physical ill health, and experiencing academic pressures are just some of the common risk factors for suicide among young people.[3] Of course, though, most young people will experience these stresses and not go on to take their own lives.



Academic pressures and bullying were found to be more common before suicide in young people under 20[3]

Workplace, housing and financial problems were more common for 20-24 year-olds[3]

Suicide-related internet use was found in 26% of deaths in under 20s and 13% of deaths in 20-24 year-olds[3]

Findings taken from the The National Confidential Inquiry into Suicide and Homicide by People with Mental Illness: *Suicide by children and young people in England.*

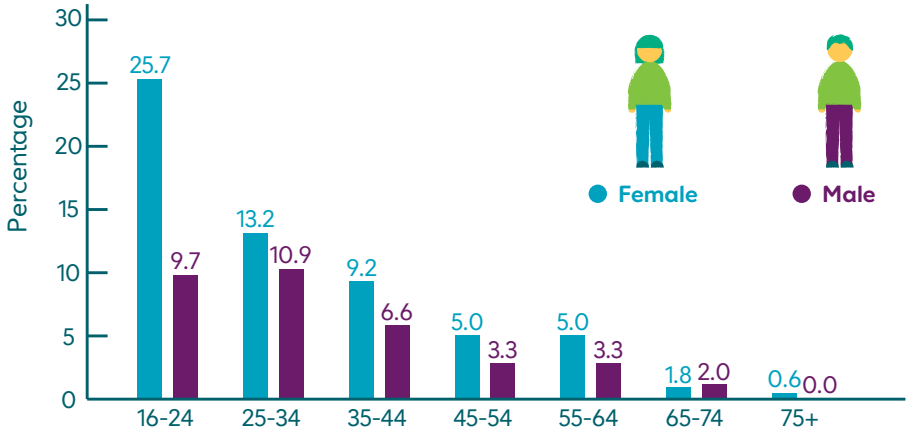
Young people and self-harm

A major concern is the increase in self-harm among young people over the last 15 years. Self-harm is a sign of serious emotional distress and, while most people who self-harm will not go on to take their own life, it is a strong risk factor for future suicide[4,5].

There are many definitions of self-harm. Researchers, clinicians, charities and media all often use the term to mean different things. Samaritans defines 'self-harm' as any deliberate act of self-poisoning or self-injury *without* suicidal intent. This excludes accidents, substance misuse and eating disorders.

Self-harm is more common among young people than other age groups[6]. Self-harm increased across all age groups between 2000 and 2014, but it increased the most among young women[7].

Percentage of adults in England reporting that they have self-harmed at some point in their lives



Data source: Adult Psychiatric Morbidity Survey 2014[5]

Focus on young people...

Why do young people self-harm?

Self-harm is often used as a way of trying to obtain relief from emotional distress[8] or expressing feelings that are difficult to communicate[9]. Evidence shows that people who self-harm may feel distress more intensely[10] and be more likely to try and avoid negative thoughts and feelings, even when doing so may lead to more harm in the long run[11]. In this way self-harm can become a repeated behaviour[12], used as a response to emotional distress[9].

However, research shows that longer term self-harm is ineffective at managing emotional distress[12]. And longer term self-harm is associated with developing thoughts about suicide[4].

Why is the increase in self-harm concerning?

We still don't know enough about why self-harm is increasing among young people. The increase is concerning because it might lead to:

- self-harm becoming further normalised as a way to cope with emotional distress
- self-harm becoming a long-term response to emotional distress
- an increase in future suicides

What do we want to see?

Self-harm needs to be prioritised by governments with ambitious, comprehensive plans put in place to achieve a reduction in the rates of self-harm. These need to include actions to ensure:

- Young people are aware of and equipped to use effective, healthy coping mechanisms when they are struggling.
- Stigma around self-harm is reduced leading to more young people who self-harm seeking help.
- Support is in place for every young person who needs it, with services available and being accessed.
- Everyone who self-harms is entered into a care pathway that meets their needs; social prescribing is offered where appropriate; and GPs have the skills and resource to respond effectively to every person they see.
- Research is undertaken to better understand the link between self harm and suicide and which interventions are most effective in supporting those who self harm

In the coming months, Samaritans will work to secure policy and attitudinal change to help reduce rates of self-harm among young people. We will place the voices and experiences of young people at the heart of this work, using evidence to drive change, as well as adding to the existing evidence base through our research work.

Samaritans' response to suicide trends

What are Samaritans calling for?

- **We need improved data and further research into risk factors and high-risk groups.** In particular, we need to understand more about 'what works' for high-risk groups, such as middle-aged men. We need to understand more about the transition from thinking about suicide to attempting suicide and which risk factors are most influential for at-risk groups.
- **We need to know more about why rates of suicide are increasing among young people.** This will help ensure appropriate support and interventions are available and targeted for those most at risk of suicide.
- **The views of people with lived experience, including young people, should be at the heart of suicide prevention policy.** National and local government should support a safe, supported network to enable on-going engagement with a representative group of people with lived experience.
- **Governments should have in place comprehensive, ambitious, cross-government workplans** that include clear actions on how to reach the two-thirds of people who die by suicide who are not in touch with mental health services.
- **There should be improved, timely national data collection,** minimising delays in registering and reporting suicide, to allow local areas to respond quickly to suicide and offer bereavement support.
- **Local areas need more support and resources with sharing of suicide prevention best practice,** to reduce duplication and enhance effectiveness. Robust evaluation of activity that is rooted in public health and focused on impact and delivery is key.

What will Samaritans do?

We will continue to focus on the groups who are most at risk of suicide and who are hardest to reach. We will carry out new analysis to understand more about our callers. We'll also undertake research to understand more about the support available for people who self-harm, putting the voice of people with lived experience at the centre of this work.

Middle-aged men continue to experience the highest rates of suicide of any demographic. We will undertake research to gain insight into 'what works' to prevent suicide among this group. We will also work to understand more about how inequality impacts on suicide risk among middle-aged men.

We will work to ensure the online environment is as safe as possible for young and vulnerable people. This will include working with online providers in the development of best practice standards, helping companies monitor and remove harmful content while promoting content that will help keep people safe.

Samaritans is currently developing new services to help people access emotional support in the ways that suit them. We are developing a new Online Chat service, which will provide one-on-one real-time written word emotional support 24/7 from a trained Samaritan; an Online Self-help tool, which will provide approved self-help resources for self-care; and a peer support tool, which will help people identify and support others in emotional distress. These new services will increase Samaritans' capacity to support people who are struggling to cope and also offer effective alternative channels for those who prefer to access support digitally.

What do we want to see?

Improvements to the accuracy and availability of suicide data.

To improve the reliability and availability of data we need more accurate and timely statistics across the UK and Republic of Ireland, and are calling for the following:

- **Revision of the statistical definition of suicide in the Republic of Ireland to align with the UK and other countries**
  In the UK, the statistical definition of suicide includes deaths and events of undetermined intent. This improves the accuracy of suicide statistics, as it accounts for the known underreporting of suicides due to the misclassification of deaths. However, in the Republic of Ireland deaths of undetermined intent are not included in the national definition, which means that suicide is potentially underreported (see page 24 for further information).
- **Review of the death registration process in England, Wales, Northern Ireland and the Republic of Ireland**
  In Scotland the maximum time between a death and registration is eight days. In other countries, deaths are registered after an inquest, which means there can be delays of a year or more before a death is recorded and appears in suicide data. This makes it harder to pick up changes to suicide rates and respond quickly. We would like to see a process in line with Scotland (see page 22 for further information).
- **More timely reporting of suicide from the Northern Ireland Statistics and Research Agency (NISRA) to align with the publication of statistics from other agencies**
- **National database of inquest and procurator fiscal findings**
  In England, Wales, Northern Ireland and the Republic of Ireland, coroners conduct detailed inquests when someone dies unexpectedly, speaking to family members and friends to understand the life experiences affecting the person who died. But this information is kept locally in coroner records or within the Procurator Fiscal Service and only basic demographics such as sex, age and location are reported nationally. This makes it difficult to research risk factors systematically and hugely restricts our knowledge of suicide. A centralised electronic database would overcome this issue and dramatically improve our understanding of the risk factors associated with people who die by suicide.

> Measuring the success, or lack thereof, of efforts to reduce suicides, suicide attempts or the impact of suicide on society at large requires access to reliable and valid data.
>
> **World Health Organisation, 2014; Preventing suicide: A global imperative[3]**

Understanding suicide statistics

Understanding suicide statistics can be tricky. Figures are not always as straightforward as they might appear. Below are some important things to consider when using suicide statistics:

- **It's all about rates per 100,000** The number of suicides in a group (e.g. in a country or a specific age group) can give a misleading picture of the incidence of suicide when considered alone. Rates per 100,000 people are calculated in order to adjust for the underlying population size. An area or group with a larger population may have a higher number of suicides than an area or group with a smaller population, but the rate per 100,000 may be lower.
- **Age-standardised vs. crude rates** "Age-standardised" rates have been standardised to the European population so that comparisons between countries can be made with greater confidence. "Crude rates" have not been standardised in this way and are a basic calculation of the number of deaths divided by the population (x100,000). The two types of rate are not necessarily comparable.
- **Be careful of small groups/populations** The size of populations should be considered when looking at suicide rates. Smaller populations often produce rates that are less reliable as the rates per 100,000 are based on small numbers. Therefore, differences in the number of suicides may have a bigger impact on the rate than in a larger population. An example of this might be suicide in older people (e.g. over 80 years), as the population size is lower than in younger age groups.
- **Rates for a whole country can mask regional variations** It is important to note that within countries there are significant regional and local differences in suicide rates.
- **Year-on-year fluctuations can be misleading** It is important to look at suicide trends over a relatively long period of time. Increases and decreases year-on-year should not necessarily be viewed as 'true' changes to the trend that are attributable to any specific psycho-social factors (e.g. an increase in unemployment).
- **Sensitive and responsible use of suicide statistics** When talking about suicide publicly, including in the media, it is crucial to do so sensitively and responsibly, to minimise the risk of contagion (suicidal behaviour that seems to occur as a result of previous suicides or attempts by others). Also, when talking to particularly vulnerable groups, e.g. children and young people, caution should be taken with the use of statistics which although may be shocking, may have the effect of normalising suicide. Samaritans' Media Guidelines provide advice for how to talk about suicide responsibly and sensitively.

