Probable suicides

A briefing on confirmed deaths classified as suicide or probable suicide in Argyll & Bute and Highland

Publication date: November 2025

Introduction

On 16 September 2025, the National Records of Scotland (NRS) published its **latest annual statistics** on confirmed deaths due to probable suicide. This briefing draws on those national figures, alongside death registrations provided to NHS Highland, to highlight recent trends and patterns in probable suicide across Argyll and Bute, Highland, and the wider NHS Highland area. Where relevant, we compare local findings with the national picture for Scotland.

Why this matters

Every suicide is a tragedy with lasting impacts on families, communities, and services. Understanding the patterns behind these deaths helps us work together—across health and social care services, local authorities, and community partners—to prevent future loss and support those at risk. The national **Creating Hope Together strategy** emphasises a whole-system approach to suicide prevention, recognising that effective action requires collaboration across sectors, including education, housing, third-sector organisations, and lived-experience networks, to strengthen protective factors, reduce risk, and ensure that support reaches those who need it most.[1]

What do we mean by ‘probable suicide’?

Not all suicides are straightforward to classify. Some deaths where intent cannot be conclusively established are still likely to be suicides. For this reason, both ‘suicide’ and ‘probable suicide’ are used throughout this report.

In Scotland, suicide statistics include:

- **Intentional self-harm**
- **Deaths of undetermined intent**—cases where available evidence is insufficient to distinguish between accident, self-harm, or assault.

All deaths included in these categories have been through the Procurator Fiscal process and are formally coded by the National Records of Scotland (NRS) using ICD-10 classifications. The term ‘probable suicide’ simply reflects the inclusion of undetermined intent cases, which are considered likely suicides even though intent cannot be proven beyond doubt.

A significant change occurred in 2009, when the Crown Office and Procurator Fiscal Service updated their notification process to the NRS of fatalities. Since then, the number of deaths classified as ‘undetermined’ has fallen sharply.[2,3]

Evolving definitions

The definition of probable suicide was updated in 2011, following changes to the World Health Organisation’s International Classification of Diseases (ICD-10). All figures in this briefing use the revised coding rules applied by NRS since 2011.[2]

How are deaths counted?

NRS reports deaths by council and health board area, based on the deceased’s usual address (if resident in Scotland). If this information is unavailable, the place of death is used.[2]

What do we mean by Highland?

In this report, **‘Highland’** refers to the Highland Council area, while **‘NHS Highland’** refers to the NHS Highland Board area.

What's new in the latest data?

- **Significant decrease in probable suicides:** The number of probable suicide deaths in Scotland fell by 11% in 2024, reaching the lowest level since 2017. Both Argyll and Bute and Highland followed this national trend, recording fewer deaths compared to 2023.
- **Highland remains above the national average:** The suicide rate in Highland continues to be significantly higher than the Scottish average, though the number of deaths has decreased from recent peaks. Dundee City has the highest rate over the most recent five-year period, but several rural council areas, including Highland, are above the national average.
- **Rural and remote areas still at greater risk:** Both Argyll and Bute and Highland, as predominantly rural and remote areas, continue to experience higher suicide rates than many urban parts of Scotland. Remote small towns have the highest rates nationally, underscoring the ongoing challenges faced by rural communities.
- **Persistent inequalities:** Nationally, the rate of probable suicide remains 2.5 times higher in the most deprived communities compared to the least deprived, though this gap has narrowed over the past two decades.
- **Male deaths remain the majority:** As in previous years, the majority of probable suicides are among males, with the male rate nearly three times higher than the female rate.
- **Lochaber's rates of probable suicide have increased** from a low point in 2013–2017, and between 2020 and 2024, the area recorded the highest age-standardised rate in NHS Highland, significantly above the overall Board average. However, this rate was not statistically different from several other local areas and should be interpreted with caution due to the small number of events within individual areas across NHS Highland.

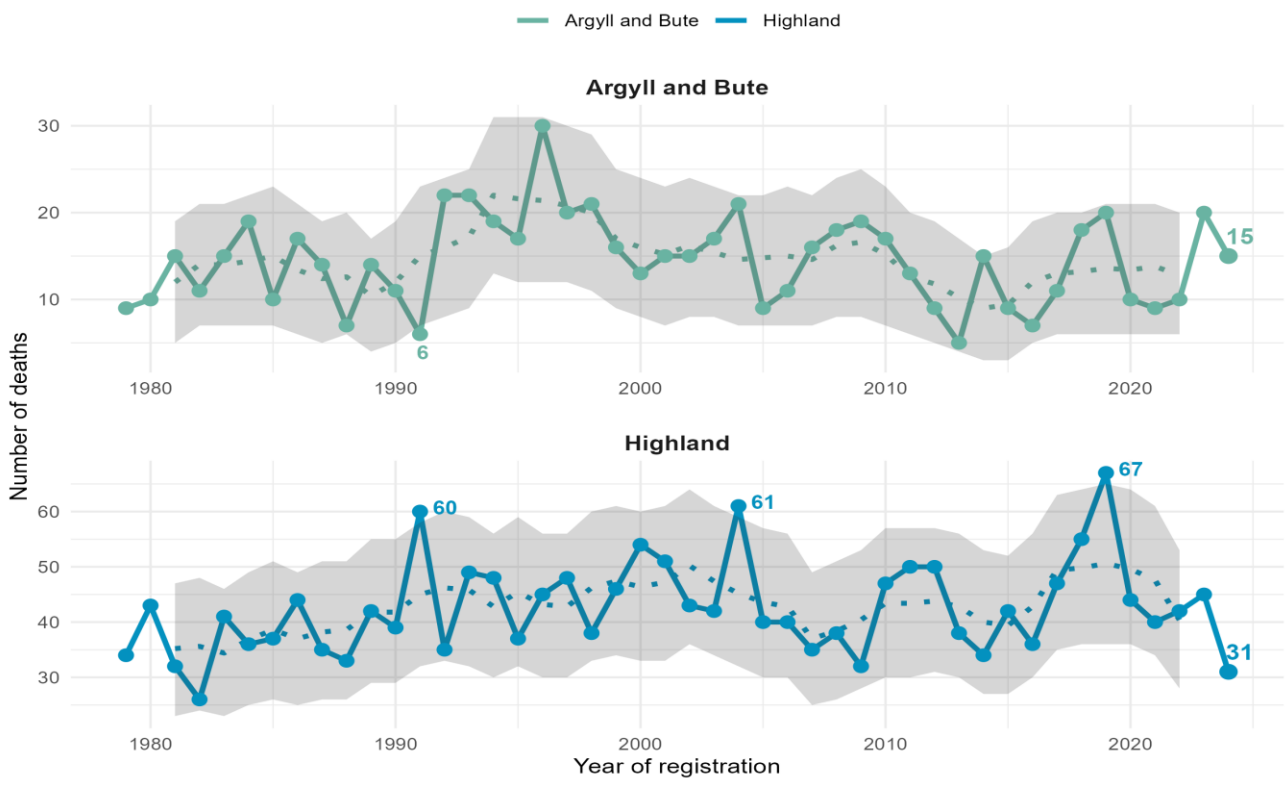
Probable suicide deaths

In 2024, there were 15 deaths recorded as probable suicide in the Argyll and Bute area, compared to 20 in 2023. In Highland, the number of deaths decreased from 45 to 31 over the same calendar year.

The number of probable suicides reported in Argyll and Bute is consistent with the average observed over recent years, although there continues to be considerable annual variation.

In Highland, the number of deaths is at the lower end of the historical range, representing the lowest absolute figure recorded since 1982. However, caution is necessary when comparing with earlier years, as definitions and reporting processes have changed over time.

Figure 1: Number of deaths by probable suicide in Argyll and Bute and Highland council areas, 1979-2024, with five-year moving averages



Source: National Records of Scotland[4]

1 The shaded area of the charts shows the likely upper and lower range of events based upon the five-year average indicated by the dotted line.

While annual numbers are often a focus of local concern, age-standardised rates calculated over a five-year rolling period provide a more reliable measure for monitoring patterns and reducing the effect of year-to-year variation.

These rates also reflect improvements in classification practices over time. For example, enhanced ascertainment has sharply reduced the number of deaths left as 'undetermined intent,' meaning that recent trends are based on more precise categorisation than in earlier years.

Probable suicide rates

The number of deaths each year can vary considerably, and a five-year average provides a more reliable guide to trends.

Figure 2 shows the trend in age-standardised probable suicide rates per 100,000 for Argyll and Bute and Highland from 1981-1985 to 2020-2024, using five-year rolling averages, following the approach used by the NRS to report on areas with smaller populations.[4] Age-standardised rates enable more reliable comparisons, adjusting for changes in the population structure of areas over time and facilitating valid comparisons between the sexes.

Suicide rates increased during the 1980s and 1990s before falling in Argyll and Bute to 10.1 per 100,000 population in 2012-2016. From this point, rates in Argyll and Bute increased to a level around 15 per 100,000 population, with the rate in 2020-2024 being 14.9 per 100,000.

The Highland suicide rate also increased during the 1980s and 1990s before falling and remaining relatively flat between 2005-2009 and 2013-2017. An increase occurred from this point, with the rate rising to 22.2 per 100,000 population between 2017-2021. The number of events in 2019 (67) in Highland elevated the suicide rate in periods until the latest five-year period of 2020-2024, when the rate was 17.4 per 100,000.

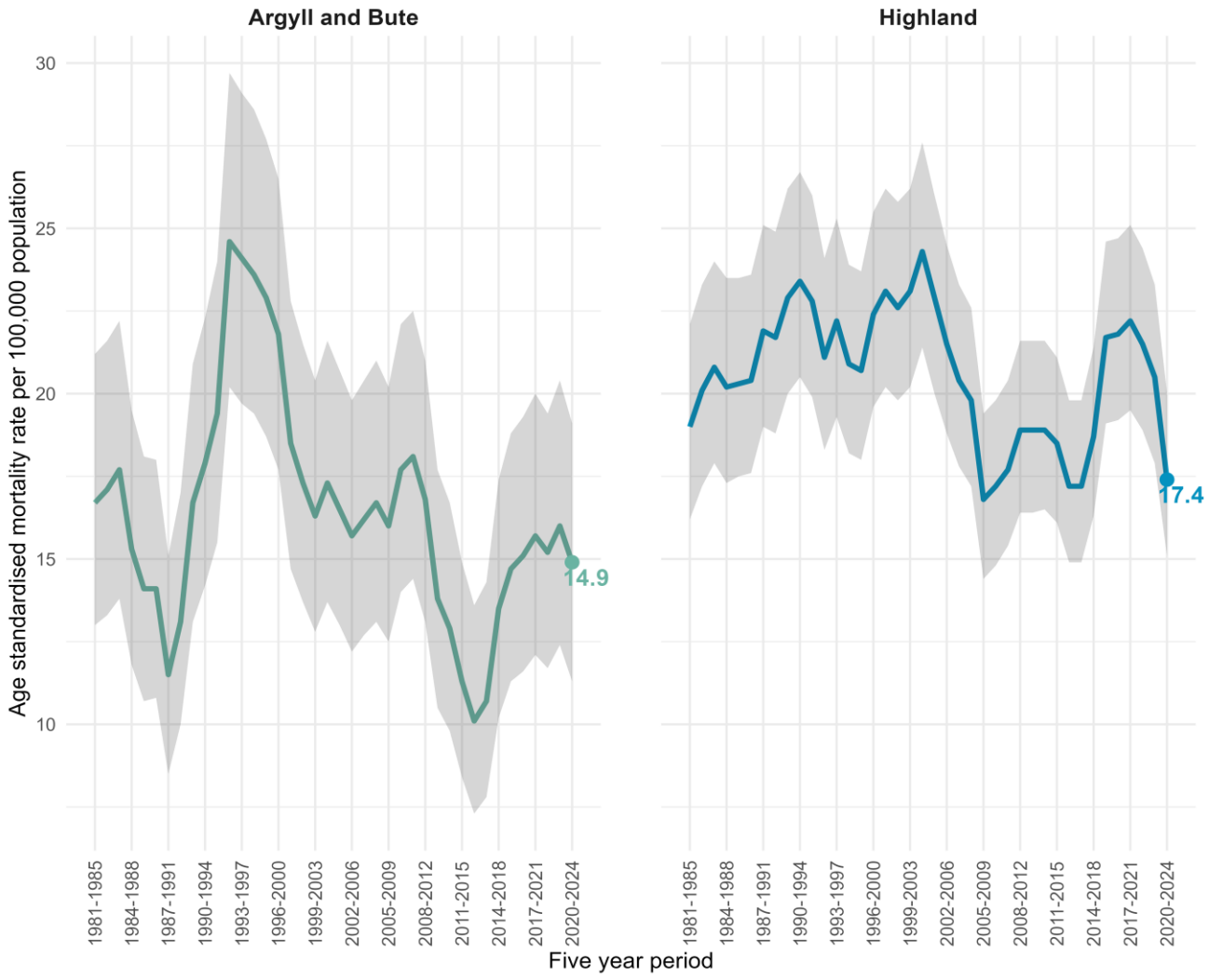
The age-standardised suicide rates per 100,000 population have been consistently higher in Highland compared to Argyll and Bute from 2009-2013.

However, the difference in the rates between Argyll and Bute and Highland in 2020-2024 is not statistically significant.

In 2020-2024, the age-standardised rate of suicide in Highland remains among the highest in Scotland, a rate significantly higher than the national average (Figure 3).

Over the last fifteen years, suicide rates in Highland have been consistently significantly higher than those nationally (Figure 4).

