COMMONWEALTH of VIRGINIA
Department for the Aging

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AAA TUESDAY E-MAILING
June 15, 2010

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Note: The web addresses (links) in this document may change over time. The Department for the Aging does not attempt to refresh the links once the week has passed. However, this document is maintained on the web for a period of time as a reference. Some links may require registration.

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10-72

COMMONWEALTH of VIRGINIA
Department for the Aging

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Tim Catherman
Director of Administrative Services

DATE: June 15, 2010

SUBJECT: Chronic Disease Self-Management Program (CDSMP) Grant Assistance

VDA has hired two part-time individuals to help with the Chronic Disease Self-Management Program (CDSMP) Grant. Elaine will oversee both individuals as they provide assistance on the Grant.

Catherine Fields will be the CDSMP Coordinator. Ms. Fields is currently the part-time CDSMP Coordinator for the Department of Health. Her experience working with the program and having been trained in the Stanford Model will be invaluable as we launch this initiative for the elderly population. Ms. Fields is working on her Masters in Health Administration from Ohio University. She has a Bachelor of Science in Health, Physical Education and Exercise Science from VCU. VDA will be augmenting her hours at VDH where she will work out of her VDH office. Her phone number is 864-7886.

April Holmes will be the Coordinator for Prevention Programs for Older Adults. Recently she has worked with the Rappahannock Rapidan Community Services Board on their Aging Together program. Prior to this she was the Project Director for the Jefferson Area Board for Aging 2020, Long-Term Care Partners Acting Together for Health initiative. Previous work experience includes Instructor for Rehabilitation Research at VCU as well as several positions working in the rehabilitation community in Richmond and Charlottesville. Ms. Holmes has an M.S. Ed. in Special Education from the State University College of New York in Buffalo and a Bachelor of Arts from the same university. Her phone number will be 662-7631.

Please join me in welcoming both Catherine Fields and April Holmes to the VDA team.

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10-73

COMMONWEALTH of VIRGINIA
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MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Bill Peterson

DATE: June 15, 2010

SUBJECT: AoA Diversity Toolkit

FYI: the attached link for the "Diversity Toolkit" has been developed by AoA as an invitation for AAAs to make a cultural shift in your perspective: to learn, to grow, and to fully appreciate the people you have dedicated your career to serving. Making a cultural shift takes partnership and collaboration. This "Toolkit" supports the full participation of professionals, agencies, and other partners to work together to serve diverse populations with respect, inclusiveness, and sensitivity.

http://www.aoa.gov/AoARoot/AoA_Programs/Tools_Resources/DOCS/AoA_DiversityToolkit_full.pdf

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10-74

COMMONWEALTH of VIRGINIA
Department for the Aging

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Ellen Nau, Human Services Program Coordinator

DATE: June 15, 2010

SUBJECT: Information for Care Coordinators

The National Legal Resource Center
Webinar on Health Care Reform & the Aging Population
Title: Health Care Reform & the Aging Population: How the Patient Protection & Affordable Care Act will impact low-income older adults
Date: Wednesday, June 23, 2010
Time: 2:00 PM - 3:30 PM EDT
Space is limited.
Reserve your Webinar seat now at:
https://www1.gotomeeting.com/register/188759809

Administration on Aging (AoA) Consumer Direction Webinar, *Consumer-Directed Programs: Challenges, Insights, and Successes of Training*
Presented by the National Resource Center for Participant-Directed Services (NRCPDS) at Boston College.
Wednesday June 30, 2010
Time: 3:00-4:30 PM (EST)

Part 1 of the webinar will focus on the transition of case managers to consumer-directed counselors. Consumer-directed counselors will share their experiences with this transition, the changes in their roles and responsibilities, and the importance of training. Part 2 of the webinar will focus on training participants, representatives, and workers. A copy of the presentation slides and accompanying Resource Guide will be available on our website, www.training.participantdirection.org, prior to the webinar.

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To register for the webinar, click here:
http://nrcpds.acrobat.com/e36994762/event/registration.html?campaign-id=email

Toolkit for Serving Diverse Communities

The Toolkit consists of a four-step process and a questionnaire that assists professionals, volunteers and grassroots advocates with every stage of program planning, implementation and service delivery for older adult communities, their families and caregivers. The Toolkit can be found at:
http://www.aoa.gov/AoAroot/Press_Room/For_The_Press/pr/archive/2010/June/DiversityToolkit.aspx

10-75

COMMONWEALTH of VIRGINIA
Department for the Aging

MEMORANDUM

TO: Executive Directors
Area Agencies on Aging

FROM: Ellen Nau, Human Services Program Coordinator

DATE: June 15, 2010

SUBJECT: Caregiving

Family Caregiver Alliance Caregiver Blog
The Family Caregiver Alliance recently launched a new blog to cover news, trends and issues that are relevant to family caregiving. Join the blog conversations at: http://caregiver.org/caregiver/jsp/content_node.jsp?nodeid=2404

Caregiving.com
Caregiving.com has posted the results of its 2010 Annual Family Caregiver Survey; you can review them here: http://www.caregiving.com/2010/06/2010-family-caregiver-survey-results/

Alzheimer's Association
The Alzheimer's Assn has new tips for Alzheimer's caregivers concerned about their loved one's driving and safety:
http://www.alz.org/safetycenter/we_can_help_safety_driving.asp

Aging Together - Community Conversations on Aging
The last two sessions in a June series of community meetings center on aging will be held by the Aging Together Regional Caregiver Coalition centered in Culpeper, Virginia. Listening sessions will be held on Thursday, June 17th 6 pm at the Daniel Technology Center, Culpeper and on Tuesday, June 22nd 5:30 pm at Wetsel Middle School, Madison. Come discuss how you, boomers, and government are going work together in making the lives of our elderly valuable and worthwhile. For further information, contact: info@agingtogether.org or Chris Miller at 540-829-6405.

