



Suicide statistics report 2017

Including data for 2013-2015



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There were 6,639 suicides
in the UK and Republic of
Ireland in 2015

Suicide statistics report 2017 Including data for 2013-2015

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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, 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. Reducing suicide means reaching more people who may be at risk of taking their own lives. This can only be achieved by understanding which groups of individuals are at risk of suicidal thoughts and behaviours.

This report pulls together the data about deaths by suicide for the UK and Republic of Ireland, which is available from official statistics bodies and provides a description of the latest suicide rates. It also provides information about the challenges we have with suicide data, guidance about how to (and how not to) use statistics, and the differences between how the individual countries produce the final suicide statistics.

The collation of suicide statistics for the UK, England, Wales, Scotland, Northern Ireland and the Republic of Ireland is not routinely provided by any other organisation.

In order to understand and prevent suicide, it is important that suicide data is as accurate and as comprehensive as possible. This report also includes some further comments on these issues, specific details of suicide statistics and the availability of data.

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 2015-21¹

Samaritans' response to recent trends in suicide

What are the recent trends?

Data for 2015 shows:

- 🕒 There were **6,639 suicides** in the UK and Republic of Ireland.
- 🕒 **6,188** suicides were registered in the **UK** and **451** in the **Republic of Ireland**.
- 🕒 The **highest suicide rate** in the **UK** was for **men aged 40–44**.
- 🕒 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 was slight increase in suicide in the **UK**, and a slight decrease in **England** between 2014 and 2015.
- 🕒 The suicide rate in **Wales** and **Northern Ireland** increased between 2014 and 2015.
- 🕒 The overall suicide rates in **Scotland** and **Republic of Ireland** have **continued to fall** since 2011.
- 🕒 **Northern Ireland** shows **higher suicide rates than other UK nations** – however rates are not necessarily directly comparable.
- 🕒 The suicide rate in **Northern Ireland** has increased dramatically over the last 30 years – the male rate has increased by 82% in this time.
- 🕒 Rates in the **Republic of Ireland** have **fluctuated** more than in the UK in recent years, but it is currently at its **lowest since 1993**.

Female suicide in 2015:

- 🕒 In **England and the UK**, **female suicide rates are at their highest** in a decade.
- 🕒 **Rates have increased** in the **UK** (by 3.8%), **England** (by 2%), **Wales** (61.8%) and **Northern Ireland** (18.5%) since 2014 – however increases in Wales and Northern Ireland may be explained by inconsistencies in the processes for recording and registering suicides in these countries, see pages 29-30).
- 🕒 Rates have decreased in **Scotland** (by 1.4%) and the **Republic of Ireland** (by 13.1%) since 2014.

Male suicide in 2015:

- 🕒 Male rates remain **consistently higher than female suicide** rates across the UK and Republic of Ireland – most notably 5 times higher in Republic of Ireland and around 3 times in the UK.
- 🕒 **They have decreased** in the **UK** (by 1.2%), **England** (by 3.8%), **Scotland** (by 4.1%) and **Republic of Ireland** (6.4%) since 2014.
- 🕒 **Rates have increased** in **Wales** (by 37.3%), and **Northern Ireland** (by 17.5%) between 2014 and 2015 – however these increases may be explained by inconsistencies in the processes for recording and registering suicides in these countries, see page 15).

What do the trends tell us?

The recent rise in female suicide could be an indication of the picture of suicide risk changing. It now appears that male rates are decreasing and female rates are increasing. However, we must be mindful that these changes are based on year-on-year data, which could be natural fluctuations, rather than the beginning of a longer-term trend. This needs careful monitoring. The recent rise in female suicide is concerning but it is too early to tell whether it is a long term trend.

Men remain around three times more likely to take their own lives than women in the UK and five times in the Republic of Ireland, but we must pay attention to the risks in both genders. Research suggests that social and economic factors influence the risk of suicide in women as well as men (as described in our [Men, Suicide and Society research](#)), reinforcing the need to address inequalities to reduce suicide.²

See the 'Trends over time' sections (pages 28-30 and page 33) for suicide trends from the UK (and each of the constituent nations) and the Republic of Ireland.

What will Samaritans do?

We need to be better at identifying those most at risk and finding ways to reach them. Samaritans is committed to developing our work based on research and evidence so that we can better support those who need us and achieve our vision, that fewer people die by suicide.

This year we will be developing a range of new services in order to reach more vulnerable people struggling to cope, including through digital services and more outreach work.

We will continue to work with leading academics in the field of suicide prevention, to better understand who is most at risk of suicide and how to prevent it. This year we will publish a report examining the link between socio-economic disadvantage and suicidal behaviour, which will include recommendations for policy and practice.

There are many factors which contribute to suicide, and we need all parts of society working together to reduce it. We will continue to strengthen our influencing voice, working closely with policy-makers, decision-takers and practitioners. We need to work together to improve the content and implementation of local and national suicide prevention policies and plans, as well as other areas of public policy which impact on suicide.

What do we want to see?

Improvements to the accuracy and availability of suicide data.

We welcome some recent improvements to the availability of suicide data from agencies and groups in the UK such as Office for National Statistics (ONS), Scottish Suicide Information Database (ScotSID), and Public Health England (PHE). Suicide data is now available more quickly and in more useful formats. However, there are still many challenges with suicide data across the UK and Republic of Ireland, which will hinder our understanding of suicide unless they are addressed.

Knowing who dies by suicide, and when, is fundamental to preventing suicide. We want to see improvement to death registration processes to produce more accurate and timely suicide data. Samaritans is calling for a review of the death registration process in the UK, in order to reduce the time it takes to register deaths, more in line with processes in Scotland – where the maximum time between a death and registration is eight days.

The delay of suicide death registrations has obvious implications of slowing down the process of understanding how many people and which groups of people are dying by suicide. Our suicide prevention efforts extend across the UK and Republic of Ireland, and yet comparability of statistics across nations is challenging. Differences in suicide rates between countries could indicate that there are different patterns of suicide in the different nations, or it could simply be a consequence of different recording and registration processes.

Back in 2014, we joined forces with Sense about Science and other organisations to bring this issue to the attention of the Prime Minister in an [open letter](#) – there have been no improvements since this time.

Other inconsistencies, which add to the problems with suicide data and need to be resolved can be found listed on page 19.

Consistent inclusion of deaths of undetermined intent across the UK and Republic of Ireland.

This document highlights the differences in the collection and presentation of suicide statistics across the UK and the Republic of Ireland. These differences seem unnecessary and unhelpful in a group of nations so socially, economically and politically linked. The difference in the operational definition of 'suicide' between the UK (all nations) and the Republic of Ireland (see pages 15-17) is the most obvious.

We would welcome consideration of a review of the suicide definition in the Republic of Ireland to align with that of the UK and many other countries. This would include those deaths classified as undetermined intent, in order to counter the widely acknowledged under-reporting of suicide due to misclassification of deaths.

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.

We are calling on every area of the UK and Republic of Ireland to have an effective suicide prevention plan and active multi-agency group in place, which addresses those areas highlighted by national and local data. Local activity needs to be resourced properly, and monitored to ensure that the activity which has the greatest impact and evidence of effectiveness is being delivered.

We need to raise awareness of the issues, reduce stigma, encourage people to seek help before they reach a crisis point, ensure appropriate support and services are accessible to everyone and reduce access to means, for example by limiting physical access and ensuring responsible portrayal of suicide in the media.

Understanding suicide statistics

Understanding suicide statistics can be tricky. The 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 (eg 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 (eg 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**

When examining suicide trends over time it is important to look over a relatively long period. Increases and decreases for a year at a time should not be considered in isolation. There may be fluctuations year-on-year but these should not be viewed as ‘true’ changes to the trend that are attributable to any specific psycho-social predictors (eg unemployment).

• Sensitive and responsible reporting of suicide

When talking about suicide publically or in the media, it is crucial to do so sensitively and responsibly, to minimise the risk of contagion (a phenomenon of suicidal behaviours that seems to occur as a result of previous suicides or attempts by others). [Samaritans' Media Guidelines](#) provide advice for journalists about how to do this. These guidelines are often most related to reporting of occurrences of suicides, however, the principles of these guidelines should be followed for the reporting of suicide statistics and particularly when reporting on increases of suicides in particular groups.

For the definition of suicide see Box 1 on page 15; for full data tables of numbers and rates – see tables in Appendices. More information on the challenges with suicide statistics can be found on page 19.



Suicide rates in the UK and Republic of Ireland – 2015

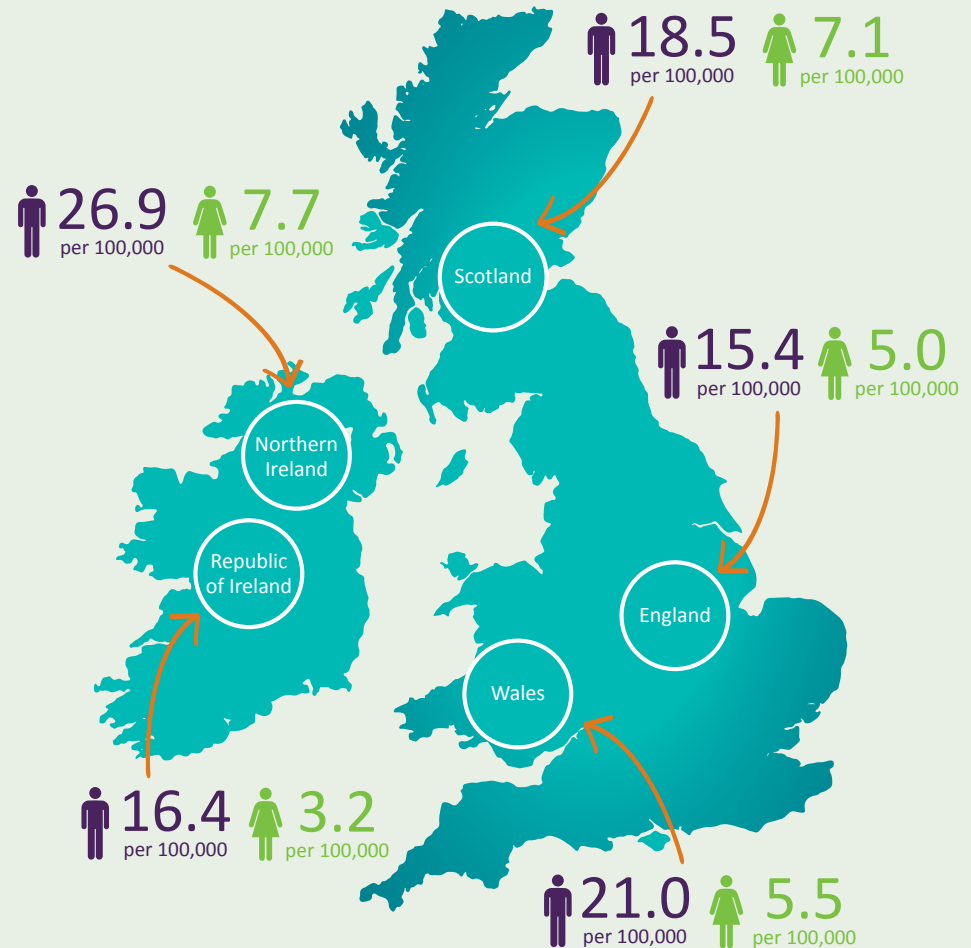
Rates are per 100,000 population.