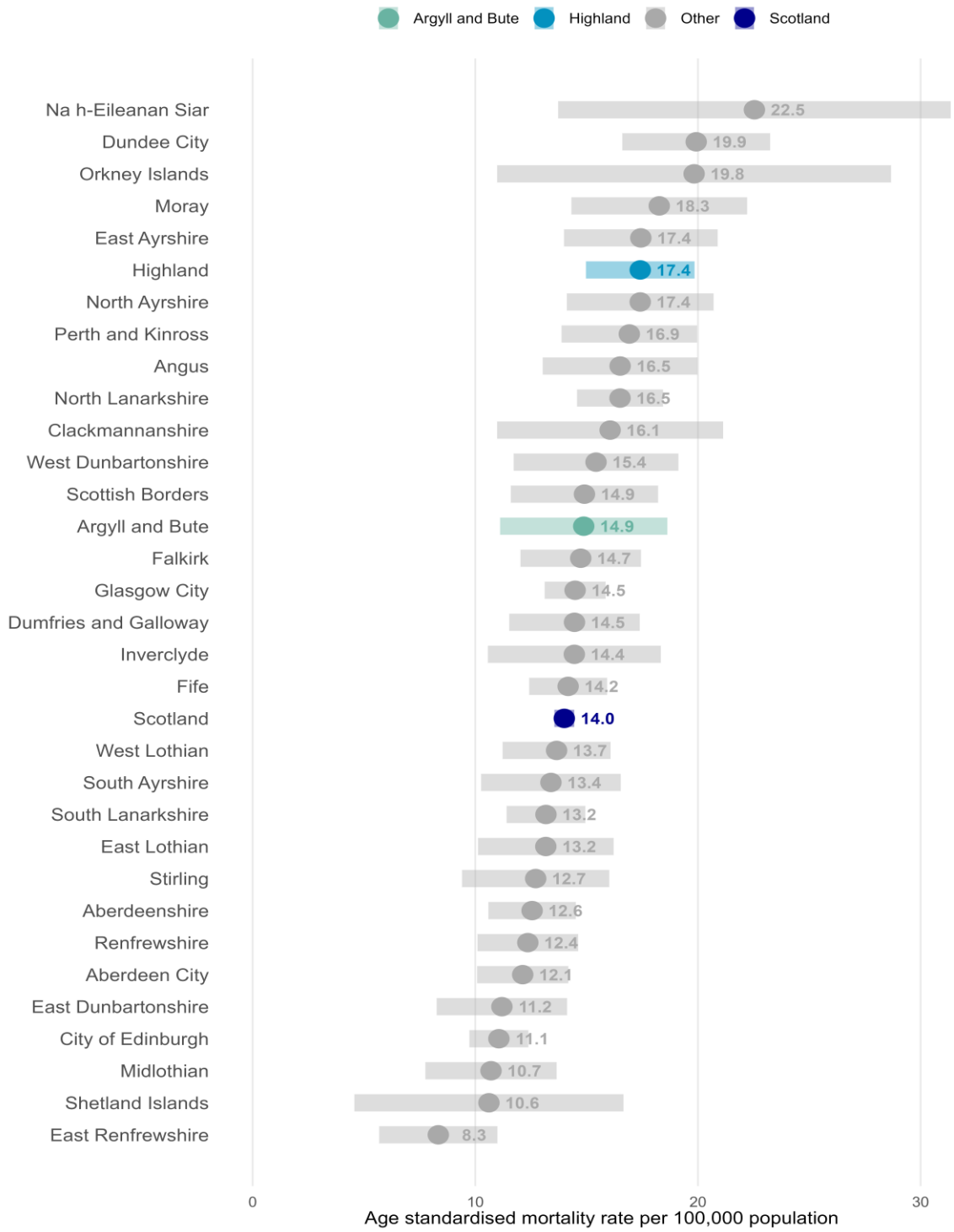
Figure 2: Age-standardised mortality rate for probable suicide in Argyll and Bute and Highland council areas, rolling five-year periods, 1981-1985 to 2020-2024



Source: National Records of Scotland[5]

1. The shaded area represents the 95% confidence interval range of the rate

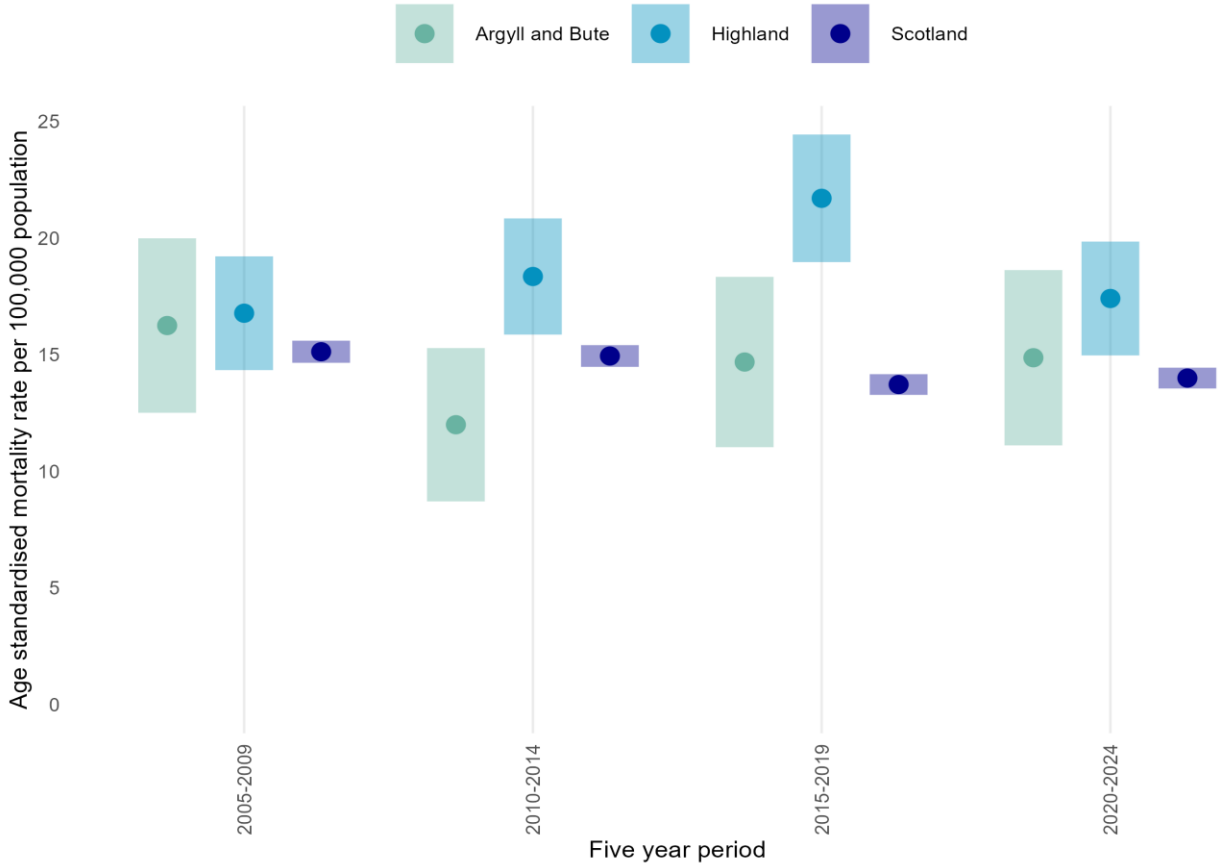
Figure 3: Age-standardised mortality rates of suicide by council area, 2020-2024



Source: National Records of Scotland[4]

1. The shaded area represents the 95% confidence interval range of the rate

Figure 4: Age-standardised mortality rates of suicide in Argyll and Bute, Highland and Scotland, 2005-2009 to 2020-2024



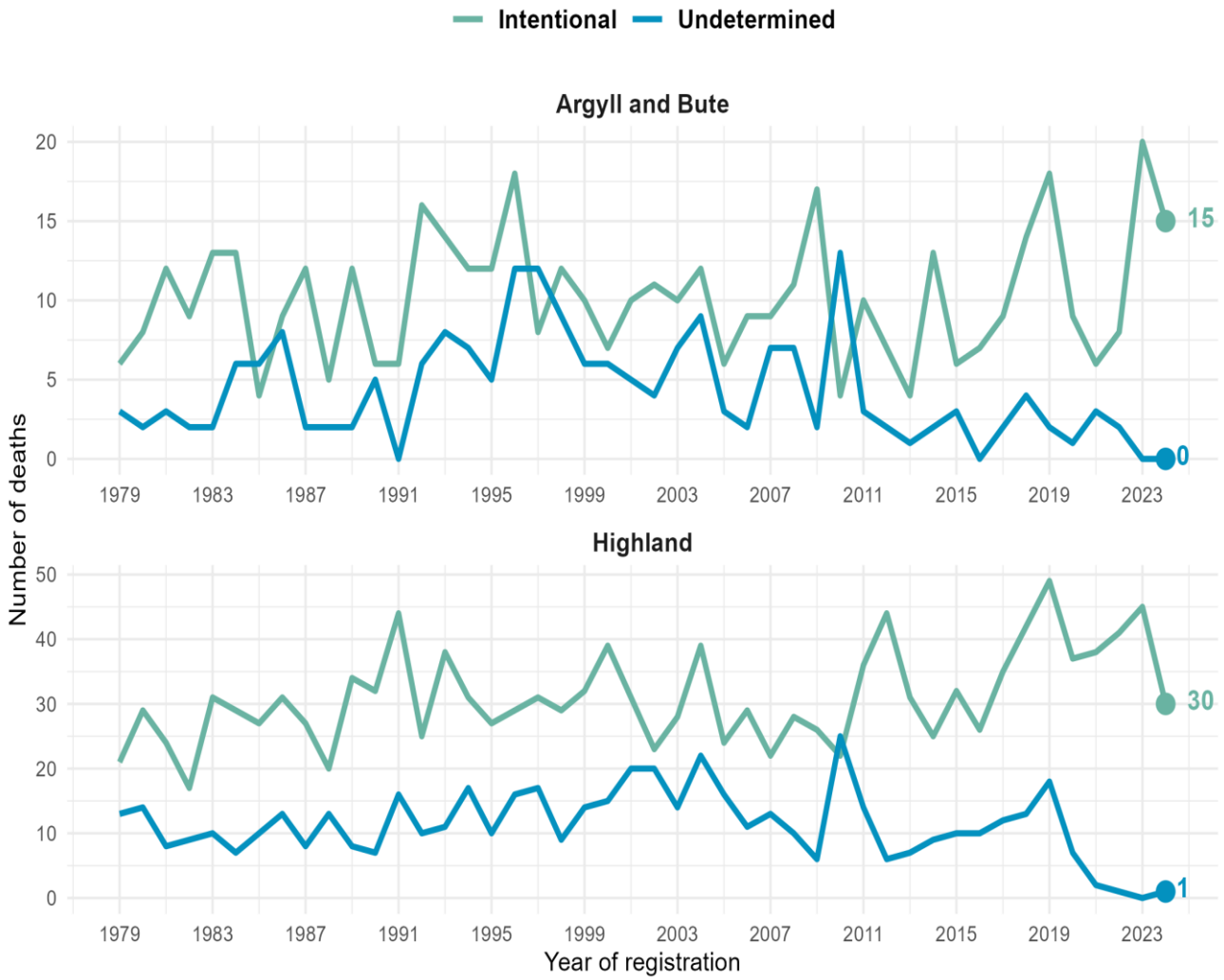
Source: National Records of Scotland[4]

1. The shaded area represents the 95% confidence interval range of the rate

Improved ascertainment of probable suicides means that more deaths are now classified with greater clarity, reducing the number of cases left as “undetermined intent.”

In 2024, a single death in Highland classified as probable suicide was recorded as undetermined intent, with only 31 of the 704 deaths recorded in Scotland in the category.[4]

Figure 5: Number of deaths from intentional self-harm and undetermined intent in Argyll and Bute and Highland council areas, 1979-2024



Source: National Records of Scotland[4]

Probable suicide deaths by sex and age

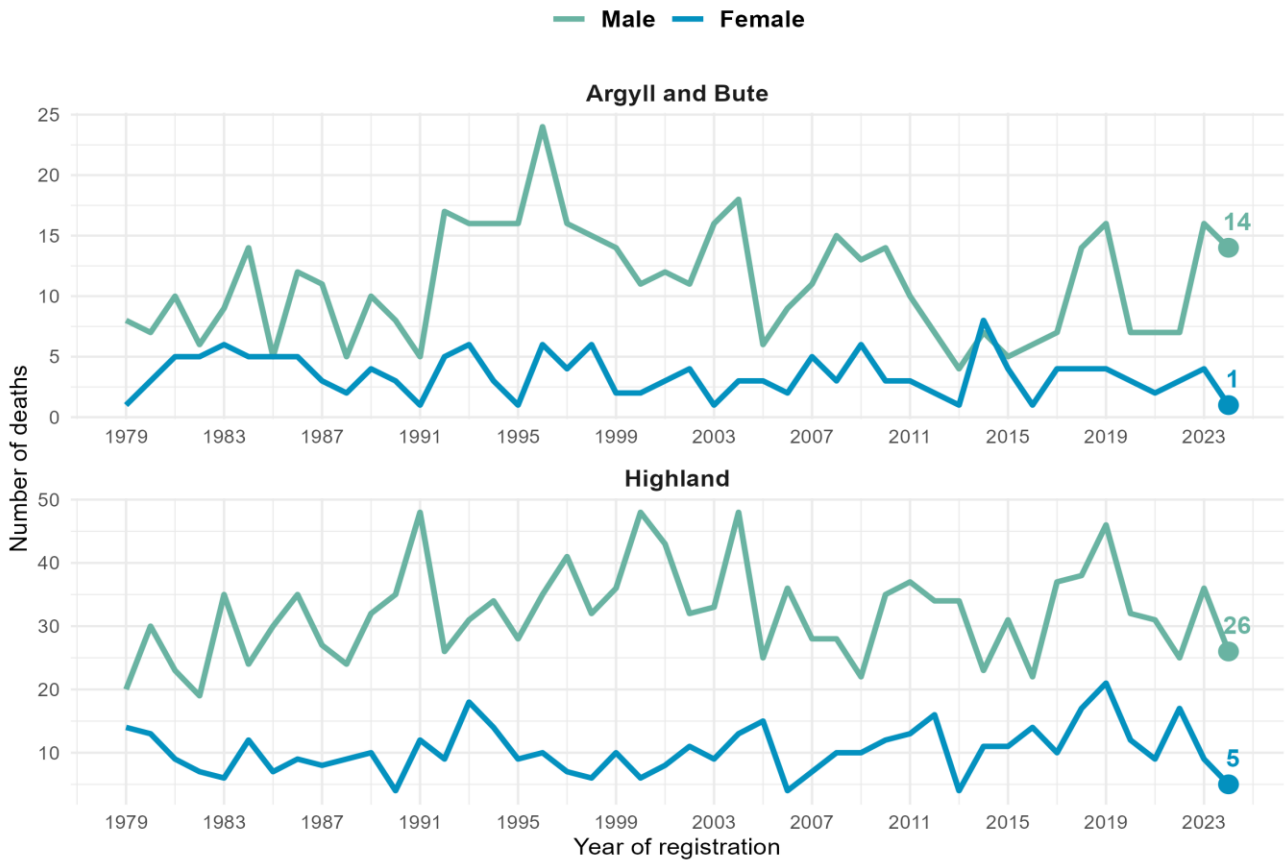
Sex

In Argyll and Bute, there were 14 male deaths by probable suicide in 2024, a decrease of two compared to 2023. There was one female death in 2024, down from four in the previous year.

