Results Violence – physical assault, sexual assault, drink-driving crashes, and suicide – comprised 84% of the burden in Alexandria, 74% in Zacatecas, 65% in Leuven, and 56%-59% elsewhere. Physical and sexual assault alone comprised 32%-72%. Drink-driving comprised 10%-21%.

Conclusions Achieving this SDG goal will require creating effective violence prevention programs. Our physical assault estimates greatly exceed GBD's estimates. GBD's assault incidence sets a high severity threshold for qualifying cases. Its alcohol-attributable fractions for physical assault average one third of the estimates in widely respected multi-national studies. GBD 2017 also attributed no sexual violence to harmful alcohol use.

7C.003 DRINK SPECIAL LAWS AND ALCOHOL-RELATED FATAL CRASHES IN THE UNITED STATES

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Background In the United States, every day, close to 30 people die in alcohol-impaired related crashes. Given the known role of alcohol in traffic injuries, we assessed the impact of drink special laws on alcohol- and non-alcohol-related fatal motor vehicle crash rates.

Methods We performed a synthetic control analysis of US data from 1982 to 2017. We used publicly available data to evaluate the effects of implementing any drink special law at the state-level during the study period on fatality rates per 100 million vehicle-miles of travel. We used an enhanced version of the SC method for the analysis of multiple treated units.

Results Overall, treated states with any drink special law reduced alcohol-related fatal crashes per 100 million VMT by 0.01 (p-value = 0.84) in year one, 0.10 (p-value = 0.14) in year three, 0.07 (p-value = 0.28) in year five, and 0.16 (p-value = 0.01) in year 10 post-implementation compared to the synthetic control trend. Implementation of any drink special law also produced reductions of non-alcohol-related fatal crashes per 100 million VMT by 0.19 (p-value = 0.11) in year one, 0.24 (p-value = 0.03) in year three, 0.25 (p-value = 0.00) in year five, and 0.18 (p-value = 0.00) in year 10 compared to the synthetic control trend. Findings for the number of laws implemented and each drink special laws were mixed.

Conclusions Drink special laws appeared to be associated with larger reductions of non-alcohol-related fatal crashes but no with the hypothesized target population, the alcohol-related fatal crashes.

7D – Road – Alcohol, March 25, 2021

7D.001 DRINK DRIVING – WHY WE OFTEN FAIL TO LEARN FROM BEST PRACTICE

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In Europe, approximately 25% of all traffic accident fatalities are alcohol-related. Governments and other responsible authorities have carried out a number of more or less effective and (also) ineffective measures to prevent drink driving. Some policies and measures are proven to be successful (e.g. more frequent random BAC tests for all drivers, zero tolerance for novice and professional drivers, lower BAC levels in general, alcolocks for repeat offenders, structured and long-term campaigns and educational programmes etc.), but are still not fully included in many legislations and are not consistently implemented in practice. Despite the fact that drivers today are aware of the tragic and financial consequences they can bring to themselves and others while driving drunk, and that the public opinion with regard to drink driving largely changed (most Europeans nowadays openly oppose to drink driving), drunk drivers are still responsible for about a quarter of all fatal accidents in Europe. Therefore, new, better and more effective measures are urgently needed. The authors will present an extensive existing scientific evidence from many studies and research in a structured way and present many good examples from practice as well (e.g. evidence-based interventions). Presentation will be based on the document (guidelines and recommendations) which was recently published by author (Košir) and co-author (Talić) in Slovenia and co-sponsored by the Slovenian Traffic Safety Agency and the Ministry of Health. Link to the document: <https://goo.gl/cU4zWg>.

7E – intentional, March 25, 2021

7E.001 IF WE DON'T ASK, WE DON'T KNOW AND WE CAN'T HELP

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Context In Australia, one woman is murdered by a partner every 9 days and 26,000 children are homeless every year due to domestic violence. Consumer-centred, cost-effective violence prevention programs are urgently needed.

Research indicates those exposed to violence want to be asked about it. However, clinicians find it too awkward and too time-consuming. As a result, questions are not asked and the exposure to violence continues. Our aim is to design and implement an innovative screening program for partner violence that is acceptable to both consumers and health staff, transferable to other settings and sustainable into the future.

Process 1) developed screening and risk assessment tools, validated by consumers and health staff; 2) developed referral pathways; 3) trained staff; 4) modified clinic layout to be consumer-centred; 5) implemented program at Sexual Health Quarters; 6) collected staff and consumer feedback before and after implementation.

Analysis quantitative analysis of 1) prevalence of violence; 2) characteristics of survivors; 3) support required; 4) staff and consumer feedback.