6,639
people died by suicide
in the UK and ROI*

4,997
males



1,642
females



Please note not all nations collect data on suicide in the same way and therefore rates are not necessarily comparable (see page 23).

Data sources

Data sources – UK

The UK data in this document have been provided by official statistical bodies: Office for National Statistics (ONS)³ (for combined UK data, England, and Wales), the National Records of Scotland (NRS)⁴ (for Scotland with data compiled by the Scottish Public Health Observatory (ScotPHO)⁵) and the Northern Ireland Statistics and Research Agency (NISRA)⁶ (for Northern Ireland).

The most recent data available and discussed in this document relates to 2015 (data published or obtained in 2016/2017). All suicide rates shown have been calculated by the respective statistical agencies named above. ONS reproduce suicide rates for Scotland and Northern Ireland, however these differ slightly from the NRS and NISRA calculated rates. The rates produced by the respective national agencies are used within this report, rather than ONS rates for Scotland and Northern Ireland.

Rates provided by the ONS for the UK, England, and Wales, and by ScotPHO for Scotland 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. All rates provided by NISRA are crude rates. For an explanation of these terms, see page 10.

Data sources – Republic of Ireland

Republic of Ireland data are provided by the Central Statistics Office for Ireland (CSO) upon request. CSO have provided provisional data for suicides in 2015, which is subject to future revision, and provided final data for suicides in 2013 and 2014.

Data for the Republic of Ireland are presented separately to UK data since there are fundamental differences between the definitions of suicide between these countries, which means the figures are not comparable.

Note: suicide rates per 100,000 for 2013 and 2014 differ from those reported in the 2016 edition of this report; CSO provided raw data rather than calculated rates in the previous year and our calculation methods differed. 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.

Local suicide data

ONS provides the number of suicides by Local Authority for England and Wales from 2002 to 2015, and age-standardised three-year aggregate suicide rates where the latest period is 2013–2015. These data can be downloaded from its [website](#).

Public Health England (PHE) has recently produced an online [Suicide Prevention Atlas](#), which maps data on suicide, related risk factors and related service contacts for every local authority in England, giving people important information to help them in their plans to prevent suicide. It also shows which local authorities have suicide prevention plans in place.

PHE also provides an [online Suicide Prevention Profile](#), which includes a range of publically available data on suicide (rates by regions, local authority and levels of deprivation), risk factors eg self-reported wellbeing and prisoner population, and service related local data among groups at increased risk such as self-harm hospital admissions. This tool allows 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 1985–2015 for NHS Boards and Local Authorities in Scotland, which can be downloaded from [its 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 1997–2015, 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 2001–2015. No rates per 100,000 are available for this local or deprivation data. These data can be downloaded from [its website](#).

Suicide definition

Suicide definition – UK

The UK definition of suicide in statistical terms can be found in Box 1. This is in line with guidance from the ONS on how a death is classified as suicide; NRS and NISRA also use this definition. This definition combines deaths where the underlying cause (according to the International Statistical Classification of Diseases, Injuries, and Causes of Death 10th Revision; ICD-10) is **intentional self-harm** (ICD10: X60-X84) and **events of undetermined intent** (ICD10: Y10-Y34). The inclusion of deaths of undetermined intent is a solution to the known under-reporting of suicide using only deaths from clearly intentional self-harm (see page 19 for further explanation).

Data for the UK from ONS, NISRA and NRS all relate to deaths **registered** (but not necessarily occurring) in a given year.

In England, Wales and Northern Ireland, a coroner is able to give a verdict of suicide for those as young as 10 years old. All ONS data is for persons aged 10 and over. In previous years, ONS have only provided suicide data for those 15 years and over, but in recent years have revised their data to include deaths of those aged 10 and over.

NISRA produce rates for those younger than 10 years, since there are self-inflicted deaths with undetermined intent recorded in those younger than 10 years in Northern Ireland. However, they produce rates for those aged

‘15 and under’ and do not break down the age groups within this for disclosure reasons. They modify the data presented to ensure that information can not be attributed to an individual.

ScotPHO does not present annual numbers or crude rates for ages 0-14 and 85+ in Scotland for reasons of robustness and comparability; as a higher proportion of probable suicide deaths in these extreme age groups are coded as events of undetermined intent. NRS does however provide rates for all age groups and rates for all persons, males and females are based on all ages.

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.

Coding changes in recent years

In 2011, ONS, NRS and NISRA adopted a change in the classification of deaths in line with the new coding rules of the World Health Organisation (WHO). The change results in some deaths previously coded under 'mental and behavioural disorders' now being classed 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 (Box 1 on page 15).

ONS only produce data using the new coding rules since the change (data since 2011). They note that 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 for each year since the change to reflect what figures would show using both the old and new coding rules. They note that, 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 the new coding rules since the change (data since 2011). Preliminary checks by NISRA 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.

* Explanation taken from ScotPHO website, updated August 2016; www.scotpho.org.uk/health-wellbeing-and-disease/suicide/key-points

Suicide definition – Republic of Ireland

The Republic of Ireland definition **does not include** deaths classified as **undetermined intent** as suicides; suicide numbers and rates include only deaths classified as **intentional self-harm** (ICD-10 codes X60-X84, see Box 1 on page 15). It would therefore be misleading to compare data for the Republic of Ireland directly with those for the UK. Data for suicides in the Republic of Ireland from CSO for **2015** relate to the number of deaths **registered** in that year, but data for **previous years** reflect deaths **occurring** in a calendar year; provisional data is published initially and subsequently updated to reflect the number of deaths that occur in a given year. CSO produce rate for all age groups.

The coding change adopted by UK agencies in 2011 does not affect Republic of Ireland data since their definition of suicide does not include deaths where the underlying cause is of undetermined intent.





Challenges with suicide statistics

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. We need to recognise the limitations with suicide mortality data so that we draw the right conclusions from data.

This section explores some of the challenges with collecting and reporting on suicide data.

The under-reporting of suicide

It is commonly acknowledged within the field of suicide research and prevention that official statistics underestimate the 'true' number (and, therefore, rate) of suicide. This is not only the case in the UK and the Republic of Ireland but in most (if not all) countries. There are various reasons and explanations for this under-reporting, which will be described in this section.

One of the main reasons for the under-reporting of suicide is the misclassification of deaths. This means that the cause of death is coded as something other than suicide. An example of this is where a coroner cannot establish whether there was intent by the individual to take their own life. Consequently, the cause of death may be recorded as one of

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 imperative⁷

'undetermined intent' or 'accidental'. This may occur in situations where the death involved a road traffic accident or is long-term illness. It could also be difficult to determine whether there was intent to die in situations of self-harm leading to suicide.

The difference in methods of suicide between males and females is discussed by many researchers historically: 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 females⁸.

It could also be suggested that the subjective nature of the coronial system can also lead to under-reporting. There may be many reasons that a coroner may classify a death as something other than suicide. A coroner should record a cause of death based on the principle of 'beyond doubt' as opposed to 'on the balance of probabilities'*. The coroner may not believe there is enough evidence to prove that suicide was the cause of death. There may be stigma attached to a death being reported as suicide. This could be particularly relevant for instances such as child deaths, or related to the socio-cultural norms of the individual, their family or community, or to cultural or religious taboos; eg suicide rates in Islamic communities seem to be very low, which may be attributed to under-reporting due to familial stigma^{9,10}. It has been suggested that in the UK, there continues to be a stigma attached to suicide from a time when it was a criminal offence. In some countries, it is still a criminal offence and so there may be even more stigma attached, and therefore more under-reporting of suicide.

In the UK, part of the solution to under-reporting has been to include 'deaths of undetermined intent' within the official statistical category of suicide (see page 15 for the definition of suicide based on cause of death codes). This attempts to correct known under-reporting and is thought to produce a more accurate total (and rate) of suicide in a given year. However, this may cause problems in the ability to compare suicide statistics across countries, some of which, eg Republic of Ireland, do not include this category in the official operational definition of suicide.

In England, Wales and Northern Ireland, narrative verdicts allow coroners to give a verdict that does not necessarily have to be restricted to one cause of death. A narrative account of the circumstances surrounding a death is given. This may eliminate some of the problems they face of trying to restrict a verdict to one "short form" code. However, when a narrative verdict is given, the statistical agencies (eg ONS) are still required to assign a code to the death in the usual way. The narrative accounts can still clearly state the intent of an individual, ie whether the death was accidental, but some do not – and if they do not they are regarded as "hard-to-code" narrative verdicts. These such deaths are subsequently coded as accidental, not undetermined intent³. These deaths are therefore not included in the UK count of suicide and may add further to the under-reporting problem.

The use of narrative verdicts varies considerably between coroners and regions. The use of narrative verdicts has the potential to impact on the reliability of suicide rates since, if lots of deaths which are likely to be suicides are given hard-to-code narrative verdicts, they will not be included in suicide figures. 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)³.

* Please note that coroners operate England, Wales and Northern Ireland but Scotland has an independent system. In Scotland Procurator Fiscals determine the cause of death and do not need to prove beyond doubt that a death is a suicide – they would record probable suicides and deaths from undetermined intent.

It is also important to note that suicide is not the only cause of death that suffers under-reporting through misclassification. While it would be unrealistic to expect death reporting to have no error, since it is, after all, a human process based in part on judgement, every effort should be made to make sure statistics are as accurate as possible.

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 (including suicide prevention) strategies. It is therefore important to assess 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. The reliability of statistics is obviously affected by the misclassification of deaths leading to under-reporting (see section above). There are several other additional factors that need to be considered. There is a lack of research into the reliability of suicide statistics and there is a tendency in international data to under-report suicide¹¹.

It has been suggested that there may be inconsistencies in coroners' processes to establish a cause of death and individual coroners may record deaths differently to others. For example, a coroner may decide not to give a statement of intent on the death registration in some situations, such as in the

deaths of children, possibly out of sympathy for the family or sensitivity to the cultural/religious beliefs of a family. Differences may also arise in situations that prove difficult for the coroner to establish one cause of death eg when chronic illness is a factor in the death or in road accidents where there may also have been suicidal intent. Such situations leave room for interpretation and subjectivity.

As well as the death registration processes being subject to interpretation and inconsistencies within a country, there are also likely to be inconsistencies between countries. There are different death registration processes across the UK nations. Therefore, it cannot be assumed that suicide statistics in one country are measuring the same phenomenon as those in another country.

