Homelessness and Violent Death

A report from the Virginia Violent Death Reporting System

Commonwealth of Virginia
Virginia Department of Health
Office of the Chief Medical Examiner

October, 2013
Homelessness and Violent Death

A Report from the Virginia Violent Death Reporting System

October, 2013

by:
Marc E. Leslie, MS, VVDRS Coordinator

with:
Jennifer Burns, VVDRS Surveillance Coordinator
Debra Clark, VVDRS Surveillance Coordinator
Tom Kincaid, VVDRS Surveillance Coordinator
Keshara Luster, VVDRS Surveillance Coordinator
Virginia Powell, PhD, VVDRS Principal Investigator

Cover design and layout by Debra Clark

Questions or comments should be directed to:
Marc Leslie
(804) 205-3855
marc.leslie@vdh.virginia.gov

VVDRS online: http://www.vdh.virginia.gov/medExam/NVDRS.htm

This paper was created to provide information that can be used to prevent violent death in the future. Please notify Marc Leslie (see contact information above) if you distribute or use any portion of this report for training, policy decisions, or other uses.


The research files for this report were created on February 17, 2012. Data may continue to be entered and altered in VVDRS after this date.

The publication was supported by Award Number U17/CE001315 from the Centers for Disease Control and Prevention. Its contents are solely the responsibility of the authors and do not necessarily represent the official views of the Centers for Disease Control and Prevention.
Acknowledgements
This report is possible through the support and efforts of those who generously contribute their time and expertise to the VVDRS. We gratefully acknowledge the ongoing contributions of the OCME’s Forensic Pathologists and Pathology Fellows whose expertise adds depth to our knowledge; the OCME State and District Administrators who support the project’s human resources requirements; the critical role of our Medicolegal Death Investigators and Medical Examiners in the collection and analysis of information that is the foundation for our work; and the support of all office and forensic staff who participate actively in our quest for information. Finally, we applaud the efforts of our Surveillance Coordinators, past and present, whose commitment moves this project forward.

Virginia Violent Death Reporting System
Advisory Committee Members

Heather Board
Injury Prevention Program Manager
Division of Prevention and Health Promotion
Virginia Department of Health

Rita L. Katzman
Program Manager
Child Protective Services
Virginia Department of Social Services

Joseph L. Cannon
Special Agent in Charge
Department of Alcoholic Beverage Control

James M. Martinez, Jr., MEd
Director
Office of Mental Health Services
Virginia Department of Behavioral Health and Developmental Services

K. Scott Downs
First Sergeant
Virginia Department of State Police

Janet M. Rainey
Director
Division of Vital Records
Virginia Department of Health

Andrew Goddard
President
Virginia Center for Public Safety

Calvin T. Reynolds
Director
Division of Health Statistics
Virginia Department of Health

Sherrie N. Goggans
Project Manager
Virginia Sexual and Domestic Violence Action Alliance

William T. Gormley, MD
Acting Chief Medical Examiner
Office of the Chief Medical Examiner
Virginia Department of Health

Dana G. Schrad, Esq.
Executive Director
Virginia Association of Chiefs of Police

Linda C. Jackson
Director
Virginia Department of Forensic Science

Johanna W. Schuchert
Executive Director
Prevent Child Abuse Virginia

John W. Jones
Executive Director
Virginia Sheriff’s Association

Anne Zehner
Epidemiologist
Division of Policy and Evaluation
Virginia Department of Health

Virginia Violent Death Reporting System
Office of the Chief Medical Examiner, Virginia Department of Health ■ October, 2013
Other Reports Available from the VVDRS at
http://www.vdh.virginia.gov/medExam/NVDRS.htm

