Injury and Violence

Injury is a leading cause of death and disability in North Carolina and Durham County. The two major categories that define injury data are *intentional* and *unintentional.* Intentional injuries result from interpersonal or self-inflicted violence and include homicide, assaults, suicide and suicide attempts, child abuse and neglect, intimate partner violence, elder abuse, and sexual assault. Unintentional injuries include, but are not limited to, those that result from motor vehicle crashes, falls, poisonings, drowning, suffocations, choking, and recreational and sport-related activities.

This chapter includes:

Section 9.01 *Unintentional injuries*

Overview

Injury and violence are significant problems in North Carolina, causing thousands of deaths and disabilities each year. Unintentional injuries account for more than two-thirds of all injury deaths in the United States and North Carolina.[1] Injury is a serious cause of disability, resulting in more than 148,000 hospitalizations, 819,000 emergency department (ED) visits, and an unknown number of outpatient visits and medically unattended injuries in North Carolina each year.[2] The effects of these injuries are very costly with an estimated $80 billion in medical cost and over four times that amount in lost productivity each year in the US.[3]

The three leading causes of death and hospitalizations due to unintentional injury are motor vehicle crashes, poisoning and falls.

Healthy NC 2020 Objective

Injury and Violence (1, 2); Environmental Health (3)

Healthy NC 2020 Objective[4]	Current Durham	Current NC[5]	2020 Target
1. Reduce the unintentional poisoning mortality rate to 9.9 (per 100,000 population).*	7.6 (2007-09)[i]	11 (2008)	9.9
2. Reduce the unintentional falls mortality rate to 5.3 (per 100,000 population)	9.3 (2009); 6.6 (2007–09)[ii]	8.1 (2008)	5.3
3. Reduce mortality rate from work-related injuries (per 100,000 population)	6.32 (2005-09)[6]	3.9 (2008)	3.5

*The number of poisonings in 2009 was too small to calculate a reliable rate, so three years were combined.

Secondary Data: *Major findings*

In 2010, the top three leading causes of deaths due to injuries in North Carolina were all related to unintentional injuries:

1. Motor vehicle accidents (MVA) (1,301 deaths)
2. Poisonings (947 deaths)
3. Falls (854 deaths).[7]

Similarly, three of the top four leading causes of injury deaths in Durham from 2007-2009 were due to *unintentional injuries* and are as follows:

1. Motor vehicle accidents (MVA) (79 deaths)

[i] Injury Prevention and Control Branch, North Carolina Department of Health and Human Services. Written (email) communication. June 1, 2011.
[ii] Injury Prevention and Control Branch, North Carolina Department of Health and Human Services. Written (email) communication. June 1, 2011.

2. Poisonings (60 deaths)
3. Falls (52 deaths).[8]

Durham data is depicted in Figure 9.01(a) below.

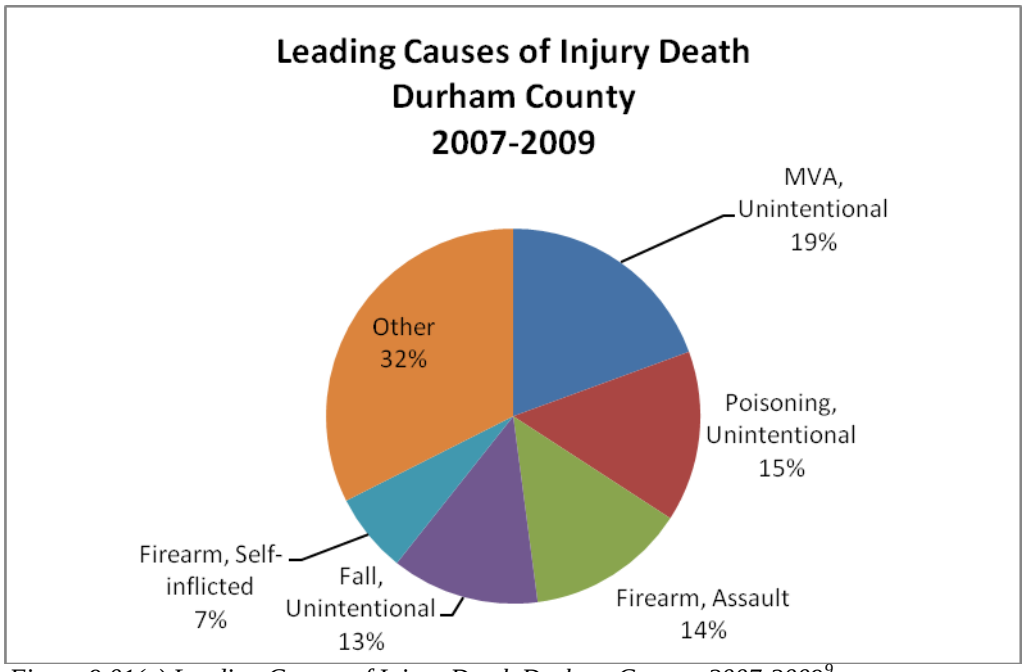


Figure 9.01(a) Leading Causes of Injury Death Durham County, 2007-2009[9]

There are far more hospitalizations (4,902) and visits to the Emergency Department (47,736) due to injuries than there are deaths (407). The two leading causes of unintentional injury hospitalization and injury-related emergency department visits in Durham County, as seen in Tables 9.01(b) and (c), are falls and motor vehicle trauma.[10]

Table 9.01(b)

**Leading Causes of Injury Hospitalization
All Ages: 2007 to 2009
DURHAM**

Rank	Cause	#
1	Fall, Unintentional	1,756
2	MVT, Unintentional	527
3	Poisoning, Self-inflicted	416
4	Poisoning, Unintentional	361
5	Unspecified, Unintentional	318
	Other	1,524
TOTAL		**4,902**

Table 9.01(c)

**Leading Causes of Injury ED Visits
All Ages: 2007 to 2009
DURHAM**

Rank	Cause	#
1	Fall, Unintentional	10,019
2	MVT, Unintentional	7,753
3	Overexertion, Unintentional	6.097
4	Struck, Unintentional	5,581
5	Cut/pierce, Unintentional	3,777
	Other	14,509
TOTAL		**47,736**

Each of these leading causes of unintentional injury is discussed in more depth throughout the remainder of this section.

Motor Vehicle Injuries

Motor vehicle injuries are the leading cause of unintentional injury death in North Carolina and Durham County.[11] They are also the leading cause of unintentional injury hospitalization and injury-related emergency department visits in Durham County. Factors that largely contribute to this pervasive public health issue include speeding, driving while intoxicated (DWI), driving while distracted (DWD), non-use or misuse of seatbelts/child restraints, poor conditions on the road and the vehicle and the driver's risk-taking behavior, inexperience and immaturity.

Injuries from motor vehicle crashes and falls are the two most common causes of Traumatic Brain Injury (TBI). At least 1.7 million people sustain a TBI in the United States each year; of those individuals, about 52,000 die, 275,000 are hospitalized, and 1.4 million are treated and released from an emergency department.[12] According to the Centers for Disease Control and Prevention (CDC), the number of people with TBI who are not seen in a hospital or emergency department or who receive no care is currently unknown.[13] It is important to understand the impact of TBI associated with a motor vehicle collision and falls because many of these individuals sustain long-term injuries requiring ongoing medical care, alterations in their ability to care for themselves and loss of productive years. TBI costs the nation about $60 billion for ongoing care and rehabilitation; and the greatest number of TBIs occur in people aged 15–24, making the cost to society high due to loss of productive years, disability and death.[14] Knowing who is affected by TBIs and how they occur can help shape prevention strategies, priorities for research, and also support the need for services among individuals living with TBI.

Between 2001 and 2009, rates of unintentional motor vehicle injuries have decreased in Durham County. Between 2001 and 2003, the motor vehicle traffic-related mortality rate was 13.1 per 100,000; by 2009, this number dropped to 10 per 100,000. As shown in Figure 9.01(d), Durham's rates have remained consistently lower than North Carolina's and its peer counties during this same 8-year time period.[15]

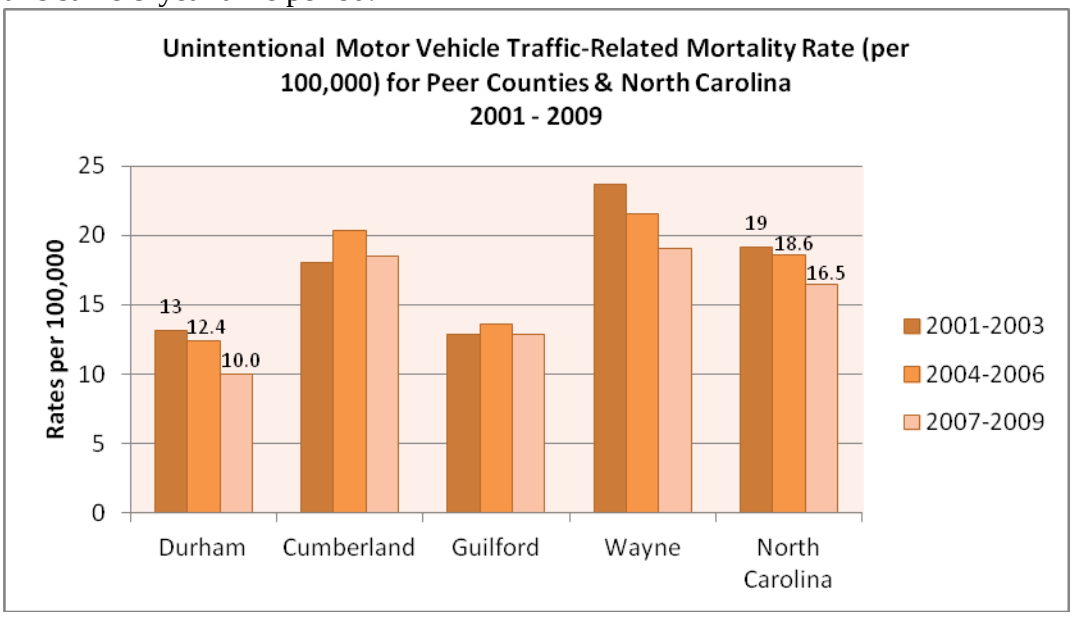


Figure 9.01(d) Unintentional Motor Vehicle Mortality Data[16]

Unintentional Poisonings

Unintentional poisonings are the second leading cause of unintentional injury-related deaths in North Carolina and Durham County.[17] The average North Carolinian fills 14 prescriptions annually, totaling over 127 million prescription drugs that enter our households each year.[18] In 2008, 72% of North Carolina's poisoning deaths were caused by narcotics, cocaine, heroin and methadone.[19] The state rate of poisoning-related deaths has increased by more than 210% since 1999.[20] Over the past decade, unintentional poisoning-related deaths in Durham County increased by 140%.[21] If deaths from unintentional poisonings continue to escalate at the current rate in North Carolina, the number of unintentional poisoning deaths will surpass motor vehicle deaths by the year 2017; this alarming trend has already become a reality in seven states and the District of Columbia.[22]

