

Publication Report



The Scottish Suicide Information Database Report 2011

2009 Data

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Contents

Contents	2
About ISD	4
Official Statistics	4
Introduction.....	5
Acknowledgements.....	6
Key points.....	7
Executive Summary.....	8
Results and Commentary	10
1. BACKGROUND AND POLICY CONTEXT.....	10
1.1 Epidemiology of Suicide.....	10
1.1.1 The Situation in Scotland	10
1.1.2 Scotland Compared to the UK and Europe.....	12
1.1.3 Aetiology and Risk Factors.....	14
1.1.3.1 Previous Findings.....	14
1.1.3.2 The National Confidential Inquiry.....	15
1.2 Policy Context.....	15
2. METHODS.....	16
2.1 Definition of Probable Suicides for the Scottish Suicide Information Database.....	16
2.2 The Scottish Suicide Information Dataset.....	16
2.3 Data Sources	17
2.4 Data Confidentiality and Information Governance	18
2.5 Data Quality Assurance	19
2.6 Internal Record Linkage Process	19
2.7 External Data Linkage Phase.....	20
2.7.1 GP Pilot.....	20
2.7.1.1 Method	20
2.7.1.2 Outcome.....	21
2.7.1.3 Summary of Findings.....	22
2.7.1.4 Time Analysis	22
2.7.1.5 General Issues	22
2.7.1.6 Conclusion	23
2.7.2 Police Sudden Death Report/ Procurator Fiscal Pilot.....	23
2.7.2.1 Method	23
2.7.2.2 Outcome.....	24
2.7.2.3 Time Analysis	25
2.7.2.4 General Issues	25
2.7.2.5 Conclusion	25
2.7.3 Healthcare Improvement Scotland (HIS)	25
3. SCOPE OF REPORT	25
4. DATA ANALYSIS.....	26
4.1 The Scottish Suicide Information Database Cohort for 2009	26
4.2 Socio-demographics	26
4.2.1 Geographical Area	26
4.2.2 Age and Gender.....	27
4.2.3 Marital Status	28
4.2.4 Employment Status and Occupation	29
4.3 Circumstances of Death	31
4.3.1 Method of Suicide	31
4.3.2 Month & Day of Death	33
4.3.3 Post Mortem Undertaken	33
4.3.4 Place Where Suicidal Act & Death Occurred	33
4.4 Contact with Health Services	34
4.4.1 General Hospital Discharges.....	34

4.4.2 Psychiatric Hospital Discharges	38
4.4.3 Psychiatric Outpatient Appointments	41
4.5 Life Events	43
4.6 Lifestyle and Risk Factors – Contact with Drug Services.....	43
5. Discussion and Next Steps	45
References	46
Glossary	48
List of Tables	49
List of Figures	50
Contact	51
Further Information	51
Rate this publication	51
Appendix.....	52
A1 – The proposed Scottish Suicide Information Database 2011 Dataset.....	52
A2 – Difference between ScotSID and NRS Figures.....	67
A3 – ScotSID Data Items Used During the GP and Procurator Fiscal Service Pilot.....	68
A4 – The Scottish Suicide Information Database Steering Group	70
A5 – Publication Metadata (including revisions details).....	71
A6 – Early Access details (including Pre-Release Access)	73

About ISD

Scotland has some of the best health service data in the world combining high quality, consistency, national coverage and the ability to link data to allow patient based analysis and follow up.

Information Services Division (ISD) is a business operating unit of NHS National Services Scotland and has been in existence for over 40 years. We are an essential support service to NHSScotland and the Scottish Government and others, responsive to the needs of NHSScotland as the delivery of health and social care evolves.

Purpose: To deliver effective national and specialist intelligence services to improve the health and wellbeing of people in Scotland.

Mission: Better Information, Better Decisions, Better Health

Vision: To be a valued partner in improving health and wellbeing in Scotland by providing a world class intelligence service.

Official Statistics

Information Services Division (ISD) is the principal and authoritative source of statistics on health and care services in Scotland. ISD is designated by legislation as a producer of 'Official Statistics'. Our official statistics publications are produced to a high professional standard and comply with the Code of Practice for Official Statistics. The Code of Practice is produced and monitored by the UK Statistics Authority which is independent of Government. Under the Code of Practice, the format, content and timing of statistics publications are the responsibility of professional staff working within ISD.

ISD's statistical publications are currently classified as one of the following:

- National Statistics (ie assessed by the UK Statistics Authority as complying with the Code of Practice)
- National Statistics (ie legacy, still to be assessed by the UK Statistics Authority)
- Official Statistics (ie still to be assessed by the UK Statistics Authority)
- other (not Official Statistics)

Further information on ISD's statistics, including compliance with the Code of Practice for Official Statistics, and on the UK Statistics Authority, is available on the [ISD website](#).

Introduction

This is the first report from the Scottish Suicide Information Database (ScotSID): It reports on deaths due to probable suicide occurring during the calendar year 2009. It is widely recognised that the limited information available on people who complete suicide in Scotland, other than those in contact with mental health services, hampers our understanding of the risk factors for their behaviour and may therefore reduce the relevance and effectiveness of preventive efforts.

While there are data available on the number of suicides, there is limited information on the prior health and wider social circumstances of those who have completed suicide in Scotland. In the absence of such information, reliance is placed on findings of suicide research published in international literature. These findings may be a reasonable 'general' guide to suicide but cannot, by definition, highlight the specific features of suicide in Scotland which may be different from those found elsewhere. Whilst risk factors such as gender, psychiatric illness, and drug and alcohol disorders have been identified previously, much more is required to understand the circumstances surrounding the event in order to inform local and national policies in Scotland.

The overall aim of the Scottish Suicide Information Database is therefore to provide a central repository for information on all probable suicide deaths in Scotland, in order to support epidemiology, preventive activity, and policy making.

The database covers demographic information, contact with health services and related health data, and will eventually provide details relating to the suicide event and individuals' wider social circumstances.

The National Records of Scotland (formerly General Register Office for Scotland) undertakes national reporting of all deaths due to intentional self harm or undetermined intent on an annual basis and routinely sends information relating to these deaths to the Information Services Division (ISD). These deaths provide the basis for the Scottish Suicide Information Database. Along with analysis from the National Records of Scotland (NRS) Deaths Database, ISD's own datasets have been interrogated to provide further insight in order to inform future preventive efforts and reduce deaths due to intentional self harm.

Information retrieval from social care systems is not in the scope of this project due to the complexities of gathering and accessing this information at a national level.

Acknowledgements

The Scottish Suicide Information Database was initiated by Dr Laurence Gruer OBE, Director of Public Health Science with NHS Health Scotland, who also chairs the ScotSID Steering Group. The ScotSID project team is funded by NHS Health Scotland as part of its mental health improvement programme.

This report was prepared by Parveen Chishti, Celina Davis, Lisa Reddie, Gordon Thomson, Rachael Wood (all ISD) and Laurence Gruer (NHS Health Scotland).

We would like to take this opportunity to thank the members of the ScotSID Steering Group who have provided valuable support and advice on the process from beginning to end (see membership in Appendix A4).

Thank you also to Practitioner Services Division, National Services Scotland, for all their assistance during the GP pilot and equally to the Scottish Fatalities Investigation Unit, for their support and assistance during the Procurator Fiscal pilot.

We would also like to acknowledge Frank Dixon from NRS who has provided helpful support and clarity during the process of writing this report.

Key points

- There was a total of 760 deaths due to suicide and events of undetermined intent in 2009. Of these, 744 were Scottish residents.
- Almost three quarters of those who died were male and almost half aged between 35 and 54 years.
- Among those of employment age, 68% were in employment and a wide range of occupations were represented.
- Seventy one percent of suicidal acts occurred in a private dwelling.
- Sixteen percent of those completing suicide died in hospital.
- Of the Scottish residents, 441 (59%) had been an inpatient in a general hospital less than five years before death.
- Of these 441 inpatients, 26% had a diagnosis of 'Injury from Intentional Self Harm' and 20% had a diagnosis of 'Unintentional Injury (including assault by another person)', at discharge.
- Twenty one percent had been a psychiatric inpatient less than five years before death.
- Mood disorders, substance misuse and schizophrenia were the most frequent diagnoses at discharge from a psychiatric unit.

Executive Summary

Introduction

It is widely recognised that the limited information available on people who complete suicide in Scotland, other than those in contact with mental health services, hampers our understanding of the underlying problems and may therefore reduce the relevance and effectiveness of preventive measures.

During the 2008 “Choose Life” summit, NHS Health Scotland made a commitment to lead work to establish a Scottish Suicide Information Database (ScotSID), in order to improve the quality of information available on suicides in Scotland. A steering group was set up and ISD was commissioned to develop, analyse and maintain the database. This is the first ScotSID report. It describes the development of the database so far and presents new findings covering the calendar year 2009. Many of these have been made possible by linking each individual's death record with information about previous contacts with a range of NHS services. It is expected that future reports will include information from a wider range of sources as these are added to the database

Methods

The ScotSID database starts with death records of probable suicides and deaths due to undetermined intent routinely submitted to ISD by the National Records of Scotland. Following carefully designed procedures to ensure the security and confidentiality of the data, these are then electronically linked to other databases already held by ISD relating to general and psychiatric hospital admissions, outpatient attendances, obstetric care, and treatment for drug misuse.

Pilot exercises to determine the feasibility of obtaining additional data items for ScotSID from GP records, and police sudden death reports submitted to the Procurator Fiscal, have been completed and the findings are presented in this report.

Results

In 2009, there were 760 people whose deaths were recorded as due to suicide or undetermined intent. Of these, 744 had been resident in Scotland and 16 elsewhere. Almost three-quarters were male, and almost half aged between 35 and 54 years. About 70% were single, widowed or divorced. Among those of employment age, 68% were in employment and a wide range of occupations were represented. Half of the men died by hanging, strangulation and suffocation, and half the women by poisoning.

There were no statistically significant differences in the incidence of suicide by day of the week or month of the year.

The majority of suicidal acts occurred in a private dwelling (71%). Sixteen percent of all deaths occurred in hospital; the location where the suicidal act occurred was unspecified in the majority of these cases. The remaining 84% are likely to have died at the same location as where the suicidal act occurred.

Of the Scottish residents, 59% percent had been an inpatient in a general hospital less than five years before death. Of these, almost 26% were due to intentional self-harm and 20% to an unintentional injury or assault. Twenty-one percent had been a psychiatric inpatient less than five years before death, most commonly due to depression or other affective disorders. Most

of these psychiatric admissions had been voluntary, with only 12 individuals having been detained under the mental health act.

Of the women, 22% were found to have biological children under the age of 16. Of these, 20 had one child, 15 had two children, and eight had three or more.

Fifty-three individuals were known to specialist drug services, for 36 of whom further information regarding drug misuse was available. Of these, 12 had had an assessment with drug services less than six months before death, and a further eight, within six months to a year. The most common drugs used were heroin, cannabis, diazepam and ecstasy.

Conclusion

The report sets out the origins and aims of the ScotSID and how it has been set up. It summarises the results of the pilot studies exploring the practicalities of obtaining information from primary care records and procurator fiscal reports. It then uses the data currently in the database for those people who completed suicide in Scotland in 2009, to provide more information about the circumstances of their death and their health and social circumstances during the months and years before it occurred.

At this stage, ScotSID is only able to provide limited additional information about the people who died. However, it does show the wide range of their backgrounds and indicates that many had had recent general hospital admissions for a wide range of reasons, with intentional self-harm and unintentional injury or assault being particularly frequent. Many had made use of psychiatric inpatient or outpatient services, with mood disorders, substance misuse and schizophrenia being the most frequent diagnosis. However, perhaps equally importantly, it also shows that 40% of the cases had had no admission to a general hospital in the previous five years and almost 80% had not had a psychiatric admission during that period.

Over the next few years ScotSID will provide a much larger body of information based on thousands of cases. This will include the linkage of further data items derived from other data sources such as Procurator Fiscal records. Changes in the patterns of suicides which occur over the years will be more evident. The growing number of cases, the greater detail, and the trends over time will together provide an increasingly strong foundation for understanding suicide in Scotland, for identifying common factors at which preventive efforts could be directed, and for evaluating whether what is being done is having a beneficial effect.

Results and Commentary

1. BACKGROUND AND POLICY CONTEXT

1.1 Epidemiology of Suicide

1.1.1 The Situation in Scotland

Over the last decade suicide and non-fatal self-harm have become increasingly recognised as important issues for public health policy and practice in Scotland. A key reason for this interest is the high suicide rates observed in Scotland compared to the rest of the UK.

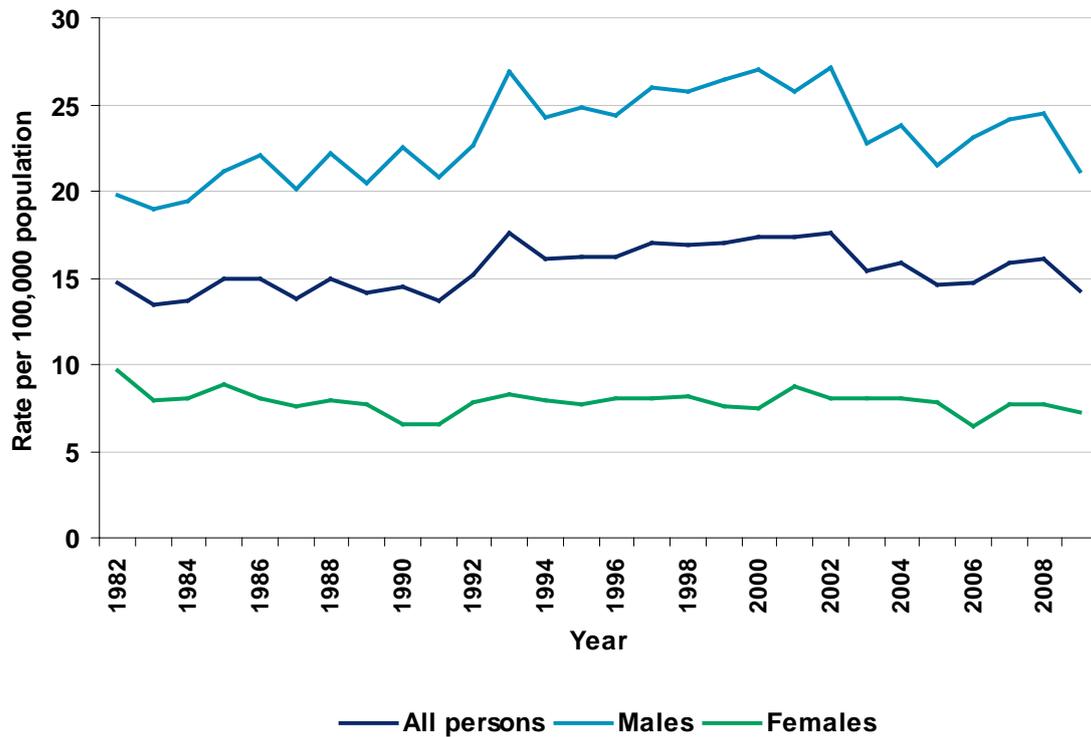
In its annual report on mortality statistics for 2009, the NRS recorded 746 deaths due to probable suicide (intentional self harm and due to events of undetermined intent). These included 549 males and 197 females [1]. Further analysis by the Scottish Public Health Observatory (ScotPHO) reported that this represented a European age-sex standardised rate of 14.2 deaths per 100,000 population, the lowest rate since 1982 when it was 14.7 per 100,000 [2]. The rate peaked in 1993 at 17.6 per 100,000 (Figure 1). Of the 746 deaths that occurred in Scotland, 731 were residents of Scotland and 15 from countries elsewhere [1].

