Suicide Prevention Scotland.

Data & Information

Local Suicide Prevention Planning and Implementation Toolkit

Local Suicide Prevention Planning and Implementation Toolkit

What will this document support you to do?

- Consider which local and national data sources might be relevant to your work
- Provide insight on how to interpret, use and present data
- Understand some principles around information sharing and where to find out more
- Provide practical examples of how to use the data to inform your practice
- Identify potential support for further data analysis that might be required

When might this document be most helpful?

- Developing or reviewing a local area action plan
- Developing targeted interventions or activities
- Considering data-informed actions
- Considering monitoring, evaluation or impact

Contents

Suicide Prevention Scotland.

Introduction

Local areas should develop suicide prevention action plans with supporting activities based on local need.

Nationally and locally available data can be used to help determine that need alongside other sources of evidence. Data can also help us to determine changes over time that we might need to be alert to and can highlight the impact of our work.

This section of the Local Area Suicide Prevention Planning and Implementation Toolkit will focus on utilising local and national datasets. You can find further information about gaining practice insight, subject expertise and living and lived experience insight in the **Action Plan Development** and **Involving People with Lived and Living Experience sections** of this toolkit.

Work around access to suicide prevention related data is ongoing with regular updates and improvements being made. For further information on the latest practice examples and update, visit the **Suicide Prevention Scotland website**.

Receiving suicide-related data and information can be distressing for the recipient and/or those involved in analyses, interpretation and discussion around the data. It can be difficult to predict which datasets or information you might find distressing, and when or if you might find this distressing. Before receiving and sharing information it's worth considering the level of detail that you need to support the work of yourself or others and discussing with others some strategies that will help when dealing with potentially upsetting data and information.

The **You First podcast series** and accompanying resource explores experiences of people working in potentially stressful and emotionally demanding roles and insight into how they look after their own wellbeing.

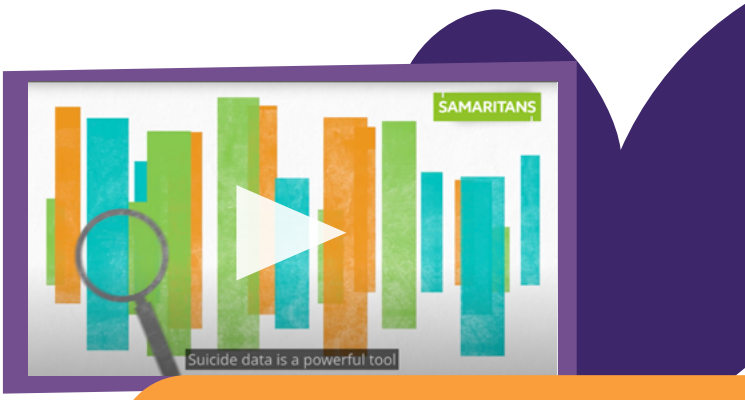
What data allows us to do

Knowing who dies by suicide, when and how, as well as the factors that might make some people more at risk of suicide, is fundamental to reaching people at risk. Data can also be used to look at where there might have been opportunities for intervention. This data can help us to understand which groups of the population might be at further risk of suicide and informs decisions around where we should focus our suicide prevention efforts.

Why we look at suicide statistics

If we are sharing, collecting, analysing, and / or interpreting data we need to be clear about **why** we are doing it. The data that we collect can be used in a number of different ways:

- To gather an overview of the trends in the local area to inform suicide prevention action plan and/ or service development
- As surveillance for potential clusters or identification of locations of concern
- To activate a postvention / support response
- To demonstrate the impact of suicide prevention activities (see **Outcomes, Monitoring and Evaluation section** of Toolkit)
- To conduct a multi-agency suicide review or contribute to other death review processes



Watch the video "why we look at suicide statistics"

Suicide Prevention Scotland.

