CD Summary

November 12, 2014
Vol. 63, No. 22

Telephone 971-673-1111
Fax 971-673-1100

cd.summary@state.or.us
http://healthoregon.org/cdsummary

OREGON PUBLIC HEALTH DIVISION • OREGON HEALTH AUTHORITY

HOMICIDES IN OREGON

Violence is a significant public health issue and a major 'upstream' driver for many costly physical and mental health problems. In 2010, >16,250 people in the U.S. were victims of homicide. Homicide* is an extreme outcome of interpersonal violence; it not only adversely affects the health of Oregonians, but also drives the need for many other services delivered through the criminal justice, corrections, educational and social service systems.

The Oregon Violent Death Reporting System (ORVDRS) is part of the National Violent Death Reporting System[1] which collects detailed information on all homicides, suicides, deaths from firearms, and those of undetermined intent and legal intervention. ORVDRS obtains data from Oregon medical examiners, police agencies, death certificates, and the Homicide Incident Tracking System.

This *CD Summary* describes trends and characteristics of homicides in Oregon during the period 2003–2012; and discusses strategies aimed at violence prevention, policy, and planning.

HOMICIDE TRENDS IN OREGON

Over the past 25 years, the age-adjusted homicide rate in Oregon has decreased; the highest rate occurred in 1994 at 5.6 per 100,000; the lowest rate occurred in 2007 at 2.1 per 100,000 (Figure 1). During 2003–2012, >1,041 people in Oregon died by homicide.

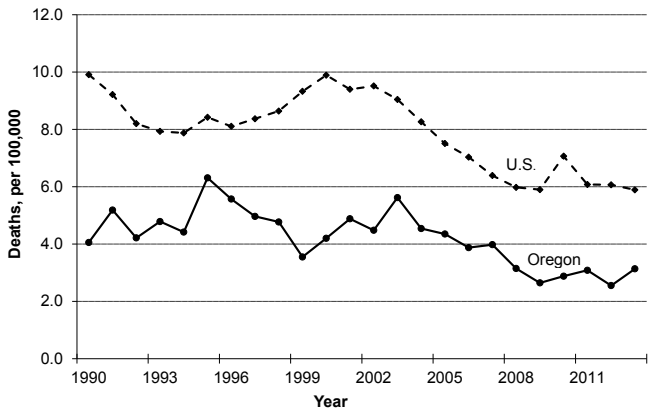
Oregon homicide rates have been consistently lower than the national rate; Oregon ranked 38th among all U.S. states in homicides in 2011.

WHO IS DYING BY HOMICIDE?

During 2003–2012, 70% of homicide victims in Oregon were male. The male homicide rate (3.8 per 100,000) was more than twice the rate for females (1.6 per 100,000). By age, the highest homicide rate occurred among infants, followed by persons 15–34 years of age (Figure 2).

By race, African American males have the highest rates of homicide (10.6 per 100,000); for African American males aged 25–34 years the rate was 41.5 deaths per 100,000, almost 10 times higher than the rate for non-Hispanic white males of the same age group (4.2 deaths per 100,000). Homicide was the leading cause of death among African American males aged 1–34 years.

Figure 1. Age-adjusted homicide rates by year; 1990–2012; U.S. and Oregon



Source: Oregon - ORVDRS; National — CDC's Web-based Injury Statistics Query and Reporting System (WISQARS); see www.cdc.gov/injury/wisqars/fatal_injury_reports.html.

CIRCUMSTANCES

Gunshot injuries were the most common mechanism of homicide. Guns were used by suspects to kill 57% of male homicide victims and 45% of female homicide victims; 18% of both men and women were killed by a sharp instrument; and 9% of men and 7% of women were killed by a blunt instrument. The majority (77%) of homicides occurred at a home.

Arguments, intimate partner violence, and drug-related crimes were common circumstances surrounding homicides in Oregon. Homicides related to drug crime decreased from 2003–2012, while homicides related to gang violence and burglary/robbery remained stable.

HOMICIDE SUSPECTS

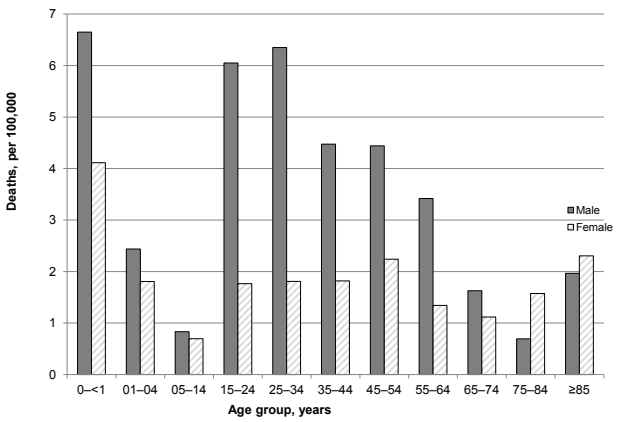
During 2003–2012, >80% of homicide suspects were male. By race, 82% were white, 17% were Hispanic, 7% were African American and 3% were Asian. Persons 15–44 years of age were suspects in homicides disproportionate to their numbers in the general population.