European age-standardised rates over time are shown in Figure 1 for both males and females separately [2]. For males, rates peaked in the 1990's and early 2000's, the highest being observed in 2002 (27.1 per 100,000) with a decline thereafter. A peak was observed again in 2008 but not at the same level as during the previous decade.

For females, rates decreased from 9.7 deaths per 100,000 women in 1982, the highest rate observed over the time period, to 7.2 per 100,000 in 2009 [2]. Suicide rates remained consistently lower among females than males. More recent temporal comparisons based on three-year rolling averages, show that between 2000-02 and 2007-09 there was a 13% fall in suicide rates in males and a 7% fall in females. In 2009, the rate for males was around three times that for females.

A separate study examining whether there was a significant change in trend over the period 2000-2004, reported a 42% reduction in suicide rates in 15-29 year old males, implying a significant reduction in suicide rates in that age group [3].

Figure 1: Intentional Self Harm and Events of Undetermined Intent Death Rates (EASRs), Scotland



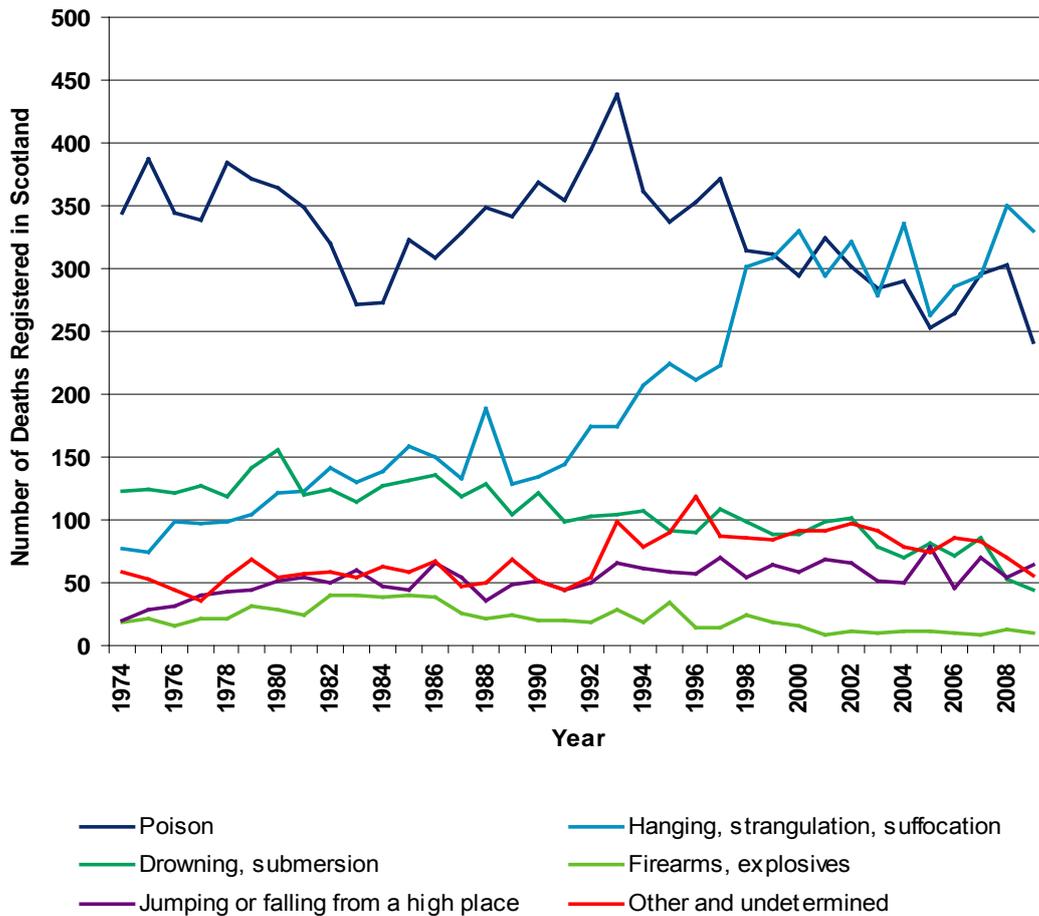
Source: Scottish Public Health Observatory 2010

Age-specific suicide rates (averaged over period 2007-2009) show that for males, the highest rates were found in the 25-34 and 35-44 years age groups, at 39.1 and 40.8 per 100,000 respectively. The highest rates for females were observed in the 35-44 and 45-54 years age groups, at 12.7 and 12.3 per 100,000 respectively. Compared to previous years (1987-1989), both genders experienced an increase in rates for those aged under 55 years but there was a decrease in the 55+ age groups [2].

In recent years, the most common method of suicide has been ‘hanging, strangulation and suffocation’ (44% in 2009), followed by ‘poisoning’ (32%). Nine percent killed themselves by jumping or falling from a high place, and 6% by drowning or submersion; only 1% used firearms or explosives [1]. Methods of suicide have changed over the years. In the 1970s over half took ‘poison’, only about one in eight used hanging, and almost a fifth drowned (Figure 2).

A national study previously reported that the main method of suicide was different for males and females [4]. Hanging was most common amongst males and self-poisoning amongst females.

Figure 2: Number of 'Intentional Self Harm and Events of Undetermined Intent' Deaths by Method



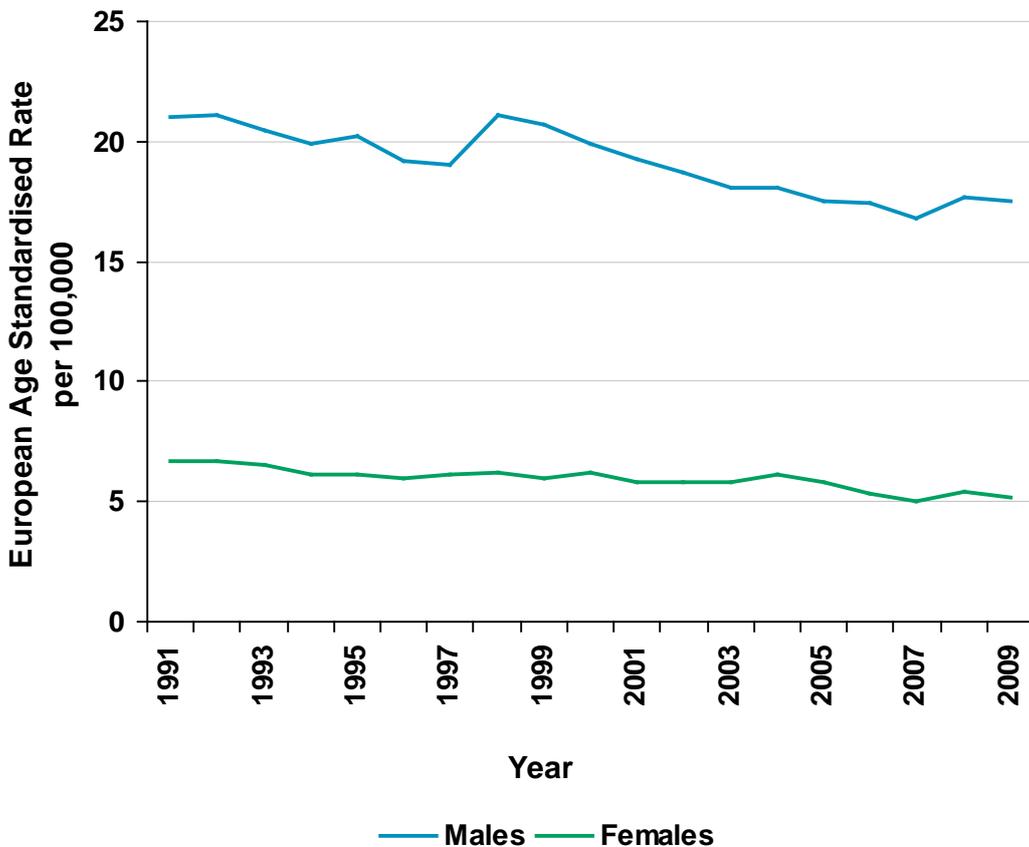
Source: National Records of Scotland 2010

1.1.2 Scotland Compared to the UK and Europe

A report by the Office for National Statistics recently reported that during the period 1991 to 2009, the number of suicides in people aged 15 years and over in the UK gradually decreased [5]. Numbers peaked in 1998 to 6,354 deaths but continued to fall until 2007 to 5,377. A temporary increase was observed in 2008 but numbers declined again in 2009 to 5,675.

As in Scotland, there are more suicides among males than females in the UK as a whole [5]. Between 1991 and 2009, suicide rates in females in the UK aged 15 years and over were consistently lower than males (Figure 3). Rates for both sexes experienced a general downward trend over time, although for males the rate peaked in 1998 at 21.1 per 100,000. Slight increases were again experienced for both in 2008.

Figure 3: Intentional Self Harm and Events of Undetermined Intent Death Rates (EASRs), United Kingdom



Source: Office for National Statistics 2011

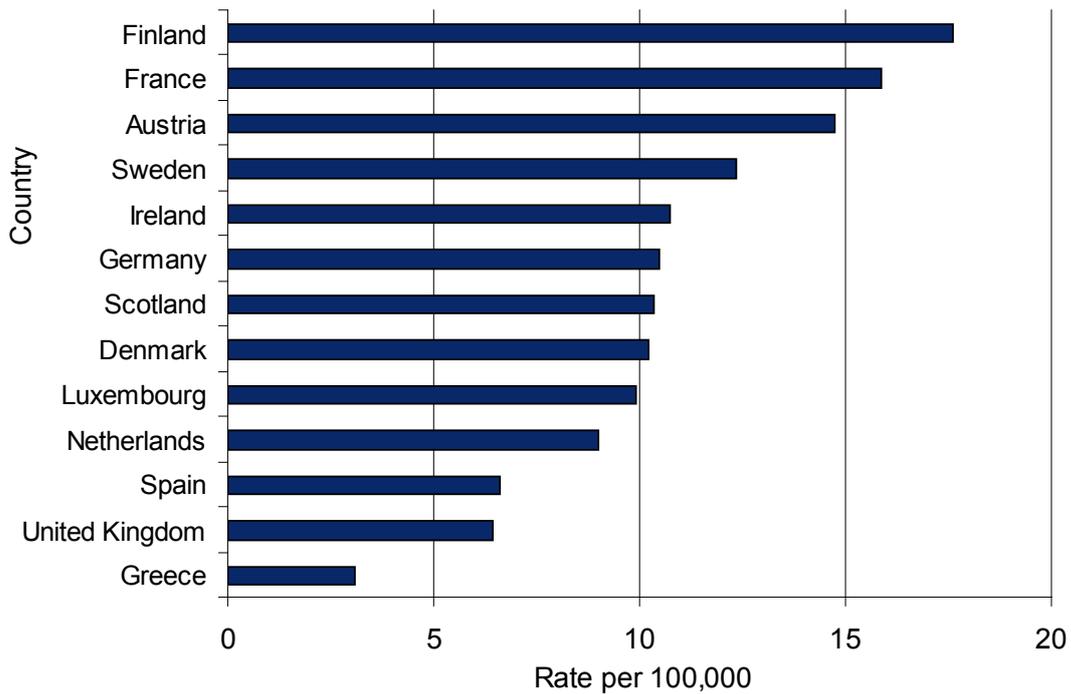
Suicide rates in Scotland in 2008 (the latest comparable year available) were significantly higher than in England and Wales[†] and similar to those in Northern Ireland [6]. For males, the rate was 24.1 per 100,000 for Scotland, 12.6 in England and Wales and 24.7 in Northern Ireland. For females the rate was 7.7 per 100,000 in Scotland, 3.8 in England and Wales and 7.2 in Northern Ireland.

Comparisons of suicide rates (excluding events of undetermined intent) across selected European Union countries[‡] for the year 2005 (latest available year for most EU countries), showed that Scotland ranked lower than many of the other countries (Figure 4) [7]. In fact, Scotland had the 7th lowest suicide rate (10.3 per 100,000) out of a total of 13 countries (including the UK as a whole). Greece experienced the lowest rate (3.1 per 100,000) followed by the UK (6.4 per 100,000 respectively). Rates were not available for males and females separately.

[†] 'England and Wales' covers both Residents and Non-Residents, comparable with Scotland and Northern Ireland data. Separate 'England' and 'Wales' categories cover Residents only therefore individual rates for these countries have not been quoted.

[‡] EU members before 2004 are displayed as these countries represent the most-established and most-developed countries in the EU. Comparable rates were not available for Belgium, Italy or Portugal.

Figure 4: European Age Standardised Mortality Rates (Intentional Self Harm Only - All Ages) for Scotland and Selected European Union Countries, 2005



Source: Scotland and the European Health for All (HFA) Database 2009

1.1.3 Aetiology and Risk Factors

1.1.3.1 Previous Findings

Recent international literature reviews examining risk and protective factors for suicide and suicidal behaviour highlighted the following risk factors: a diagnosis of mental health, a history of suicide attempts, drug or alcohol misuse, anxiety, recent bereavement, unemployment and poverty [8, 9, 10]. Being married appeared protective, possibly through providing a stronger motivation to stay alive or through support from the spouse at difficult times. Many of these factors have also been identified as strong predictors of suicidal behaviour in a previous study of 100 patients who made severe suicide attempts. [11].

A study focusing on risk factors in Scotland demonstrated the need to give greater priority to the effects of social class (at individual level) and socio-economic deprivation (at area level) in local and national suicide prevention strategies and action plans [4]. Furthermore, it was highlighted that it was not enough to target preventive activities exclusively on areas of social disadvantage, as this would not meet the needs of those in the lowest social classes who live outside areas of economic deprivation. The analyses indicate that the influence of individual social class was far stronger than the influence of area-level of socio-economic deprivation.

Studies from various countries have reported associations between particular occupations and high or low suicide rates [12, 13, 14]. Among Scottish men, doctors, farmers, horticulturalists, farm managers, gardeners and groundsmen, and fishermen were shown to have higher rates of suicide [15]. Findings are similar in England and Wales with higher rates among men observed in doctors, pharmacists, veterinarians and those from rural occupations already mentioned, as well as forestry workers, gardeners and groundsmen [16]. A higher risk among

men working in occupations with access to lethal means of suicide, have been highlighted. In women, occupations such as doctors, pharmacists, veterinarians, waitresses and cleaners were found to have higher rates than in the general population

1.1.3.2 The National Confidential Inquiry

The most recent National Confidential Inquiry into Suicide and Homicide by People with Mental Illness revealed that inquiry cases in Scotland were more likely to be in the under 25 age group and less likely to be in the over 65s when compared to England and Wales [17].

For those in the inquiry cohort, people dying by suicide in Scotland were more likely to have been in contact with mental health services in the previous year compared to those in England and Wales. It was also observed that a higher proportion of cases in Scotland were unmarried, living alone or unemployed.

The report also revealed that 33% of inquiry cases in Scotland had never had an inpatient admission compared to 27% in England and Wales. Fewer cases in Scotland had been in contact with services within 24 hours or a week before death.

Alcohol misuse also played a greater part in the lives of suicide cases in Scotland than of those in England and Wales. Seventeen percent of inquiry cases in Scotland had a primary diagnosis of alcohol or drug dependence compared to only 8% in England and Wales. Fifty-eight percent of cases in Scotland were known to misuse alcohol compared to 44% in England and Wales. Drug misuse followed a similar pattern.

