

# Chapter 5

## INJURY

### Unintentional Injury

#### *What is it?*

Physical injury that is not purposely inflicted is unintentional injury. We think of unintentional injuries as accidents, and we sometimes think of accidents happening as a result of chance.

#### *Why is it important?*

Nationally, two-thirds of injury deaths are unintentional, and 94% of nonfatal injuries treated in emergency departments are unintentional.<sup>1,2</sup> About 29.7 million injuries were treated in hospital emergency departments in 2001.<sup>3</sup> The majority of these were unintentional; less than two million were violence-related.

Unintentional injuries are one of the major causes of premature death and lifelong disability. Most unintentional injuries are predictable and preventable. Motor vehicle accidents are the primary source of unintentional injury death, followed by poisoning, falls, suffocation, drowning, and fire.<sup>4</sup> Falls cause the greatest number of unintentional, nonfatal injuries treated in emergency departments. Next are injuries from being struck by or against an object, motor vehicle accidents, overexertion, and cuts.<sup>2</sup>

About two-thirds of poisoning deaths are unintentional, and 93% of unintentional poisonings are related to drugs. Narcotics are responsible in half of all unintentional poisonings.<sup>1</sup>

In 2003, 105,695 people died of unintentional injuries in the United States.<sup>5</sup> Nearly two-thirds of those were male. The age-adjusted rate of unintentional injury death in the United States was 36.1 per 100,000 in 2003. The rate among males was 51.5 per 100,000, over twice the female rate of 23.5.<sup>3</sup> The death rates for males between 18 and 64 years were two to four times the rates for females. Persons over 70 years had the highest death rates.<sup>1</sup>

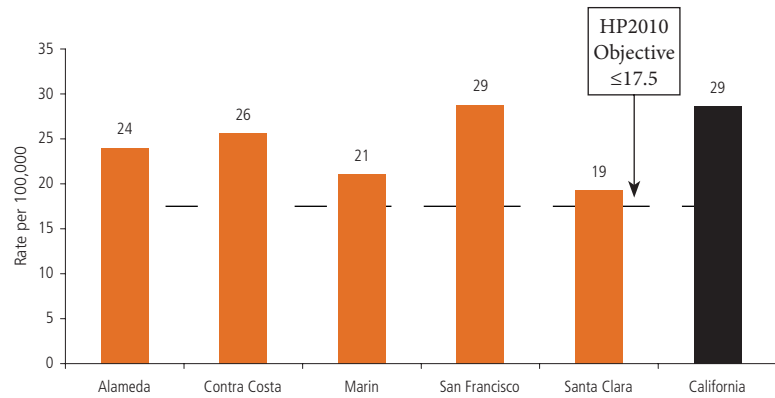
In California, the rate of unintentional injury deaths was 28.6 per 100,000.<sup>6</sup> Both national and state rates exceed the HP2010 objective of 17.5 or less.<sup>7</sup> Unintentional injuries were the fifth leading cause of death in the United States in 2003.<sup>5</sup> For those under 35 years, they were the leading cause of death as they have been for the last 50 years.<sup>1,8</sup> The death rate for unintentional injury declined from 1950 until 1992 and then increased slightly. In 2002, the age-adjusted death rate increased more than 3% from 2001.<sup>9</sup> However, the preliminary data for 2003 showed the rate decreased about 2% from 2002.<sup>5</sup> American Indians have disproportionately high rates of death from unintentional injury. Rural or isolated living, minimal emergency medical services, and great distances from sophisticated trauma care contribute to these increased rates.<sup>7</sup>

## What is Alameda County's status?

### Unintentional Injury Mortality

Alameda County's unintentional injury death rate for the period 2001 to 2003 was higher than those in Marin and Santa Clara Counties and lower than in San Francisco County and the state as a whole. However, the Alameda County rate was statistically significantly different only from Santa Clara's. Neither the counties nor the state have met the HP2010 objective of 17.5 or fewer unintentional injury deaths per 100,000 people.

Figure 5.1: Unintentional Injury Mortality, Selected Counties and California, 2001-2003

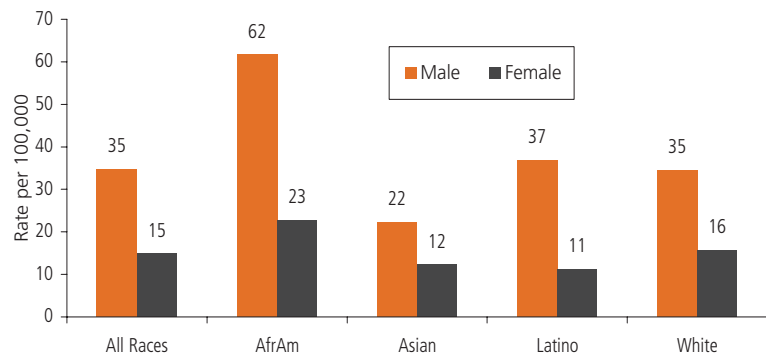


Source: CAPE; ACPHD Vital Statistics files; CADHS County Health Profiles; Census 2000; DOF.

From 2001 to 2003, an average of 348 people per year died from unintentional injury in Alameda County. The corresponding mortality rate was 24.2 per 100,000 people.

Male unintentional injury death rates were about two to three times higher than those for females in every race/ethnic group. The death rate among African American males was significantly higher than any other race/ethnic group—almost three times the rate of Asians and over 1.5 times the rates of Latinos and Whites. The female African American rate was almost twice the rates of Asians and Latinos. Only Asian, Latina, and White females have met the HP2010 objective of no more than 17.5 deaths per 100,000 people.

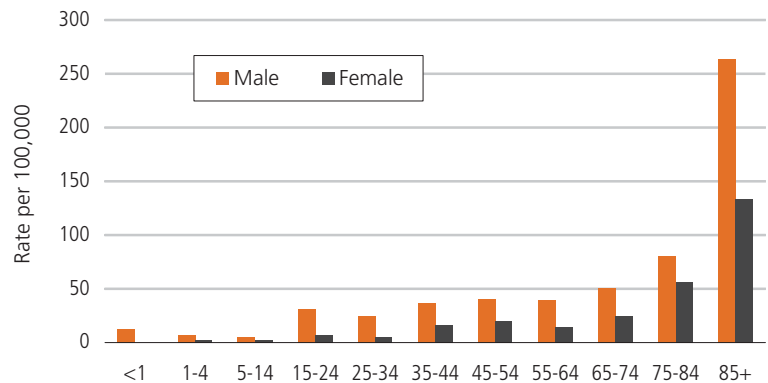
Figure 5.2: Unintentional Injury Mortality by Race/Ethnicity and Gender, Alameda County, 2001-2003



Source: CAPE; Alameda County vital statistics files, Census 2000, DOF.

Deaths due to unintentional injuries were higher among males than females in every age group. The highest rate was seen among males 85 years and older. It was two times higher than that among females 85 and older.

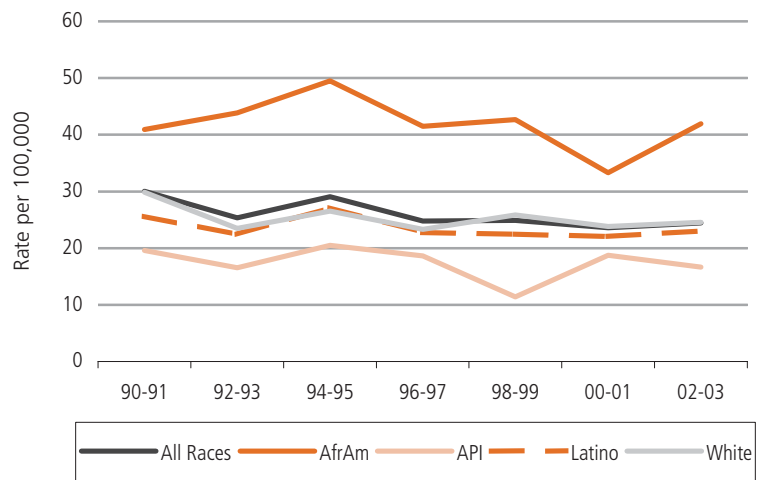
Figure 5.3: Unintentional Injury Mortality by Age and Gender, Alameda County, 2001-2003



Source: CAPE; Alameda County vital statistics files, Census 2000, DOF.