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The Guided Care Program for Families and Friends (GCPFF)
This program was developed at the Johns Hopkins Bloomberg School of Public Health has been shown to support family caregivers of older adults with complex health needs. **Guided Care** is a proactive, comprehensive health care model for people with several chronic health conditions. Guided Care is a type of "medical home" in which the patient's care is closely coordinated by a specially trained registered nurse, working as a team with the patient's physician. For more information, please visit http://www.GuidedCare.org/caregiver.asp for details about GCPFF.

The Middle Class Task Force - Caregiver Initiative
The 2010 health care legislation will complement and enhance the Task Force's Caregiver Initiative. The link below takes a quick look at the ways in which health reform will help family caregivers and their loved ones.
http://www.whitehouse.gov/blog/2010/03/29/support-caregivers-health-care-reform

10-76

COMMONWEALTH of VIRGINIA
Department for the Aging

MEMORANDUM

TO: Directors and Staff
Area Agencies on Aging

FROM: Bill Peterson

DATE: June 15, 2010

SUBJECT: Intimate Partner Homicide Among Virginians Age 50 and Older

FYI: Virginia's *Office of the Chief Medical Examiner* has issued a report on **Intimate Partner Homicide: An Analysis of Homicide in Virginia Among Those 50 Years or Older, 1999 – 2007**. I am sharing this report as a way to sensitive you and your staff to this issue. From 1999 through 2007, there were 583 homicides in Virginia where the victims were age 50 or older. Note that 145 of these victims were the result of conflict between intimate partners that resulted in death.

Attachment

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Intimate Partner Homicide: An Analysis of Homicide in Virginia Among Those 50 Years or Older, 1999 – 2007

Nicole Lynn Lee, Ph.D.
Family and Intimate Partner Homicide Surveillance Coordinator
Office of the Chief Medical Examiner, Virginia Department of Health

Commonwealth of Virginia
Virginia Department of Health
Office of the Chief Medical Examiner
Published June, 2010

Intimate Partner Homicide: An Analysis of Homicide
in Virginia Among Those 50 Years or Older, 1999-2007

Nicole Lynn Lee, Ph.D.
Office of the Chief Medical Examiner

June, 2010

Older adults are a significant part of Virginia's population. Between the years 2000 and 2007, the population of those 50 or older living in Virginia increased 22% (U.S. Census Bureau, 2008). Currently, almost one in three Virginians is 50 or older (30%) and U.S. Census Bureau projections indicate that this population will continue to grow. When developing and implementing public health programs for Virginians, public health officials must remember to evaluate the needs of those persons 50 or older. Evaluating the needs of this group requires having the knowledge necessary to understand any special circumstances facing those 50 or older so that appropriate public health approaches can be developed and implemented.

The purpose of this brief article is to increase the knowledge regarding those 50 or older who were killed due to discord or violence in intimate partner relationships. This article will examine intimate partner homicide among this population by answering the following two questions: (1) what were the characteristics of persons 50 years of age or older who were killed as a result of intimate partner discord or violence and (2) what were the circumstances surrounding intimate partner homicide events in which decedents were persons 50 years of age or older? This article will conclude with a brief discussion regarding working with intimate partner violence survivors aged 50 or older.

Methodology

Data analyzed are from the Family and Intimate Partner Homicide Surveillance Project. This state-wide project identifies and collects information on all family and intimate partner homicides in Virginia. Data are gathered during a review of published articles and death records, including police and autopsy reports, and then entered into a computer database for analysis.

In this article, the term *homicide* is defined by the Virginia Office of the Chief Medical Examiner (OCME) as an intentional act of fatally injuring a person. The phrase *combined intimate partner homicide* (CIP) is a category that includes two types of homicide, intimate partner homicide (IPH) and intimate partner associated homicide (IPA).

Intimate partner homicide (IPH) occurs when a decedent is killed by a current or former intimate partner (e.g., spouse or boyfriend/girlfriend). This category also includes same-sex partners and those killed as a result of a stalking relationship in which a stalker's advances were not reciprocated by the decedent.

Intimate partner associated (IPA) homicide occurs when a decedent is fatally injured as a result of being "caught in the crossfire" of an intimate partner relationship. Examples include (1) co-workers or friends intentionally or mistakenly killed while trying to protect the intended target from the intimate partner, (2) new intimate partners killed by their current partner's former partner, and (3) an intimate partner killed by a current or former intimate partner's family member. Analyzing these types of homicide together (IPH and IPA) provides a greater

understanding of the full range of homicides related to discord, violence, or conflict within intimate partner relationships.