While the confidential Inquiry focuses only on those suicide cases that were in contact with mental health services, it provides vital insights into potential associated risk factors and underlines again, the disproportionately high rates of suicide not just amongst those in contact with mental health services but in Scotland as a whole.

It should be acknowledged, however, that risk factors for suicide may differ between those with and without a mental illness at the time of death; and, even among those with a mental illness, there may be differences in risk factors between those known and not known to mental health services. It is hoped that the Scottish Suicide Information Database will enable more detailed analysis of such risk factors for those people completing suicide in the general Scottish population.

1.2 Policy Context

The Scottish Government's Choose Life strategy and action plan was launched in December 2002 [18]. This ten year action plan had seven objectives, the last of which stated:

Knowing What Works: *improving the quality, collection, availability and dissemination of information on issues relating to suicidal behaviour (and self-harm) and on effective interventions to ensure the better design and implementation of responses and services and use of resources.*

During the 2008 "Choose Life" summit, NHS Health Scotland made a commitment to lead work to establish a Scottish Suicide Information Database, in order to address the dearth of contextual information available within a central resource. As a direct result of this, ISD were commissioned by NHS Health Scotland to develop, analyse and maintain such a database (ScotSID).

In 2010, the national suicide prevention working group, led by the Scottish Government, met to consider the findings of two evaluations of the Choose Life strategy undertaken thus far, in order to determine the next stage of action. The aim of each evaluation was as follows:

- a) Phase 1 Evaluation: Assess whether a sustainable infrastructure had been developed nationally and locally to support the Choose Life Strategy in achieving its objectives.

and

- b) Phase 2 Evaluation: To examine progress against the original objectives; whether, and to what extent, the lessons of Phase 1 had been implemented; and whether Choose Life had influenced national and local policies.

The working group published a document 'Refreshing the National Strategy and Action Plan to Prevent Suicide in Scotland' [19] which recommended a more focused approach, targeting in particular, high risk groups. This report identified six refreshed objectives; the key objective most pertinent to the role of ScotSID was:

"Ensure interventions to reduce suicidal behaviour are informed by evidence from research and evaluated appropriately".

The working group emphasised that the new objectives took account of progress during the implementation of Choose Life and built on the objectives originally identified in the programme.

2. METHODS

2.1 Definition of Probable Suicides for the Scottish Suicide Information Database

The definition of a suicide for the ScotSID database is based on the National Records of Scotland classification of a probable suicide i.e. those deaths coded by NRS as intentional self harm and corresponding to categories X60–X84, Y87.0 of the International Classification of Diseases, Tenth Revision (ICD10). The definition also includes deaths by events of undetermined intent (ICD10 codes Y10-Y34, Y87.2), i.e., those where it is not clear whether the death was the result of intentional self-harm, an accident or an assault. It is generally accepted that many of these deaths will actually be suicides but they have not been 'confirmed' as such for NRS statistics. It is accepted international practice to combine both categories in order to achieve a better approximation to a 'true' (although unknown) suicide rate than using intentional self-harm deaths alone.

2.2 The Scottish Suicide Information Dataset

A proposed set of data items (with associated definitions) for inclusion in the ScotSID database was drawn up by ISD in conjunction with the ScotSID steering group. The data items covered the following domains:

- Demographics
- Circumstances of Death
- Medical History
- Contact with Services
- Life Events
- Lifestyle and Risk Factors

- Criminal Justice
- General / Other

A complete list of the proposed ScotSID data items can be found in Appendix A1.

The proposed list has been revised as the ScotSID project has progressed, reflecting increasing understanding of the data items available from particular sources. Further revisions will occur as the project continues to develop.

2.3 Data Sources

ScotSID is based on linkage of routinely available administrative data rather than de novo data collection wherever possible. The starting point for the database was the NRS death records of people dying from probable suicide as described above. Data items from other administrative data sources were then appended to the death records using record linkage techniques to build up detailed information on each individual dying by suicide.

Several potential sources of information were identified in order to meet the core data requirements of the ScotSID. These included:

- Health records held by the Information Services Division ('Scottish Morbidity Records')
- GP records
- Police Sudden Death Reports/Procurator Fiscal Services
- Healthcare Improvement Scotland
- Scottish Prison Service

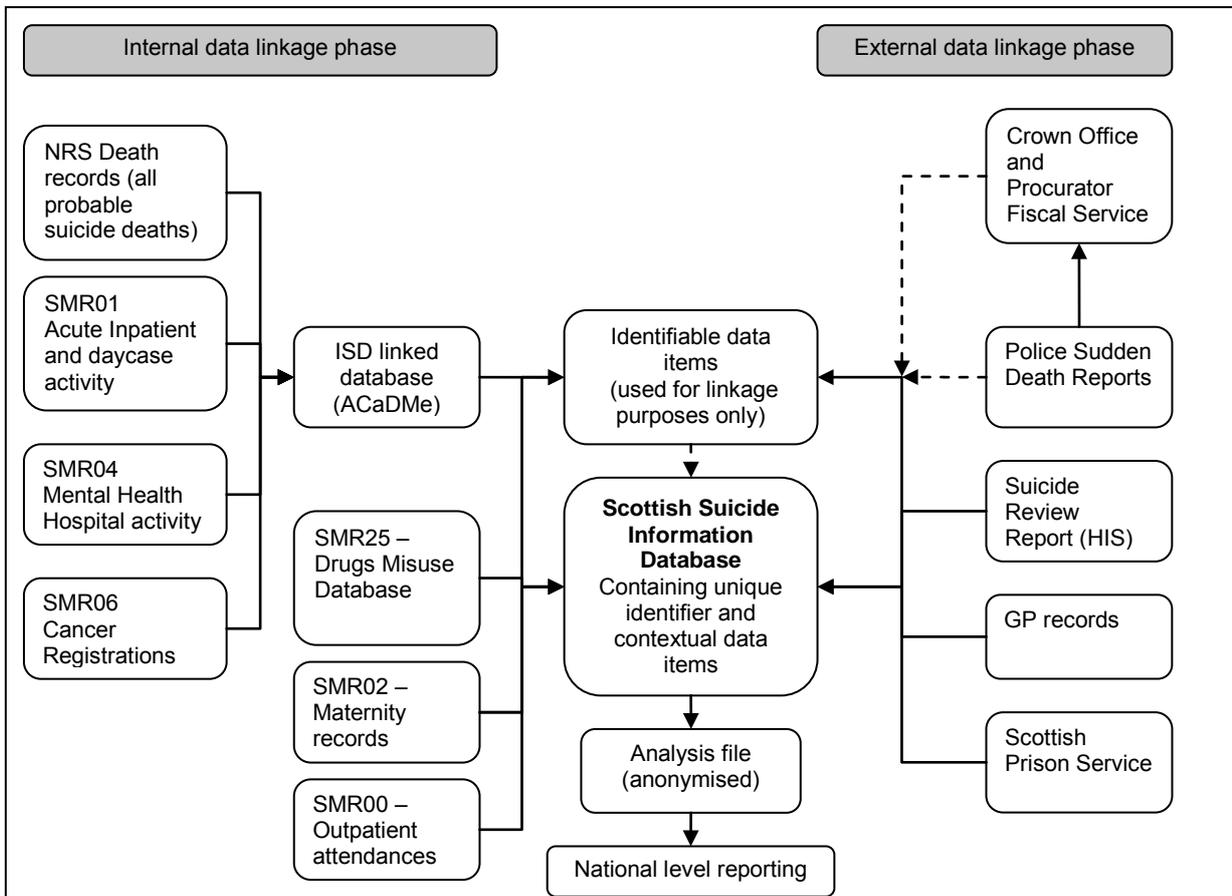
ISD holds a number of different Scottish Morbidity Record (SMR) datasets. For example, whenever a patient is discharged from an acute general hospital in Scotland, an SMR01 record giving information on the patient and their admission is returned to ISD. These datasets provide vital information to support the planning and delivery of health care for the Scottish population, and also are a rich research resource.

For the first phase of the ScotSID project, all Scottish Morbidity Records (SMRs) were interrogated to determine how many of the proposed ScotSID data items they could provide. The ISD datasets identified as being of most value to ScotSID were ISD's linked database ACaDMe (includes records of admissions to acute general and psychiatric hospitals), Outpatient Attendances (SMR00), Maternity Records (SMR02) and Substance Misuse treatment (SMR25). Once all relevant data items from these datasets had been determined, they were appended to the NRS deaths records within ScotSID as described in Section 2.6. At the time of writing, the ScotSID database contains the death records of all probable suicides occurring in Scotland from January 2009 along with the additional variables derived from the individuals' SMR records. The quantitative results presented in this report are therefore based on this first phase of available data.

It is hoped that the same techniques will be applied in future during the external data phase where linkage will be undertaken on information from datasets outwith ISD. It is anticipated these will include GP records, information on suicides of persons under the care of mental health services held by Healthcare Improvement Scotland (formerly NHS Quality Improvement Scotland), Police Sudden Death Reports via Procurator Fiscal Services, and Scottish Prison Service records. Pilot exercises to determine the feasibility of obtaining additional data items for ScotSID from GP records and police sudden death reports submitted to the Procurator Fiscal have been completed and these are reported in Section 2.7.

The diagram below (Figure 5) illustrates the information flow to the ScotSID from each of the different data sources, internal and external.

Figure 5: Internal and External Data Flow to ScotSID



2.4 Data Confidentiality and Information Governance

The ScotSID database links existing information relating to all people who have completed suicide from a range of sources. The specific data elements that were linked for this report include individuals’ death records, and hospital outpatient and inpatient attendance records. It is envisaged that future linkages will extend to GP records, police sudden death records and suicide review reports from mental health services. The linkage of this information will enable as complete a picture as possible to be built up of those individuals who have completed suicide and help identify high risk groups.

Full Privacy Advisory Committee (PAC) approval for the linkage of data items from individuals’ SMR records into ScotSID was granted: the PAC grants approval for data linkage requests for data held by National Services Scotland and NRS.

The person identifiable information used for linkage purposes and contained within the Scottish Suicide Information Database included:-

- Forename
- Surname
- Previous Name

- Community Health Index (CHI) Number[§]
- Gender
- Postcode
- Date of Birth
- Date of Death / Date Death Registered

The ScotSID database is held within ISD in accordance with established information security and data protection/confidentiality procedures. Access is limited to authorised ISD personnel only. All ISD staff are aware of the rules governing the handling of confidential data appropriately and all sign the 'Confidentiality Guidelines for ISD staff'. Although information on those who have died is not directly covered by the Data Protection Act 1998, ISD considers that such data are protected by a Duty of Confidence and its confidentiality needs to be protected. ISD produced the document 'How the Scottish Suicide Information Database Project Meets the Six Caldicott Guardian Principles' which was disseminated to all NHS Board Caldicott Guardians.

The person identifiable data is stored separately from any contextual information and used only for linkage purposes to incorporate other datasets. For the purposes of this report, analysis was undertaken on a pseudo-anonymised dataset (data for which the personal identifiers had been removed and replaced with a unique identifier).

2.5 Data Quality Assurance

ISD routinely evaluates and ensures that all SMR datasets are accurate, consistent and comparable across time and between sources. Every healthcare activity is subjected to an agreed, national validation, and completeness of all SMR submissions by health boards is monitored closely; the only exception being SMR25 where much of the information requested is not mandatory and solely reliant on the drug user providing information to drugs services.

More specifically, before undertaking any formal analyses for the purpose of this report, the total number of cases in the ScotSID cohort was compared to the number published by the NRS. Although the NRS deaths database was used to inform the ScotSID, there were discrepancies between the two sets of total deaths reported. This was wholly attributable to the fact that the NRS published its annual figures by 'year of registration' while the ScotSID based its figures on 'year of death'. This meant that the NRS included deaths that may have occurred in 2008 but were registered in 2009. ScotSID on the other hand included deaths that occurred in 2009 but may not have been registered until 2010 by the NRS: these would appear in NRS's 2010 published figures. Appendix A2 provides further explanation of the difference between the ScotSID cohort and NRS reported figures.

2.6 Internal Record Linkage Process

Record linkage is a means of identifying records in different databases that relate to the same individual [20]. For the purposes of the ScotSID database, two approaches were employed in order to link the different records together:

[§] The CHI number is a unique numeric identifier, allocated to each patient on first registration with healthcare services. The CHI number is a 10-character code consisting of the 6-digit date of birth (DDMMYY), two digits, a 9th digit which is always even for females and odd for males and an arithmetical check digit.

- Deterministic (or Exact) matching – uses a common unique identifier (e.g. CHI)
- Probability matching – uses a set of identifiers to estimate the *probability* that the two records correspond and to decide the threshold (level) of agreement for matching of records.

Deterministic matching was used when there was a common unique identifier between the datasets to be linked, for example the CHI number. In order to link other datasets where there was no common identifier or there were completeness/data quality issues with the CHI number, probability matching was used, which required other personal identifiers.

Probability matching reduced the number of non-matching records and took account of typing errors, movement between geographical areas and other issues that may have arisen during data recording. This allowed the “linker” to quantify the implications of levels of agreement and disagreement between the records.

Probability matching was employed during the linking of ISD’s substance misuse dataset to ISD’s Linked Database which includes all NRS death records. This was the method of choice due to the absence of CHI numbers during the recording of substance misuse information by drugs services. The results of the linkage indicated that approximately 80% of records could be linked between the two datasets.

2.7 External Data Linkage Phase

In parallel to the internal linkage phase, external (non-ISD) sources of information were also identified as possibly containing data items of value to ScotSID (see Section 3.3). To date, pilot exercises exploring the feasibility of extracting data from GP notes and Procurator Fiscal records have been completed. Together these pilots will help inform how ScotSID continues to develop and capture a wider range of information on the health and wider social circumstances of individuals.

2.7.1 GP Pilot

2.7.1.1 Method

In order to assess the feasibility of GP notes as a potential source for the ScotSID, a pilot exercise was undertaken. Two pilot Health Board sites, Lanarkshire and Lothian, were selected by the ScotSID steering group. Deaths registered with an underlying cause of ‘Intentional Self Harm’ or ‘Events of Undetermined Death’ in 2009 were then extracted for these two Health Boards via the NRS deaths database and a sample of their cases was reviewed.

For each area, it was decided that a sample of 16 cases would be extracted, with one male and one female from each age category (10 year age bands). However, due to small numbers in certain age categories the eventual sample size for each site was somewhat smaller (see Table1):

Table 1: Sample of Cases for GP Pilot Exercise

HB Area	Total deaths registered	Number in Sample (%)	M:F
Lanarkshire	80	13 (16%)	7:6
Lothian	106	14 (13%)	7:7

Following approval from the Directors of Public Health at the selected Health Boards, GP notes for individuals in each of the samples were then requested via NSS Practitioner Services Division and reviewed by named ISD staff over a period of a few weeks.

The GP Pilot tool comprised a subset of data items from the provisional Scottish Suicide Information Database. These were defined by seven broad headings:

- Demographics
- Psychiatric Diagnoses
- Contact with Health Services or Other Services
- Medical History
- Life Events
- Medication Details
- Lifestyle/Risk Factors

2.7.1.2 Outcome

Lanarkshire cases were piloted first. The process of extracting information from the notes was relatively time consuming. Notes were generally in both electronic and paper form.