Alameda County overall experienced a significant decline in unintentional injury deaths in the past decade of about 1.6% per year. Rates for individual race/ethnic groups are suggestive of a downward trend, particularly in the middle of the decade, but the declines are not significant, probably due to small numbers and variable rates.

Figure 5.4: Unintentional Injury Mortality, Alameda County, 1990-



Source: CAPE; Alameda County vital statistics files, Census 1990 and 2000, DOF.

Unintentional injury mortality among African Americans has been consistently higher than any other race/ethnic group throughout the past decade—40% to 70% higher than the county rate. It also has been two to three times higher than rates for APIs, the group with the lowest rates.

## Unintentional Injury Hospitalization

From 2001 to 2003, an average of 5,488 hospitalizations per year for unintentional injury occurred in Alameda County. The rate was 397 per 100,000 people.

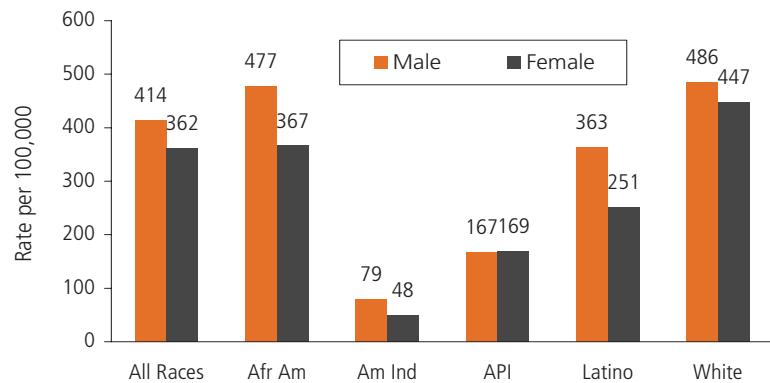
Unintentional injury hospitalization was highest among males in every race/ethnic group except Asian/Pacific Islanders. Rates were equally high among African American and White males, followed by White females. They were lowest among American Indians and APIs.

The rate of unintentional injury hospitalization increased dramatically after age 65. In Alameda County, prior to age 65, rates were higher among males than females, but after age 65 female rates exceeded male rates by large margins. Females in the 85 and older age group were particularly vulnerable to unintentional injury, largely due to falls.

Over the past decade, the rate of unintentional injury hospitalization declined significantly among all race/ethnic groups except Latinos.

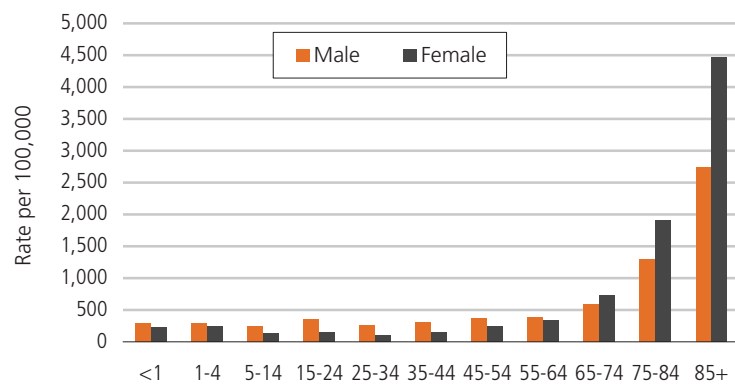
A significant decline was seen for both African Americans and Whites. However, the African American rate declined more steeply than the White rate. Thus the gap between African Americans and the county as a whole narrowed from 11% in 1992-1993 to 5% in 2002-2003. Presently, the White rate is 20% higher than the county rate.

Figure 5.5: Unintentional Injury Hospitalization by Race/Ethnicity and Gender, Alameda County, 2001-2003



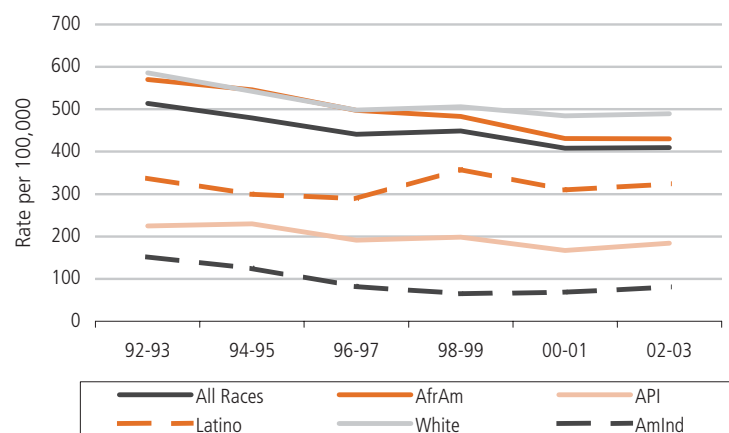
Source: CAPE; California OSHPD, Census 2000, DOF

Figure 5.6: Unintentional Injury Hospitalization by Age and Gender, Alameda County, 2001-2003



Source: CAPE; California OSHPD, Census 2000, DOF

Figure 5.7: Unintentional Injury Hospitalization by Race/Ethnicity, Alameda County, 1992-2003



Source: CAPE; California OSHPD, Census 1990 and 2000, DOF

## Motor Vehicle Crashes

### *What are they?*

Motor vehicle crash injuries include all injuries to motor vehicle occupants during a collision, as well as injuries in which a pedestrian or cyclist was struck by a vehicle.

### *Why are they important?*

Motor vehicle crashes are the single largest cause of all injury mortality in the United States, and they are the leading cause of death and disability for young children and young adults.<sup>1,8</sup> Two times as many males as females die in motor vehicle crashes.<sup>4</sup> American Indians and Alaska Natives have disproportionately higher death rates from motor vehicle crashes than any other race/ethnic groups.<sup>7</sup>

Nationally, in 2003, there were 44,059 motor vehicle crash deaths, comprising 42% of all unintentional injury deaths.<sup>5</sup> The age-adjusted death rate from motor vehicle crashes was 15.0 per 100,000.<sup>5</sup> In California, the death rate from motor vehicle crashes was 12.0 per 100,000 for the period 2001-2003.<sup>6</sup> Both national and state rates exceed the HP2010 objective of 9.2 or less.<sup>7</sup>

In 2000, there were 3.3 million nonfatal motor vehicle-related injuries treated in emergency departments in the United States.<sup>2</sup>

There has been a significant decline in deaths attributable to motor-vehicle crashes, especially in the 1990s. Prevention of motor vehicle-related injuries has focused on environmental interventions such as highway and vehicle safety, reduction of risky behaviors such as drunken driving, and legislation on vehicle occupant protection such as helmet and seat belt laws. These strategies have substantially reduced the burden of injury morbidity and mortality.<sup>10,11</sup>

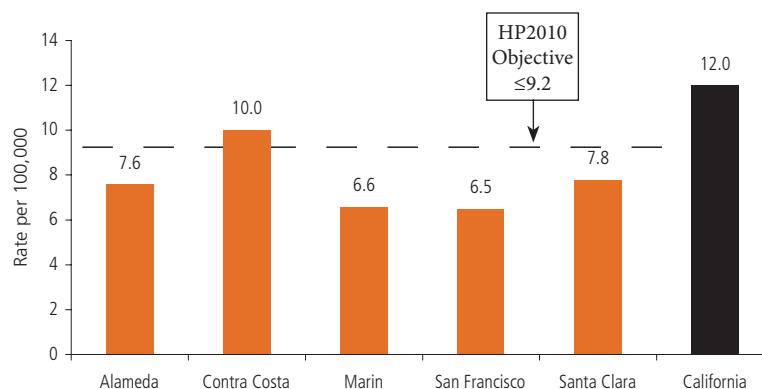
### *What is Alameda County's status?*

#### **Motor Vehicle Crash Mortality**

From 2001 to 2003, an average of 111 people per year died in motor vehicle crashes in Alameda County. The corresponding mortality rate was 7.6 per 100,000 people.