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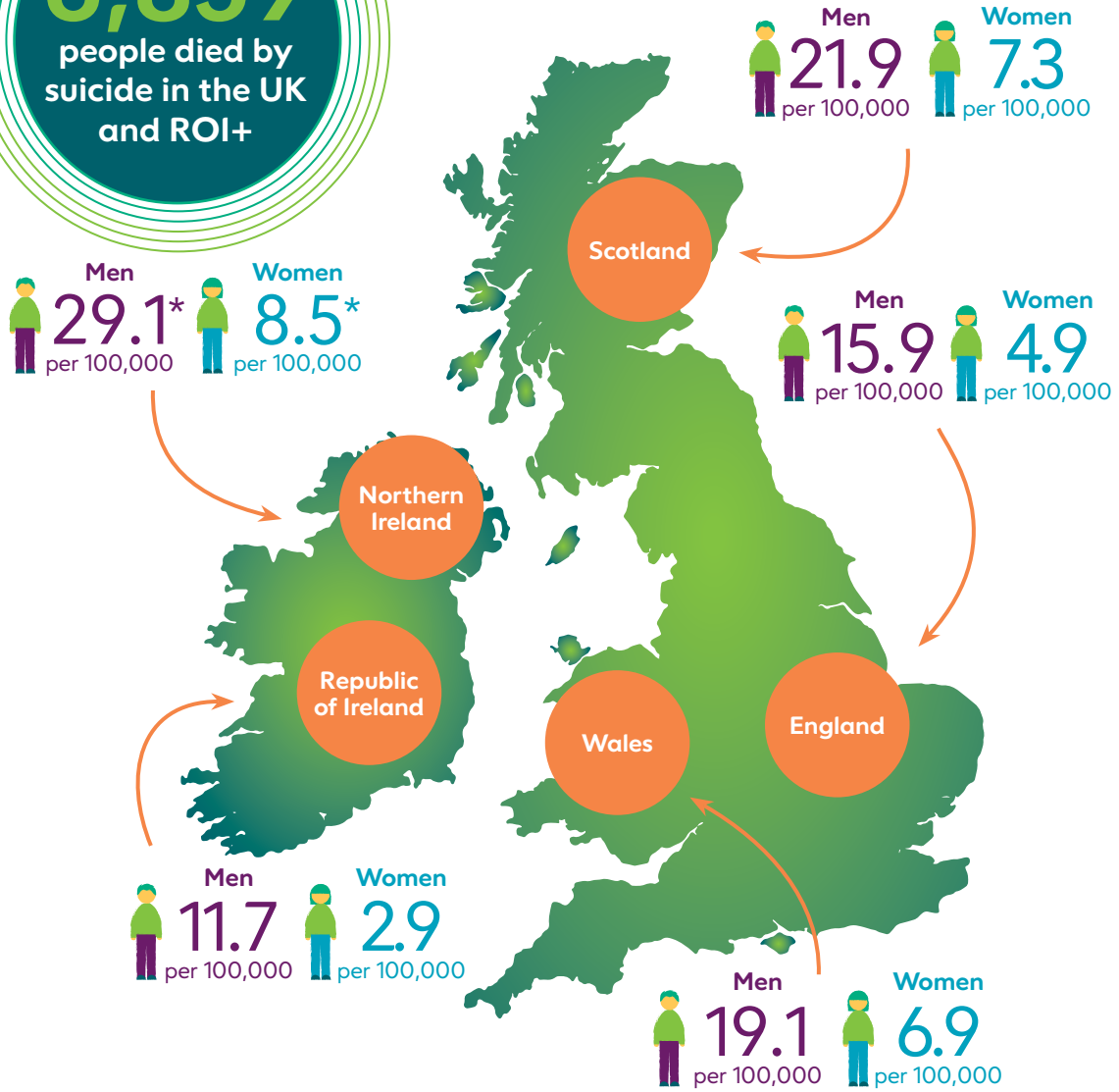
Suicide rates in the UK & Republic of Ireland

6,859 people died by suicide in the UK and ROI+



5,185 men

1,674 women

+ Please note the total number of deaths does not equal the sum of the UK constituent nations and the Republic of Ireland. This is due to ONS including the deaths of non-residents in the UK total figure but not in regional breakdown of deaths in England and Wales. NRS and NISRA include deaths of non-residents as standard.

Rates for the UK are age standardised; rates for ROI are crude.

Please note not all nations collect data on suicide in the same way and therefore rates are not necessarily comparable.

Data sources: Office for National Statistics (ONS), Northern Ireland Statistics and Research Agency (NISRA) and Central Statistics Office (CSO).

*2018 data for Northern Ireland not yet available at time of publication. This report will be updated when data becomes available before the end of 2019.

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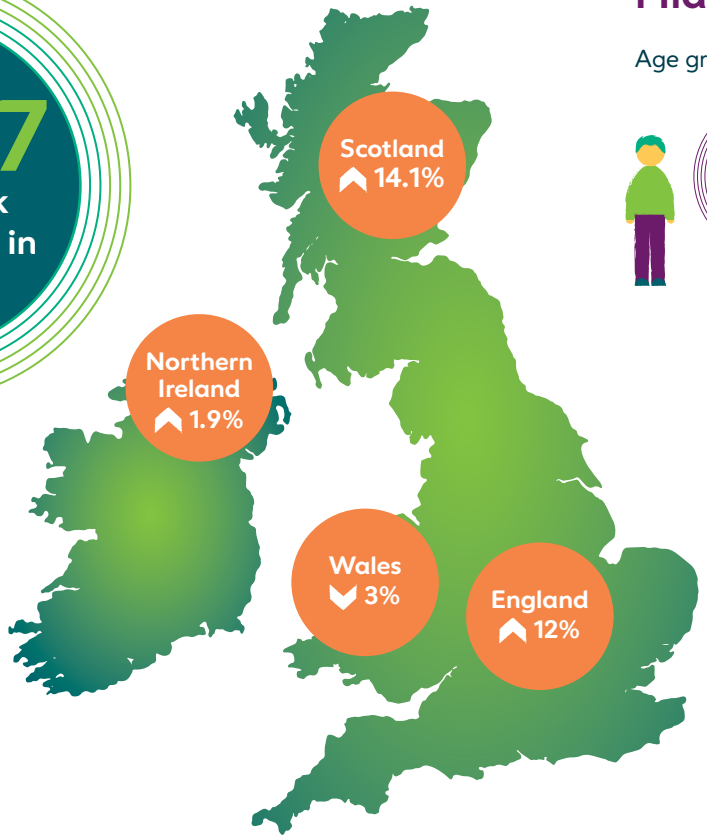
Suicides in the UK

6,507 people took their own life in 2018



4,903
men
75% | 17.2 per 100,000

1,604
women
25% | 5.4 per 100,000

Suicide rate has risen by 10.9%

The **male suicide** rate has increased **11%** between 2017 and 2018.

The **female suicide** rate has increased by **10.2%** between 2017 and 2018

Middle aged men are still at greatest risk

Age groups with highest rate per 100,000

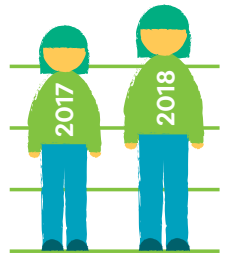
27.1
Men 45–49 years

9.2
Women 45-49 years

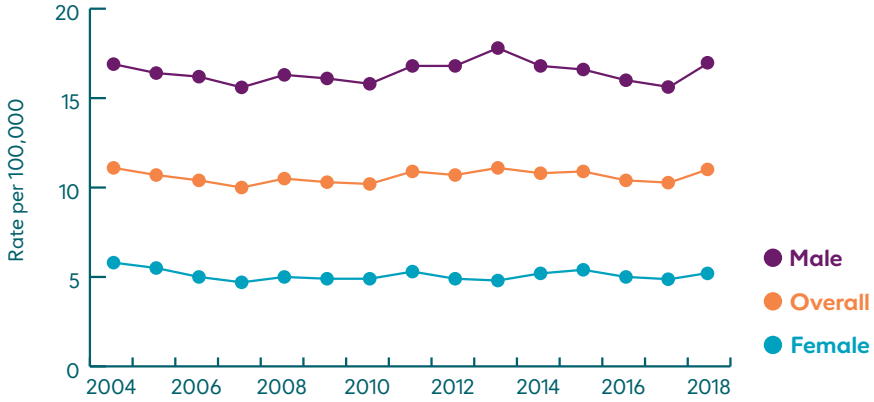
Suicide rates increased for people aged 20-24 and 45-49 in 2018.

The suicide rate increased among **women aged 45–49** by 39.4%.

Women 45–49 years



Suicide rate per 100,000 in the UK 2004–2018



Notes about data: Data sources – Office for National Statistics (ONS), National Records of Scotland (NRS), Northern Ireland Statistics and Research Agency (NISRA). Suicide refers to deaths where the underlying cause is intentional self-harm and events of undetermined intent. Increases/decreases are based on one year of data and may not reflect longer term trends. Overall rates for women, men and all persons are age standardised. Rates broken down by age group are crude.

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Suicides in England

5,021 people took their own life in 2018

3,800 men

76% | 15.9 per 100,000

1,221 women

24% | 4.9 per 100,000

Suicide rate has risen by 12%

The **male suicide** rate has increased by **13.6%** between 2017 and 2018.