Information about contact between the GP and the patient or relative was surprisingly difficult to obtain. Electronic notes recorded all forms of communication with patients, services and families, as well as reviews of results (blood and other health measurements), in chronological order. Attempting to distinguish between meetings with the patient, family and reviews proved difficult.

Information pertaining to contacts with health services and psychiatric diagnosis was generally available. However, detailed information about referrals to psychiatric services was almost impossible to ascertain in the Lanarkshire pilot. As a result, the relevant data items were revised for the Lothian pilot and a higher level set of items established. This enabled better completion during the Lothian pilot, but on occasion it was still difficult to establish exactly which category a specific mental health service belonged to e.g. community mental health, specialist services etc.

A significant amount of time was spent attempting to retrieve specific dates. This led to several revisions to the original dataset in order to maximise data capture in the future and minimise time spent searching for information that may not exist.

Basic information on excessive alcohol use was routinely recorded. However, it was difficult to ascertain how long the problem had been in existence. Most drug misuse information was incomplete or non-existent, although this may have been due to the fact that drug misuse was rare in the cases sampled. For this reason, the ISD Substance Misuse Database was considered as an option for specific drug related information, although this would only be applicable to those individuals who had previous contact with drug treatment services.

2.7.1.3 Summary of Findings

The following table (Table 2) summarises some key variables and the frequency of occurrence in the cases sampled.

Table 2: Key Variables Assessed During GP Pilot and Frequency
n=27

Variable	No of Cases
Psychiatric Diagnosis	19
General Medical Conditions	20
Chronic Pain	9
Terminal Illness	0
Prescriptions	18
Recent Event	8
Previous Self-Harm Attempts	13
Number of Previous Self-Harm Attempts	Range 1 - 6
Problematic Alcohol Use	8
Illicit Drug Use	2
Number of Contacts with GP (Last 12 months)	Range 0 - 27
Contact with MH Services (Last 12 months)	9

2.7.1.4 Time Analysis

The total time taken to review the 27 case notes was 33hrs 36mins. Below is a brief summary of the mean times by Health Board.

Mean time taken per case note:

Lanarkshire 1hr 19mins
 Lothian 1hr 10mins
 Overall 1hr 15mins

Minimum 10mins
 Maximum 2hrs 30mins

2.7.1.5 General Issues

- There was duplication of information in the GP notes.
- The notes were not always in chronological order.
- Typically dates of life events and psychiatric diagnoses were not specific.

- There was very limited formal coding of ICD / Read / BNF codes within the notes.
- Electronic notes did not result in easier extraction – often they were scanned versions of referral letters.
- There was a variation in the completeness of notes across the different NHS Board areas.

2.7.1.6 Conclusion

GP notes appeared to be a rich source of information for significant life events, previous suicide attempts, current medications and psychiatric diagnoses, although this information would require to be manually extracted from the notes.

In order to review GP notes for all probable suicide deaths across Scotland (~800 per year) the following would need to be considered:

- Resources required to review the notes at national level
- Time taken to retrieve and review notes
- Cost – From January 2011, Practitioner Services Division charged a fee for the retrieval of GP notes.

2.7.2 Police Sudden Death Report/ Procurator Fiscal Pilot

The Crown Office and Procurator Fiscal Service (referred to as Procurator Fiscal from hereon) has a duty to investigate all sudden and unexplained deaths, as well as deaths in suspicious circumstances. Deaths are usually reported to the Procurator Fiscal by the police, a doctor or the Registrar of Births, Deaths and Marriages.

2.7.2.1 Method

In order to assess the quality and feasibility of police sudden death reports submitted to the Procurator Fiscal (PF) as a further source of data for ScotSID, a pilot exercise was undertaken by staff at the Scottish Fatalities Investigation Unit. The unit holds information on all sudden, suspicious, accidental and unexplained deaths in a central location, for all 11 Procurator Fiscal areas in Scotland.

For consistency, the same cases used in the GP pilot were reviewed by the PF team. This would allow for comparisons to be made regarding the completeness of a similar set of variables across the two data sources.

The pilot tool comprised a subset of items taken from ScotSID that were specific to circumstances surrounding the suicide event. These came under two broad headings:

- Circumstances of Death
- Lifestyle (including Living Arrangements)

In addition, those items included in the GP pilot (revised version – see Appendix A3) were also incorporated into the PF pilot tool in order to ascertain the level of health related information

collected by PF services. The intention was to optimise the data extraction process by locating a single source for the information required for ScotSID.

2.7.2.2 Outcome

Of the 27 cases provided to the PF, two had not been reported to the PF and one case was still under active investigation by the relevant PF area and therefore data were not accessed, and two cases, on assessing the information held centrally and electronically, did not appear to be suicidal deaths. The latter two cases may have resulted in an unintentional death classification after the NRS froze its statistical database for 2009. (NRS does not revise the classification of death after it freezes the database, even though this would change what appears in the public record of the death.)

For the remaining 22 cases, a review was undertaken of the electronically held police reports that are routinely submitted to the PF.

Some data items, such as “evidence of planning” and “avoiding detection” were considered to be highly subjective. For example where there was a detailed suicide note left behind by a deceased detailing funeral arrangements and/or management of his/her estate, it could be said that planning was evident. However, in some instances where there was only the use of a single household item to facilitate the suicide, planning could not be inferred: this may just have been a spontaneous use of such an object.

Data relating to the circumstances of the death were generally available. The date and time of occurrence of the suicide event was routinely recorded. Nevertheless, there was uncertainty as to whether this was in fact the date and time of the death or when the event actually occurred. This could lead to inaccuracies in instances where the body was not found until days after the event, thus compromising the true ‘date of occurrence’. All dates provided matched the recorded dates of death exactly.

Information on living arrangements was less available, although data relating to whom the deceased resided with, were more readily available.

Data items that were considered during the GP pilot exercise were also assessed by the PF team. GP-specific information such as ‘date of last contact’ and ‘presenting problem’ was variable. Only seven of the 11 dates of “last contact with GP” matched those retrieved during the GP pilot. However, this was not to say that those generated by the GP exercise were more accurate.

Information pertaining to contact with health services and psychiatric diagnosis was generally poor, with much of it missing. Data on previous conditions were more available, although differed in some instances from that collected via the GP pilot, e.g., more conditions identified via GP or alternatively different condition altogether.

Histories of previous self-harm episodes were generally available and matched well with equivalent information collected through the GP pilot. In some instances, the GP pilot yielded more incidences of self harm for a particular case; this was possibly due to a greater volume of information available in the GP notes.

Similar to the GP pilot, information on excessive alcohol use was available. Little information on drug use was provided, although, again, this may have been due to the fact that drug misuse was rare in the cases sampled.

2.7.2.3 Time Analysis

The PF team reported that in total, approximately 18 hours of work time was required to complete the pilot exercise. This corresponded to an average of 50 minutes per case. In future however, the time taken per case would be expected to reduce considerably as data collection would focus on core data items determined through this pilot exercise.

2.7.2.4 General Issues

- There was no formal coding of ICD / Read / BNF codes
- 'No' and 'Not known' may have been used synonymously. For example, in the case of the variable "seen by MH services", is there enough evidence to indicate that the deceased never had contact with MH services or firm evidence lacking ('don't know')?
- 'Yes'/'No' provided on occasion where, for example, an actual (psychiatric) condition was expected e.g. depression.

2.7.2.5 Conclusion

As with the GP pilot, the PF pilot exercise provided a rich source of information that would be difficult to obtain otherwise. In order to sustain the level of commitment required to obtain such data for the ScotSID project, and for the entire cohort of suicide cases, the following would have to be considered:

- Resources required to review the notes at National level. The PF team agreed to undertake the pilot exercise on a small sample of cases. However, it could not commit to annual extraction of information for all suicides without additional resources.

The complete list of data items that formed the GP and PF pilot collection tools can be found in Appendix A3.

2.7.3 Healthcare Improvement Scotland (HIS)

The ScotSID project team are currently in discussions with HIS in order to incorporate information on whether individuals had had a suicide review and whether they were referred to the Mental Welfare Commission.

3. SCOPE OF REPORT

As previously mentioned, the purpose of this report is to describe the contextual information related to those people who have completed suicide. Only the information obtained from linkage of ISD health records and death records has been presented in this instance, and analysis has been provided at national level.

The key areas covered by this report include:

- Demographics
- Circumstances of Death
- Medical History
- Contact with Services
- Life Events
- Lifestyle & Risk Factors

It is anticipated that future publications will include more detailed information relating to the above areas, as well analysis of additional data items derived from other data sources.

4. DATA ANALYSIS

4.1 The Scottish Suicide Information Database Cohort for 2009

A total of 760 individuals were included in the ScotSID for 2009 (556 males, 204 females). Of these 574 were classified by the NRS as deaths by suicides while 186 were classified as deaths due to events of undetermined intent. For reasons mentioned earlier, these were combined and represented the final ScotSID cohort of deaths due to suicide. These will be referred to as 'completed suicides' from hereon.

As the NRS publish information on all deaths that occur in Scotland, including non-resident persons, for the purpose of this report all analysis relating to person demographics was conducted using the full cohort. However, analysis pertaining to health information has only been presented for those people whose place of usual residence was recorded as Scotland (by the NRS). The reason was that for those people who completed suicide in Scotland but were not residents, it would be unlikely that they would have had any contact with acute services; thus they would not be eligible for record linkage using Scottish health service data.

Of the 760 deaths in 2009, 744 (544 males, 200 females) were Scottish residents and 15 were residents of countries outwith Scotland. For one person the country of residence was not known.

4.2 Socio-demographics

4.2.1 Geographical Area

Table 3 shows the numbers and mortality rates for completed suicides by Health Board area. The highest standardised mortality rate was observed in Shetland (21.8 per 100,000 population), followed by Dumfries & Galloway and Greater Glasgow & Clyde (17.0 and 16.6 per 100,000, respectively). The lowest rate was for the Orkney area (8.8 suicides per 100,000 population).

Male age standardised rates were predominantly higher than those for females for most Health Board areas. The only exception was Orkney – although it must be remembered that standardised rates for any one year, for an area with a relatively low population, may be misleading, because there may be large percentage year-to-year fluctuations in its small numbers of probable suicides. The highest rate for males was observed in Shetland while for females, rates were highest in Greater Glasgow and Clyde.

Table 3: Completed Suicides and Rates (Crude and European Standardised Rates) by NHS Board

NHS Board	Number of Deaths	Population¹	Crude Mortality Rate per 1,000 Pop'n	Age-Sex Standardised Rates (All)	Age Standardised Rates (Males)	Age Standardised Rates (Females)
Scotland	760	5,194,000	14.6	14.5	21.5	7.4
Ayrshire & Arran	49	367,160	13.3	14.5	22.6	6.3
Borders	15	112,680	13.3	15.7	28.0	3.4
Dumfries & Galloway	23	148,510	15.5	17.0	26.6	7.5
Fife	51	363,385	14.0	14.4	24.3	4.4
Forth Valley	33	291,383	11.3	11.8	18.6	5.0
Grampian	85	544,980	15.6	15.1	22.3	8.0
Greater Glasgow & Clyde	205	1,199,026	17.1	16.6	23.7	9.5
Highland	52	310,530	16.7	15.6	22.7	8.5
Lanarkshire	80	562,215	14.2	14.4	20.9	7.9
Lothian	108	826,231	13.1	12.6	17.9	7.2
Orkney	2	19,960	10.0	8.8	8.5	9.0
Shetland	5	22,210	22.5	21.8	34.7	8.9
Tayside	49	399,550	12.3	12.0	18.3	5.8
Western Isles	3	26,180	11.5	10.1	13.7	6.5

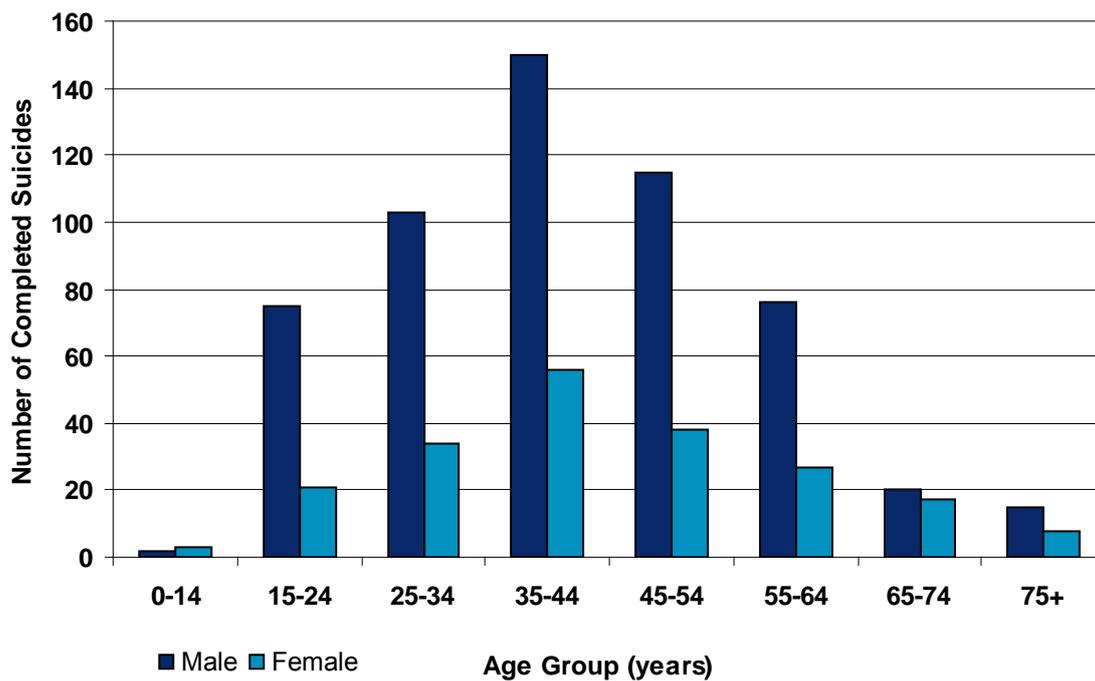
¹NRS 2009 population data

15 persons who completed suicide in Scotland were not residents of Scotland; 1 not known

4.2.2 Age and Gender

The gender and age group breakdown of the ScotSID cohort is shown in Figure 6. Almost three quarters of these were males (556, 73.2%). The median age at death for men was 41.5 years and for women, 42.5 years. The highest proportion of deaths occurred in the 35-44 year age group (27.1%), followed by the 45-54 year age group (20.1%). Patterns were similar for both males and females.

Figure 6: Completed Suicides by Age and Gender



4.2.3 Marital Status

Marital status was known for 759 (99.9%) of all cases (Table 4). Of these, almost 70% of cases were reported as single, widowed or divorced (n=531) at the time of their death and the remaining 30% married (n=228).

Table 4: Completed Suicides by Marital Status

Marital Status	Number of Deaths	%
Single	381	50.2
Married/Civil Partnership	228	30.0
Widowed/Surviving Civil Partner	32	4.2
Divorced/Civil Partnership Dissolved*	118	15.5
Total	759	100.0
Not Known	1	-

*Includes marriage/civil partnership annulled/married divorce pending.
 Note: Due to rounding, percentages may not add up to 100%

4.2.4 Employment Status and Occupation

Of the 760 cases, 691 individuals were of employment age (16-64 years). Employment status was known in 689 cases (Table 5). Over two thirds of these (67.8%) were in employment at the time of their death. Just under one third were either unemployed, students or unable to work due to a long term condition (32.2%).