Alameda County's unintentional injury death rate for the period 2001 to 2003 was significantly higher than those in Marin and San Francisco Counties. All but Contra Costa County were significantly lower than the California rate. Alameda County has met the national HP2010 objective of 9.2 or fewer motor vehicle crash deaths per 100,000 people.

Figure 5.8: Motor Vehicle Crash Mortality, Selected Counties and California, 2001-2003



Source: CAPE; ACPHD Vital Statistics files; CADHS County Health Profiles; Census 2000; DOF.

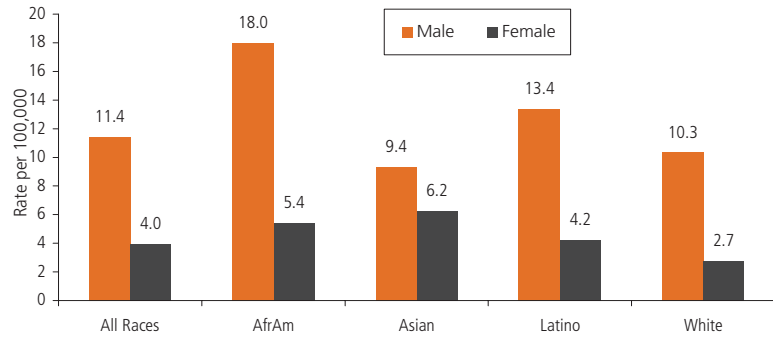
Motor vehicle crash death rates among males were over three times higher than those among females for every race/ethnic group except Asians. Among Asians, the male rate was only 1.5 times higher than female rate.

African American males had the highest death rate due to motor vehicle crashes, followed by Latino males. The African American male rate was almost two times the rate of Asians, and more than 1.5 times the rate of Whites.

Among females, Asians had the highest rate, approximately twice the White rate and 1.5 times the Latina rate. Females of every race/ethnic group have met the HP2010 objective of no more than 9.2 motor vehicle crash deaths per 100,000 people.

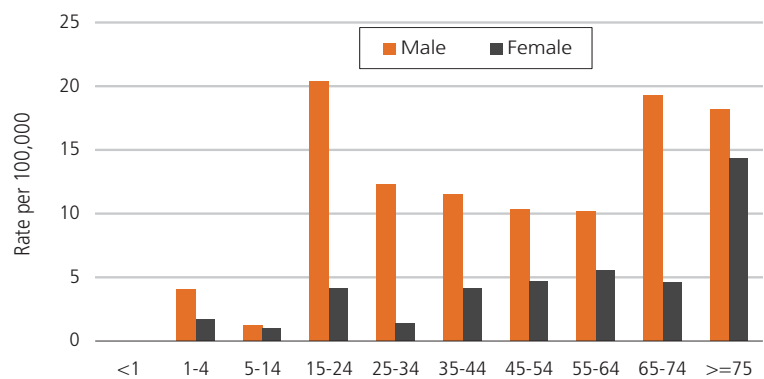
Deaths due to motor vehicle accidents were much higher among males than females in almost every age group. The highest rates were seen among males aged 15-24, 65-74, and 75 and older.

Figure 5.9: Motor Vehicle Crash Mortality by Race/Ethnicity and Gender, Alameda County, 2001-2003



Source: CAPE; Alameda County vital statistics files, Census 2000, DOF.

Figure 5.10: Motor Vehicle Crash Mortality by Age and Gender, Alameda County, 2001-2003

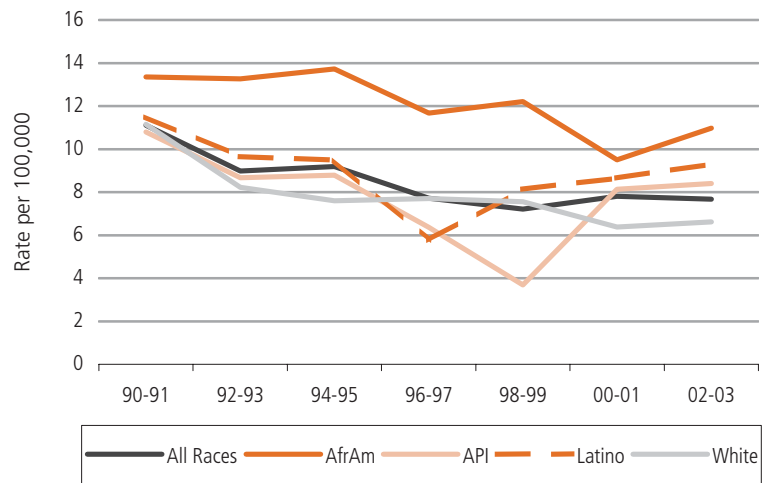


Source: CAPE; Alameda County vital statistics files, Census 2000, DOF.

Motor vehicle crash (MVC) mortality for all race/ethnic groups in Alameda County declined throughout most of the 1990s. An increase for Latinos and APIs was observed late in the decade. The flattening or increase seen in trend lines after 1999 suggest that the declining trends of the 1990s have ended for now and that MVC death rates may actually be climbing again. Additional years of data will be needed to identify current trends.

African American MVC death rates have been higher than any other race/ethnic group throughout the past decade. The gap between African Americans and the county increased from 20% in 1990-91 to 69% in 1998-99. Recent trends suggest the gap may be closing.

Figure 5.11: Motor Vehicle Crash Mortality, Alameda County, 1990-2003



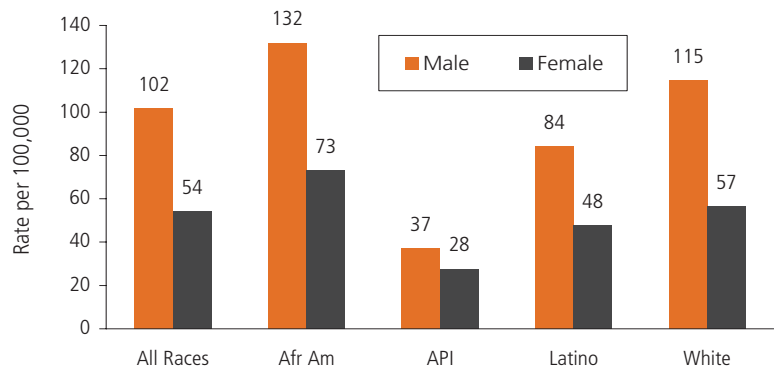
Source: CAPE; Alameda County vital statistics files, Census 1990 and 2000, DOF.

### Motor Vehicle Crash Hospitalization

From 2001 to 2003, an average of 1,152 motor vehicle crash hospitalizations per year occurred in Alameda County. The rate was 78 per 100,000 people.

MVC hospitalization was approximately twice as high among males as females in every race/ethnic group but API, where the margin is smaller. Rates among African American and White males were highest, followed by Latino males and African American females.

Figure 5.12: Motor Vehicle Crash Hospitalization by Race/Ethnicity and Gender, Alameda County, 2001-2003

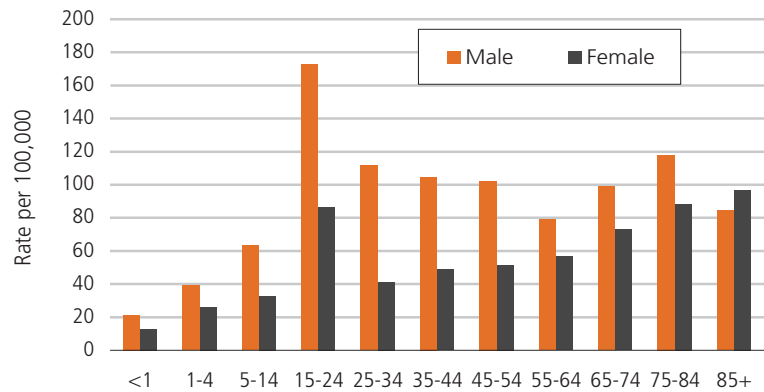


Source: CAPE; California OSHPD, Census 2000, DOF

There is a great deal of variability in the rates by sex and race. For instance, the African American male rate was 3.6 times higher than the API male rate and the African American female rate was 2.7 times the API female rate.