Reliability is affected by the multiple definitions of suicide. Silverman¹² suggested that a decade ago, 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 subject¹³. 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. For example, the clinical and legal definitions of suicide differ; within a legal definition (used by coroners) there must be evidence that there was intent to take one's life, whereas a clinical definition is based on a less stringent concept of proof. ▶

Therefore, there may be under-reporting where there is insufficient evidence of suicide available to satisfy coronial requirements – but where researchers or clinicians would describe behaviours as suicidal. Of course, the inclusion of deaths of undetermined intent goes some way in accounting for this under-reporting as described in the previous section.

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. 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 would be reasonably constant over time. Therefore, differences in suicide trends between countries could be validly explored. Changes in rates and fluctuations may be valid if under-reporting remains stable over time¹⁴. In this way, suicide statistics will still give us valuable information about suicide over time and about different groups who may be at risk.

However, if statistics were systematically invalid and any group or set of circumstances were more prone to under-reporting or misclassification, we may continue to miss important risk factors or vulnerable groups over time.

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 previous section), but there may also be other group characteristics which are more subtle and missed for other reasons.

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 suicide¹⁵. 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.

It is also worth noting that, due to the human nature of registration and reporting and the complexity of suicidal behaviour and actions, it is inevitable that suicide statistics will never be completely reliable. It can be argued that this will always be the case¹⁴ – 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 information¹⁶.

Difficulties comparing suicide statistics

As has been mentioned in previous sections, there are some differences in the way different 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.

Consequently, 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 suicide¹⁴. 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 caution¹⁷. 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.

However, this document highlights the differences in the collection and presentation of suicide statistics across the UK and the Republic of Ireland. The difference in the operational definition of 'suicide' between the UK (all nations) and the Republic of Ireland (see pages 15–17) is the most obvious. Furthermore, even within the UK, the constituent nations' statistics are not directly comparable. For example, as a result of differences in the time taken to register a death in England and Wales compared to

Northern Ireland or Scotland, some annual figures reflect a truer picture of the occurrence of suicide than others³.

Some of the inconsistencies of data collection and reporting processes between nations, which lead to further confusion and challenges in use of these data, include:

- Differences in the process of reaching a death verdict, the use of narrative verdicts that are hard-to-code, and the processes for registering such deaths.
- Fundamental differences in the definitions of suicide and what suicide data represents; eg the inclusion/exclusion of deaths of undetermined intent, or whether data refers to deaths occurring or registered in a given year between UK and Republic of Ireland data.
- Multiple data sets are produced for individual nations by different agencies, leading to confusion as to which data sets are official; eg ONS reproduce rates for Scotland and Northern Ireland, which differ from those produced in these nations.
- Data are published by different age groupings, limiting comparability between countries.
- There are differences in the methods for calculating suicide rates and the rules for when rates can and cannot be reliably produced between countries.

Suicide in the UK - 2015

See Appendices 1 and 2 for full data tables including a breakdown of suicide by age groups. See page 23 for information about comparing suicide statistics between nations.

Table 1: Number of suicides in UK, 2015

	Overall	Male	Female
UK*	6,188	4,622	1,566
England	4,820	3,600	1,220
Wales	350	274	76
Scotland	672	476	196
Northern Ireland	318	245	73

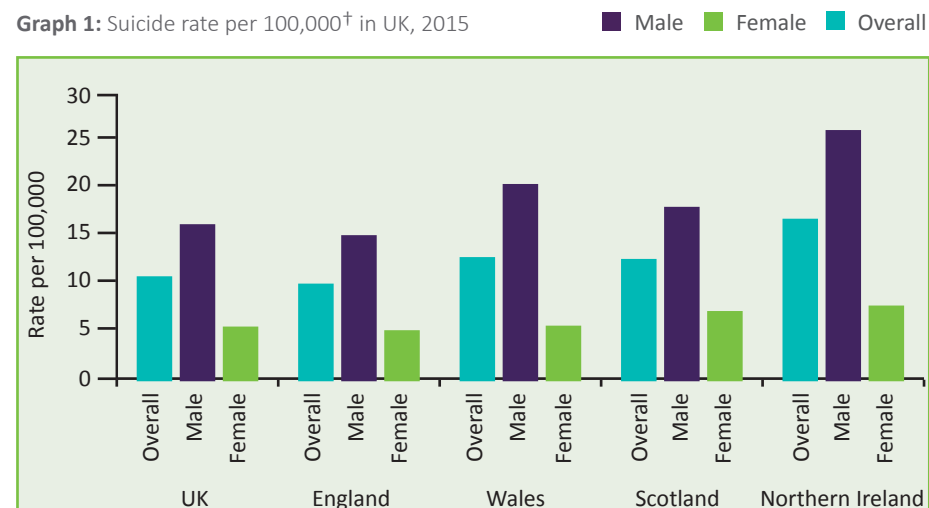
Table 1 shows that the highest number of suicides occurred in England for all persons, males and females. The lowest number of suicides for all persons, males and females occurred in Northern Ireland. There was a 1% increase in the number of suicides in the UK between 2014 and 2015.

Only looking at the number of suicides in a nation may be misleading as to where suicide is more prevalent. This is due to difference in population size. Rates per 100,000 are used to give a truer picture of where suicide is more prevalent – see Graph 1.

* Total number of deaths for the UK does not equal the sum of the constituent nations. This is due to ONS including the deaths of non-residents in the 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 UK, England, Wales, and Scotland are age standardised to the European Standard Population; Northern Ireland are crude rates.

Graph 1: Suicide rate per 100,000[†] in UK, 2015



Graph 1 shows:

- The highest suicide rate per 100,000 for all groups (males, females and for all persons) was in Northern Ireland.
- The lowest rates for all groups was in England.
- Across the UK, male suicide rates are consistently higher than female rates;
 - In Scotland, 2.6 times higher.
 - In UK as a whole, and in England, 3.1 times higher.
 - In Northern Ireland, 3.5 times higher.
 - In Wales, 3.8 times higher.

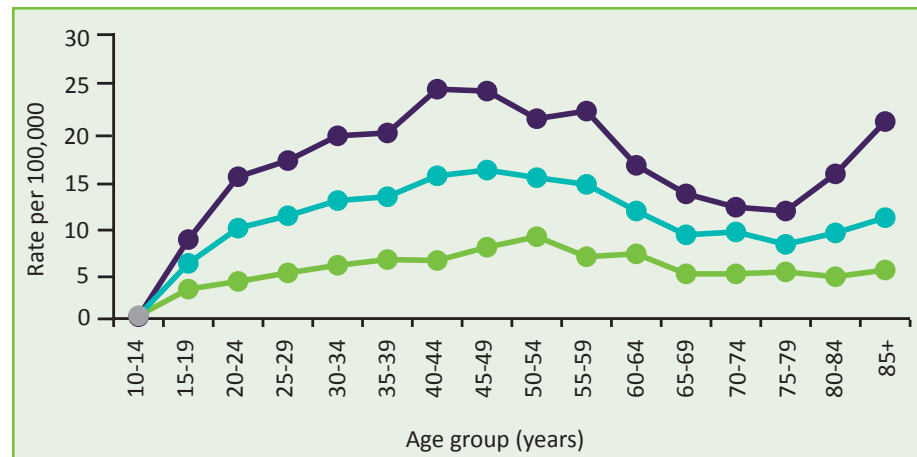
UK suicide by age group – 2015

Data presented in this section are of the suicide rate per 100,000 rather than the number of suicides in an age group.

See page 10 for an explanation of why rates, rather than numbers, are used. The number of deaths by age group, and full data tables with numerical rates can be found in the tables within Appendices 1 and 2.

Graph 2: Suicide rates in UK by age group, 2015

Male Female Overall

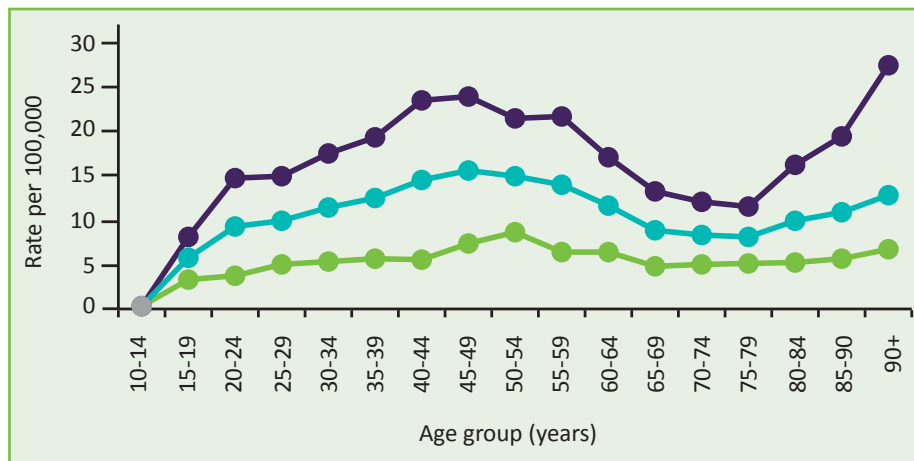


Graph 2 shows that in the UK:

- The age groups with the highest suicide rate per 100,000 are:
 - 45-49 years, for all persons
 - 40-44 years for males
 - 50-54 years for females.
- There is an indication of a slight bimodal distribution of suicide (where there are two peaks across the ages) with increases in both the mid-years and those aged over 85 years.
- Greyed out data points should be treated with caution – they indicate where ONS considers data to be unreliable due to the low number of deaths in these age groups; ie rates calculated from fewer than 20 deaths.