Between 2008 and 2009, the North Carolina Poison Control Center answered over 252,000 calls from families and healthcare facilities requesting treatment information for poisonings. Prescription and non-prescription pain medicines (analgesics) were the most frequently involved substances in these exposures.[23] Contributing factors to unintentional poisoning may include illicit or street drugs used for recreational purposes, alcohol, illegally obtained prescription medications, improper usage of prescribed medications by the elderly and ingestions by children.[24]

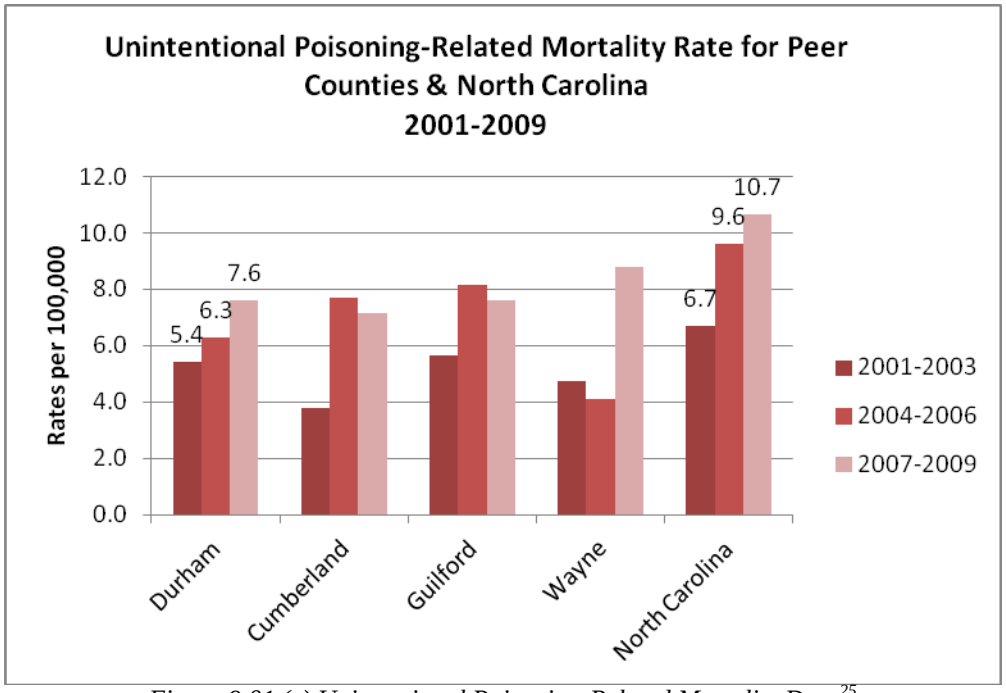


Figure 9.01 (e) Unintentional Poisoning-Related Mortality Data[25]

As shown in Figure 9.01 (e) above, North Carolina reflects the unfavorable upward trend in unintentional poisoning-related deaths. Between 2001 and 2009, the rates of unintentional poisoning-related deaths almost doubled statewide from 6.7 to 10.7 per 100,000. In Durham

county, the rates during this same 8-year time period increased from 5.4 to 7.6 per 100,000, respectively.[26]

Unintentional Falls

Unintentional falls are the third leading cause of unintentional injury related deaths and the leading cause of injury-related Emergency Department visits in North Carolina. They are the leading cause of injury hospitalizations in Durham County and the second leading cause in North Carolina.[27] In adults, alcohol and drugs are large contributors to unintentional falls; and in children, contributing factors include inadequate supervision around playground equipment, trampolines, stairs and open windows. In the elderly, however, the list of contributing factors to unintentional falls is longer, and may include: polypharmacy (the use of multiple medications); environment, such as poor lighting and irregular floor surfaces; and physical and cognitive deficits, such as impaired gait or strength, alteration in mentation, acute or chronic medical conditions.[28] An estimated 10% of those persons over 65 will die of complications related to a fall, and falls are associated with 40% of admissions to long term facilities.[29] Healthcare expenses due to falls were expected to reach $54.9 billion in 2010, nearly tripling in 20 years.[30]

As depicted in Figure 9.01 (f), deaths due to unintentional falls Durham County have steadily risen in recent years. There have been little change in rates between the years 2001-03 and 2004-06 (4.0 and 4.9 per 100,000, respectively); however, between 2007 and 2009 the mortality rate due to unintentional falls rose significantly, topping out at 6.6 per 100,000.[31]

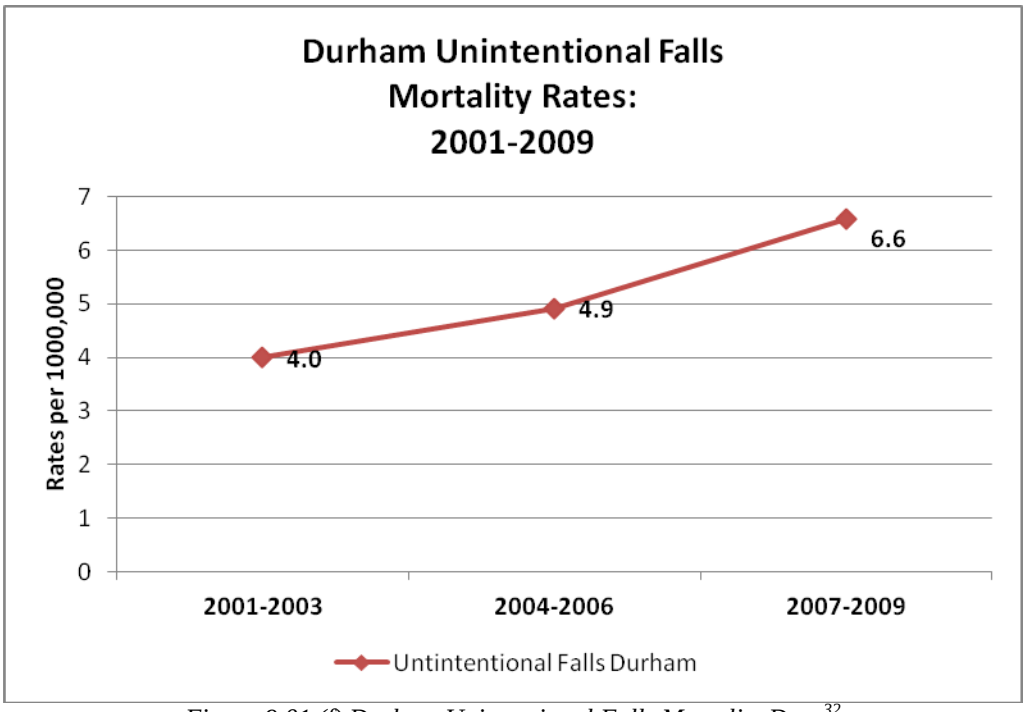


Figure 9.01 (f) Durham Unintentional Falls Mortality Data[32]

Seventy-five percent of North Carolina's counties are projected to have more people over the age of 59 than under the age of 18 by the year 2030; this shift in the percentage of older adults will

result in a falls "epidemic" unless falls risks are addressed.[33] In 2009, according to data gathered by the North Carolina Injury and Violence Prevention Branch, unintentional falls account for almost 40% of all hospitalizations in Durham with costs totaling $91,479,475.[34]

Primary Data

The impact of unintentional injury and violence on the Durham community is reflected in the results of the 2010 Durham County Community Health Opinion Survey. When survey respondents were asked to pick what they felt were the top three risky behaviors that have the greatest impact on the quality of life in Durham County, six injury-related topics made the top three. A selection of the injury-related responses from the *risky behaviors* question is shown in Figure 9.01 (g).[35]

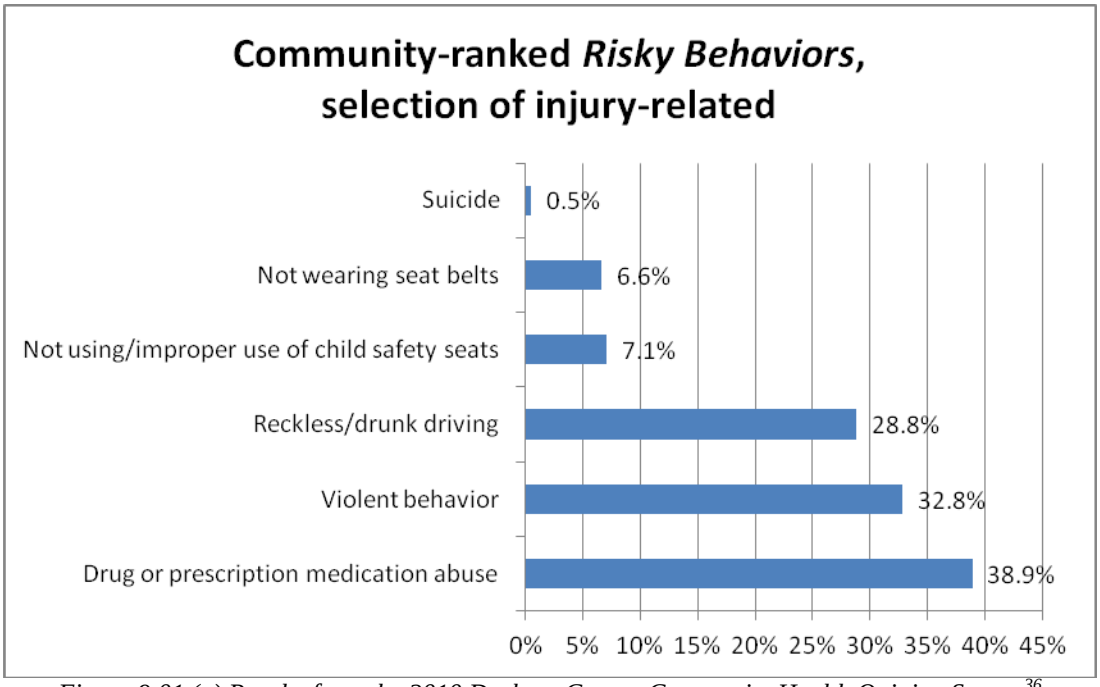


Figure 9.01 (g) Results from the 2010 Durham County Community Health Opinion Survey[36]

Interpretations: *Disparities, gaps, emerging issues*

Disparities

Death rates due to falls in North Carolina among the white population are almost three times that of African Americans, and women account for 30% more emergency department visits than men.[37] Falls are a dramatically life-altering event for adults over the age of 65 because the death rate is 23 times greater than that of adults younger than 65, and 16 times greater than the death rate from motor vehicle collisions.[38]

Emerging Issues

Unintentional prescription drug poisoning, mostly from painkillers is a growing epidemic in North Carolina. Prescription drugs are commonly sold like illegal drugs such as heroin, marijuana and cocaine. Abuse of the prescription drugs is perceived by many teens and young adults to be "safer" because it is a drug that has been prescribed by a doctor. In 2010, a White House white paper on drug abuse indicated that nearly 56% of people 12 years of age or older who abuse drugs obtained them from the household medicine chest, a family member or friend.[39] Safety issues emerge because the abuser does not know the appropriate dose for their age and weight, whether it will have an adverse reaction to other medications (prescribed, illicit or over the counter) being taken, how the medicine will react if mixed with alcohol or if they will develop an allergic reaction to the medicine. Prescription medicines are more readily available to this age group at home, in school and at social gatherings.

