

**SAMARITANS**

# Suicide statistics report

Latest statistics for the UK and Republic of Ireland

December 2018



# Contents

<b>Samaritans – working together to reduce suicide</b>	<b>5</b>	<b>Journey to suicide statistics</b>	<b>18</b>
<b>Samaritans’ response to recent trends in suicide</b>	<b>6</b>	Cause of Death	19
What are the recent trends?	6	Registration	20
What do the trends tell us?	7	Coding	21
What will Samaritans do?	7	Calculating suicide numbers and rates	22
What do we want to see?	8	Reporting	23
<b>Understanding suicide statistics</b>	<b>10</b>	<b>Data sources used in this report</b>	<b>24</b>
<b>Suicide rates in the UK &amp; Republic of Ireland</b>	<b>11</b>	<b>Other nationally available statistics</b>	<b>25</b>
Suicides in the UK	12	<b>Additional notes on the statistics</b>	<b>26</b>
Suicides in England	13	The reliability and validity of suicide statistics	26
Suicides in Wales	14	Further notes on narrative verdicts	30
Suicides in Scotland	15	Further notes on changes to coding rules	30
Suicides in Northern Ireland in 2016*	16	The availability of suicide statistics	31
Suicides in the Republic of Ireland	17	<b>References</b>	<b>32</b>

### Appendix: Data tables UK and Republic of Ireland

<b>Table 1:</b> UK suicide rates for all persons, males and females and by age group, 2015–2017	33	<b>Table 9:</b> Northern Ireland suicide rates for all persons, males and females and by age group, 2014–2016	42
<b>Table 2:</b> UK suicide numbers for all persons, males and females and by age group, 2015–2017	34	<b>Table 10:</b> Northern Ireland suicide numbers for all persons, males and females and by age group, 2014–2016	43
<b>Table 3:</b> England suicide rates for all persons, males and females and by age group, 2015–2017	35	<b>Table 11:</b> Republic of Ireland suicide rates for all persons, males and females and by age group, 2015–2017	44
<b>Table 4:</b> England suicide numbers for all persons, males and females and by age group, 2015–2017	36	<b>Table 12:</b> Republic of Ireland suicide numbers for all persons, males and females and by age group, 2015–2017	45
<b>Table 5:</b> Wales suicide rates for all persons, males and females and by age group, 2015–2017	37		
<b>Table 6:</b> Wales suicide numbers for all persons, males and females and by age group, 2015–2017	38		
<b>Table 7:</b> Scotland suicide rates for all persons, males and females and by age group, 2015–2017	39		
<b>Table 8:</b> Scotland suicide numbers for all persons, males and females and by age group, 2015–2017	40		
	41		

# There were 6,213 suicides in the UK and Republic of Ireland in 2017

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

**Author:** Charlotte Simms and Elizabeth Scowcroft



# 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, a family and a community devastated by their loss.

Samaritans' strategy, *Working together to reduce suicide 2015-21*, outlines our commitment to achieve our vision. 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 the statistics from national statistical agencies to provide you with an overview of the latest suicide rates and trends for the UK and Republic of Ireland. It also presents some of the key challenges with suicide statistics, which are important to understand, so that we can use them effectively to help us understand who is at risk.

To understand the challenges we have with suicide statistics, we must know how they are generated. 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.

There are currently some challenges related to the consistency and availability of suicide statistics across the UK and Republic of Ireland. In this report we provide an overview of these challenges and how we think they can be addressed.

**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.**

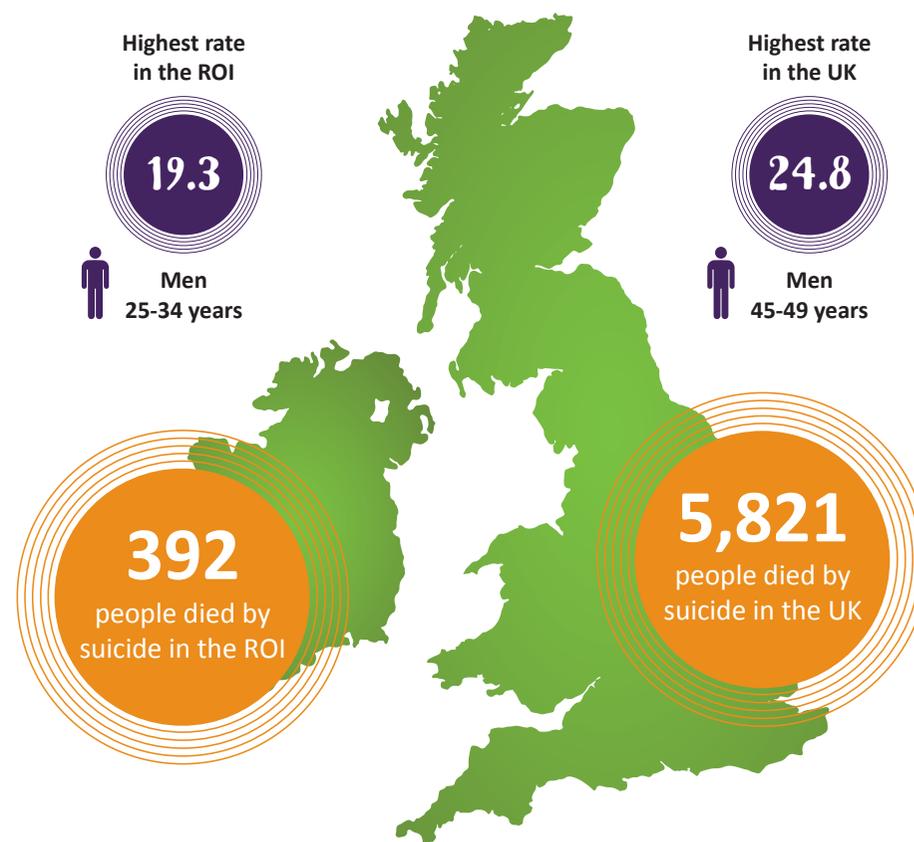
Samaritans: Working together to reduce suicide <sup>1</sup>

# Samaritans' response to recent trends in suicide

## What are the recent trends?

### Statistics for 2017 show:

- There were **6,213 suicides** in the UK and Republic of Ireland.
- 5,821** suicides were **registered** in the **UK** and **392** occurred in the **Republic of Ireland**.
- In the UK men remain **three times as likely** to take their own lives than women, and in the Republic of Ireland **four times as likely**.
- The **highest suicide rate** in the **UK** was for **men aged 45-49**.
- The **highest suicide rate** in the **Republic of Ireland** was for **men aged 25-34** (with an almost identical rate for men aged 45-54).
- There has been a **significant decrease in male suicide** in the UK, and the male suicide rate is the **lowest in over 30 years**.
- The suicide rate in Scotland decreased between 2016 and 2017 – this appears to be **driven by a decrease in the female suicide rate**.
- Suicide in **young men** in Scotland **increased** for the third consecutive year in 2017.
- The suicide rate in **Northern Ireland** has remained relatively stable between 2016 and 2017. There was an **increase in the male suicide rate** and decrease in the female rate.
- Suicide rates for men and women, are higher in Northern Ireland than other UK nations** – however rates are not necessarily directly comparable.
- Suicide has continued to **fall in both males and females** in the **Republic of Ireland**.
- Rates in the **Republic of Ireland** have **fluctuated** more than in the UK in recent years, but it is currently at its **lowest since 1989**.