Graph 3: Suicide rates in England by age group, 2015

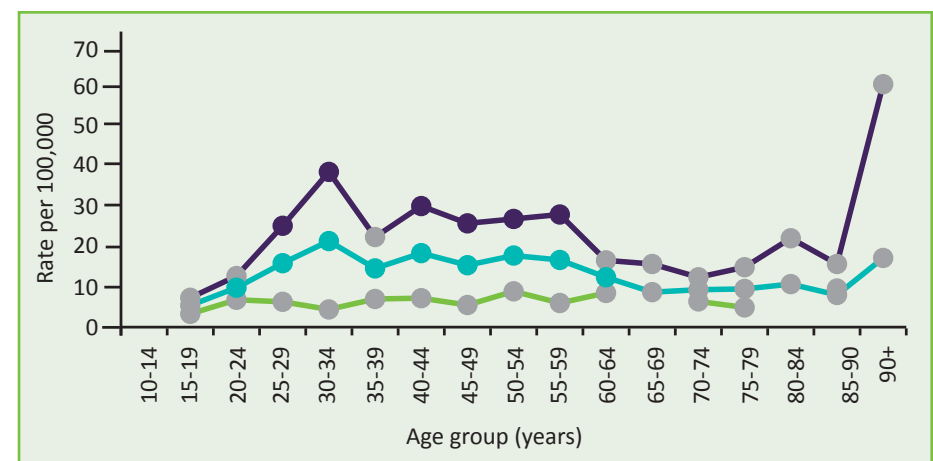
● Male ● Female ● Overall

**Graph 3 shows that in England:**

- The age groups with the highest suicide rate per 100,000 are:
 - 45-49 years, for all persons.
 - 90+ years for males, followed by 45-49 years – however, groups with small populations, such as older age groups, should be treated with caution as large fluctuations year on year and suddenly high rates can be observed which are not necessarily indicative of longer terms trends. If boarder age categories were used, the groups with the highest suicide rate for males would be seen in the mid years.
 - 50-54 years for females.
- There is an indication of a slight bimodal distribution of suicide (where there are two peaks across the ages) with increases in both the mid-years and those aged over 85 years. However, see note of caution in the point above. Greyed out data points should be treated with caution – they indicate where ONS considers data to be unreliable due to the low number of deaths in these age groups; ie rates calculated from fewer than 20 deaths. See notes on page 10 in *Understanding Suicide Statistics for information on rates within small populations.*

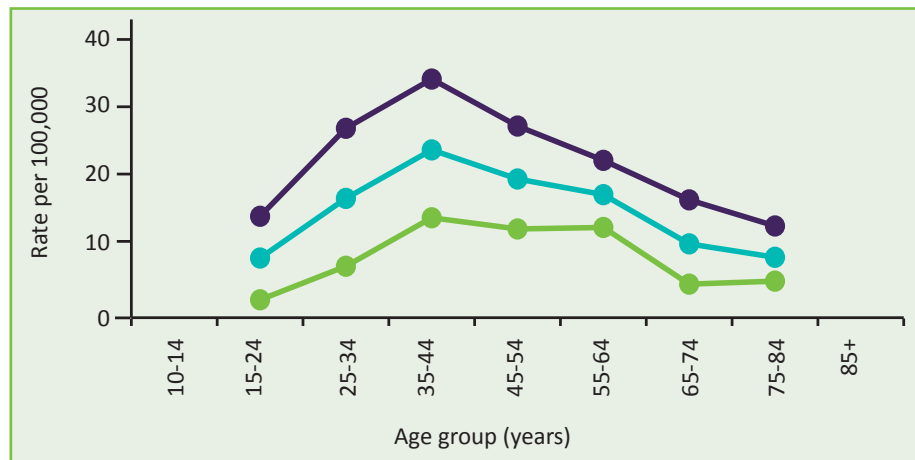
Graph 4: Suicide rates in Wales by age group, 2015

● Male ● Female ● Overall

**Graph 4 shows that in Wales:**

- The age groups with the highest suicide rate per 100,000 are:
 - 30-34 years, for all persons.
 - 30-34 years, for males.
- Greyed out data points should be treated with caution – they indicate where ONS considers data to be unreliable due to the low number of deaths in these age groups; ie rates calculated from fewer than 20 deaths. While it may appear that the male rate is highest among those aged 90 and over, this is likely to be because of the small population in that age group.
- No rate is provided for some groups; ONS do not produce a rate when there are fewer than three deaths in an age category. See notes on page 10 in *Understanding Suicide Statistics for information on rates within small populations.*

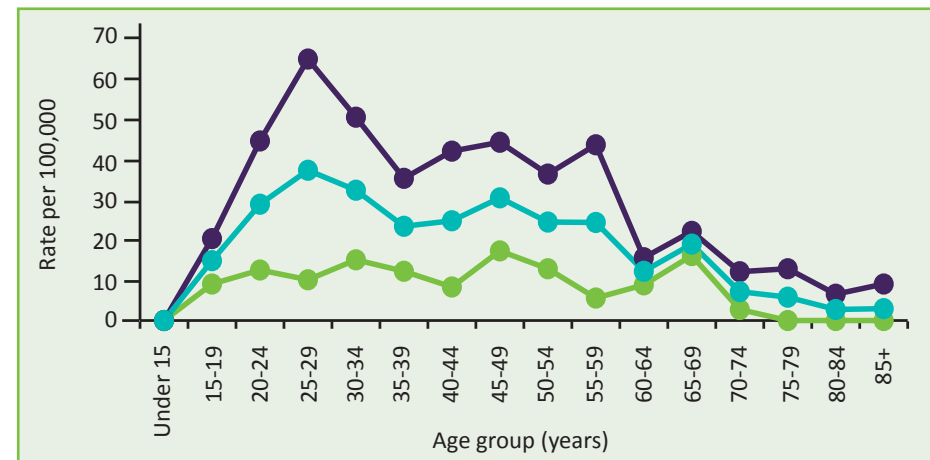
Graph 5: Suicide rates in Scotland by age group, 2015 ● Male ● Female ● Overall



Graph 5 shows that in Scotland:

- The age groups with the highest suicide rate per 100,000 are:
 - 35-44 years, for all persons, males and females.
- No rate is provided for the oldest and youngest age groups; ONS do not produce a rate when there are fewer than three deaths in an age category. ScotPHO do not produce a rate per 100,000 for these groups "for reasons of robustness and comparability, as a higher proportion of probable suicide deaths in these extreme age groups are coded as events of undetermined intent". See notes on page 10 in *Understanding Suicide Statistics for information on rates within small populations.*

Graph 6: Suicide rates in Northern Ireland by age group, 2015 ● Male ● Female ● Overall



Graph 6 shows that in Northern Ireland:

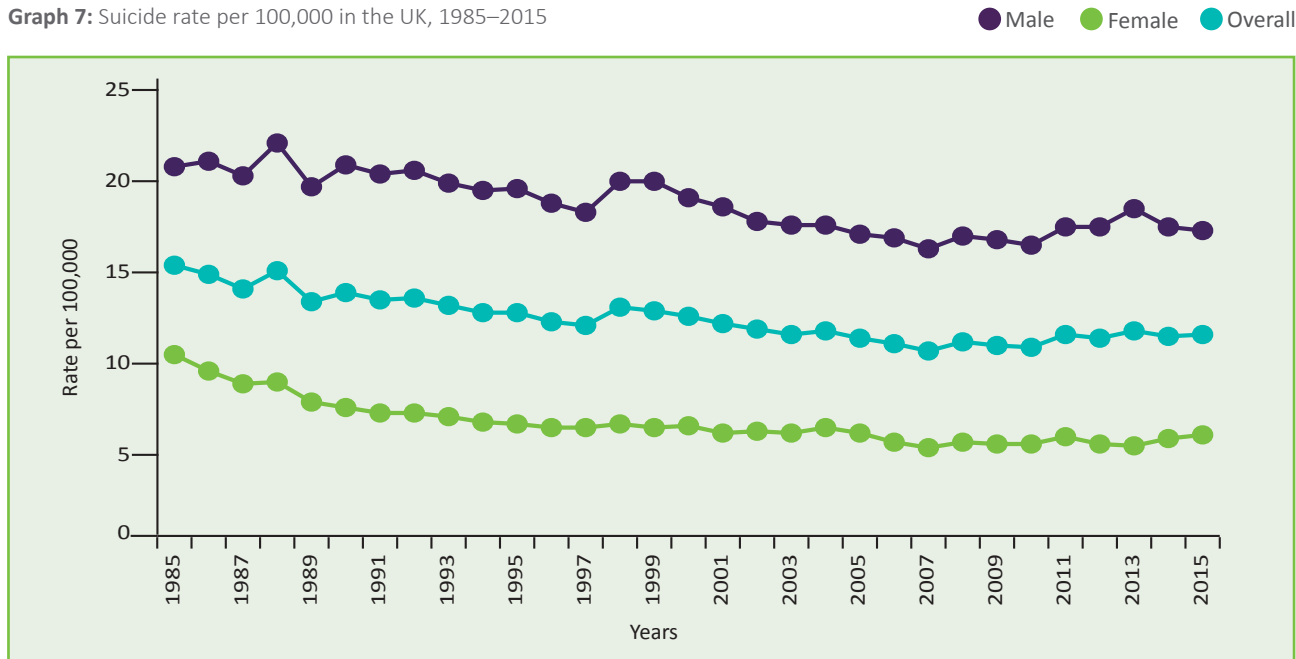
- The age groups with the highest suicide rate per 100,000 are:
 - 25-29 years, for all persons and males.
 - 45-49 years, for females.
- Among the three groups there is an indication of a bimodal age distribution (where there are two 'modes'/peaks in the distribution across the ages), with a second peak around 65-69 years.

UK suicide rates – trends over time

This section provides a narrative description of the suicide trends for the UK and each nation over the last thirty years (1985–2015). Commentary of percentage change for each set of data is based on rates, rather than numbers, which is calculated by Samaritans where this has not been provided by the statistical agencies.

Commentary next to graphs regarding significance of changes in rates has been taken directly from the statistical agencies' publications for each nation's suicide data, and is not calculated by Samaritans.

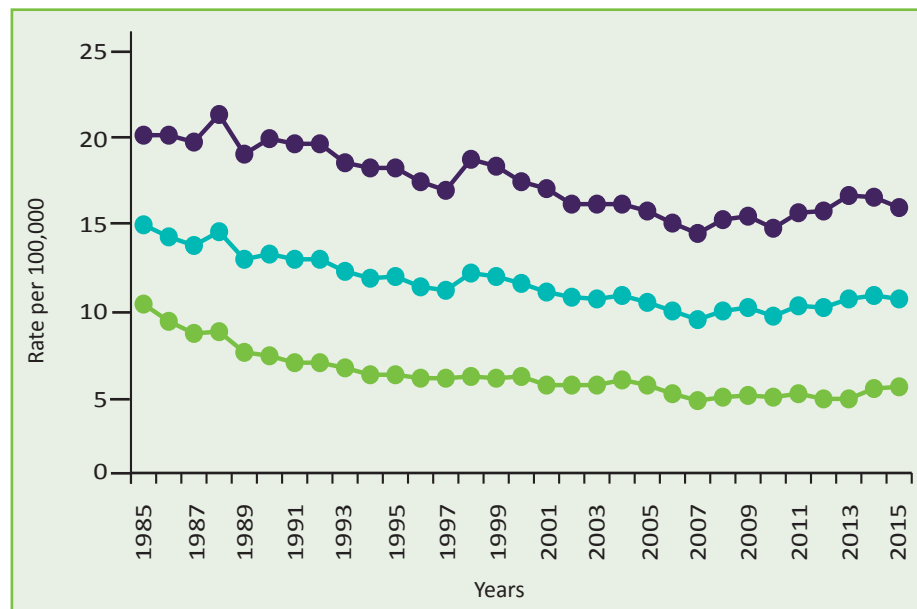
Graph 7: Suicide rate per 100,000 in the UK, 1985–2015



Graph 7 shows, in the UK:

- There has been a decreasing trend in the UK suicide rate until around 2007. Since then, there has been a general increase in rates.
- There was a 0.9% increase in the overall suicide rate between 2014 and 2015; this was driven by the increase in female suicide rates.
- Male trend:** Similar to the overall trend, the male suicide rate shows a general decrease until 2007, and a subsequent increase but the most recent year of data shows that male suicide in the UK decreased for a second year, by 1.2% between 2014 and 2015.
- Female trend:** The UK female rate significantly decreased between 1983 and 2007 and has remained relatively constant since then with yearly fluctuations in 2011 and 2015. In 2015 the female suicide rate increased, for the second year, by 3.8% since 2014 and is now the highest rate in a decade.

