

Intentional Deaths

Fatal Injury in West Virginia

A report by

The West Virginia Injury Prevention Coalition

In association with

**The Center for Rural Emergency Medicine
West Virginia University
Morgantown, West Virginia**

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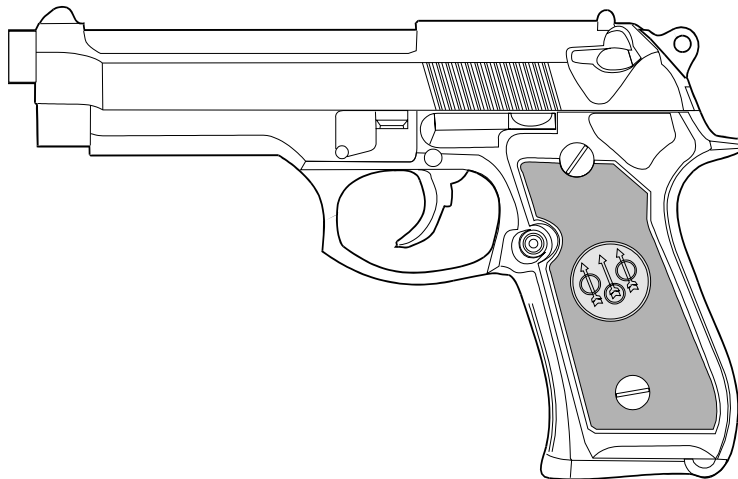
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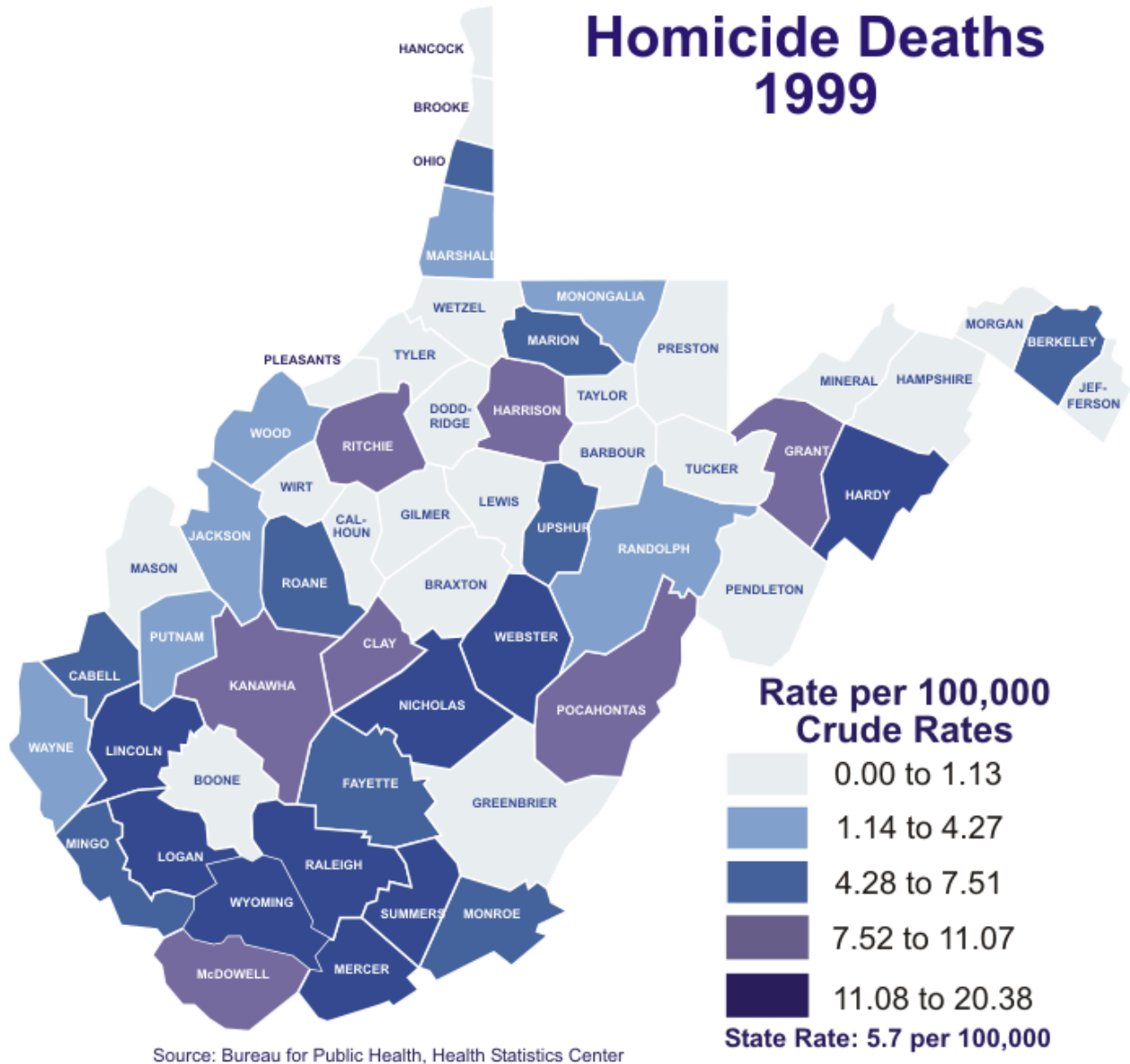
Homicide