## What do the trends tell us?

It is encouraging to see a significant decrease in male suicide, and we believe the focus of suicide prevention in recent years to tackle the higher rates in men has contributed to this. However, 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. We must continue to target expertise and resources at preventing men from taking their own lives.

The female rate of suicide has remained stable over the last decade, but we believe that more needs to be done to understand why women take their own lives and what works in terms of prevention.

Suicide rates are increasing among young people in the UK and Republic of Ireland. We need to continue to monitor this trend and understand more about why young people take their own lives and what might be driving this increase.

Suicide is complex, and it is a problem of inequality. Research shows that it affects the most vulnerable and disadvantaged people in society, both male and female, disproportionately (as described in our [Men, Suicide and Society](#) research). To reduce suicide, we need to address inequalities<sup>2</sup>.

## What will Samaritans do?

Samaritans is committed to developing our work based on research and evidence so that we can better support those who need us and reach our ultimate aim, that fewer people die by suicide.

In the last year, we have been working with people who have been suicidal to explore new ways of supporting people who may not be able to, or may not wish to, discuss their suicidal thoughts with a Samaritans volunteer. We will be continuing this work as part of our commitment to ensuring our services are accessible to all who need them.

We will also continue to work with leading academics focusing on high risk populations such as prisoners and use our policy influencing work to make sure that local and national governments are prioritising evidence-based work to prevent suicide amongst vulnerable groups, in particular amongst people from disadvantaged communities and men.

## What do we want to see?

### **Improvements to the accuracy and availability of suicide data.**

We welcome the [recent High Court ruling](#) in England and Wales, which has lowered the standard of proof required for a suicide verdict (although at the time of writing this report, we understand it may be subject to appeal). Until now, 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.

However, many challenges remain with suicide data. For example, delays in registering and reporting suicide mean that emerging trends are seen later, and therefore we may miss opportunities for early intervention.

We need more accurate and timely statistics across the UK and ROI, therefore we are calling for action to improve the consistency and availability of data:



### **Review of the death registration process in England, Wales, Northern Ireland and the Republic of Ireland**

In these countries, deaths are registered after an inquest, which means there can sometimes be delays of a year or more before a death is recorded. This clearly has implications for the timeliness of reporting suicide deaths. We would like to see a process more in line with that of Scotland – where the maximum time between a death and registration is 8 days (see page 20 for further information).



### **Revision of the statistical definition of suicide in the Republic of Ireland**

In the UK, and many other countries, the statistical definition of suicide includes deaths where the underlying cause is intentional self-harm and events of undetermined intent. Including deaths of undetermined intent 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.

This means that these statistics are not comparable with those of the UK, and that suicide is potentially under-reported in the Republic of Ireland. We are urging a revision of the statistical definition of suicide in the Republic of Ireland to align with the UK and other countries (see page 22 for further information).



### More timely reporting of suicide in Northern Ireland

We welcome recent efforts to produce suicide statistics in a more timely manner from the Office for National Statistics (ONS), National Records for Scotland (NRS) and the Central Statistics Office for Ireland (CSO). We would like to see improvements to the availability of statistics from the Northern Ireland Statistics and Research Agency (NISRA) to align with the publication of statistics from other agencies.

**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<sup>3</sup>

### Focus on local suicide prevention

We want to see a greater focus at local and regional levels on the co-ordination and prioritisation of suicide prevention activity, particularly targeting areas with high levels of socio-economic deprivation.

With differing pictures across the nations of the UK and the Republic of Ireland around local plans, we are calling for every local area to ensure they have a high quality suicide prevention plan in place with concrete actions leading to a reduction in suicide.

Activity needs to be resourced properly with good monitoring and evaluation, ensuring impact and adding to the evidence base of what works. Supporting local areas with a strong quality improvement process, encouraging learning from each other and avoiding “reinventing the wheel” will be critical to make best use of the limited resource available.

We need all of us working together to achieve a reduction in stigma, an increase in people seeking help before they reach a crisis point, to ensure appropriate support and services are accessible to everyone and prevent access to means in a range of areas.

# 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:

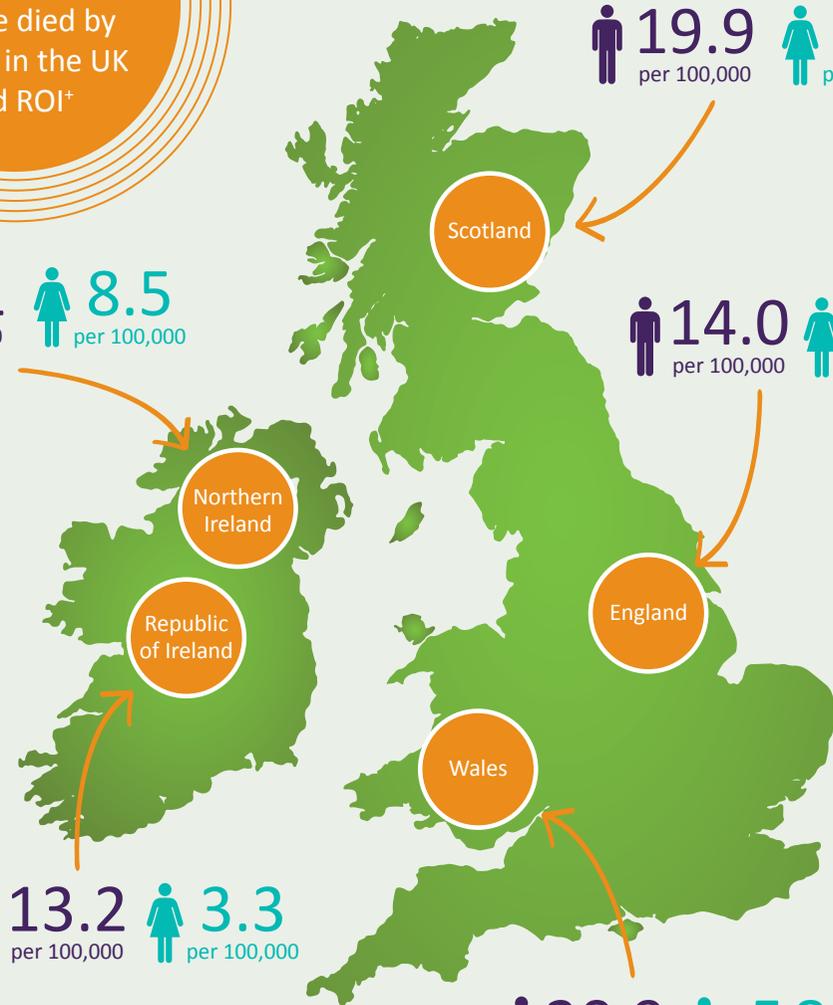
- **It's all about rates per 100,000** The number of suicides in a group (e.g. in a country or a specific age group) can give a misleading picture of the incidence of suicide when considered alone. Rates per 100,000 people are calculated in order to adjust for the underlying population size. An area 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.

# SAMARITANS

## Suicide rates in the UK & Republic of Ireland



+ 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.