Table 5: Completed Suicides by Employment Status – 16-64 Year Olds

Employment Status	Number of Deaths	%
Student/Unemployed*	222	32.2
Employed/Self Employed	467	67.8
Total	689	100.0
Not Known	2	-

*Includes long term conditions and independent means

The last known occupation was available for 545 of the 691 individuals of employment age (Table 6). The occupation of 146 was not known. Due to the vast range of different occupations of the ScotSID cohort, Table 6 summarises the occupations by 'sub-major group', with groups listed in order of seniority.

The most common occupational group for those individuals completing suicide was the 'Elementary Trades, Plants and Storage Related Occupations' group (52 cases), followed by the 'Skilled Metal and Electrical Trades' group (49 cases).

Table 6A provides a detailed list of the most frequently occurring specific occupations within the cohort of cases under consideration. The most common occupation was labourers in building and woodwork (33 cases). This constituted 63.5% of those in the 'Elementary Trades, Plants and Storage Related Occupations' sub-major group mentioned above. Electricians and electrical fitters were also one of the more common occupations (15 cases) and in fact account for 30.6% of those in the 'Skilled Metal and Electrical Trades' also mentioned above. Other commonly occurring occupations were care assistants/home carers, gardeners and groundsmen/groundswomen, and students.

Table 6: Completed Suicides by Occupational Group – 16-64 Year Olds

Occupational Group	Number of Deaths	%
Corporate Manager	13	2.4
Mangers and Proprietors in Agriculture and Services	11	2.0
Science and Technology Professionals	11	2.0
Health Professional	6	1.1
Teaching and Research Professional	12	2.2
Business and Public Service Professionals	7	1.3
Science and Technology Associate Professionals	6	1.1
Health and Social Welfare Associate Professionals	18	3.3
Protective Service Occupations	8	1.5
Culture, Media and Sports Occupations	11	2.0
Business and Public Service Associate Professionals	15	2.8
Administrative Occupations	17	3.1
Secretarial and Related Occupations	8	1.5
Skilled Agricultural Trades	22	4.0
Skilled Metal and Electrical Trades	49	9.0
Skilled Construction and Building Trades	46	8.4
Textiles, Printing and Other Skilled Trades	18	3.3
Caring Personal Service Occupations	27	5.0
Leisure and Other Personal Service Occupations	9	1.7
Sales Occupations	17	3.1
Customer Service Occupations	5	0.9
Process, Plant and Machine Operatives	41	7.5
Transport and Mobile Machine Drivers and Operatives	48	8.8
Elementary Trades, Plants and Storage Related Occupations	52	9.5
Elementary Administration and Service Occupations	44	8.1
Students	17	3.1
Other	7	1.3
Total	545	100.0
Not Known	146	-

Groupings have been determined using the [Standard Occupational Classification 2000](#)

Note: Due to rounding, percentages may not add up to 100%

Table 6A: Completed Suicide by Most Common Occupations (count >10)

Occupational Type	Number of Deaths
Nurses	11
Gardeners and Groundsmen/Groundswomen	15
Electricians, Electrical Fitters	15
Carpenters and Joiners	12
Painters and Decorators	13
Care Assistants and Home Carers	17
Labourers in Building and Woodworking Trades	33
Cleaners, Domestic	12
Students	17

Groupings have been determined using the [Standard Occupational Classification 2000](#)

4.3 Circumstances of Death

4.3.1 Method of Suicide

The most common method of suicide was hanging, strangulation & suffocation (43.7%). This was followed by poisoning (33%) (Table 7).

A gender-specific breakdown of the methods used (Table 7) showed that hanging, strangulation & suffocation was the most common method amongst males (50.2%), while poisoning was most common amongst females (50.5%). This concurred with previous finding by Platt et al in 2007 [4]. Poisoning was the second method of choice for males (26.6%) and hanging, strangulation & suffocation for females (26.0%).

Table 7: Completed Suicides by Method and Gender

Method of Suicide	Number of Deaths	%
All Deaths	760	100.0
Hanging, Strangulation & Suffocation	332	43.7
Poisoning	251	33.0
Jumping or Falling from High Place	66	8.7
Drowning & Submersion	46	6.1
Sharp Object	16	2.1
Jumping or Lying before moving object	18	2.4
Firearm	10	1.3
Smoke, Fire & Flames	6	0.8
Other	15	2.0
Males	556	
Hanging, Strangulation & Suffocation	279	50.2
Poisoning	148	26.6
Jumping or Falling from High Place	46	8.3
Drowning & Submersion	32	5.8
Sharp Object	12	2.2
Jumping or Lying before moving object	13	2.3
Firearm	10	1.8
Smoke, Fire & Flames	5	0.9
Other	11	2.0
Females	204	
Hanging, Strangulation & Suffocation	53	26.0
Poisoning	103	50.5
Jumping or Falling from High Place	20	9.8
Drowning & Submersion	14	6.9
Sharp Object	4	2.0
Jumping or Lying before moving object	5	2.5
Firearm	0	0.0
Smoke, Fire & Flames	1	0.5
Other	4	2.0

Note: Due to rounding, percentages may not add up to 100%

4.3.2 Month & Day of Death

The most common month for completed suicides was April (74; 9.7% of suicides) however there was no statistically significant association between occurrence of suicide and month of the year. Similarly, the most common day for completed suicides was Wednesday (129; 17%) but again there was no significant association between occurrence of suicide and the day of the week.

4.3.3 Post Mortem Undertaken

Most sudden and unexpected deaths are referred for post mortems in order to determine the cause of death. Of the 760 suicide deaths in the ScotSID cohort, 703 cases (92.5%) had a post mortem performed, while for 7% of cases, a post mortem was not performed (Table 8). In four cases, it was not possible to determine whether or not a post mortem was undertaken. This may occur in instances where the NRS did not hear back from a certifying doctor or Procurator Fiscal.

Table 8: Indication of Whether Post-Mortem was Performed

Post Mortem Indicator	Number of Deaths	%
Has been performed	703	92.5
Not performed	53	7.0
Not Known*	4	0.5
Total	760	100.0

*Cases recorded as 'may be performed' but outcome was not known at time of NRS data freeze

4.3.4 Place Where Suicidal Act & Death Occurred

When examining where an individual carried out the suicidal act, it was clear that the majority of events that eventually caused the death occurred in a private dwelling (71.4%) (Table 9). The second most frequent category was 'other specified place', which included locations such as a beach, campsite, canal, forest, hill, railway line, river etc.

Table 9: Place Where Suicidal Act Occurred

Place of Occurrence	Number of Deaths	%
Private Dwelling*	462	71.4
Street or Highway	12	1.9
Trade and Service Area	10	1.5
Residential Unit	6	0.9
Industrial and Construction Area	5	0.8
Other Specified Place	152	23.5
Total	647	100.0
Not Known (Unspecified Place)	113	-

* Private Dwelling refers to a person's home, or someone else's home, garage, garden, driveway etc.
Note: Due to rounding, percentages may not add up to 100%

Of the total of 760 deaths, 122 (16.1%) died in hospital. The location where the act occurred was unspecified in the majority of these cases. The remaining 83.9% are likely to have died at the same location as where the suicidal act occurred.

It is anticipated that more comprehensive information regarding the place where a suicide was attempted may be available from the Procurator Fiscal. Where an actual suicide was attempted and where the individual actually died are not always the same, as seen from the data already available. Information from the Procurator Fiscal should shed some light on the locations recorded as 'other specified place' and 'unspecified place' in Table 9.

4.4 Contact with Health Services

4.4.1 General Hospital Discharges

Tables 11, 12 and 13 show the number and percentage of cases that had a general admission and discharge (alive) within the last 30 days, 12 months and five years respectively, before death (Table 10 provides an age-sex breakdown of the deaths due to suicide for reference purposes). Of the 744 individuals who were resident in Scotland at time of death, just under 10% had been an inpatient and discharged within 30 days of their suicide, whilst almost one third (241) of all cases had been discharged within one year. Over half (441, 59.3%) had been discharged from a general hospital within five years of their death. It should be noted that these figures are cumulative. In cases where an individual had multiple admissions, only the most recent episode before death was considered. The remaining 303 individuals had no record of a general hospital discharge in the five years before their death.

In general, individuals in the older age group who completed suicide were more likely to have had a prior admission than those in the other groups. Nevertheless, in comparison, admission rates were still relatively high in the younger groups, in particular those under 35 years.

Prior admission rates were higher for females than males. Overall admission rates in the general population are known to be higher for females than males in all but the youngest and oldest age groups.

The diagnosis at discharge of the 441 cases who had a general hospital admission within five years before death are presented in Tables 14 & 14A. High level ICD10 chapter headings were employed to categorise the relevant conditions due to the large volume of detailed ICD10 diagnostic codes used to diagnose at discharge.

The most frequent reason for treatment as an inpatient was intentional self-harm, followed by an unintentional injury or assault. This pattern was consistent across each time period (30 days, 12 months, five years). Of the 70 individuals who were discharged within 30 days of their death, 29 (41.4%) were treated for a self inflicted injury. This increased to 71 out of 241 (29.5%) within 12 months of death, and 113 out of 441 (25.6%) within five years.

General Hospital Admission before Completed Suicide

Table 10: Total Number of Completed Suicides

Gender	Age <35	Age 35-44	Age 55+	Total
Males	177	257	110	544
Females	56	93	51	200
Total	233	350	161	744

Table 11: Cases Where Completed Suicide Occurred Within 30 Days of Discharge

Gender	Age <35		Age 35-54		Age 55+		Total	
	Number	%	Number	%	Number	%	Number	%
Males	11	6.2	24	9.3	15	13.6	50	9.2
Females	4	7.1	12	12.9	4	7.8	20	10.0
Total	15	6.4	36	10.3	19	11.8	70	9.4

Table 12: Cases Where Completed Suicide Occurred Within 12 Months of Discharge

Gender	Age <35		Age 35-54		Age 55+		Total	
	Number	%	Number	%	Number	%	Number	%
Males	38	21.5	79	30.7	43	39.1	160	29.4
Females	23	41.1	35	37.6	23	45.1	81	40.5
Total	61	26.2	114	32.6	66	41.0	241	32.4

Table 13: Cases Where Completed Suicide Occurred Within 5 Years of Discharge

Gender	Age <35		Age 35-54		Age 55+		Total	
	Number	%	Number	%	Number	%	Number	%
Males	90	50.8	144	56.0	73	66.4	307	56.4
Females	33	58.9	65	69.9	36	70.6	134	67.0
Total	123	52.8	209	59.7	109	67.7	441	59.3

Table 14: Number of Completed Suicides Who Had a General Hospital Admission and Were Discharged, by Diagnosis

Diagnosis	Number of suicides with discharge within:		
	5 years	12 months	30 days
Malignant and non-malignant neoplasms	12	8	1
Mental and behavioural disorders	12	7	3
Diseases of the circulatory system	15	8	2
Diseases of the respiratory system	16	6	4
Diseases of the digestive system	50	27	9
Symptoms and abnormal findings not elsewhere classified	47	28	8
Injury, poisoning and other external causes – Intentional Self Harm*	113	71	29
Injury, poisoning and other external causes – Unintentional & Assault	86	41	9
Other	90	45	5
Total suicides with discharge before death	441	241	70
Total with no hospital admission or discharge within 5 years of death	303		
Total number of suicides	744		

*For 5 cases, the contributing cause was 'Intentional Self Harm' however, this was not indicated in the main diagnosis. For example: Main Diagnosis – Toxic Liver Disease; Contributing Cause – Intentional Self Poisoning. One case was recorded as 'Undetermined Intent'

Table 14A: Percentage of Completed Suicides Who Had a General Hospital Admission and Were Discharged, by Diagnosis

Diagnosis	Percentage of suicides with discharge within:		
	5 years %	12 months %	30 days %
Malignant and non-malignant neoplasms	2.7	3.3	1.4
Mental and behavioural disorders	2.7	2.9	4.3
Diseases of the circulatory system	3.4	3.3	2.9
Diseases of the respiratory system	3.6	2.5	5.7
Diseases of the digestive system	11.3	11.2	12.9
Symptoms and abnormal findings not elsewhere classified	10.7	11.6	11.4
Injury, poisoning and other external causes – Intentional Self Harm	25.6	29.5	41.4
Injury, poisoning and other external causes – Unintentional & Assault	19.5	17.0	12.9
Other	20.4	18.7	7.1
Total suicides with discharge before death	100.0	100.0	100.0

4.4.2 Psychiatric Hospital Discharges

Tables 16, 17 and 18 show the number and percentage of cases that had a psychiatric admission and discharge within the last 30 days, 12 months and five years, respectively, before death (Table 15 provides an age-sex breakdown of the deaths due to suicide for reference purposes). Of the 744 individuals in the Scottish cohort, 37 (5%) had been psychiatric inpatients, discharged within 30 days of their suicide. A total of 102 (13.7%) individuals completed suicide within 12 months of discharge and 21% of all suicide cases (158) experienced a psychiatric discharge within five years of death. These figures are cumulative. In cases where an individual had multiple admissions, only the most recent episode before death was considered. The remaining 586 individuals had no record of a psychiatric hospital discharge in the five years before death.

Similar to general admissions, those in the older age group who completed suicide were more likely to have had a prior psychiatric admission than younger people. Again this was not unexpected; however what perhaps was surprising was the relatively flat gradient in prior admission rates with increasing age. Prior admission rates were higher for women than men.

The main psychiatric diagnoses at discharge of the 158 cases who had a psychiatric admission within five years of death are presented in Tables 19 & 19A. The most common condition at discharge was mood (affective) disorders. This was the leading condition for all three time periods under consideration. Other common conditions were schizophrenia, schizotypal and delusional disorders, and mental and behavioural disorders due to psychoactive substance use.

The majority of admissions to a psychiatric hospital were informal in status (Tables 20 & 20A), i.e., the individual was voluntarily admitted to a mental health facility. Within five years of discharge only 12 individuals were detained under the provisions of the Mental Health (Care and Treatment) (Scotland) Act 2003 (formal admission).

Closer inspection of date of death and its proximity to date of discharge showed that nine cases had a date of death that matched the date of discharge. This could indicate that the individual completed suicide whilst in hospital, whilst on pass from an inpatient unit or ward⁴, or shortly after discharge.

⁴ For Mental Health specialties the definition of a 'pass' applies only when the length of absence does not exceed twenty eight nights.