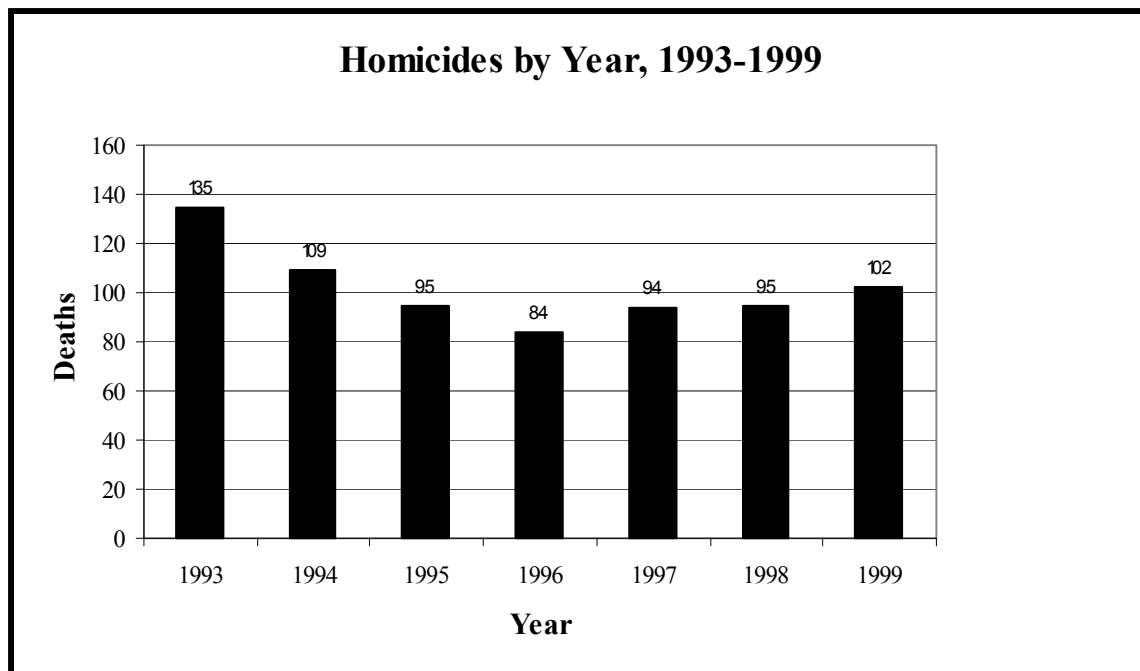
The 1998 rate of homicide for males in WV was twice that for females in both WV and the country as a whole; however, the national rate among males was 1.6 times higher than the rate in WV males.