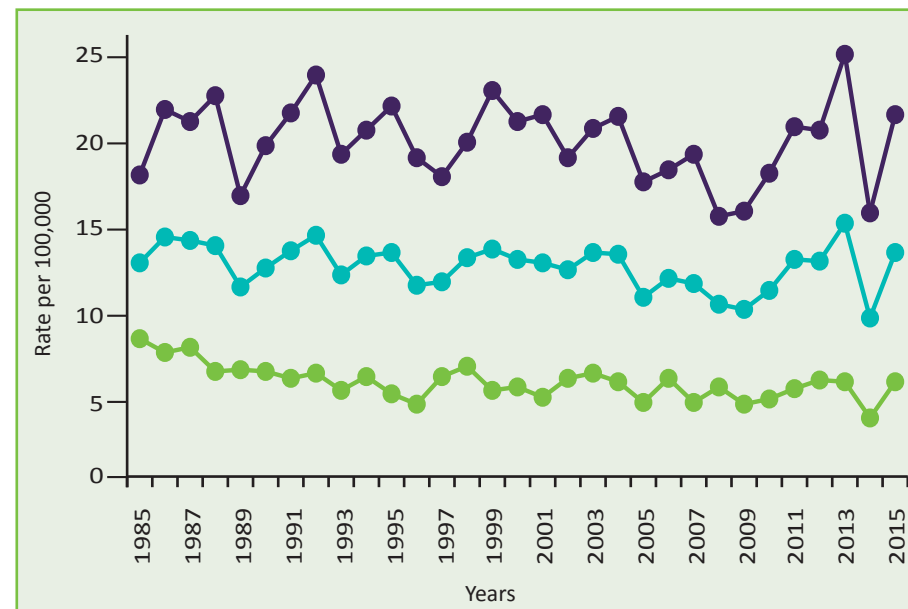
Graph 8: Suicide rate per 100,000 in England, 1985–2015 ● Male ● Female ● Overall



Graph 8 shows, in England:

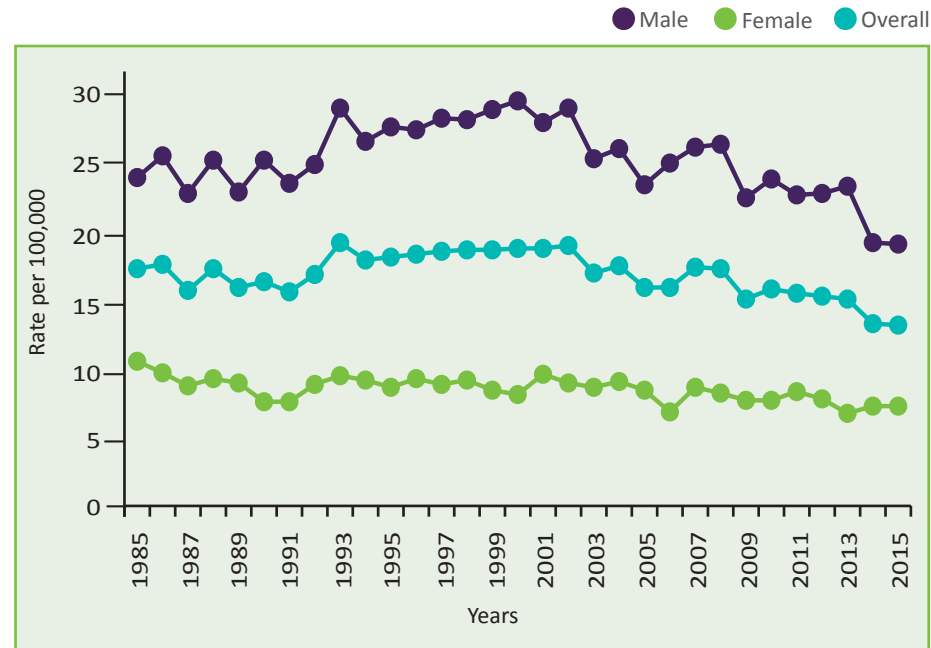
- There has been a general decrease in suicide over the last 30 years, but there has been a small rise in the last 10 years.
- There was an overall decrease of 1.9% between 2014 and 2015.
- Male trend:** The male suicide rate has also generally decreased over the last 30 years. However, the increase in the last decade in the England suicide rate is driven by the male suicide rate increase in this period. The overall rate for England tends to mirror the male trend due to the high proportion of male suicides. The male rate decreased by 3.8% between 2014 and 2015.
- Female trend:** The female suicide rate in England has seen a general decrease over the last 30 years, and has remained relatively constant over the last decade and has approximately halved since 1985. However, the most recent data show there was an increase for the second year, by 2% between 2014 and 2015, the highest female rate in a decade.

Graph 9: Suicide rate per 100,000 in Wales, 1985–2015 ● Male ● Female ● Overall



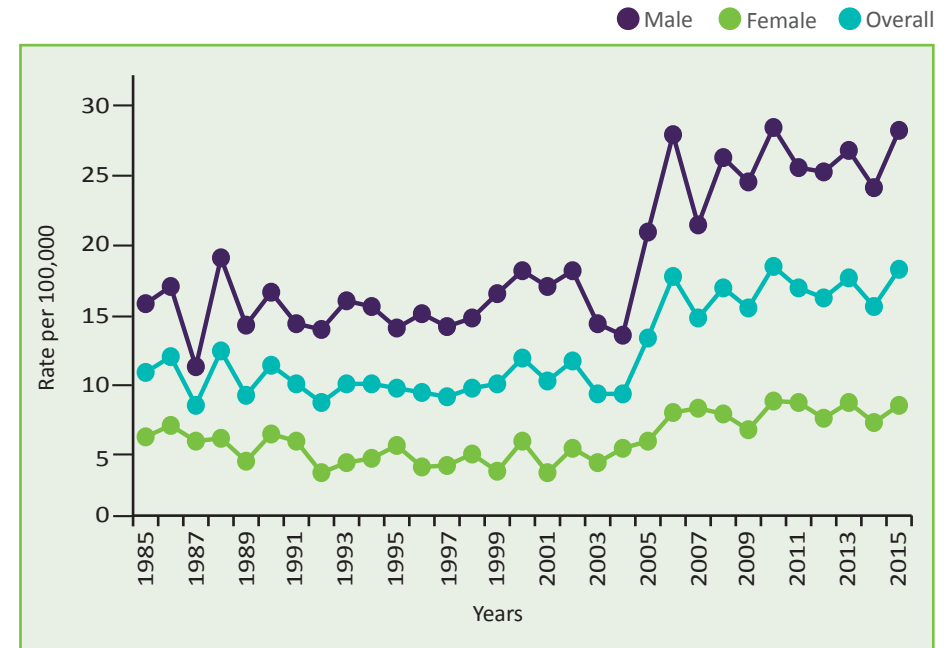
Graph 9 shows, in Wales:

- There has been an overall increase over the last 30 years, with the overall rate slightly higher in 2015 than in 1985.
- There are large fluctuations in 2013-2014 and 2014-2015 data – showing a sharp decrease one year and a subsequent sharp increase the following year. ONS note that this could be due to a higher proportion of suicides occurring in previous years, but registered in 2015 than previous years, and also the decrease in use of hard-to-code narrative verdicts in Wales since 2014. This demonstrates why it is useful to look at trends over time as well as year on year fluctuations, since they might be misleading and longer periods of data show more accurate trends.
- Male trend:** Over the last thirty years there has been a general increase in suicide with notable fluctuations. The are obvious fluctuations in the latest available data, which may be explained as noted above, however the data also show a trend of increase since around 2008.
- Female trend:** Female suicide in Wales has decreased over the last thirty years. However, in line with the male trend, there has been a period of general increase since 2008, with the exception of the notable fluctuations which could be explained as noted.

Graph 10: Suicide rate per 100,000 in Scotland, 1985–2015***Graph 10 shows, in Scotland:**

- There has been an overall decrease in suicide over the last 30 years with a fairly steep decline from 2009, and a more subtle decrease in the most recent data.
- Between 2014 and 2015 there was a decrease of 0.8% overall.
- Male trend:** The male rate showed a general increase during the 1990s, little change during the 1990s and a decrease since about 2000. The most recent year of data shows that there was a 0.5% decrease in male suicide between 2014 and 2015.
- Female trend:** The female rate has gradually decreased over the 30 year period, with less fluctuation than the male rates. The female rate has remained stable in the latest year of data, between 2014 and 2015.

* Data in Graph 10 only includes deaths coded using 'old-rules' (see notes in UK suicide definition section, page 15). This is because data using 'new-rules' for 2011 to 2015 is not directly comparable to the previous years' data and, as advised by ScotPHO, 'old rules' data should be used when making comparisons over time.

Graph 11: Suicide rate per 100,000 in Northern Ireland, 1985–2015**Graph 11 shows, in Northern Ireland:**

- There has been a general increase in the overall rate since 1985, with significant fluctuations and a marked increase around 2006. These fluctuations have continued in recent years and the suicide rate is currently at a record high following an increase of 17.8% between 2014 and 2015. ONS note that this increase could be due to longer registration delays; it was taking longer than usual for a death to be registered and therefore more deaths which occurred in 2014 were registered (and therefore appear in the data for) 2015.
- Male trend:** The male suicide rate has increased by 82% over the last 30 years, and the latest available data shows an increase of 17.5% between 2014 and 2015. However, this increase should be treated with caution as noted above, as the delays in registering suicides may account in part for the increase.
- Female trend:** There has also been a general increase in female suicide over the last 30 years, but less severe than in males. There was a general decrease until around 2003, but rates have been increasing steadily since then with some fluctuations. Between 2014 and 2015, there was a 18.5% increase in the female suicide rate. However, this increase should be treated with caution as noted above, as the delays in registering suicides may account in part for the increase.

Suicide in the Republic of Ireland – 2015

The data for suicide in the Republic of Ireland is presented in a separate section because these statistics are not comparable to those for the UK. For a full explanation of the reasons for this, please see the information on page 9.

For full data tables see Appendices 3 and 4.