Psychiatric Hospital Admission before Completed Suicide

Table 15: Total Number of Completed Suicides

Gender	Age <35	Age 35-44	Age 55+	Total
Males	177	257	110	544
Females	56	93	51	200
Total	233	350	161	744

Table 16: Cases Where Completed Suicide Occurred Within 30 Days of Discharge

Gender	Age <35		Age 35-54		Age 55+		Total	
	Number	%	Number	%	Number	%	Number	%
Males	7	4.0	9	3.5	5	4.5	21	3.9
Females	3	5.4	8	8.6	5	9.8	16	8.0
Total	10	4.3	17	4.9	10	6.2	37	5.0

Table 17: Cases Where Completed Suicide Occurred Within 12 Months of Discharge

Gender	Age <35		Age 35-54		Age 55+		Total	
	Number	%	Number	%	Number	%	Number	%
Males	18	10.2	29	11.3	10	9.1	57	10.5
Females	11	19.6	18	19.4	16	31.4	45	22.5
Total	29	12.4	47	13.4	26	16.1	102	13.7

Table 18: Cases Where Completed Suicide Occurred Within 5 Years of Discharge

Gender	Age <35		Age 35-54		Age 55+		Total	
	Number	%	Number	%	Number	%	Number	%
Males	30	16.9	44	17.1	17	15.5	91	16.7
Females	14	25.0	34	36.6	19	37.3	67	33.5
Total	44	18.9	78	22.3	36	22.4	158	21.2

Table 19: Number of Completed Suicides that had a Psychiatric Hospital Admission and Were Discharged Within the Last 30 Days, 12 Months and 5 Years Before Death, by Diagnosis

Main diagnosis	Number of suicides with discharge within:		
	5 years	12 months	30 days
Mental and behavioural disorders due to psychoactive substance use	36	17	6
Schizophrenia, schizotypal and delusional disorders	27	20	10
Mood (affective) disorders	59	40	13
Neurotic, stress related and somatoform disorders	14	10	4
Disorders of adult personality and behaviour	11	10	3
Other	11	5	1
Total discharges	158	102	37
Total with no hospital admission or discharge within 5 years of death	586		
Total number of suicides	744		

Table 19A: Percentage of Completed Suicides that had a Psychiatric Hospital Admission and Were Discharged Within the Last 30 Days, 12 Months and 5 Years before Death, by Diagnosis

Main diagnosis	Percentage of suicides with discharge within:		
	5 years	12 months	30 days
Mental and behavioural disorders due to psychoactive substance use	22.8	16.7	16.2
Schizophrenia, schizotypal and delusional disorders	17.1	19.6	27.0
Mood (affective) disorders	37.3	39.2	35.1
Neurotic, stress related and somatoform disorders	8.9	9.8	10.8
Disorders of adult personality and behaviour	7.0	9.8	8.1
Other	7.0	4.9	2.7
Total discharges	100.0	100.0	100.0
Total with no hospital admission or discharge within 5 years of death	586		
Total number of suicides	744		

Table 20: Number of Completed Suicides that had a Psychiatric Hospital Admission and Were Discharged Within the Last 30 Days, 12 Months and 5 Years before Death, by Status on Admission

Status on admission	Number of suicides with discharge within:		
	5 years	12 months	30 days
Informal admission ¹	146	94	32
Formal admission ²	12	8	5
Total discharges	158	102	37
Total with no hospital admission or discharge within 5 years of death	586		
Total number of suicides	744		

¹ Informal admission refer to voluntary mental health admission

² Formal admissions are patients detained under the provisions of the Mental Health (Care and Treatment) (Scotland) Act 2003

Table 20A: Percentage of Completed Suicides that had a Psychiatric Hospital Admission and Were Discharged Within the Last 30 Days, 12 Months and 5 Years before Death, by Status on Admission

Status on admission	Percentage of suicides with discharge within:		
	5 years	12 months	30 days
Informal admission	92.4	92.2	86.5
Formal admission	7.6	7.8	13.5
Total discharges	100.0	100.0	100.0
Total with no hospital admission or discharge within 5 years of death	586		
Total number of suicides	744		

4.4.3 Psychiatric Outpatient Appointments

Information relating to the most recent psychiatric outpatient appointment before death was also considered. Of the 744 individuals who were resident in Scotland before death, 45 individuals were known to have been allocated a psychiatric outpatient appointment within 30 days of their death (Table 22). The equivalent figure for completed suicides within 12 months was 140 (Table 23), representing 18.8% of the total suicide cases. The remaining 604 cases had no record of an outpatient appointment in the 12 months before their death. (Table 21 provides an age-sex breakdown of the deaths due to suicide for reference purposes.)

Of the 140 individuals given an appointment within a year of death, 104 attended the appointment whilst 36 did not attend (DNA) and gave no prior warning. Of these 36 DNAs, 12 were among the 45 individuals who had an appointment allocated 30 days before death.

The type of appointment allocated was also assessed. Of the 140 individuals, just over half (73, 52.1%) were new appointments while the remaining 47.9% (67) were follow up/return

appointments (Table 24). It should be noted that not all hospitals submit outpatient data (SMR00) for return appointments as completion of this information is not mandatory. Therefore, the figures quoted here may be an underestimation of the overall number of people completing suicide, who may have had an outpatient appointment within 12 months of their death.

Psychiatric Outpatient Appointment before Completed Suicide

Table 21: Total Number of Completed Suicides

Gender	Age <35	Age 35-44	Age 55+	Total
Males	177	257	110	544
Females	56	93	51	200
Total	233	350	161	744

Table 22: Cases Where Completed Suicide Occurred Within 30 Days of Appointment

Gender	Age <35		Age 35-54		Age 55+		Total	
	Number	%	Number	%	Number	%	Number	%
Males	7	4.0	14	5.4	5	4.5	26	4.8
Females	3	5.4	9	9.7	7	13.7	19	9.5
Total	10	4.3	23	6.6	12	7.5	45	6.0

Table 23: Cases Where Completed Suicide Occurred Within 12 Months of Appointment

Gender	Age <35		Age 35-54		Age 55+		Total	
	Number	%	Number	%	Number	%	Number	%
Males	36	20.3	41	16.0	15	13.6	92	16.9
Females	11	19.6	22	23.7	15	29.4	48	24.0
Total	47	20.2	63	18.0	30	18.6	140	18.8

Table 24: Appointment Type by Clinic Attendance Status

Appointment type	Attended	Did not attend	Total
New outpatient	58	15	73
Follow-up/ return outpatient	46	21	67
Total	104	36	140

4.5 Life Events

Of the 200 females in the cohort, maternity records indicated that 43 had biological children under the age of 16. This represented 21.5% of all female suicide cases. Of these 43 cases, 46.5% had one child, 34.9% had two children and 18.6% had three or more (Table 25).

Five females gave birth less than 12 months before completing suicide, representing 2.5% of all female suicides. The outcome for all five births was a live birth.

This analysis was based on females who had given birth to a child within a Scottish maternity unit. Any details of those who had given birth to children outwith Scotland would therefore not be captured. It is however anticipated that such information, including that of biological fathers, may be available via the Procurator Fiscal.

Table 25: Female Completed Suicides by Number of Biological Children Under 16 Years of Age

Number of Children under 16 years	Number of deaths	%
1	20	46.5
2	15	34.9
3+	8	18.6
Total	43	100.0

4.6 Lifestyle and Risk Factors – Contact with Drug Services

Of the 744 cases in the ScotSID cohort, 57 were known to specialist drug services (statutory and non-statutory) as well as medical services such as general practice and hospitals. This represented 7.7% of the total cohort. Of these 57 cases, further information was only available for 36 individuals due to a change in data collection procedures in 2006.

Information relating to whether individuals were known to services as ever having injected drugs showed that 18 out of the 36 cases had injected at some point in their lives. Fifteen had never injected and no information was available for three individuals.

Table 26 shows the last 'known' year of client contact with drug services. This date represents the date of the client's initial assessment and does not represent any follow-up the client may have had thereafter. Further analysis determined that 12 of the 36 cases had undergone assessment with drug services within six months of their death, while a further eight, within six months to a year (Table 27).

Table 26: Year of Last Known Contact with Drug Services

Year of last known contact	Number of deaths	%
2006	4	11.1
2007	7	19.4
2008	13	36.1
2009	12	33.3
Total	36	100.0

Note: Due to rounding, percentages may not add up to 100%

Table 27: Time Period of Last Contact with Drug Services before Death

Months/Years	Number of deaths	%
Within 6 months	12	33.3
6 to 12 months	8	22.2
12 months to 2 years	10	27.8
Over 2 years	6	16.7
Total	36	100.0

For the 20 cases that were assessed within one year of their death, 11 had reported using drugs in the past month while seven reported that they had not. There were two cases where there was no information recorded. For those that had used drugs, five out of the 11 individuals had taken one drug in the past month and a further five had taken two or more. There was no information for one individual. The most common drugs reported to have been used were heroin, cannabis (unspecified), diazepam and ecstasy.

It is clear that the information on drug use in this section is very limited and inferences regarding its role in the suicide of those individual in the ScotSID cohort, cannot be made. Nonetheless, this section has been included in order to illustrate the type of analysis that will be possible in future years, using data derived from future linkages as well as information gained via the Procurator Fiscal.

From 2009, ISD introduced an enhanced Scottish Drug Misuse Database Follow-up Reporting System. This new system is designed to collect information on clients throughout their Care Episode, and not just at the point of initial assessment at drugs agencies/services. This will include an initial assessment, 12 week follow-up and annual follow-ups, thereafter. It is anticipated that the inclusion of this enhanced data in ScotSID will provide a much clearer picture with regards to the drug use of those who go on to complete suicide.

5. Discussion and Next Steps

This is the first report from the Scottish Suicide Information Database. It briefly describes the recent epidemiology of suicide in Scotland in a UK and European context. It sets out the origins and aims of the database and how it has been set up, summarising the results of the pilot studies exploring the practicalities of obtaining information from primary care and Procurator Fiscal records. It then uses the data currently in the database for those people who completed suicide in Scotland in 2009 to provide more information about the circumstances of their death and their health and social circumstances during the months and years before it occurred.

At this stage, the database is only able to provide limited additional information about the people who died; showing the wide range of their backgrounds. It indicates that many had had recent general hospital admissions for a wide range of reasons, with intentional self-harm and unintentional injury or assault being particularly frequent. Many had made use of psychiatric inpatient or outpatient services, with mood disorders, substance misuse and schizophrenia being the most frequent diagnosis. However, perhaps equally importantly, it also shows that 40% of the cases had had no admission to a general hospital in the previous five years and almost 80% had not had a psychiatric admission during that period.

At this stage, it is inevitable that the database does not take us much further forward in understanding why these particular individuals took their own lives. It demonstrates, however, that as more information is brought together, it should be of immense value. The pilot exercises using primary care records and Procurator Fiscal reports showed that these are potential sources of further information not available elsewhere. In the coming year, further consideration will be given to bringing this and other information such as prescribing data into the system. This will enable much more detailed analyses to be performed, linking data from these new sources with what is already in the system on each individual, whilst maintaining confidentiality. This should provide a much clearer picture of the factors leading to these tragic events and the circumstances in which they took place. The accumulating number of cases, the greater detail and the trends over time will together provide an increasingly strong foundation for understanding suicide in Scotland, for identifying common factors at which preventive efforts could be directed, and for evaluating whether what is being done is having a beneficial effect.

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Glossary

ACaDMe	Acute Cancer Deaths and Mental Health
HIS	Healthcare Improvement Scotland
ICD 10	The International Classification of Diseases and Related Health Problems, Tenth Revision
ISD	Information Services Division
NRS	National Records of Scotland
ScotSID	Scottish Suicide Information Database
SMR00	Scottish Morbidity Record: Outpatient Attendance
SMR01	Scottish Morbidity Record: Acute Inpatient & Daycase
SMR02	Scottish Morbidity Record: Maternity Inpatient & Daycase
SMR04	Scottish Morbidity Record: Mental Health Inpatient & Daycase
SMR25	Scottish Morbidity Record: Substance Misuse Treatment
Suicide	Deaths for which the underlying cause is classified as 'intentional self-harm' or 'event of undetermined intent'

List of Tables

Table No.	Name	Time period
1	Sample of cases for GP pilot exercise	2009
2	Key variables assessed during GP pilot and frequency	2009
3	Completed suicides and rates (crude and European standardised rates) by NHS board	2009
4	Completed suicides by marital status	2009
5	Completed suicides by employment status – 16-64 year olds	2009
6	Completed suicides by occupational group -16-64 year olds	2009
6A	Completed suicides by most common occupations (count>10)	2009
7	Completed suicides by method and gender	2009
8	Indication of whether post-mortem was performed	2009
9	Place where suicidal act occurred	2009
10	Total number of completed suicides	2009
11	Cases where completed suicide occurred within 30 days of discharge	2009
12	Cases where completed suicide occurred within 12 months of discharge	2009
13	Cases where completed suicide occurred within 5 years of discharge	2009
14	Number of completed suicides who had a general hospital admission and were discharged, by diagnosis	2009
14A	Percentage of completed suicides who had a general hospital admission and were discharged, by diagnosis	2009
15	Total number of completed suicides	2009
16	Cases where complete suicide occurred within 30 days of discharge	2009
17	Cases where completed suicide occurred within 12 months of discharge	2009
18	Cases where completed suicide occurred within 5 years of discharge	2009
19	Number of completed suicides that had a psychiatric hospital admission and were discharged within the last 30 days, 12 months and 5 years before death, by diagnosis	2009
19A	Percentage of completed suicides that had a psychiatric hospital admission and were discharged within the last 30 days, 12 months and 5 years before death, by diagnosis	2009

Table No.	Name	Time period
20	Number of completed suicides that had a psychiatric hospital admission and were discharged within the last 30 days, 12 months and 5 years before death, by status on admission	2009
20A	Percentage of completed suicides that had a psychiatric hospital admission and were discharged within the last 30 days, 12 months and 5 years before death, by status on admission	2009
21	Total number of completed suicides	2009
22	Cases where completed suicide occurred with 30 days of appointment	2009
23	Cases where completed suicide occurred within 12 months of appointment	2009
24	Appointment type by clinic attendance status	2009
25	Female completed suicides by numbers of biological children under 16 years of age	2009
26	Year of last known contact with drug services	2009
27	Time period of last contact with drug services before death	2009

List of Figures

Figure No.	Name	Time period
1	Intentional Self Harm and Events of Undetermined Intent Death Rates (EASRs), Scotland	1982-2010
2	Number of 'Intentional Self Harm and Events of Undetermined Intent' Deaths by Method	1974-2009
3	Intentional self harm and events of undetermined intent death rates (EASRs), United Kingdom	1991-2009
4	European Age Standardised Mortality Rates (Intentional Self Harm Only - All Ages) for Scotland and Selected European Union Countries, 2005	2005
5	Internal and External Data Flow to ScotSID	-
6	Completed Suicides by Age and Gender	2009

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Further Information

Further information can be found on the [ISD website](#)

For information related to current national policy on suicide prevention in Scotland please visit the Choose Life website: www.chooselife.net

If you are feeling suicidal or worried about someone else call Samaritans on 08457 90 90 90 or Breathing Space on 0800 83 85 87.

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Appendix

A1 – The proposed Scottish Suicide Information Database 2011 Dataset

Formal Names, Definitions and Codesets

This proposed list has been iteratively revised as the ScotSID project has progressed, reflecting increasing understanding of the data items available from particular sources. Further revisions will occur as the project continues to develop. Those data items marked as Phase 1 appear in the ScotSID database for 2009 data.