- West Virginia is fortunate to have a homicide rate below the 1999 national rate (5.7 WV and 6.8 U.S.). However, homicides are not evenly distributed across the state. Several counties have rates that exceed both state and national rates.







- The 102 homicides in 1999 were the highest number during the past 5 years.
- Two-thirds of West Virginia's homicide victims from 1995 through 1999 were killed with firearms.
- In the U.S., 12% of reported homicides are related to domestic violence events. In West Virginia this figure is near 40%.
- While females account for about one-quarter of all homicides in the U.S. and about one-third in West Virginia, females account for about 60% of all domestic violence-related homicides nationwide and about 55% of West Virginia's.

Healthy People 2010 Objectives:

- 15.1 Reduce intimate partner violence by reducing the rate of domestic-violence related homicides to less than 1.3 per 100,000.



Prevention Strategies

In West Virginia during the late 1990s, homicide was the third leading cause of death in 15-24 year olds and the fifth leading cause among 25-34 and 35-44 years olds. While the risk of homicide varies widely by age and gender, a majority of homicidal events and those specifically resulting from domestic violence are perpetrated by the use of firearms. Thus, realistic and viable prevention strategies must address this topic.

Strategies to substantially reduce and prevent the incidence of homicides must involve both broad social changes and specific interventions aimed at cases of potential or actual homicidal violence. These strategies must integrate social and cultural changes, health and related-social services, criminal justice changes, and environmental changes. Elements of these domains are listed below:

Social and Cultural Changes

- ▲ Decrease the cultural acceptance of violence.
- ▲ Reduce gender inequality and support more flexible male role models.
- ▲ Reduce the consumption of alcohol and other drugs.

Health and Related Social Services

- ▲ Develop educational programs to teach conflict-resolution skills and initiate public awareness programs which teach that violence is not the best solution.
- ▲ Increase education for family life, family planning, and child rearing.
- ▲ Develop programs to train high-risk adolescents and to make jobs available for them.
- ▲ Improve the identification and treatment of perpetrators of violence by the health care system.
- ▲ Improve communication and cooperation among health care providers, police departments, and schools.
- ▲ Improve the ability of the health care system to recognize and treat consequences of violence other than injuries.
- ▲ Develop programs of referral through emergency departments and urgent care centers for victims of domestic and intimate partner violence.

Criminal Justice Changes

- ▲ Police should treat physical assaults among family members, intimates, and acquaintances as criminal behavior.

- ▲ Train police and citizen intervention teams.
- ▲ Improve linkages between police and social services in response to violence.

Environmental and Other Changes

- ▲ Define high-risk settings and occupations and determine interventions specific for them.
- ▲ Create safe environments such as well-lit roads, parks, and courtyards.
- ▲ Keep all guns unloaded and away from children.
- ▲ Design firearms which are difficult to fire (i.e., trigger locks).
- ▲ Ensure that mandatory “waiting periods” for the purchase of handguns are enforced and proper registration procedures are followed.