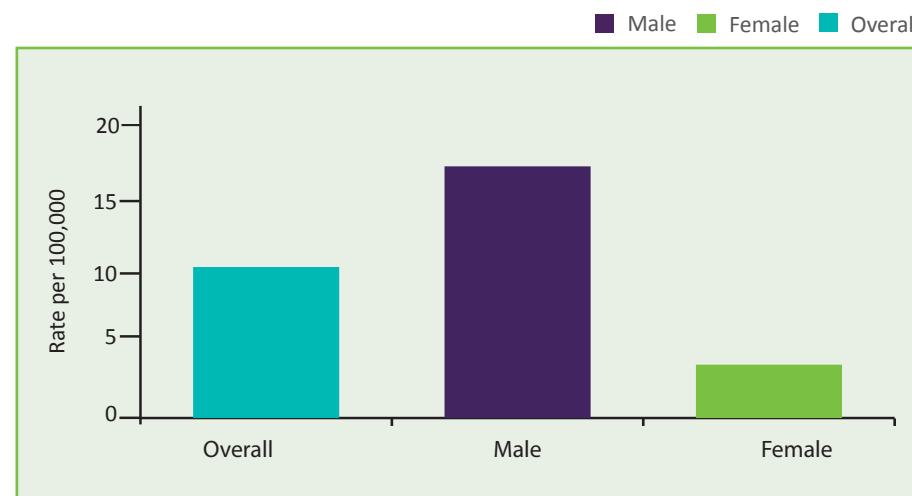
Table 2: Number of suicides in Republic of Ireland, 2015 (provisional*)

	Overall	Male	Female
Republic of Ireland	451	375	76

Table 2 shows that the highest number of suicides occurred in males, with approximately four times as many male as female suicides.

Looking only at the number of suicides in a nation may be misleading because it ignores the size of the groups at risk. Rates per 100,000 are used to give a more accurate picture of differences between groups – see Graph 12.

Graph 12: Suicide rates per 100,000 in Republic of Ireland, 2015



Graph 12 shows, in Republic of Ireland:

- The suicide rate among males is more than 5 times higher than the rate among females.

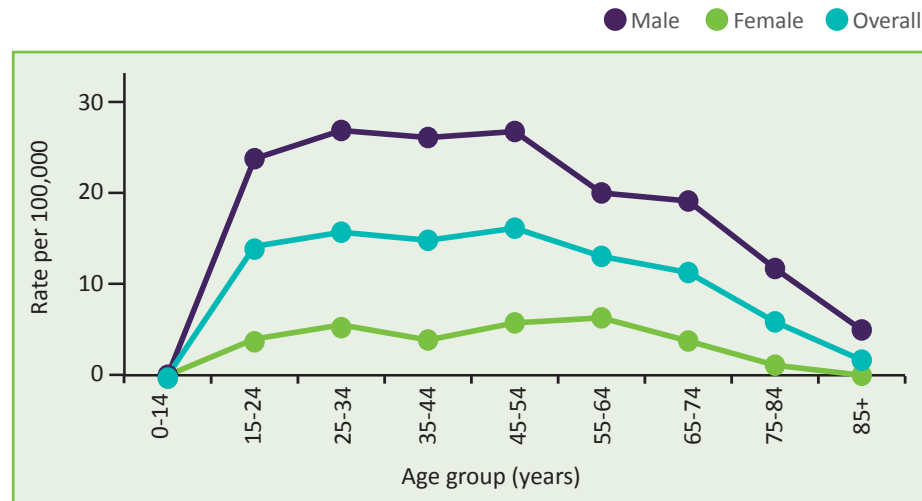
* Data will be finalised in subsequent years; provisional data reflects the suicides registered in 2015, final data will reflect the suicides that occur in that year.

Republic of Ireland suicide by age group - 2015

Data in this section are of the suicide rate per 100,000, rather than the number of suicides in an age group; looking at the number of suicides may be misleading due to differences in population sizes. Rates are used to give a truer picture of the groups in which suicide is more prevalent.

The number of deaths by age group, and full data tables with numerical rates can be found in the tables within Appendices 3 and 4.

Graph 13: Suicide rates in Republic of Ireland by age group, 2015



Graph 13 shows, in the Republic of Ireland:

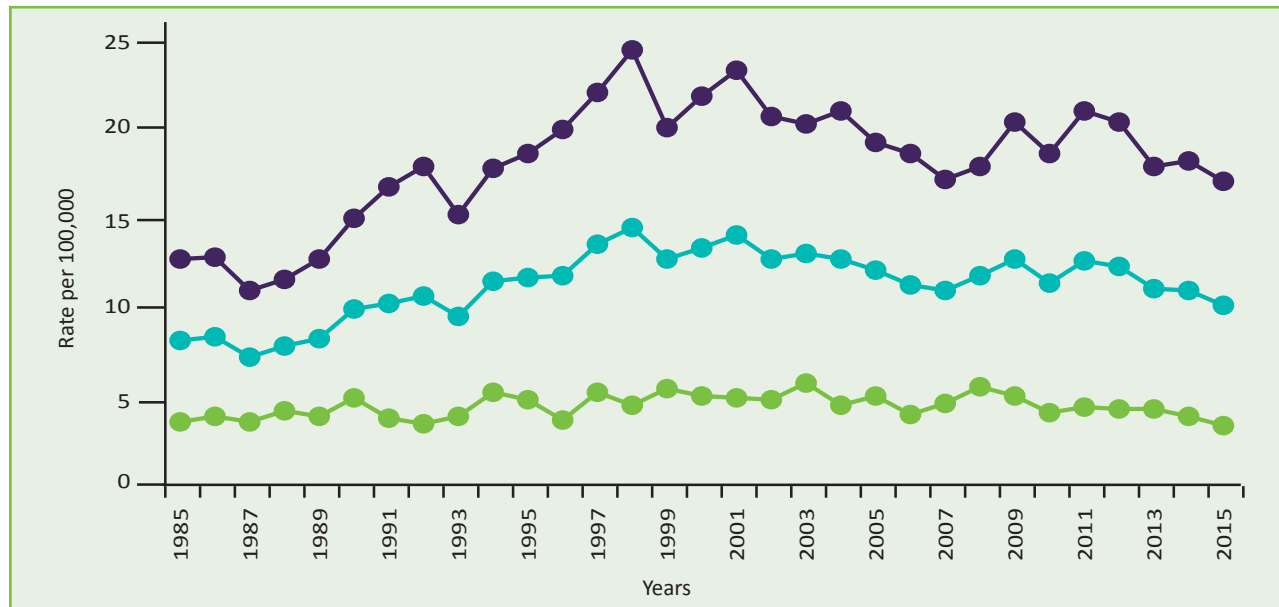
- The age groups with the highest suicide rate per 100,000 are:
 - 45-54 years, for all persons.
 - 25-34 years (very similar to 45-54 years; 0.1 difference), for males.
 - 55-64 years, for females.

Republic of Ireland suicide rates – trends over time

This section provides a narrative description of the trends in suicide for the Republic of Ireland over the last thirty years (1985-2015). Commentary of percentage change is based on rates, rather than numbers and is calculated by Samaritans.

Graph 14: Suicide rate per 100,000 in Republic of Ireland, 1985–2015

● Male ● Female ● Overall



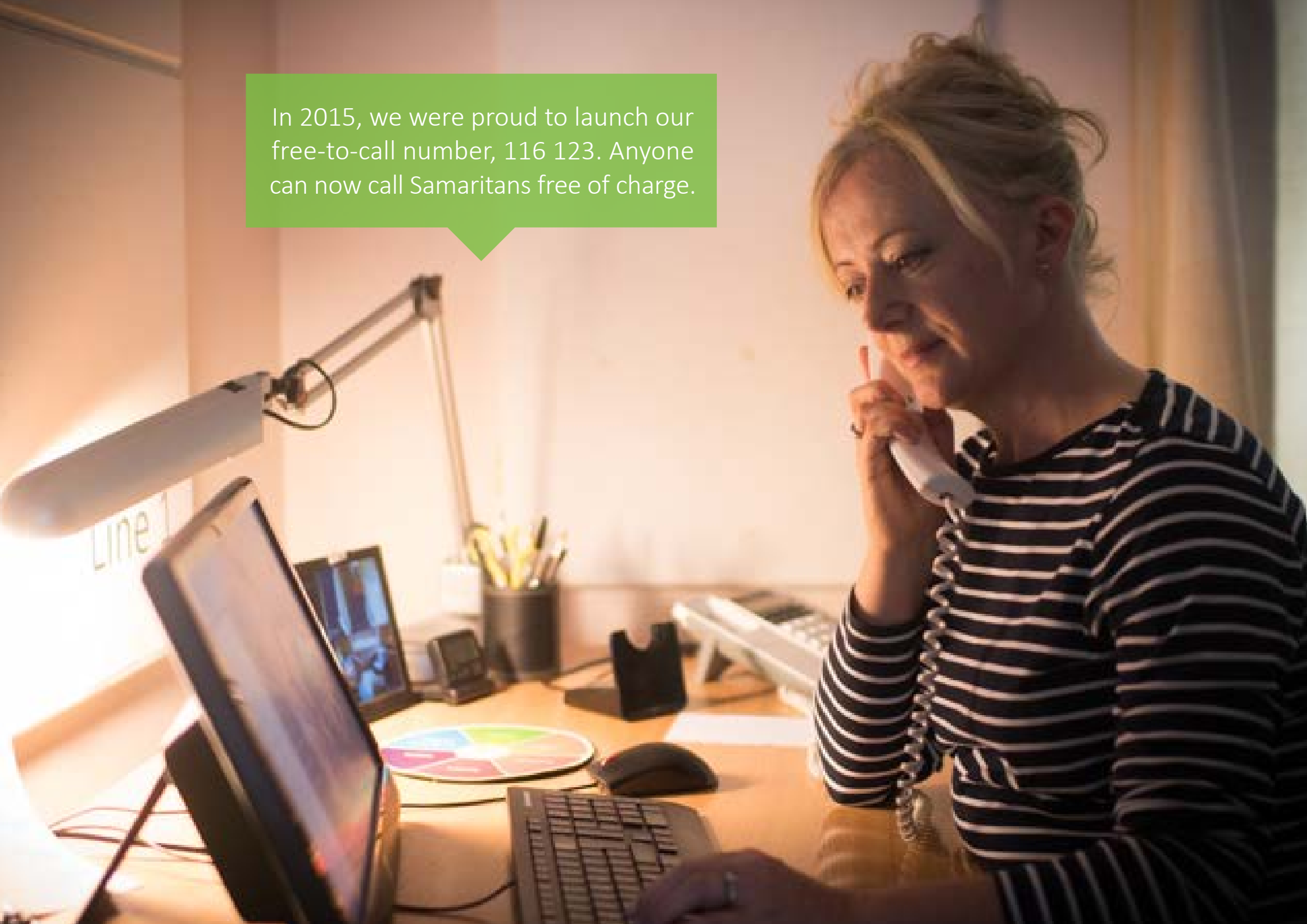
Graph 14 shows, in the Republic of Ireland:

- There has been a general increase in suicide over the last 30 years.
- There was an increase until the late 1990s, and since then there has been a declining trend. After a period of fluctuation, the Republic of Ireland suicide rate has been decreasing since 2011. The overall suicide rate in the Republic of Ireland is at its lowest since 1993 and between 2014 and 2015, there was a decrease of 8%.
- Male trend:** The male suicide rate increased to a peak in 1998, since then it has decreased with some fluctuations. The male suicide rate has decreased by 6.4% between 2014 and 2015.
- Female trend:** The female suicide rate has remained relatively stable over the last 30 years, and is currently at its lowest rate. The highest rate was seen in 2003.