Suicide Behaviour:
What data & information sharing allows us to do

Locations of concern

- Identification of new locations
- Monitoring of existing understanding around demographics
- Evidence to support preventative action

Information could include:

Age
Sex
Postcode (locus/residence)
SIMD
Method
Ethnicity
Employment Status
Occupation/Employer
Possible Contributory Factors
Service Contact

Suicide Clusters

- Exploration of connections between suicide incidents in order to determine or rule out clusters
- Informing cluster response plans

Support for those affected

- Bereavement support or information
- Witness support or information
- Identification of vulnerable people or communities affected
- Ensuring affected staff are notified and supported

Key Partners could include:

Public Health
Police
Fire & Rescue
Samaritans/Network Rail
British Transport Police
Health & Social Work
Third Sector & Community
Service Providers
Education / DBI

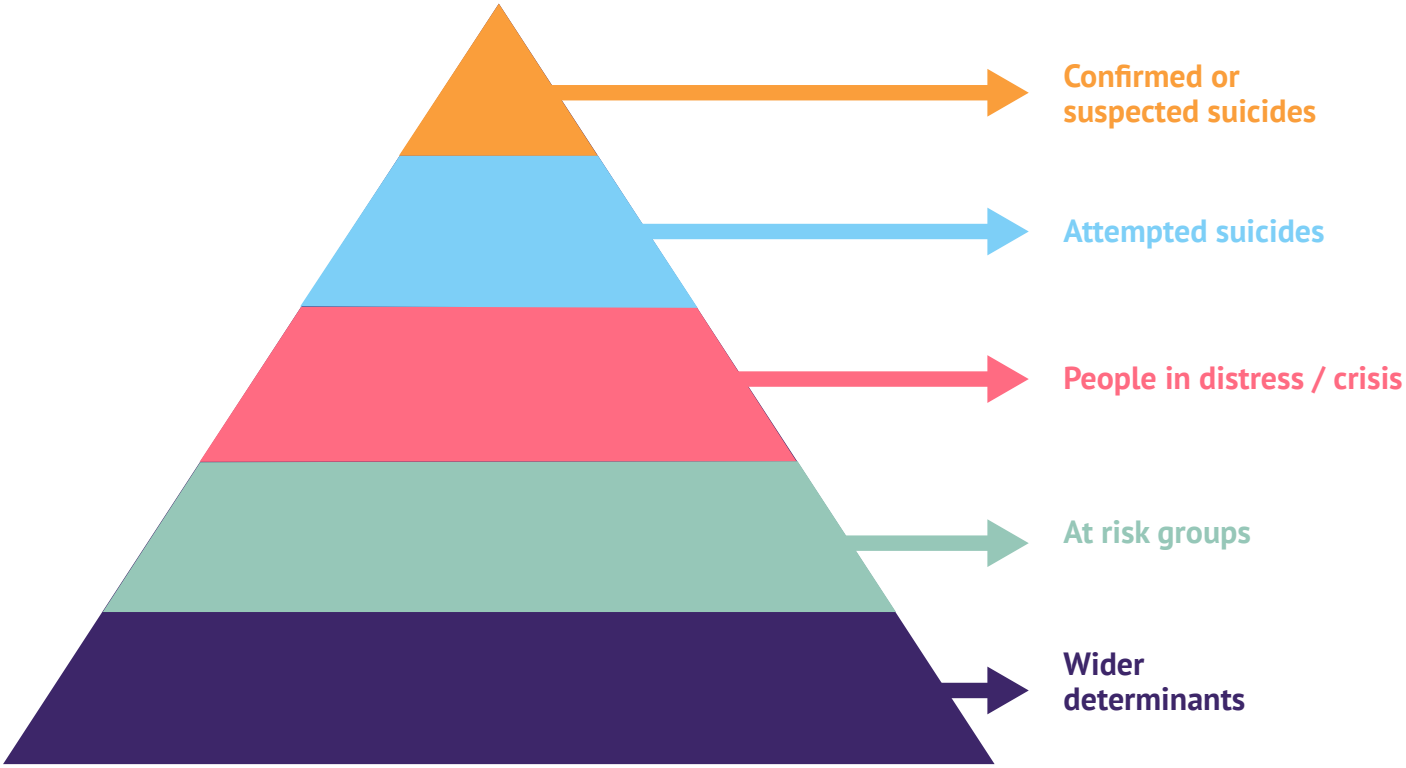
Informing preventative actions

- Trends in demographics & methods
- Understanding of common contributory factors
- Targeted learning or training
- Media/social media monitoring and engagement
- Service development or improvement
- Inform local activites
- Campaign development & community awareness
- Multi agency suicide reviews

Monitor to demonstrate the impact of all of the above activities/interventions/actions.

Sources of suicide prevention data

There are a number of types of data relating to suicide prevention that might be important in shaping your work.