There are racial disparities among unintentional prescription drug poisoning; white males are eight times more likely to die from unintentional overdose than blacks and almost two-thirds are between the ages of 25 and 54.[40]

Recommended Strategies

Table 9.01 (d) **Evidence-Based and Promising Practices**[41]

Setting	Name and Website	Description
Individual	San Francisco Community Home Injury Prevention Program for Seniors (CHIPPS) http://www.sfdph.org/dph/comupg/oprograms/CHPP/Injury/CHIPPS.asp	The goal of the CHIPPS program is to: create awareness that many injuries to older people can be prevented; develop simple ways to recognize and correct injury hazards; and provide resources and information to health professionals and the public.
Workplace	Fall-Safe Project http://cbpp-pcpe.phac-aspc.gc.ca/intervention/549/view-eng.html	The Fall-Safe intervention is an initiative developed by the Safety and Health Extension at West Virginia University and designed as an organizational intervention which targets construction contractors. The aim of Fall-Safe is to increase the use of established fall prevention practices and technologies
Community	Operation Medicine Drop http://www.ncdoi.com/osfm/safekids/sk_OperationMedicineDrop.asp	Operation Medicine Drop is a take back initiative that is part of a grassroots effort working on medication disposal. By providing safe and secure ways for people to get rid of unwanted medications, Operation Medicine Drop helps prevent accidental poisonings and drug abuse while protecting our waters. This is a partnership of the River Keepers of NC, Community Anti-Drug Coalitions of NC and local law enforcement agencies.

School	Children Act Fast, So Do Poisons! http://www.ncpoisoncenter.org/body.cfm?id=95	A curriculum designed to educate children pre-K to 3rd grade about the dangers of poisons.

Current Initiatives & Activities

- ***North Carolina Buckle Up Program***

Safe Kids North Carolina, through grant funding from Governor's Highway Safety Program, distributes car seats to Buckle Up agencies across North Carolina. In Durham County, that agency is Safe Kids Durham County. At-risk families are provided seats at permanent checking stations and community check up events.

Website: www.buckleupnc.org
Phone Number: (800) 672-4527 toll free in NC, 8-5pm Monday-Friday

- ***Safe Kids North Carolina Operation Medicine Drop***

Safe Kids North Carolina partners with the State Bureau of Investigation, the Drug Enforcement Administration and local Safe Kids Coalitions and law enforcement agencies to provide a safe disposal method for over the counter medicines and old or unneeded prescriptions. This initiative helps prevent accidental poisonings and drug abuse while protecting our waterways. A majority of North Carolina take back events occur in March, Poison Prevention month.

Website: www.ncdoi.com
Phone Number: (888) 347-3737

- ***Welcome Baby***

Durham County residents can attend a car seat information session to learn about the correct use of car seats. Discounted car seats are available for eligible parents. Classes are held two or three times a month (one class is in Spanish) and pre-registration is required.

Website: www.welcomebaby.org
Phone Number: (919) 560-7150

- ***Durham County Permanent Checking Stations***

There are three locations in Durham County where families can get information on proper use of their child's car seat and have a certified car seat technician assist with proper installation of that seat in their vehicle.
EMS Station 6 (226 Milton Rd)- for appointment call 560-8287 between the hours of 9-5pm Monday-Friday. Families can make their own appointments by accessing the appointment calendar at www.co.durham.nc.us, click on the Community Portal and follow the directions to choose a date and time.
Parkwood Fire Department (1409 Seaton Rd). Call for an appointment (919) 361-0927. Appointments preferred but drop in possible based on availability of technicians.

Bethesda Fire Department (1724 S. Miami Boulevard)-Call for an appointment (919) 596-7862. Drop-in possible based on availability of technicians.

Website: www.co.durham.nc.us
www.pvfd.com
www.bethesdavfd.org
Phone Number: (919) 560-7150

- ***Safe From the Start: A Child Passenger Awareness Program***

Safe From the Start is a program developed through Children's Miracle Network funding at Duke Children's Hospital and was designed to give healthcare professionals basic knowledge about child passenger safety. This four hour class allows hospital employees caring for infants and children to give families evidenced-based information about safe transportation in vehicles. *Safe From the Start* also includes information on children with special health care needs; special orthopedic appliances, low birth weight infants and post-surgical indications. Questions regarding *Safe From the Start* can be directed to Theresa Cromling at Theresa.cromling@duke.edu

- ***Helmets Are a Necessity Not an Accessory Program***

Safe Kids Durham County and the Durham Bike Co-op work together to provide bike helmets to our community. Access to these helmets is through community health/ social fairs, mobile repair clinics and the "Earn a Bike" program.

Website: www.durhambikecoop.org
Phone Number: (919) 675-2453

- ***Click It or Ticket Campaign***

North Carolina's "Click It or Ticket" program began in 1993 to increase seat belt and child safety use rates through stepped-up enforcement of the state's seat belt law. Nearly every law enforcement agency in the state participates in "Click It or Ticket," one of the most intensive law enforcement efforts of its kind. North Carolina's "Click It or Ticket" program is so successful that it serves as a model for the National Highway Traffic Safety Administration (NHTSA). States throughout the country conduct "Click It or Ticket" campaigns, increasing awareness of seat belt safety daily.

Website: www.ncdot.gov
Phone Number: **(**919) 715-7000

Section 9.02 *Intimate Partner Violence (IPV)*

Overview

Intimate partner violence (IPV) refers to any physical, sexual, or psychological/emotional aggressive or controlling behavior one wields over an intimate partner. IPV can occur among heterosexual or same-sex couples. Each year, over 4 million women and 2 million men are the victims of intimate partner related physical assaults.[42,43]

IPV not only affects primary victims (those who are abused), but also has a substantial effect on secondary victims (e.g., family members, friends and co-workers), and the community at large. Children who grow up witnessing IPV are among those seriously affected by this crime as they learn that violence is a normal way of life. IPV greatly impacts primary and secondary victims' mental and physical health. Victims often become predisposed to numerous social and physical problems and are at increased risk of becoming the next generation of victims and abusers.[44]

About 42% of women and 20% of men who were physically assaulted sustained injuries during their most recent victimization. Injuries range from minor (e.g., scratches and bruises) to chronic and stress-induced (e.g., fibromyalgia and irritable bowel syndrome) to most severe (eg. death).[45] There were an estimated 2,340 intimate partner homicide victims in 2007, including 1,640 women and 700 men.[46] Psychological abuse often accompanies physical violence and frequently contributes to emotional problems, such as depression and suicidal ideation.[47] The challenge for healthcare professionals is to learn to ask the right questions and make the right associations in order to provide appropriate referrals and resources, as emotional assaults are hidden and not easily recognized. Healthcare providers may lose the opportunity to provide timely help to suffering victims if they overlook the connection between emotional abuse and physical symptomatology.

Pregnant women are often at increased risk of IPV. Pregnancy offers an important opportunity to screen for violence, however, most women report that they are not asked about violence during pregnancy.[48]

There is overlap between some risk factors for IPV victimization and perpetration. Cyclically, childhood physical or sexual victimization is a risk factor for future IPV perpetration and victimization. Individual factors (e.g., adherence to strict gender roles), relational factors (e.g., economic strain), community factors (e.g., restricted access to resources) and societal factors combine to increase the risk of becoming a victim or perpetrator of IPV.[49]

Healthy NC 2020 Objective

There is not a Healthy NC 2020 Objective for Intimate Partner Violence.

Secondary Data: *Major findings*

IPV places a huge burden on society. It is estimated that in 2003, costs associated with IPV exceeded $8.3 billion, which included $6.2 billion for physical assault, $461 million for stalking, and $1.2 billion in the value of lost lives.[50] Each year victims of severe IPV lose close to 8 million days of paid work and approximately 5.6 million days of household productivity.[51]

Statewide, IPV is of great concern. Figure 9.02(a) illustrates the number of IPV-related homicides in North Carolina from 2006 – 2010.[52] In 2009, there were 494 homicides, indicating that IPV-related deaths could account for as many as one-fifth of all homicides in the state. "Domestic Violence is a dangerous crime and can lead to deadly results," Attorney General Roy Cooper said in a news release. "North Carolina has to work to get victims the help they need to stop early signs of violence before people are seriously hurt and killed."[53]

As of May 7, 2011, there were three IPV-related homicides in Durham, one of which culminated in the murder of a 22-month-old who was shot by her father, who later took his own life. Durham Crisis Response Center (DCRC) works to repudiate myths that compel people to ask, "Why doesn't she just leave him?" or to imply that it is actually an act of love that prompts a man to kill his partner or others. In fact, two of the three homicides this year occurred after the victims left their relationships. Immediately after leaving a relationship is one of the most dangerous times for victims. The greatest chance of IPV-related homicides is when the relationship ends. If a victim of IPV is planning to end the relationship, it is critical that a safety plan is established. Figure 9.02(b) illustrates the number of IPV homicides in Durham over the past five years. According to the North Carolina Department of Justice, Durham was among the top five counties with the highest rates of IPV related homicides in 2008, 2009 and as of July 2010.[54]

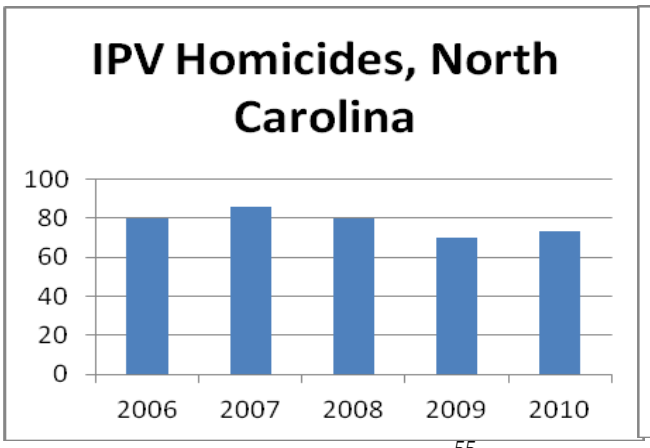


Figure 9.02(a) IPV Homicides, NC[55]

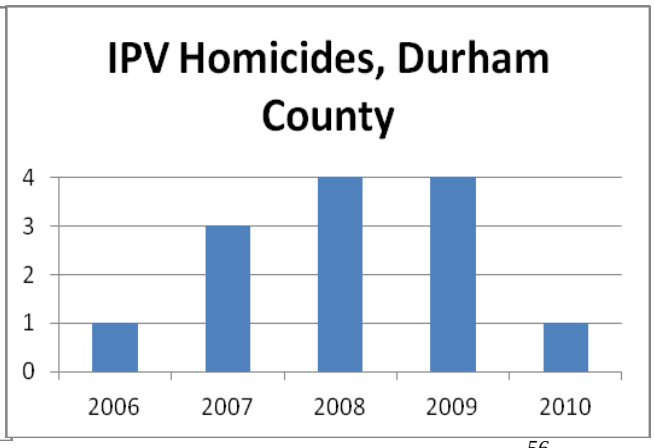


Figure 9.02(b) IPV Homicides, Durham[56]