Phase	Data item	Definition	Codeset
A. FOR LINKAGE PURPOSES – FOR INTERNAL USE ONLY			
1	Unique Case Identifier	Automatically Generated Unique Identifier	Numeric
1	Year of Registration	Year that the death was registered	Date
1	Registration District Number	Code representing the district of registration	Numeric
1	Entry Number	Entry number in registration district's register	Numeric
1	First Forename	First forename of the deceased	Characters
1	Surname	Surname of the deceased	Characters
1	Community Health Index (CHI) Number	Community Health Index Number of the deceased	Alpha-numeric
1	Postcode	The usual residence of the deceased before death. Record full postcode if known or partial postcode if that is all that is available. If deceased was homeless at time of death, record as 'NFA' (no fixed abode). If the deceased was living in a hostel or other temporary accommodation at time of death, record the postcode of this accommodation.	Full or partial postcode or NFA (no fixed abode)
1	Date of Birth	Date of birth of the deceased	Date
B. DEMOGRAPHICS			
1	Gender	Gender of the deceased	<ul style="list-style-type: none"> • Male • Female • Other • Not Known
1	Age at death	Derived field	Numeric

1	Ethnicity	Ethnic group of the deceased. An ethnic group is a group of people having racial, religious, linguistic and/or other cultural traits in common. The ethnic group to which a person belongs is judged by the person.	<ul style="list-style-type: none"> • White <ul style="list-style-type: none"> - Scottish - English - Welsh - Northern Irish - British - Irish - Gypsy/ Traveller - Polish - Any other white ethnic group • Mixed or multiple ethnic groups <ul style="list-style-type: none"> - Any mixed or multiple ethnic groups • Asian, Asian Scottish or Asian British <ul style="list-style-type: none"> - Pakistani, Pakistani Scottish or Pakistani British - Indian, Indian Scottish or Indian British - Bangladeshi, Bangladeshi Scottish or Bangladeshi British - Chinese, Chinese Scottish or Chinese British - Other • African, Caribbean or Black <ul style="list-style-type: none"> - African, African Scottish or African British - Caribbean, Caribbean Scottish or Caribbean British - Black, Black Scottish or Black British - Other • Other ethnic group <ul style="list-style-type: none"> - Arab - Other • Refused/Not provided by patient • Not Known
1	Employment Status	The employment status of the deceased at time of death.	<ul style="list-style-type: none"> • Students, independent means, no occupation, handicapped • Employees, apprentices, armed forces - other ranks • Managers, superintendants, armed forces – officers • Foremen • Self-employed, with employees • Self-employed, without employees
1	Occupation Code	The job title of the most recent position held by the deceased before death as recorded by NRS.	Numeric

Phase	Data item	Definition	Codes et
1	Marital Status	Marital status of the deceased at time of death.	<ul style="list-style-type: none"> • Single • Married/ Civil Partnership • Widowed/ Surviving Civil Partner • Divorced/ Civil Partnership Dissolved/ Marriage Annulled/ Civil Partnership Annulled/ Married Divorce Pending • Not Known
1	Health Board of Residence Code	As recorded by NRS	Alpha-numeric
1	Country of Residence	The deceased person's county of residence before death	Alpha-numeric
1	Deprivation Category	Derived field from postcode	Numeric
1	CHP Code	Derived field from postcode	Alpha-numeric
1	Council Area	Derived field from postcode	Alpha-numeric
C. CIRCUMSTANCES OF DEATH			
1	Date of Death	The date that the death occurred. If this is not known, record the date of registration of the death	Date
1	Time of Death	Time of death	Record for a 24 hour clock
1	Place Where Death Occurred	The place where the death occurred. It may or may not be the same as place of suicidal act.	<ul style="list-style-type: none"> • Non-Institution (e.g. Home) • Hospital • Prison • Residential Unit • Other (please specify)
1	Primary Cause of Death	Underlying cause of death as recorded by NRS	ICD10 codes
1	Secondary Cause of Death	Contributing cause of death as recorded by NRS	ICD10 codes
1	Post Mortem Indicator	An indication of whether or not a post mortem was proposed and/or performed.	<ul style="list-style-type: none"> • Has been performed • May be performed • Not proposed • Proposed and performed later • Proposed but not performed later • Not proposed but performed later
1	Place of Suicidal Act	The place where the deceased carried out the suicidal act. This is not necessarily the same as place where death occurred.	<ul style="list-style-type: none"> • Private dwelling • Residential Institution • School, other institution and public administrative area • Sports and athletic area • Street or highway • Trade and service area • Industrial and construction area • Farm • Other specified place • Unspecified place/Not known <p>Specific Details (please state eg bridge, hillside, office)</p>

Phase	Data item	Definition	Codes et
2	Suicide Note	Whether any final communication was left by the deceased.	<ul style="list-style-type: none"> • Yes • No • Not Known
2	Circumstances of Death	Provide any additional details not already recorded regarding the circumstances of the death.	Free Text
D. MEDICAL HISTORY			
2	Medical Conditions (Last 12 Months)	List any medical conditions recorded in any health service records that existed in the last 12 months before death.	Record up to 4 medical conditions Free Text
2	Medical Conditions (Last 12 Months) - ICD10/Read codes	Record exact ICD-10/Read codes for all diagnoses.	Record up to 4 medical conditions ICD 10 Codes/Read Codes
2	Date of Diagnosis (Medical conditions)	The date the deceased was diagnosed with a specific medical condition(s).	Date
2	Terminal Illness	Whether or not the deceased was deemed to have a terminal illness as recorded in any health service records, before death.	<ul style="list-style-type: none"> • Yes • No • Not Known
2	Chronic Pain	Whether or not the deceased suffered from chronic pain as recorded in any health service records, before death.	<ul style="list-style-type: none"> • Yes • No • Not Known
E. CONTACT WITH SERVICES			
1	General Hospital Admissions (Last 12 months)	Whether there were any general hospital admissions recorded on SMR01 in the 12 months before death.	<ul style="list-style-type: none"> • Yes • No • Not Known
1	General Hospital Diagnoses (Last 12 months)(ICD10)	List any diagnoses for general hospital admissions in the 12 months before death.	ICD10 codes
1	Date of Most Recent Admission to General Hospital	Deceased's most recent date of admission recorded on SMR1.	Date

Phase	Data item	Definition	Codeset
1	Admission Type of Most Recent General Admission	The type of admission for the most recent inpatient episode as assessed by the receiving consultant.	<ul style="list-style-type: none"> • Routine Admission, no additional detail added • Routine elective (i.e. from waiting list as planned, excludes planned transfers) • Patient admitted on same day or following day as Attendance at Outpatients, not for medical reasons, but because suitable resources are available • Planned transfers • Routine Admission, type not known • Urgent Admission, no additional detail added • Patient delay (for domestic, legal or other practical reasons) • Hospital delay (for administrative or clinical reasons e.g. arranging appropriate facilities, for test to be carried out, specialist equipment, etc.) • Emergency Admission, no additional detail added • Patient Injury - Self Inflicted (Injury or Poisoning) • Patient Injury - Road Traffic Accident (RTA) • Patient Injury - Home Accident (including Accidental Poisoning in the home) • Patient Injury - Accident at Work • Patient Injury - Other Injury (including Accidental Poisoning other than in the home) - not elsewhere classified • Patient Non-Injury (e.g. stroke, MI, Ruptured Appendix) • Other Emergency Admission (including emergency transfers) • Emergency Admission, type not known

Phase	Data item	Definition	Codes et
1	Admission Reason for Most Recent General Admission	Indication of the primary reason why the deceased was admitted for general inpatient or day case care.	<ul style="list-style-type: none"> • Acute Admission no additional detail added • Admission for treatment • Pre-operative preparation • Observation • Radiotherapy/Chemotherapy • Rehabilitation • Convalescence • Self-medication training • Other type of Acute Admission • Acute Admission, type not known • Professional examinations (i.e. medical staff undergoing exams) • Readmission for treatment, same condition (e.g. incomplete abortion following complete abortion episode) • Self-inflicted injury • Assessment • Accidental Injury • Other injury • Clinical drug trials • Assault • Respite care • Investigation • Palliative Care • Geriatric Admission, no additional detail added • Continuing Care • Respite Care – planned • Respite Care - non-elective • Admission awaiting local authority residential home • Admission awaiting private residential home • Admission awaiting voluntary residential home • Admission awaiting nursing home care • Other type of geriatric admission • Geriatric admission, type not known • Geriatric Assessment • Geriatric Palliative Care
1	Length of Most Recent General Hospital Admission (days)	Length of stay of most recent admission before completed suicide attempt.	Numeric
1	Psychiatric Diagnoses (ever)	List any psychiatric diagnoses recorded at any time in any medical records: GP, Psychiatric, General Hospital. Record most recent episode first. Record for up to 8 separate episodes.	Free text
1	Psychiatric Diagnoses (ever) ICD10/Read Codes	Record ICD10/Read Code for any psychiatric diagnosis recorded at any time in any medical records: GP, Psychiatric, General Hospital. Record for up to 8 separate	ICD10 codes/Read Codes

Phase	Data item	Definition	Codes et
		episodes	
1	Date of Most Recent Psychiatric Diagnosis	The date of the most recent psychiatric diagnosis. This could be either through most recent admission or a more current GP diagnosis.	Date
1	Source of Most Recent Psychiatric Diagnosis Information	The main source from where information on most recent psychiatric diagnosis was obtained.	<ul style="list-style-type: none"> • GP • General Hospital Services (SMR01) • Psychiatric Services (SMR04) • Police • Social Work • N/A • Other (please specify)
1	Date of Most Recent Psychiatric Admission	The date of admission of most recent psychiatric inpatient or day case admission as recorded on SMR04.	Date
1	Admission Type of Most Recent Psychiatric Admission	The type of admission for the most recent psychiatric inpatient episode as assessed by the receiving consultant.	<ul style="list-style-type: none"> • Routine Admission, no additional detail added • Routine elective (i.e. from waiting list as planned, excludes planned transfers) • Patient admitted on same day or following day as Attendance at Outpatients, not for medical reasons, but because suitable resources are available • Planned transfers • Routine Admission, type not known • Urgent Admission, no additional detail added • Patient delay (for domestic, legal or other practical reasons) • Hospital delay (for administrative or clinical reasons e.g. arranging appropriate facilities, for test to be carried out, specialist equipment, etc.) • Emergency Admission, no additional detail added • Patient Injury - Self Inflicted (Injury or Poisoning) • Patient Injury - Road Traffic Accident (RTA) • Patient Injury - Home Accident (including Accidental Poisoning in the home) • Patient Injury - Accident at Work • Patient Injury - Other Injury (including Accidental Poisoning other than in the home) - not elsewhere classified • Patient Non-Injury (e.g. stroke, MI, Ruptured Appendix) • Other Emergency Admission (including emergency transfers)

Phase	Data item	Definition	Codes et
			<ul style="list-style-type: none"> Emergency Admission, type not known
1	Admission Reason for Most Recent Psychiatric Admission	Indication of the primary reason why the deceased was admitted for psychiatric inpatient or daycase care.	<ul style="list-style-type: none"> Mental Health Admission, no additional detail added Diagnostic Therapeutic/Clinical crisis Self-inflicted injury Poisoning Accidental injury Other injury Rehabilitation Other type of psychiatric admission Admission after extended pass Respite/holiday care Learning disability
1	Status on Psychiatric Admission	The status of the patient at the time of admission to the episode with respect to the Mental Health (Care and Treatment) (Scotland) Act of 2003.	<ul style="list-style-type: none"> Formal Informal
1	Psychiatric Diagnosis (most recent psychiatric admission)	Record exact ICD-10 codes for any psychiatric diagnosis/es for the most recent episode recorded on SMR04.	ICD10 codes
1	Psychiatric Diagnosis (most recent psychiatric admission) - Specialty	The psychiatric specialty under which the deceased was diagnosed with their psychiatric diagnosis/es - most recent admission.	<ul style="list-style-type: none"> General Psychiatry (Mental Illness) Child and Adolescent Psychiatry Child Psychiatry Adolescent Psychiatry Forensic Psychiatry Psychiatry of Old Age Learning Disability (Mental Handicap) Psychotherapy
1	Date of Discharge of Most Recent Psychiatric Admission	The date of discharge of most recent psychiatric admission.	Date
1	Inpatient in Psychiatric Hospital at Time of Suicide	Whether the deceased was an inpatient at time of death.	<ul style="list-style-type: none"> Yes No Not Known
1	Length of Most Recent Psychiatric Admission (days)	Length of stay most recent psychiatric admission	Numeric
1	NHS Board of Treatment of Most Recent Psychiatric Admission	The NHS Health Board Area Code associated with the deceased person's most recent psychiatric admission.	Alpha-numeric
1	Number of Psychiatric Outpatient Attendances in the Last 12 Months	The number of psychiatric outpatient attendances by the deceased in the last 12 months before death.	Numeric

Phase	Data item	Definition	Codeset
1	Date of Most Recent Psychiatric Outpatient Appointment	The date of the most recent psychiatric outpatient appointment before death.	Date
1	Appointment Type - Psychiatric Outpatients	An indication of whether the most recent appointment before death was a new appointment (first) or review (return/follow-up) appointment.	<ul style="list-style-type: none"> • New Appointment • Review Appointment • N/A
1	Attendance Record - Most Recent Psychiatric Outpatient Appointment	Whether or not the deceased attended the most recent psychiatric outpatient appointment before death.	<ul style="list-style-type: none"> • Patient was seen • Patient attended but was not seen (CNW) • Patient did not attend (DNA)
1	Date of Last Psychiatric Outpatient Appointment Attended	If did not attend most recent psychiatric outpatient appointment, what was date of last one attended?	Date
1	Date of Most Recent Referral to Psychiatric Outpatients	The most recent date of referral to psychiatric outpatients before death.	Date
2	Number of GP Visits in the Last 12 Months	The number of GP visits by the deceased in the last 12 months before death.	Numeric
2	Date of last Contact with GP	The date of last contact with GP before death.	Date
2	Presenting Problem at Last Contact with GP	The problem the patient presented with at their last GP appointment before death.	<ul style="list-style-type: none"> • Psychiatric Condition • Non-Psychiatric Condition • Not Known
2	Current / Recent Prescriptions (Last 12 months)	Any prescriptions issued in 12 months before death.	<ul style="list-style-type: none"> • Yes • No • Not Known
2	Names of Drugs Prescribed (Last 12 months)	List all drugs prescribed in last 12 months before death.	Free text Up to 9 drugs can be listed
2	BNF Code for Drugs Prescribed (Last 12 months)	The BNF code associated with the drug name.	Alpha-numeric
2	Seen by Other MH Team/Service in Last 12 Months	Whether or not the patient was seen by mental health services, other than psychiatric outpatients or inpatients, in the last 12 months before death.	<ul style="list-style-type: none"> • Yes • No • Patient Declined • Not Known e.g. indication that individual was referred but no evidence to suggest that they attended.
2	Type of Other MH Service Seen in Last 12 Months	The type of mental health service(s) attended by the deceased within the last 12 months before death. This does not include psychiatric outpatients or inpatients.	<ul style="list-style-type: none"> • Community Mental Health Team • Specialist Psychological Services • Private Hospital / MH Service • Other (Specify) • N/A
2	Active MH Management before Death	Whether or not the deceased's psychiatric illness was being actively managed before death. This could be through medication or specific therapies/interventions.	<ul style="list-style-type: none"> • Yes • No • Patient Declined • N/A • Not Known e.g. previously treated but no indication of continuation of treatment before death.