MVC hospitalization in Alameda County was highest among males in every age group but the oldest. The male rate peaked in the age 15-24 age group and then declined into middle age before starting up again. In contrast, the female rate dropped abruptly after age 24 and then climbed gradually with age.

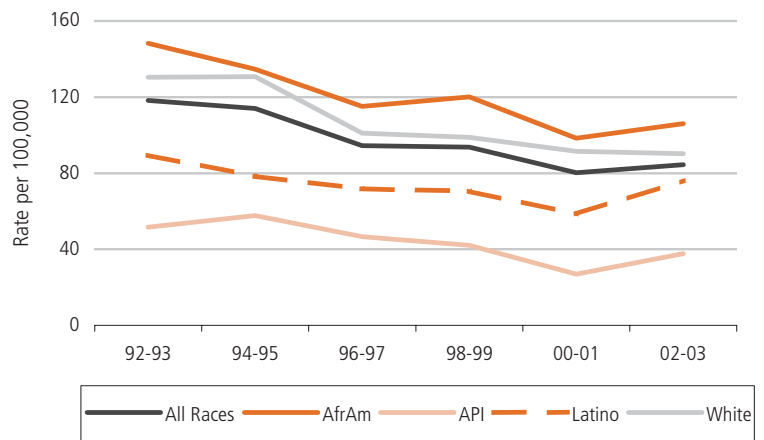
Figure 5.13: Motor Vehicle Crash Hospitalization by Age and Gender, Alameda County, 2001-2003



Source: CAPE; California OSHPD, Census 2000, DOF

The MVC hospitalization rate has declined significantly over the past decade in every race/ethnic group but Latinos. With the exception of Whites, every group witnessed an increase in the rate during the most recent period. African Americans have had the highest rate of MVC hospitalization throughout the decade. The size of the gap between African Americans and the county as a whole has persisted at about 25% during this time.

Figure 5.14: Motor Vehicle Crash Hospitalization by Race/Ethnicity, Alameda County, 1992-2003



Source: CAPE; California OSHPD, Census 1990 and 2000, DOF

Rates for Latinos and APIs were below the county rate for the past decade, at least until recently when the Latino rate approached the county rate.

## Homicide and Assault

### *What is it?*

Homicide is any intentionally inflicted fatal injury to another person. These exclude deaths caused by law enforcement officers in the line of duty. Assault is intentionally inflicted injury to another person that may, or may not, involve an intent to kill.

### *Why is it important?*

Nationally, preliminary data for 2003 showed the age-adjusted rate of homicide was 5.8 per 100,000.<sup>5</sup> In 2002, the homicide rate among males was 9.4, more than three times the female rate of 2.8.<sup>4</sup> In California, the homicide rate was 6.7 per 100,000 for the period 2001-2003.<sup>6</sup> Both national and state rates exceed the HP2010 objective of 3.0 or less.<sup>7</sup>

In 2003, there were 17,096 known homicide victims in the United States.<sup>5</sup> More than 75% were males.<sup>4</sup> Homicide was the second leading cause of death, after unintentional injury, for the 15-24 age group.<sup>8</sup> For the 25-34 age group, homicide ranked third after unintentional injury and suicide.<sup>8</sup> Homicide victimization was especially high among African American males, exceeding the White male rate by more than six times.<sup>4</sup> Among African American males 15 to 19 years, 20 to 24 years, and 25 to 34 years, homicide was the leading cause of death, accounting for 44%, 51%, and 31% of deaths, respectively, in those age groups.<sup>8</sup>

Nationally, homicide rates among children and young adults increased between 1960 and the mid-1990s, and have been declining since.<sup>9</sup> Fifty-six percent of homicides involve firearms.<sup>1</sup>

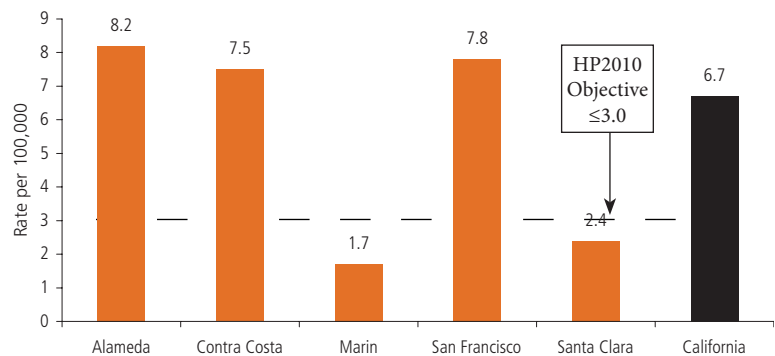
### *What is Alameda County's status?*

#### Homicide Mortality

Alameda County, along with Contra Costa and San Francisco counties, had a homicide rate for 2001 to 2003 that was four times higher than Marin and Santa Clara Counties. Alameda County's homicide rate, in addition to exceeding the statewide rate, was almost three times higher than the national HP2010 objective of 3.0 or fewer homicides per 100,000 people.

From 2001 to 2003, an average of 129 people per year died from homicide in Alameda County. The homicide rate was 8.2 per 100,000.

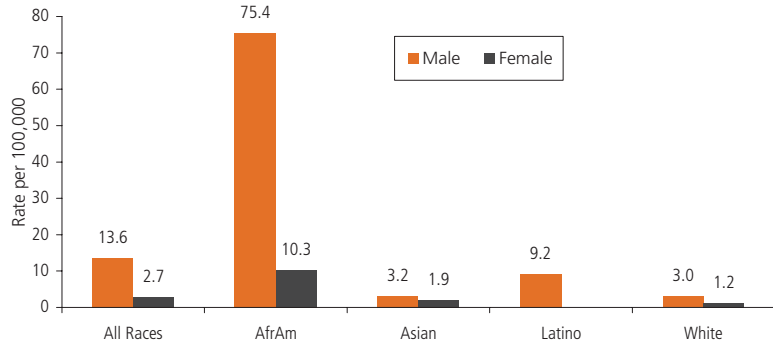
Figure 5.15: Homicide Mortality, Selected Counties and California, 2001-2003



Source: CAPE; ACPHD Vital Statistics files; CADHS County Health Profiles; Census 2000; DOF.

For both African American men and women, homicide rates were significantly higher than any other race/ethnic group. The African American male rate was over twenty times Asian and White rates and eight times Latino rates. The African American female rate was five times the Asian rate and eight times the White rate.

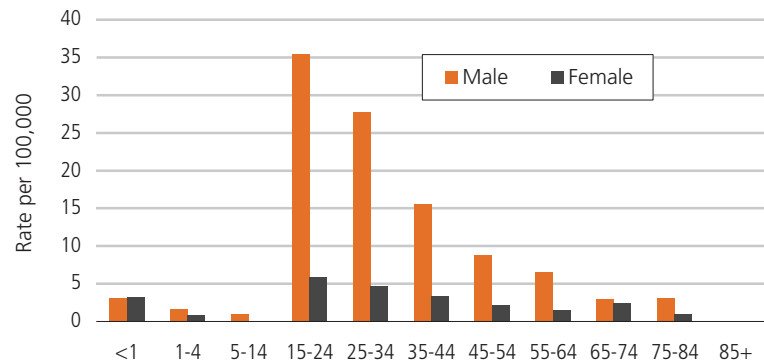
Figure 5.16: Homicide Mortality by Race/Ethnicity and Gender, Alameda County, 2001-2003



Source: CAPE; Alameda County vital statistics files, Census 2000, DOF.

Homicides were many times higher among males than females in almost every age group. Rates were highest among teen and young adult males, approximately six times higher than among females of the same ages.

