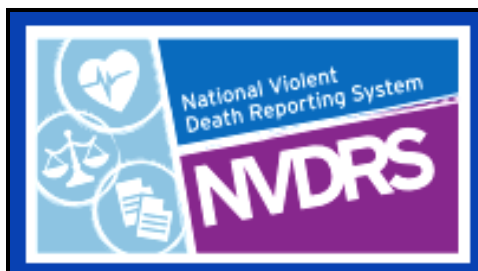


## Establishing the Violent Death Reporting System in Connecticut

In 2002, a new federal surveillance system called the National Violent Death Reporting System (NVDRS) was initiated by the Centers for Disease Control and Prevention (CDC). The states of Massachusetts, Maryland, New Jersey, Oregon, South Carolina and Virginia were chosen to begin collecting data for entry into this reporting system. NVDRS has expanded several times to include new states, most recently the Connecticut Department of Public Health (CTDPH) was awarded CDC funds in 2014 for a 5-year period to establish the Connecticut Violent Death Reporting System (CTVDRS). In 2015, CTDPH began collecting data on violent deaths. Currently, all 50 states, Puerto Rico and Washington, D.C. participate in NVDRS.



According to the NVDRS specifications, the definition of a violent death is as follows:

- 1) A death that results from the intentional use of physical force or power, threatened or actual, against oneself, another person, or a group or community.
- 2) The person using the force or power need

only to have intended to use force or power; they need not to have intended to produce the consequence that actually occurred.

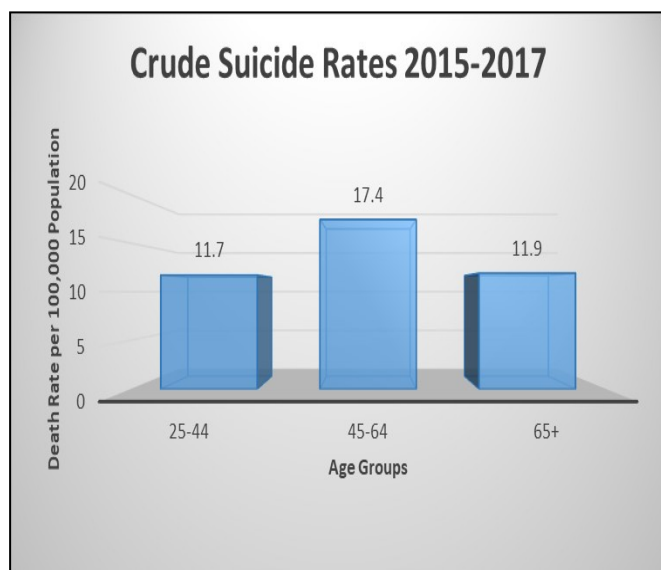
According to this definition, violent deaths include suicides, homicides, deaths from legal intervention, terrorism, deaths of undetermined intent, and accidental firearms deaths.

The major sources of violent death data for CTVDRS are the Office of the Chief Medical Examiner (OCME) (autopsy, investigator, and toxicology data), death certificates from the CTDPH Office of Vital Records, and law enforcement reports that include Supplementary Homicide Reports from the Department of Emergency Services and Public Protection (DESPP), and the Connecticut State Police. The data from these reports include the circumstances of suicides (e.g. depression, relationship problems) and homicides (e.g. committed during a crime such as a robbery or intimate partner violence). From this data, CTVDRS and key stakeholders develop violence prevention efforts statewide.

This newsletter was created by the CT DPH Office of Injury and Violence Prevention (OIVP) for law enforcement personnel and focuses on suicides in Connecticut from 2015 to 2017. Between 2015 and 2017, CT averaged 392 suicides per year (1,170 total suicides). Often people think most of the deaths by suicide occurring in CT are among young people; people less than 25 years of age. To the contrary, CT residents younger than 25 years of age accounted for only 10% of the state's suicides

deaths. Whereas, ninety percent (90%) of the state's suicide deaths occurred in people 25 years of age and older. The average age of death by suicide was 49 years old. Chart 1 below describes the crude suicide rate (number of suicides per 100,000 CT population) between 2015 and 2017. It shows that residents ages 45 to 64 years old had the highest rate of suicide (17.7 per 100,000 population), followed by residents 65 years and older (11.9), and residents between the ages of 25 and 44 years old (11.7).