In Highland, 26 male deaths were recorded in 2024, compared to 36 in 2023. There were five female deaths in 2024, a reduction from nine in 2023.

Across both areas, seven out of every eight probable suicide deaths in 2024 were among males, reflecting the persistent gender disparity observed nationally.

Figure 6: Number of deaths by probable suicide in Argyll and Bute and Highland council areas by sex, 1979-2024



Source: National Records of Scotland[5]

Annual suicide numbers in small populations such as Argyll and Bute and Highland are subject to year-to-year change, which may reflect a combination of individual, social, economic, and service-related factors. These short-term fluctuations should be interpreted with caution.

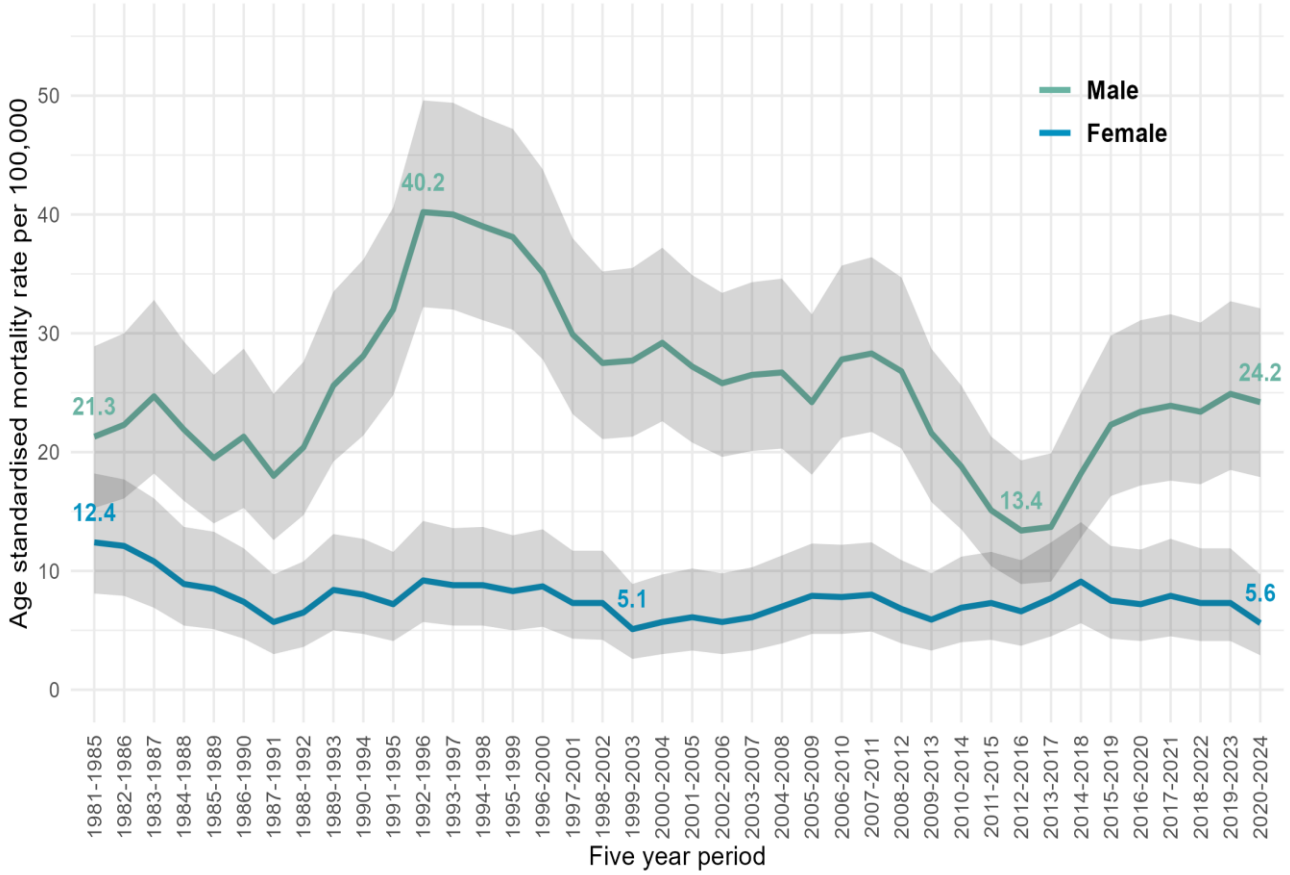
A more reliable understanding can be gained by examining longer-term trends and rates per 100,000 population, which help account for population size and variability.

Figure 7 illustrates that female age-standardised rates of probable suicide in Argyll and Bute have been relatively stable since the early 1990s, fluctuating within a range of 5.1 to 9.2 deaths per 100,000 population. This consistency contrasts with more pronounced changes observed in male rates.

The male suicide rate in Argyll and Bute has shown a substantial increase from 13.4 per 100,000 population in the 2012-2016 period to 24.2 per 100,000 population in 2020-2024. This increase is the primary driver of the recent rise in the area’s overall suicide rate.

During the most recent period (2020-2024), the male suicide rate was 4.3 times higher than the female rate, based on age-standardised figures. Over the whole time series shown in Figure 7, the rate ratio between males and females has ranged from 1.7 to 5.4, highlighting a persistent gap in suicide mortality between sexes that has increased in recent years.

Figure 7: Age-standardised mortality rate for probable suicide in Argyll and Bute by sex, rolling five-year periods, 1981-1985 to 2020-2024

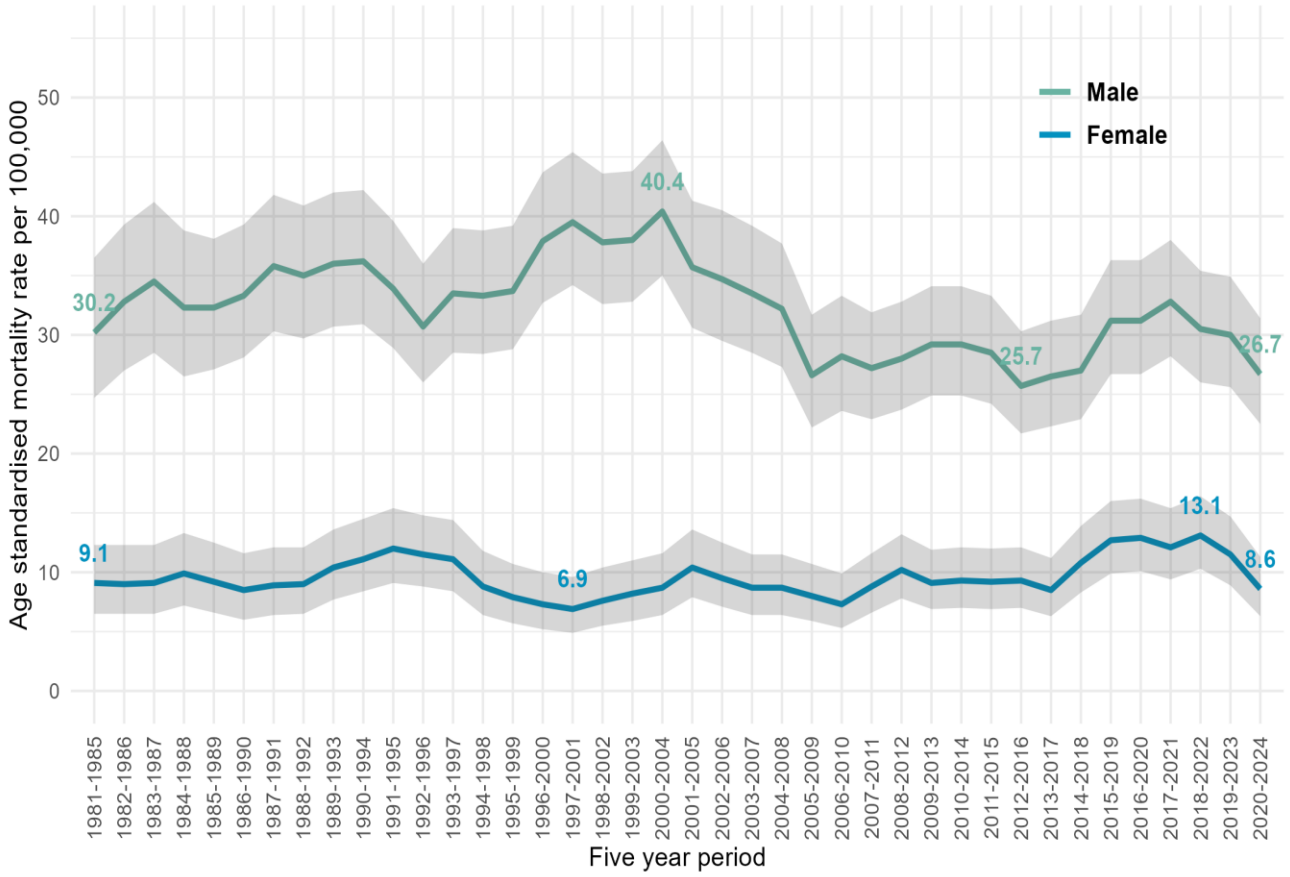


Source: National Records of Scotland[5]

1. The shaded area represents the 95% confidence interval range of the rate

In Highland, male rates were 3.1 in 2020-2024 than female rates, with the difference ranging from 2.3 to 5.7 over the entire period, as shown in Figure 8.

Figure 8: Age-standardised mortality rate for probable suicide in Highland by sex, rolling five-year periods, 1981-1985 to 2020-2024

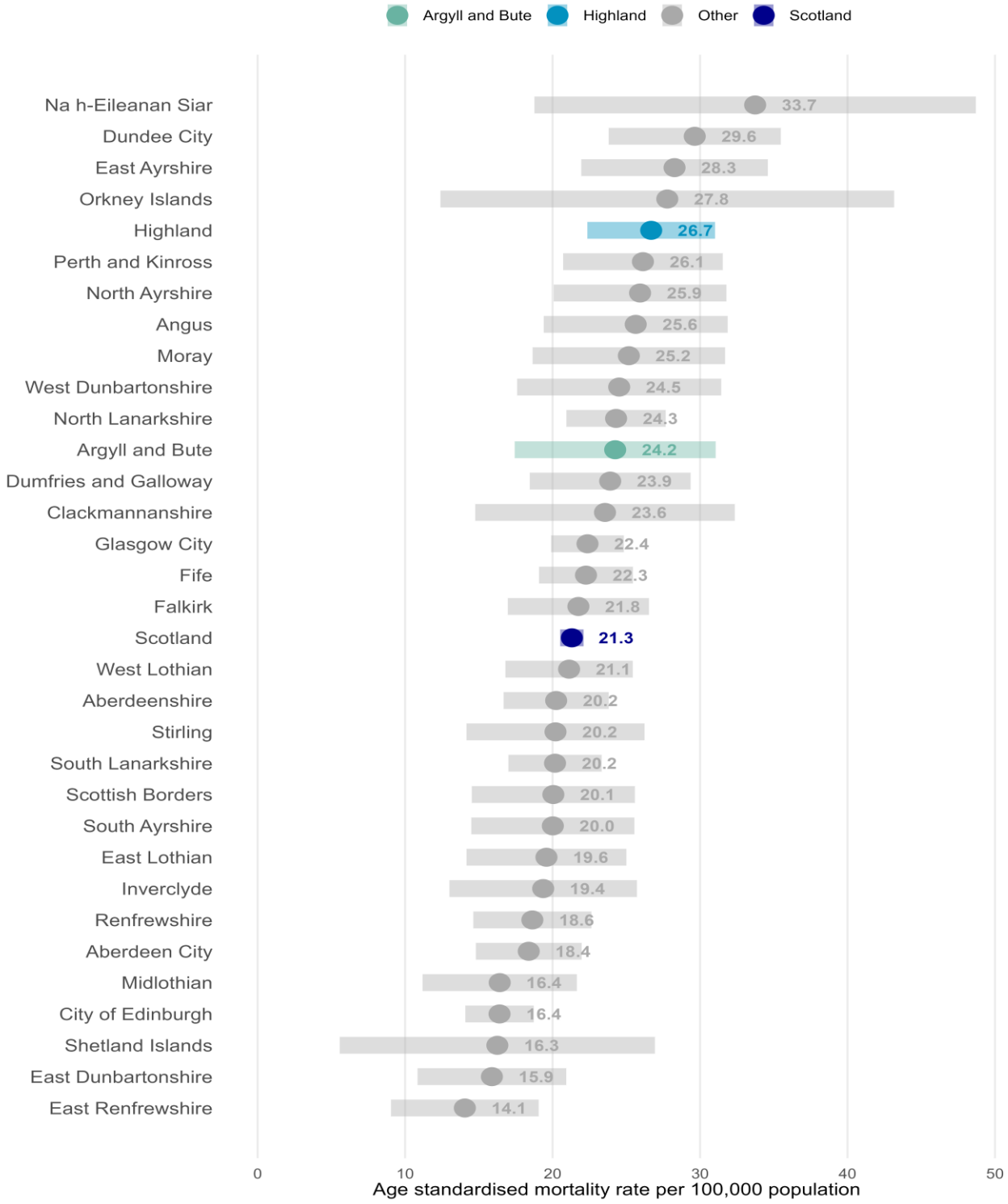


Source: National Records of Scotland[5]

1. The shaded area represents the 95% confidence interval range of the rate

The age-standardised rate of male suicide in the Highland Council area was significantly higher than the Scottish average during 2020-2024, ranking fifth highest among all local authorities (Figure 9). This elevated rate has been statistically significant for two consecutive five-year periods, indicating a persistent disparity (Figure 10).