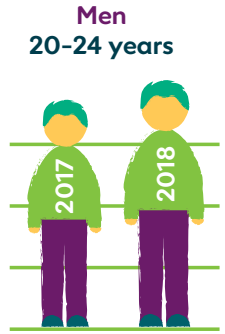
The **female suicide** rate increased by **6.5%** between 2017 and 2018.

Men aged 45-49 have highest suicide rate

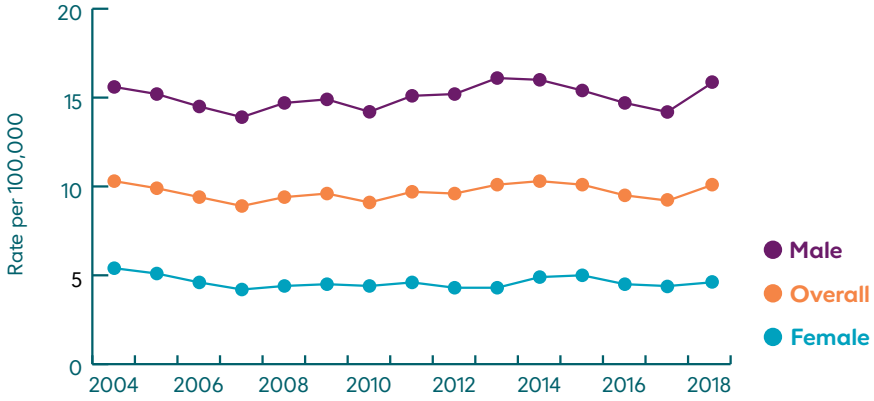
Age groups with highest rate per 100,000

Suicide rates increased for people aged 20-24 and 45-49.

For the first time, the suicide rate for **men aged 20-24** increased significantly. The increase was 39.1%.



Suicide rate per 100,000 in England 2004–2018



Notes about data: Data source – Office for National Statistics (ONS). Suicide refers to deaths where the underlying cause is **intentional self-harm** and **events of undetermined intent.** Increases/decreases are based on one year of data and may not reflect longer term trends. Overall rates for women, men and all persons are age standardised. Rates broken down by age group are crude.

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Suicides in Wales

349 people took their own life in 2018

252 men

72% | 19.1 per 100,000

97 women

28% | 6.9 per 100,000

Suicide rate has decreased by 3%

The **male suicide** rate decreased by **8.6%** between 2017 and 2018.

The **female suicide** rate increased by **19%** between 2017 and 2018.

Note about fluctuations shown in graph – the male and female suicide rates for Wales show a volatile pattern due to the relatively smaller number of deaths. Sharper increases and decreases between 2013 and 2015 may be due to registration delays and coroner processes; see ONS for further details.

Men aged 40-44 have highest suicide rate

Age groups with highest rate per 100,000

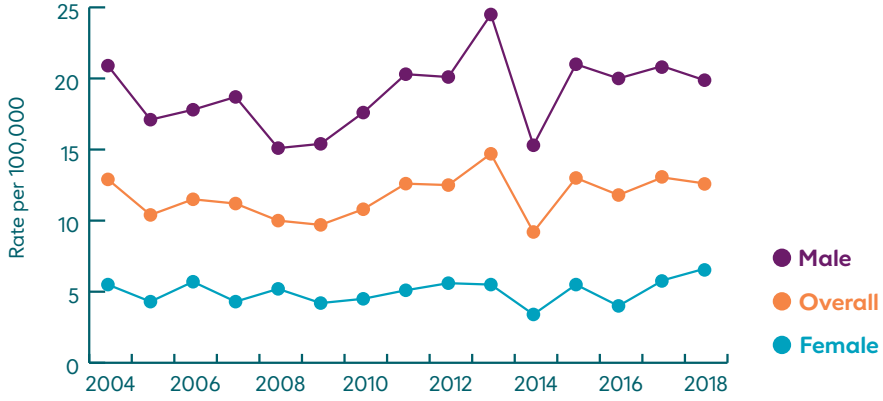
33.6

Men 40–44 years

The female age group with the highest rate is not shown because the Office for National Statistics (ONS) considers data to be unreliable when there are fewer than 20 deaths in an age group.

The male suicide rate is almost three times higher than the female rate.

Suicide rate per 100,000 in Wales 2004–2018



Notes about data: Data source – Office for National Statistics (ONS). Suicide refers to deaths where the underlying cause is **intentional self-harm** and **events of undetermined intent**. Increases/decreases are based on one year of data and may not reflect longer term trends. Smaller populations often produce rates that are less reliable, therefore, differences in the number of suicides may have a bigger impact on the rate than in a larger population. Overall rates for women, men and all persons are age standardised. Rates broken down by age group are crude.

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Suicides in Scotland

784
people took their own life in 2018

581
men
74% | 21.9 per 100,000

203
women
26% | 7.3 per 100,000

Suicide rate has increased by 14.1%

The **male suicide** rate has increased by **10.3%**.

The **female suicide** rate has increased by **27.5%**, following a decrease of **24.3%** in 2017.

Men aged 35–44 have highest suicide rate

Age groups with highest rate per 100,000

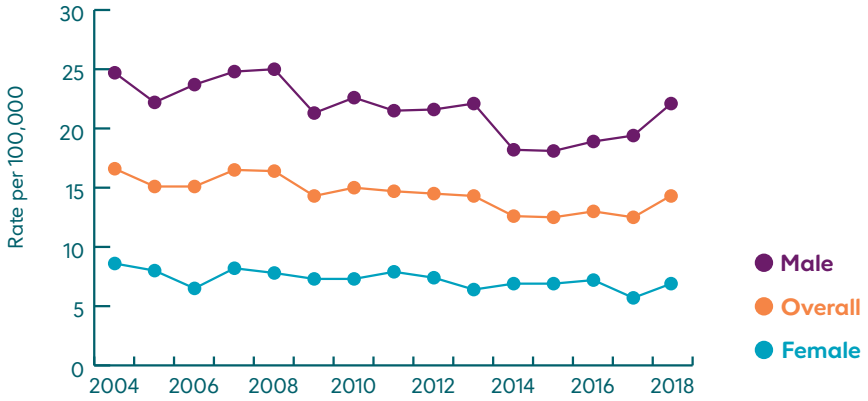
36.5
Men 35–44 years

12.4
Women 45–54 years

The suicide rate among young people aged 15-24 increased by 52.7% between 2017 and 2018.

The rate for this age group is the highest it has been since 2007.

Suicide rate per 100,000 in Scotland 2004–2018



Notes about data: Data source – National Records of Scotland (NRS). Suicide refers to deaths where the underlying cause is intentional self-harm and events of undetermined intent. Increases/decreases are based on one year of data and may not indicate longer term trends. Overall rates for women, men and all persons are age standardised. Rates broken down by age group are crude. Data in the graph only includes deaths coded using 'old-rules'. This is because data using 'new-rules' for 2011 to 2018 are not directly comparable to the previous years' data.

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Suicides in Northern Ireland in 2017*

305 people took their own life in 2018

234 men

77% | 29.1 per 100,000

71 women

23% | 8.5 per 100,000

Suicide rate has increased by 1.9%

The **male suicide** rate increased by **6.1%** between 2016 and 2017.

The **female suicide** rate increased by **8.1%** between 2016 and 2017.

Although the data shows a fall in the overall suicide rate, Northern Ireland continues to have the highest rate in the UK. However, comparisons between nations should be made with caution, since rates are not directly comparable.

Men aged 35-39 have highest suicide rate

Age groups with highest rate per 100,000

56.1

Men 35–39 years

22.1

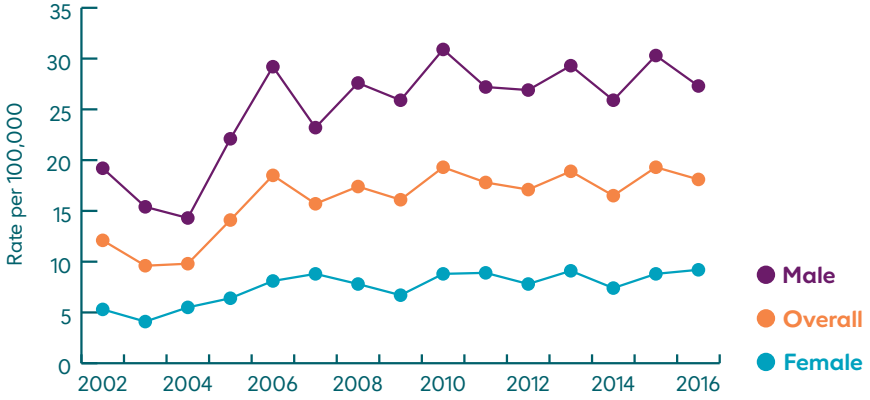
Women 30–34 years

Please note the suicide rate for women aged 30–34 should be used with caution as it is based on fewer than 20 deaths.

The male suicide rate is three times higher than the female rate.

x3

Suicide rate per 100,000 in Northern Ireland 2003–2017



Notes about data: Data source – Northern Ireland Statistics and Research Agency (NISRA). *Data not yet available for 2018 at time of publication. This report will be updated when data becomes available before the end of 2019. Suicide refers to deaths where the underlying cause is **intentional self-harm** and **events of undetermined intent.** Increases/decreases are based on one year of data and may not reflect longer term trends. Smaller populations often produce rates that are less reliable, therefore, differences in the number of suicides may have a bigger impact on the rate than in a larger population. Overall rates for women, men and all persons are age standardised. Rates broken down by age group are crude.