Homicide Across the Life Course

Elder Suicide in Virginia: 2003-2010

Violent Death in Custody

Violent Death in the Workplace

Military-Related Suicide in Virginia: 2003-2010

Physical Health Problems and Suicide in Virginia: 2007-2010

Suicide Trends in Virginia: 2003-2010


Suicide Among College Students in Virginia: 2003-2008

Suicide and Criminal Legal Problems in Virginia: 2007-2008

Suicide in the Eastern Health Planning Region: 2003-2008

Suicide in the Northern Health Planning Region: 2003-2008

Suicide in the Central Health Planning Region: 2003-2008

Suicide in the Northwest Health Planning Region: 2003-2008

Suicide in the Southwest Health Planning Region: 2003-2008

Suicide Methods in Virginia: Patterns by Race, Gender, Age, and Birthplace

Alcohol Consumption Before Fatal Suicides


Suicide and Mental Health in Virginia: 2003-2007

Final Exit: What Type of Suicide Victim Seeks Guidance?

Deaths from Violence: A Look at 17 States

Substance Use and Violence

Violent Death in Virginia: 2006

Unintentional Firearm Deaths in Virginia, 2003-2006
Table of Contents

Acknowledgements ........................................................................................................................................ ii
Other Reports Available from the VVDRS ............................................................................................... iii
Introduction ................................................................................................................................................ 1
Data Sources ............................................................................................................................................ 1
Rates ...................................................................................................................................................... 1
Homelessness Defined ............................................................................................................................ 1
Overall Results ....................................................................................................................................... 2
Suicide ................................................................................................................................................... 3
Homicide .................................................................................................................................................. 3
Summary ............................................................................................................................................... 4
Conclusion ............................................................................................................................................. 7
INTRODUCTION

The condition of homelessness poses unique health and safety challenges for persons who are homeless and, as this report will show, significant risks for violent death. The stress of homelessness may increase suicide risk. Living outside, often out of a conventional social structure, may increase risk for interpersonal violence. This report examines homeless persons who lived in Virginia and died from a violent death between 2003 and 2011. There were 147 persons who were homeless who died from suicide, homicide, unintentional firearm injury, or a death of an undetermined manner.

DATA SOURCES

Violent death data used in this report come from the Virginia Violent Death Reporting System (VVDRS). The VVDRS is part of the National Violent Death Reporting System (NVDRS). The NVDRS documents violent deaths that originate within a state’s borders. It compiles information from sources used in violent death investigation, and links decedents to circumstances to explain such issues as the role of substance abuse and mental health in the death, why a homicide occurred, and the relationship between a victim and a suspect. The VVDRS is the operation and reporting system of the NVDRS within Virginia, and uses the same methodology, definitions, coding schema, and database of the NVDRS.

The VVDRS abstracts death investigation information from several sources, primarily the Office of the Chief Medical Examiner, law enforcement, the Virginia Division of Health Statistics, and the Virginia Department of Forensic Science. Each relevant death record is reviewed by a Coordinator. The Coordinator ensures that all information sources required by the NVDRS are in the record, requests reports that are not already in the file, and abstracts and manually enters the relevant information into the database. Continuous quality assurance activities maintain data accuracy as well as consistency among Coordinators. Deaths entered into the VVDRS are reconciled with deaths reported by the Virginia Division of Health Statistics and the Virginia Office of the Chief Medical Examiner for the purpose of comprehensive case identification.

RATES

Rates would strengthen the information in this report by tying the number of homeless persons to population data, thereby capturing the magnitude of violent death among the homeless. Calculating a rate would require a reliable statewide population number for persons who are homeless during a given year. Unfortunately, reliable estimates of the homeless are not available. Throughout this report, numbers and percentages are used to describe violent death among homeless persons.

HOMELESSNESS DEFINED

Homelessness is defined by the NVDRS project as “having no fixed address and living in a shelter, on the street, in a car, or in makeshift quarters in an outdoor setting.” While other working definitions of homelessness include persons living in long-term hotels/motels, and persons living temporarily with friends or family due to a recent loss of their own home, the NVDRS definition includes only persons who are literally homeless. Persons were coded as being homeless if a reliable source described them as being homeless or if the description of their living conditions (i.e., in a tent in the woods) clearly indicated homelessness.