The OCME collects data on decedents' localities of residence, injury, and death. In this article, homicide victims are listed by the locality of their fatal injury. This method of identification is important in public health and allows policy and program planners to understand where violence occurs geographically.

Overview

During the years 1999 through 2007, there were 583 homicide victims who were 50 years of age or older. Of these victims, one in four (*n* = 145, 24.9%) were killed as a result of violence stemming from discord in an intimate partner relationship.

From 1999 to 2007, there was a net increase in the number of combined intimate partner (CIP) deaths for those 50 or older; there were 12 deaths in 1999 and 22 in 2007. The yearly number of CIP homicide deaths varied from a low of 11 deaths in 2002 to a high of 24 in 2005. For each of the years examined, IPH was more common than IPA; however, the number of IPA deaths as a percentage of the total number of CIP deaths increased steadily during the study period. In 1999, 8.3% of the deaths related to intimate partner discord were classified as IPA. However, in 2007, that figured increased to 36.4%.

The two most common types of IPA events were a past boyfriend/girlfriend killing a former intimate partner's new boyfriend/girlfriend and an intimate partner killing a former partner's family member. Figure 1 shows the number of IPA and IPH deaths for each year in the study period. For example, in 2007 there were 22 deaths of which 14 were IPH and 8 IPA. Table 1 shows the percentage of IPA deaths as a percentage of the total CIP deaths.

Figure 1: IPH and IPA Deaths for Persons 50 Years of Age or Older in Virginia, 1999-2007 (*N* = 145)

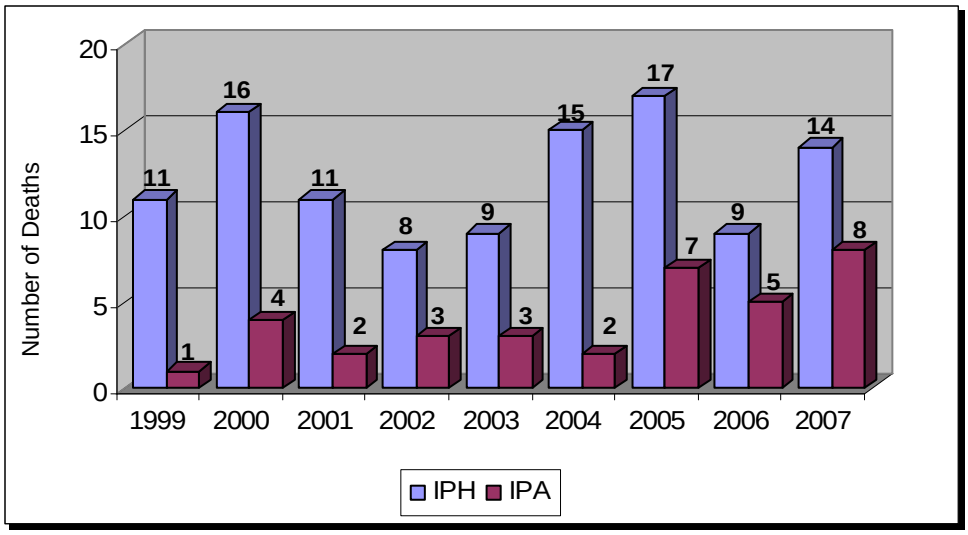


Table 1: Percentage of IPH and IPA Deaths as a total of CIP Deaths in Virginia, 1999-2007, (*N* = 145)

Year	# CIP Deaths	% IPH Deaths	% IPA Deaths
1999	12	91.7	8.3
2000	20	80.0	20.0
2001	13	84.6	15.4
2002	11	72.7	27.3
2003	12	75.0	25.0
2004	17	88.2	11.8
2005	24	70.8	29.2
2006	14	64.3	35.7
2007	22	63.6	36.4

Characteristics of Victims

This section describes the characteristics for those ages 50 or older who were killed as a result of an intimate partner relationship (*N* = 145). Characteristics discussed include age, gender, racial/ethnic group, marital status, and alcohol use at the time of the fatal injury.

Victims ranged from 50 to 89 years of age with the average age of victim being 62.26 years (*SD* = 10.3). Half of the selected population was 59 years of age or older. Males were younger than females, 59.11 years (*SD* = 8.8) and 64.24 years (*SD* = 10.8),[1] respectively. Intimate partner homicide and intimate partner associated homicide victims in the population were of similar age, 62.50 years (*SD* = 10.4) and 61.49 years (*SD* = 10.1), respectively.[2]

Most decedents were female (*n* = 89, 61.4%). However, when the type of homicide was divided into IPH or IPA, gender differences emerged. More IPA victims were male (*n* = 24, 68.6%) than female (*n* = 11, 31.4%). Conversely, more IPH victims were female (*n* = 78, 70.9%) than male (*n* = 32, 29.1%).[3] Figures 2 and 3 show the gender differences in IPH and IPA events.