The Suicide Prevention Data Sources Summary table highlights detailed information relating to the most frequently used data sets around confirmed or suspected suicides, and additional datasets around attempted suicide, mental health service use and wider datasets relating to the social determinants of mental health and suicide.

Local areas will have access to different levels of data and information depending on their local agreements. However, the most frequently used datasets are listed in the next section.

Classification of suicide

The International Statistical Classification of Diseases and Related Health Problems (ICD), is used to code the causes of deaths. ICD-10 is the tenth version of these classifications and has separate categories for deaths which, on the basis of the information that is available, can be classified as being the result of:

- intentional self-harm (ICD-10 codes X60-X84 plus Y87.0) and
- events of undetermined intent (ICD-10 codes Y10- Y34 plus Y87.2.)

Intentional self-harm includes cases where it is clear that the person's intention was suicide. This might include a note being left, or something that the person has said or done. **Intentional self -harm** also includes cases where the evidence establishes that a person died as a result of self-inflicted injuries, even if it is not clear that suicide was the intention.

Events of undetermined intent are cases where it is not clear whether the death was the result of intentional self -harm, an accident or an assault. It is thought that most of the deaths which are classified as being the result of events of **undetermined intent** are likely to be suicides, it is conventional to combine them with the **intentional self-harm** deaths to produce these statistics. This will over-estimate the true number of suicides, because some **undetermined intent** deaths will not have been suicides - but their numbers are unknown. There is also the potential for under-recording of deaths as where there is a lack of evidence a death might be classified using the cause rather than suicide, for example falling from a high place or road traffic accident.

In some datasets you will see the data referred to as probable suicides or suspected suicides, this is because sometimes an investigation will take place around the circumstances of the death and that can take some time for the death certificate to be released to clarify the cause of death. For example a suspected suicide could later be reclassified as a drugs related death and this would result in the death being re-coded. Datasets noted in the tables below as preliminary or unverified mean that the data is not drawn from the final classification of death and could still be subject to change.

National Records of Scotland (NRS) Annual Suicide Data

Published by	Frequency	Data type	Restrictions
National Records of Scotland (NRS)	Annual (usually August for the previous calendar year)	Verified	Publicly available

Deaths in the past year by intentional self-harm and by undetermined intent in Scotland in a given year. The data provides details of the number of suicides in Scotland broken down to local authority and health board level and include gender, age, deprivation, and method. It allows comparisons across areas in Scotland and also has links to similar data for other countries in the UK.

Five year averages are used to show a more accurate picture of mortality at council and heath board level. This is because the small numbers involved make calculating an age-standardised rate quite difficult. For smaller council areas, confidence intervals can still be quite wide.

The publication regarding deaths by probable suicide 2024 is available here: **Probable suicides 2024 - National Records of Scotland (NRS)** You should check the NRS website as a more recent publication could be available.

Scottish Suicide Information Database (ScotSID)

Published by	Frequency	Data type	Restrictions
Public Health Scotland	Annual	Verified	Publicly available

The overall purpose of ScotSID is to provide a central repository for information on all probable suicide deaths in Scotland, in order to support epidemiology, policy-making and preventive activity. The database includes information on rates, socio-demographic characteristics, methods of suicide and contact with health care services. Future development of ScotSID is planned and will eventually provide details relating to the suicide events and the wider social circumstances of the deceased.

The latest ScotSID reports are available below:

- **Healthcare Contact Pathways of the ScotSID Cohort (2024)**
- **A profile of deaths by suicide in Scotland 2011 to 2021 (2023)**
- **Suicide among young people in Scotland (2022)**
- **Suicide in Scotland in the COVID-19 pandemic (2021)**

If requested Public Health Scotland can also provide further local area or health board breakdown.

Further information is available **Public Health Scotland Website** or by emailing **phs.mentalhealthanalytics@phs.scot**

More Timely Data

Published by	Frequency	Data type	Restrictions
Police Scotland / Public Health Scotland	Frequently throughout the year	Preliminary	Management information*

This report is produced on a frequent basis throughout the year, utilising the Scottish Suicide Information Database (ScotSID) and data received through collaboration between Police Scotland and Public Health Scotland. Outputs are presented at a local authority level and are released as management information only to named recipients responsible for suicide prevention work in each area.

Categories of information included are annual and quarterly deaths by suicide broken down by sex, age group, method, deprivation category, marital status, employment status and contact with healthcare services.