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Suicides in the Republic of Ireland

352 people took their own life in 2018

282 men
80% | 11.7 per 100,000

70 women
20% | 2.9 per 100,000

Men aged 55-64 have highest suicide rate

Age groups with highest rate per 100,000

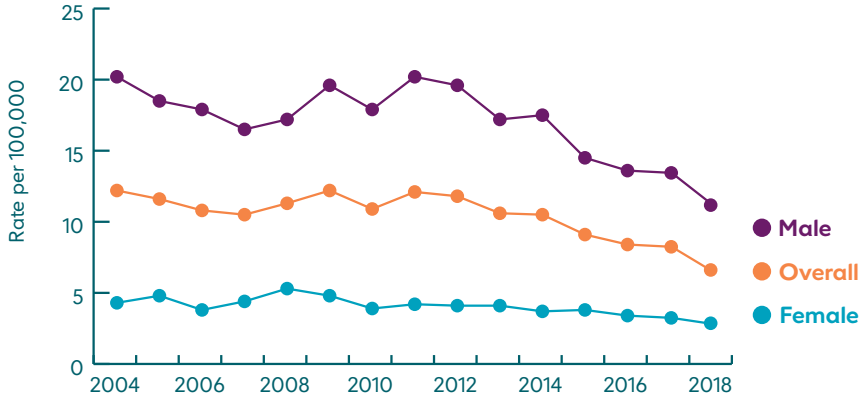
Men 55–64 years

Women 15–24 years

The male suicide rate is four times higher than the female rate.

Please note the suicide rate for women aged 15–24 should be used with caution as it is based on fewer than 20 deaths.

Suicide rate per 100,000 in the Republic of Ireland 2004–2018



Suicide rate has fallen by 11.7%

The **male suicide** rate decreased by **11.2%** between 2017 and 2018.

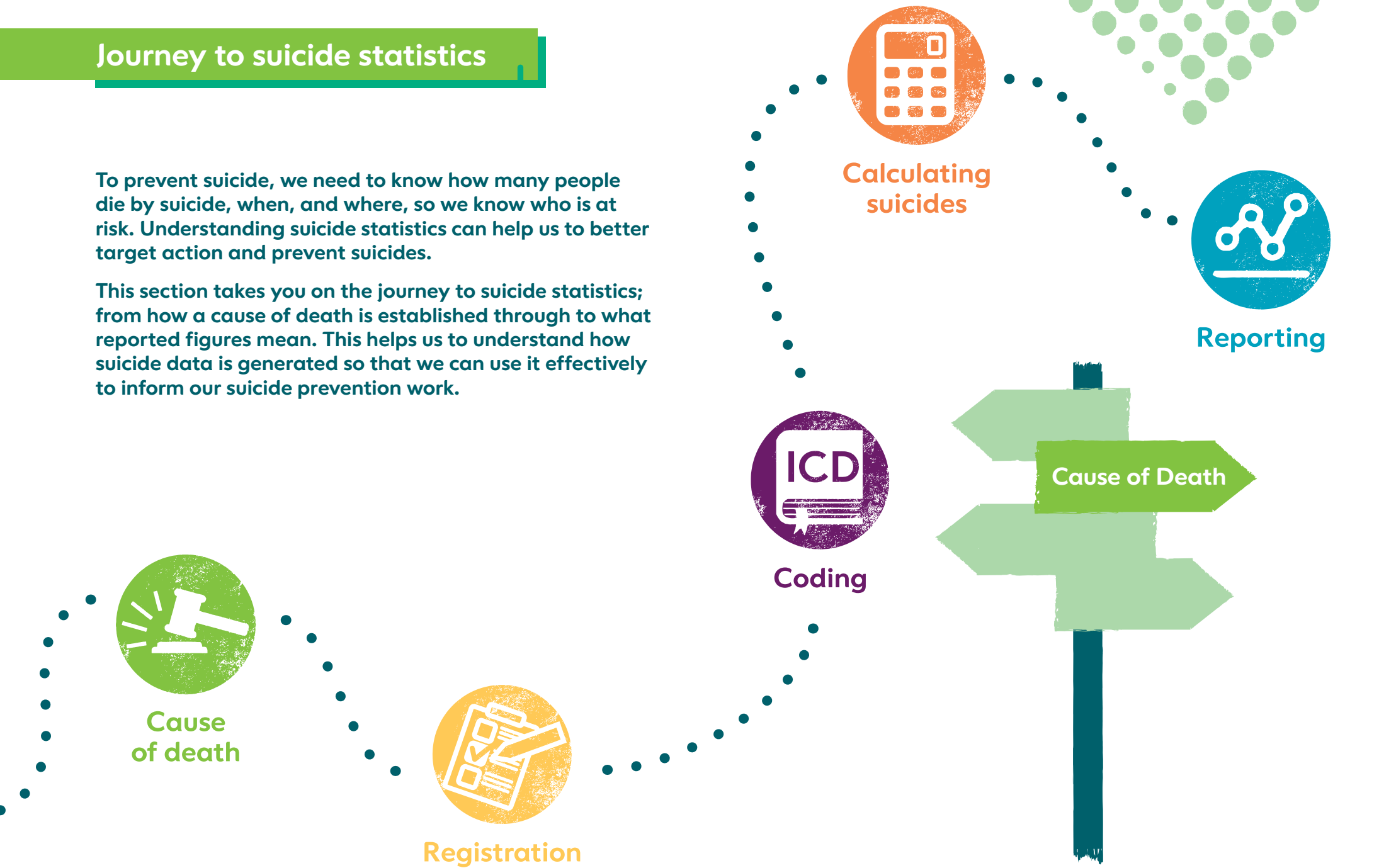
The **female suicide** rate has decreased by **13.6%** between 2017 and 2018.

Notes about data: Data source – Central Statistics Office (CSO). Suicide refers to deaths where the underlying cause is intentional self-harm, but does not include events of undetermined intent, meaning it is not directly comparable to UK data. Increases/decreases are based on one year of data and may not reflect longer term trends. Data for 2017 and 2018 is provisional.

Journey to suicide statistics

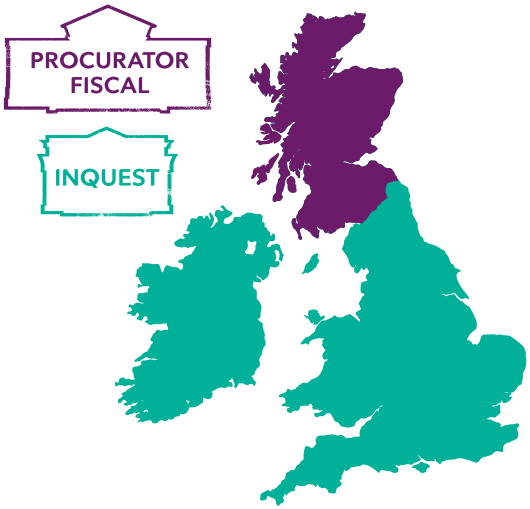
To prevent suicide, we need to know how many people die by suicide, when, and where, so we know who is at risk. Understanding suicide statistics can help us to better target action and prevent suicides.

This section takes you on the journey to suicide statistics; from how a cause of death is established through to what reported figures mean. This helps us to understand how suicide data is generated so that we can use it effectively to inform our suicide prevention work.



Cause of death

When someone dies suddenly, the circumstances are investigated to establish the cause of death. In England, Wales, Northern Ireland and Republic of Ireland this is done by a coroner, through an inquest. And in Scotland, it is investigated by the Procurator Fiscal.



OR

MISCLASSIFIED

However, sometimes it can be difficult to establish whether the cause of death was suicide, which can result in deaths being **misclassified**.

- In certain circumstances, a suicide might seem to be an accident, rather than intentional – and so it might be recorded as an **accidental death**. For example, this can occur in situations where the death involved a road traffic accident. It can also be difficult to determine whether there was intent to die in situations of self-harm leading to suicide.

- Or there **may not be enough evidence** to say whether a death was either accidental or a suicide. **When there is not enough evidence an 'open verdict' or 'narrative verdict' can be given.**

Each of these factors can lead to the misclassification of suicides, which can lead to underreporting.

- **Social or cultural factors may also influence verdicts.** While suicide is no longer a criminal offence, ongoing stigma means suicide verdicts are sometimes less likely to be given – particularly if there are cultural or religious taboos around suicide, and for the death of a child.

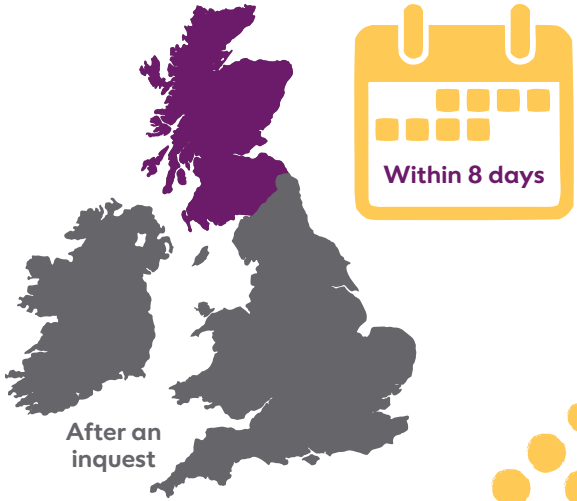
i A narrative verdict gives a brief description about the circumstances surrounding the death and is given instead of a short form verdict (such as 'suicide' or 'accidental death').

i The difference in methods of suicide between males and females has been discussed by researchers for many years: males seem to choose more 'final' and 'obvious' methods than females. It may be that in methods more commonly used by females, the intent cannot be determined (or assumed) as easily as in methods more common to males. This may, in part, explain some of the variation in rates between the genders, as there may be more under-reporting of suicidal deaths in females[13].