Figure 2: Gender Distribution of IPH in Virginia, 1999-2007 (*N* = 110)

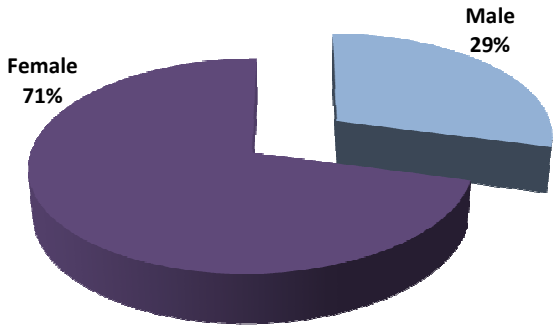
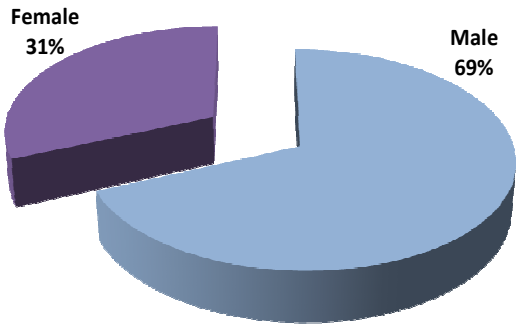


Figure 3: Gender Distribution of IPA in Virginia, 1999-2007 (*N* = 35)



[1] Student's *t*-test indicated a statistically significant difference between males and females on age [$t(133) = 3.14$, p = .002].
[2] Student's *t*-test failed to indicate a statistically significant difference between IPH and IPA victims for mean age [$t(143) = .51$, $p = .61$].
[3] Pearson's Chi-Square test indicated a statistically significant relationship between gender and type of homicide (IPH or IPA) [$X^2 = 17.46$, $p < .001$].

The most frequently reported racial/ethnic group was White (*n* = 106, 73.1%), followed by Black (*n* = 34, 23.4%), Asian (*n* = 4, 2.8%), and Hispanic (*n* = 1, <1.0%). On average, Black decedents were younger than White decedents, 58.71 years (*SD* = 8.9) and 63.55 years (*SD* = 10.6), respectively.[4]

Most decedents were married at the time of the fatal injury (*n* = 94, 65.7%).[5] The next most frequently occurring marital status was divorced (*n* = 30, 21.0%), followed by widowed (*n* = 12, 8.4%), and never married (*n* = 7, 4.9%).

More than one in five decedents (*n* = 37, 28.7%) had a positive blood alcohol level at the time of death.[6] The blood alcohol level ranged from 0.01 to 0.38 with 63.9% of decedents having a blood alcohol level of higher than 0.07. On average, decedents who had a positive blood alcohol level were younger than those without a positive blood alcohol level, 57.81 years (*SD* = 8.1) and 64.32 years (*SD* = 10.8), respectively.[7]

The Alleged Offender

There were 133 alleged offenders who were responsible for 145 homicides. Most alleged offenders were male (*n* = 93, 73.8%).[8] They ranged from 19 to 90 years of age with an average age of 55.49 years (*SD* = 15.9). Almost 38% (*n* = 46, 37.7%) of alleged offenders were under the age of 50.[9]

In most cases, the alleged offender and the victim were in a current relationship at the time of the fatal injury. Almost half of alleged offenders were current spouses (*n* = 71, 53.4%). The next most frequently occurring relationship was boyfriend/girlfriend (*n* = 29, 21.8%). Further, almost all victims lived with the alleged offender at some time during their relationship (*n* = 108, 95.6%).[10]

Most offenders were White (*n* = 85, 69.7%) followed by Black (*n* = 35, 28.7%).[11] Whether the alleged offender had alcohol in his or her system at the time of the fatal injury was known for 54.1% (*n* = 72) of cases. Among these cases, 20.8% (*n* = 15) had positive blood alcohol levels. In addition, there was evidence to suggest that the offender's mental health difficulties (e.g., depression, bipolar, or anxiety disorders) contributed to the fatal event in seven cases.

Alcohol use was known for all of the alleged offenders in homicide-suicide events (*n* = 45). At the time of the fatal event, 22.2% (*n* = 10) of alleged offenders involved in homicide-suicide events had alcohol present in his or her blood stream.