Outputs are aggregated and provide as up to date data as possible, with currently a 6 week time lag. Figures for the previous year are subject to change as death records are updated to reflect decisions on probable suicides (for example a suspected suicide may later be classified as a drugs-related death). Recent figures should be assessed with caution until NRS figures are published for that year.

Further information is available from Public Health Scotland on **phs.mentalhealthanalytics@phs.scot**

* See page 18 for further explanation of restrictions around datasets marked Management Information Only

Police Notification Form

Published by	Frequency	Data type	Restrictions
Police Scotland	Ad-hoc	Unverified	Management information only*

Police Scotland can provide information to designated local partners when someone dies by suspected suicide in the local area. This information is shared as close to real time as possible, and usually within 24-72hrs depending on the local arrangement.

The data that can be shared includes identifiable information such as name, date of birth, postcode of residence and locus (place of death). The form can also provide other information from drop down menus including method and suspected contributory factors.

Some local areas will have existing agreements where similar data may be shared, however all local areas should be able to access the above information as a minimum if they are able to use it as part of their suicide prevention work.

For further information please contact your local Police Scotland representative.

Deaths by suicide on the railway

Published by	Frequency	Data type	Restrictions
British Transport Police	Ad-hoc	Unverified	Management information*

The British Transport Police provides a notification proforma of death or serious injury on the railway for Scotland as a region, this includes suspected suicides. Local partners can request access to this notification proforma and this is shared as close to real time as possible, and usually within 24-72hrs. The data that is shared includes the date and time of incident, the location and route, and whether there were witnesses. Also included is the age bracket, gender, and the distance the person had travelled from home address and if there are any potential contributory factors. Sometimes further details of the death are provided in the narrative.

Local areas can also reach out to the British Transport Police to discuss cases or receive demographic information of those who have died by or attempted suicide on the railway in their area. This can include demographics of frequent presenters.

Further information is available by contacting: **NationalVulnerabilityUnitAnalysis@btp.police.uk**

* See page 18 for further explanation of restrictions around datasets marked Management Information Only

Other related datasets

In addition to the datasets outlined above there are a number of other datasets providing information around service use, attempted suicide and the wider factors that might increase risk of suicide. A summary of these datasets is provided in the **Suicide Prevention Data Sources Summary table** with some of the more commonly used sources of data also highlighted below:

Office of National Statistics (ONS)
The ONS produce annual reports of the data available for all countries in the United Kingdom. This data allows comparisons across the UK and includes information about age, gender and method. **Data for England and Wales** is available. Helpful summaries are available on the **Samaritans website.**

World Health Organization (WHO)
The WHO produce **information** at a global level for deaths by suicide. This is most useful for work at a national level but may also be of interest for local areas. Data analysis and collection can vary across countries and this should be taken into account when making comparisons.

The National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH)
For over 20 years the **NCISH** has collected and analysed the suicide deaths of mental health patients from across the UK. They produce an annual report for this data and a number of themed reports each year. The information has helped to improve, shape and support changes in patient safety for those with mental illness.

Annual attempted suicide data (Scottish Health Survey)
The Scottish Health Survey collects information on the percentage of adults who made an attempt to take their own life, by taking an overdose of tablets or in some other way, in the last year. You can compare attempted suicide percentage and self-harm percentage by age, sex, deprivation and comparison over time.

Mental Health Quality Indicators Dashboard
The **MHQI publication** was created to provide an overview of mental health services across Scotland, by combining previously published and new information into a single profile.

Equalities and inequalities datasets

The **Evidence Narrative** that supports the Scottish Government's Mental Health and Wellbeing Strategy provides an overview of evidence around mental health and wellbeing including links to specific datasets on population groups. The Evidence Narrative notes the gaps in data around people belonging to different population groups, for example those with intersecting protected characteristics.

The **EQIA** for Creating Hope Together highlights a number of different sources of data relating to people with protected characteristics.

The **Scottish Index of Multiple Deprivation** is often used to learn about the local area, as suicide rates are usually higher in the most deprived areas.

There is ongoing work to address gaps in our data and knowledge around suicide prevention in relation to inequalities. For example the team working on ScotSID are exploring the potential linkage of other datasets such as the Public Health Scotland race and ethnicity index and data on care experience.