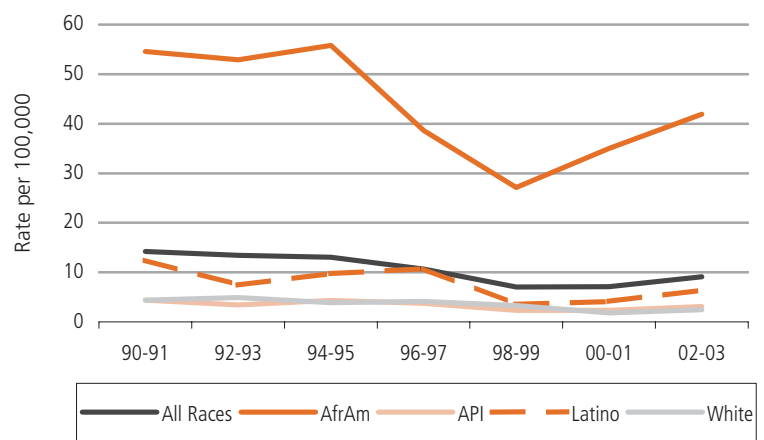
Figure 5.17: Homicide Mortality by Age and Gender, Alameda County, 2001-2003



Source: CAPE; Alameda County vital statistics files, Census 2000, DOF.

Rates of death due to homicide declined significantly for every race/ethnic group throughout the 1990s. However, in 2000, the downward trends began to reverse and every group experienced an increase in recent years. The largest increases were among Latinos and African Americans.

Figure 5.18: Homicide Mortality by Race/Ethnicity, Alameda County, 1990-2003



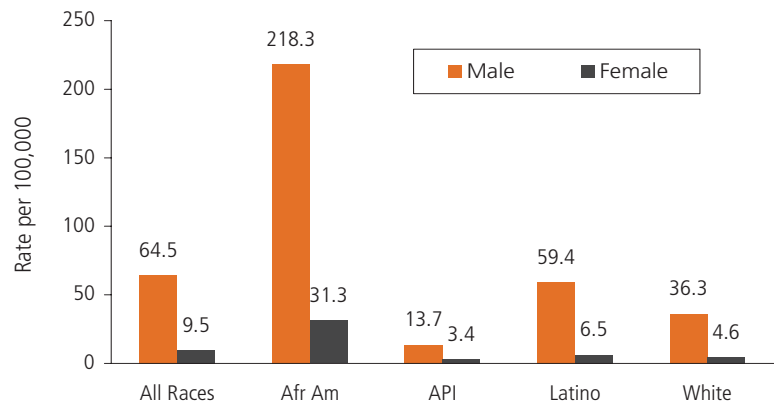
Source: CAPE; Alameda County vital statistics files, Census 1990 and 2000, DOF.

## Assault Hospitalization

From 2001 to 2003, an average of 572 hospitalizations per year for assault-related injuries occurred in Alameda County. The rate was 37 per 100,000 people.

Assault hospitalizations were higher among males in every race/ethnic group. African American males were hospitalized for assault at 16 times the rate of Asian/Pacific Islander males, six times the rate of White males, and nearly four times the rate of Latino males. Rates among African American females also exceeded those of other racial groups by large margins.

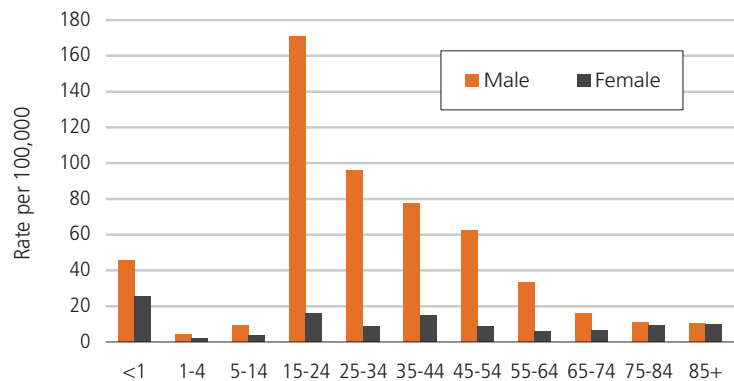
Figure 5.19: Assault Hospitalization by Race/Ethnicity and Gender, Alameda County, 2001-2003



Source: CAPE; California OSHPD, Census 2000, DOF

Rates of hospitalization for assault in Alameda County were highest among males of every age group, but particularly males 15-24 years of age. Male rates declined with age between 25 and 75 years while female rates showed no clear pattern. Infants are particularly vulnerable to serious injury from violence.

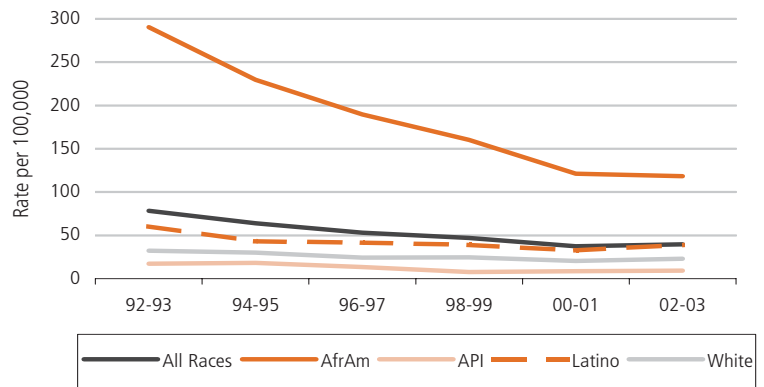
Figure 5.20: Assault Hospitalization by Age and Gender, Alameda County, 2001-2003



Source: CAPE; California OSHPD, Census 2000, DOF.

Over the past decade the rate of hospitalization for assault among African Americans dropped by nearly 60%. Significant declines were also seen for the other race/ethnic groups. The county rate declined by 50% over the period. Thus the size of the disparity between African Americans and the county as a whole has grown smaller. However, in the most recent period, African Americans were at least three times more likely than other race/ethnic groups to be hospitalized for an assault-related injury.

Figure 5.21: Assault Hospitalization by Race/Ethnicity, Alameda County, 1992-2003