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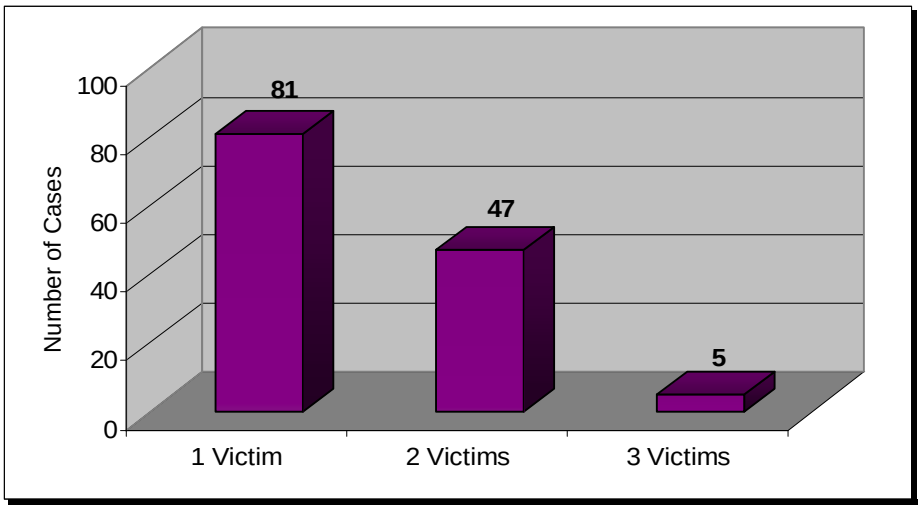
[4] Student's *t*-test indicated a statistically significant difference between Whites and Blacks on age [$t(138) = 2.40$, $p = .018$].
[5] Marital status was known for 98.6% of decedents (*n* = 143).
[6] Blood alcohol level was known for 89.0% of decedents (*n* = 129).
[7] Student's *t*-test indicated a statistically significant difference between age for those with and without a positive blood alcohol content at the time of death [$t(88) = -3.73$, $p < .001$].
[8] The alleged offender's gender was known for 94.7% of alleged offenders (*n* = 126). One alleged offender could have multiple victims.
[9] The alleged offender's age was known for 91.7% of cases (*n* = 122).
[10] Whether an alleged offender lived with the decedent was known for 85.0% of alleged offenders (*n* = 113).
[11] Race of alleged offender was known for 92.8% of alleged offenders (*n* = 122).

The Event

Multiple deaths were common in combined intimate partner events involving those 50 years or older. Of the 133 events, more than one in three (*n* = 52, 39.1%) had multiple decedents. Examples include a parent killing two children or a spouse killing his or her partner and a child. In addition, one in three events was a homicide-suicide event (*n* = 45, 33.8%) in which an alleged offender killed a person and then took his or her own life within seven days of the homicide. In almost all of the 45 homicide-suicide events, the alleged offender was the current or former intimate partner (*n* = 43, 95.6%). Figure 4 identifies the number of victims in each event. For example, in 47 events there were two victims.

Figure 4: Total Number of Persons Killed in Each Intimate Partner Related Event in Virginia (*N* = 190)*



*There were 133 events that resulted in 190 deaths. One hundred and forty-five of the 190 deaths were homicide victims 50 years of age or older. Forty-five of the 190 deaths were suicide victims who killed themselves after killing one or more victim.

Further, there was evidence to suggest that deteriorating mental or physical health, or the perception of these conditions, may have contributed to the alleged offender's actions. In one out of five (*n* = 9, 20.0%) of the 45 homicide-suicide cases of those 50 or older, the alleged offender said or left evidence documenting that the crime was committed due to the alleged offender or decedent's deteriorating physical and/or mental health

Most fatal injuries occurred in a residence (*n* = 120, 84.5%).[12] A firearm (*n* = 96, 66.2%), followed by a sharp instrument (*n* = 22, 15.2%) and strangle/choke by ligature or hands (*n* = 6, 4.1%) were the most frequently reported items used to kill victims.

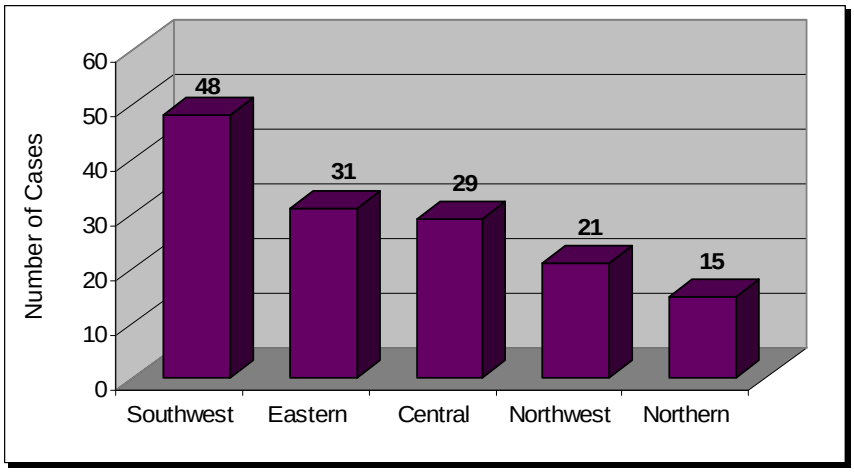
Most fatal injuries were inflicted in the Southwest Health Planning Region (*n* = 48, 33.3%).[13] The second most frequently reported Health Planning Region of injury was Eastern (*n* = 31,

[12] Premise of injury was known for 97.9% of cases (*n* = 142).
[13] Health Planning Region of fatal injury was known for 99.3% of cases (*n* = 144)

21.5%), followed by Central (*n* = 29, 20.1%). Figure 5 shows the CIP homicide deaths by Virginia Health Planning Region.