Practice example: QES recording and reporting system on deaths by probable suicide

Building on earlier test pilots of suicide review processes and commissioned as part of the Creating Hope Delivery Plan, local areas can access an electronic system to support the recording, collation and reporting of reviews undertaken on those who have died by probable suicide. Data from Police Scotland can be used to input to the system locally.

This system, supported by QES through training and ongoing help, allows local stakeholders to provide information on key aspects that cover data including demographic and social information, engagement with services and previous suicidal behaviour known about those who have died. It has the potential to link to local bereavement support services and to visually map locations or methods to aid forward planning and preventative activities. Access to the data is managed by local stakeholders. The system can also be used for regular monitoring and surveillance of suicide trends in a local area.

As of September 2025, nine areas in Scotland are actively using QES with continuous feedback used to improve recording and reporting, and the intention is for more local areas to use the system over time. The long term intention is to draw on local data to enhance the national ScotSID reports as well as helping to identify where further action is required.

Reflective questions:

Why are you collecting data?

What data sources do you currently have and how do you use them?

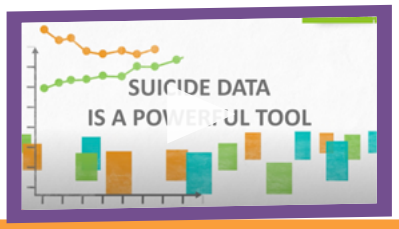
Are there any gaps in the data?

Is there any data that you are collecting but not using that you can stop collecting?

Turning data into intelligence: analysis and interpretation

Analysing and interpreting data is the process of turning numbers and rates into intelligence that you can act upon.

Samaritans have also issued **advice** on using suicide data, which has been supplemented below:



Watch the film from Samaritans on How to interpret suicide data Samaritans

Purpose

As we receive, analyse and interpret data we should keep in mind the purpose of doing so, and how we will be using it. Sometimes people refer to this as answering the **what now** or the **so what** questions. If we have access to the data then how will it be used?

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 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 take account of differences in the age structure of populations between different countries or regions, so that comparisons 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).

Be careful of small groups/populations

The size of populations should be considered when looking at suicide rates. Differences in the number of suicides may have a bigger impact on the rate in a small population than in a larger population. For example, in a hypothetical Health Board area, with a population of 20,000, an increase in the number of deaths from suicide from 4 to 5 would result in an increase in rate from 20 to 25 per 100,000, whereas the same increase in numbers from 4 to 5 in a Health Board area with a population of 1,000,000 would result in a much smaller increase in rate from 0.4 to 0.5 per 100,000.

Health Board Area	A (population 20,000)	B (population 1,000,000)
Number of suicide deaths Y1	4	4
Rate per 100,000 Y1	20 per 100,000	0.4 per 100,000
Number of suicide deaths Y2	5	5
Rate per 100,000 Y2	25 per 100,000	0.5 per 100,000

This can affect whether a local area appears higher in a table highlighting suicide rates in Scotland, and can sometimes be misinterpreted by decision makers and media around significant changes year on year.

Rates for a whole country can mask local and regional variations

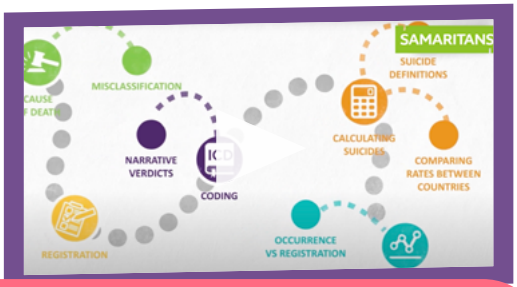
It is important to note that within countries there may be significant regional and local differences in suicide rates.

Year-on-year fluctuations can be misleading

It is important to look at suicide trends over a relatively long period of time, for example NRS data provides a 5 year rolling average. Increases and decreases year-on-year occur and should not necessarily be viewed as 'true' changes to the trend that are attributable to any specific psycho-social factors (eg, an increase in unemployment). Any changes to the way data are collected or analysed should also be ruled out.

Variation in datasets

Sometimes there can be variation in datasets, this is often related to the source and timing of the data being shared. For example, data from ScotSID is updated each month from NRS submissions on probable suicides, and as such figures are subject to change until NRS finalise the previous year's data. This might be as a result of a suspected suicide being reclassified as a different cause of death. Data obtained locally for suspected suicides may not capture all deaths that subsequently go on to be classified as a probable suicide in NRS records and may also contain suspected suicides that eventually are not classified as probable suicides. For these reasons, discrepancies between locally obtained data and that held within ScotSID are likely. This is reflected in the descriptions of datasets in the **Suicide Prevention Data Sources table** as verified or unverified. Verified means that this is based on the final classification of death, whereas unverified refers to preliminary reports.