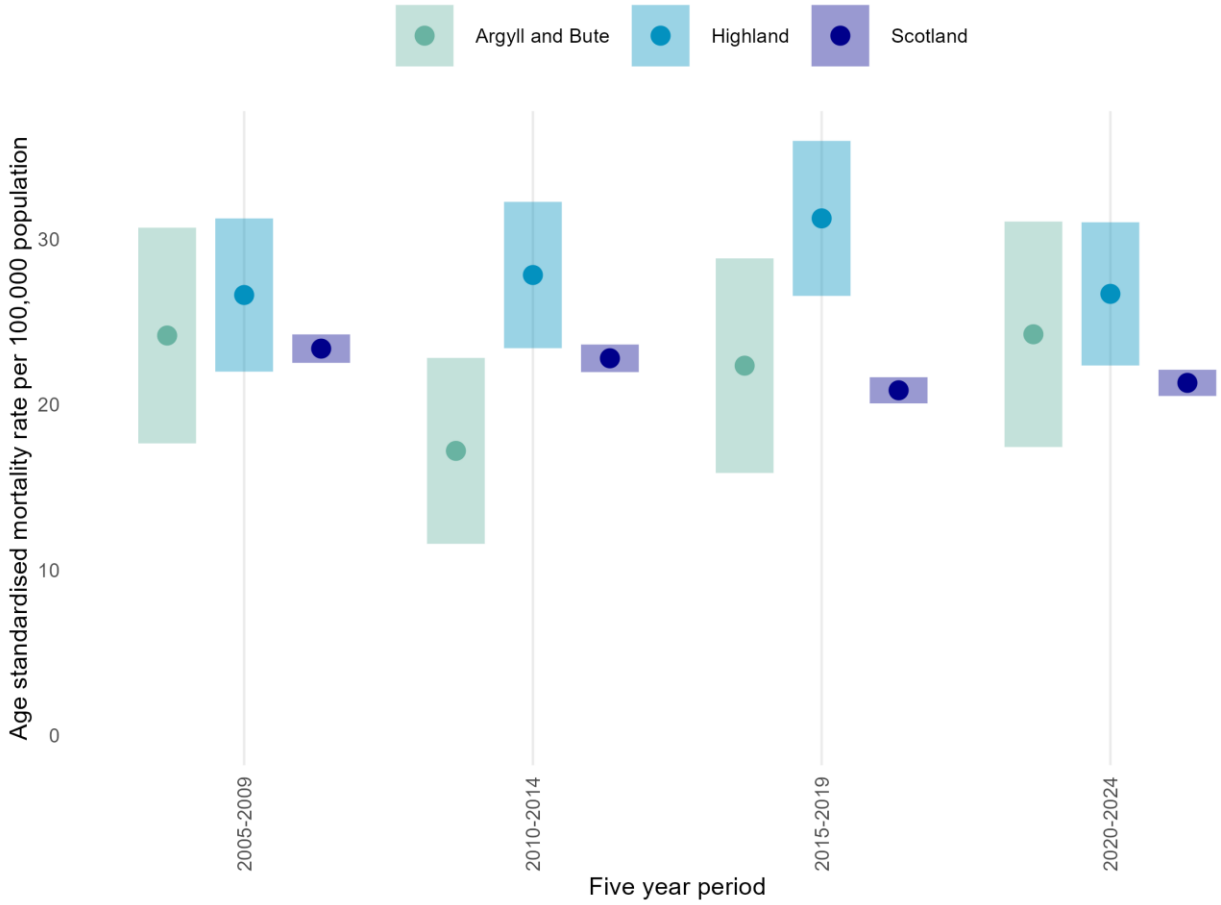
Figure 9: Age-standardised mortality rates from male suicide by council area, 2020-2024



Source: National Records of Scotland[4]

1. The shaded area represents the 95% confidence interval range of the rate

Figure 10: Age-standardised mortality rates of male suicide in Argyll and Bute, Highland and Scotland, 2005-2009 to 2020-2024

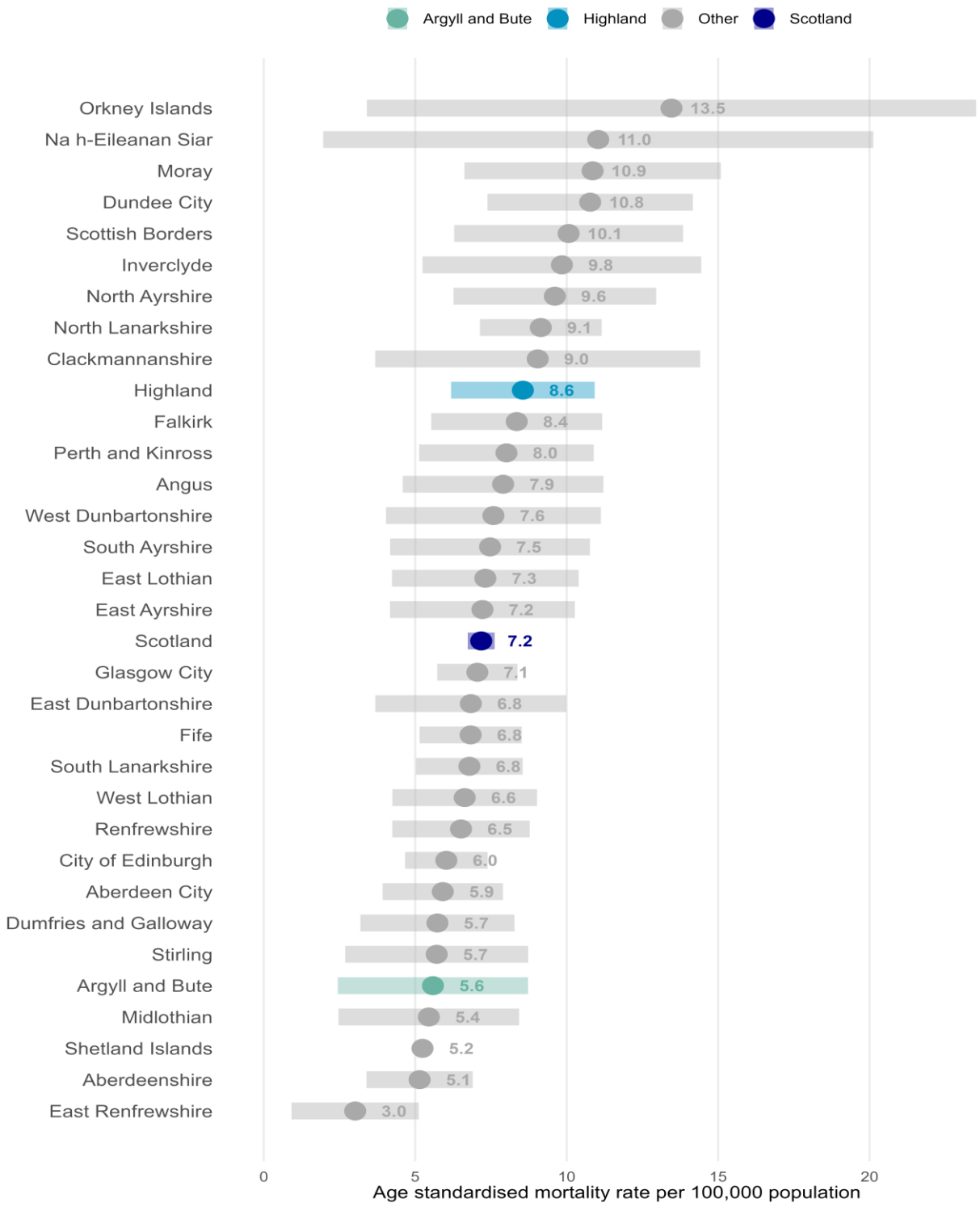


Source: National Records of Scotland[4]

1. The shaded area represents the 95% confidence interval range of the rate

The age-standardised rate of female suicide in the Highland Council area remains higher than the Scottish average, although the difference was not statistically significant in the most recent five-year period (2020-2024). The elevated rate in the previous period was notably influenced by a higher number of deaths in 2019 (Figure 12).

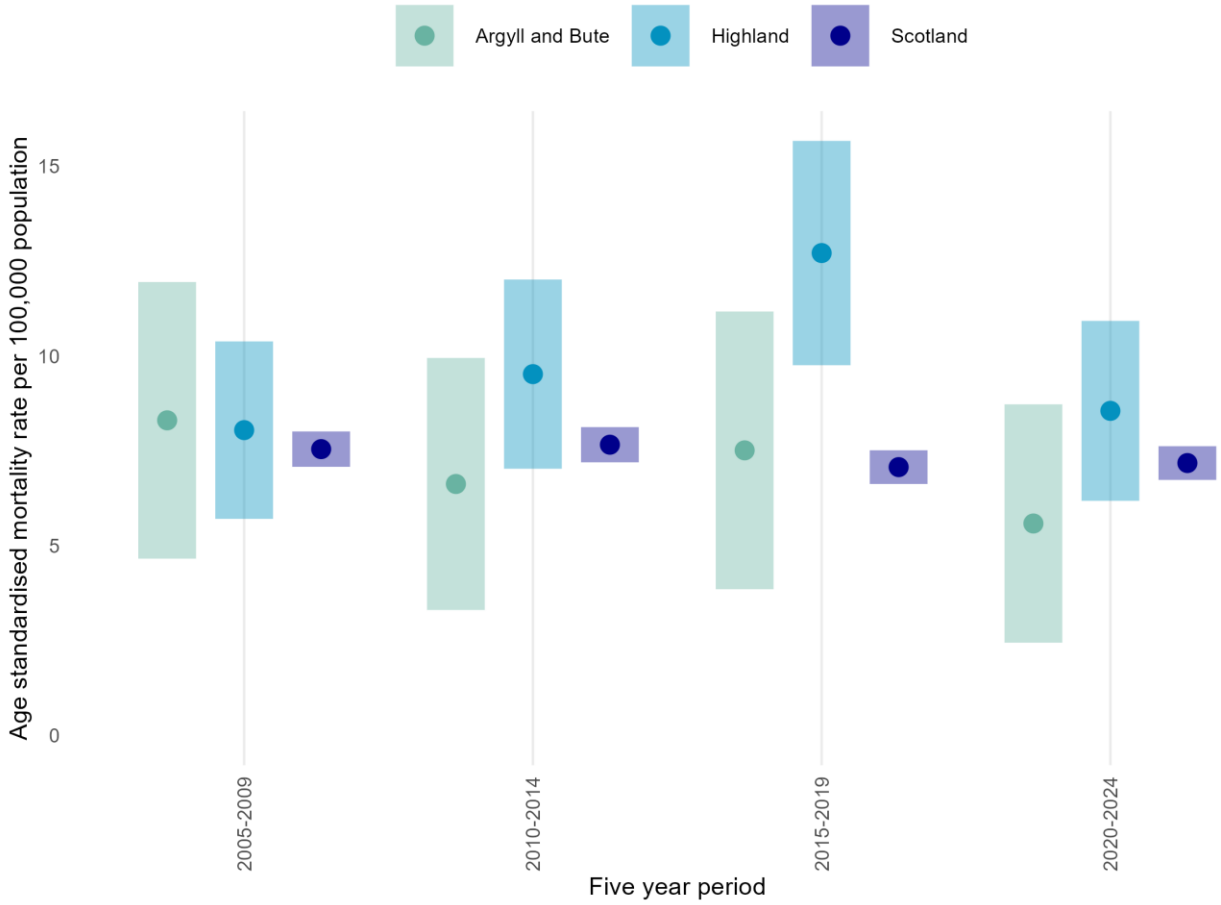
Figure 11: Age-standardised mortality rates from female suicide by council area, 2020-2024



Source: National Records of Scotland[4]

1. The shaded area represents the 95% confidence interval range of the rate

Figure 12: Age-standardised mortality rates of female suicide in Argyll and Bute, Highland and Scotland, 2005-2009-2020-2024



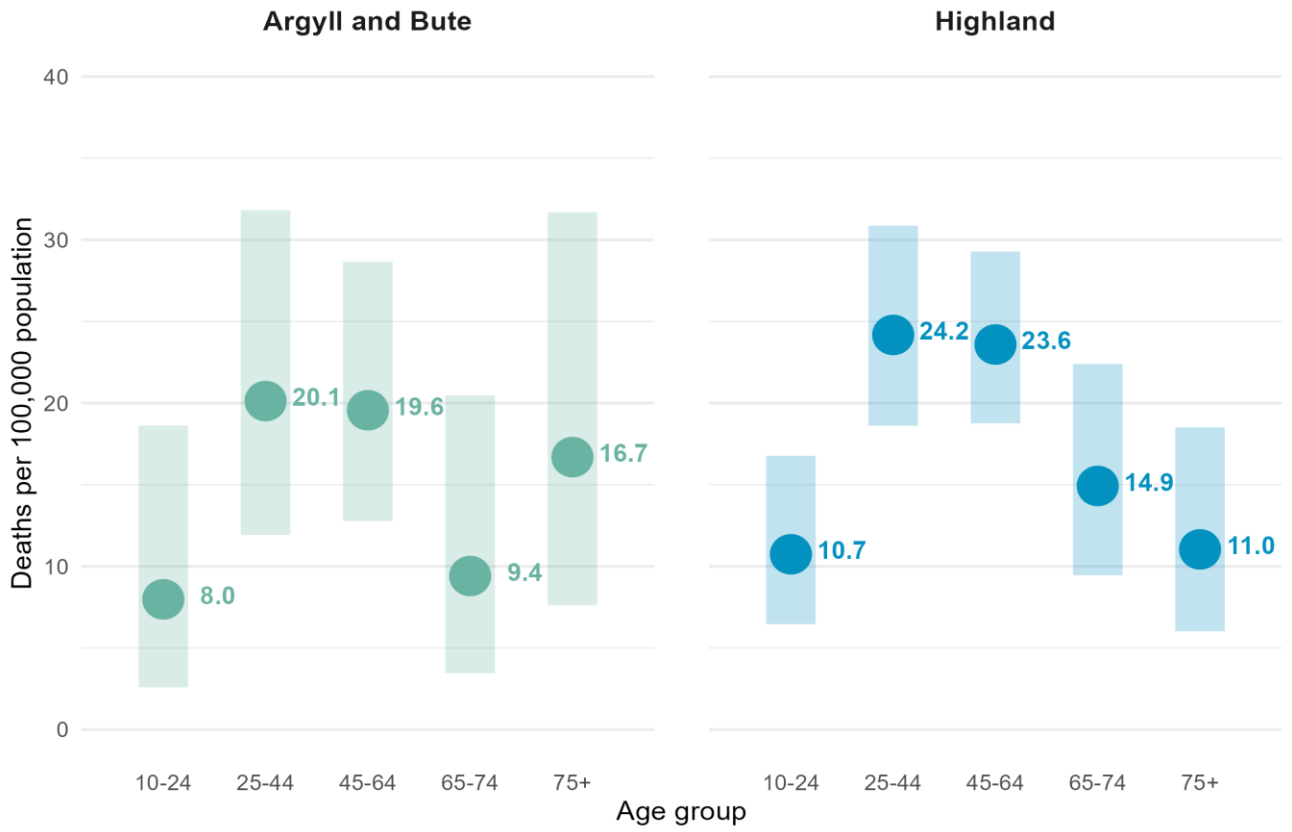
Source: National Records of Scotland[4]

1. The shaded area represents the 95% confidence interval range of the rate

Age

In line with national trends, the highest mortality rates for probable suicide in Argyll and Bute and Highland are among those aged 25 to 64. In both areas, the rates are more than twice as high as those for people under 25, although not significantly different from the rates of other age groups in the area (Figure 13).