Information was available on the relationship between suspect and victim for 854 of 1,041 homicides; of these, 42% of suspects either were a victim's friend or acquaintance; 19% of suspects were intimate partners; and 18% were family members. Only 11% of suspects (95 suspects) did not know their victims.

INTIMATE PARTNER VIOLENCE

Intimate partner violence (IPV) is actual or threatened physical aggression, sexual assault, and psychological/emotional abuse directed toward a current or former spouse, boyfriend or girlfriend.[2] During 2003–2012, 243 homicides (23%) were IPV-related.

Figure 2. Homicide rate by age and sex, Oregon, 2003–2012



*International Classification of Diseases, Tenth Revision (ICD-10) codes of X85–X99, Y00–Y09, and Y87.1. www.cdc.gov/ncipc/pubres/nvdrs-coding/VS2/default.htm

CD Summary
Oregon Health Authority/Public Health Division
800 NE Oregon St. Suite 772
Portland, OR 97232

November 12, 2014
Vol. 63, No. 22

Oregon Health Authority

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Females were more likely than males to be killed by an intimate partner. Of the 270 homicides among females ≥15 years old, 141 victims (52%) were killed by their current or ex- intimate partners. Two-thirds of the IPV-related homicides involved victims and perpetrators who were living together.

PHYSICAL ABUSE OF CHILDREN

During 2003–2012, 133 homicides occurred among children <18 years old. Of those, 88 children died due to physical abuse by parents or caregivers: 61% were killed by a parent (of those, 74% by their fathers); and 23% were killed by a boyfriend/girlfriend of the parent (of those, 85% were killed by the mother's boyfriend). Fifteen children died from Shaken Baby Syndrome.

HOMICIDE-SUICIDE†

Nearly 60% of intimate partner homicides were followed by a suicide or suicide attempt by the homicide suspect. On average, nine homicide-suicide events occurred each year in Oregon. Victims most commonly were: females (75%), or children (21%). Suspects most commonly were male: (94%).

COMMENT

While homicide deaths have been decreasing in Oregon, they continue to be a significant public health concern. Homicides disproportionately affect young African American men, infants <1 year, and women in violent relationships with intimate partners.

An emerging body of literature demonstrates that many forms of violence are interconnected; share the same root causes; and can happen concurrently or at different stages of life.[3] Childhood violence and trauma, including abuse, neglect (i.e., Adverse Childhood Experiences) can negatively impact child development and contribute to short and long term health problems, (e.g., alcohol and drug abuse, intimate partner violence, suicide attempts, behavioral health problems).[4] Community-level factors that contribute to violence include low social cohesion and poverty, among others.

Addressing violence will require strong collaborations between public health at federal, state and local levels; nonprofit organizations; community leaders; academic institutions; policy makers; and business leaders.

Success in violence prevention will depend on breaking down silos that are focused on single problems, understanding that most violence stems from common root causes, and providing leadership to integrate key practices into clinical settings, schools, families, juvenile justice, child welfare, behavioral health, and public safety.[5]

Potential strategies include:

- Screening for and treating depression in men of all ages.
- Conducting collaborative homicide death reviews to assess the circumstances surrounding deaths and disseminate guidance to the community.
- Identifying youth at risk for involvement in firearm violence, and targeting wrap-around services that address education, employment, mental health, substance abuse, mentoring, skill building, faith community involvement, and health.
- During clinical assessments and law enforcement interventions, including individual and family guidance to remove firearms in high risk situations.

FOR MORE INFORMATION:

- Public Health Division's "Safe and Nurturing Environments" Initiative, contact Lisa Millet at *Lisa.M.Millet@state.or.us*
- OHA Injury and Violence Prevention Program. See website: *http://public.health.oregon.gov/DiseasesConditions/InjuryFatalityData/Pages/nvdrs.aspx*
- CDC Injury Prevention and Control: Division of Violence Prevention. See: *www.cdc.gov/violenceprevention/overview/index.html*

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† A homicide-suicide is one or more homicides with the subsequent suicide of the suspect/perpetrator in 24 hours.