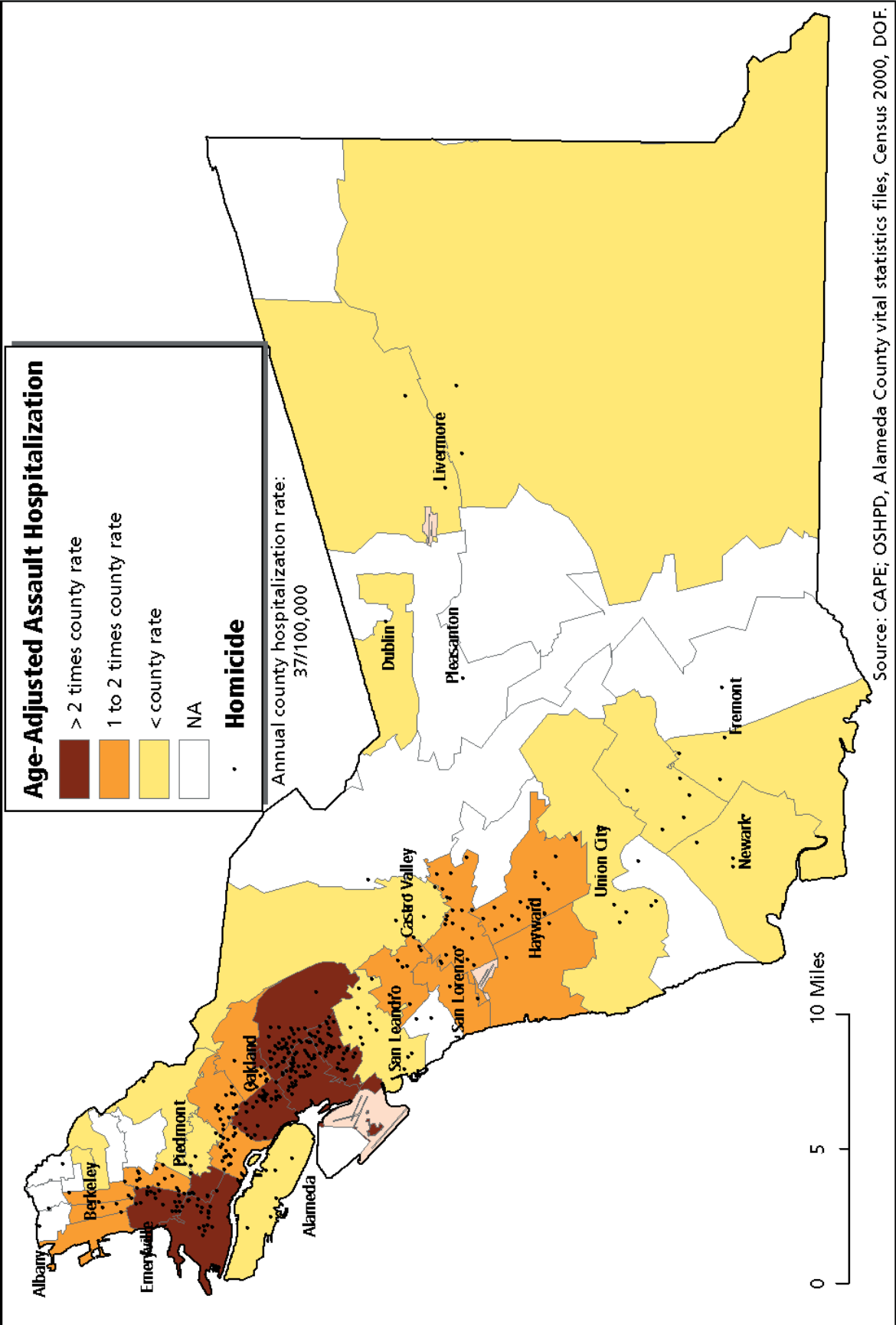


Source: CAPE; California OSHPD, Census 1990 and 2000, DOF.

### Map 5: Assault Hospitalization Rates and Homicides

Map 5 shows rates of hospitalization for assault by zip code of residence with homicides overlaid as points. Each point represents a homicide victim's residence. Homicides are most numerous throughout North, West and East Oakland, as well as the Fruitvale area. These areas are also where the highest rates of assault hospitalizations are found, rates that are at least twice as high as the county average of 37 per 100,000 population.

**Map 5: Assault Hospitalization and Homicide, Alameda County, 2001-2003**



Source: CAPE; OSHPD, Alameda County vital statistics files, Census 2000, DOF.

## Suicide and Self-Inflicted Injury

### What is it?

Suicide is any purposely self-inflicted injury that is fatal. Fatal injury events that involve reckless behavior, such as driving at high speeds or drinking and driving, are not classified as suicides. Non-fatal self-inflicted injury of the type seen in emergency departments is often, but not always, the result of a suicide attempt.

### Why is it important?

Nationally, suicide is the second leading cause of death in the 25-34 age group, and the third leading cause of death in the 15-19 and 20-24 age groups. Among those 25-34, for all races combined, the male rate exceeds the female by more than four to one (20.5 per 100,000 compared to 4.6 in 2002).<sup>8</sup>

In 2003, there were 30,642 suicides in the United States. Overall, the age-adjusted suicide rate was 10.5 per 100,000 population.<sup>5</sup> In California, the suicide rate was 9.5 per 100,000 for the period 2001-2003.<sup>6</sup> Both national and state rates exceed the HP2010 objective of 5.0 or less.<sup>7</sup>

More than 30,000 persons died from firearm injuries in the United States. Firearm suicide accounted for 56.6% of all firearm injury deaths in 2002.<sup>4</sup>

In 2000, nationally an estimated 264,108 nonfatal self-inflicted injuries were treated in hospital emergency departments. Of these, 57.4% were females.<sup>12</sup> About 90% of self-inflicted injuries were the result of poisoning or being cut/pierced with a sharp instrument.<sup>12</sup>

Among males 25-34 years of age, American Indians have the highest suicide rates, followed by Whites. Among females in this age group, Whites have the highest suicide rates followed by Asian/Pacific Islanders.<sup>8</sup>

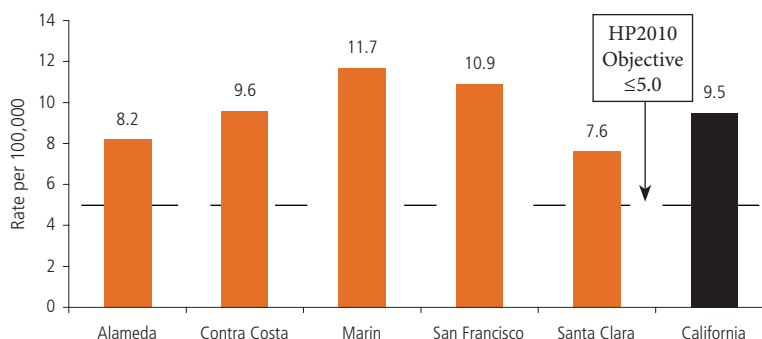
### What is Alameda County's status?

#### Suicide Mortality

From 2001 to 2003, an average of 119 people per year died from suicide in Alameda County. The suicide rate was 8.2 per 100,000.

Alameda County's suicide rate for the period 2001 to 2003 was lower than those in Contra Costa, Marin and San Francisco counties. Neither the counties nor the state have met the national HP2010 objective of 5.0 or fewer suicides per 100,000 people.

Figure 5.22: Suicide Mortality, Selected Counties and California, 2001-2003



Source: CAPE; ACPHD Vital Statistics files; CADHS County Health Profiles; Census 2000; DOF.

Suicide rates among males are three to four times higher than those among females. The rate of suicide among White men was highest, about 3.5 times the rate of Asian men and over twice those of Latino and African American men.

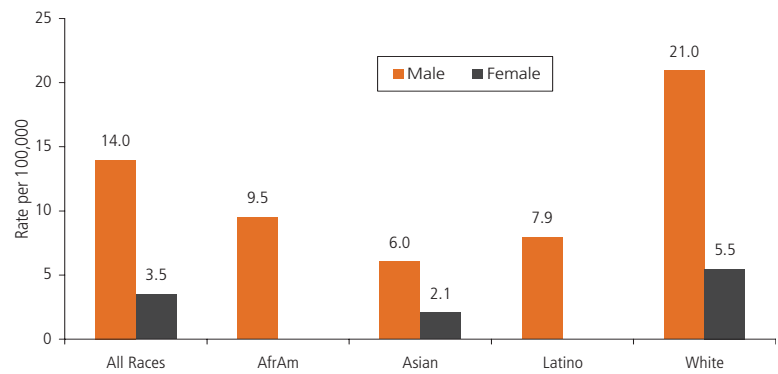
Asian females were the only race/ethnic group to meet the HP2010 objective of no more than 5.0 deaths per 100,000. Rates were not calculated for Latina and African American females due to small numbers.

Suicide rates were much higher among males than females in every age group. The highest suicide rates were among the oldest males.

Suicide mortality in Alameda County has declined significantly over the past decade, by about 3% per year. The same trend was observed for Whites. No clear pattern was seen for APIs, African Americans, or Latinos.

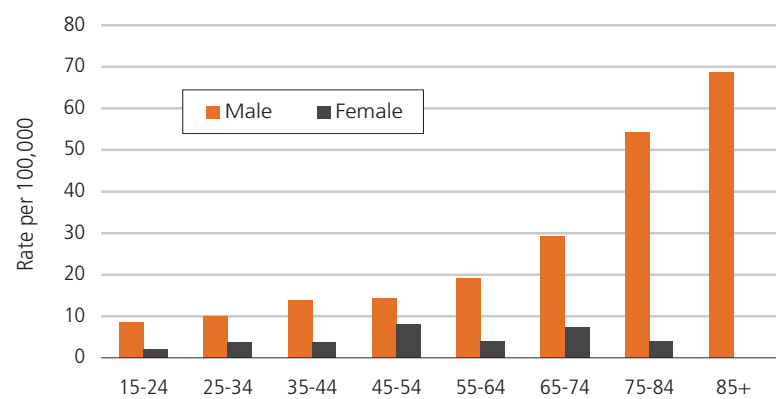
Rates of suicide have been higher among Whites in Alameda County over the past decade than any other race/ethnic group. During this time, White suicide rates were 30% to 50% higher than the county rate and roughly two to four times higher than those of other race/ethnic groups. These gaps do not appear to be closing.