Figure 13: Age-specific mortality rates from probable suicide by age group in Argyll and Bute and Highland, 2020-2024



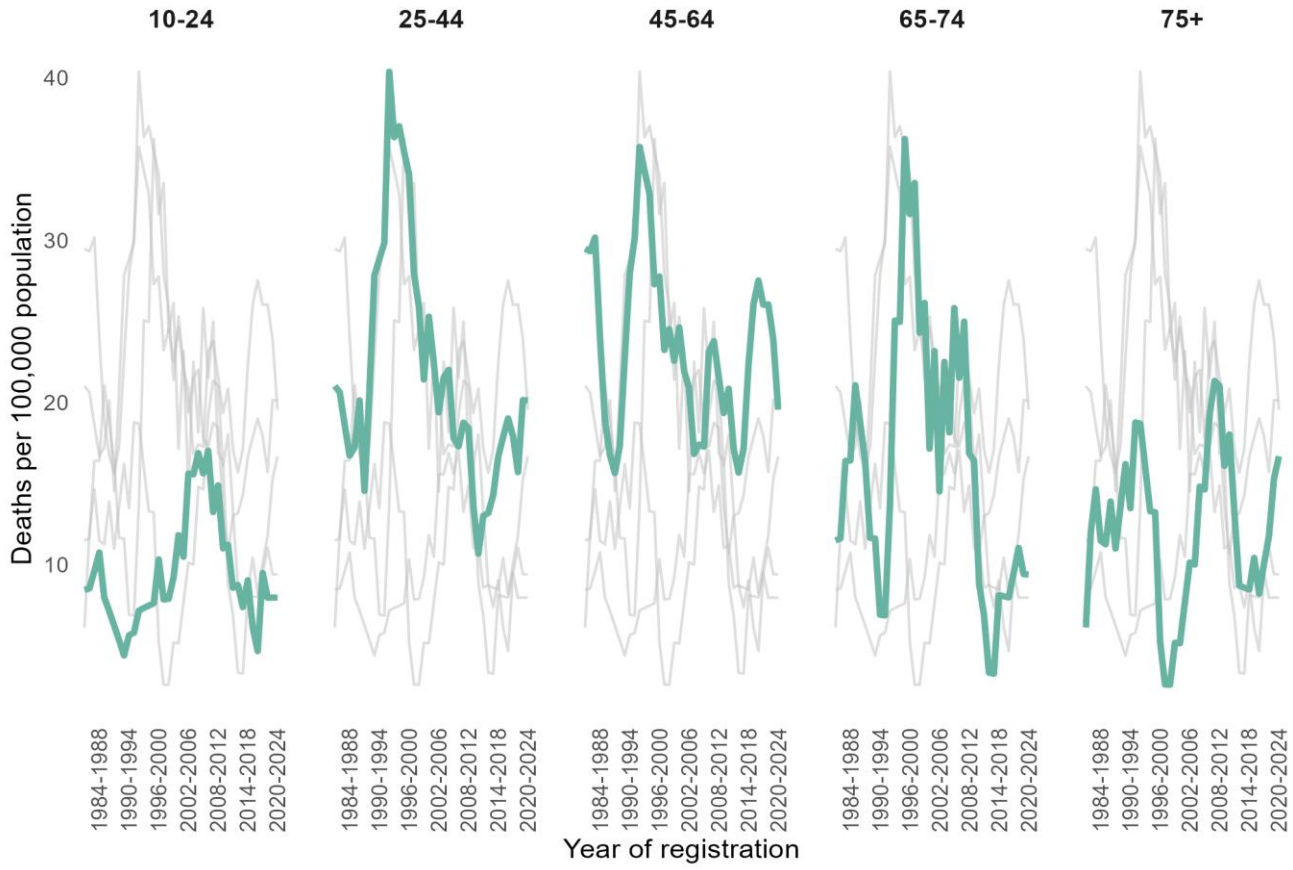
Source: National Records of Scotland[5]

1. The shaded area represents the 95% confidence interval range of the rate

National trends in probable suicide show that middle-aged adults (ages 25–64) have consistently experienced the highest rates of suicide mortality, with particularly elevated levels during the 1990s and 2000s. While rates among younger adults have declined over time, those aged 45–64 continue to show persistently high levels, and the average age at death has gradually increased.

The trends in Argyll and Bute generally follow the national pattern; however, due to its smaller population, even five-year rolling averages can mask considerable annual fluctuations, making it difficult to determine whether recent changes reflect real shifts in underlying risk.

Figure 14: Mortality rates from probable suicide in Argyll and Bute by age group, rolling five-year periods, 1981-1985 to 2020-2024

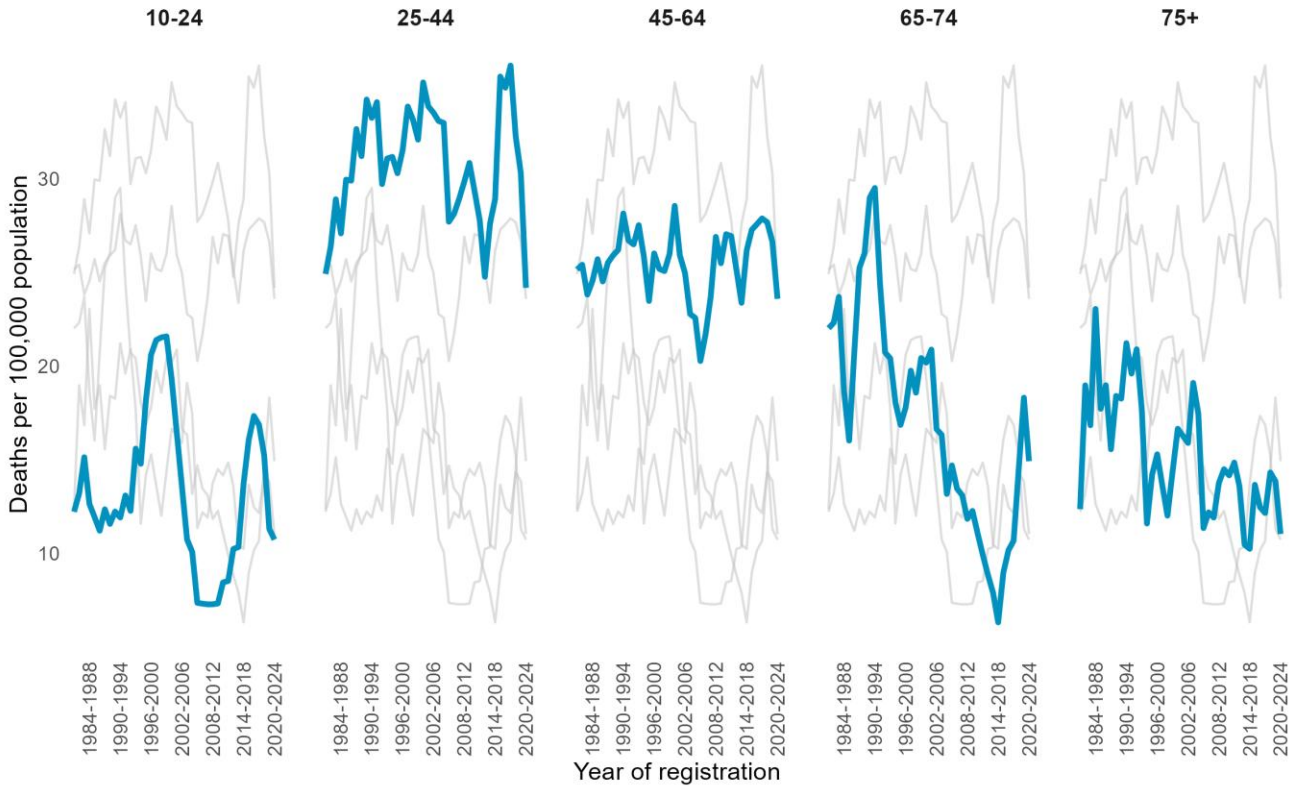


Source: National Records of Scotland[5]

1. Grey lines provide context by showing other age group categories

In Highland, rates among those aged 25–44 began rising again in the late 2010s before reducing to the current low. More recently, rates in the 65–74 age group have also shown an upward trend.

Figure 15: Mortality rates from probable suicide in Highland by age group, rolling five-year periods, 1981-1985 to 2020-2024



Source: National Records of Scotland[5]

1. Grey lines provide context by showing other age group categories

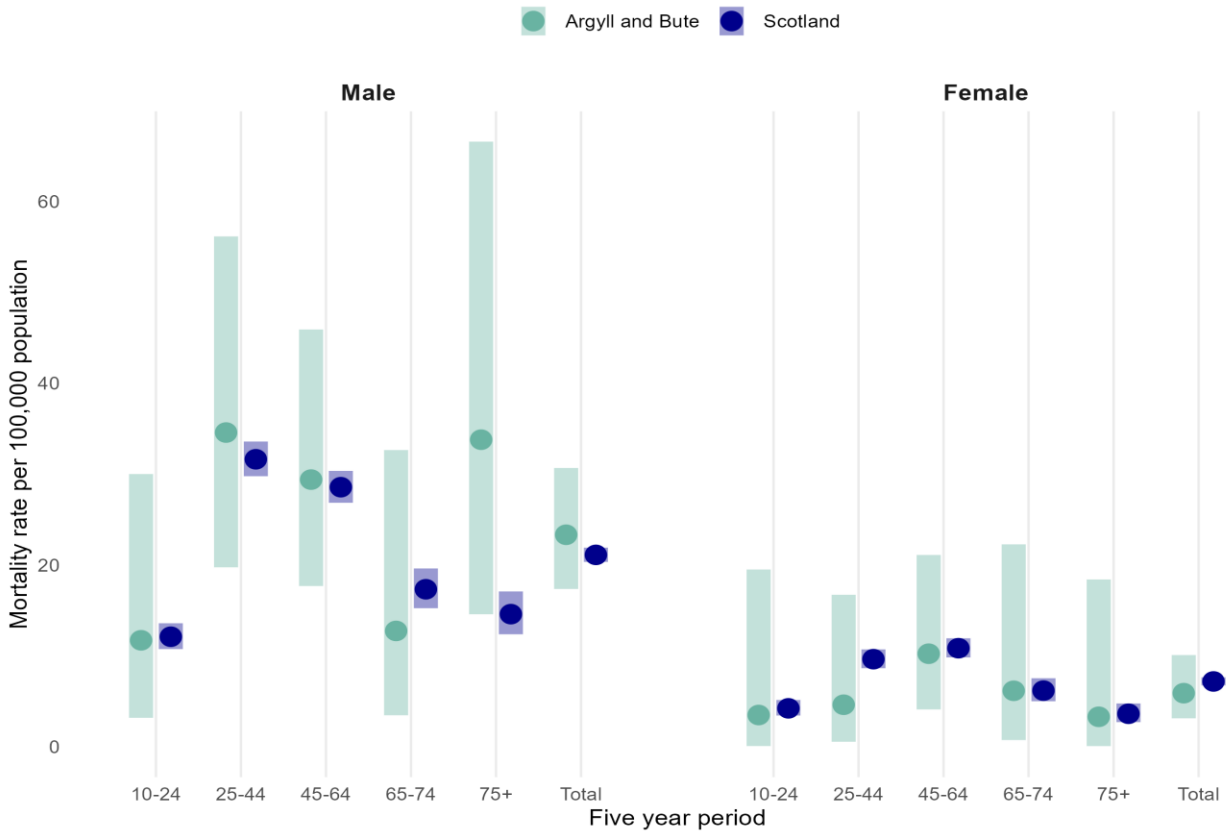
Patterns by sex and age

Figures 16 and 17 present age-specific suicide rates for males and females in Argyll and Bute and Highland compared to Scotland for the five years 2020-2024.

In Argyll and Bute, the age-specific rates closely mirror the national pattern for both sexes, with consistently higher rates among males across all age groups.

However, even over five years, the confidence intervals around the rates in Argyll and Bute remain wide, reflecting the small population size and the limited number of deaths. The statistical uncertainty makes it challenging to determine whether observed differences or changes over time are meaningful.

