

**Conclusions** Approaches adopted to distribute the survey, the response rate and demographics of the population who completed it, and comparison of responses of Geraldton residents with those in the NCAS will be discussed.

**Learning Outcomes** It is feasible to administer a shorter survey based on the NCAS, to measure particular attitudes on which to focus violence prevention education for a regional population.

### 2E.002 CYCLE OF VIOLENCE: CHILDHOOD ABUSE AND RISK OF VIOLENCE REVICTIMISATION IN ADULTHOOD

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Interpersonal violence is a serious threat to the attainment of the Sustainable Development Goals (SDGs). A public health approach to violence prevention is crucial, and addressing risk factors is a key priority. Global research has demonstrated that childhood adversity increases risk of a range of poor outcomes across the lifecourse. This study used data from a nationally representative survey of household residents (n=21,845), to examine the impact of childhood abuse (physical, sexual and psychological abuse, and witnessing domestic violence) on risk of adulthood violence revictimisation (physical assault (PA), intimate partner violence (IPV), and sexual violence (SV)).

Compared to individuals who experienced no child abuse, those who experienced one type were, twice as likely to experience PA, and three times as likely to have experienced IPV and/or SV. Individuals who experienced multiple types were three, six and seven times more likely to experience PA, IPV, and SV, respectively. After controlling for the number of types experienced, associated types differed by adult violence outcome; child psychological and physical abuse were associated with IPV; psychological and sexual abuse with SV; and psychological abuse with PA.

Findings from the study will be presented with consideration of strategies to prevent and respond to child abuse and the potential downstream effect on preventing interpersonal violence across the lifecourse and achieving the SDGs. With adulthood victimisation likely to compound the already detrimental effects of childhood abuse, and given that many associated outcomes represent adversities for the next generation, breaking the cycle of violence represents a critical priority.

### 2E.003 BURDEN OF SUICIDE IN NEPAL: AN ANALYSIS OF POLICE RECORDS

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**Background** Suicide is a complex human behaviour which might be initiated with an onset of psychic pain. It is the leading cause of unnatural deaths in Nepal, and the number is rising continuously. Due to issues regarding the legality, social

stigma, and logistical problems, there is an underreporting of suicide cases in Nepal.

**Methods** We studied the records of Nepal Police for five years between 2015 and 2019. Access to the dataset was obtained through institutional research collaborations. The socio-demographic variables for each individual case of deaths were extracted and analysed.

**Results** During the five years, 25,316 cases of suicidal deaths were recorded; an average of 14 people each day. The data revealed that people aged 19 to 35 years accounted for almost 60% of all suicide deaths. Overall, there is an increase in suicidal deaths by 33% in 2019 compared to 2015 whereas the increase in females was 200%. Hanging was the most common (70.13%) method followed by the consumption of poison (26.55%).

**Conclusion** Suicide is a serious but neglected public health problem in Nepal. It has been found that adolescents, youths, and females are the most vulnerable population for suicide. The findings warrant an urgent need for suicide prevention in Nepal.

**Learning Outcomes** Police records are currently the only reliable source for information regarding suicides occurring within the nation. There still may be cases that might not have been recorded. Large-Scale researches can identify factors associated with suicides in Nepal in order to inform prevention interventions.

### 2E.004 ZERO SUICIDE HEALTHCARE: PROGRAM THEORY TO GUIDE EVALUATION FOR SAFER SUICIDE CARE

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**Context** The World Health Organisation estimates one person dies by suicide every 40 seconds. In Australia it's estimated around 20% of suicides are people who have been in the Australian healthcare system. This is not an acceptable outcome for modern healthcare systems.

**Process** The Zero Suicide Healthcare (ZSH) framework has been adopted in many developed countries, comprised of seven elements designed to build organisational capability, improve clinical practice and create better service pathways for recovery.

**Analysis** ZSH draws on techniques of quality management and continuous improvement. It implicitly assumes suicide prevention can be addressed in health care settings in the same way, and with the same absolute improvements, as has been done in wound management, infection control and medication management. It advances evidence-based practice in suicide prevention as a standardised and systematic reform. It encourages the use of data and measurement to monitor performance for continuous improvement within healthcare settings.

However, there is no single source of understanding of how the elements of the ZSH framework interact to achieve outcomes. The development of the Theory of Change for ZSH provides greater clarity about the overall design of the framework using program theory. This will also underpin the evaluation of ZSH across projects.

**Outcomes** A model will be presented demonstrating alignment to the ZSH framework and giving a consistent approach to