The Durham Police Department has a Domestic Violence Unit that is dedicated to handling cases of IPV in Durham. Compared to reported rates in 2007 and 2008, 2009 saw increases in IPV related aggravated assaults (223 reported cases) and robberies (14 reported cases), and decreases in IPV related rapes (9 reported cases) and property crimes (114 reported cases).[57]

Primary Data

Durham Crisis Response Center (DCRC) is the only agency in Durham with a dedicated 24-hour phone line to assist victims of IPV. Figure 9.02(c) compares the number of IPV calls received in Durham and Peer Counties in fiscal year 09-10.[58]

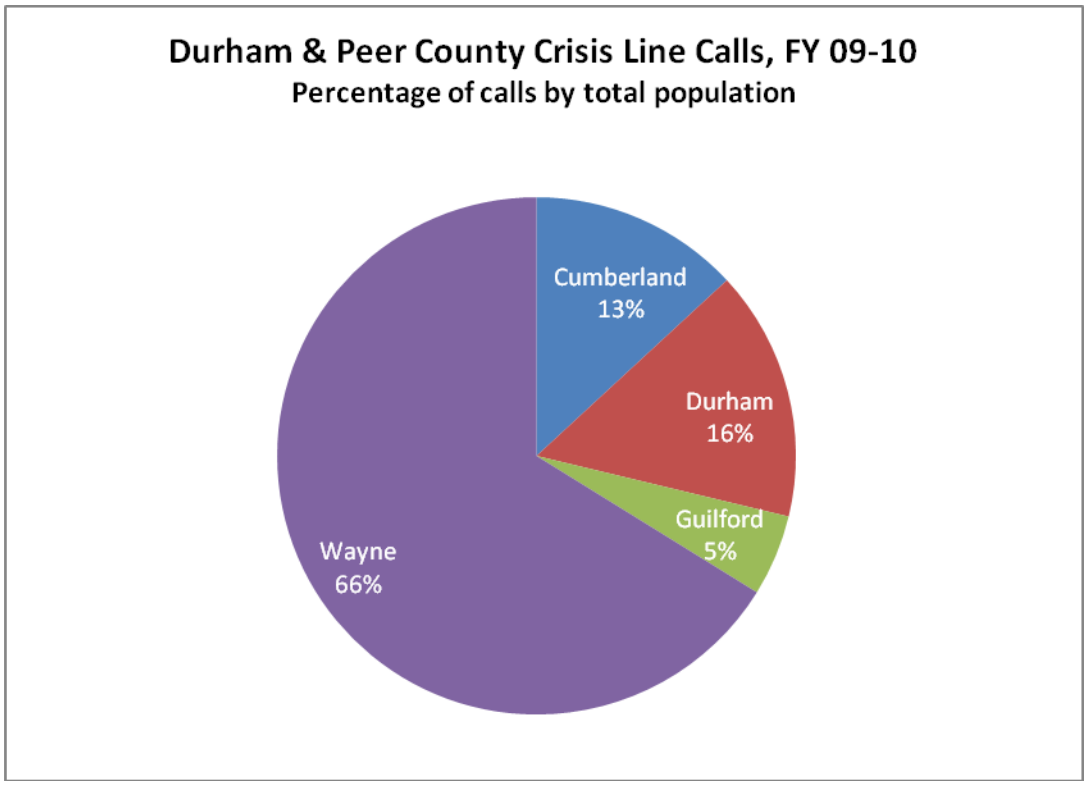


Figure 9.02(c) Durham and Peer County Crisis Line Calls, FY 09-10

IPV is also a serious concern for Durham youth. The 2009 Youth Risk Behavior Survey (YRBS) data indicates that 15% of Durham high school student respondents had been hit, slapped or physically hurt on purpose by their boyfriend or girlfriend over the preceding year.[59]

> "When answering the crisis line, it is not uncommon to have a female victim state that her abuse increased tremendously during her pregnancy. Many times female victims report an increase in physical violence during pregnancy such as punches to the abdomen, strangulation and being thrown across the room. What we have been able to conclude from this type of behavior over the years is that a victim's level of fear is increased due to her vulnerability and due to the potential harm to her unborn child."
>
> *--Paige Wiggs, Community Educator, DCRC*

Durham teenagers who participated in 2009 focus group interviews with DCRC reported that they see some type of emotional and/or physical abuse among their peers on a regular basis.[60]

Interpretations: *Disparities, gaps, emerging issues*

Poverty is a risk factor for IPV victimization. When a poor household is located in a disadvantaged neighborhood the prevalence of IPV increases dramatically. Thus, women living in these circumstances are most at risk. A higher percentage of African Americans live in impoverished environments and therefore tend to experience higher rates of IPV compared to Whites. However, a comparison of African Americans and Whites of similar income levels reveals comparable rates of IPV.[61] 2000 Census data indicated that in Durham there were 46,934 families that reported living below the poverty level, which equates to 11.1% of the population. More than 24,000 children under age 18 live in these homes.[62]

Durham County's Latino/Hispanic population has grown to 13.5% of the overall population, up from 1% in 1990.[63] For non-White and immigrant victims, race, ethnicity, class, language and immigration status often serve as significant barriers to accessing help in IPV situations. To better serve the growing Latino/Hispanic population, DCRC added a Spanish Crisis Line in FY 09-10. Spanish Crisis Line advocates have noticed a marked increase in IPV calls as well as an increase in the number of young Latina women, under the age of 18, who are seeking help in response to IPV perpetrated by older men with whom they were partnered.

Additional concerns exist regarding IPV within Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex (LGBTQQI) communities. Despite the prevalence of this issue, LGBTQQI victims of IPV face significant barriers to accessing remedies such as a lack of culturally competent social, criminal justice and medical service providers.[64]

People with disabilities are also at great risk of IPV. The 2007 National Crime Victimization Survey data indicated that 16% of nonfatal violence experienced by women with disabilities was IPV related, and 5% of nonfatal violence experienced by men with disabilities was IPV related.[65]

Men, as well as women, are victimized by violence. However, men and boys are less likely to report the violence and seek out support given challenges such as the stigma attached to being a male victim, perceived failure to personify the "macho stereotype," a fear of not being believed, being denied victim status, and the lack of support from society as well as loved ones.[66] Male victims of IPV often encounter significant barriers to IPV remedies. For instance, in Durham, there are currently no IPV emergency shelters that accept men. Additionally, male victims may encounter bias or ignorance from service providers who are more accustomed to working with female victims of IPV.[67]

IPV knows no age limits. It is estimated that over two million Americans are victims of IPV in later life.[68] Identifying IPV among the elderly can be harder to recognize and is sometimes dismissed or not believed by the community at large.

Recommended Strategies

The CDC recommends preventing IPV through strategies that include encouraging respectful, nonviolent intimate partner relationships on multisystemic levels.[69, 70]

Current Initiatives & Activities

- ***Durham Crisis Response Center (DCRC)***

DCRC's sole mission is to provide comprehensive services to primary and secondary victims of intimate partner and sexual violence through a myriad of services such as a 24-hr crisis line, crisis intervention, shelter, counseling, legal advocacy, and support groups.

Website: www.durhamcrisisresponse.org
Phone Number: (919) 403-9425

- ***InStepp***

InStepp, Inc. is a community-based non-profit company that works to empower at-risk adult women and adolescent girls to succeed personally and professionally through gender-responsive training, education and prevention services.

Website: www.instepp.org
Phone Number: (919) 680-8000

- ***El Centro Hispano***

A grassroots community based organization dedicated to strengthening the Latino community and improving the quality of life of Latino residents in Durham and surrounding areas.

Website: www.elcentronc.org
Phone Number: (919) 687-4635

- ***KIRAN***

KIRAN is a multi-cultural, non-religious, community based, South Asian organization that values and maintains confidentiality while promoting the self-reliance and empowerment of South Asian women and men who are in crisis through outreach, peer support, and referrals.

Website: www.kiraninc.org
Phone Number: 1 (877) 625-4726

- ***Legal Aid of North Carolina***

Legal Aid of North Carolina has attorneys who can help victims of intimate partner violence, regardless of their income.

Website: www.legalaidnc.org
Phone Number: 1 (866) 219-5262

- ***Durham Regional Hospital***

Medical professionals are available to provide care to victims in the wake of intimate partner violence.

Website: www.durhamregional.org
Phone Number: (919) 470-4000

- ***Duke University Hospital***

Medical professionals are available to provide care to victims in the wake of intimate partner violence.

Website: www.dukehealth.org
Phone Number: (919) 684-8111

- ***Durham Police Department – Domestic Violence Unit***

The Durham Police Department seeks to represent and enforce the Durham community's intolerance of violent behavior, whether it occurs outside or inside the home.

Website: www.durhampolice.com/dvu/
Phone Number: (919) 560-4910

Section 9.03 *Sexual violence*

Overview

Sexual violence is a term that encompasses a broad array of offenses and includes: 1) rape, legally defined in North Carolina as nonconsensual, forced vaginal penetration[71,72]; 2) sexual assault, including any unwanted sexual contact that comes short of rape[73]; and 3) sexual offenses in which there is no physical contact, such as voyeurism and verbal threats of sexual assault.[74] Force includes psychological as well as physical coercion.[75] In the United States as much as 60% of all sexual assaults go unreported, and many consider sexual assault to be the most underreported violent crime.[3,76]

Sexual violence continues to be a huge problem with far reaching negative effects on not only the (primary) victims, but also the victims' loved ones (secondary victims), the Durham community and society as a whole. Primary victims of sexual violence often experience a host of physical, psychological and behavioral health concerns, many of which have a likelihood of becoming chronic without adequate and proper treatment. Some possible health consequences include gynecological complications, depression and Post Traumatic Stress Disorder (PTSD).[77] Secondary victims are also at risk for a number of psychological concerns such as anxiety and sadness.[78]

Healthy NC 2020 Objective

There is not a Healthy NC 2020 Objective on Sexual Violence.

Secondary Data

Victims of sexual violence make reports to law enforcement agencies, seek services from agencies that support victims (e.g., DCRC and hospitals), and/or disclose their experiences to other third parties, such as researchers. Incidents of sexual violence are not reported uniformly and varying language is often used across sources; therefore, it can be difficult to accurately gauge the full impact of sexual violence. The data presented in this section, gathered from multiple sources, helps present a more comprehensive picture of sexual violence.

Women between the ages of 12 and 34 are at most risk for becoming primary victims of sexual assault. Best estimates are that about 10% of sexual assault victims are men, however this number is likely an underestimation as males are the least likely to report sexual assault.

Nationally, in 2009, an estimated 88,097 forcible rapes occurred. The same year, in North Carolina, there were 2,306 reported forcible rapes. Table 9.03(a) shows the breakdown of forcible rape offenses known to North Carolina law enforcement that occurred in Durham County and its three peer counties in 2009.