References

1. Samaritans. Working together to reduce suicide: Samaritans strategy 2015–2021. www.samaritans.org/about-us/our-organisation/our-strategy, updated 2015.
2. Sun BQ, Zhang J. Economic and sociological correlates of suicides: Multilevel analysis of the time series data in the united kingdom. *J Forensic Sci.* 2016.
3. ONS. Suicides in the United Kingdom, 2015 registrations. Office for National Statistics. 2016.
4. NRS. Probable suicides: Deaths which are the result of intentional self-harm or events of undetermined intent. www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/suicides, updated 2016.
5. ScotPHO. Suicide: Key points. www.scotpho.org.uk/health-wellbeing-and-disease/suicide/key-points, updated 2016.
6. NISRA. Suicide deaths. www.nisra.gov.uk/publications/suicide-statistics, updated 2016.
7. World Health Organization. Preventing suicide: A global imperative. World Health Organization; 2014.
8. Cantor CH, Leenaars Aa, Lester D. Under-reporting of suicide in Ireland 1960–1989. *Arch Suicide Res.* 1997;3(1):5-12.
9. De Leo D. Cross-cultural research widens suicide prevention horizons. *Crisis.* 2009;30(2):59-62.
10. De Leo D. Struggling against suicide: The need for an integrative approach. *Crisis.* 2002;23(1):23-31.
11. Tøllefsen IM, Hem E, Ekeberg Ø. The reliability of suicide statistics: A systematic review. *BMC Psychiatry.* 2012;12(1):1.
12. Silverman MM. The language of suicidology. *Suicide and Life-Threatening Behavior.* 2006;36(5):519-532.
13. Silverman MM. Challenges to defining and classifying suicide and suicidal behaviors. *The International Handbook of Suicide Prevention.* 2016:11.
14. Sainsbury P, Jenkins J. The accuracy of officially reported suicide statistics for purposes of epidemiological research. *J Epidemiol Community Health.* 1982;36(1):43-48.
15. Franklin JC, Ribeiro JD, Fox KR, et al. Risk factors for suicidal thoughts and behaviors: A meta-analysis of 50 years of research. 2016.
16. Goldney RD. A note on the reliability and validity of suicide statistics. *Psychiatry, Psychology and Law.* 2010;17(1):52-56.
17. Gjertsen F. Head on into the mountainside—accident or suicide? about the reliability of suicide statistics. *Suicidologi.* 2000;5:18-21.

In 2015, we were proud to launch our free-to-call number, 116 123. Anyone can now call Samaritans free of charge.



Appendix 1: Rate per 100,000 of deaths by suicide* in the UK, 2013–2015

Table 3: UK suicide rates for all persons, males and females and by age group, 2013–2015

UK	2013			2014			2015		
Rate per 100,000 for persons aged 10+	Overall 11.1	Male 17.8	Female 4.8	Overall 10.8	Male 16.8	Female 5.2	Overall 10.9	Male 16.6	Female 5.4
Rate per 100,000 by age group (years)	Overall	Male	Female	Overall	Male	Female	Overall	Male	Female
10-14	0.3†	0.3†	0.2†	0.4†	0.4†	0.3†	0.3†	0.2†	0.3†
15-19	4.4	7.0	1.6	4.9	7.0	2.7	5.8	8.3	3.1
20-24	9.0	14.3	3.5	9.2	13.7	4.5	9.5	14.9	3.9
25-29	9.6	15.9	3.4	10.5	16.5	4.6	10.8	16.6	4.8
30-34	12.2	19.5	4.9	11.4	17.9	5.0	12.4	19.2	5.6
35-39	15.4	23.6	7.2	13.2	20.1	6.4	12.8	19.5	6.2
40-44	16.7	26.9	6.7	16.2	25.7	7.0	15.0	24.1	6.1
45-49	17.1	26.8	7.7	16.8	26.5	7.3	15.6	23.9	7.5
50-54	15.7	24.7	6.9	16.4	24.9	8.0	14.8	21.0	8.6
55-59	14.8	23.3	6.4	12.8	19.5	6.3	14.1	21.8	6.5
60-64	11.2	18.4	4.2	10.1	15.4	5.0	11.3	16.1	6.8
65-69	7.7	11.5	4.0	8.1	12.2	4.3	8.8	13.1	4.7
70-74	8.0	13.0	3.5	8.5	12.9	4.6	8.0	11.7	4.7
75-79	7.8	12.3	4.0	8.1	13.1	4.0	7.8	11.3	4.9
80-84	8.8	14.4	4.7	8.4	14.3	4.1	9.0	15.2	4.4
85+	11.2	22.6	5.5	9.6	17.1	5.7	10.6	20.7	5.1

† 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 15.

Table 4: England suicide rates for all persons, males and females and by age group, 2013–2015

England	2013			2014			2015		
Rate per 100,000 for persons aged 10+	Overall 10.1	Male 16.1	Female 4.3	Overall 10.3	Male 16.0	Female 4.9	Overall 10.1	Male 15.4	Female 5.0
Rate per 100,000 by age group (years)	Overall	Male	Female	Overall	Male	Female	Overall	Male	Female
10-14	0.2 [†]	0.3 [†]	--	0.2 [†]	0.2 [†]	0.3 [†]	0.3 [†]	0.3 [†]	0.3 [†]
15-19	3.8	6.0	1.4	4.4	6.1	2.5	5.4	7.6	3.1
20-24	8.0	12.8	3.2	8.6	12.9	4.1	8.7	13.8	3.5
25-29	8.5	14.1	2.9	9.4	14.9	3.8	9.3	14.0	4.7
30-34	10.2	16.2	4.3	10.6	16.6	4.6	10.7	16.4	5.0
35-39	13.4	20.7	6.2	11.7	17.8	5.7	11.7	18.1	5.3
40-44	14.9	24.3	5.7	15.1	24.1	6.3	13.6	22.0	5.2
45-49	15.0	23.4	6.9	16.0	25.3	6.8	14.6	22.4	6.9
50-54	14.7	23.3	6.2	16.0	24.7	7.6	14.0	20.1	8.1
55-59	13.5	21.2	5.8	12.5	19.2	6.0	13.1	20.3	6.0
60-64	10.4	17.2	3.9	10.0	15.2	5.0	10.9	16.0	6.0
65-69	7.4	11.3	3.6	8.1	12.1	4.3	8.3	12.4	4.5
70-74	7.3	11.6	3.3	8.2	11.9	4.8	7.8	11.3	4.7
75-79	7.7	11.8	4.2	8.3	13.0	4.3	7.6	10.8	4.8
80-84	8.7	13.8	4.9	9.1	15.0	4.6	9.3	15.2	4.9
85-90	11.9	23.0	5.4	10.4	18.2	5.8	10.2	18.2	5.3
90+	10.4	22.8	5.6	8.9	15.5	6.3	12.0	25.7	6.3

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

Table 5: Wales suicide rates for all persons, males and females and by age group, 2013–2015

Wales	2013			2014			2015		
Rate per 100,000 for persons aged 15+	Overall 12.5	Male 20.1	Female 5.6	Overall 14.7	Male 24.5	Female 5.5	Overall 13.0	Male 21.0	Female 5.5
Rate per 100,000 by age group (years)	Overall	Male	Female	Overall	Male	Female	Overall	Male	Female
10-14	--	--	--	--	--	--	--	--	--
15-19	4.1 [†]	6.0 [†]	--	5.7 [†]	11.1 [†]	--	5.4 [†]	7.3 [†]	3.3 [†]
20-24	9.3	13.6 [†]	4.7 [†]	11.9	18.8	4.7 [†]	9.8	12.7 [†]	6.8 [†]
25-29	11.3	20.2 [†]	--	10.1 [†]	14.6 [†]	5.4 [†]	15.9	25.2	6.3 [†]
30-34	24.2	38.4	10.1 [†]	19.8	30.9	8.8 [†]	21.4	38.6	4.4 [†]
35-39	17.9	31.6	4.6 [†]	20.9	36.1	5.9 [†]	14.6	22.4 [†]	7.0 [†]
40-44	16.7	29.3	4.7 [†]	22.5	38.0	7.7 [†]	18.4	30.1	7.2 [†]
45-49	17.2	26.8	8.0 [†]	26.4	46.5	7.1 [†]	15.4	25.8	5.5 [†]
50-54	12.1	17.7 [†]	6.6 [†]	16.1	25.1	7.5 [†]	17.8	26.9	8.9 [†]
55-59	13.3	18.4 [†]	8.3 [†]	20.0	33.3	7.2 [†]	16.7	28.0	6.0 [†]
60-64	14.3	19.8 [†]	9.1 [†]	13.7	24.7	3.1 [†]	12.4	16.6 [†]	8.5 [†]
65-69	9.9 [†]	14.7 [†]	5.4 [†]	9.5 [†]	8.6 [†]	10.4 [†]	8.7 [†]	15.7 [†]	--
70-74	7.3 [†]	12.2 [†]	--	12.8 [†]	22.2 [†]	4.1 [†]	9.3 [†]	12.4 [†]	6.4 [†]
75-79	12.7 [†]	17.8 [†]	8.4 [†]	7.1 [†]	13.5 [†]	--	9.5 [†]	14.9 [†]	4.9 [†]
80-84	8.7 [†]	14.8 [†]	--	14.7 [†]	32.0 [†]	--	10.7 [†]	22.1 [†]	--
85-89	14.1 [†]	27.9 [†]	--	6.1 [†]	--	--	8.0 [†]	15.7 [†]	--
90+	14.6 [†]	41.8 [†]	--	18.0 [†]	40.1 [†]	--	17.2 [†]	60.4 [†]	--

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

Table 6: Scotland suicide rates for all persons, males and females and by age group, 2013–2015

Scotland	2013			2014			2015		
Rate per 100,000 for all persons	All 15.2	Male 23.7	Female 6.7	All 13.3	Male 19.3	Female 7.2	All 12.8	Male 18.5	Female 7.1
Rate per 100,000 by age group (years)	All	Male	Female	All	Male	Female	All	Male	Female
0-14	--	--	--	--	--	--	--	--	--
15-24	9.6	15.1	4.1	9.7	13.2	6.2	8.0	13.6	2.4
25-34	20.8	34.6	7.4	14.9	20.9	9.0	16.0	25.4	6.9
35-44	26.3	40.8	12.5	24.6	36.7	13.0	22.5	32.0	13.4
45-54	24.1	37.7	11.2	22.6	32.8	12.9	18.6	25.7	11.9
55-64	17.9	28.4	8.0	13.4	19.9	7.3	16.5	21.1	12.1
65-74	9.8	15.0	5.1	10.1	16.2	4.6	9.9	15.8	4.5
75-84	8.3	14.3	3.9	6.9	12.5	2.7	8.1	12.3	4.9
85+	--	--	--	--	--	--	--	--	--

Source: ScotPHO. New coding rules for all years, see page 16.