1 Persons who die in Virginia, but were residents of another state, are excluded.
OVERALL RESULTS

From 2003-2011 there were 147 persons that died an NVDRS-defined violent death, were known to reside in Virginia, and were known to be homeless. Homeless persons comprise 1% of all persons noted as dying a violent death. Most deaths involving homeless persons were either suicides (62 persons) or homicides (58 persons). Additionally, there were 25 deaths of an undetermined manner\(^2\) and two deaths resulting from unintentional self-inflicted firearm wounds.

![Figure 1. Violent Deaths Types Among Persons Who are Homeless, Virginia: 2003-2011](image)

After a brief description of all violent deaths to homeless persons, this paper will focus on suicides and homicides.

- Most homeless persons who died from a violent death were male (87%). Those who died were either White (63%) or Black (37%). Their median age was 42, with 77% of decedents falling between the ages of 25 and 54.
- A firearm was the most frequently used method of fatal injury (25%), followed by hanging/strangulation/suffocation (18%), poisons (13%), sharp instruments (12%), and blunt instruments (12%).
- The most common location of injury was a natural area such as a wooded area (25%), followed by a house or apartment (15%).
- More than half of all decedents (53%) had alcohol, cocaine, and/or opiates in their system at death, indicating an overall problem with alcoholism and substance abuse.\(^3\) This was more common among males (55%) than among females (41%).

\(^2\) Of the 25 undetermined manner deaths, 19 (76%) had no known cause of death; this means that little information was known about the nature of the death.

\(^3\) Information on the presence of these substances excludes persons who died due to a poisoning by these substances. Opiates may be legal or illegal substances; legal opiates may have been obtained by legal or illegal means.
More than one-third (38%) had a Blood Alcohol Concentration (BAC) of .08 or greater. It is notable that decedents more often had a BAC of .08 or greater (38%) than they did of below .08 (14%). Fourteen percent of homeless violent death decedents had cocaine in their system at the time of their death.

SUICIDE

- A total of 62 suicides among persons who are homeless occurred from 2003-2011, representing 1% of all suicides.
- Homeless suicide decedents were primarily male (81%) and White (81%). The median age was 42.
- The most common location of injury was a natural area such as a wooded area (34%), followed by a house or apartment (16%).
- Greater than two-thirds (67%) had given explicit warning signs of suicide risk by disclosing intent to commit suicide and/or having prior non-fatal suicide attempts.
- Most homeless suicide decedents (58%) had a mental health problem; of those with a mental health problem, 89% were known to have been treated for a mental health problem either currently or in the past. Most (53%) also had a problem with alcohol and/or other substances. Combined, 73% had a problem with mental health, alcohol, and/or other substances.
- Other common circumstances included conflict with an intimate partner (33%), a recent loss of housing (25%), and felony-level legal problems (18%).
- The most common methods of fatal injury were hanging/strangulation/suffocation (39%), poisoning (26%), and firearms (23%). Males, who typically favor firearms in suicides, used hanging/strangulation/suffocation more frequently (42%) than they used firearms (28%).
- Thirty-one percent had alcohol, cocaine, and/or opiates in their system at death. This proportion increased to 43% for those with a known alcohol and/or other substance problem, and decreased to 17% for those who were not known to have these problems.
- The most common area where homeless suicide decedents lived was the northwestern area of Virginia (26%) followed by the eastern part of the state (23%).
- Eleven percent were military veterans; no persons were currently serving in the military.
- Most (53%) were unemployed at the time of the suicide. This includes persons listed as being disabled (7%).

HOMICIDE

- A total of 58 homicides among homeless persons occurred during this time period, representing 2% of all homicides.

4 A BAC of .08 or greater is the legal standard for driving while intoxicated in Virginia. Although individual tolerance varies, the level of .08 is used as an indicator of possible intoxication.
• Homicide decedents who were homeless were primarily male (95%) and Black (62%). Their median age was 43.