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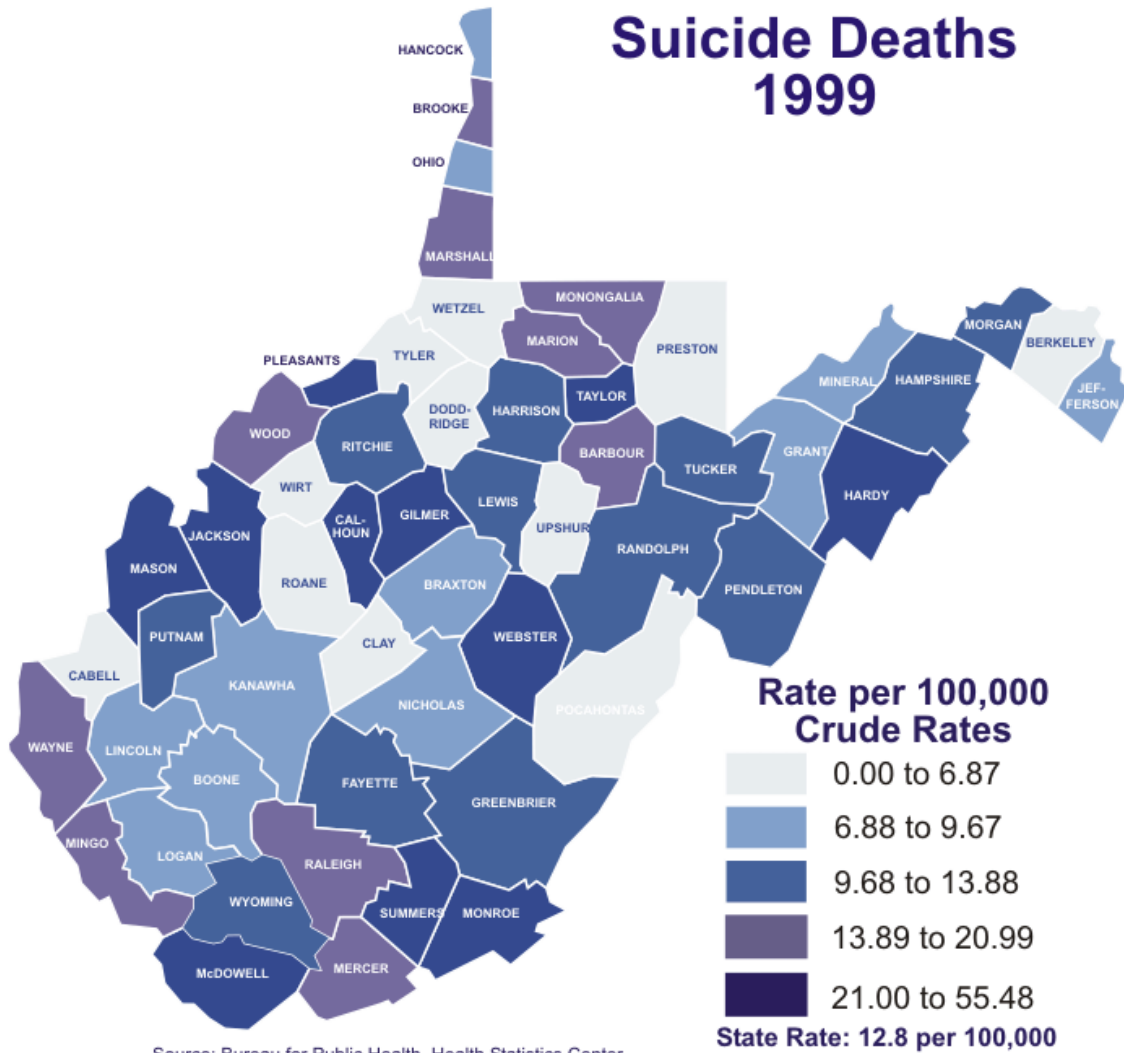
Suicide