Registration

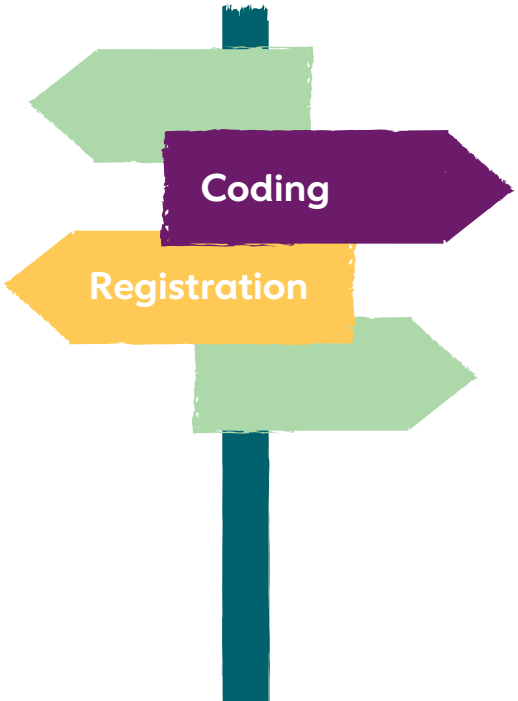
In each country, all deaths are officially registered.

In Scotland deaths are registered within 8 days. In the rest of the UK and Republic of Ireland, deaths are registered after an inquest. This means that there can sometimes be registration delays of a year or more.



Delays in registration mean that some deaths may not appear in official statistics for over a year. This means it takes longer for us to understand how many people, and which groups of people, are dying by suicide, which can prevent us from being able to respond to increases in suicide rates quickly.

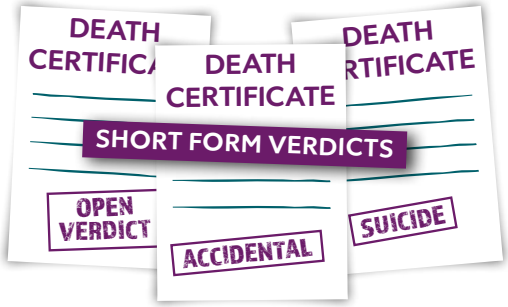
Once registered, information is collated by the national statistical agencies in different nations. You can find out more about the statistical agencies on page 26 of this report.



Coding

Once registered, the statistical agencies code deaths based on ICD coding rules provided by the World Health Organisation (WHO). Short form verdicts (such as suicide, accidental, and open verdicts) are easily coded in this way, however some **narrative verdicts can be more problematic.**

Narrative verdicts – Statistical agencies can code narrative verdicts as suicides if the description clearly shows that the individual intended to take their own life. When this isn't clear they are referred to as **'hard to code' narrative verdicts,** which are coded as accidental deaths.



The use of hard-to-code narrative verdicts has been shown to have a real impact on our understanding of suicide. Increases in the use of narrative verdicts and a decrease in the use of suicide verdicts may make it look like suicide rates are going down when they might not be[14].

In 2011, ONS, NRS and NISRA adopted a change in the classification of deaths in line with the new coding rules of the WHO. The change resulted in some deaths previously coded under 'mental and behavioural disorders' now being classified as 'self-poisoning of undetermined intent' and therefore included in the suicide figures*. Theoretically, this could mean that more deaths could be coded with an underlying cause of 'event of undetermined intent', which is included in the national definition of suicide (see box 1 on page 24). This change does not affect the Republic of Ireland statistics since their definition does not include deaths of undetermined intent (further information on changes to coding rules on page 31).

*Explanation taken from ScotPHO website, updated July 2018; scotpho.org.uk/health-wellbeing-and-disease/suicide/key-points

Calculating suicides

After coding, each statistical agency calculates the total number of suicides. To do this they add together deaths that resulted from a range of different causes that describe what actually happened. The causes of death included as suicides are determined by each country's definition of suicide. However some countries use different definitions.

The UK's definition includes deaths where the underlying cause is 'intentional self-harm' and 'events of undetermined intent'. Including both helps to account for the problem of under-reporting, mentioned on page 21.

This means the Republic of Ireland and the UK are adding up different things to get the total number of suicides, so statistics about suicide in the UK and Republic of Ireland are not necessarily comparable.

Agencies also calculate suicide rates based on population data. This shows how many suicides there are per 100,000 people. This allows us to compare suicides between groups, as numbers can be misleading. For example, two places might have the same number of suicides but if one has a smaller population, their suicide rate will be higher.

Because of differences in processes and definitions, figures don't always mean exactly the same thing in different countries (see previous steps in the journey). So, the 'suicide rate' in one country might mean something different to the rate in another. This means that it can be unhelpful to compare them. Instead we can compare suicide trends between countries, considering increases or decreases over time.

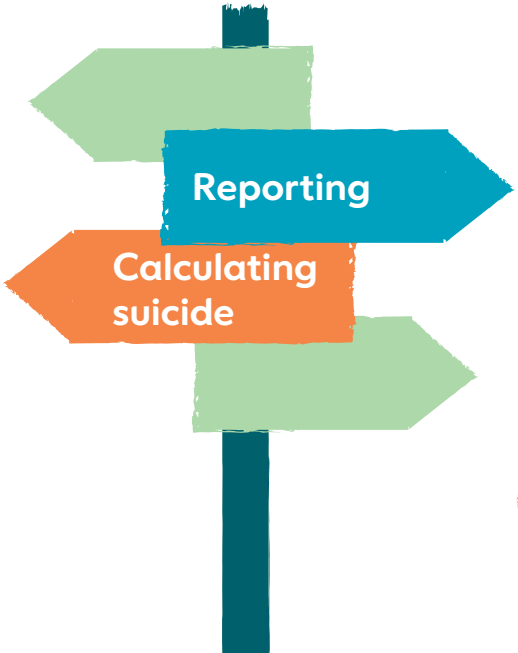
Box 1: UK definition of suicide

ICD-10 code	Description
X60–X84	Intentional self-harm
Y10–Y34[1]	Injury/poisoning of undetermined intent
Y87.0/Y87.2[2]	Sequelae of intentional self-harm/injury/ poisoning of undetermined intent

Table notes:

1. Excluding Y33.9 where the coroner's verdict was pending in England and Wales, up to 2006. From 2007, deaths which were previously coded to Y33.9 are coded to U50.9.
2. Y87.0 and Y87.2 are not included in England and Wales.

The Republic of Ireland's definition is different from the UK. It does not include deaths of undetermined intent, only deaths of intentional self-harm.



Reporting

After calculating the number and rates of suicides, each agency makes them available by publishing them or providing them on request, just like they do for births and other deaths.

All agencies provide annual suicide statistics.

Registration delays

In the UK, routine data reflect the date of death registration. However, because of registration delays some deaths may not have happened in that year. In Scotland, deaths are registered within 8 days, so data will mostly include deaths that happened in that year.

In the Republic of Ireland, data represent when the death occurred, not when it was registered.

Agencies provide data for males, females and by age groups.

The national statistical agencies also report on the data by age groupings differently and this also impacts on the comparability of data.

ONS provide data that includes suicides and self-inflicted deaths with undetermined intent for persons aged 10 and over.

ScotPHO does not present annual numbers or crude rates for ages 0-14 and 85+ in Scotland. NRS does however provide rates for all age groups and rates for all persons, males and females are based on all ages.

NISRA provide data that includes suicides and self-inflicted deaths with undetermined intent for persons aged 10 and over.

CSO does not present annual data by age groups. However, data will be provided on request and includes crude rates for ages 0-14 and 75+.

Other organisations also use the statistics and publish further detail. For example, Public Health England and the Scottish Public Health Observatory provide statistics by local authority area (see page 27 for further information and links to access). This is useful for understanding more about who dies by suicide and where they are.

The journey to suicide statistics is complex and there are also some key challenges that still need to be addressed to improve the accuracy and consistency of data.

However, suicide data is an important public health surveillance tool and gives us a powerful starting point to help us target our work to prevent future suicides.

Data sources used in this report

Data sources – UK

The map shows the sources for the data shown in this report for the UK and Republic of Ireland in 2018 (published or obtained in 2019).

Rates provided by the ONS for the UK, England, and Wales, by ScotPHO for Scotland, and by NISRA for Northern Ireland are age-standardised to the 2013 European Standard Population for overall male, female and person rates. Rates broken down by age group are crude (age specific) rates. Rates provided by CSO for the Republic of Ireland are all crude. Data provided for suicides in 2018 is provisional and subject to future revision.

*ONS also reproduce suicide rates for Scotland and Northern Ireland, however the rates produced by the respective national agencies are used within this report.

National Statistical Agencies

NISRA

Northern Ireland Statistics and Research Agency (NISRA)[18]. Source for Northern Ireland.

NRS

The National Records of Scotland (NRS)[16]. Source for Scotland with data compiled by the Scottish Public Health Observatory (ScotPHO)[17]

CSO

Central Statistics Office for Ireland (CSO)[19]. Source for Republic of Ireland.

ONS

Office for National Statistics (ONS)[15]. Source for combined UK data* and for England, and Wales.

Other nationally available statistics

ONS provides the number of suicides by Local Authority for England and Wales from 2002 to 2018, and age-standardised three-year aggregate suicide rates where the latest period is 2016-2018. These data can be downloaded from their website.

Public Health England (PHE) has created an online Suicide Prevention Profile which brings together a range of publicly available data. In the tool you can filter data by local authority area and regions of England to see which have higher, similar or lower than the national average suicide rates among different groups. It also includes local data for suicide risk factors, such as depression, mental health and unemployment, and service related local data such as emergency hospital admissions for intentional self-harm.

ScotPHO provides the number, crude rates and age-standardised rates of suicide in aggregate five-year periods from 1983–2018 for NHS Boards and Local Authorities in Scotland, which can be downloaded from their website. Data broken down by deprivation, which shows that the most deprived areas of Scotland have the highest suicide rates, are also available on the ScotPHO website.

NISRA provides the number of suicide deaths per year in Northern Ireland, from 1997–2017, by Local Government District, Health and Social Care Trust, Parliamentary Constituency, Assembly Area, and by Urban Rural Classification. They also provide the number of suicide deaths by deprivation, from 2001–2017. No rates per 100,000 are available for this local or deprivation data. These data can be downloaded from their website.