Figure 16: Age-specific mortality rates from probable suicide in Argyll and Bute and Scotland by sex, 2020-2024

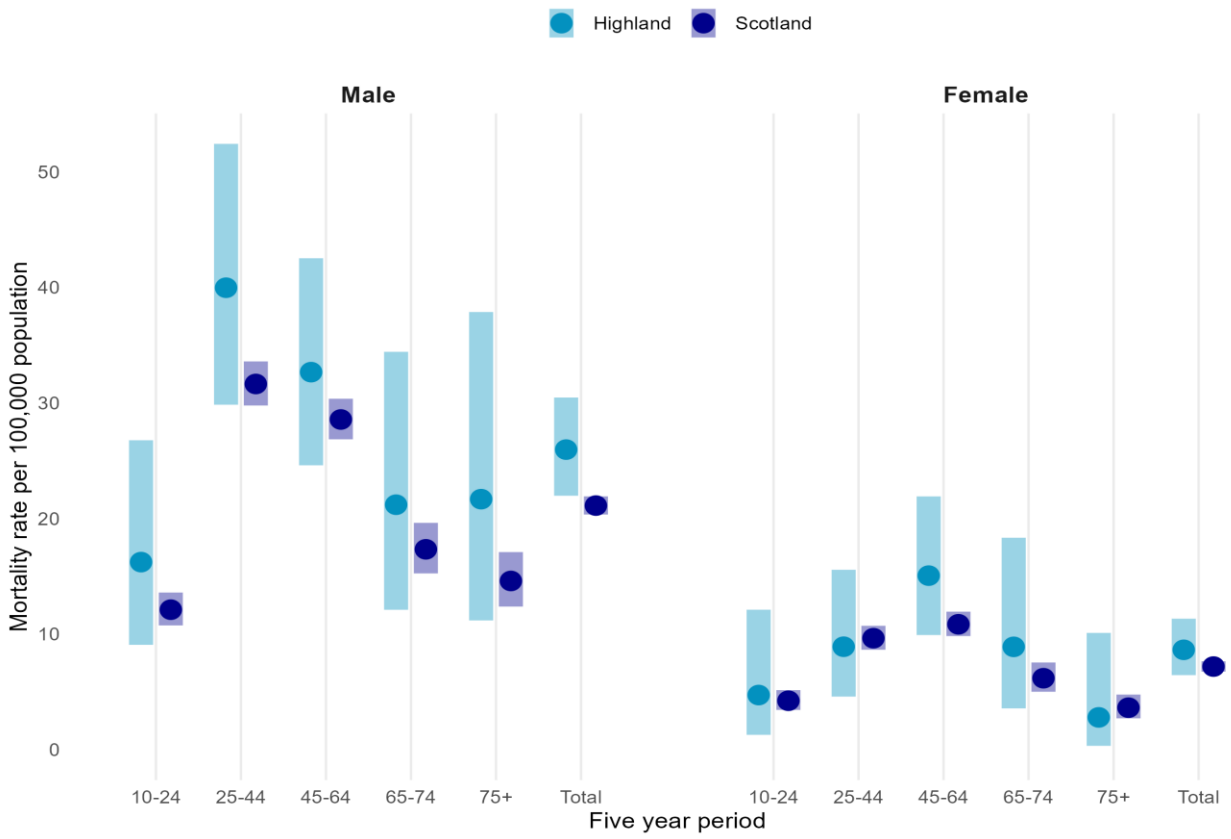


Source: National Records of Scotland[4]

1. The shaded area represents the 95% confidence interval range of the rate

In Highland during 2020-2024, male suicide rates were higher across all age groups compared to the Scottish average, although these differences were not statistically significant. For females, rates in Highland were higher than the national average across all age groups except those aged 75 and over. Consistent with national patterns, suicide rates among males were higher than those among females across all age groups in both Highland and Scotland.

Figure 17: Age-specific mortality rates from probable suicide in Highland and Scotland by sex, 2020-2024



Source: National Records of Scotland[4]

1. The shaded area represents the 95% confidence interval range of the rate

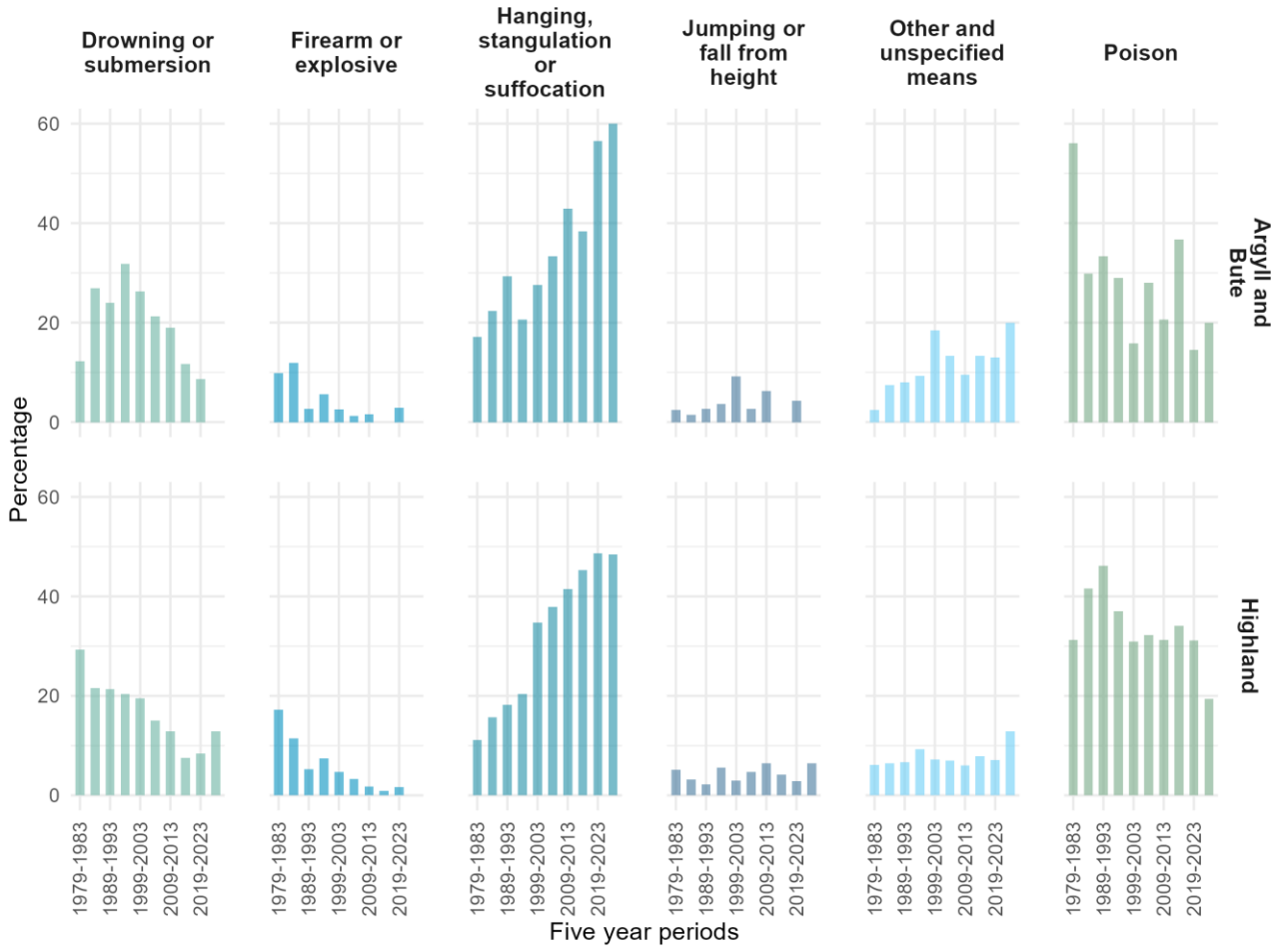
Methods of suicide

Understanding patterns and trends in methods of suicide is essential for informing effective prevention strategies.[6]

The most common method of suicide continues to be hanging, strangulation or suffocation (grouped), accounting for 60 percent of all suicides in Argyll and Bute and 48.4 percent in Highland during the period 2020-2024.

The second most common method remains poisoning, responsible for 20 percent of suicides in Argyll and Bute and 19.4 percent in Highland over the same period.

Figure 18: Proportion of probable suicides by method, Argyll and Bute and Highland, registered between 1981-1985 to 2020-2024

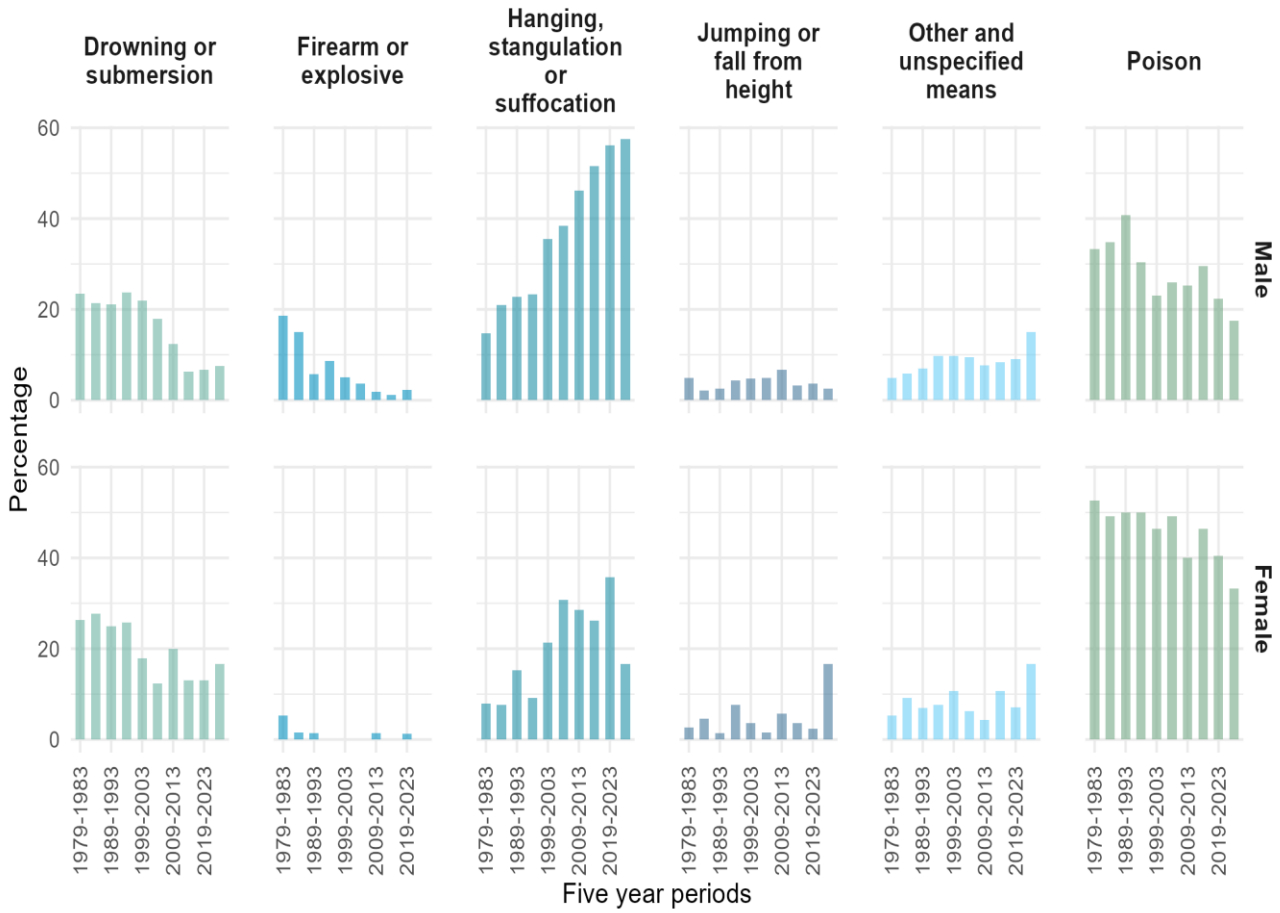


Source: National Records of Scotland[5]

In NHS Highland, hanging, strangulation, or suffocation currently accounts for 57.5 percent of male suicides. Among females, poisoning remains the most commonly used method.

Academic literature has documented a rising proportion of suicides by hanging in the UK, particularly among women, a trend that may be linked to reduced availability of other methods—such as prescription drugs used in overdose—and to misconceptions that hanging is a quick and painless way to die.[7]

Figure 19: Proportion of probable suicides by method and sex, NHS Highland, registered between 1981-1985 to 2020-2024



Source: National Records of Scotland[5]

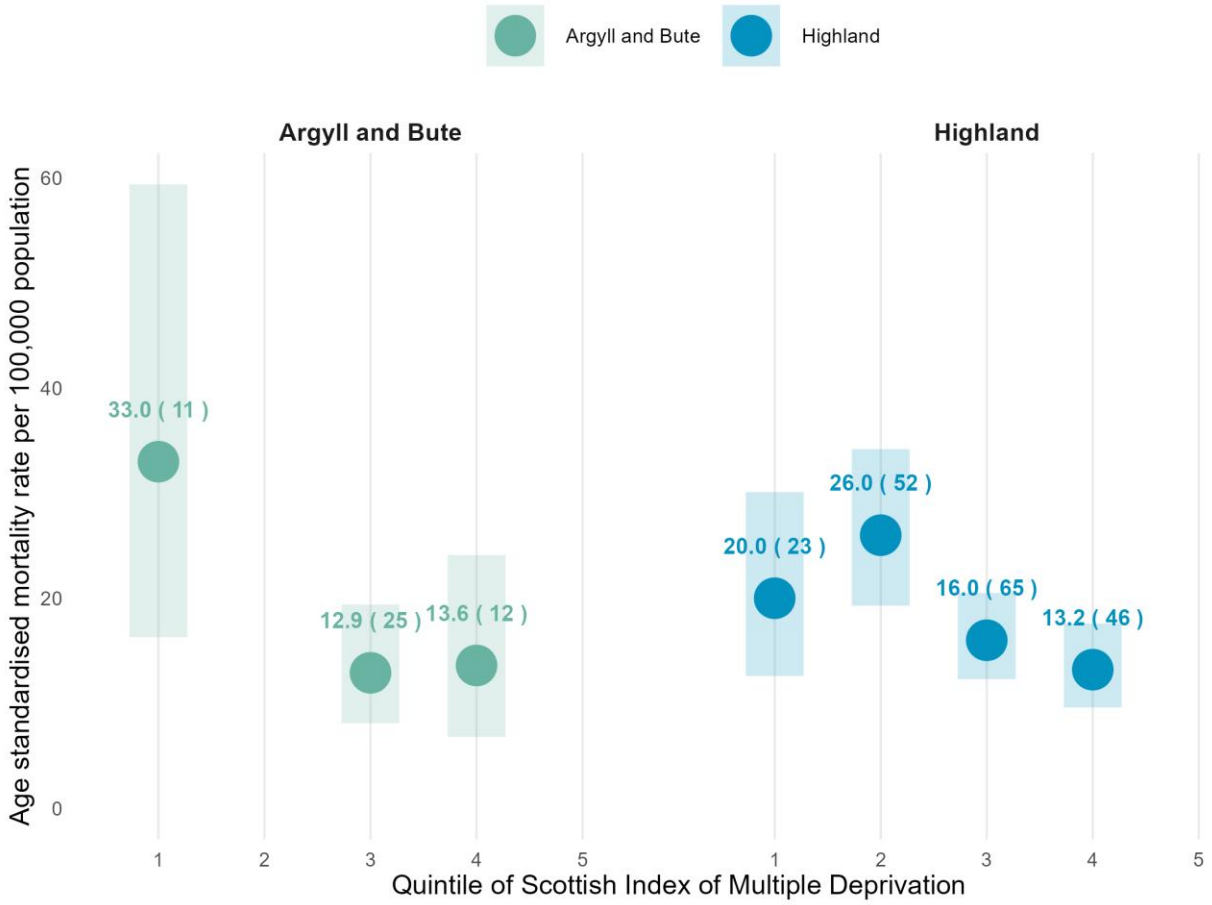
Deprivation

There is a well-established association between socioeconomic deprivation and suicide risk. In Scotland, this relationship is characterised by a clear gradient, with suicide rates increasing as levels of deprivation rise. National data consistently show that individuals living in the most deprived areas experience suicide mortality rates more than twice those of individuals in the least deprived areas.[5] This gradient reflects the cumulative impact of social, economic, and health-related disadvantage, and underscores the importance of addressing structural inequalities as part of suicide prevention efforts.[8]

In Argyll and Bute and Highland, the deprivation gradient is less clearly defined. While suicide rates are elevated in more deprived areas—particularly in Argyll and Bute—the small population sizes and limited number of deaths mean that confidence intervals remain wide, even when using five-year rolling averages. This statistical uncertainty makes it difficult to determine whether observed differences are meaningful. Additionally, other contextual factors such as rurality, geographic isolation, and access to services may confound the relationship between deprivation and suicide risk, suggesting the need for locally tailored approaches to prevention.[7,9]

Figure 20 presents age-standardised suicide rates by deprivation quintile for Argyll and Bute and the Highland Council area during the period 2020-2024. Rates of suicide mortality are higher in more deprived areas, with this pattern being more pronounced in Argyll and Bute. Due to small numbers, rates are not calculated for deprivation quintiles with fewer than ten deaths, and caution is advised when interpreting differences across quintiles.