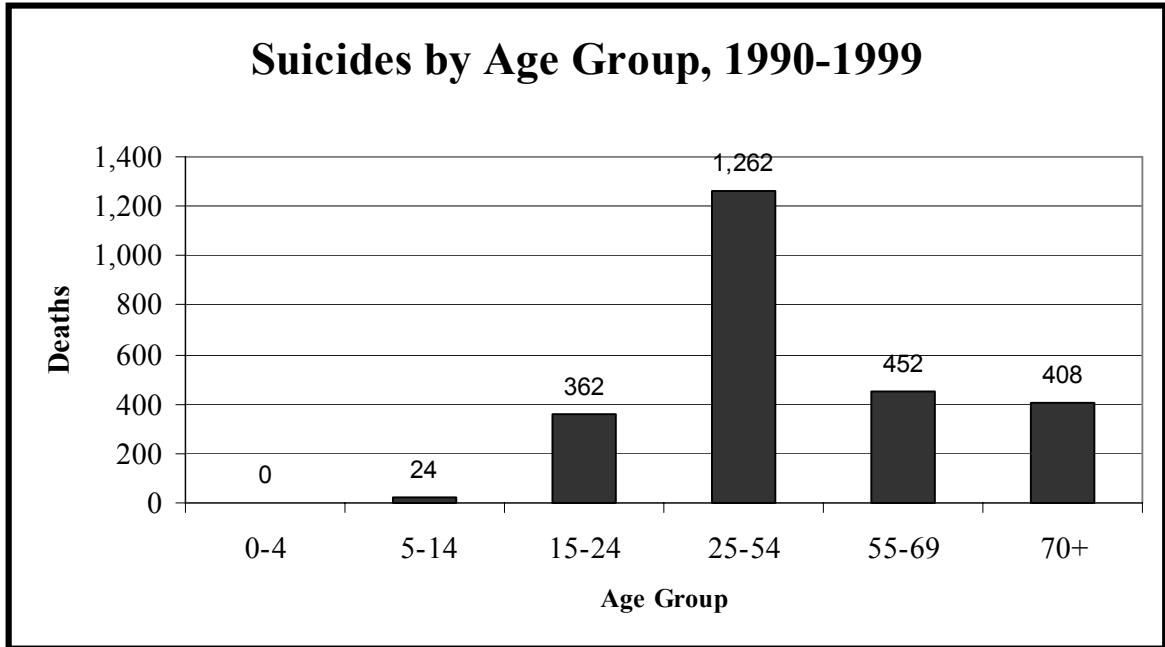
Suicide was the 11th leading cause of death in 1999 with males having a rate nearly 7 times higher than females.



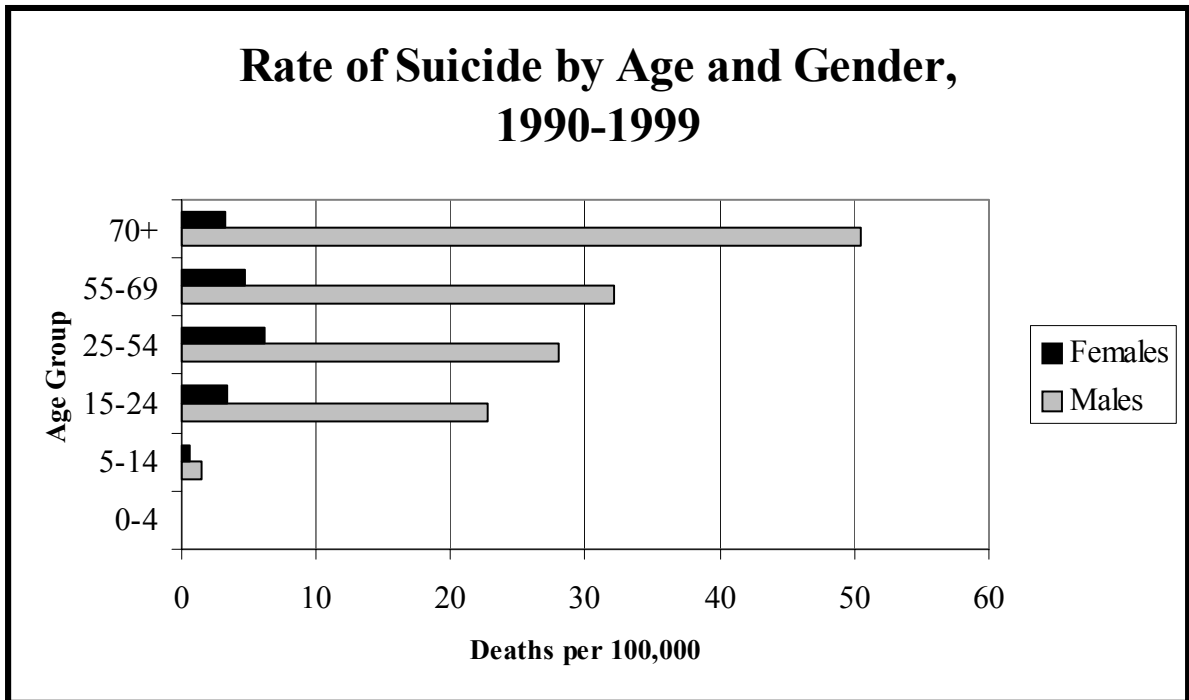
- The state suicide rate for 1999 was slightly higher than the 1998 nationwide rate (12.8 WV and 11.3 U.S.). Suicide rates are substantially higher in some counties than in others, particularly in the southern and north-central regions of the state.



