2004–2013. The external causes of death were based on the International Classification of Diseases, the 10th revision (ICD-10) and the underlying cause of death was determined as Intentional self-harm (X60-X84, ICD-10). In the study a total number of suicide deaths was used as well as overall and specific mortality rates cross-classified by year, age and gender.
Results In period 2004–2013 there were 488 suicides in SDC (an average annual rate of 10.5 per 100,000), representing 1.3% of total male deaths and 0.6% of total female deaths. Suicide was the second or the third leading cause of injury death for all ages-accounting for one-fifth of all injury deaths in the observed period. As study results showed, males were two times likely to commit suicide than females. The suicide rate for males was 2.1 times higher than rate for females (14.2 versus 6.5 per 100,000). Although suicide deaths affect almost all age groups, those aged 35–54 had the highest rates. The suicide rates have declined in recent years, but the growing trend of suicide deaths in young males is concerning fact.
Conclusions Our study results can be used as a base for developing specific suicide prevention programs at regional level. Preventive strategies implemented at regional level identifying vulnerable population groups could be more effective than global strategies.

567 AN EXPLORATION OF CHILDREN SUICIDES IN QUEENSLAND, AUSTRALIA. CONSIDERATIONS FOR PREVENTION, INTERVENTION AND POSTVENTION

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Background Youth and child suicide prevention is a national and global priority. In Australia 35% of all male deaths and 26% of all female deaths by suicide were in the 15–19 years old group. Analysis of available suicide data could inform policy and practice focused on prevention, early intervention and post intervention.
Methods Deidentified child suicide data for the period 1 July 2004 to 30 June 2014 was analysed using Leximancer version 4 and SPSS Version 22. Variables analysed included gender, age, residence, child safety system records, method of suicide, mental health issues, child abuse and precipitating event among others.
Results Between 2004–2014, 159 children commited suicide. Three quarters were 15–17 years of age, with the youngest being 9 years of age. Two thirds were male. Compared to females, males were less likely to be known to the child safety system within the last 3 years before death ($p = 0.097$), have known mental health of behavioural issues ($p = 0.032$), show previous suicidal thoughts ($p = 0.014$) or attempts ($p = 0.001$) or self-harm ($p < 0.001$), or have a history of child abuse ($p = 0.009$). Forty five percent were from very low or low socio-economic areas. Hanging was the most frequent method of suicide and was associated with precipitating arguments. Non-hanging deaths were more likely in metropolitan and outer regional areas, in families with a history of mental illness and in cases with a history of physical abuse. Evidence of planning was present in over half of the cases.
Conclusion Better understanding of characteristics of suicides is important for early detection and prevention. Indicators of planning need to be identified and documented in order to empower communities to take action that protects the children. Multi-level interventions that address the child, the family, the community and health services integration are necessary for both pre and post suicide periods.

Violence

Post Mon 1.15

568 PROACTIVE COMMUNITY-POLICING RESPONSES TO DOMESTIC AND INTIMATE PARTNER VIOLENCE (D/IPV) IN CANADA

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Background The Canadian Observatory on the Justice System's Response to Intimate Partner Violence (IPV) is an international network of academics, governments, and community-based organisation providing enhanced understanding of how justice responses to IPV operate. Since 2007 the Canadian Observatory conducted policy reviews; engaged governments in dialogue to share data collection strategies and facilitate research collaborations; and developed mechanisms to mobilise knowledge. In 2012, the Canadian Observatory initiated a reflection on police intervention in IPV situations that led to create a national dialogue on police practices and to provide evidence-based research on police response to IPV. In this perspective a national think tank was held in June 2014 with 35 ranking police from across Canada to discuss best practices implemented in different Canadian communities in regards to intimate partner violence. The event led to the creation of a working group of experts that is developing a national framework on police proaction and intervention to D/IPV.
Description In June 2015, the group of experts comprised of researchers, communities and police agencies met to determine the different steps for the development of a national framework. The creation of a national framework will provide: A foundation for consistent language, standards and policy for Canadian Police Agencies, to guide police proaction and intervention on D/IPV; Resources for collaborative education, prevention, intervention, and supports for victims, abusers and communities; The creation of visual and narrative reference model on proactive D/IPV response to be used by all Canadian police. The group of experts is to complete their work by the end of March 2016.
Results The development of a national framework encompasses a dialogue with police forces, communities and academics, including working sessions with the group of experts, consultations with community stakeholders, police forces and other professionals involved in the area of D/IPV intervention. In this presentation, we will discuss the process that led to the development of a national framework on Proactive Community-Policing Responses to D/IPV in Canada and how such process led to a supported dialogue among police agencies on the issue.