The locality with the most deaths during the study period was Norfolk City (*n* = 10). Localities with five or more deaths included Richmond City (*n* = 9), Washington County (*n* = 8), Augusta County (*n* = 6), Fairfax County (*n* = 6), Henry County (*n* = 5), and Virginia Beach City (*n* = 5).[14]

Figure 5: Distribution of Combined Intimate Partner Homicide in Virginia by Health Planning Region, 1999-2007 (*N* = 144)



In each Health Planning Region, the most frequently reported type of death was IPH. The region with the greatest percentage of IPA homicides for the study period was the Northwest region (*n* = 8, 38.1%). Table 2 shows the distribution of cases by type for each Health Planning Region.

Table 2: Health Planning Region of Injury for those 50 or Older Killed in IPH and IPA in Virginia, 1999-2007 (*N* = 144)

Health Planning Region	# IPH Cases	# IPA Cases	IPA Cases as a Percentage of CIP Cases
Northwest	13	8	**38.1**
Southwest	35	13	**27.1**
Central	23	6	**20.7**
Northern	12	3	**20.0**
Eastern	26	5	**16.1**

[14] An analysis of median ages for localities (1999 – 2007) indicated that Northumberland, Lancaster, Middlesex, Mathews, Highland, Westmoreland, and Nelson had the highest median ages for population in Virginia. These localities are predominately in the Central Office of the Medical Examiner District and the Eastern Health Planning Region.

Approximately eight percent of the 133 events were witnessed by a child or children aged 17 years or less (*n* = 10, 7.5%). Of the ten cases witnessed by a child, seven were IPH cases. A child witness could have seen or heard the event, found the victim dead or injured, or been attacked during the event.

Risk Factors

This section provides a summary of risk factors present in intimate partner homicide (IPH) cases only (n = 110) and may represent a conservative estimate of the actual risk present. A risk factor is a situation or behavior that increases the probability of future violence or death. The risk factors used in the study were those identified in research conducted by Campbell (1995) and Websdale (2000). Risk factors were collected for decedents by examining existing medicolegal death investigation records and published articles regarding the event.

At least one risk factor was identified in 60.9% (*n* = 67) of IPH events. The most frequently occurring risk factor was that the relationship had ended or was ending (*n* = 37, 55.2%), followed by a history of physical assault between intimate partners (*n* = 35, 52.2%) and receiving threats of harm to self or a family member (*n* = 20, 29.9%). Table 3 provides a summary of risk factors.

Table 3: Summary of Risk Factors for Virginias Aged 50 years or Older Killed in Intimate Partner Homicide, 1999-2007 (*n* = 67)

Risk Factor	# Events	%
The relationship had ended or was ending	37	55.2
History of physical assault between IP	35	52.2
Abuser threatened harm to decedent or family member(s)	20	29.9
911 calls to the police for domestic violence	19	28.4
Abused partner was stalked	9	13.4
Abused partner received medical treatment for injuries inflicted by IP	7	10.4
Abuser destroyed IP's personal property	7	10.4
Broke into IP's home	5	7.5
Had a current protective order	4	6.0

CIP Homicide Rates for Persons Aged 50 or Older

This section provides a summary of the CIP homicide rate for those aged 50 or older. Rates provide a standard unit of measurement and permit comparisons between groups. However, it is important to note that because of the possibility of increased error, rates based on small numbers of cases (20 or fewer) should be interpreted with caution. Further, all rates presented in this section are per 100,000 persons and based on U.S. Census Bureau population estimates.

Figure 6 shows a longitudinal analysis of the CIP homicide rate for those aged 50 or older. The rate decreased during the first three years but began to fluctuate during the last years of the study. At the end of the analysis period, the combined intimate partner rate for 2007 was identical to the rate in 2000.

Figure 6: Longitudinal Analysis of the CIP Rate For Those 50 or Older in Virginia, 2000 - 2007 (*N* = 133)

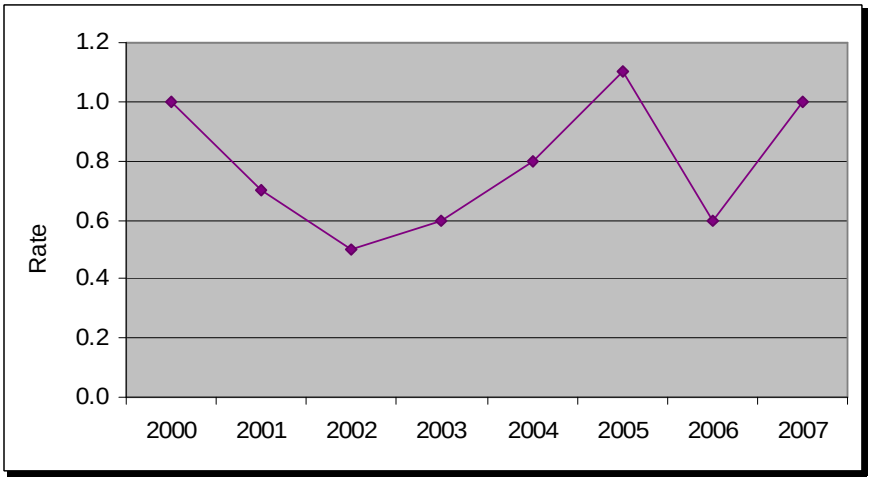
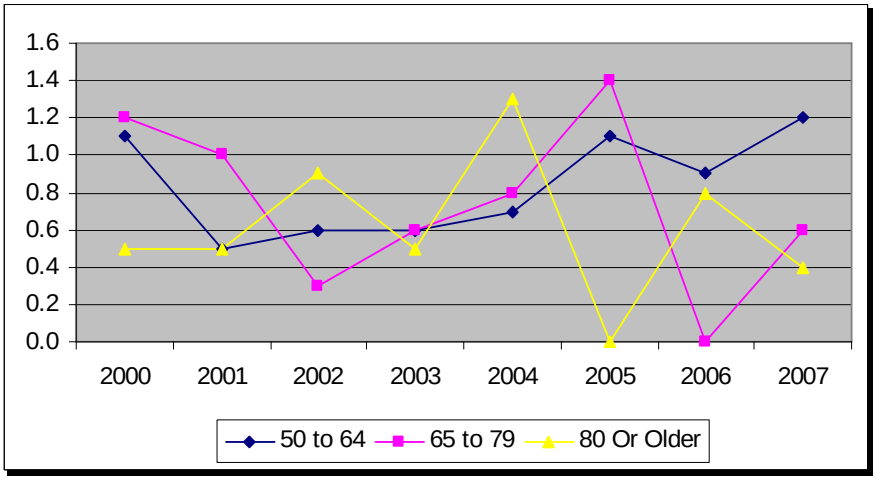