• A firearm was the most common method of fatal injury (36%), followed by a sharp instrument (28%) and a blunt instrument (24%).

• The most common location of injury was a house or apartment (19%), followed by a natural area such as a wooded area (17%), and the street or road (17%).

• Nearly three-fourths (74%) of homeless homicide decedents had alcohol, cocaine, and/or opiates in their system at death. This was more common for Whites (82%) than Blacks (69%). Fifty-eight percent had a BAC of .08 or greater and 15% had a BAC of less than .08. Eighteen percent had cocaine in their system.

• Homicides were frequently preceded by an unspecified argument (37%) or an argument over money, property, or drugs (20%). In 29% of homicides, the death was precipitated by another crime such as robbery. In 46%, the victim and suspect were friends or acquaintances, and in 63% the victim knew at least one of the suspects.

• These homicides most commonly took place in eastern Virginia (36%) and central Virginia (29%).

• Ten percent were military veterans; no persons were currently serving in the military.

• Most (69%) were not employed at the time of the homicide.

SUMMARY

Table 1 provides summary information about violent death, suicide, and homicide among persons who are homeless.
Table 1. Selected Traits of Persons Who are Homeless and Die a Violent Death, Virginia: 2003-2011

<table>
<thead>
<tr>
<th></th>
<th>Violent Death (147, 100%)</th>
<th>Suicide (62, 42%)</th>
<th>Homicide (58, 40%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>128 (87%)</td>
<td>Male 50 (81%)</td>
<td>Male 55 (95%)</td>
</tr>
<tr>
<td><strong>Race</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White</td>
<td>92 (63%)</td>
<td>White 50 (81%)</td>
<td>Black 36 (62%)</td>
</tr>
<tr>
<td>Black</td>
<td>55 (37%)</td>
<td>Black 12 (19%)</td>
<td>White 22 (38%)</td>
</tr>
<tr>
<td><strong>Race and Gender</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>White male</td>
<td>80 (54%)</td>
<td>White male 42 (68%)</td>
<td>Black male 33 (57%)</td>
</tr>
<tr>
<td>Black male</td>
<td>48 (33%)</td>
<td>Black male 8 (13%)</td>
<td>White male 22 (38%)</td>
</tr>
<tr>
<td><strong>Hispanic Status</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hispanic</td>
<td>11 (8%)</td>
<td>Hispanic 3 (5%)</td>
<td>Hispanic 6 (10%)</td>
</tr>
<tr>
<td><strong>Virginia Health Planning Region</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eastern</td>
<td>41 (28%)</td>
<td>Northwest 16 (26%)</td>
<td>Eastern 21 (36%)</td>
</tr>
<tr>
<td>Northern</td>
<td>29 (20%)</td>
<td>Eastern 14 (23%)</td>
<td>Central 17 (29%)</td>
</tr>
<tr>
<td>Central</td>
<td>27 (18%)</td>
<td>Northern 13 (21%)</td>
<td>Northern 13 (22%)</td>
</tr>
<tr>
<td><strong>Circumstances</strong></td>
<td>Not applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Health Problem</td>
<td>35 (35%)</td>
<td>Non-specific Argument 13 (37%)</td>
<td></td>
</tr>
<tr>
<td>Alcohol/Substance Abuse</td>
<td>32 (53%)</td>
<td>Crime Related 10 (29%)</td>
<td></td>
</tr>
<tr>
<td>Prior Attempts/Disclosure</td>
<td>40 (67%)</td>
<td>Argument over Money/Property 7 (20%)</td>
<td></td>
</tr>
</tbody>
</table>
Table 1. Selected Traits of Persons Who are Homeless and Die a Violent Death, Virginia: 2003-2011 (continued)