This **video** from Samaritans explains why a death can be misclassified.

Dig deeper into different variables

Think about specific variables, and combinations of variables, that are relevant. Age, sex, method, occupation status, marital status, health service contacts are all available and presented individually within More Timely Data reports, but ad-hoc requests can combine these and others. For example, are there particular groups of males who are more at risk of suicide in your area?

Additional context

Consider use of wider national and local datasets that can be combined with suicide data to explore potential questions. The **Suicide Prevention Data Sources table** is a good starting point to explore existing datasets. Data is only one source of information and evidence that can inform your work and so it is usually important to consider this in the wider context of academic evidence, living and lived experience insight and practice insight when considering improvements or interventions.

Support for analysis and interpretation

You may be able to access local support for collecting, managing, analysing and interpreting data locally from your local Public Health Team or NHS Health Intelligence colleagues. In addition, relevant specialists linked to other areas of data might be able to help you to understand the datasets and trends in relation to their area of work.

Practice example

Exploring how wider sources of evidence might support our understanding of suicide risk.

One local area has had low numbers of death by suicide in recent years and wanted to explore what other sources of data might support local discussions about priorities for suicide prevention and mental health work.

As part of this, the local area requested Public Health Scotland data on hospital admissions for self-harm. This data included the total number of admissions with a recorded self-harm diagnosis by age groupings and sex in the local area. The local area also looked at the number of unique patients to consider the contribution that people with multiple presentations made. One significant finding was that while there had been very few deaths by suicide of children and young adults in the previous 10 years, a high proportion of those attending hospital for self-harm were young adults.

If there had not been this further analysis the local area could have drawn inaccurate conclusions around the need for self-harm and suicide prevention work with children and young people.

However, it should be noted that there are a variety of problems currently with service data for people who present with self-harm in Scotland due to a lack of recording of intent in A+E systems and in discharge data and coding rules if no information is provided on intent.

Also, NHS service attendance data may only show the tip of the iceberg of the issue as many people will not attend services, as the physical consequences of the self-harm may not be severe enough to require medical intervention.

Practice example

There is limited data around a specific location of concern. Is there more information I can find out to expand our understanding and make decisions on the most appropriate interventions?

In more than one local area Police Scotland have provided further information about individuals who attend a specific location of concern. In these instances Police Scotland have been able to search their database for call outs to the location in relation to mental health, self-harm and attempted suicide and completed suicides. They were also able to provide further information relating to gender, age, home postcodes, and peak times / days. In some instances Police negotiators can provide qualitative data from the Police Negotiator Database which can highlight some of the challenges being faced by the individuals attending the location, and by the negotiators in supporting someone in distress. Depending on the location there may also be data or intelligence from Fire and Rescue, site managers, RNLI or Scottish Ambulance Service that could supplement this data.

Reflective questions:

What additional questions do you have that data might help to support your learning around?

What further sources of evidence (e.g academic, professional practice, lived and living experience insight) might you need?

Who can help you to analyse and interpret that data?

How will you use this data?

Information sharing

Many of the datasets mentioned within this document are publicly available, this means that you can share this information with partners and through any wider communications or documents that may be publicly available.

Other datasets mentioned are for **Management Information Only** and therefore onward sharing is restricted. This is usually because:

- the data is unverified and therefore could change
- there is potentially identifiable information
- the information has the potential to cause harm (for example sharing information about methods of suicide can increase risk of vulnerable people using that method).

Usually data that is for **Management Information Only** will be provided to designated individuals in the local area who are able to act on this information, this will depend on the dataset. Some local areas will aggregate the data so that it is not identifiable and share this with a limited group, such as the Suicide Prevention Steering Group or subgroup to help inform suicide prevention efforts.