CSO provide the number and crude rates of suicide, for the years 2018, 2017 and 2013 by county, which can be downloaded from their website.

Additional notes on the statistics

The reliability and validity of suicide statistics

Suicide statistics should be and are commonly used to directly influence decisions about public policy and public health strategies (including suicide prevention). It is therefore important that we understand the validity (are we measuring what we think we're measuring) and reliability (do we measure in the same way, over time) of them to ensure we are basing decisions on good information.

Valid and reliable data about suicide is essential for understanding the scale of suicide, to identify those most at risk and to evaluate the effectiveness of interventions to prevent suicide.

Validity of suicide data

Validity refers to 'how good' the data is, and whether it is a measure of what we intend it to be. We need to understand whether suicide data actually tells us about suicide, and not another behaviour. The validity of suicide data is important since we need to be sure that data is an accurate representation of who is at risk so that we can target our work and prevent suicide. If suicide data does not give us a good understanding of who takes their own lives, interventions may not be targeted most effectively.

> Measuring the success, or lack thereof, of efforts to reduce suicides, suicide attempts or the impact of suicide on society at large requires access to reliable and valid data.
>
> **World Health Organisation, 2014; Preventing suicide: A global imperative[3]**

Reliability of suicide data

Reliability refers to whether data demonstrates consistency in measurement. We need to understand whether, if we counted the number of suicides in a group twice, we would come to the same number. Having reliable data about suicide is clearly important for being able to monitor and prevent suicides. In order to understand when, and for who, suicide rates are increasing we must have a reliable measure of suicide.

Challenges with the validity and reliability of suicide data

In order to use suicide data effectively, and draw the right conclusions from it, we need to understand and recognise the limitations in relation to the validity and reliably. This report details some of the complexities in the process for recoding and reporting suicides across the UK and Republic of Ireland. These different processes and definitions inevitably affect the validity and reliability of suicide data within and between countries; more detail about how this can impact on our understanding of suicide is provided over page.

Misclassification and the under-reporting of suicide

As mentioned earlier suicides are sometimes misclassified, which can lead to under-reporting since deaths are being recorded as something other than a suicide (see page 21). There are several factors that can lead to the misclassification of deaths, such as:

- Suicides appear to be accidental – in certain circumstances, a suicide might seem to be an accident, rather than intentional – and so it might be recorded as an accidental death.
- Social and cultural factors – while suicide is no longer a criminal offence, ongoing stigma means suicide verdicts are sometimes less likely to be given – particularly if there are cultural or religious taboos around suicide, and for the death of a child.
- Hard-to-code narrative verdicts – 'hard to code' verdicts are coded by statistical agencies as accidental deaths. This has been shown to have a real impact on our understanding of suicide (see page 21 for further information).

Each of these factors means that suicide data may not be capturing all suicides. And this may add to some systematic inaccuracies in suicide data; for example, it is suggested that female suicides are more likely to be coded as accidental or undetermined intent due to the methods chosen (see page 21), but there may also be other group characteristics which are more subtle and missed for other reasons.

Variation within countries

As discussed in the journey to suicide statistics, each country has their own process for recording, registering and reporting on suicides. Although there are standard processes within a country, for the reasons mentioned above, data still may not be completely accurate, and suicide might for example be under-reported. In addition to this, the process for reaching a verdict about the cause of death is subjective, so suicide may not be consistently under-reported because one coroner might take a different approach to another.

Variation between countries

As well as the death registration processes being subject to interpretation and inconsistencies within a country, there are also inconsistencies between countries. There are some differences in the way countries register deaths and therefore how deaths are classified as suicides. This potentially undermines confidence in the value of comparing suicide statistics across countries. Lower or higher rates may be an artefact of lower or higher quality (or just different) registration procedures between countries, rather than a reflection of true differences in suicide risk. For example, in the UK, deaths of undetermined intent are included in the definition of suicide, however in the Republic of Ireland these deaths are not included in the definition and are not represented in the data (see page 24).

For these reasons, some suggest that cross-country comparison should not be made or assumed to provide any reliable information about which populations may be at more risk of suicide[20]. Others suggest that the differences in coding and registration of suicides pose problems that make comparisons difficult, but not impossible, and that the rates should be compared with caution[21]. In this view, the differences are not enough to stop comparisons between countries and to do so would prove unhelpful in understanding the epidemiology of suicide.

Defining suicide

Silverman[22] suggested over a decade ago, that there were more than 27 definitions of suicide used in the research literature. Today, the problem of defining and classifying suicide and suicidal behaviours in research is still a problem which hinders our understanding of the subject[23]. This adds another dimension to the problem of reliability, as suicide is defined differently by different researchers and research disciplines, and in different contexts and professions. The recent high court ruling to lower the standard of proof required for a suicide verdict from criminal to civil (see page 32) means that the legal definition of suicide in England and Wales is more closely aligned with the definition of other professions and disciplines. This ruling is positive and is likely to improve the validity of suicide data as more deaths may be classified as suicides in future. However, the ruling will impact on the reliability of data and analyses will need to be taken to establish the effect on long term trends to inform how statistics are compared before and after the ruling.

There is a lack of research into the reliability of suicide statistics and there is a tendency in international data to under-report suicide[24]. Researchers have different views about the reliability of suicide statistics and how, or even if, they can be used effectively. Some reject the use of official suicide statistics on the grounds of poor reliability; others argue that the statistics are still reliable enough to be used to establish trends over time.

What does this mean?

It can be argued that suicide statistics have poor validity (they might not measure exactly what we think they measure) but reasonable reliability (they measure the same thing over time). This would mean that, even if we accept the limitations to the statistics, the data is still likely to have some temporal stability and any limiting factor (such as those associated with misclassification) would be reasonably constant over time. Changes in rates and fluctuations may be valid if under-reporting remains stable over time[20]. The addition of deaths of 'undetermined intent' is a solution to the known under-reporting of suicide. In this way, suicide statistics will still give us valuable information about suicide over time and about different groups who may be at risk.

It is worth noting that, due to the subjective nature of registration and reporting and the complexity of suicidal behaviour and actions, it is inevitable that suicide statistics will never be completely accurate. It can be argued that this will always be the case[20] – the subjective nature of recording deaths and the differences between countries' registration processes will forever pose a problem for any official statistics and their wider use. However, we still must address these issues and continue to do everything possible to limit these confounding factors, so that suicide statistics are as reliable as possible. Also, fluctuations and trends should not be ignored because of the issues of under-reporting, misclassification and limited reliability. All mortality figures will be subject to some degree of error, but they do still provide valuable insights and predictive information[25].

It has been suggested that over the last 50 years, the field of suicide research has failed to generate new and novel risk factors that can lead to major advancements in the understanding and therefore prevention of suicide[26]. Perhaps improving the official data in this area is a place to start in moving the field forwards and ensuring we are measuring this phenomenon accurately in a valid and reliable way to understand it enough to advance.

Further notes on narrative verdicts

When there is not enough evidence to say whether a death was either accidental or a suicide an 'open verdict' or 'narrative verdict' can be given. Statistical agencies can code narrative verdicts as suicides if the description clearly shows that the individual intended to take their own life. When this isn't clear they are referred to as 'hard to code' narrative verdicts, which are coded as accidental deaths. The use of hard-to-code narrative verdicts has been shown to have a real impact on our understanding of suicide. As the use of these narrative verdicts increases, the use of suicide verdicts decreases, which can make it look like suicide rates are going down when they might not be.

ONS have carried out analyses on the use of narrative verdicts, which suggest that for the 2015 data, the use of narrative verdicts does not seem to have a significant impact on suicide rates. However, they note that the increased use of such verdicts in Wales in particular, in previous years accounted for a sharp decline (and now a subsequent sharp increase) in the suicide rate (adding further support to the note of caution around over interpreting year-on-year fluctuations)[14].

Further notes on changes to coding rules

As noted earlier in this report (see page 23) ONS, NRS and NISRA adopted a change in the classification of deaths in 2011, to align with new coding rules introduced by the World Health Organisation (WHO). The table below outlines what statistical agencies provide since they adopted this change, and the impact of the change on the comparability of statistics*.

Statistical agency	Data provided after coding change	Effect of coding change on comparability of statistical data
ONS	Only produce data using new coding rules.	Caution should be used when comparing data with old and new coding as they are not directly comparable. Preliminary analyses of the data suggest no significant change as a result of the coding changes; however, this finding should still be treated with caution.
NRS	Produce two sets of suicide data each year to reflect what figures would show using both the old and new coding rules.	When examining trends over time (older than 2011), data using the old coding rules should be used; 2011 onwards data, based on the new rules, is not directly comparable to old data.
NISRA	Only produce data using new coding rules.	Preliminary checks have indicated only minimal differences to the coding change, and NISRA therefore does not expect that there will be a significant impact on the figures reported.

*The Central Statistics Office (Republic of Ireland) did not adopt the coding change introduced by the WHO and is not included in the table.

The availability of suicide statistics

Routine data on the epidemiology of suicide published by official national statistical bodies are limited to age and gender, and age bands differ between countries. Data on socio-economic status are collected by some statistical agencies but not routinely published, while other socio-demographic information (such as ethnicity) is typically not included in the recording of a suicide. ONS provide details about suicide methods/ cause of death, but these details are not included in this document.

Further notes on changes to coroners practice in England and Wales.

When someone dies suddenly, the circumstances are investigated to establish the cause of death. In England and Wales this is done by a coroner, through an inquest. In July 2018 the standard of proof used by coroners to determine whether a death was caused by suicide was lowered in England and Wales. Before this, for a death to be recorded as a suicide, the burden of proof was on a par with that of a crime. Coroners and jurors needed to be satisfied that a person took their own life 'beyond reasonable doubt'. The lowering of the standard of proof, from criminal to civil, means that coroners and jurors may return a verdict of suicide on 'the balance of probabilities'. This is likely to mean that more deaths will be classified as suicides in future. This is something that Samaritans and others have been calling for, for several years because we believe it will help get a more accurate picture of the number of people who take their own lives and help to reduce the stigma around suicide. The ONS will monitor the impact that this change has on suicide data.

