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OREGON PUBLIC HEALTH DIVISION • DEPARTMENT OF HUMAN SERVICES

HOMICIDE-SUICIDE IN OREGON

During 2009, 11 homicide-suicide events occurred in Oregon, in which 27 people died. Most of these 2009 incidents occurred in close succession. This *CD Summary* presents analysis from the Oregon Violent Death Reporting System. Understanding the incidence and risk factors associated with homicide-suicide events may shed some light on this tragic form of interpersonal violence, and help to demonstrate why all forms of interpersonal violence are a grave public health concern.

THE NUMBERS

Homicide-suicide (also referred as murder-suicide or homicide followed by suicide) is defined as a person killing one or more others, and then taking his/her own life within 24 hours.[1] There are no national data on the exact frequency of homicide-suicide events due to the lack of a national surveillance system. However, research estimates that 1,000 to 1,500 people in the U.S. die annually from homicide-suicide, for an annual incidence rate of 0.2 to 0.3 per 100,000 persons.[2–4]

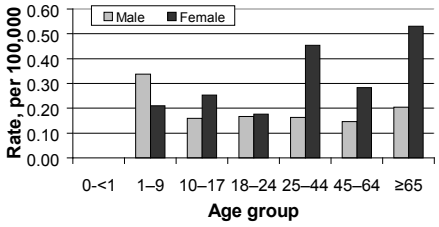
From 2003 to 2009, 58 homicide-suicide events occurred in Oregon — about eight events each year, with a rate of 0.2 per 100,000 persons. These events resulted in 125 deaths. The deaths due to homicide-suicide counted for approximately 8% of all homicides and 1.4% of all suicides in Oregon. The number of events and associated deaths was relatively stable over the 7 years.

VICTIMS AND PERPETRATORS

Three of four victims were women or children. The victims ranged in age from one to 89 years, with an average age of 40 years. For victims 24 years or younger, the rates among males and females were similar; for those 25 years and older, rates in women were 2–3 times higher than in men (figure). Most victims were white (85%) and 7% were of Hispanic ethnicity. Nearly one half of the victims were married and 31% were single, never married.

During 2003–2009, 90% of perpetrators were male. Perpetrator ages ranged from 21 to 91 years; 69% were between 25 and 64 years; 21% were adults ages 65 and older. Most perpetrators were white (76%) and 9% were of Hispanic ethnicity. One third of the perpetrators were married.

Age specific rate of homicide victims in homicide-suicide events by sex, Oregon, 2003–2009



The majority of victims were killed by an intimate partner or family member (table, *verso*). Ninety-two percent of female adults were killed by their current or former husbands or boyfriends. Seventy percent of children were killed by their parents. Eight percent of homicide-suicide events were familicides, in which the perpetrator killed their spouse and child(ren).

CIRCUMSTANCES

Overall, two of three homicidal deaths were directly related to intimate partner violence. Marital conflict is a common factor; 53% of perpetrators were reported to have a relationship problem with their spouse or other partner; 29% of intimate partner violence-related homicide incidents ended with a suicide or suicide attempt.

Physical health problems are a significant factor, especially among older adults. Nine events involved a caregiver (mostly male) killing his/her ailing spouse and then himself/herself. Of 58 perpetrators, 29% were reported to have mental health problems such as a mental disorder, alcohol/substance use problem and/or depressed mood at the time of death. Loss job and/or financial problems were reported among 20% of events.

Firearms accounted for 86% of all deaths in homicide-suicide events, followed by poisoning (5%), sharp instruments (5%), and hanging/suffocation (3%).

Seventy percent of incidents took place in the home.

PREVENTION

Homicide-suicide events have warning signs and they often involve threats. Threats with a weapon or threats to kill should always be taken seriously — especially where access to firearms is a concern.[5]

The clinical setting is an important place to identify, aid, and refer victims of intimate partner violence, and older caregivers who are depressed and desperate. Reducing violence among intimate partners is the key to preventing homicide-suicide. Women who may be at risk can be assessed using the Danger Assessment tool (see Resources below), which is a series of 20 questions that can identify women who may be at risk of being killed by an intimate partner.[5] Campbell et al recommend that practitioners assess risk systematically, with this tool or others with some evidence of validity, and also carefully explore the victim's perception of homicide risk.[5, 6]

Premeditated intent is often linked to suicidality, depression and substance abuse. More can be done to identify and treat depression, mental disorders, and substance abuse universally among men. Screening and providing appropriate treatment for men is critical to their health and the health and safety of their families and the community.

Healthcare providers and mental health or substance abuse clinicians should include identification and assessment of patient risk for harm-

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Table. Relationship characteristics among homicide-suicide events, Oregon, 2003–2009

Relationship to victim	Female		Male	
	0–17 yrs	≥18 yrs	0–17 yrs	≥18 yrs
I. Intimate partner				
Spouse (current or former)	0	30	0	0
Boy/Girl friend (current or former)	0	5	0	2
Same sex	0	1	0	0
II. Family member				
Mother/Stepmother	0	1	0	0
Father/Stepfather	2	0	6	0
Child/Stepchild	0	1	0	3
Other family member or relative	1	1	1	0
III. Other				
Some associated with intimate partner (ex-boy/girl friend of intmate partner)	0	0	0	5
Stranger	1	1	0	1
Other (neighbor, friend of IPV's victim)	0	0	0	5
Total	4	40	7	16

ing themselves or others as a routine part of practice. Oregon law allows clinicians to exercise discretion with respect to confidentiality and permits clinicians to warn potential victims. However, clinicians should be aware of all of the legal, ethical, and practice-based policy with regard to exercising discretion.[7]

Primary prevention among children and youth has potential for reducing future violence and the high cost of public safety and treatment response. Adding primary prevention that complements coordinated community response will require additional resources and must engage professionals from many sectors of the community that don't traditionally have a role in addressing violence. Health promotion and prevention professionals can play a key role in developing primary prevention strategies that include non-violence education in schools — starting in grade school, and gender specific strategies to prepare young boys and young girls for adulthood.

Even so, efforts to strengthen support for victims, reform laws and policies, encourage treatment for perpetrators, and restrict access to firearms must continue as a robust primary prevention infrastructure is developed.[8]

RESOURCES

- Portland Women's Crisis Line 503-235-5333 *OR TOLL-FREE* 1-888-235-5333
- National Domestic Violence Hotline at 1-800-799-SAFE (7233)
- Download the Danger Assessment Tool at: *www.dangerassessment.org/WebApplication1/pages/da/*

FOR MORE INFORMATION

Visit the state Injury Prevention Program web site at *www.oregon.gov/DHS/ph/ipe/index.shtml*

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