Table 7: Northern Ireland suicide rates for all persons, males and females and by age group, 2013–2015

Northern Ireland	2013			2014			2015		
Rate per 100,000 for all persons	Overall 16.6	Male 25.5	Female 7.9	Overall 14.6	Male 22.9	Female 6.5	Overall 17.2	Male 26.9	Female 7.7
Rate per 100,000 by age group (years)	Overall	Male	Female	Overall	Male	Female	Overall	Male	Female
Under 15	0.6	0.5	0.6	0.8	1.6	-	0.0	0.0	0.0
15-19	10.6	17.4	3.3	12.3	19.1	5.1	14.1	19.3	8.6
20-24	20.5	30.7	9.9	22.2	34.1	10.0	27.4	42.3	11.9
25-29	18.5	32.6	4.8	24.1	40.6	8.0	35.4	61.6	9.6
30-34	23.6	40.3	7.9	28.4	51.5	6.3	30.7	47.9	14.3
35-39	32.0	46.1	18.5	26.0	41.1	11.8	22.2	33.5	11.6
40-44	30.5	40.0	21.4	18.3	26.1	10.9	23.5	39.9	7.9
45-49	30.7	44.2	17.7	23.4	35.4	11.8	28.9	42.0	16.4
50-54	25.1	37.7	12.8	20.6	28.9	12.5	23.2	34.5	12.2
55-59	19.8	30.3	9.4	9.2	9.2	9.1	23.1	41.4	5.3
60-64	21.4	34.5	8.5	18.0	25.6	10.5	11.6	14.8	8.4
65-69	8.0	16.7	-	9.1	16.5	2.2	18.0	21.0	15.3
70-74	10.3	18.8	2.8	7.1	15.0	-	6.8	11.5	2.6
75-79	7.6	12.8	3.4	11.1	16.5	6.7	5.5	12.2	0.0
80-84	5.3	6.6	4.4	2.6	6.4	-	2.6	6.2	0.0
85+	9.1	26.5	-	4.5	12.8	-	2.8	8.6	0.0

Source: NISRA

Appendix 2: Number of deaths by suicide* in the UK, 2013–2015

Table 8: UK suicide numbers for all persons, males and females and by age group, 2013–2015

UK	2013			2014			2015		
Number of deaths for persons aged 10+	Overall 6,242	Male 4,863	Female 1,379	Overall 6,122	Male 4,630	Female 1,492	Overall 6,188	Male 4,622	Female 1,566
Number of deaths by age group (years)	Overall	Male	Female	Overall	Male	Female	Overall	Male	Female
10-14	9	5	4	13	7	6	10	4	6
15-19	170	139	31	188	138	50	221	164	57
20-24	388	313	75	396	301	95	408	326	82
25-29	419	345	74	463	363	100	478	371	107
30-34	527	420	107	496	387	109	543	419	124
35-39	611	467	144	527	399	128	524	396	128
40-44	749	597	152	713	558	155	646	513	132
45-49	802	620	182	784	610	174	721	545	176
50-54	682	530	152	730	549	181	674	474	200
55-59	555	433	122	493	370	123	557	426	131
60-64	396	320	76	355	265	90	396	276	121
65-69	268	196	72	290	211	79	317	230	87
70-74	203	156	47	224	161	63	219	152	67
75-79	163	117	46	174	128	46	169	112	57
80-84	136	94	42	132	95	37	143	103	40
85+	164	111	53	144	88	56	161	110	51

* Suicide as defined by the Office for National Statistics – for coding and definition see Box 1, page 15.

Table 9: England suicide numbers for all persons, males and females and by age group, 2013–2015

England	2013			2014			2015		
Number of deaths for persons aged 10+	Overall 4,727	Male 3,688	Female 1,039	Overall 4,882	Male 3,701	Female 1,181	Overall 4,820	Male 3,600	Female 1,220
Number of deaths by age group (years)	Overall	Male	Female	Overall	Male	Female	Overall	Male	Female
10-14	5	4	1	7	3	4	8	4	4
15-19	123	101	22	142	102	40	174	126	48
20-24	290	234	56	310	237	73	313	252	61
25-29	314	260	54	349	278	71	351	264	87
30-34	376	297	79	392	307	85	399	305	94
35-39	452	348	104	398	301	97	406	313	93
40-44	566	457	109	561	443	118	493	397	96
45-49	590	453	137	625	490	135	566	431	135
50-54	531	417	114	596	454	142	535	379	156
55-59	419	327	92	399	303	96	428	329	99
60-64	305	247	58	291	217	74	316	227	89
65-69	215	161	54	240	175	65	251	181	70
70-74	153	116	37	179	124	55	178	122	56
75-79	134	94	40	148	107	41	137	90	47
80-84	113	76	37	119	84	35	124	87	37
85-89	94	67	27	84	55	29	84	57	27
90+	47	29	18	42	21	21	57	36	21

Table 10: Wales suicide numbers for all persons, males and females and by age group, 2013–2015

Wales	2013			2014			2015		
Number of deaths for persons aged 10+	Overall 393	Male 317	Female 76	Overall 247	Male 199	Female 48	Overall 350	Male 274	Female 76
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	0	1
15-19	11	11	0	13	11	2	10	7	3
20-24	26	21	5	7	7	0	21	14	7
25-29	19	14	5	17	12	5	31	25	6
30-34	36	28	8	22	16	6	39	35	4
35-39	35	30	5	22	20	2	25	19	6
40-44	46	38	8	33	28	5	35	28	7
45-49	58	50	8	25	23	2	33	27	6
50-54	34	26	8	23	16	7	39	29	10
55-59	38	31	7	26	21	5	33	27	6
60-64	26	23	3	14	11	3	23	15	8
65-69	18	8	10	13	7	6	17	15	2
70-74	18	15	3	15	13	2	14	9	5
75-79	8	7	1	4	4	0	11	8	3
80-84	12	11	1	6	6	0	9	8	1
85-89	3	1	2	7	4	3	4	3	1
90+	5	3	2	0	0	0	5	5	0

Table 11: Scotland suicide numbers for all persons, males and females and by age group, 2013–2015

Scotland	2013			2014			2015		
Number of deaths for persons aged 10+	All 795	Male 611	Female 184	All 696	Male 497	Female 199	All 672	Male 476	Female 196
Number of deaths by age group (years)	All	Male	Female	All	Male	Female	All	Male	Female
0-14	-	-	-	-	-	-	2	0	2
15-24	66	52	14	66	45	21	54	46	8
25-34	144	118	26	104	72	32	114	86	25
35-44	181	137	44	166	121	45	151	101	46
45-54	193	147	46	181	128	53	149	98	49
55-64	119	92	27	90	65	25	112	70	42
65-74	51	37	14	54	41	13	54	41	13
75-84	26	19	7	22	17	5	26	17	9
85+	-	-	-	-	-	-	10	8	2

Source: ScotPHO. New coding rules for all years, see page 16.

Table 12: Northern Ireland suicide numbers for all persons, males and females and by age group, 2013–2015

Northern Ireland	2013			2014			2015		
Number of deaths for all persons	Overall 303	Male 229	Female 74	Overall 268	Male 207	Female 61	Overall 318	Male 245	Female 73
Number of deaths by age group (years)	Overall	Male	Female	Overall	Male	Female	Overall	Male	Female
Under 15	2	1	1	3	3	-	-	-	-
15-19	13	11	2	15	12	3	17	12	5
20-24	25	19	6	27	21	6	33	26	7
25-29	23	20	3	30	25	5	44	38	6
30-34	29	24	5	35	31	4	38	29	9
35-39	37	26	11	30	23	7	26	19	7
40-44	39	25	14	23	16	7	29	24	5
45-49	41	29	12	31	23	8	38	27	11
50-54	31	23	8	26	18	8	30	22	8
55-59	21	16	5	10	5	5	26	23	3
60-64	20	16	4	17	12	5	11	7	4
65-69	7	7	-	8	7	1	16	9	7
70-74	7	6	1	5	5	-	5	4	1
75-79	4	3	1	6	4	2	3	3	-
80-84	2	1	1	1	1	-	1	1	-
85-89	2	2	-	1	1	-	1	1	-
90+	-	-	-	-	-	-	-	-	-

Source: NISRA

Appendix 3: Rate per 100,000 deaths by suicide* in Republic of Ireland, 2013–2015

Table 13: Republic of Ireland suicide rates for all persons, males and females and by age group, 2013–2015

Republic of Ireland	2013			2014			2015†		
Rate per 100,000 for persons aged 15+	Overall 11.8	Male 19.6	Female 4.1	Overall 10.3	Male 17.4	Female 3.4	Overall 10.0	Male 16.4	Female 3.2
Rate per 100,00 by age group (years)	Overall	Male	Female	Overall	Male	Female	Overall	Male	Female
0-14	0.2	0.4	0.0	0.2	0.4	0.0	0.0	0.0	0.0
15-24	9.9	16.1	3.5	14.1	23.4	4.3	12.8	21.5	3.6
25-34	13.0	19.9	6.6	14.6	24.4	5.6	14.2	24.3	5.0
35-44	13.4	21.6	5.4	13.7	22.6	5.0	13.4	23.6	3.5
45-54	19.5	31.4	7.7	17.5	28.2	6.9	14.6	24.2	5.2
55-64	15.6	27.1	4.2	11.0	18.0	4.1	11.8	18.1	5.7
65-74	14.0	23.5	4.8	12.7	22.6	2.9	10.2	17.3	3.4
75-84	3.9	6.3	2.0	4.9	8.5	2.0	5.3	10.6	1.0
85+	3.2	5.0	2.4	1.6	4.8	0.0	1.5	4.5	0.0

* Suicide as defined by the CSO – for coding and definition see page 17.

† Provisional data that will be finalised in subsequent years; provisional data reflects the suicides registered in 2015, final data will reflect the suicides that occur in that year.

Appendix 4: Number of deaths by suicide* in Republic of Ireland, 2013–2015

Table 14: Republic of Ireland suicide numbers for all persons, males and females and by age group, 2013–2015

Republic of Ireland	2013			2014			2015 [†]		
Number of deaths for all persons	Overall 487	Male 391	Female 96	Overall 486	Male 399	Female 87	Overall 451	Male 375	Female 76
Number of deaths by age group (years)	Overall	Male	Female	Overall	Male	Female	Overall	Male	Female
0-14	2	2	0	2	2	0	0	0	0
15-24	53	44	9	74	63	11	66	57	9
25-34	92	68	24	100	80	20	93	76	17
35-44	95	76	19	98	80	18	97	84	13
45-54	116	93	23	106	85	21	90	74	16
55-64	74	64	10	53	43	10	58	44	14
65-74	46	38	8	43	38	5	36	30	6
75-84	7	5	2	9	7	2	10	9	1
85+	2	1	1	1	1	0	1	1	0

* Suicide as defined by the CSO – for coding and definition see page 17.

† Provisional data that will be finalised in subsequent years; provisional data reflects the suicides registered in 2015, final data will reflect the suicides that occur in that year.

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