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Appendix:

Data tables UK and Republic of Ireland

Appendices

UK suicide* rates for all persons, males and females and by age group, 2016-2018

Table 1

UK	2016			2017			2018		
Rate per 100,000 for persons aged 10+	Overall 10.4	Male 16	Female 5.0	Overall 10.1	Male 15.5	Female 4.9	Overall 11.2	Male 17.2	Female 5.4
Rate per 100,000 by age group (years)	Overall	Male	Female	Overall	Male	Female	Overall	Male	Female
10-14	0.1†	0.2†	-	0.4†	0.4†	0.4†	0.4†	0.5†	0.3†
15-19	5.3	7.5	2.9	5.6	7.6	3.5	6.7	9.0	4.4
20-24	10.4	14.8	5.7	8.7	12.9	4.3	11.2	16.9	5.1
25-29	10.9	17.5	4.2	10.6	17.0	4.2	12.0	18.3	5.5
30-34	12.0	19.1	5.0	11.6	17.7	5.7	13.3	21.0	5.6
35-39	11.8	19.0	4.7	12.2	19.0	5.6	13.1	19.9	6.3
40-44	15.3	24.1	6.7	14.4	22.7	6.3	15.2	23.6	6.9
45-49	14.9	23.1	6.9	15.6	24.8	6.6	18.1	27.1	9.2
50-54	15.1	22.0	8.3	14.1	21.6	6.8	15.2	23.5	7.2
55-59	13.2	19.9	6.6	11.9	18.8	5.3	12.1	18.4	5.9
60-64	9.9	14.4	5.5	9.6	14.2	5.2	10.9	16.2	5.9
65-69	8.0	12.0	4.2	8.0	11.6	4.6	8.6	12.5	5.0
70-74	6.8	10.1	3.9	6.8	9.8	4.0	7.0	10.8	3.5
75-79	6.3	10.4	2.7	7.9	11.4	4.9	8.0	13.0	3.7
80-84	8.2	14.7	3.2	6.1	9.1	3.8	9.1	17.2	2.8
85-89	8.2	15.0	3.9	9.2	17.1	4.2	10.5	19.4	4.8
90+	10.7	22.1	5.8	9.0	17.4	5.2	9.9	20.7	5.0

*Suicide as defined by the Office for National Statistics – for coding and definition see box 1, page 22

† Potentially unreliable rates due to low number of deaths in this age group.

Appendices

UK suicide numbers for all persons, males and females and by age group, 2016-2018

Table 2

UK	2016			2017			2018		
Number of deaths for persons aged 10+	Overall 5,965	Male 4,508	Female 1,457	Overall 5,821	Male 4,382	Female 1,439	Overall 6,507	Male 4,903	Female 1,604
Number of deaths by age group (years)	Overall	Male	Female	Overall	Male	Female	Overall	Male	Female
10-14	5	3	2	16	8	8	16	10	6
15-19	199	145	54	207	144	63	247	169	78
20-24	441	323	118	367	279	88	467	363	104
25-29	491	397	94	483	389	94	544	420	124
30-34	530	419	111	515	389	126	592	466	126
35-39	494	395	99	523	403	120	572	432	140
40-44	640	498	142	586	458	128	607	468	139
45-49	688	526	162	713	559	154	814	603	211
50-54	699	503	196	658	496	162	711	541	170
55-59	535	400	135	500	388	112	519	390	129
60-64	350	250	100	347	251	96	401	291	110
65-69	290	212	78	278	195	83	293	206	87
70-74	195	137	58	211	146	65	228	168	60
75-79	135	103	32	172	114	58	178	134	44
80-84	131	102	29	100	65	35	152	126	26
85-89	81	57	24	93	67	26	108	78	30
90+	61	38	23	52	31	21	58	38	20

Appendices

England suicide rates for all persons, males and females and by age group, 2016-2018

Table 3

England	2016			2017			2018		
Rate per 100,000 for persons aged 10+	Overall 9.5	Male 14.7	Female 4.5	Overall 9.2	Male 14.0	Female 4.6	Overall 10.3	Male 15.9	Female 4.9
Rate per 100,000 by age group (years)	Overall	Male	Female	Overall	Male	Female	Overall	Male	Female
10-14	-	-	-	0.3†	0.3†	0.3†	0.3†	0.4†	0.3†
15-19	4.5	6.3	2.6	5.0	6.5	3.4	5.7	7.6	3.8
20-24	9.0	13.5	4.4	7.4	11.0	3.6	10.2	15.3	4.7
25-29	9.4	14.9	3.7	9.1	14.1	4.0	10.2	15.2	5.2
30-34	10.6	16.6	4.6	10.3	15.6	5.0	11.7	18.6	4.8
35-39	10.6	17.1	4.2	10.8	16.8	4.8	11.3	17.3	5.4
40-44	14.0	21.9	6.2	12.8	19.8	5.8	13.4	20.9	6.0
45-49	13.9	21.7	6.3	14.3	22.4	6.3	17.1	26.1	8.2
50-54	14.0	20.2	8.0	12.8	19.7	6.2	14.2	22.0	6.6
55-59	12.3	19.0	5.8	11.2	17.2	5.2	11.1	17.0	5.5
60-64	8.9	13.0	5.0	8.7	13.3	4.4	10.3	15.2	5.5
65-69	7.3	11.0	3.8	7.9	11.7	4.4	8.1	11.6	4.7
70-74	6.2	9.2	3.5	6.7	9.7	4.0	6.8	10.8	3.2
75-79	6.3	10.4	2.8	7.6	10.5	5.0	8.2	13.8	3.4
80-84	8.2	14.5	3.3	6.6	9.9	4.0	9.8	18.6	2.8
85-90	8.8	16.7	3.9	9.7	18.2	4.2	11.0	20.5	4.8
90+	11.3	21.7	6.8	8.7	15.0	5.8	10.4	21.5	5.3†

† Potentially unreliable rates due to low number of deaths in this age group.

Appendices

England suicide numbers for all persons, males and females and by age group, 2016-2018

Table 4

England	2016			2017			2018		
Number of deaths for persons aged 10+	Overall 4,575	Male 3,464	Female 1,111	Overall 4,451	Male 3,328	Female 1,123	Overall 5,021	Male 3,800	Female 1,221
Number of deaths by age group (years)	Overall	Male	Female	Overall	Male	Female	Overall	Male	Female
10-14	2	1	1	10	5	5	10	6	4
15-19	143	102	41	155	104	51	178	121	57
20-24	322	246	76	261	199	62	358	277	81
25-29	357	287	70	349	273	76	391	294	97
30-34	398	311	87	387	293	94	443	351	92
35-39	378	303	75	392	304	88	420	319	101
40-44	495	384	111	440	339	101	456	353	103
45-49	539	416	123	549	426	123	648	491	157
50-54	542	386	156	502	380	122	555	424	131
55-59	416	317	99	388	296	92	398	299	99
60-64	261	187	74	261	194	67	313	227	86
65-69	222	162	60	229	163	66	228	159	69
70-74	148	105	43	175	121	54	186	141	45
75-79	113	86	27	137	88	49	153	119	34
80-84	110	85	25	90	59	31	137	115	22
85-89	74	54	20	83	61	22	95	70	25
90+	55	32	23	43	23	20	52	34	18

Appendices

Wales suicide rates for all persons, males and females and by age group, 2016-2018

Table 5

Wales	2016			2017			2018		
Rate per 100,000 for persons aged 15+	Overall 11.8	Male 20.0	Female 4.0	Overall 13.2	Male 20.9	Female 5.8	Overall 12.8	Male 19.1	Female 6.9
Rate per 100,000 by age group (years)	Overall	Male	Female	Overall	Male	Female	Overall	Male	Female
10-14	-	-	-	-	-	-	-	-	-
15-19	8.8†	13.8†	3.4†	11.2	16.3†	5.8†	6.9†	12.2†	-
20-24	14.2	15.5†	12.8†	11.5	15.6†	7.1†	12.2	18.5	5.1†
25-29	12.9	24.3	-	18.6	32.7	4.0†	15.5	24.8	5.9†
30-34	16.4	28.5	4.4†	16.7	24.9	8.6†	12.7	21.2	4.2†
35-39	15.4	27.6	3.4†	12.8	19.2†	6.6†	19.6	27.5	11.9†
40-44	16.0	29.3	3.3†	20.7	37.4	4.5†	20.1	33.6	7.0†
45-49	11.7	23.1	-	21.9	36.0	8.4†	17.5	20.9	14.2†
50-54	14.0	19.4	8.8†	15.8	24.0	7.9†	18.5	30.6	7.0†
55-59	17.8	25.2	10.6†	14.0	26.6	1.9†	13.2	18.4†	8.3†
60-64	10.8	18.9†	3.2†	15.5	18.7†	12.5†	13.7	21.6	6.2†
65-69	11.6	19.7†	4.0†	8.5	10.8†	6.2†	6.5†	5.6†	7.4†
70-74	8.4†	16.1†	-	5.4	7.4†	3.5†	8.6†	7.1†	9.9†
75-79	2.6†	5.6†	-	11.0	18.1†	4.7†	6.6†	-	9.2†
80-84	9.4†	21.5†	-	-	2.6†	-	9.1†	20.7†	-
85-89	-	-	-	13.5†	19.7†	9.5†	11.4†	14.4†	9.4†
90+	10.1†	34.3†	-	10.1†	22.3†	-	16.8†	43.4†	-

† Potentially unreliable rates due to low number of deaths in this age group.