Figure 5.23: Suicide Mortality by Race/Ethnicity and Gender, Alameda County, 2001-2003



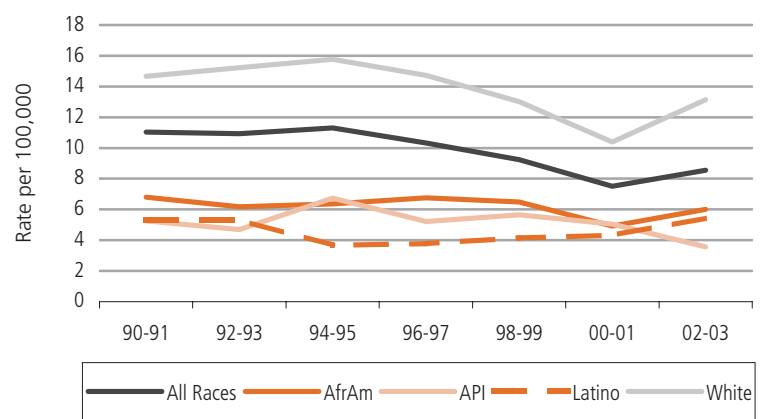
Source: CAPE; Alameda County vital statistics files, Census 2000, DOF.

Figure 5.24: Suicide Mortality by Age and Gender, Alameda County, 2001-2003



Source: CAPE; Alameda County vital statistics files, Census 2000, DOF.

Figure 5.25: Suicide Mortality by Race/Ethnicity, Alameda County, 1990-2003



Source: CAPE; Alameda County vital statistics files, Census 1990 and 2000, DOF.

## Self-Inflicted Injury Hospitalization

From 2001 to 2003, an average of 408 hospitalizations per year for self-inflicted injury occurred in Alameda County. The rate was 27 per 100,000 people.

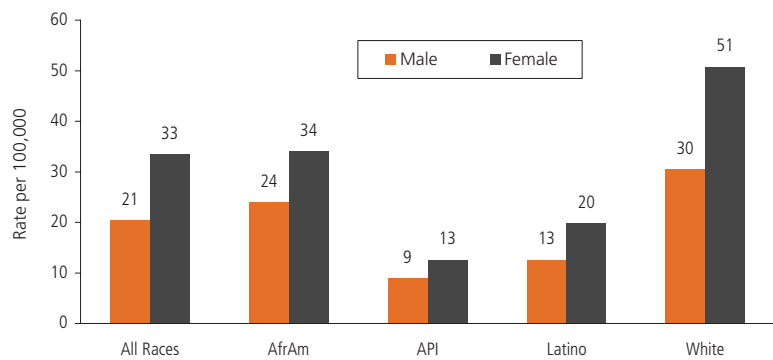
Self-inflicted injury hospitalization rates were higher among females than males in every race/ethnic group. This is in contrast to suicide rates, which were higher among males of every race/ethnic group.

Self-inflicted injury hospitalization was highest among White females followed by African American females.

White females were four times more likely than API females and 2.5 times more likely than Latinas to be hospitalized for self-inflicted injury.

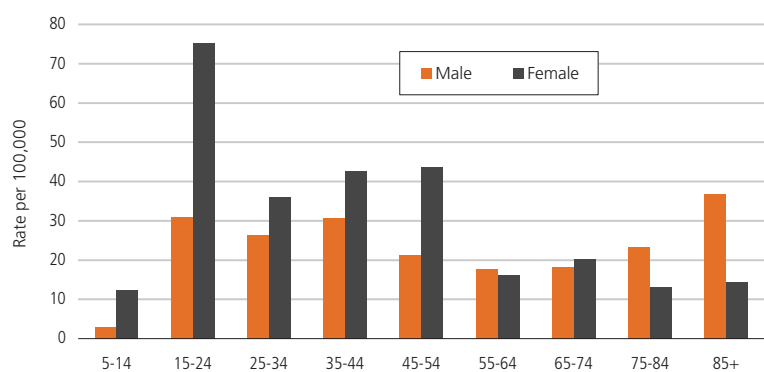
The rate of self-inflicted injury hospitalization in Alameda County was very high among females 15-24 years of age. Rates for both males and females dropped off somewhat in the 55-64 age group; however they climbed again among elderly males.

Figure 5.26: Self-Inflicted Injury Hospitalization by Race/Ethnicity and Gender, Alameda County, 2001-2003



Source: CAPE; California OSHPD, Census 2000, DOF.

Figure 5.27: Self-Inflicted Injury Hospitalization by Age and Gender, Alameda County, 2001-2003

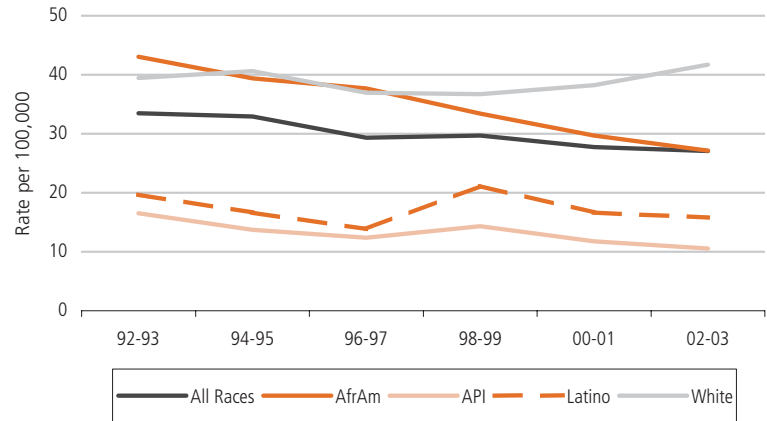


Source: CAPE; California OSHPD, Census 2000, DOF.

Over the past decade, the rate of self-inflicted injury hospitalization in the county declined by about 2% per year. Among African Americans it declined steadily by about 4% per year. In recent years, the African American rate dropped well below the White rate, which did not change significantly over the decade.

Through the mid-1990s, the African American rate was 20% to 30% higher than county rate, but its decline has brought it even with the county rate. In contrast, the disparity between the White rate and the county rate has grown from approximately 20% in the early 1990s to over 50% in the 2002-03 period. Rates among APIs and Latinos were consistently lower than the county rate during the period and did not change significantly.

Figure 5.28: Self-Inflicted Injury Hospitalization by Race/Ethnicity, Alameda County, 1992-2003



Source: CAPE; California OSHPD, Census 1990 and 2000, DOF.

## Injury Deaths by Mechanism and Intent

Table 5.1 presents figures on death due to injury by both mechanism and intent using the External Cause of Death coding scheme. The matrix is developed by the Injury Control and Emergency Health Services (ICEHS) section of the American Public Health Association and the International Collaborative Effort (ICE) on Injury Statistics.<sup>1</sup> It is a standard framework for presentation of injury mortality statistics. The mechanism describes the way someone died, such as fall, motor vehicle crash, or poisoning. The intent of the injury describes whether the injury is inflicted purposefully or not. If purposefully inflicted, it describes whether the injury is self-inflicted or inflicted by another person.<sup>1</sup>

Nationally, the leading mechanisms of injury death—motor vehicle crashes, firearms, poisonings, falls, and suffocation—accounted for 78% of all injury deaths.<sup>1</sup>