Phase	Data item	Definition	Codeset
2	Number of Emergency Department Attendances (in last 12 months)	The number of emergency department attendances by the deceased in the last 12 months.	Numeric
2	Date of Most Recent Emergency Department Attendance	Date of most recent emergency department attendance before death.	Date
2	Diagnoses at Most Recent Emergency Department Attendance	List all diagnoses recorded for most recent emergency department attendance in last 12 months. Record up to 3.	Free Text
2	Known Attendance at Other Services in Last 12 Months	A record of whether or not the deceased attended any other services in the past 12 months before death?	<ul style="list-style-type: none"> • Yes • No • Not Known
2	Type of Other Service Attended in Last 12 Months	The type of service attended by the deceased 12 months before death. Record up to 3.	<ul style="list-style-type: none"> • Social Services • Counselling Agency • Alcohol Services • Housing • Drug Treatment Services • Primary Care Based Self Help • Occupational Health • Other (specify) • N/A • Not Known
F. LIFE EVENTS			
1	Child Born in Last 12 Months	Whether or not the deceased has given birth in the last 12 months. Maternity history. Record for Females only.	<ul style="list-style-type: none"> • Yes • No • Not Known
1	Date of Delivery (child born in last 12 months)	The date of delivery of any child(ren) born in the last 12 months. Record single date in the event of multiple births.	Date
1	Outcome of Pregnancy	The outcome of the most recent pregnancy in the last 12 months before death.	<ul style="list-style-type: none"> • Livebirth • Stillbirth • Livebirth dying within the first 6 days (early neonatal death) • Livebirth dying on or after the 7th completed day but before the 28th day (late neonatal death). • Livebirth dying on or after the 28th completed day, but before the end of the first year of life (post-neonatal death). • Abortion of a dead fetus of a multiple pregnancy ending before 24 wks of gestation in which the other babies are live born. • N/A
2	Recent Event (Last 12 months)	Any recent events known of in past 12 months before death?	<ul style="list-style-type: none"> • Yes • No • Not Known

Phase	Data item	Definition	Codes et
2	Recent Event Type (Last 12 months)	The type of event experienced by the deceased in the past 12 months before death. Record up to 3.	<ul style="list-style-type: none"> • Breakdown of a significant relationship • Bereavement of close family member • Dispute/fight with family member • Loss of child custody • Job loss • Moving house • Ill health / recent diagnosis • Financial problems • Other (please specify) • N/A • Not Known
2	History of Self Harm	A record of whether or not the deceased had a history of self harming as recorded in any health service notes.	<ul style="list-style-type: none"> • Yes • No • Not Known
2	Number of Previous Self Harm Episodes	The total number of previous self harm episodes.	<ul style="list-style-type: none"> • 0 • 1 • >1
2	Method of Previous Self Harm Episodes	The method(s) used in previous self harm episodes. Record up to 4.	<ul style="list-style-type: none"> • Hanging/suffocation • Jump/Fall • Moving vehicle impact • Drug related poisoning • Other poisoning eg car exhaust • Drowning • Cutting/stabbing • Burning • Firearms • Other (please specify) • Not Known
2	Attitude After Most Recent Self Harm Episode	An indication of the deceased person's attitude after their most recent self harm episode.	<ul style="list-style-type: none"> • Did not want to die • Wanted to die • Components of both the previous 2 answers • N/A • Not Known
G. LIFESTYLE AND RISK FACTORS			
1	Known Illicit Drug User	Whether the deceased had any history of illicit drug use	<ul style="list-style-type: none"> • Yes • No
1	Known IV Drug User	Whether the deceased had any history of IV drug use	<ul style="list-style-type: none"> • Yes • No
1	Recent Illicit Drug User	Whether the deceased was using illicit drugs in the month before last known contact with drug services.	<ul style="list-style-type: none"> • Yes • No

Phase	Data item	Definition	Codes et
1	Illicit Drug Use in Past Month and Frequency	List all drugs used illicitly in the month before last known contact with drug services and the frequency.	<ul style="list-style-type: none"> • Heroin • Heroin BP • Cannabis Resin • Cannabis unspecified • Diazepam • Benzodiazepines unspecified • Crack cocaine • Cocaine Unspecified • Valium • Methadone unspecified • DF118 • Dihydrocodeine • Ecstasy • Amphetamines unspecified • Mephadrone • Speed • Methadone DFT Mixtuire • Co-codamol • Mephadrone • Other (please specify) • N/A • Not Known <p>For each drug selected, state how often:</p> <ul style="list-style-type: none"> • Daily • Most Days • Weekends • Weekly • Fortnightly • Monthly
1	Assessment Completed Date	The date when the most recent assessment was completed by drug services for a client before death. This would be the last known contact with drug services.	Date
2	Living Where	This refers to the living arrangements of the deceased at time of death. More than one can be selected if the deceased lived between more than one place around the time of death.	<ul style="list-style-type: none"> • Own home – owned • Rented accommodation • Relatives home • Friends home • No fixed abode • Hostel • Sleeping rough • Other (please specify) • Not Known
2	Living With Whom	These are the person(s) with whom the deceased had normally lived.	<ul style="list-style-type: none"> • Living alone • With spouse/partner (+/- kids) • With friends • With children only • With parents • Other shared • Other non-shared • Other (please specify) • Not Known
2	Any Children <16	If the deceased had any children under the age of 16. This includes children living with the deceased and living elsewhere. Non-biological	<ul style="list-style-type: none"> • Yes • No • Not Known

Phase	Data item	Definition	Codeset
		children (for example step-children and Foster children) should be included.	
2	Ages of Children <16	The ages of the children <16 living with the deceased and living elsewhere at the time of death . Non-biological children (for example step-children and Foster children) should be included.	Free text
2	How Many Children <16 Lived With Deceased	This refers to the number of children who lived predominantly with the deceased at the time of death. Non-biological children (for example step-children and Foster children) should be included.	Numeric
2	Problematic Alcohol Use	Whether the deceased was known to have problems with alcohol use. Any mention of excess alcohol, harmful use of alcohol, alcohol dependence or recommendations to reduce alcohol consumption should be recorded as Yes. Yes includes problematic alcohol use noted by any source. Yes includes those who were not known to a service or receiving treatment for problematic alcohol use.	<ul style="list-style-type: none"> • Yes - recent problem within 6 months before death • Yes - ongoing problem longer than 6 months before death and up to death • Yes - previously a problem (separate episode) that occurred before 6 months before death. • Yes - time of problem not indicated • Yes 1&3 above • Yes 2&3 above • No • Not Known
2	Source of Problematic Alcohol Use Information	The main source of the information relating to problematic alcohol use.	<ul style="list-style-type: none"> • GP • General Hospital Services • Psychiatric Services • Police • Social Work • N/A • Other (please specify)
2	Problematic Alcohol Use - How Long	How long the deceased was known to have problematic alcohol issues. If more than one episode record for most recent.	<ul style="list-style-type: none"> • Up to 1 month • 1-6 months • 7-12 months • 1-5 years • 6-10 years • 11-19 years • 20+ years • N/A • Not Known
2	Frequency of Problematic Alcohol use	The frequency of alcohol use by the deceased.	<ul style="list-style-type: none"> • Daily • Most days • Weekly • N/A • Not Known

Phase	Data item	Definition	Codes et
2	Recent Treatment Received for Problematic Alcohol Use	Whether the deceased received any treatment in the 6 months before death. Do not include prescribed B vitamins. More than one treatment should be selected if appropriate.	<ul style="list-style-type: none"> Pharmacotherapy and community based detoxification Inpatient detoxification and residential / community rehabilitation Community based psychosocial therapy Self help (individual and group-based) Other (please specify) N/A Not Known
H. CRIMINAL JUSTICE			
2	Subject of Statutory Justice Interventions	Whether the deceased was or had just been the subject of a Statutory Justice Intervention.	<ul style="list-style-type: none"> No Yes <ul style="list-style-type: none"> Supervised Attendance Order Probation Order Community Service Order Other (Please specify) Previously known to Procurator Fiscal services
2	Been in Police Custody	Whether the deceased had been in police custody in the past 6 months	<ul style="list-style-type: none"> Yes No Not Known
2	Ever Been in Prison	Whether the deceased had ever been in prison	<ul style="list-style-type: none"> Yes No Not Known
2	If Deceased Has Been in Prison, Remand or Convicted	The status of the deceased's stay in prison, remand or convicted.	<ul style="list-style-type: none"> Remand Convicted Not Known
2	What was the Charge	The charge for which the deceased was in prison.	Free text <ul style="list-style-type: none"> N/A Not Known
2	Length of Time in Custody	Record the length of the most recent prison stay. This can be recorded in days, months or years depending on which unit is most appropriate for the time period.	Days, Months, Years <ul style="list-style-type: none"> N/A Not Known
2	Date of Release	Date of release from most recent prison stay	Date
I. GENERAL			
2	Review Undertaken by Mental Health Services	Whether a suicide review has been undertaken by Mental Health Services. This includes any local suicide review and further investigations.	<ul style="list-style-type: none"> Yes No Not Known
2	Referred to the MWC	Whether or not the deceased has been referred to the Mental Welfare Commission for further review.	<ul style="list-style-type: none"> Yes No Not Known

Phase	Data item	Definition	Codeset
2	Any Other Relevant Information	Use this question to record any information, not necessarily specific to the deceased, which may be of importance. For example if there may be a cluster of suicides in an area, recent closure of large local employers, changes to drug services etc	Free text

A2 – Difference between ScotSID and NRS Figures

The summary below highlights the reason for the difference between NRS’s overall reported figure for suicides in 2009 and the ScotSID cohort for the same year.

NRS deaths; deliberate self harm and events of undetermined intent

Calendar Year Of Registration	Calendar Year Of Death	
	2008	2009
2009	12	734
2010	0	26

Count by year of registration = 746 (NRS reported deaths for 2009)

Count by year of death = 760 (ScotSID reported deaths for 2009)

A3 – ScotSID Data Items Used During the GP and Procurator Fiscal Service Pilot

GP Dataset

- Psychiatric diagnoses (ever)
- Source of psychiatric diagnosis information
- Date of last contact with GP
- Presenting problem at last contact with GP
- Number of GP visits in the last 12 months
- Seen by MH Team/Service in last 12 months
- Type of MH Services seen in last 12 months
- Active MH management before death
- Date of most recent emergency department attendance
- Number of emergency department attendances (in last 12 months)
- Diagnoses at most recent emergency department attendance
- Known attendance at other services in last 12 month
- Type of other service attended in last 12 months
- Medical conditions (last 12 months)
- Medical conditions (last 12 months) – ICD10/Read codes
- Date of diagnosis (medical conditions)
- Terminal Illness
- Chronic Pain
- Recent event (last 12 months)
- Recent event Type (last 12 months)
- History of suicide attempts*
- Number of previous suicide attempts*
- Method of suicide attempt*
- History of self harming*
- Family history of suicide*
- Attitude after most recent self harm attempt
- Current/Recent prescriptions(last 12 months)
- Names of drugs prescribed (last 12 months)
- Problematic alcohol use
- Frequency of problematic alcohol use

- Known illicit drug user
- Known illicit drug user for how long
- Illicit drug use in past month and frequency
- IV drug use
- How long IV drug user

As a result of the GP pilot findings those fields marked '**' were revised in conjunction with the ScotSID Steering Group and replaced with the following three items:

- History of self harm
- Number of previous self harm episodes
- Method of previous self harm episodes

This revised dataset will be used in future for the potential linkage of further information from GP notes to ScotSID.

Procurator Fiscal Service Dataset

- Date of occurrence
- Time of occurrence
- Place of suicidal act
- Evidence of planning
- Avoiding detection
- Suicide note
- Circumstances of death
- Recent event (last 12 months)
- Recent event type (last 12 months)
- Living where
- Living with whom
- Any children <16
- Ages of children < 16
- How many children <16 lived with deceased

A4 – The Scottish Suicide Information Database Steering Group

Name	Title/Organisation
Alana Atkinson	Choose Life Programme Manager, NHS Health Scotland
Parveen Chishti	Data Development Officer, NHS National Services Scotland, Information Services Division
Denise Coia (until March 2011)	Principal Medical Officer; Scottish Government
Moira Connolly (from Nov 2011)	Principal Medical Officer, Scottish Government
Celina Davis (from August 2011)	Principal Analyst, NHS National Services Scotland, Information Services Division
Frank Dixon	National Records of Scotland
Sean Docherty	NHS Healthcare Improvement Scotland
Laurence Gruer (Chair)	Director of Public Health Medicine, NHS Health Scotland
Monica Merson	Head of Health and Wellbeing Team, NHS Health Scotland
Steve Platt	Professor of Health Policy Research, University of Edinburgh
Lisa Reddie (until July 2011)	Principal Analyst, NHS National Services Scotland, Information Services Division
Michael Sibley	Programme Principal, NHS National Services Scotland, Information Services Division
Andrew Sim	Samaritans
Cameron Stark	Consultant in Public Health Medicine, NHS Highland
James Taylor (until April 2011)	Mental Health & Suicide Risk Management Adviser, Scottish Prison Services
Rachel Watson	Lothian and Borders Police
Anna Wimberley	Clinical Governance Support and Development, Healthcare Improvement Scotland
Rachael Wood	Consultant in Public Health Medicine, NHS National Services Scotland, Information Services Division

A5 – Publication Metadata (including revisions details)

Metadata Indicator	Description
Publication title	The Scottish Suicide Information Database Report 2011
Description	This publication describes the development of the Scottish Suicide Information Database (ScotSID). The database contains death records of probable suicides and deaths due to undetermined intent routinely submitted to ISD by the National Records of Scotland. This release includes all deaths reported in the year 2009.
Theme	Health and Social Care
Topic	Mental Health
Format	PDF document
Data source(s)	Scottish Suicide Information Database (ScotSID)
Date that data are acquired	August 2011
Release date	20 December 2011
Frequency	Annual
Timeframe of data and timeliness	Suicides occurring in 2009
Continuity of data	This is the first report of its kind but data showing annual comparisons are expected in future years.
Revisions statement	Dynamic data sources will include revised data in future publications.
Revisions relevant to this publication	None
Concepts and definitions	Suicides according to NRS are taken to be deaths due to intentional self harm or undetermined intent.
Relevance and key uses of the statistics	Making information publicly available for suicide prevention, provision of comparative information and planning purposes.
Accuracy	Quality checks are conducted by ISD. Figures are compared to previously published data and expected trends.
Completeness	SMR data to 2009 are reported to vary between 93% and 100% completeness. The results of the internal record linkage indicated that approximately 80% of records could be linked between the two datasets.
Comparability	Some data contained in the report are comparable to that of other European countries and studies carried out in England and Wales.
Accessibility	It is the policy of ISD Scotland to make its web sites and products accessible according to published guidelines .
Coherence and clarity	The report is produced as a PDF document and follows the ISD standard presentation guidelines.

Metadata Indicator	Description
Value type and unit of measurement	Numbers, percentages and rates per 100,000.
Disclosure	The ISD protocol on Statistical Disclosure Protocol is followed.
Official Statistics designation	Official Statistics
UK Statistics Authority Assessment	Not submitted for assessment.
Last published	-
Next published	December 2012
Date of first publication	20 December 2011
Help email	parveen.chishti@nhs.net
Date form completed	06 December 2011

A6 – Early Access details (including Pre-Release Access)

Pre-Release Access

Under terms of the "Pre-Release Access to Official Statistics (Scotland) Order 2008", ISD are obliged to publish information on those receiving Pre-Release Access ("Pre-Release Access" refers to statistics in their final form prior to publication). The standard maximum Pre-Release Access is five working days. Shown below are details of those receiving standard Pre-Release Access and, separately, those receiving extended Pre-Release Access.

Standard Pre-Release Access:

Scottish Government Health Department
NHS Board Chief Executives
NHS Board Communication leads
NHS Health Scotland

Extended Pre-Release Access

Extended Pre-Release Access of 8 working days is given to a small number of named individuals in the Scottish Government Health Department (Analytical Services Division). This Pre-Release Access is for the sole purpose of enabling that department to gain an understanding of the statistics prior to briefing others in Scottish Government (during the period of standard Pre-Release Access).

Scottish Government Health Department (Analytical Services Division)

Early Access for Quality Assurance

These statistics will also have been made available to those who needed access to help quality assure the publication:

ScotSID Steering Group members