569 THE ROLE OF ONE-STOP CRISIS MANAGEMENT CENTRES (OCMCS) IN VIOLENCE PREVENTION

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10.1136/injuryprev-2016-042156.569

Background Over the last three years, the MoHP has established sixteen OCMCs in sixteen districts cross Nepal. Each OCMC aims to provide an integrated package of services for survivors of violence through a 'one-door' system. OCMCs are designed to follow a multi-sectoral and locally coordinated approach to provide survivors with a comprehensive range of services including health care, psycho-social counselling, access to safe homes, legal protection, personal security and vocational skills training.
Methods Reports, monitoring visits, national level annual review with stakeholders inclusive of hospitals, Police, Attorney, Ministry of Women, MoHP, Chief District Officers, Representatives from Prime Ministers and Counsel of Ministers, I/NGOs and survivors.
Results The district report showed that from October 2013 – October 2014, OCMCs have provided essential services required by survivors with 2,273 individuals (2,133 (94%) women and 140 (6%) men) accessing services. A high percentage of women receiving services (53.6%) were victims of intimate partner violence, while 26% had experienced sexual violence. 16% had suffered extreme mental abuse and 4.8% 'other types of violence (trafficking, child marriages). The breakdown of data by age-group shows that violence is common among women between the ages of 15 and 49 years with 1645 women in this category, suggesting married women as the prime targets.
Conclusions OCMCs are a new and challenging initiative. The challenges can be overcome through improved awareness raising activities; capacity building; survivor follow-up; improved screening and coordinating strategies; and more social protection activities. Supporting the establishment of OCMCs in all 75 districts is essential.

570 HEALTH PROFESSIONALS' ROLE IN THE HUMANITARIAN DISARMAMENT MOVEMENT AND PREVENTING ARMED VIOLENCE

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Background Disarmament and war prevention are now widely perceived as humanitarian goals by governments and non-governmental organisations alike. In recent years, "humanitarian disarmament" campaigns have taken on some of the world's worst weapons, including landmines, cluster munitions, small arms, drones, and nuclear weapons.
Description of the problem An evidence-based awareness of the impact of war and all forms of armed violence on public health, documented by health professionals in hospitals and emergency rooms and conveyed through the stories of the victims and their ravaged communities, has catalysed successful campaigns to prohibit the most inhumane weapons and to impose strict new limits on trafficking in others. While the term is relatively new, humanitarian disarmament has been at the heart of health-based organisations' efforts such as the International Committee of the Red Cross and International Physicians for the Prevention of Nuclear War's work for decades. For example, the medical evidence that nuclear war would be a humanitarian catastrophe to which physicians could organise no meaningful response helped mobilise the international community towards a nuclear test ban and non-proliferation.
Results The health facts about nuclear weapons and the devastation they cause have become the foundation of a Humanitarian Pledge to "stigmatise, prohibit and eliminate nuclear weapons" that, at this writing, has been joined by 117 countries. The human consequences of armed violence has been a central concept in achieving landmark treaties and agreements on conventional weapons including the Mine Ban Treaty, the United Nations Programme of Action on Small Arms and Light Weapons, the Convention on Cluster Munitions and the Arms Trade Treaty.
Conclusions Health organisations and agencies have a key role to play in bringing the humanitarian perspective to the development and implementation of policy instruments and agreements designed to prevent armed violence.

571 ANALYSIS ON THE VIOLENCE PREVALENCE AND PREVENTION STATUS IN CHINA

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Background Violence prevention is the priority of public health; and to master the prevalence state and risk factors of violence is the base to develop the prevention strategies. This study aimed to evaluate the violence prevalence and prevention status in China, and to provide reference for the prevention and control of violence.
Methods Violence data were obtained from the National death surveillance data set and National Injury surveillance system. The laws policies, capacity for data collection, programmes and services for violence prevention were described.
Results The trend of violence mortality has declined during 2006–2013. The mortality has decreased from 1.21/100000 in 2006 to 0.65/100000 in 2013. decreased by 46.3%. The violence mortality was high in young adult men, while it was high in female infants and old women who were over 85 years. Chinese laws and policies included the strategies on violence prevention, but not integrated. There were lack of the nonfatal violence data. Most of the prevention programmes were limit and transient.
Conclusions The different violence prevention strategies could be implemented according to gender differences. China could carry out more work in the aspects of legislation, data collection and service routinization.

572 VIOLENCE IN THE HEALTH WORK PLACE SURVEY ABOUT 521 CASES AMONG HEALTH STAFF IN TUNISIA

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10.1136/injuryprev-2016-042156.572

Background Violence in the health work place is actually a serious problem in Tunisia. This phenomenon can be explained by the weakness of the security measures in the health facilities, but also by other causes such as lack of health staff or equipment which make timeouts very long and create a kind of pressure in the health care settings.

In Tunisia, the overall situation has changed since January 2011 when the revolution occurred; the general situation in the country became characterised of violence and insecurity. Some national actions have been taken by Ministry of Health in late 2011 in order to eliminate this phenomenon in the health care settings.