- The 1999 suicide rate among WV males was 6.8 times higher than WV females (23.0 vs. 3.4) compared to the 1998 national gender differential of 4.2 (18.6 vs 4.4).

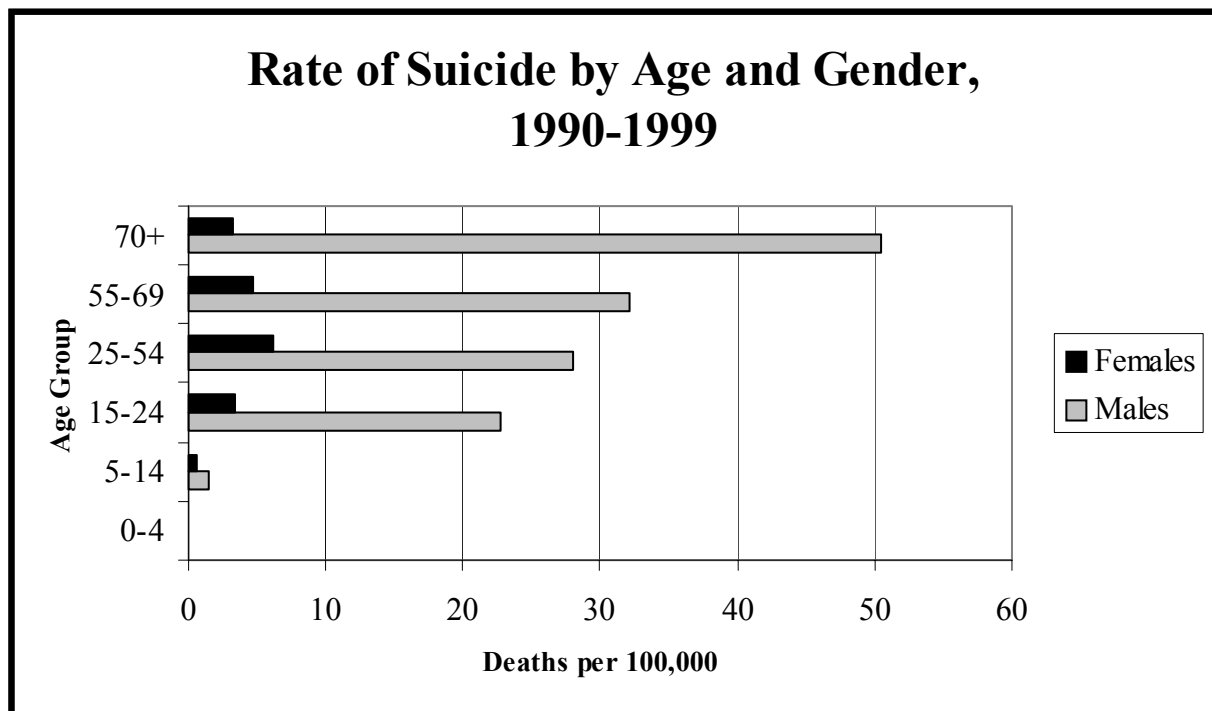


- Half of all suicides in WV occurred in the 25 to 54 year age group. Rates among males far exceed female rates for ages 15 and older.