Table 9.03(a) **Forcible Rapes Known to Law Enforcement – 2009**[79]

	Durham	Cumberland	Guilford	Wayne
Forcible rapes reported by sheriff's office or county police department	**1**	**23**	**7**	**2**
Forcible rapes known to law enforcement by *cities per county	**63**	**94**	**109**	**9**

*Figures reflect available data on forcible rapes reported to city law enforcement in incorporated cities per county.

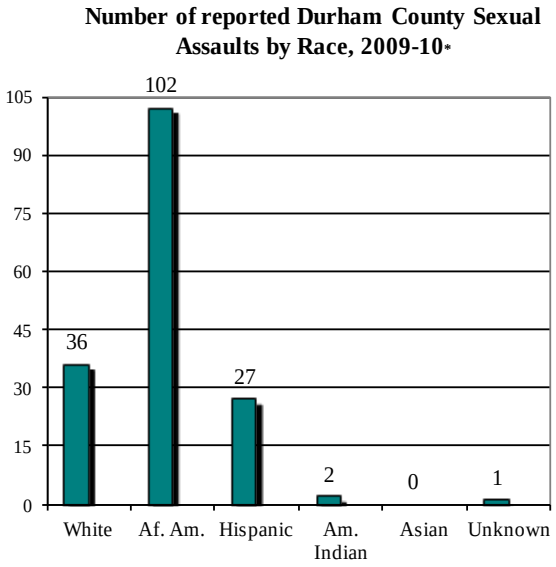
The Durham Crisis Response Center (DCRC) is the only agency in Durham County with the sole mission of offering comprehensive services to support victims of sexual and intimate partner violence. Table 9.03(b) shows the number of sexual violence victims served by DCRC over the past 5 years.

Table 9.03(b) **Numbers of Sexual Assault (SA)Victims Served by DCRC, by Fiscal Year**[80]

	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010
SA Crisis Line Calls	345	196	136	128	321
SA Hospital Accompaniments	91	43	40	10	144

*Figures are likely an under representation of the actual numbers of clients served by DCRC each year.

Of the 168 individuals who reported having been sexually assaulted in Durham in 2009-10, 81% were between the ages of 18 and 40. Additionally, of the 168 victims, 152 identified as female while 16 identified as male.[81] Contrary to messages often promulgated in the media, most acts of rape are not committed by assailants who are strangers to the victims.[82] Assailants were known to victims in over 80% of the sexual assault cases (reported to the NC Council for Women) in Durham in 09-10.[83]



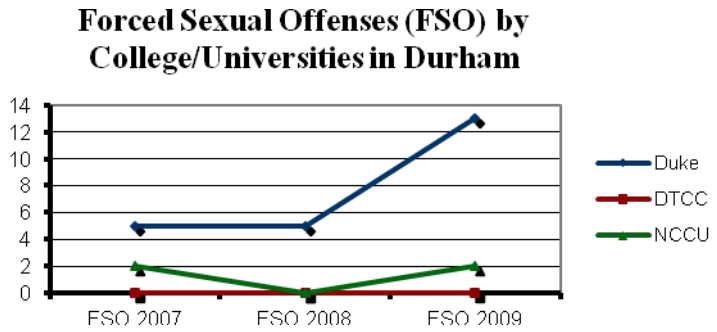
*

Figure 9.03(a) Chart figures are based on self-report of sexual assault victims who sought services from Durham Crisis Response Center (DCRC).[84]

If an individual who has been sexually victimized seeks medical attention from a hospital, or reports sexual victimization to the DCRC, s/he is not mandated to report her/his experiences to law enforcement. Thus, the numbers of cases of sexual violence reported by law enforcement and those reported by the DCRC will rarely correspond. Furthermore, it is not possible to draw a direct comparison between the number of sexual assaults reported to the DCRC and Durham law

enforcement in any given year because while the DCRC subsumes rape under the broader category of sexual assault, law enforcement only reports one type of sexual assault – forcible rape. Given that nationally, sexual assault goes unreported 60% of the time, it is reasonable to assume that there is also a large disparity between the number of sexual assaults that take place and the number of sexual assaults reported to law enforcement on a local level. Moreover, it has been demonstrated elsewhere that sexual assault cases that have been reported to law enforcement are rarely prosecuted.[85] It is not possible to compare the number of sexual assault cases reported to local law enforcement with the number of sexual assault cases that have been prosecuted locally because the number of sexual assault cases that have been prosecuted (in recent years) has not been made available.[86]

Nationally, 1 in 5 women experience rape during their college years.[87] In compliance with the Clery Act, each year Durham's post-secondary educational institutions report the number of sexually violent crimes committed on and around their campuses.[88] The chart below shows the number of reported forcible sex offenses at Duke University, Durham Technical Community College (DTCC) and North Carolina Central University (NCCU).[89,90,91]



Each of the colleges/ universities reported 0 non-forced sexual offenses in years 2007, 2008 and 2009.

There are a number of reasons that Clery data may only represent a small proportion of the actual number of sexual offenses committed on and around college/university campuses. For instance, sometimes when students are sexually assaulted at their off-campus residences, only local police investigate and neither campus police nor other university officials become involved.[92]

Primary Data

In 2010, the Durham Crisis Response Center conducted an assessment of Durham community members' knowledge, attitudes, beliefs and behaviors related to sexual violence. The majority of respondents surveyed were women between the ages of 18 and 45. Major findings were: 1) the majority of respondents were engaged bystanders and had accurate attitudes, beliefs and behaviors towards sexual violence; 2) about 58% of respondents reported having witnessed inappropriate sexual behavior among family members, friends, co-workers and peers; and, 3) about 69% of respondents reported having experienced inappropriate sexual behavior. Focus groups conducted with Durham teens in

"Many of the Durham Crisis Response Center advocates receive crisis line calls where the victim describes being manipulated, coerced, guilted and threatened into having sex by their partner, boyfriend and or spouse, but they do not think it is rape because physical force or weapon was not used." *Tasha Venters, Former Rape Prevention Educator, DCRC*

2010 revealed participants' beliefs that sexual violence is considered 'normal,' and that participants had witnessed some type of emotional and/or physical violence among their peers on a regular basis.[93]

The 2009 Youth Risk Behavior Survey (YRBS) data indicate that, at some point in their lives, 9.6% of Durham teenage respondents had been forced to have sexual intercourse when they did not want to. Statewide, 8.6% of North Carolina high schools students reported similar experiences.[94]

Interpretations: *Disparities, gaps, emerging issues*

Sixty percent of sexual assaults in the United States go unreported.[95] Generally, sexual assault goes unreported because: 1) when victims know their assailants, victims often do not label their experiences as sexual assault; 2) victims expect they will be revictimized if they report having been sexually assaulted; 3) victims expect nothing can or will be done even if they report having been sexually assaulted; 4) victims consider the assaults too private to report to law enforcement; 5) victims are afraid they will not be believed; 6) victims do not want to relive their assaults and may therefore try to forget any assault was perpetrated; and, 7) victims do not consider their experiences important enough to report. [96,97] In addition to the reasons already listed, male victims may be less likely to report in the context of a society that values a construct of masculinity in which there is no room for perceived vulnerability.[98]

For non-White and immigrant victims, race, ethnicity, class, language and immigration status often serve as significant barriers to accessing help in sexual violence situations. Given the rising Latino and Asian immigrant populations in Durham, it is imperative that services be culturally and linguistically competent.[99,100]

Although heterosexuals and members of Lesbian, Gay, Bisexual, Transgender, Queer, Questioning, Intersex (LGBTQQI) communities face about the same risk of being sexually assaulted by assailants who are known to them, LGBTQQI individuals are at greater risk of being sexually assaulted by strangers than are heterosexuals. Many barriers may preclude LGBTQQI community members from getting help including a fear of hostile, homophobic responses from representatives of the legal system, and trouble locating culturally competent service providers. [101]

Individuals with disabilities are also particularly vulnerable to sexual violence.[102] It is estimated that well over 1/2 of adult women and almost 1/3 of adult men with developmental disabilities are the victims of sexual assault, yet only 3% of sexual abuse cases among this population are ever reported.[103] Sexual assault agencies are often ill prepared to meet the needs of individuals with disabilities for several reasons, such as service providers' unfamiliarity with issues unique to individuals with disabilities.[104] Thus, people with disabilities often go without the support and services they need.

Recommended Strategies

Consistent with the Center for Disease Control's (CDC) recommendations for sexual violence prevention, the DCRC has a staff member whose work is dedicated to Rape Prevention Education (RPE). The RPE staff member, utilizing primary prevention principles set forth by the CDC, will continue to seek out various schools and other community agencies to implement evidence-based curricula focused on creating healthy relationships and preventing acquaintance and intimate partner rape with community members of all ages.[105]

Current Initiatives & Activities

- ***Durham Crisis Response Center (DCRC)***

DCRC offers the following services to victims of sexual assault: **24-Hour Crisis Lines (in English and Spanish), information and referrals, c**ase management, crisis intervention and ongoing emotional support, support groups (in English and Spanish), counseling, advocacy and accompaniment to the police, court, hospital, and follow-up medical appointments.

Website: http://www.durhamcrisisresponse.org/
Phone Number: (919) 403-6562 (24 hr crisis line)

- ***Lincoln Community Health Center***

Lincoln Community Health Center (LCHC) provides accessible, affordable, high quality outpatient health care to the medically underserved. LCHC also provides free, confidential HIV testing.

Website: http://www.lincolnchc.org/index.html
Phone Number: (919) 956-4000

- ***Duke Healthcare System***

The Duke Healthcare System offers the service of Sexual Assault Nurse Examiners (SANEs), who collect evidence from victims of sexual assault who present in the Emergency Departments of Duke and Durham Regional Hospitals.

Website: http://www.dukehealth.org/services/emergency/programs/emergency_medicine_and_trauma_center
Phone Number: (919) 684-2413; (919) 470-4000

Section 9.04 *Child maltreatment*

Overview

Child maltreatment includes all types of abuse and neglect of children under the age of 18, by a caregiver or custodian (e.g., parent, sibling, teacher, coach, or clergy). There are four major types of child maltreatment; physical abuse (use of physical force against a child, including hitting, kicking, shaking, and burning), sexual abuse (engaging in sexual acts with the child, including fondling, rape and vicarious exposure to sexual acts), emotional abuse (behaviors that harm a child's self-worth including name calling, shaming, ridicule, rejection, threatening and withholding care or love) and neglect, which is the failure to address a child's basic needs including housing, food, clothing, education, supervision and access to medical care.