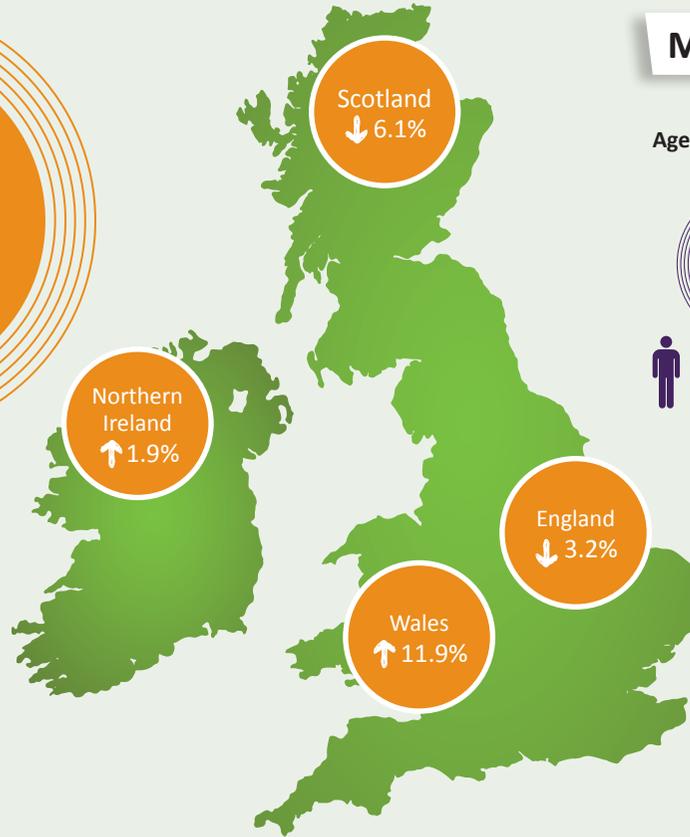
Rates for the UK are age standardised; rates for ROI are crude.

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).



# Suicides in the UK



## MIDDLE AGED MEN ARE STILL AT GREATEST RISK

Age groups with highest rate per 100,000

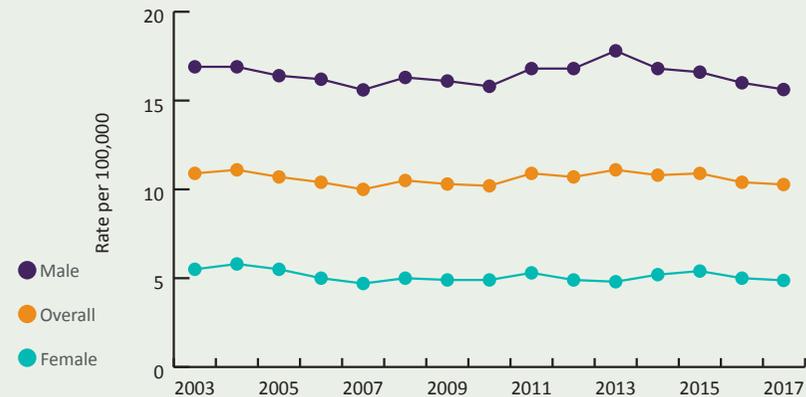


Suicide rates decreased across most age groups for men in 2017.

The suicide rate increased among men aged 45-49 by 7.4%.



Suicide rate per 100,000 in the UK 2003-2017



## SUICIDE RATE HAS FALLEN BY 2.9%

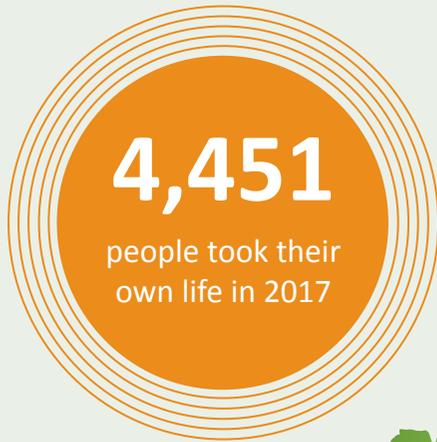
The **male suicide** rate is the lowest in over 30 years. It decreased by **3.1%** between 2016 and 2017.

The **female suicide** rate decreased by **2%** between 2016 and 2017.

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.



# Suicides in England



## MEN AGED 45-49 HAVE HIGHEST SUICIDE RATE

Age groups with highest rate per 100,000

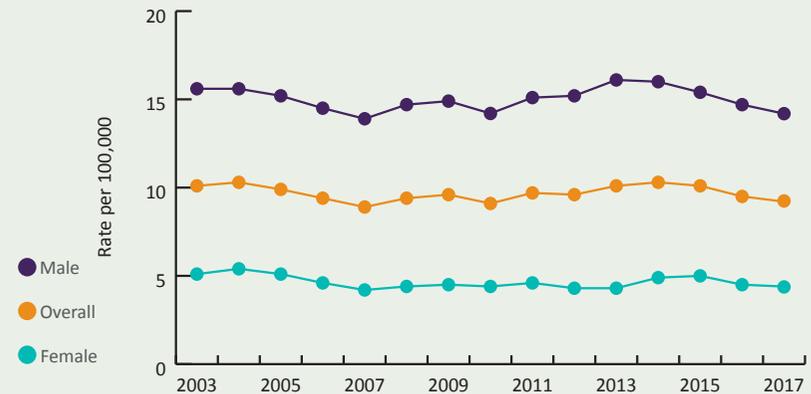


Suicide rates decreased across most age groups for men in 2017.

However, reflecting the UK picture the suicide rate has increased among men aged 45-49 by 3.2%.



Suicide rate per 100,000 in England 2003-2017



## SUICIDE RATE HAS FALLEN BY 3.2%

The **male suicide** rate has decreased by **4.8%** between 2015 and 2016, the lowest male rate since 2007.

The **female suicide** rate has increased by **2.2%** between 2016 and 2017.

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.



# Suicides in Wales



## MEN AGED 40-44 HAVE HIGHEST SUICIDE RATE

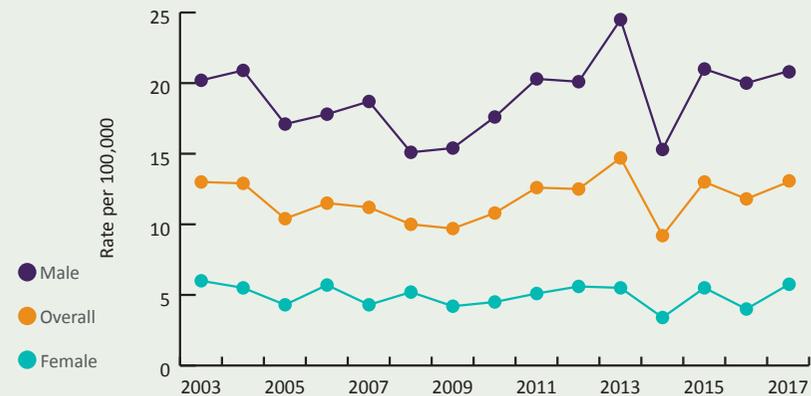
Age group with highest rate per 100,000



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 more than three times higher than the female rate.

Suicide rate per 100,000 in Wales 2003-2017



## SUICIDE RATE HAS INCREASED BY 11.9%

The **male suicide** rate increased by **4.5%** between 2016 and 2017.