Figure 20: Age-standardised suicide rate by Scottish Index of Multiple Deprivation quintiles in Argyll and Bute and Highland, 2020-2024



Source: National Records of Scotland[5]

1. The chart series annotation shows the age-standardised rate per 100,000 and the number of events in the period in brackets.
2. Rates were calculated using the Scottish Index of Multiple Deprivation 2020 release.
3. The shaded area represents the 95% confidence interval range of the rate.

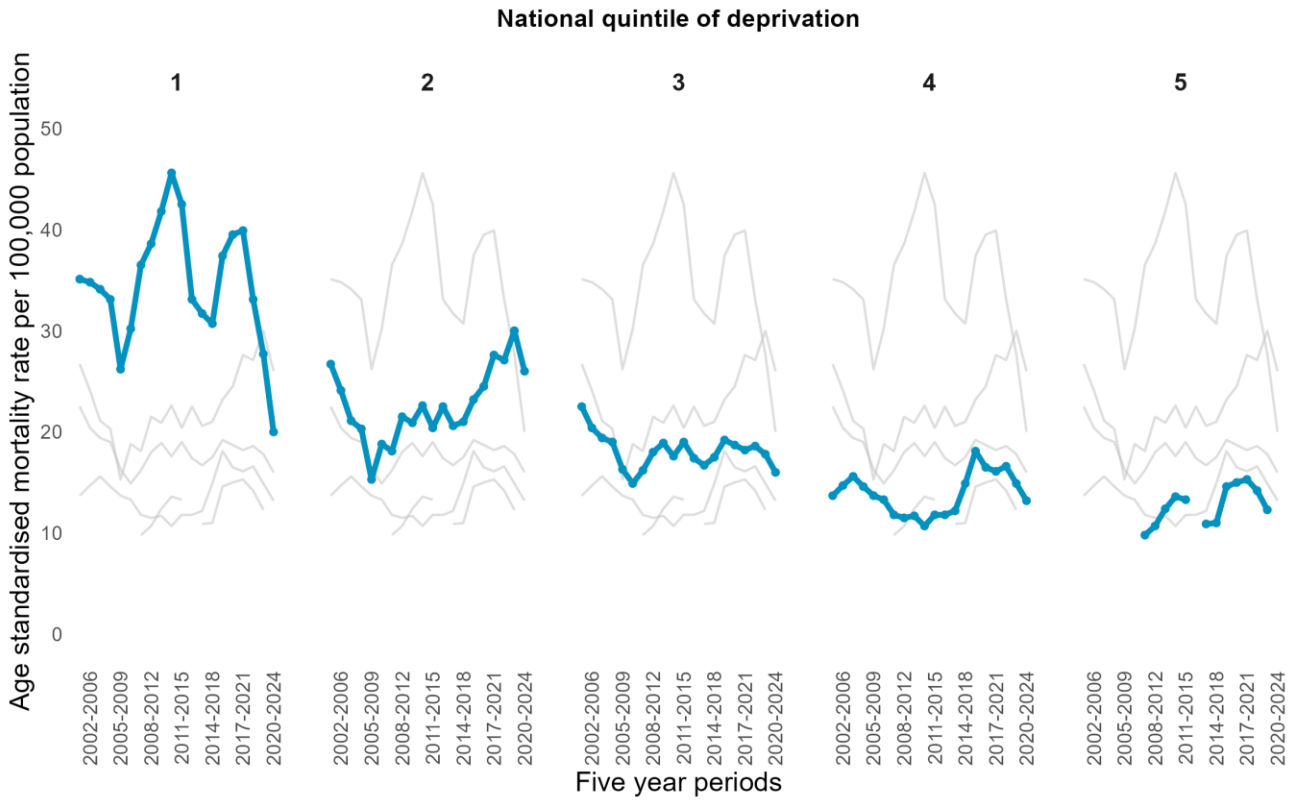
In the most deprived areas of Highland, suicide mortality rates show two distinct peaks over the period beginning 2001-2005, with the current rate falling to 20 per 100,000 in 2020-2024. However, this recent rate is not statistically significantly different from the rate observed between 2015 and 2019.

In contrast, suicide rates among individuals living in deprivation quintile two in Highland have increased in recent years, reaching levels comparable to those in the most deprived quintile.

Gaps in the line series for the most deprived quintile reflect periods where fewer than ten deaths were recorded, and age-standardised rates were therefore not calculated.

The equivalent graphic for Argyll and Bute is not presented due to multiple five-year periods with fewer than ten observed deaths per quintile, limiting the reliability of trend interpretation.

Figure 21: Age-standardised suicide rate by Scottish Index of Multiple Deprivation quintiles in Highland[1], rolling five-year periods, 2001-2005 to 2020-2024



Source: National Records of Scotland[5]

1. Rates were calculated using the appropriate Scottish Index of Multiple Deprivation release for the five-year periods.
2. Grey lines provide context by showing other SIMD quintiles.

Urban-rural patterns

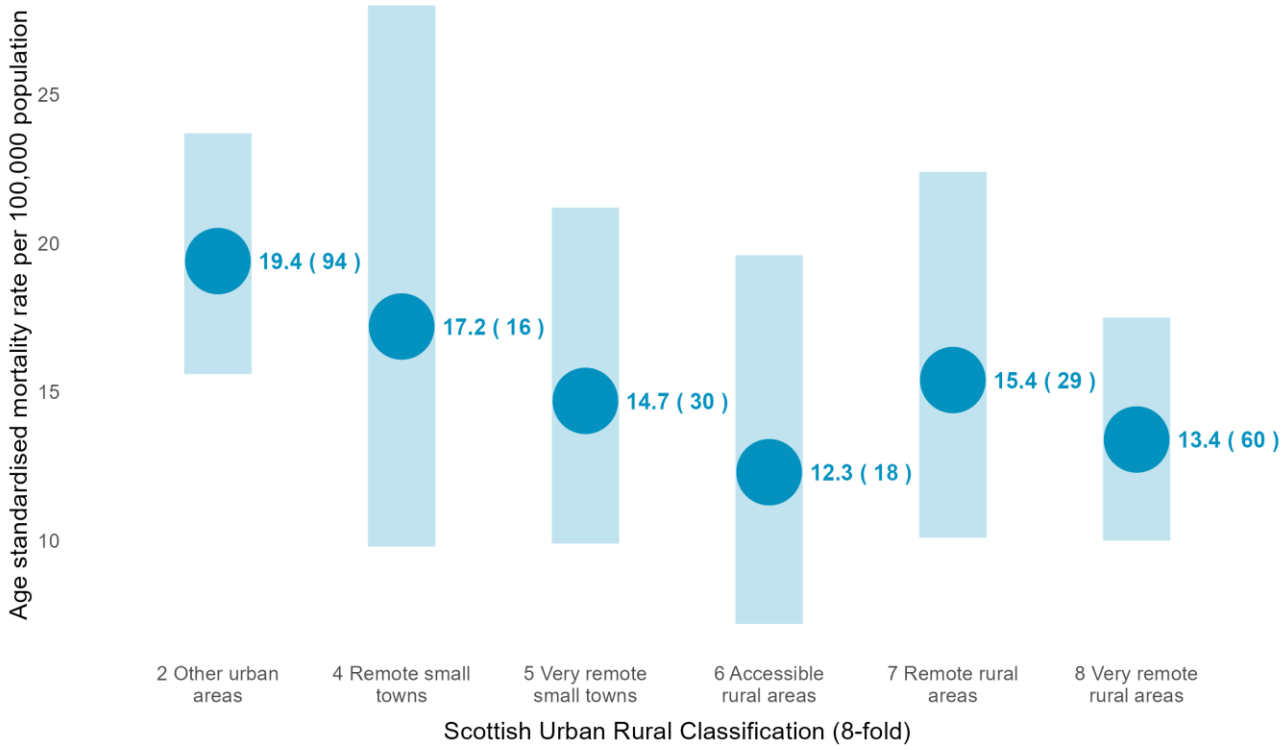
Figure 22 shows the pattern of deaths from probable suicide across urban and rural areas of NHS Highland between 2020 and 2024. Age-standardised suicide rates ranged from 19.4 per 100,000 in other urban areas to 12.3 per 100,000 in accessible rural areas.

Although previous Scottish studies have observed lower suicide rates in accessible rural areas[9,10], there is currently no statistically significant difference between urban–rural categories within NHS Highland. At a national level, historically higher rates of probable suicide in remote rural small towns have declined over time. In NHS Highland, similar reductions have contributed to a narrowing of urban–rural disparities in suicide rates (Figure 23).

The convergence of suicide rates across urban and rural settings suggests that risk is now more evenly distributed geographically within NHS Highland. The pattern may reflect improvements in access to support services, particularly in remote small towns, changing social dynamics, or broader shifts in population mental health.

The statistical convergence, however, does not imply uniformity in underlying risk factors. The recent increase in suicide rates among individuals living in deprivation quintile two in Highland also suggests a complex interplay of factors. Even in areas not classified as most deprived, residents may experience economic precarity, insecure employment, or housing instability—factors known to influence mental health.[9]

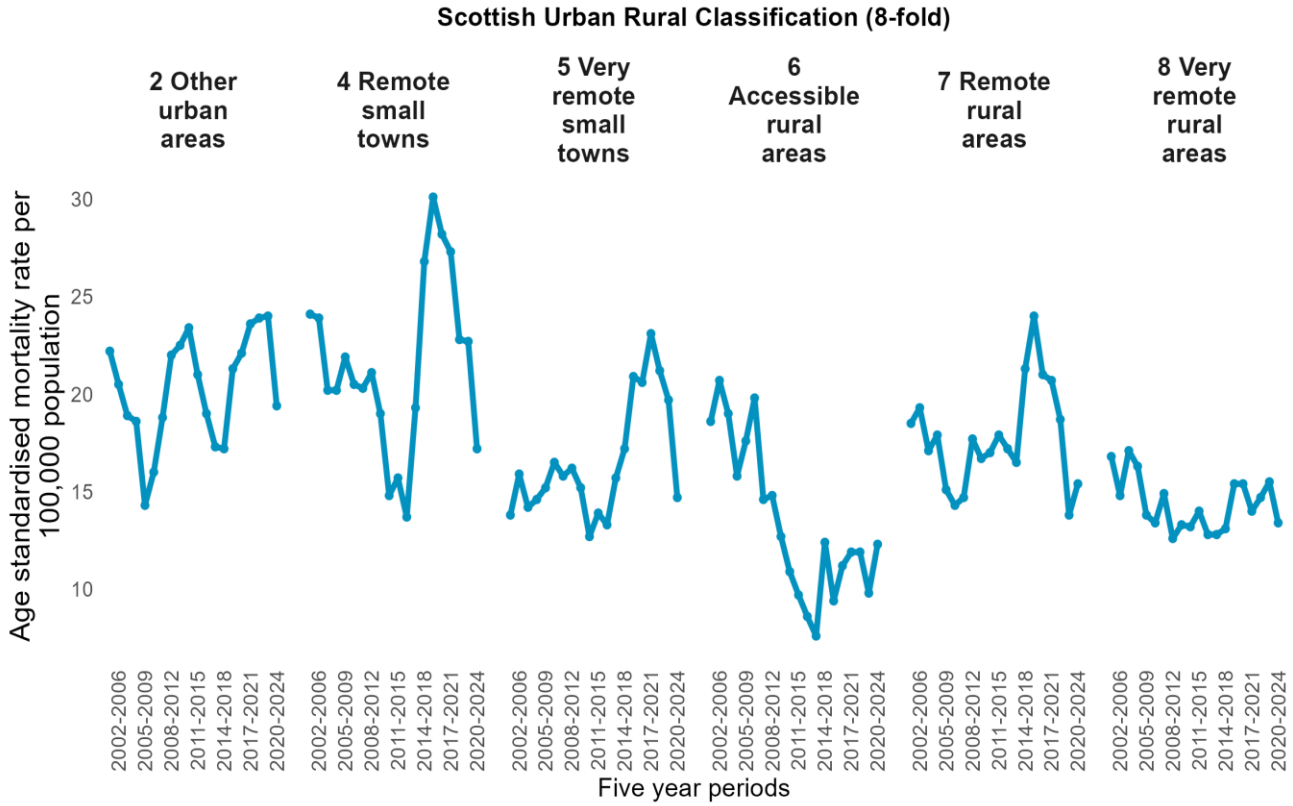
Figure 22: Age-standardised suicide rate by eight-fold 2020 urban-rural classification in NHS Highland, 2020-2024



Source: National Records of Scotland[5]

1. Scottish Government Urban Rural Classification 2020
2. There were fewer than ten deaths from suicide in areas classified as accessible small towns (category three) in the period in NHS Highland, and age-standardised rates are not calculated.
3. The shaded area represents the 95% confidence interval range of the rate

Figure 23: Age-standardised suicide rate by eight-fold 2020 urban-rural classification in NHS Highland, rolling five-year periods, 2001-2005 to 2020-2024



Source: National Records of Scotland[5]

1. Scottish Government Urban Rural Classification 2020
2. There were fewer than ten deaths from suicide in areas classified as accessible small towns (category three) in the period in NHS Highland, and age-standardised rates are not calculated.