Figure 7 provides a more detailed analysis of the combined intimate partner homicide rate by dividing the population into three age groups: 50 to 64 years, 65 to 79 years, and 80 years and older. An examination of the first and last years shows a net decrease for those aged 65 to 79 and those 80 and older. Those aged 50 to 64 showed a slight increase in 2007 as compared to 2000.

Figure 7: Longitudinal Analysis of the CIP Rate For Those 50 or Older by Age Group in Virginia, 2000 – 2007, (*N* = 133)



Discussion[15]

Between 1999 and 2007, intimate partner homicide remained a public health issue for those aged 50 or older. An analysis of demographic trends showed that characteristics and specific

[15] Characteristics for all intimate partner homicides and intimate partner associated homicides were obtained from data collected for the Family and Intimate Partner Homicide Surveillance Project.

risk/lethality factors were similar to the overall population of those killed as a result of domestic violence. However, there were some characteristics and trends that were specific to older adults. This section provides a brief discussion of trends and indicates whether trends were consistent with trends identified for the overall population of those killed by intimate partner violence/discord in Virginia between 1999 and 2007.

Connection to Alleged Offender

Decedents, regardless of age, had close personal ties with alleged offenders; however, a greater percentage of decedents aged 50 or older were married (65.7%) than those under 50 years of age (38.2%).[16] In addition, a greater percentage of those 50 or older (95.6%) lived with the alleged offender at least some time in their relationship than those under 50 years of age (88.5%). [17]

The "connectedness" of persons within the relationship was important to examine. Those 50 or older who experienced homicide may have had barriers to leaving the relationship. Barriers may have included an extended history with the alleged offender and/or legal connections such as marriage. These barriers were similar to those noted by decedents under 50; however, the prospect of leaving a relationship and "starting over" may have generated different choices for persons 50 or older. Thus, the victim's age and perceived investment in the relationship may have impacted his or her perceptions of the pros and cons of remaining in the relationship.

Gender Differences

Older intimate partner homicide victims were predominately women; however men had a greater probability of being "caught in the crossfire" of intimate partner relationships. In most cases, the alleged offender was a man. These findings were consistent with findings noted for persons under 50.

As noted above, gender differences related to the type of intimate partner homicide were present throughout the life cycle. There was an increased probability that offenders, regardless of age, would be male and direct violence toward (1) women with whom they were in intimate partner relationships or (2) other men when "love triangles" were present.

These findings are important and illustrate that men of all ages have the capacity to experience emotional conflict due to intimate partner relationships. Program planners and developers must understand that older men *do* become involved in intimate relationships and may need skills to improve the functioning and maintenance of these relationships.

Age

Decedents were present in each of the older age groups; however, during the last year of the study, those ages 50 to 64 showed the highest CIP homicide rate. These results should be interpreted cautiously. As mentioned earlier, interpreting percentages or rates for populations

[16] Pearson's Chi-Square test indicated a statistically significant relationship between age and marital status [X^2 (3)= 109.76, $p < .001$].

[17] Pearson's Chi-Square test indicated a statistically significant relationship between age and whether intimate partners lived together at some point in their relationship [$X^2 = 5.05$, $p = .03$].

with less than 20 cases may produce skewed results. Subdividing this group created three smaller groups and increased the potential for the erroneous interpretation of results.

Alcohol Use

Alcohol use may have contributed to the fatal injuries of those 50 or older. One in five decedents had a positive blood alcohol level at the time of the fatal injury. Among decedents with alcohol present, more than half were legally intoxicated at the time of the fatal injury. Further, the proportion of alleged offenders with a positive blood alcohol was one in five, the same proportion as the victims. Thus, alcohol was present in the same proportion regardless of whether the victim or alleged offender was examined.