**Chart 1. Crude Suicide Rates in CT by Age Group for People ≥ 25 Years Old, 2015-2017 (Men and Women Combined)**



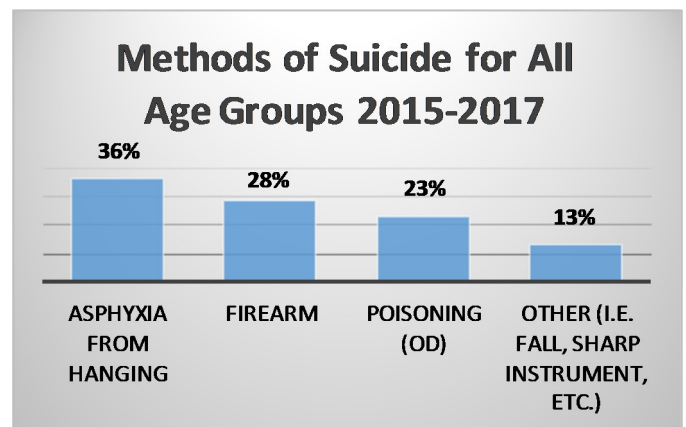
In this 2015-2017 time period, White non-Hispanic men accounted for 80 percent (n=681) of the suicides among all ages. White non-Hispanic men between 45 to 64 years old had the highest overall rate of suicide.

The age adjusted suicide rate for CT increased 7.2% from 2016 to 2017, 9.7 deaths per 100,000 population in 2016 to 10.4 in 2017. The CT age adjusted suicide rates for 2016 was lower than the national age adjusted suicide rate of 13.4 deaths

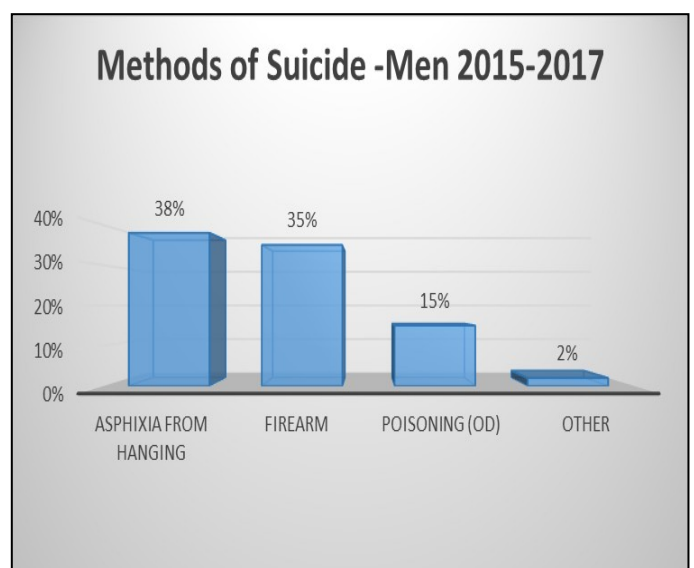
per 100,000 population.<sup>1</sup>

In the United States, the most common weapon used in suicides is a firearm. Contrary to the national suicide reports, the most common method of death by suicide in CT is asphyxia from hanging, followed by firearm, then poisoning (especially intentional drug overdose), including among men only. See Chart 2 and Chart 3.

**Chart 2. Methods of Suicide (Men and Women Combined), All Age Groups, 2015-2017**



**Chart 3. Methods of Suicide for Men, All Age Groups, 2015-2017**



## Known Circumstances

Mental illness and feeling depressed are the leading risk factors for death by suicide for all ages and genders. Why are White non-Hispanic men between 45 to 64 years old most vulnerable to suicide? In addition to mental illness and feeling depressed, middle-aged White non-Hispanic men had the highest incidence of intimate partner problems (e.g. divorce), financial and job problems, followed by eviction or foreclosure of their homes than any other age group in 2015-2017.