Probable suicide rates in partnership areas

Suicide statistics in smaller geographies within NHS Highland represent deeply personal and tragic losses. In many areas, the number of deaths is low, and while each life lost is significant, the small numbers mean that apparent differences between areas may reflect statistical variation rather than underlying patterns.

Figure 24 shows that between 2020 and 2024, the highest age-standardised mortality rate from probable suicide was in the Lochaber area, while the lowest was in Mid Ross. The rate in Lochaber is statistically significantly higher than the NHS Highland average, but lower than when elevated rates in the early 2010s previously caused concern in the area.

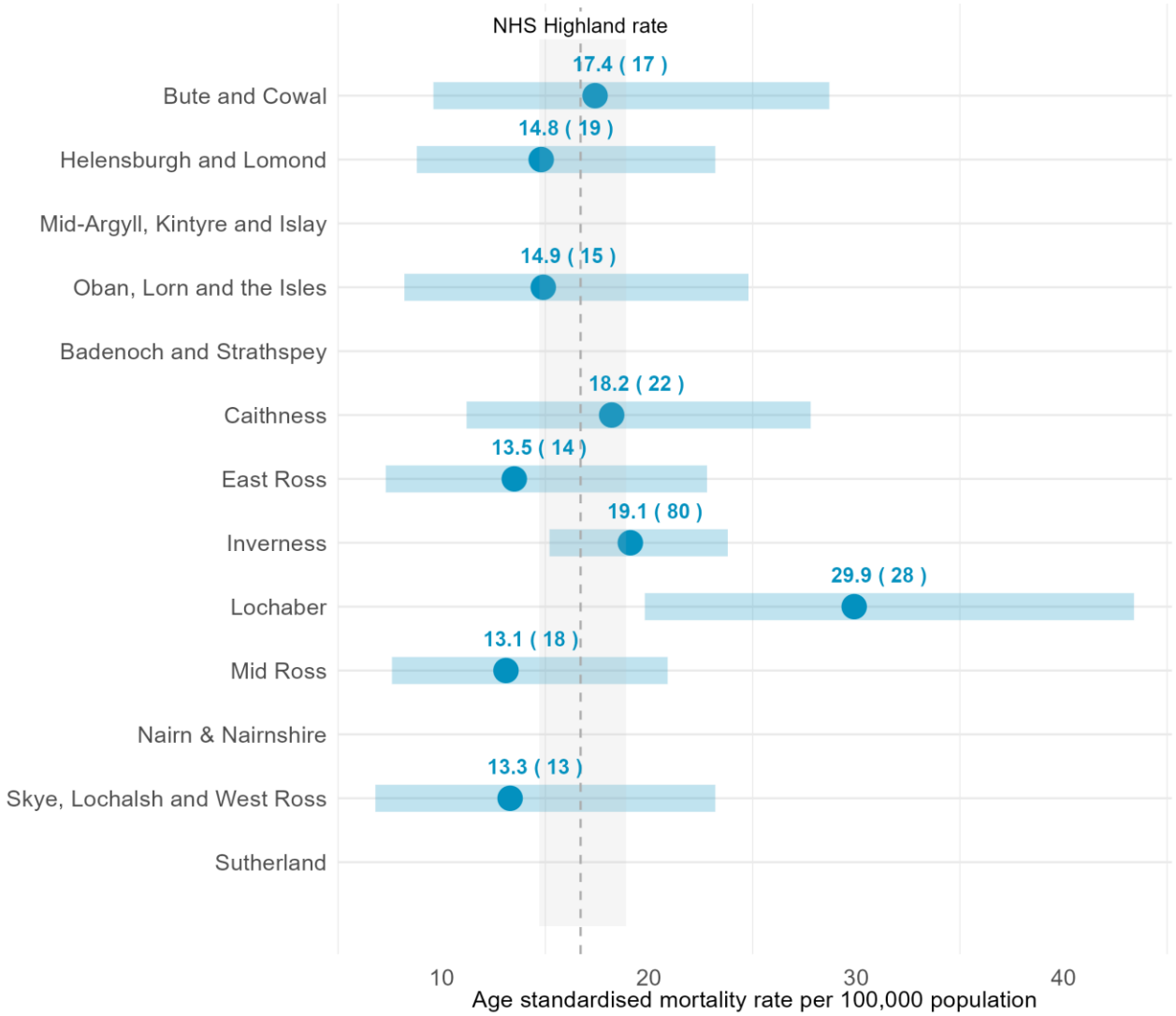
In several areas—Badenoch and Strathspey (5), Nairn & Nairnshire (6), Sutherland (6), and Mid-Argyll, Kintyre & Islay (9)—there were fewer than 10 deaths during the period, making it unsuitable to calculate reliable age-standardised rates.

Looking at trends over time (Figure 25), the most notable recent changes are a consistent increase in the age-standardised suicide rate in Lochaber since its low point in 2013–2017, and a decline in rates in East Ross. In contrast, rates in most other areas have remained relatively stable over the period.

For local suicide prevention planning, these patterns highlight the importance of maintaining universal approaches while remaining responsive to emerging localised needs.

Given the uncertainty inherent in small-area data, responses should be proportionate. Where concerning patterns emerge, more detailed suicide reviews, such as multi-agency thematic analyses, may help clarify underlying drivers of risk and inform targeted prevention efforts. Scotland's national suicide prevention strategy, **Creating Hope Together**, explicitly supports multi-agency learning from suicide deaths to strengthen local and national responses.

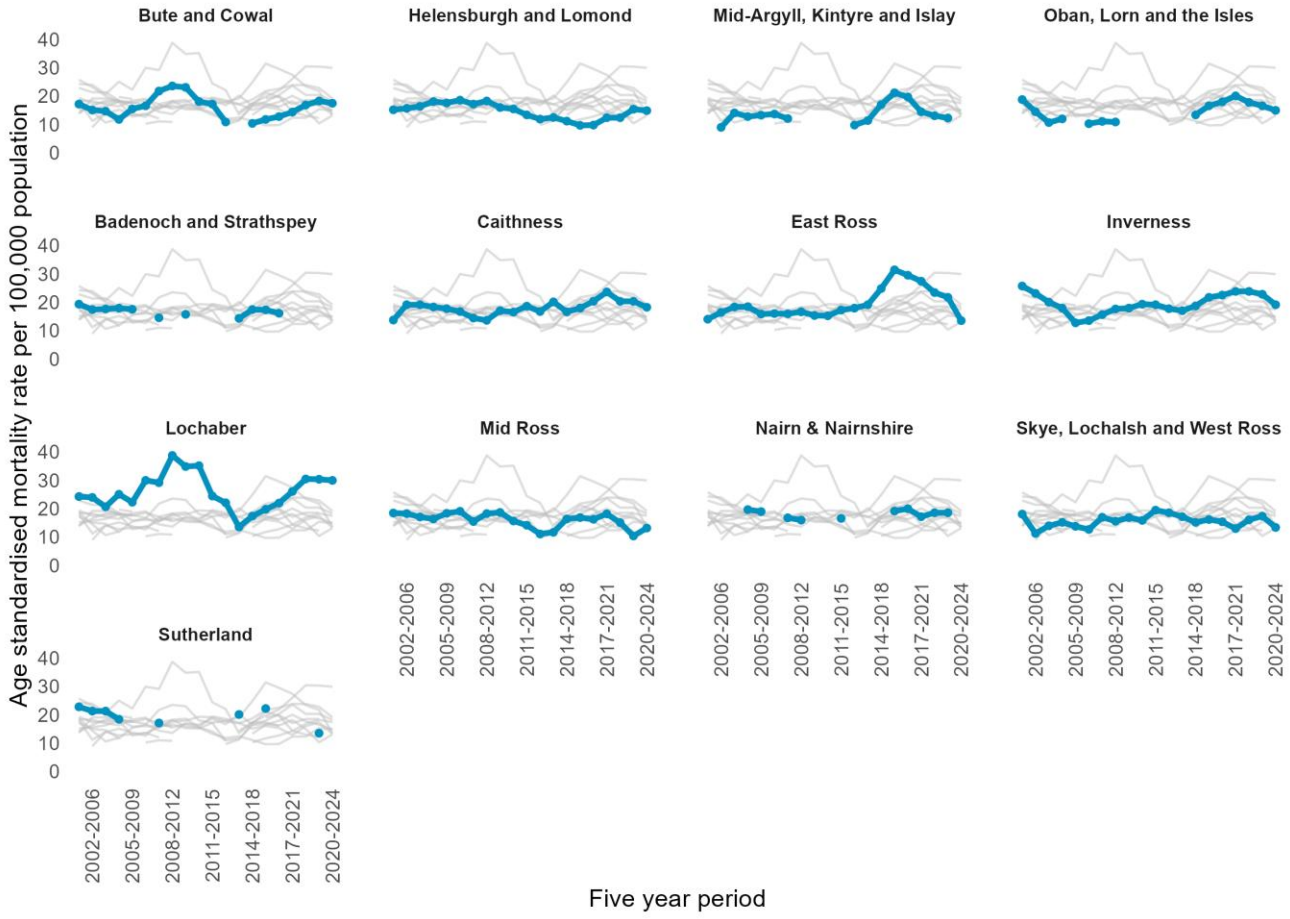
Figure 24: Age-standardised suicide rates in NHS Highland Community Partnerships and Localities, 2020-2024



Source: National Records of Scotland[5]

1. The grey shaded area shows the NHS Highland rate's 95% confidence interval range.
2. The chart series annotation shows the age-standardised rate per 100,000 and the number of events in the period in brackets.
3. There were fewer than ten deaths from suicide in Badenoch and Strathspey, and age-standardised rates are not calculated.

Figure 25: Age-standardised suicide rates in NHS Highland Community Partnerships and Localities, rolling five-year periods,2001-2005 to 2020-2024



Source: National Records of Scotland[5]

1. Gaps in an area's time series occur when the number of deaths in a five-year period is less than ten and age-standardised rates have not been calculated.
2. Grey lines provide context by showing the rates of other areas.

Contact

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Data

Probable suicide data is available to download from the **National Records of Scotland**.

The next update of this publication is scheduled for September 2026

Glossary

Age-specific mortality rate

The age-specific mortality rate is the total number of deaths per 100,000 people in a specific age group, allowing for comparisons between specified age groups.

Age-standardised mortality rate

The age-standardised mortality rate is a weighted average of the age-specific mortality rates per 100,000 people, standardised to the 2013 European Standard Population. Age-standardised mortality rates allow for differences in the age structure of populations, enabling valid comparisons between geographic areas and the sexes over time.

In this report, age-standardised rates are not calculated when the total count of deaths across all age groups is less than ten, in accordance with the technical advice provided by Public Health England on **public health statistics**.

Confidence intervals

A confidence interval indicates the degree of uncertainty of a rate. Lower and upper limits define these values.

The width of the interval depends on the number of deaths, the size of the population denominator and the confidence level used. A 95% confidence level is used, meaning that, on average, 19 out of 20 (95%) times, we would expect the rate to fall within the confidence interval range. A large standard error will result in a wider interval that indicates a less precise estimate.

Confidence intervals were calculated for the report using Dobson's method with Byar's method as recommended for Public Health England's **indicators**.

Deprivation

Deprivation quintiles each contain 20% of Scotland's total population. Deprivation area 1 includes the most deprived 20% of the population, while area 5 contains the least deprived 20%.

Populations

Mortality rates are calculated using the number of deaths and mid-year population estimates produced by the National Records of Scotland for **Scottish administrative areas** and for **small areas**.

To calculate small area rates, as well as rates for deprivation and urban-rural categories, for events occurring from 2023 onwards, we have used the latest available Small Area Population Estimates (SAPE) published by the National Records of Scotland (NRS). These estimates are based on **mid-2022 data** and reflect population distributions across Scotland's 6,976 data zones.

Estimates for mid-2023 and mid-2024 are expected in winter 2025. Until then, the current SAPE dataset remains the best available source for calculating small-area rates. Users should be aware that these estimates are subject to revision and should interpret rate-based analyses accordingly.

Scottish Index of Multiple Deprivation

The Scottish Index of Multiple Deprivation (SIMD) is an area-based measurement of multiple material deprivation that combines seven domains (income, employment, education, housing, health, crime, and geographical access) into an overall index.

The **Public Health Scotland advice** on using the most appropriate release of the SIMD for time trend analysis was used in this report.

Scottish Urban Rural Classification

The Urban-Rural Classification is the Scottish Government's official tool for identifying urban and rural communities in Scotland, based on settlement size and drive times. It is based upon two main criteria:

- population as defined by the National Records of Scotland, and
- accessibility based on drive time analysis to differentiate between accessible and remote areas in Scotland.

The categories for the 8-fold classification are as follows:

(1) Large Urban Areas - Settlements of 125,000 people and over

(2) Other Urban Areas - Settlements of 10,000 to 124,999 people

(3) Accessible Small Towns - Settlements of 3,000 to 9,999 people, and within a 30-minute drive time of a Settlement of 10,000 or more

(4) Remote Small Towns - Settlements of 3,000 to 9,999 people, and with a drive time of over 30 minutes but less than or equal to 60 minutes to a Settlement of 10,000 or more

(5) Very Remote Small Towns - Settlements of 3,000 to 9,999 people, and with a drive time of over 60 minutes to a Settlement of 10,000 or more

(6) Accessible Rural Areas - Areas with a population of less than 3,000 people, and within a drive time of 30 minutes to a Settlement of 10,000 or more

(7) Remote Rural Areas - Areas with a population of less than 3,000 people, and with a drive time of over 30 minutes but less than or equal to 60 minutes to a Settlement of 10,000 or more

(8) Very Remote Rural Areas - Areas with a population of less than 3,000 people, and with a drive time of over 60 minutes to a Settlement of 10,000 or more

For further details on the methodology, please see the publication report accessible from the main Urban Rural Classification topic page on the **Scottish Government's website**.

Statistical significance

Significance has been determined using the 95% confidence intervals, where instances of non-overlapping confidence intervals between figures indicate the difference is unlikely to have arisen from random fluctuation.

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