Table 5.1: Injury Deaths by Mechanism and Intent, Alameda County, 2001-2003

	Unintentional Injuries		Homicide		Suicide		All Other		Total	
	Count	%	Count	%	Count	%	Count	%	Count	%
Cut/pierce	0		33	8.5	13	3.6	2	5.3	48	2.6
Drowning	47	4.5	2	0.5	7	2.0	3	7.9	59	3.2
Fall	179	17.1	0	0.0	10	2.8	1	2.6	190	10.4
Fire/hot object or substance	38	3.6	2	0.5	0		0	0.0	40	2.2
Firearm	8	0.8	294	76.0	152	42.6	4	10.5	458	25.1
Machinery	4	0.4	0		0		0		4	0.2
All transport	359	34.4	0		0		0		359	19.7
<i>Motor vehicle crash</i>	333	31.9							333	18.2
<i>All other transport-related</i>	26	2.5							26	1.5
Natural environmental	6	0.6	0		0		0		6	0.3
Overexertion	1	0.1	0		0		0		1	0.1
Poisoning	280	26.8	1	0.3	69	19.3	4	10.5	354	19.4
Struck by or against	9	0.9	7	1.8	0	0.0	0		16	0.9
Suffocation	37	3.5	13	3.4	88	24.6	2	5.3	140	7.7
Other/unspecified	76	7.3	35	9.0	18	5.0	22	57.9	151	8.3
<b>Total</b>	<b>1,044</b>	<b>100.0</b>	<b>387</b>	<b>100.0</b>	<b>357</b>	<b>100.0</b>	<b>38</b>	<b>100.0</b>	<b>1,826</b>	<b>100.0</b>

Source: CAPE; Alameda County vital statistics files, Census 2000, DOF.

More than half of injury deaths in Alameda County from 2001 to 2003 were unintentional (57.2%). An additional 21.2% of injury deaths were from homicides, 19.6% from suicides, and 2.1% from other or unknown causes.

The leading mechanism of unintentional injury death was transport-related (34.4%), primarily involving motor vehicle crashes. Motor vehicle crashes accounted for almost one third of unintentional injury deaths. The second leading mechanism of unintentional injury death was poisoning (26.8%), followed by falls (17.1%), drowning (4.5%), fire/hot object or substance (3.6%) and suffocation (3.5%).

Guns were involved in the majority of homicides (76.0%). A smaller number of homicides involved stabbing, suffocation, or striking (8.5%, 3.4%, and 1.8% respectively).

Guns were used in 42.6% of suicides. Most others involved suffocation (24.6%), and poisoning (19.3%), while a smaller number was from cuts, falls, and drowning.

In 2001-2003, the five leading mechanisms of injury death accounted for 81% of all injury deaths in Alameda County: firearm (25.1%), transport-related (19.7%), poisoning (19.4%), falls (10.4%), and suffocation (7.7%).

## *What Are We Doing?*

### **Violence Prevention**

In July 2005, the Alameda County Board of Supervisors adopted a countywide violence prevention plan, known as A Lifetime Commitment to Violence Prevention: The Alameda County Blueprint.<sup>13</sup> The blueprint was developed through a county-wide participatory process involving county agencies (public health, social services, education, probation), city agencies, and community partners. The plan focuses on four key policy and program goals for violence prevention: 1) Influencing individual behavior change by encouraging activities in the community that support self-esteem building and empowerment, 2) Mobilizing neighborhoods toward systemic change, 3) Strengthening organizations that provide violence prevention programs and services; and 4) Encouraging the development of networks in high crime/distressed neighborhoods. The Public Health and the Probation departments jointly oversee the implementation of plan activities in partnership with community based organizations and residents. Specific violence prevention activities are:

- The creation of the Family Justice Center in 2005, a one-stop service delivery center for victims of domestic violence. The countywide Domestic Violence Collaborative and the Maternal, Paternal, Adolescent and Child Health Program of the ACPHD provide on-site support for referrals to entitlement programs, counseling, and health services for women and children impacted by domestic violence.
- Serving over 80 youth per year through Project New Start, a tattoo removal program and part of ACPHD's Community Health Services Division. Youth participants are also linked to mentorship, employment, and education support programs.
- Mobilizing neighborhoods and building community capacity to work towards healthier, safer neighborhoods, the ACPHD works in partnership with the cities of Oakland and Hayward, as well as with local residents, in three low-income, at-risk neighborhoods. Activities include: building community cohesion and leadership through site based activities like neighborhood watch, local city park redevelopment and leadership training; developing resident action groups that respond to local issues and engage in civic activities; encouraging local residents, churches and other community based organizations to build positive youth-adult relationships and to develop programs aimed at increased employment and educational activities for youth.
- In partnership with the Schools Subcommittee of the Violence Prevention Initiative, the Safe Passages program is developing and implementing a violence prevention/conflict resolution curriculum in Oakland Unified School District with plans to expand to other districts in the future.

- The new Urban Male Initiative, of the ACPHD, is in formative stages. Its aim is to work with San Quentin parolees re-entering the local community in order to increase chances for success. Participants will be connected to sources of primary health care and job skills training along with other supportive services.
- ACPHD is working in partnership with the Probation Department to develop a Continuum of Care Plan, including an After Care Program, for youth at Camp Sweeney. Toward this end, ACPHD is in the process of identifying gaps and service needs of youth in the juvenile justice system.
- The Violence Prevention Data and Evaluation Committee has been formed. Partners with ACPHD in this effort are: Urban Strategies, Probation, Safe Passages, UCSF, and the Prevention Institute. The aim of the committee is to develop mechanisms for effective tracking of violence-related data, including risk and resiliency factors that will be shared with agency and community partners to inform prevention efforts.
- The Alameda County Violent Death Reporting System (ACVDRS) is a new ACPHD surveillance project that will track all fatal violent injuries (homicides and suicides). The focus in the first year is on homicide. The system links multiple data sources (information on victim and perpetrator using police, death certificate, coroner, supplemental homicide reports, and newspaper data sources). The goal is to assist policy makers and providers in developing and evaluating strategies to reduce violence in Alameda County. This effort is part of a larger statewide project, the California Violent Death Reporting System (CVDRS), coordinated by the California Department of Health Services and funded by CDC's National Violent Death Reporting System (NVDRS).

### **Unintentional Injury Prevention**

- ACPHD is working in collaboration with Community Recovery Services, a community based organization, to implement an underage drinking and driving prevention grant with a strong youth development component. This project assesses the drinking patterns of adolescents in Oakland and will develop recommendations to reduce underage drinking and its consequences.
- The Senior Injury Prevention Project (SIPP), of the EMS Division, ACPHD, is a collaborative made up of public and private partners, advocacy groups and other community-based organizations. The SIPP hosts statewide conferences and conducts discussion groups and safety fairs aimed at preventing falls and other injuries common among older adults.
- The Injury Prevention Program of the EMS Division provides education to providers, parents and school age children on childhood injury and distributes equipment. The Program also serves as the lead for the Alameda County Safe Kids Coalition, part of the National Safe Kids Coalition, dedicated to raising awareness about the risks from injuries that children face and how to prevent them
- The Injury Prevention Program oversees the Child Passenger Safety Seat Work Group, which is comprised of representatives from community based organizations, child care organizations, and health clinics. This work group distributes car seats to eligible low income families. The program also works in conjunction with the courts, to offer a court diversion class for car seat and seat belt violations.

## *What else do we need to do?*

### **Assessment**

- Continue to monitor the prevalence of intentional and unintentional injury in Alameda County as well as the behavioral and environmental risk factors associated with such injuries. Make information available through a data warehouse provided through the departmental web page.
- Obtain Emergency Department data from local hospitals in order to monitor most frequent causes of ER visits.
- Optimize the Alameda County Violent Death Reporting Surveillance System and produce reports.
- Maintain an up-to-date county-wide directory of violence prevention and intervention programs.

### **Program and Service Delivery**

- Increase our partnerships with local school districts to ensure violence prevention curricula are included at every grade level.
- Develop a joint social service, health, housing and employment strategy targeting re-entry adults and youth needing aftercare upon exiting incarceration.
- Continue to provide support and build community capacity in neighborhoods with high crime rates.

### **Policy Development**

- Support enforcement of existing safety regulations including housing codes, pedestrian, traffic, car seat, and helmet laws.
- Support legislation that reduces intentional injuries (including domestic violence, homicide and suicide) and unintentional injuries (including motor vehicle accidents).
- Explore additional policy interventions to reduce the root causes of violence in Alameda County.

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