Practice example

Tayside Multi-Agency Suicide Review Group (TMASRG)

The TMASRG is chaired by Public Health and reviews all Tayside suicide deaths. Recommendations for suicide prevention activity are made based on in-depth local knowledge and research evidence. When someone dies by suicide in the region the Public Health team reach out to agencies (police, primary care, secondary care mental health and substance use services, social work) to find out if they have additional information relating to the individual. This intelligence is then collated and discussed at a multi-agency review group which has restricted membership to review the cases and consider any overall trends or improvement actions that could be taken. An annual report is produced which is shared with partners and available online which combines NRS data alongside an overview of data from the TMSARG process. This allows further breakdown of characteristics, for example the Annual Report 2022 highlights the use of cocaine amongst people who died by suicide in Dundee over a 5 year period.

If you are working with another partner agency locally to share information about individuals it's likely that you will need an information sharing agreement. Sometimes this will be covered by existing agreements in place to support the protection of individuals and in other cases a new agreement will need to be signed off by all partners.

Ensuring that only relevant parties have access to any data and that your systems and processes are ready to receive and send this data is key. This might include considering who will receive the data, how it will be stored and in what circumstances it can be shared and why.

Sharing information about people who are living (such as people who have attempted suicide or family members) has additional protocols which should be followed, although it is also good practice to follow these when sharing information about people who have died. Often there can be good reasons for sharing information about people under public protection arrangements, for example if you are worried about the welfare of a child or adult.

The Caldicott Principles are eight principles to ensure people's information is kept confidential and used appropriately. These principles apply to the use of confidential information within health and social care organisations and when such information is shared with other organisations and between individuals, both for individual care and for other purposes. They include considering the purpose for using confidential information, using confidential information only when necessary, it should also be kept to a minimum and shared on a need-to-know basis.

Support around information sharing

Guidance and templates to assist in the development of information sharing agreements are available.

You can refer to **Adult Support and Protection Guidance** or **Child Protection Guidance** for information on your duties and powers, or contact your local Information Governance Team for further information or support.

Although developed for use in England you may find these documents helpful when further exploring appropriate information sharing:

- **Information sharing and suicide prevention: consensus statement - GOV.UK**
- **SHARE: consent, confidentiality and information sharing in mental healthcare and suicide prevention**

Practice example

NHS Orkney Online Module: Information Sharing in Crisis

Appropriate information sharing can have a major impact on outcomes for patients. In crisis situations, time is of the essence and staff need to feel confident to act in the best interest of the patient without any undue delays. To help support staff in their role NHS Orkney developed an online self-directed learning module on TURAS about **information sharing in crisis.**

This was developed as an overview for health, social care and partner agencies working in Orkney to encourage them to share information to prevent harm or loss of life for an individual, and to safeguard vulnerable adults and children. The module outlines the law around data protection and is clear around what you can share when someone is in a mental health crisis and when it might be appropriate to disclose, who it can be shared with and how information should be shared. The module addresses an underlying fear that can be felt by practitioners by answering the question 'will I get into trouble for sharing people's information?'

Some other local areas are now looking at adopting a similar module.

Reflective questions:

Do you know who the information governance specialists are within your organisation?

Do you need an Information Sharing Agreement or other documentation to support your project?

Can local data analysts or health intelligence teams support you?

Who can help you to understand what you can and can't share?

Are you clear when you can share information, in what circumstances and who with?

Resources and support

The following resources and support may be useful when considering your work around data.

Local support

You may be able to access local support for collecting, managing, analysing and interpreting data locally from your local Public Health Team or local NHS Health Intelligence colleagues. In addition, the Information Governance team or Data Protection Officer locally should be able to support you with any Information Sharing Agreements that might be required.

Suicide Prevention Scotland

Suicide Prevention Scotland has recorded a series of podcasts including one on Data and Intelligence. The podcast explores some of the terminology used when discussing data, some of the opportunities and challenges when analysing and interpreting data, and some examples and advice around improving your local approach to using data.

You can listen to the **Suicide Prevention Scotland Podcast**

Samaritans

Samaritans have produced a number of resources to support the interpretation of suicide data.

Understanding suicide statistics video

Understanding suicide statistics video explains how deaths are registered and classified across the UK and the implications this can have for the data that is produced. The video also explains how suicide rates can be used to compare the number of suicides between groups or geographical areas.

Why we look at suicide statistics video

This video highlights why using suicide statistics is important in our efforts to prevent suicide.

How to interpret suicide data video

This video provides three key principles for the interpretation of suicide data.

The publication **Understanding UK and ROI Suicide Statistics** provides further detail on the information provided in the videos.

For further information contact Public Health Scotland on phs.suicidepreventionteam@phs.scot