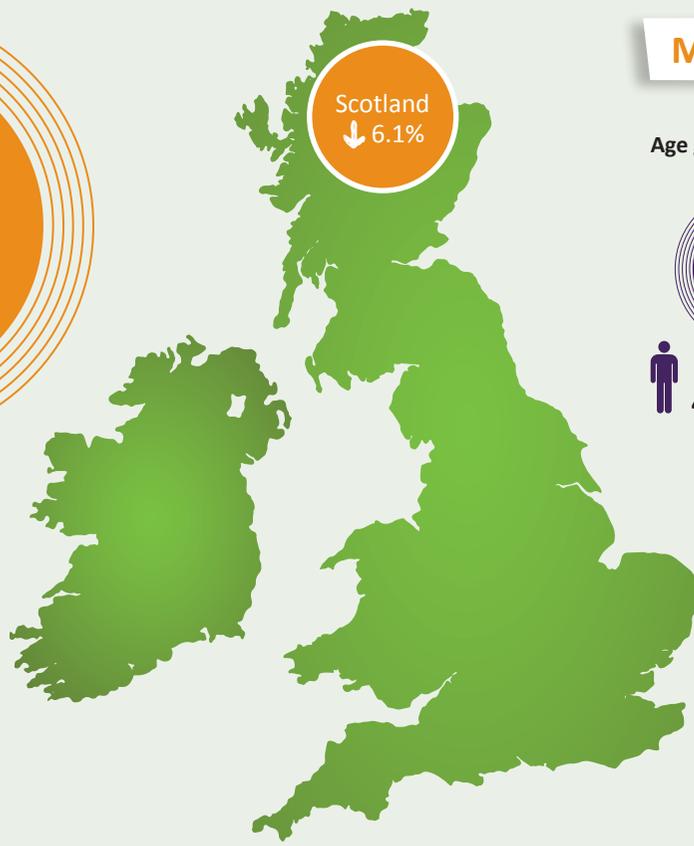
The **female suicide** rate increased by **45%** between 2016 and 2017.

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.

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.

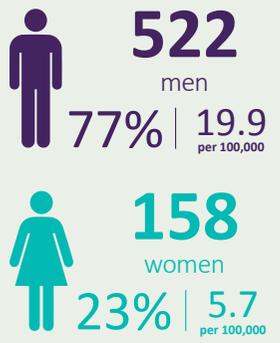
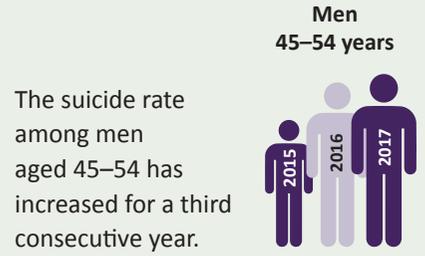


# Suicides in Scotland

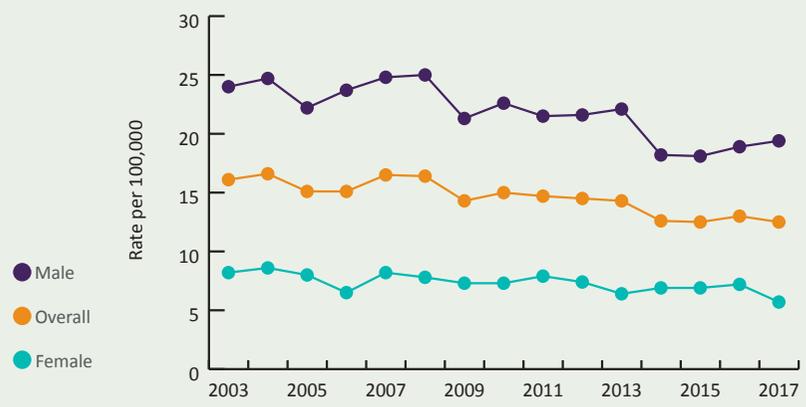


## MEN AGED 45–54 HAVE HIGHEST SUICIDE RATE

Age groups with highest rate per 100,000



Suicide rate per 100,000 in Scotland 2003–2017



## SUICIDE RATE HAS DECREASED BY 6.1%

The **male suicide** rate has increased by **1%**.  
The **female suicide** rate has decreased by **24.3%**.

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 2017 are not directly comparable to the previous years' data.



# Suicides in Northern Ireland



## MEN AGED 35–39 HAVE HIGHEST SUICIDE RATE

Age groups with highest rate per 100,000

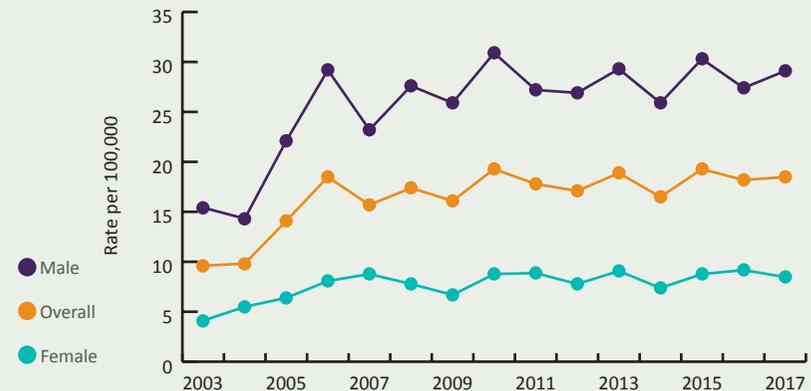


Please note the suicide rate for women aged 30–34 should be used with caution as it is based on fewer than 20 deaths.

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



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



## SUICIDE RATE HAS INCREASED BY 1.9%

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

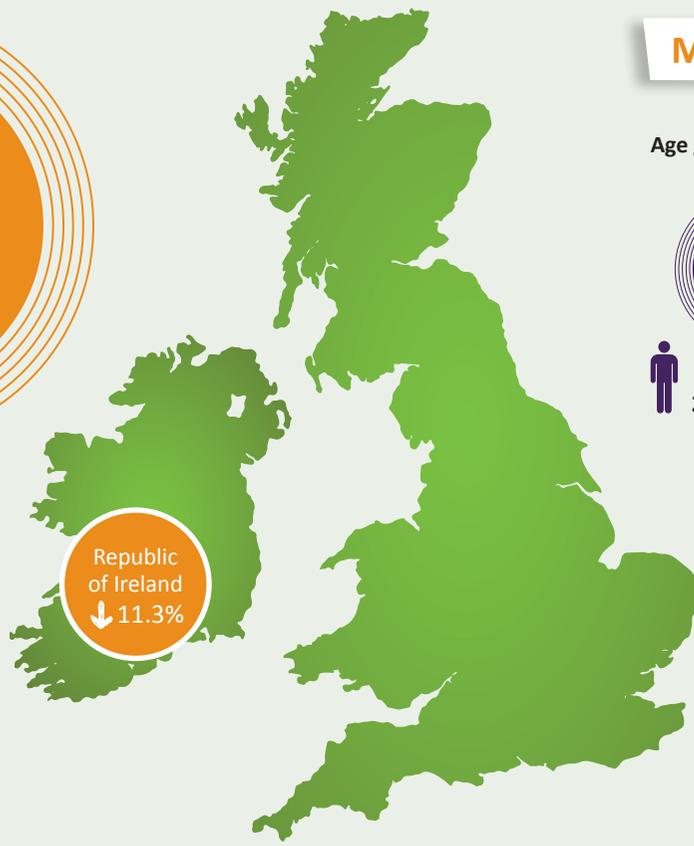
The **female suicide** rate decreased by **8.1%** between 2016 and 2017.

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.

Notes about data: Data source – 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. 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.