While suicide among 15-24 year old males are often well publicized, the rate among the



oldest males is over twice that of the younger group.

- Firearms are used in nearly three-quarters of all suicides in WV.
- There was an average of 256 suicides annually from 1995 to 1999.

Healthy People 2010 Objective:

18.2 Reduce the statewide suicide rate to 10.5 per 100,000.

Preventive Strategies

More than 30,000 Americans commit suicide every year, about one every 17 minutes, while more than 650,000 attempt suicide. For every two victims of homicide in the U.S., there are three deaths from suicide. Research has helped to provide a greater awareness that some deaths from suicide are preventable through social and environmental changes. Evidence from a variety of perspectives indicating biological and psychosocial factors contribute to suicidal behaviors suggest that a broad-based public health preventive approach is needed. This approach includes five basic steps: 1) clearly define the problem; 2) identify risk and protective factors; 3) develop and test interventions; 4) implement interventions; and 5) evaluate effectiveness. A coalition of public and private groups representing advocates, clinicians, researchers, and survivors have developed a *National Strategy on Suicide Prevention* (NSSP). The NSSP has 4 broad aims:



- Prevent premature deaths due to suicide across the life span,
- Reduce the rates of other suicidal behaviors,
- Reduce the harmful after-effects associated with suicidal behaviors and the traumatic impact of suicide on family and friends,

- Promote opportunities and settings to enhance resiliency, resourcefulness, respect, and interconnectedness for individuals, families, and communities.

The NSSP has 11 goals and 68 specific objectives. The goals generally fall into the following categories with several objectives highlighted:

Improve identification, referral, and treatment of persons at high-risk of suicide

- ▲ Increase training of health care providers and key community gatekeepers (e.g., physicians, nurses, physician assistants social workers, psychologists, and counselors) in the recognition, treatment and referral of patients with clinical depression.
- ▲ Develop school-based screening programs designed to identify suicidal youth in the context of an evolving ‘suicide cluster.’
- ▲ Provide training for clergy, teachers and other educational staff, attorneys, correctional workers on how to identify and respond to persons at risk for suicide.
- ▲ Provide educational programs for family members of persons at elevated risk.

Treatment of underlying risk factors for suicide

- ▲ Problems in social adjustment.
- ▲ Alcohol and other substance abuse.
- ▲ Depression and other mental disorders.
- ▲ Serious medical illness (e.g., cancer, AIDS).

Decrease individual vulnerability to suicide through education of the general population

- ▲ Suicide is a public health problem that is preventable.
- ▲ Sponsor national and regional conferences on suicide and suicide prevention.
- ▲ Disseminate information through the Internet.



▲ Identify and develop understanding and coping mechanisms.

▲ Transform public attitudes.

Improve access to and community linkages with mental health and substance abuse services

▲ Integrate mental health and suicide prevention into health and social services outreach programs for at-risk populations.

▲ Define and implement screening guidelines for schools, colleges, and correctional institutions.

▲ Provide or expand the accessibility of self-referral resources (e.g., hot lines, walk-in crisis centers) for suicidal persons.

Promote efforts to reduce access to lethal means and methods of self-harm

▲ Educate health care providers and local public health officials on the assessment of lethal means in the home and actions to reduce suicide risk.

▲ Implement a public information designed to reduce accessibility of lethal means.

▲ Improve firearm safety design, establish safer methods for dispensing potentially lethal quantities of medications, and seek methods for reducing carbon monoxide poisoning from automobile exhaust systems.

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