Outcomes In the first 6 months of the program we screened 1500 women, identified exposure to violence in 18% and provided counselling to 40% of those exposed. All consumers and staff surveyed supported this program, with 90% of staff admitting that it was easier than expected.

Learning Outcomes Our program highlights the feasibility and acceptability of an intervention for the secondary prevention of partner violence. A wider roll out of this program would directly contribute to the achievement of 6 out of the 17 Sustainable Development Goals.

7E.002 SEX-SPECIFIC AND AGE-SPECIFIC SUICIDE MORTALITY BY METHOD IN 58 COUNTRIES, 2000–2015

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Background Suicide is a significant public health problem internationally. Recent suicide mortality by method is unexamined.

Methods Using mortality data from the WHO mortality database, we compared sex-, age-, and country-specific suicide mortality by method for 58 countries worldwide between 2000 and 2015. Changes in suicide mortality were quantified using negative binomial models among three age groups for males and females separately.

Results Suicide mortality declined substantially for both sexes and all three age groups studied in 37 of the 58 included countries between 2000 and 2015. Males consistently had much higher suicide mortality rates than females in all 58 countries. Hanging was the most common suicide method in the majority of countries. Sex-specific suicide mortality varied across the countries significantly for all three age groups. The spectrum of suicide method generally remained stable for 28 of the 58 included countries; notable changes occurred in the other 30 countries, including especially Colombia, Finland and Trinidad and Tobago.

Conclusion Likely as a result of prevention efforts as well as sociodemographic changes, suicide mortality decreased substantially in 37 of the included 58 countries between 2000 and 2015. Further action is recommended to explore specific drivers of recent changes (particularly for increasing suicide rates in eight countries), to understand substantial disparities in suicide rates across countries, and to develop interventions to reduce suicide rates globally.

Learning Outcomes Between 2000 and 2015, suicide mortality decreased in 37 countries but increased in 8. Suicide spectrum by method experienced substantial changes over time in several countries.

7E.003 HEALTH CARE PROVIDERS' PERCEPTIONS OF THE BARRIERS TO SUICIDE PREVENTION IN MEXICO

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Background Suicide is a growing public health issue around the world. Despite its importance, few countries have

established national programs to address suicide prevention. In middle-income countries, few studies focus on the factors that deter mental health care provision on suicide prevention. This qualitative study aimed to explore mental health care providers' perceptions of barriers to suicide prevention in Mexico.

Methods Semi-structured interviews were conducted with 25 mental health care providers who worked in outpatient mental health care units in Mexico City. Data were analyzed using framework analysis.

Results Three broad categories were identified: structural issues in service provision, health care services issues and social issues of the patient. Participants tough that the lack of a suicide program, mental health system fragmentation and the poor attention of the authorities to mental health hinders patient's access to appropriate health care. Insufficient resources, service's saturation and poor capacitation difficult opportune detection and treatment. Social problems as violence, drug use, and family disintegration are leading the patients to suicide behavior.

Conclusions Mental health issues are not a priority in the national policy agenda. The absence of a national policy to suicide prevention leads to poor resource allocation and ineffective actions to prevent suicide. Our findings suggest that suicide prevention efforts may promote intersectoral collaboration, more integrated health services, and considering social issues to achieve a comprehensive approach.

7E.004 VIOLENCE REDUCTION UNITS: PUBLIC HEALTH APPROACH TO PREVENTING VIOLENCE (ENGLAND AND WALES)

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Background In 2018, UK Government published its Serious Violence Strategy in response to increases in knife and gun crime. The strategy declared a call to action for partners across different sectors to collaborate and adopt a whole system public health approach to preventing serious violence. In June 2019, 18 areas were provided with funding to establish violence reduction units (VRUs), bringing together police, local government, health, community leaders and other key partners with a specific intent to tackle violence and its underlying causes. This study aims to identify the development and implementation of VRUs during 2019/20, including facilitating and moderating factors, and outcomes and impacts.

Methods The study focuses on three VRU areas across England and Wales (population~5 million). Methods include interviews (n~40) and engagement (e.g. via workshops; n~200) with a range of stakeholders (e.g. VRU team members/advisors; intervention programme commissioners/delivers), analyses of programme documentation, and observation of programme delivery.

Results Initial findings illustrate that the three VRUs are implementing a place-based approach to violence prevention, have developed a problem profile and strategy for future prevention activity (in the short and long-term), and implemented various interventions to prevent and respond to violence. Interventions target system change, and also consider a life course public health perspective.