# Suicides in the Republic of Ireland



## MEN AGED 25-34 HAVE HIGHEST SUICIDE RATE

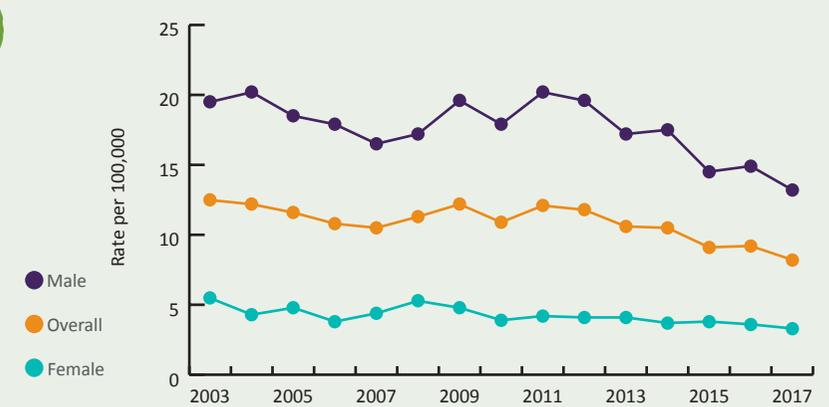
Age groups with highest rate per 100,000



The male suicide rate is four times higher than the female rate. **x4**



Suicide rate per 100,000 in the Republic of Ireland 2003-2017



## SUICIDE RATE HAS FALLEN BY 11.3%

The **male suicide** rate decreased by **11.8%** between 2016 and 2017.

The **female suicide** rate has decreased by **9.1%** between 2016 and 2017.

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 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



REGISTRATION



CODING



CALCULATING  
SUCIDES

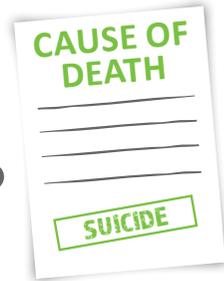


REPORTING

Cause  
of Death

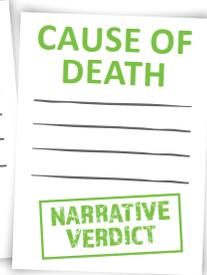


### CAUSE OF DEATH



OR

### MISCLASSIFIED



### → 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 done by a Procurator Fiscal through a Fatal Accident Inquiry.

→ 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.**

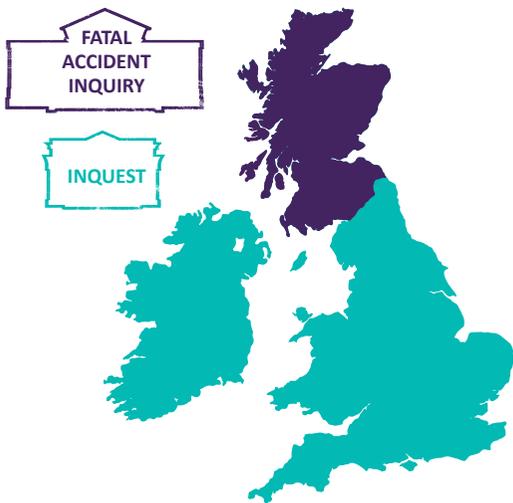
 A narrative verdict gives a brief description about the circumstances surrounding the death and is given instead of a short form verdict (such as 'suicide' or 'accidental death').



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

 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<sup>4</sup>.

→ **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.





## REGISTRATION

### → Registration

In each country, all deaths are officially registered.

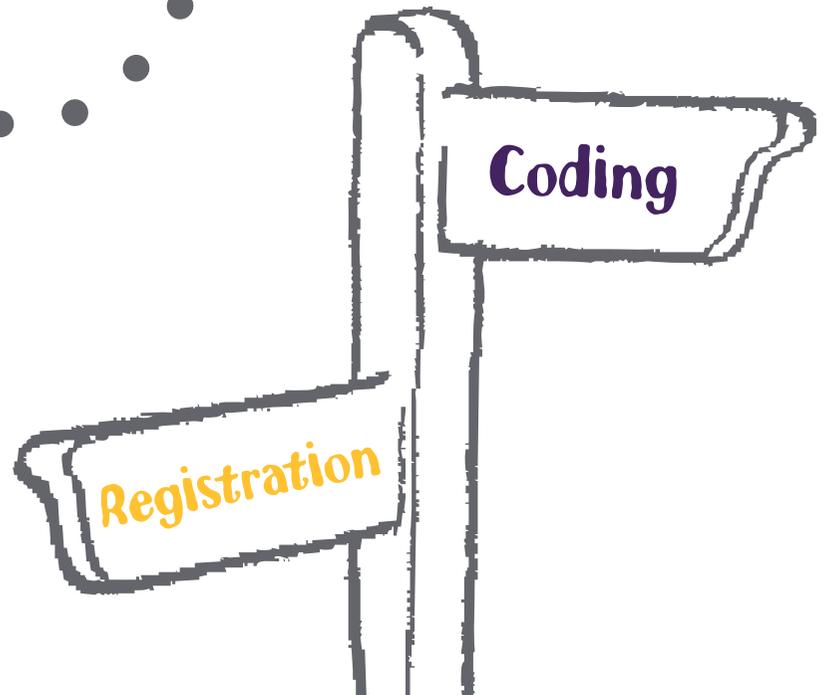
In Scotland deaths are registered within 8 days. In the rest of the UK and Republic of Ireland, deaths are registered after an inquest. This means that there can sometimes be registration delays of a year or more.



→  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 24 of this report.





**CODING**

## → 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<sup>5</sup>.



**1** 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 22). 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 30).

\*Explanation taken from ScotPHO website, updated July 2018; [scotpho.org.uk/health-wellbeing-and-disease/suicide/key-points](http://scotpho.org.uk/health-wellbeing-and-disease/suicide/key-points)



## CALCULATING SUICIDES



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.

### → Calculating suicide numbers and rates

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 19.



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.

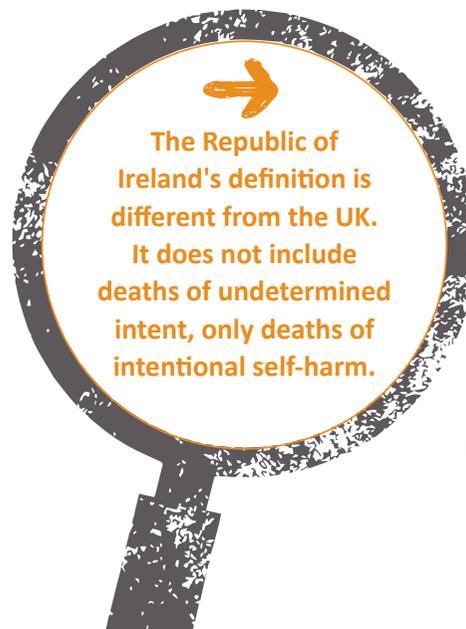
Because of differences in processes and definitions, figures don't always mean exactly the same thing in different countries (see previous steps in the journey). So, the 'suicide rate' in one country might mean something different to the rate in another. This means that it can be unhelpful to compare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

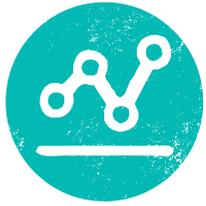
**Box 1:** UK definition of suicide

ICD-10 code	Description
X60–X84	Intentional self-harm
Y10–Y34 <sup>1</sup>	Injury/poisoning of undetermined intent
Y87.0/Y87.2 <sup>2</sup>	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.





## REPORTING



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.



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 25 for further information and links to access). This is useful for understanding more about who dies by suicide and where they are.



## 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.



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.