Appendices

Wales suicide numbers for all persons, males and females and by age group, 2016-2018

Table 6

Wales	2016			2017			2018		
Number of deaths for persons aged 10+	Overall 322	Male 265	Female 57	Overall 360	Male 278	Female 82	Overall 349	Male 252	Female 97
Number of deaths by age group (years)	Overall	Male	Female	Overall	Male	Female	Overall	Male	Female
10-14	0	0	0	0	0	0	1	1	-
15-19	16	13	3	20	15	5	12	11	1
20-24	30	17	13	24	17	7	25	20	5
25-29	26	25	1	38	34	4	32	26	6
30-34	30	26	4	31	23	8	24	20	4
35-39	27	24	3	23	17	6	36	25	11
40-44	29	26	3	36	32	4	34	28	6
45-49	25	24	1	46	37	9	36	21	15
50-54	31	21	10	35	26	9	41	33	8
55-59	36	25	11	29	27	2	28	19	9
60-64	20	17	3	29	17	12	26	20	6
65-69	23	19	4	16	10	6	12	5	7
70-74	13	12	1	9	6	3	15	6	9
75-79	3	3	0	13	10	3	8	2	6
80-84	8	8	0	1	1	0	8	8	0
85-89	2	2	0	7	4	3	6	3	3
90+	3	3	0	3	2	1	5	4	1

Appendices

Scotland suicide rates for all persons, males and females and by age group, 2016-2018

Table 7

Scotland	2016			2017			2018		
Rate per 100,000 for all persons	**All 13.6**	**Male 19.7**	**Female 7.6**	**All 12.8**	**Male 19.9**	**Female 5.7**	**All 14.6**	**Male 21.9**	**Female 7.3**
Rate per 100,000 by age group (years)	**All**	**Male**	**Female**	**All**	**Male**	**Female**	**All**	**Male**	**Female**
0-14	-	-	-	-	-	-	-	-	-
15-24	10.9	14.4	7.3	9.9	16.2	3.4	15.1	22.3	7.7
25-34	17.9	27.9	8.2	15.6	27.1	4.3	19.1	29.3	9.1
35-44	22.2	33.7	11.2	20.6	31.3	10.3	23.7	36.5	11.5
45-54	22.3	33.3	11.9	21.7	35.0	9.3	23.1	34.5	12.4
55-64	15.6	21.4	10.1	14.4	21.5	7.7	16.2	23.9	8.9
65-74	10.4	13.9	7.2	8.3	11.9	5.1	10.3	17.2	4.0
75-84	7.1	11.5	3.8	8.6	12.8	5.4	6.0	9.8	3.2
85+	-	-	-	-	-	-	-	-	-

Source: *ScotPHO*. New coding rules for all years, see page 30.

Appendices

Scotland suicide numbers for all persons, males and females and by age group, 2016-2018

Table 8

Scotland	2016			2017			2018		
Number of deaths for persons aged 10+	All 728	Male 517	Female 211	All 680	Male 522	Female 158	All 784	Male 581	Female 203
Number of deaths by age group (years)	All	Male	Female	All	Male	Female	All	Male	Female
0-14	-	-	-	-	-	-	-	-	-
15-24	72	48	24	64	53	11	96	72	24
25-34	130	100	30	115	99	16	142	108	34
35-44	148	110	38	137	102	35	158	119	39
45-54	178	129	49	172	134	38	180	130	50
55-64	108	72	36	102	74	28	117	84	33
65-74	58	37	21	47	32	15	59	47	12
75-84	23	16	7	28	18	10	20	14	6
85+	-	-	-	-	-	-	-	-	-

Source: *ScotPHO*. New coding rules for all years, see page 30.

Appendices

Northern Ireland suicide rates for all persons, males and females and by age group, 2015–2017*

Table 9

Northern Ireland	2015			2016			2017		
Rate per 100,000 for all persons	Overall 19.3	Male 30.3	Female 8.8	Overall 18.1	Male 27.3	Female 9.2	Overall 18.5	Male 29.1	Female 8.5
Rate per 100,000 by age group (years)	Overall	Male	Female	Overall	Male	Female	Overall	Male	Female
10-14*	-	-	-	0.3	0.5	-	1.7*	3.4*	-
15-19	14.1	19.3	8.6	11.0	18.0	3.5	8.6	11.7	5.4
20-24	27.4	42.3	11.9	31.2	41.0	20.8	28.3	38.2	17.7
25-29	35.4	61.6	9.6	25.8	37.2	14.5	30.7	48.7	12.9
30-34	30.7	47.9	14.3	31.5	57.6	6.3	31.3	40.7	22.1
35-39	22.2	33.5	11.6	18.4	31.1	6.5	32.9	56.1	11.2
40-44	23.5	39.9	7.9	22.5	35.8	9.8	29.7	50.6	9.9
45-49	28.9	42.0	16.4	21.4	31.4	12.0	24.7	39.6	10.6
50-54	23.2	34.5	12.2	27.5	38.8	16.6	24.3	37.0	11.9
55-59	23.1	41.4	5.3	19.9	28.1	11.9	13.5	25.7	1.7
60-64	11.6	14.8	8.4	14.4	18.6	10.3	13.0	20.2	6.0
65-69	18.0	21.0	15.3	11.2	16.1	6.5	6.7	6.9	6.6
70-74	6.8	11.5	2.6	9.1	11.0	7.4	6.3	10.7	2.4
75-79	5.5	12.2	-	12.6	19.9	6.6	3.5	7.7	-
80-84	2.6	6.2	-	2.5	6.1	-	-	-	-
85+	2.8	8.6	-	-	-	-	5.4	15.9	-

***NISRA only include deaths for persons aged 10 and over in their suicide data. In 2017 the rate calculation changed and is now based on the population of 10-14 year olds. It was previously calculated using the population of under 15's. Rates for this age group may not necessarily be comparable with previous years.**

***2018 data for Northern Ireland not available at time of publication. This report will be updated when data becomes available later in 2019.**

Source: *NISRA*

Appendices

Northern Ireland suicide numbers for all persons, males and females and by age group, 2015–2017

Table 10

Northern Ireland	2015			2016			2017		
Number of deaths for all persons	**Overall 318**	**Male 245**	**Female 73**	**Overall 297**	**Male 221**	**Female 76**	**Overall 305**	**Male 234**	**Female 71**
Number of deaths by age group (years)	**Overall**	**Male**	**Female**	**Overall**	**Male**	**Female**	**Overall**	**Male**	**Female**
10-14	-	-	-	1	1	-	2	2	-
15-19	17	12	5	13	11	2	10	7	3
20-24	33	26	7	37	25	12	33	23	10
25-29	44	38	6	32	23	9	38	30	8
30-34	38	29	9	39	35	4	39	25	14
35-39	26	19	7	22	18	4	40	33	7
40-44	29	24	5	27	21	6	35	29	6
45-49	38	27	11	28	20	8	32	25	7
50-54	30	22	8	36	25	11	32	24	8
55-59	26	23	3	23	16	7	16	15	1
60-64	11	7	4	14	9	5	13	10	3
65-69	16	9	7	10	7	3	6	3	3
70-74	5	4	1	7	4	3	5	4	1
75-79	3	3	-	7	5	2	2	2	-
80-84	1	1	-	1	1	-	-	-	-
85+	1	1	-	-	-	-	2	2	-
90+	-	-	-	-	-	-	-	-	-

Source: *NISRA*

Appendices

Republic of Ireland suicide rates for all persons, males and females and by age group, 2016-2018

Table 11

Republic of Ireland	2016			2017			2018*		
Rate per 100,000 for persons aged 15+	Overall 9.2	Male 14.9	Female 3.6	Overall 8.2	Male 13.2	Female 3.3	Overall 7.2	Male 11.7	Female 2.9
Rate per 100,00 by age group (years)	Overall	Male	Female	Overall	Male	Female	Overall	Male	Female
0-14	0.5	0.6	0.4	0.4	0.4	0.4	0.2	0.2	0.2
15-24	11.3	15.7	6.7	10.3	14.1	6.3	7.4	9.7	5.1
25-34	11.6	20.5	3.2	11.4	19.3	3.9	11.2	18.9	3.7
35-44	13.6	22.0	5.3	11.1	19.0	3.4	9.1	15.1	3.3
45-54	14.1	22.6	5.7	12.6	19.3	5.9	11.4	18.3	4.6
55-64	13.3	23.5	3.2	10.5	17.9	3.1	11.6	19.5	3.8
65-74	6.3	10.5	2.1	6.6	10.1	3.1	5.3	9.8	1.0
75+	4.6	6.3	3.3	4.5	9.5	0.7	3.2	5.8	1.3

***Provisional data that will be finalised in subsequent years; provisional data reflects the suicides registered in that year, final data will reflect the suicides that occur in that year.**

Appendices

Republic of Ireland suicide numbers for all persons, males and females and by age group, 2016-2018

Table 12

Republic of Ireland	2016				2017*^				2018*^		
Number of deaths for all persons	Overall 437	Male 350	Female 87	Number of deaths for all persons	Overall 392	Male 312	Female 80	Number of deaths for all persons	Overall 352	Male 282	Female 70
Number of deaths by age group (years)	Overall	Male	Female	Number of deaths by age group (years)	Overall	Male	Female	Number of deaths by age group (years)	Overall	Male	Female
0-14	5	3	2	0-24	64	44	20	0-14	2	1	1
15-24	65	46	19	25-34	73	60	13	15-24	45	30	15
25-34	76	65	11	35-44	84	71	13	25-34	70	58	12
35-44	101	81	20	45-54	80	61	19	35-44	70	57	13
45-54	88	70	18	55-64	54	46	8	45-54	74	59	15
55-64	67	59	8	65+	37	30	7	55-64	61	51	10
65-74	23	19	4					65-74	21	19	2
75+	12	7	5					75+	9	7	2

***Provisional data reflects the suicides registered in that year, final data will reflect the suicides that occur in that year.**
^Data have been provided in different age ranges for confidentiality reasons.

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