<table>
<thead>
<tr>
<th></th>
<th>Violent Death (147, 100%)</th>
<th>Suicide (62, 42%)</th>
<th>Homicide (58, 40%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Premise of Injury</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Natural Area</td>
<td>(37, 25%)</td>
<td>Natural area</td>
<td>House/Apartment</td>
</tr>
<tr>
<td>House/Apartment</td>
<td>(22, 15%)</td>
<td>(21, 34%)</td>
<td>(11, 19%)</td>
</tr>
<tr>
<td>Street/Road or Motor Vehicle (tie)</td>
<td>(14, 10%)</td>
<td>House/Apartment</td>
<td>Street/Road</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Motor Vehicle</td>
<td>Natural area</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(6, 10%)</td>
<td>(10, 17%)</td>
</tr>
<tr>
<td><strong>Method of Fatal Injury</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Firearm</td>
<td>(37, 25%)</td>
<td>Hanging/Strangulation/Suffocation</td>
<td>Firearm</td>
</tr>
<tr>
<td>Hanging/Strangulation/Suffocation</td>
<td>(27, 18%)</td>
<td>(24, 39%)</td>
<td>(21, 36%)</td>
</tr>
<tr>
<td>Poisoning</td>
<td>(19, 13%)</td>
<td>Poisoning</td>
<td>Sharp Instrument</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(16, 26%)</td>
<td>(16, 28%)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Firearm</td>
<td>Blunt Instrument</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(14, 23%)</td>
<td>(14, 24%)</td>
</tr>
<tr>
<td>*<em>Toxicology – Positive Results</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol (any level)</td>
<td>(63, 52%)</td>
<td>Alcohol (any level)</td>
<td>Alcohol (any level)</td>
</tr>
<tr>
<td>(46, 38%)</td>
<td></td>
<td>(15, 29%)</td>
<td>(40, 73%)</td>
</tr>
<tr>
<td>Alcohol (≥.08)</td>
<td>(17, 14%)</td>
<td>Alcohol (≥.08)</td>
<td>Alcohol (≥.08)</td>
</tr>
<tr>
<td>(6, 12%)</td>
<td></td>
<td>(9, 18%)</td>
<td>(32, 58%)</td>
</tr>
<tr>
<td>Alcohol (&lt;.08)</td>
<td></td>
<td>Alcohol (&lt;.08)</td>
<td>Cocaine</td>
</tr>
<tr>
<td>(14, 14%)</td>
<td></td>
<td>(6, 12%)</td>
<td>(10, 18%)</td>
</tr>
<tr>
<td>Cocaine</td>
<td></td>
<td>Opiates</td>
<td>Alcohol (&lt;.08)</td>
</tr>
<tr>
<td>(14, 14%)</td>
<td></td>
<td>(1, 4%)</td>
<td>(8, 15%)</td>
</tr>
</tbody>
</table>

* Toxicology percentages are based on the number of persons who were tested for each substance.
CONCLUSION

Violence prevention is a challenge for any population, but it may be especially so for homeless persons whose daily life and poor access to fundamental resources such as housing, safety, food, and health care creates the opportunity and conditions for violence. Their vulnerable status is exacerbated by substance abuse problems and mental health conditions, which may not be addressed in any meaningful way because they are homeless.

Understanding the prevalence of mental health and substance abuse problems among the homeless is difficult. Estimates from a one night census of shelters conducted nationally in 2010 found that 26% of sheltered persons had a severe mental illness and 35% had chronic substance abuse issues. Other research on the chronically homeless found over 60% had experienced lifetime mental health problems and over 80% had difficulties with lifetime alcohol and/or drug problems.

Furthermore, it is difficult to untangle cause and effect in this relationship. Does homelessness create or exacerbate mental health conditions and substance use? Or, do persons with mental illnesses and substance addictions become homeless because they have these problems? The intervention and response is likely the same in either case: early assessment, diagnosis and treatment for mental health and substance use. But the timing of those interventions could reduce the numbers of those who become homeless to begin with, address significant health and mental health problems, and thereby have a potential impact on violent deaths involving these social and personal problems.

---