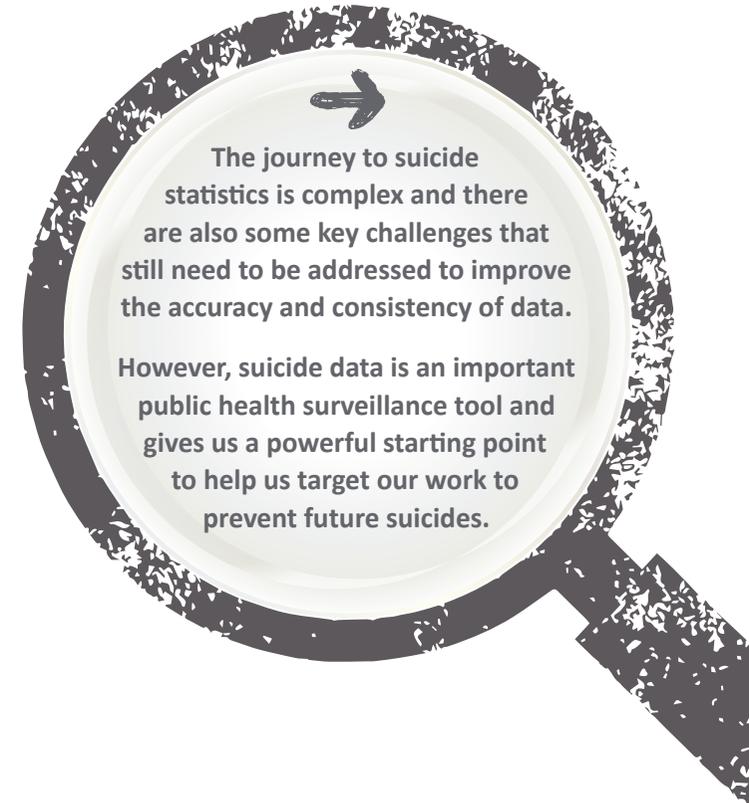


**ONS** provide data that includes suicides and self-inflicted deaths with undetermined intent for persons aged 10 and over.

**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+.



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

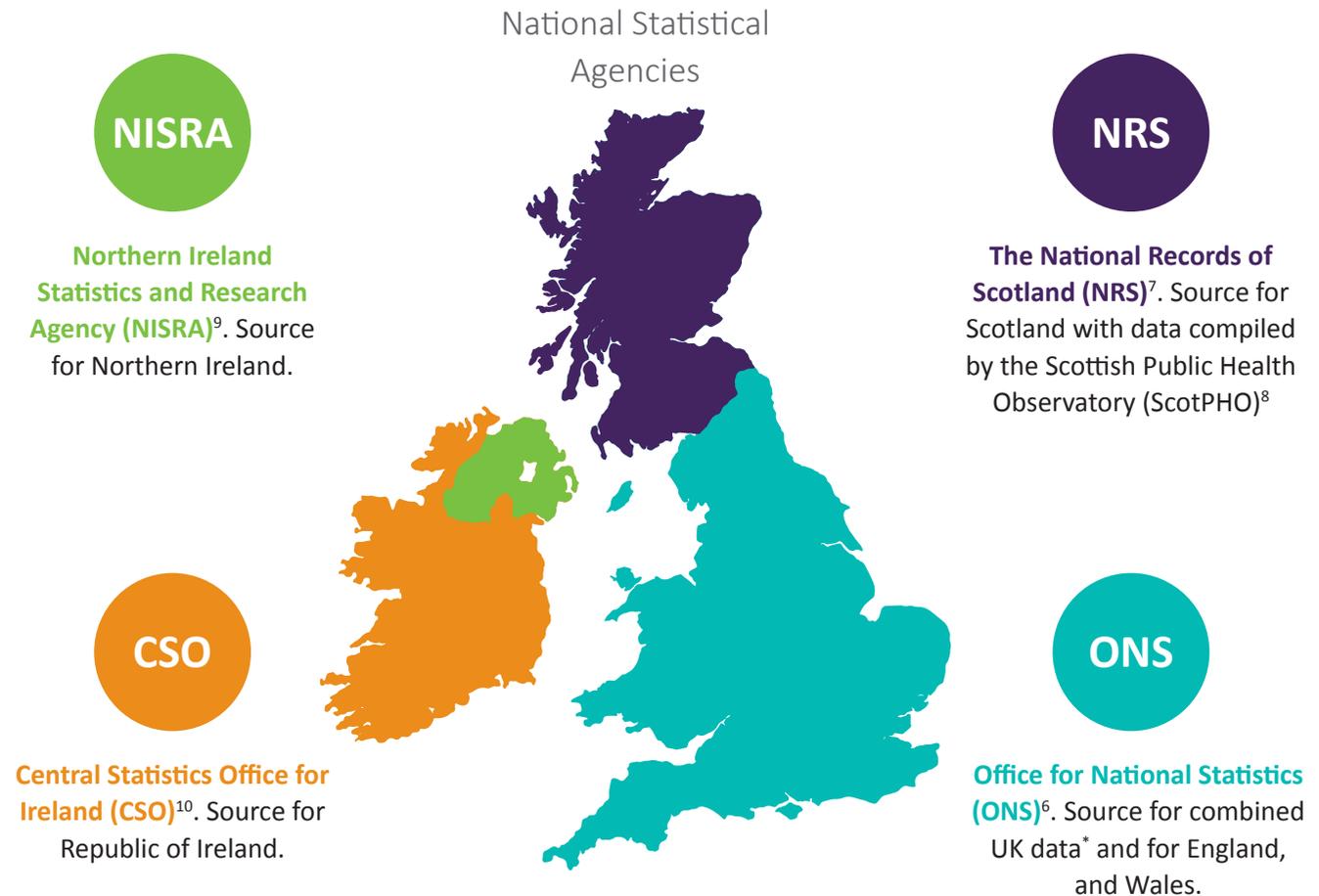
## Data sources – UK

The map shows the sources for the data shown in this report for the UK and Republic of Ireland in 2017 (published or obtained in 2018).

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 2017 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.

Note: suicide rates per 100,000 for 2015 differ from those reported in the 2017 edition of this report, as CSO provided provisional data which has since been updated. Data presented in this version should therefore be used to replace any previous figures and are the official suicide rates as provided by CSO in this update.



## Other nationally available statistics

**ONS** provides the number of suicides by Local Authority for England and Wales from 2002 to 2017, and age-standardised three-year aggregate suicide rates where the latest period is 2015-2017. These data can be downloaded from their [website](#).

**Public Health England (PHE)** has created an online [Suicide Prevention Atlas](#) which maps suicide data for each local authority area in England and allows you to see which local authority areas have higher, consistent or lower than the national average suicides among different groups, as well as showing suicide risk factors (such as unemployment) and related service contacts (such as emergency hospital admissions for intentional self-harm). PHE also provides an online [Suicide Prevention Profile](#), which brings together a range of publicly available data on suicide (rates by regions, local authority and levels of deprivation), risk factors e.g. self-reported wellbeing and prisoner population, and service-related local data among groups at increased risk such as self-harm hospital admissions. Both resources allow for comparison with other similar areas and the national average to support local planning.

**ScotPHO** provides the number, crude rates and age-standardised rates of suicide in aggregate five-year periods from 1983–2017 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 1997–2016, 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 2001–2016. 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 2017, 2016 and 2012 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.

**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<sup>3</sup>; Preventing suicide: A global imperative

## 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.

## 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 reliability. 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 below.

### 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 19). 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 19 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 19), 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 22).