Effects of child abuse and neglect last over a lifetime and may be passed on to the next generation. One-third of abused children grow up to continue patterns of inept, neglectful, or abusive parenting. A forty-year study of abused and neglected children found that half of these children had been convicted as adults of serious crimes, were mentally ill, had substance abuse problems, or died at an early age.[106] Child abuse increases an individual's chances of delinquency and adult criminality (including violent crimes) by over 40 percent.[107]

Child maltreatment has many negative acute and long-term effects on health. The CDC's most recent fact sheet reports that maltreated children often suffer immediate physical injuries including cuts, bruises, burns, and broken bones. In addition, maltreatment causes stress that can disrupt early brain development.[108] Extreme stress can harm development of the nervous and immune systems.[109] As a result, abused or neglected children are at higher risk for health problems as adults. These problems include alcoholism, depression, drug abuse, eating disorders, obesity, high-risk sexual behaviors, smoking, suicide and other chronic diseases.[110,111]

Child maltreatment risk factors include age of the child, family environment and community. According to the CDC 2010 Fact Sheet[112], children under 4 years of age are at greatest risk for severe injury and death from maltreatment. Abuse and neglect often occurs in families where there is a great deal of stress sustained over long periods of time. The stress can result from a family history of violence, substance abuse, unemployment, poverty, isolation and chronic health problems. Children who are disabled and developmentally challenged or are medical fragile have a higher incidence of abuse and neglect. Families that do not have nearby friends, relatives and other social support are at risk. On-going violence in communities creates an environment where child abuse is more prevalent. Very often, children who are maltreated have more than one form of abuse that they have to deal with (multiple traumas). In other words, some children are in situations where they are being physically and/or sexually abused, have witnessed a homicide or suicide and are separated from their family. These multiple negative exposures can have significant long-term damaging effects on their development and ability to lead healthy, active lives.

Healthy North Carolina 2020 Objective

There is not a Healthy NC 2020 Objective on Child Maltreatment.

Secondary Data: Major Findings

Table 9.04(a) presents the number of reports of abuse and neglect for Durham County compared to North Carolina collect by the Jordan Institute for Families, UNC-CH School of Social Work. Over this period (FY 2004-2005 to FY 2009-2010), the number of reports of abuse and neglect for Durham County peaked in FY 2008-09 and for North Carolina, peaked in FY 2007-08.

Table 9.04(a):

Reports of Child Abuse and Neglect in Durham County and NC by Fiscal Year (FY)*

County/State	FY2004-05	FY2005-06	FY2006-07	FY2007-08	FY2008-09	FY2009-10
Durham County	1,287	1,307	1,203	1,476	1,603	1,494
North Carolina	64,741	64,336	66,459	70,012	67,768	66,680

*http://ssw.unc.edu/ma/ (partial year data is also available for FY2010-11)

When a report about child abuse or neglect is made, Child Protective Services (CPS) decides the next course of action. If CPS decides to investigate the case, a full assessment is made to determine future actions involving the child and family. Reports can be unsubstantiated and are recorded as such. Table 9.04(b) presents the types of maltreatment findings that were reported within Durham County following the completion of a family assessment from FY2004 to FY2010. One family could have multiple types of maltreatment (eg. abuse and neglect). For this period, neglect was the most frequently reported maltreatment type when compared to abuse and neglect and abuse. For this period, abuse and neglect and neglect alone show a decreasing trend in the counts per year; however, services recommended and needed show a general increasing trend for the same time period.

Table 9.04(b):

Durham County: Type of Finding Reported Post Assessment (not exclusive)*

Type	FY2004-05	FY2005-06	FY2006-07	FY2007-08	FY2008-09	FY2009-10
Unsubstantiated	692	248	326	335	320	381
Abuse and Neglect	23	26	21	6	8	5
Abuse	32	30	6	17	35	28
Neglect	230	119	68	108	48	46
Dependency**	1	3	1	1	0	5
Services Needed	17	78	77	60	91	49
Services Recommended	74	162	250	319	249	193
Services Not Recommended	222	641	429	581	719	664
Services Provided, No Longer Needed	0	1	39	58	134	124

*http://ssw.unc.edu/ma/ (a record could be counted within more than one category) ** Dependency means that a child needs assistance or placement because either the child has no parent, guardian, or custodian responsible for their care or the child's parent, guardian, or custodian is not able to provide for the child's care because of physical or mental incapacity.

Primary Data

The 2010 Durham County Community Health Opinion Survey questions that most reflected thoughts related to Child Maltreatment are within the "Quality of Life" and "Community Problems and Issues" survey domains. For the Quality of Life domain, approximately 80% of respondents thought that Durham County is a good place to raise children and about 70% think that there is plenty of help for individuals and families during times of need in Durham County. For the Community Problems and Issues domain, substance abuse and violent behavior were the most significant *risky behaviors* identified by respondents while addiction to alcohol and drugs was rated as one of the most significant *health problems* in the community (see Appendix G for full results of the Community Health Opinion Survey).

Interpretations: *Disparities, gaps, emerging issues*

The data in Table 9.04(c) show pronounced racial and ethnic disparities within Durham County regarding child maltreatment reports. That is, within each fiscal reporting year presented, reports for Blacks were as much as 4 times the number of reports for Whites. Reports for Other Races increased over the time periods presented from 64 reports in FY2004-05 to 239 reports in FY2009-10 (almost a 4 fold increase). In addition, over this period, reports for Non-Hispanics were as much as 5 times the number of reports for Hispanics. Also, over this time period, the data show that reports for 0-5 year olds are 1.5 to 4 times more than reports for children in the other age categories.

Table 9.04(c):

Durham County: Child Abuse and Neglect Reports by Race, Ethnicity, Gender and Age*

Type	FY2004-05	FY2005-06	FY2006-07	FY2007-08	FY2008-09	FY2009-10
Black	872	846	781	994	1104	958
White	347	385	316	305	279	296
Other Races	64	75	105	177	220	240
American Indian**	4	1	1	0	0	0
Non-Hispanic	1092	1085	974	1222	1326	1218
Hispanic	195	222	229	254	277	276
Male	661	658	599	754	816	764
Female	626	649	604	722	787	730
Ages 0-5	609	665	645	769	818	815
Ages 6-12	413	413	362	447	516	481
Ages 13-17	259	213	186	250	262	189
Unknown/Missing	6	16	10	10	7	9

*http://ssw.unc.edu/ma/ (a record could be counted within more than one category)

**Includes Alaskan's

According to the UNC-CH, Jordan Institute for Families website (http://ssw.unc.edu/ma/), for the reporting period from FY 2004 to FY2010, of all children in the custody of Durham County, the percentage of Black children ranged from approximately 79% to 83%. While during the same time period, the percentage of White children and children of other races in custody ranged from 13% to 16% and 4.3% to 4.4%, respectively.

A United States Government and Accountability Office (GAO)[113] survey done in 2008 reported findings that contribute to the proportion of Black children in foster care. They include a higher rate of poverty, challenges in accessing support services, racial bias and distrust, and difficulties in finding appropriate adoptive homes. Furthermore, the survey found that families living in poverty have greater difficulty accessing housing, mental health, and other support services needed to keep families stable and children in safe environments.

Misunderstandings and distrust between child welfare decision makers and the families they serve contributes to this disparity. Black children also stay in foster care longer because of difficulties in recruiting adoptive parents, the lack of services for parents trying to reunify with their children, and a greater reliance on relatives to provide foster care who may be unwilling to terminate parental rights.

According to the report, strategies states use to address this disparity include building community supports, providing cultural competency training for caseworkers, and broadening the search for relatives to care for children. Researchers and officials also stressed the importance of carefully analyzing data to address the proportion of African American children in care.

According to the GAO survey, states viewed federal policies that promote adoption as helpful for reducing the proportion of African American children in foster care.[114] However, they also expressed concerns regarding policies that limit the use preventive services and legal guardianship arrangements. As an alternative to adoption, subsidized guardianship is considered particularly promising for helping African American children exit from foster care.

Foster Care:

There is a critical need for foster families in Durham County, particularly for Black children and sibling groups. Matching the needs of the child to the skills of the foster family requires a wide variety of available foster families – from those who can supply basic foster parenting needs to those are specially trained to house medically fragile children and provide therapeutic foster care. Respite care families can support foster families by providing weekend care or needed breaks to help prevent burnout. It is also critical for foster families to have access to experienced health professionals who can provide immediate consultation and services when needed.

Recommended Strategies

The CDC online Community Guide Book is a comprehensive resource for evidenced-based community intervention strategies (see resource list below). Also, the Guide to Clinical Preventive Services: Report of the U.S. Preventive Services Task Force, offers information on screening for Depression, Suicidal Intent and Violent Injuries. The World Health Organization also has a comprehensive report available (2006) that details prevention and treatment strategies and can be found at http://whqlibdoc.who.int/publications/2006/9241594365_eng.pdf.

Healthy North Carolina 2020 speaks indirectly to this topic by recommending strategies to prevent and reduce injury and violence.[115] For example, the 2020 report states one strategy within schools and child care would be to "establish a social environment that promotes safety and prevents unintentional injuries, violence, and suicide; maintain safe playgrounds, school grounds, and school buses; provide health, counseling, psychological, and social services to meet the needs of students; implement evidence-based healthful living curricula in schools." However, no specific strategies to address child maltreatment are presented in the 2020 report.

Current Programs/Activities

Durham County has several community-based resources available for assisting families and children in need and provides a network of referral services through county, private and related websites. Some of Durham's hallmark programs are briefly described below.

- ***Durham County Department of Social Services***

  The Durham County Department of Social Services (DSS) has a mission to partner with families and communities in achieving well-being through prosperity, permanence, safety, and support. The agency can help meet basic economic needs, provides access to health care and nutrition to improve health status and helps people find jobs, develop strong work habits and create a career path. The agency also invests in the safety and stability of families, the disabled, and the elderly. The main page for their website is located at http://www.co.durham.nc.us/departments/dssv/index.html.

  For general information on foster care and how to become a foster parent visit:

  Website: http://www.co.durham.nc.us/departments/dssv/Family_Support/Foster_Care.html
  Phone Number: (919) 560-8080

  For information on identifying maltreatment or reporting child abuse and neglect visit:
  Website: http://www.co.durham.nc.us/departments/dssv/Family_Support/Child_Protective_Ser.html
  Phone Number: (919) 560-8086

- ***Durham Connects: Growing Healthy Babies***

  Durham Connects is a resource that is housed within the Office of Community Resources. It brings together families, community agencies and healthcare providers together to give babies adequate nutrition, a safe home, educational stimulation, nurturing parents and high quality childcare. Its mission is to increase child well-being by bridging the gap between parent needs and community resources. For example, starting this year, all babies born in the county (and their families) can get up to three nursing visits. During these visits, well baby and the six-week post partum follow-up visits are reinforced. The Durham Connects program also created the GrandParent Network of Durham. The GrandParent Network recruits, trains, and matches Durham residents aged 50 and above with new families looking for an experienced mentor.