Additionally, victims 50 or older who had a positive blood alcohol level were, on average, younger than those victims 50 or older without a positive blood alcohol level. These results may indicate that the combination of youth and alcohol use may have impacted the situation. However, these results should be interpreted with caution. The difference between the two groups was 6.5 years. Those with positive blood alcohol levels may be younger; however, additional research should be conducted to examine whether the two groups represent distinct developmental stages.

In summary, alcohol seems to have played a role in these events. Lessened inhibitions may have impacted (1) the decedent's understanding of the risk inherent within the relationship or situation and (2) the alleged offender's problem-solving ability and coping mechanisms. Further, alcohol abuse by both parties may have contributed to unhealthy relationships and co-dependence; thus, making it difficult for either party to leave the other intimate partner. This is not to imply that alcohol was the "reason" for the violence or that the victim was responsible for the violence. However, the presence of alcohol interjected additional risk into volatile situations. Thus, when evaluating the potential consequences of intimate partner violence and conflict for those 50 or older, public health officials must understand the level of alcohol abuse and its potential contributions to homicide for this population.

Secondary Victims

The number of deaths for those 50 or older who were "caught in the crossfire" increased during the study period. This increase was also identified among those under 50. At the beginning of the study period, the number of yearly IPA cases with victims 50 or older represented less than one in ten of the combined intimate partner cases. However, at the completion of the study period, IPA deaths represented more than one in three cases. Conversely, at the beginning of the study period, the number of yearly IPA cases of those younger than 50 represented almost one in four of the combined intimate partner cases. However, at the completion of the study period, IPA deaths for those under 50 represented almost half of the combined intimate partner cases.

This indicates that violence and discord within intimate partner relationships, regardless of age, is not limited to current primary partners. Unfortunately, relatives, former partners, friends, and others are fatally impacted by violence. When developing domestic violence programs for those 50 or older, policy and program planners need to be cognizant of the potential risks to secondary victims such as former partners, friends, or relatives. Safety

planning should involve a detailed analysis of those who could be potential targets so that the primary victim of the abuse can accurately assess the potential consequences of domestic violence.

Homicide-Suicide Events

Overall, regardless of age, one out of five CIP deaths was part of a homicide-suicide event (22.2%). However, when victims under 50 were compared to victims 50 or older, a difference in the proportion of cases that were homicide-suicide appeared. Almost one in five victims under age 50 (19.8%) was killed in a homicide-suicide event. Conversely, this number increased to one in three for those 50 or older (33.3%). In addition, most homicide-suicides occurred during an intimate partner homicide event rather than an intimate partner associated homicide event. This was true regardless of the victim's age.

The motivation for homicide-suicide events may be different for those 50 years of age or older. For instance, for those 50 or older, there was evidence in one out of five homicide-suicide events that poor mental or physical health was present in either the decedent, alleged offender, or both parties and that this may have been a motivating factor in the event. These killings could be described by the alleged offender as "mercy killings" in which he or she killed to prevent or minimize a decedent's suffering or to minimize his or her own suffering regarding the decedent's situation. None of the alleged offenders who killed those under 50 in homicide-suicide events indicated to a third party that poor physical or mental health was a motivating factor for the event.

Risk Factors

Risk factors were present among those 50 or older who were fatally injured as a result of intimate partner violence or discord. These risk factors were the same risk factors noted for those under age 50. In addition, the top risk factors noted for those under 50 (the relationship had ended or was ending and a history of physical assault) were the same top risk factors noted for decedents 50 or older.

This may indicate that alleged offenders, regardless of age, may be impacted similarly by the loss or perceived loss of an intimate partner. This also may indicate that all age groups, including older persons, have the ability to exhibit violence toward others.

Conclusion

The population of those 50 and over is increasing and service providers and public health officials must have the knowledge necessary to understand and assist this population. This study illustrates that those 50 or older are involved in romantic relationships and these relationships may be a source of discord that ends with the taking of a life or lives. Thus, tools to build and maintain healthy relationships are crucial and needed throughout the life cycle.

Next, those 50 or older experience alcohol abuse and this may contribute to the lethality of events. In the current study, alcohol abuse by either the decedent, alleged offender, or both parties appeared to complicate the intimate partner relationships.

There were similarities between those under 50 and those 50 or older who were killed as a result of violence stemming from an intimate partner relationship. For instance, the top risk factors were the same regardless of the age of the decedent. In addition, males, regardless of age were more likely to offend or to be "caught in the crossfire" of intimate partner relationships.

Finally, there were also some differences between those under 50 and those 50 or older. For instance, older adults had a greater percentage of homicide-suicides and in some cases, poor physical and mental health conditions were cited as motivating factors for the event. In addition, those 50 or older had a smaller percentage of IPA deaths compared to those under 50. The number of IPAs showed a steady increase for both groups; however, the percentage of IPA cases remained lower for the 50 or older group.

This brief article provided a summary of the demographic characteristics of victims and the circumstances of events. Additional research is needed to better understand the motivation(s) behind the events. For example, understanding the perpetrators' beliefs and backgrounds would enhance the ability to examine events. In addition, a more detailed understanding of the mental health, substance abuse, and criminal histories for the decedents and alleged offenders would add to the knowledge base as well. Finally, specific information regarding the duration of the relationship is needed.

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