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<sup>11</sup>. 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<sup>12</sup>. 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<sup>13</sup> 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<sup>14</sup>. 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 8) 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<sup>15</sup>. **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<sup>11</sup>. 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<sup>11</sup> – 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<sup>16</sup>.

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<sup>17</sup>. 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 may 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 do 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)<sup>5</sup>.

## Further notes on changes to coding rules

As noted earlier in this report (see page 21) 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
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.

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**Appendix:**  
**Data tables UK and**  
**Republic of Ireland**

## UK suicide\* rates for all persons, males and females and by age group, 2015–2017

Table 1

UK	2015			2016			2017		
Rate per 100,000 for persons aged 10+	Overall 10.9	Male 16.6	Female 5.4	Overall 10.4	Male 16	Female 5.0	Overall 10.1	Male 15.5	Female 4.9
Rate per 100,000 by age group (years)	Overall	Male	Female	Overall	Male	Female	Overall	Male	Female
10-14	0.3†	0.2	0.3	0.1†	0.2†	-	0.4†	0.4†	0.4†
15-19	5.8	8.3	3.1	5.3	7.5	2.9	5.6	7.6	3.5
20-24	9.5	14.9	3.9	10.4	14.8	5.7	8.7	12.9	4.3
25-29	10.8	16.6	4.8	10.9	17.5	4.2	10.6	17.0	4.2
30-34	12.4	19.2	5.6	12.0	19.1	5.0	11.6	17.7	5.7
35-39	12.8	19.5	6.2	11.8	19.0	4.7	12.2	19.0	5.6
40-44	15	24.1	6.1	15.3	24.1	6.7	14.4	22.7	6.3
45-49	15.6	23.9	7.5	14.9	23.1	6.9	15.6	24.8	6.6
50-54	14.8	21	8.6	15.1	22.0	8.3	14.1	21.6	6.8
55-59	14.1	21.8	6.5	13.2	19.9	6.6	11.9	18.8	5.3
60-64	11.3	16.1	6.8	9.9	14.4	5.5	9.6	14.2	5.2
65-69	8.8	13.1	4.7	8.0	12.0	4.2	8.0	11.6	4.6
70-74	9.1	11.7	4.7	6.8	10.1	3.9	6.8	9.8	4.0
75-79	7.8	11.3	4.9	6.3	10.4	2.7	7.9	11.4	4.9
80-84	9	15.2	4.4	8.2	14.7	3.2	6.1	9.1	3.8
85-89	9.6	17.5	4.8	8.2	15.0	3.9	9.2	17.1	4.2
90+	12.2	28.1	5.6	10.7	22.1	5.8	9.0	17.4	5.2

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

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

## UK suicide numbers for all persons, males and females and by age group, 2015–2017

Table 2

UK	2015			2016			2017		
Number of deaths for persons aged 10+	Overall 6,188	Male 4,622	Female 1,566	Overall 5,965	Male 4,508	Female 1,457	Overall 5,821	Male 4,382	Female 1,439
Number of deaths by age group (years)	Overall	Male	Female	Overall	Male	Female	Overall	Male	Female
10-14	10	4	6	5	3	2	16	8	8
15-19	221	164	57	199	145	54	207	144	63
20-24	408	326	82	441	323	118	367	279	88
25-29	478	371	107	491	397	94	483	389	94
30-34	543	419	124	530	419	111	515	389	126
35-39	524	396	128	494	395	99	523	403	120
40-44	646	513	132	640	498	142	586	458	128
45-49	721	545	176	688	526	162	713	559	154
50-54	674	474	200	699	503	196	658	496	162
55-59	557	426	131	535	400	135	500	388	112
60-64	396	276	121	350	250	100	347	251	96
65-69	317	230	87	290	212	78	278	195	83
70-74	219	152	67	195	137	58	211	146	65
75-79	169	112	57	135	103	32	172	114	58
80-84	143	103	40	131	102	29	100	65	35
85-89	161	110	51	81	57	24	93	67	26
90+	68	46	22	61	38	23	52	31	21

## England suicide rates for all persons, males and females and by age group, 2015–2017

Table 3

England	2015			2016			2017		
Rate per 100,000 for persons aged 10+	Overall 10.1	Male 15.4	Female 5.0	Overall 9.5	Male 14.7	Female 4.5	Overall 9.2	Male 14.0	Female 4.6
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†	0.3†	0.3†
15-19	5.4	7.6	3.1	4.5	6.3	2.6	5.0	6.5	3.4
20-24	8.7	13.8	3.5	9.0	13.5	4.4	7.4	11.0	3.6
25-29	9.3	14.0	4.7	9.4	14.9	3.7	9.1	14.1	4.0
30-34	10.7	16.4	5.0	10.6	16.6	4.6	10.3	15.6	5.0
35-39	11.7	18.1	5.3	10.6	17.1	4.2	10.8	16.8	4.8
40-44	13.6	22.0	5.2	14.0	21.9	6.2	12.8	19.8	5.8
45-49	14.6	22.4	6.9	13.9	21.7	6.3	14.3	22.4	6.3
50-54	14.0	20.1	8.1	14.0	20.2	8.0	12.8	19.7	6.2
55-59	13.1	20.3	6.0	12.3	19.0	5.8	11.2	17.2	5.2
60-64	10.9	16.0	6.0	8.9	13.0	5.0	8.7	13.3	4.4
65-69	8.3	12.4	4.5	7.3	11.0	3.8	7.9	11.7	4.4
70-74	7.8	11.3	4.7	6.2	9.2	3.5	6.7	9.7	4.0
75-79	7.6	10.8	4.8	6.3	10.4	2.8	7.6	10.5	5.0
80-84	9.3	15.2	4.9	8.2	14.5	3.3	6.6	9.9	4.0
85-90	10.2	18.2	5.3	8.8	16.7	3.9	9.7	18.2	4.2
90+	12.0	25.7	6.3	11.3	21.7	6.8	8.7	15.0	5.8

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

## England suicide numbers for all persons, males and females and by age group, 2015–2017

Table 4

England	2015			2016			2017		
Number of deaths for persons aged 10+	Overall 4,820	Male 3,600	Female 1,220	Overall 4,575	Male 3,464	Female 1,111	Overall 4,451	Male 3,328	Female 1,123
Number of deaths by age group (years)	Overall	Male	Female	Overall	Male	Female	Overall	Male	Female
10-14	8	4	4	2	1	1	10	5	5
15-19	174	126	48	143	102	41	155	104	51
20-24	313	252	61	322	246	76	261	199	62
25-29	351	264	87	357	287	70	349	273	76
30-34	399	305	94	398	311	87	387	293	94
35-39	406	313	93	378	303	75	392	304	88
40-44	493	397	96	495	384	111	440	339	101
45-49	566	431	135	539	416	123	549	426	123
50-54	535	379	156	542	386	156	502	380	122
55-59	428	329	99	416	317	99	388	296	92
60-64	316	227	89	261	187	74	261	194	67
65-69	251	181	70	222	162	60	229	163	66
70-74	178	122	56	148	105	43	175	121	54
75-79	137	90	47	113	86	27	137	88	49
80-84	124	87	37	110	85	25	90	59	31
85-89	84	57	27	74	54	20	83	61	22
90+	57	36	21	55	32	23	43	23	20