## Crude Suicide Rate for Cities and Towns

**Table 1. Crude Suicide Rates for Injury City CTVDRS data 2015-2017**

**At least 15 incidents per City 2015-2017**

Rank (Based on Rate)	Number of Deaths	Crude rate per 100,000*	City
1	18	20.1	Vernon**
2	24	17.8	Wallingford
3	15	17.7	Branford
4	31	17.1	Bristol
5	27	16.8	Milford
6	22	16.7	Southington
7	21	15.8	Enfield
8	25	13.9	Meriden
9	16	12.9	Shelton
10	39	11.9	Waterbury**
<b>Other Major Cities</b>			
	18	10.3	Manchester
	38	9.7	New Haven**
	33	8.5	Stamford
	27	6.1	Bridgeport
	22	5.9	Hartford

\* Based on City's 2015 Census Estimated Population

\*\* Includes 1 victim/suspect (murder followed by suicide incident)

Suicide rates varied by geographic region during the period of study (See Table 1). The highest suicide rate occurred in Vernon, followed by Wallingford and Branford. Vernon's rate was about double that of Manchester and New Haven, although these latter cities had relatively high rates of suicide attempts.

## Reducing Suicide

Primary prevention is the ideal method of protection against developing suicidal ideations. Primary prevention looks to increase and enhance protective factors against suicide, such as life coping skills and resiliency, social connections with family, friends and community. However, life's demands can overwhelm one's coping skills. A parallel or simultaneous prevention strategy would be to incorporate mental health awareness and any necessary treatment. When in compliance, medication along with behavioral therapies have been shown to improve mental health. Here is a link to protective factors: <https://www.sprc.org/about-suicide/risk-protective-factors>.



## Suicide Within Law Enforcement

Between 2015 and 2017, nine active and four retired police officers died by suicide. During that time period, CT's suicide rate for active or sworn officers was 3 deaths per 10,000 sworn police officer population. A 2018 *USA Today* report indicated 140 police officers died by suicide in the

## In this issue...

United States in 2017. From 2015-2017, it is estimated that death by suicide for active police officers in the United States was about 3 per 10,000 sworn police officer population.<sup>3</sup>

### Building Relationships with Community

Law enforcement officers have become the first responders to individuals living with mental illness in the community. Evidence exists that by building relationships between law enforcement and mental health services, the safety of people with mental illness, police officers and the public is assured. Selected resources to build effective community partnerships between law enforcement and mental health services are available at: [http://www.namimass.org/wp-content/uploads/CJDPbuildingbridges\\_booklet\\_7-1.pdf](http://www.namimass.org/wp-content/uploads/CJDPbuildingbridges_booklet_7-1.pdf)



### Suicide Prevention Trainings and Resources

Question, Persuade, and Refer (QPR) training is an approach to confronting someone about their possible thoughts of suicide. QPR training could help protect your co-workers, friends, family, and community. Learn more at the following links:

<https://qprinstitute.com/>

<http://www.sprc.org/sites/default/files/resource-program/LawEnforcement.pdf>

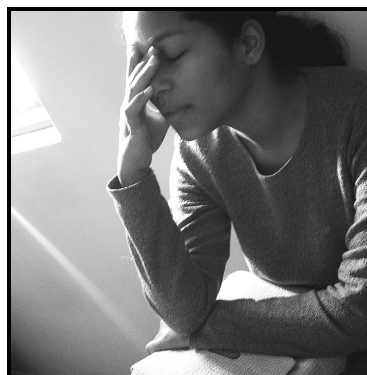
<https://afsp.org/chapter/afsp-connecticut/>

The CTDPH, other state agencies such as the Connecticut Department of Mental Health and Addiction Services and the Department of Children and Families, along with the United Way of Connecticut and Wheeler Clinic are working collaboratively to support suicide prevention initiatives such as the “1 Word, 1 Voice 1 Life” awareness campaign. The link to this campaign is:

<http://www.preventsuicidect.org/resources/training>

### Next Issue

In the next newsletter, we will examine intimate partner violence in Connecticut and discuss the new domestic violence law, Public Act No. 18-5, the “Dominant Aggressor” law.



### References:

1 <https://www.nimh.nih.gov/health/statistics/suicide.shtml> Retrieved on 11/26/2018

2 <https://www.usatoday.com/story/news/2018/04/11/officers-firefighters-suicides-study/503735002/> Retrieved on 12/19/2018

3 <https://www.usatoday.com/story/news/2018/04/11/officers-firefighters-suicides-study/503735002/> Retrieved on 12/19/2018

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