  Website: http://www.durhamconnects.org/
  Phone Number: (919) 668-3279

- ***East Durham Children's Initiative (EDCI)***

  Working with residents of the community and other key stakeholders and partners, EDCI is developing a plan to create a continuum of services from birth through high-school to college or career prep. The plan includes such services as:
  - parenting classes, home visits, high quality and affordable child care
  - after school and summer school services
  - library services, housing assistance, financial literacy, social services
  - expansion of wellness centers, adult literacy programs and job training

  Website: http://www.eastdurhamchildrensinitiative.org/
  Phone Numbe (919) 419-3474

- ***Durham's Network of Care***

  Durham's Network of Care is an online resource center for families and children. This site provides a single point of entry for a myriad of services and resources within and outside of the Durham community (e.g., information regarding access to services, child care, community networking, education, employment, financial assistance, mental health care and raising children).

  Website: http://durham.nc.networkofcare.org/family/home/

- ***CDC Community Guide Book***
  The CDC's online Guide to Community Preventive Services is a free resource that suggests effective community interventions for such topics as alcohol use, mental health, social environment and violence. For example, the website presents a recommended intervention for Early Childhood Home Visitation to Prevent Violence.

  Website: http://www.thecommunityguide.org/index.html

Section 9.05 *Human trafficking*

Overview

Human trafficking is a form of modern-day slavery. It greatly affects the most vulnerable of our population: women and children. It involves the act of recruiting, transporting, transferring, harboring or receiving a person through the use of force or threats, coercion, abduction, deception or other means, for the purposes of exploitation. Every year, thousands of men, women and children fall into the hands of traffickers in their own countries and abroad. According to the Polaris Project (a leading organization in the United States that combats all forms of Human Trafficking), more people are held in slavery today than at the height of the transatlantic slave trade. Our communities are not immune from this pervasive crime.

There are two major types of Human Trafficking. The Trafficking Victims Protection Act (TPVA) of 2000 defines sex trafficking and labor trafficking as follows:

- Sex Trafficking is the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act in which the commercial sex act is induced by force, fraud, or coercion, or in which the victim induced to perform such an act is less than 18 years of age.

- Labor Trafficking is the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purpose of subjection to involuntary servitude, peonage, debt bondage, or slavery.

Impact on Health

Victims of Human Trafficking face many physical health risks, including drug and alcohol addiction, physical injuries (broken bones, concussions, burns, vaginal/anal tearing), traumatic brain injury, sexually transmitted infections (e.g., HIV/AIDS, gonorrhea, syphilis), sterility, miscarriages, menstrual problems, TB, hepatitis, malaria, pneumonia, and forced or coerced abortions.[116]

Psychological trauma includes mind/body separation/disassociated ego states, shame, grief, fear, distrust, hatred of men, self-hatred, suicide, and suicidal ideation, Posttraumatic Stress Disorder (PTSD), acute anxiety, depression, insomnia, physical hyper alertness, and self-loathing. Victims may also suffer from traumatic bonding – a form of coercive control in which the perpetrator instills in the victim fear as well as gratitude for being allowed to live.[117]

Human trafficking is a leading source of income for organized crime and other criminal enterprises, bringing an estimated $8 billion to $10 billion a year in profit to the criminal enterprises involved.[118] Asian, Mexican, Central America, Russian and Eurasian gangs are among the major traffickers. After the illegal trade of weapons and illicit drugs, human trafficking is the next most profitable business for organized crime.[119] Though almost all countries are affected in some manner by human trafficking, the majority of victims come from Asian countries.[120] Women from the Eurasian countries and the former Soviet bloc, however, are

considered the largest source of victims for prostitution and the sex industry in Europe and North America.[121]

The problem in the United States has become so serious that President Barack Obama recently declared January "National Slavery and Human Trafficking Prevention Month" to raise awareness about this criminal enterprise that now generates approximately $32 billion dollars annually worldwide (a three-fold increase from dollars generated in 2004).[122]

Healthy NC 2020 Objective

There is not a Healthy NC 2020 Objective on Human Trafficking.

Secondary Data: *Major findings*

The United Nations estimates that at least 600,000 to 800,000 men, women, and children are trafficked across international borders every year, and between 14,500 and 17,500 of those victims are trafficked into the United States.[123] More than 80% of the victims are female and 70% of these victims are forced into the commercial sex trade.[124] The FBI estimates approximately 23% of those trafficked into the United States arrive in the Southeast.[125] Reports of trafficked or potentially trafficked victims have been documented across North Carolina, both in cities and rural areas.

According to a recent (July 2010) WBTV report out of Charlotte, North Carolina ranks 8th, as the most likely place in the United States where trafficking takes place. There are many reasons for this ranking, including the fact that human traffickers take advantage of the I-40, I-85, and I-95 network of highways to recruit, enslave and traffic victims. Traffickers and their victims typically move from one place to another and purposely don't establish roots or ties to the community, so access to major highways and interstates is ideal.

North Carolina is also a top ten agricultural state which attracts approximately 100,000 migrant farm workers (60,000 of which are Latinos) who can also be lured into forced labor and servitude. According to Legal Aid of NC, agricultural production in North Carolina is a 46 billion dollar industry which involves the 5th most farm workers of any state. Unfortunately, this industry remains intertwined with extreme exploitation and, for some, modern-day slavery.

In addition, there are 9 active military bases in North Carolina (2 Air Force, 2 Army, 1 Coast Guard, 3 Marine and 1 Navy), which can serve as magnets to sex traffickers and traders. According to a 2001 report by the Coalition Against Trafficking in Women (sponsored by the National Institute of Justice), sex businesses thrive around military areas in the Southeast.[126] Military personnel create enormous demand for the industry and, according to some accounts, facilitate the proliferation of sex businesses around the bases. For example, some servicemen are reported to be involved in direct trafficking of women from Korea, Vietnam and Japan. In Fayetteville and Greensboro, both within close proximity to Fort Bragg, there are numerous American-owned strip clubs and escort services. According to the report, there were 12 Asian-run massage parlors and health spas operating in Greensboro; and in Fayetteville, up to 13 Asian-run massage parlors, in addition to other numerous Asian bars and sex businesses.[127] In 2004,

and in response to this growing problem on bases, the Pentagon drafted a “court martial” policy to reduce sex trafficking wherever American soldiers, sailors, and airmen are stationed.

In 2007, investigators busted Durham and Raleigh brothels where they suspected women were kept as sex slaves. Detectives also raided a club that year with alleged ties to immigrant traffickers. According to US Immigration and Customs, the number of immigrant girls and women lured to North Carolina with the promise of a better life and then forced to work as prostitutes has risen in recent years.[128] "The average citizen has no idea of the magnitude of the problem that exists here, in our backyard, and which has been growing with time. So we need people to help and report cases," Delbert Richburg, ICE North Carolina Assistant Special Agent in Charge, said. "They sell big lies," he says of the migrant smugglers. "The traffickers seek out teenagers in remote towns in Latin America with the promise of getting jobs in restaurants or caring for children. On arriving here, they keep them captive and isolated." The traffickers usually take the migrants' identification and travel documents and threaten to harm them or their families if they try to escape. Besides finding and prosecuting human traffickers, says Eddie Agrait, ICE Charlotte Resident Agent in Charge, "our job is offering the victims a stable situation and immigration protection."[129]

The good news is that North Carolina passed a bill in 2007 which makes Human Trafficking a felony and offers state assistance to victims.

Primary Data

The Partnership for a Healthy Durham 2010 Community Health Opinion Survey did not directly assess knowledge, issues, or factors pertaining to Human Trafficking. No focus group results on this subject were compiled.

Interpretations: *Disparities, gaps, emerging issues*

Children are highly desired in both sex and labor trafficking and are often exploited in the commercial sex trades, performing the same jobs as adults in prostitution, pornography, and sex tourism. Outside of the illicit sex trade, children are regularly found in domestic service, migrant farm work, hotel or restaurant work, and sweat shops. In 2000, 244,000 American children and youth were estimated to be at risk of child sexual exploitation including commercial sexual exploitation.[130]

Traffickers pray on women and girls who have been coerced to become involved in the commercial sex trade. The traffickers lure them into thinking they could become models or actresses but then quickly force them into sexual servitude. Many of the victims of sex trafficking within the United States are runaways or women who have been kidnapped. According to a recent study, of the 1.6 million missing or abandoned children in the United States, over 40,000 are at risk for sexual endangerment or exploitation.[131]

Victims of labor trafficking, like sexual trafficking victims, are often kept isolated to prevent them from seeking advice or help. Traffickers “coach” them to answer questions with a cover

story about being a student or tourist and are constantly escorted and watched.[132] Victims are often blackmailed using their status as an undocumented alien or participating in an "illegal" industry. People who are trafficked often come from unstable and economically devastated places as traffickers frequently take advantage of vulnerable populations characterized by oppression, high rates of illiteracy, little social mobility and few economic opportunities.[133]

Shocked by trafficking statistics in our state, State Senator Eleanor Kinnaird, drafted Senate Bill 547, a measure that would create a state commission on human trafficking. The bill gives the Governor power to appoint 18 members in various law enforcement roles with a focus on victim assistance (http://www.ncleg.net/Sessions/2011/Bills/Senate/PDF/S547v0.pdf).

Recommended Strategies

Signs of Trafficking

Even though trafficking is often described as a "hidden crime", there are several commonalities that may help identify a trafficking situation. Some red flags to look for include situational indicators and physical indicators.[134] For example, if someone regularly comes to your office or clinic and is always accompanied by someone else, or if you notice that another person always speaks for the individual who shops at your store, or if someone has a lot of unexplained injuries, these are possible indicators that someone may be in a trafficking situation. Victims can appear malnourished or show signs of physical and/or sexual abuse or of having been physically restrained, confined, or tortured.[135] Often victims are fearful, anxious, depressed, submissive or nervous or paranoid.[136] In addition to situational indicators of trafficking, there are also many physical indicators that may be warning signs. These physical indicators include, but are not limited to:

- Barbed wire surrounding a home
- Bodyguards around a home, factory, or business
- Bars on the windows of a home, factory, or business
- Vehicles coming and going from a building at odd hours
- Men coming to and leaving a building at odd hours
- People escorted to and from a building
- Many people loaded into one vehicle and driven somewhere all together[137]

Cyber Trafficking

The internet is also a perfect venue for attracting impressionable youth, loners and runaways, and, for advertising trafficker's victims. Online (network) communities are considered a magnet for the international sex trade via adult services sections.[138] Internet ads draw the innocent into the clutches of the trafficker by offering great jobs for high pay in big cities. They often hide behind the lure of modeling, singing, or acting jobs.[139] Photo sharing sites will often bypass photo printing by allowing operations to disseminate digital photos online for viewing by prospective buyers.[140] Traffickers will also use Chatrooms or social sites such as Facebook or Myspace to recruit or trick youth into joining a trafficking scheme.[141] These sites and blogs help other traffickers to network with each other to barter, trade, and sell their victims.