## Wales suicide rates for all persons, males and females and by age group, 2015–2017

Table 5

Wales	2015			2016			2017		
Rate per 100,000 for persons aged 15+	Overall 13.0	Male 21.0	Female 5.5	Overall 11.8	Male 20.0	Female 4.0	Overall 13.2	Male 20.9	Female 5.8
Rate per 100,000 by age group (years)	Overall	Male	Female	Overall	Male	Female	Overall	Male	Female
10-14	-	-	-	-	-	-	-	-	-
15-19	5.4†	7.3†	3.3†	8.8†	13.8†	3.4†	11.2	16.3†	5.8†
20-24	9.8	12.7†	6.8†	14.2	15.5†	12.8†	11.5	15.6†	7.1†
25-29	15.9	25.2	6.3†	12.9	24.3	-	18.6	32.7	4.0†
30-34	21.4	38.6	4.4†	16.4	28.5	4.4†	16.7	24.9	8.6†
35-39	14.6	22.4†	7.0†	15.4	27.6	3.4†	12.8	19.2†	6.6†
40-44	18.4	30.1	7.2†	16.0	29.3	3.3†	20.7	37.4	4.5†
45-49	15.4	25.8	5.5†	11.7	23.1	-	21.9	36.0	8.4†
50-54	17.8	26.9	8.9†	14.0	19.4	8.8†	15.8	24.0	7.9†
55-59	16.7	28	6.0†	17.8	25.2	10.6†	14.0	26.6	1.9†
60-64	12.4	16.6†	8.5†	10.8	18.9†	3.2†	15.5	18.7†	12.5†
65-69	8.7†	15.7†	-	11.6	19.7†	4.0†	8.5	10.8†	6.2†
70-74	9.3†	12.4†	6.4†	8.4†	16.1†	-	5.4	7.4†	3.5†
75-79	9.5†	14.9†	4.9†	2.6†	5.6†	-	11.0	18.1†	4.7†
80-84	10.7†	22.1†	-	9.4†	21.5†	-	-	2.6†	-
85-89	8.0†	15.7†	-	-	-	-	13.5†	19.7†	9.5†
90+	17.2†	60.4†	-	10.1†	34.3†	-	10.1†	22.3†	-

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

## Wales suicide numbers for all persons, males and females and by age group, 2015–2017

Table 6

Wales	2015			2016			2017		
Number of deaths for persons aged 10+	Overall 350	Male 274	Female 76	Overall 322	Male 265	Female 57	Overall 360	Male 278	Female 82
Number of deaths by age group (years)	Overall	Male	Female	Overall	Male	Female	Overall	Male	Female
10-14	1	0	1	0	0	0	0	0	0
15-19	10	7	3	16	13	3	20	15	5
20-24	21	14	7	30	17	13	24	17	7
25-29	31	25	6	26	25	1	38	34	4
30-34	39	35	4	30	26	4	31	23	8
35-39	25	19	6	27	24	3	23	17	6
40-44	35	28	7	29	26	3	36	32	4
45-49	33	27	6	25	24	1	46	37	9
50-54	39	29	10	31	21	10	35	26	9
55-59	33	27	6	36	25	11	29	27	2
60-64	23	15	8	20	17	3	29	17	12
65-69	17	15	2	23	19	4	16	10	6
70-74	14	9	5	13	12	1	9	6	3
75-79	11	8	3	3	3	0	13	10	3
80-84	9	8	1	8	8	0	1	1	0
85-89	4	3	1	2	2	0	7	4	3
90+	5	5	0	3	3	0	3	2	1

## Scotland suicide rates for all persons, males and females and by age group, 2015–2017

Table 7

Scotland	2015			2016			2017		
Rate per 100,000 for all persons	All 12.8	Male 18.5	Female 7.1	All 13.6	Male 19.7	Female 7.6	All 12.8	Male 19.9	Female 5.7
Rate per 100,000 by age group (years)	All	Male	Female	All	Male	Female	All	Male	Female
0-14	-	-	-	-	-	-	-	-	-
15-24	8.0	13.6	2.4	10.9	14.4	7.3	9.9	16.2	3.4
25-34	16.0	25.4	6.9	17.9	27.9	8.2	15.6	27.1	4.3
35-44	22.5	32.0	13.4	22.2	33.7	11.2	20.6	31.3	10.3
45-54	18.6	25.7	11.9	22.3	33.3	11.9	21.7	35.0	9.3
55-64	16.5	21.1	12.1	15.6	21.4	10.1	14.4	21.5	7.7
65-74	9.9	15.8	4.5	10.4	13.9	7.2	8.3	11.9	5.1
75-84	8.1	12.3	4.9	7.1	11.5	3.8	8.6	12.8	5.4
85+	-	-	-	-	-	-	-	-	-

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

## Scotland suicide numbers for all persons, males and females and by age group, 2015–2017

Table 8

Scotland	2015			2016			2017		
Number of deaths for persons aged 10+	All 672	Male 476	Female 196	All 728	Male 517	Female 211	All 680	Male 522	Female 158
Number of deaths by age group (years)	All	Male	Female	All	Male	Female	All	Male	Female
0-14	-	-	-	-	-	-	-	-	-
15-24	54	46	8	72	48	24	64	53	11
25-34	114	89	25	130	100	30	115	99	16
35-44	151	105	46	148	110	38	137	102	35
45-54	149	100	49	178	129	49	172	134	38
55-64	112	70	42	108	72	36	102	74	28
65-74	54	41	13	58	37	21	47	32	15
75-84	26	17	9	23	16	7	28	18	10
85+	-	-	-	-	-	-	-	-	-

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

## 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.

Source: NISRA

## 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

## Republic of Ireland suicide rates for all persons, males and females and by age group, 2015–2017

Table 11

Republic of Ireland	2015			2016			2017*		
Rate per 100,000 for persons aged 15+	Overall 9.1	Male 14.5	Female 3.8	Overall 9.2	Male 14.9	Female 3.6	Overall 8.2	Male 13.2	Female 3.3
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
15-24	8.7	14.0	3.2	11.3	15.7	6.7	10.3	14.1	6.3
25-34	12.3	19.3	5.8	11.6	20.5	3.2	11.4	19.3	3.9
35-44	12.1	20.2	4.3	13.6	22.0	5.3	11.1	19.0	3.4
45-54	14.2	23.3	5.2	14.1	22.6	5.7	12.6	19.3	5.9
55-64	13.8	19.7	8.1	13.3	23.5	3.2	10.5	17.9	3.1
65-74	10.7	16.6	5.0	6.3	10.5	2.1	6.6	10.1	3.1
75+	4.3	10.2	-	4.6	6.3	3.3	4.5	9.5	0.7

\*Provisional data that will be finalised in subsequent years; provisional data reflects the suicides registered in 2017, final data will reflect the suicides that occur in that year.

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

Table 12

Republic of Ireland	2015			2016				2017**		
Number of deaths for all persons	Overall 425	Male 335	Female 90	Overall 437	Male 350	Female 87	Number of deaths for all persons	Overall 392	Male 312	Female 80
Number of deaths by age group (years)	Overall	Male	Female	Overall	Male	Female	Number of deaths by age group (years)	Overall	Male	Female
0-14	0	0	0	5	3	2	0-24	64	44	20
15-24	50	41	9	65	46	19	25-34	73	60	13
25-34	82	62	20	76	65	11	35-44	84	71	13
35-44	89	73	16	101	81	20	45-54	80	61	19
45-54	87	71	16	88	70	18	55-64	54	46	8
55-64	68	48	20	67	59	8	65+	37	30	7
65-74	38	29	9	23	19	4				
75+	11	11	0	12	7	5				

\*Provisional data reflects the suicides registered in 2017, 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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