Individuals Who are Most Likely To Encounter a Victim of Trafficking

Anyone may encounter a victim of trafficking, whether it is a nurse or neighbor. They could be someone you interact with on a daily basis but would never know it. In at least one case in North Carolina, a U.S. Postal Carrier noticed something was wrong at a home on his delivery route and contacted the appropriate law enforcement officers to check it out. Here is a list of some of the individuals who could potentially interact with someone who has been a victim of trafficking:

- **Health care professionals** (e.g., paramedics, doctors, nurses, emergency room personnel, medical clinic personnel, community lay health advisors, etc.)
- **Human service workers** (e.g., social workers, rape crisis advocates, health department workers, department of social services workers, teachers, etc.)
- **Law enforcement** (e.g., local police departments, state highway patrol, sheriff departments, FBI, State Bureau of Investigation, undercover officers, Immigration and Customs Enforcement, airport police officers, etc.)
- **Members of religious communities** (e.g., monks, rabbis, imams, priests, deacons, pastors, etc.)
- **Attorneys** (e.g., Public Defenders, District Attorneys, divorce lawyers, employment lawyers, immigration lawyers, Legal Aid attorneys, etc.)[142]

Current Initiatives & Activities

Trafficking is a large, global problem, but it often remains an invisible issue. There are numerous barriers that contribute to identifying victims, including, but not limited to:

- Trafficking victims can be very hidden
- Victims are kept moving by traffickers
- Lack of awareness of trafficking among general public and health, legal, and human service professionals
- Law enforcement often detains and removes possible victims before they can be interviewed, identified, and assisted by legal counsel[143]

If someone suspects trafficking, local law enforcement departments can be contacted. There is also a National 24/7 Human Trafficking Resource Center at 1.888.373.7888 one call for more information and assistance. Suspected Human Trafficking can also be reported at the National Center's Cyber Tipline at 1-800-the-lost or online at www.CyberTipLine.org. The FBI Human Trafficking Hotline is also available 24/7 at 866.252.6850.

One of the most impactful things we may be able to do is talk to kids about the issue. Trafficking can start with children as young as 12 years old. Improving awareness of the situation can be done by contacting our local elected officials and finding out how to advocate for change.

There are also several websites that provide a wealth of helpful information about Human Trafficking and how to get involved. For example, the Polaris Project (www.polarisproject.org) coordinates a National Human Trafficking Resource Center 24 hours a day, 7 days a week. Their website is very comprehensive and contains information about Human Trafficking, FAQs,

recognizing signs, how to take action (raising awareness, fundraising, and reporting), resources and tools, media kits, press releases and trainings. Their site also includes many links to other information including child labor information, trafficking statistics and laws that are in place to combat trafficking. Other useful websites (some of which include comprehensive reports co-sponsored by law enforcement) include:

- ***Office to Monitor and Combat Trafficking in Persons***

  The Department of State's Office to Monitor and Combat Trafficking in Persons leads the United States' global engagement on the fight against human trafficking, partnering with foreign governments and civil society to develop and implement effective strategies for confronting modern slavery. The Office has responsibility for bilateral and multilateral diplomacy, targeted foreign assistance, and public engagement on trafficking in persons.

  Website: http://www.state.gov/g/tip
  Phone Number: (202) 647-4000 or 1 (800)c877-8339

- ***NC Coalition Against Sexual Assault***
  The North Carolina Coalition Against Sexual Assault is an inclusive, statewide alliance working to end sexual violence through education, advocacy, and legislation. Among other services, the coalition provides information, referrals, and resources to individuals, rape crisis programs, and other organizations.

  Website: http://www.nccasa.org
  Phone Number: (919) 871-1015

- ***NC Victim Assistance Network***
  The North Carolina Victim Assistance Network is a nonprofit 501(c)3 organization founded in 1986. The North Carolina Victim Assistance Network promotes the rights and needs of crime victims by educating North Carolina's citizens and public policy leaders about the devastating impact that crime has on our society.

  Website: http://www.nc-van.org
  Phone Number: (919) 831-2857 or 1 (800) 348-5068 (toll free)

- ***NC Coalition Against Human Trafficking***
  Established in 2004 as a collaboration between the NC Attorney General's Office, NCCASA, and several other organizations, the North Carolina Coalition Against Human Trafficking (NCCAHT) is a group of professionals from multiple fields (including law enforcement, legal services, social services, policy, etc.) that works to raise awareness about human trafficking across North Carolina, support efforts to prosecute traffickers, and identify and assist victims.

  Website: http://humantrafficking.unc.edu/nccaht.html
  Phone Number: 1 (888) 3737-888 (toll free)

Section 9.06 *Homicide*

Overview

According to the Centers for Disease Control and Prevention (CDC), in 2007 over 18,000 people were killed as a result of homicide in the United States. Firearms accounted for 69% of those deaths.[144] The average cost per homicide in the U.S., is $1.3 million in lost productivity and $4,906 in medical cost.[145] In 2008, there were 628 homicides in North Carolina; 68% were caused by firearms.[146] From 2005-2009 in Durham County, homicide was the leading cause of death among 20-39 year olds. Homicide was also the second leading cause of death among 0-19 year olds.[147]

In addition to the immeasurable emotional and psychological impact endured by the victim and perpetrators' families, loved ones and neighborhood, there are far reaching community consequences, such as community fear and disengagement, and the strain on local resources and personnel. The Durham Police Department received 6,496 Priority 1 calls from July 1, 2009 through June 30, 2010 with an average response time of 6:06.[iii] In 2005, the Durham County EMS system responded to an average of 14 gunshot wounds each month.[148] In North Carolina, reported fatal and nonfatal injuries due to firearms resulted in 6,811 visits to the emergency department between 2006 and 2008.[149]

The majority of homicides are committed with a firearm, most often a handgun. In Durham County, 75% of homicides were committed with a firearm. The most commonly reported circumstances in which homicides occurred in Durham County included: arguments/conflicts (37%), precipitated by another crime (36%), drug related (16%) and intimate partner violence (11%). Suspicion of intoxication was reported in 26% of homicides and in most incidences the victims knew the assailant.[150]

Healthy NC 2020 Objective

Injury and Violence

Healthy NC 2020 Objective[151]	Current Durham	Current NC	2020 Target
3. Reduce the homicide rate (per 100,000 population)[152]	10.1 (2005-09)	7.0 (2005-09)	6.7

[iii] Priority 1 Calls: Higher priority calls are handled before lower priority calls. Calls where life or property may be imminently in danger are dispatched first.

Secondary Data

The North Carolina Violent Death Reporting System (NC-VDRS) collects detailed information on deaths that result from violence, such as homicide, suicide, undetermined intent and unintentional firearm deaths. From 2004 – 2009, there were 301 violent deaths from injuries sustained in Durham County. Homicides and suicides comprised the vast majority of the violent deaths. There were 170 homicides (56%) and 117 suicides (39%). This is in contrast to national data whereby suicides outnumber homicides.

From 2001 – 2009, there has been an average of 28 homicides per year in Durham County. The trendline in Figure 9.06(a) illustrates that homicides have slightly decreased over this same time period. In 2009, there were 24 homicides. Nevertheless, similar to the U.S., homicide was the leading cause of death among 20-39 year olds and the second leading cause of death among 0-19 year olds in Durham County (2005-2009).[153]

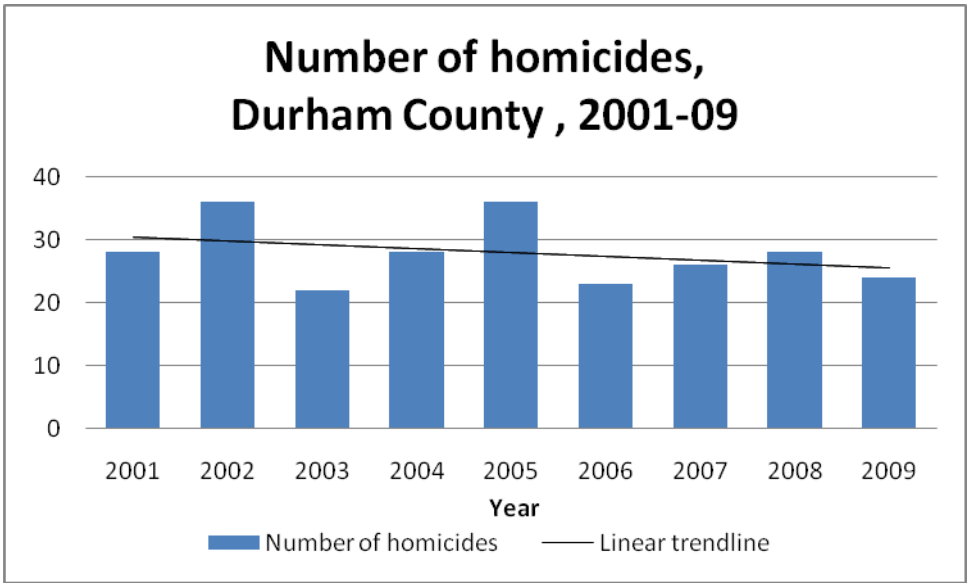


Figure 9.06(a) Number of homicides, Durham County, 2001-09

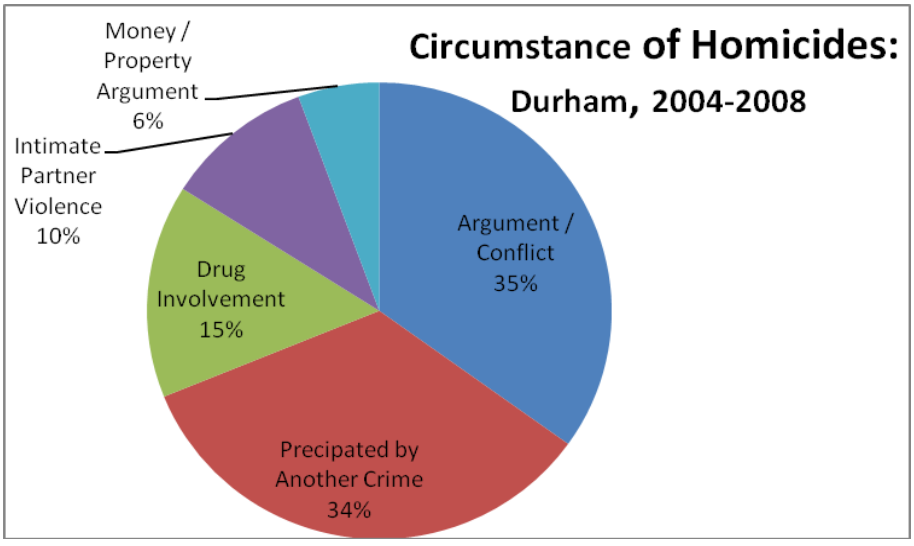


Figure 9.06(b) illustrates the identified and reported circumstances that contributed to homicides in Durham County. Conflicts and circumstances linked to another crime such as robbery, burglary, or drug trafficking accounted for 73% of the homicides.[154] *Figure 9.06(b)*

Circumstances of homicides: Durham, 2004-2008

Criminal activity tends to be more prevalent in certain sections of the city. Figure 9.06(c) illustrates the weighted distribution of violent crime, which includes homicides, within the city limits of Durham in 2009. Red indicates a "hot spot" or high level of violent crimes while yellow indicates medium level and blue indicates a lower level. The two red hotspots on the map are at the intersections of N. Roxboro Street / Old Oxford Road and Holloway St / N. Alston Ave (NC-55).[155]

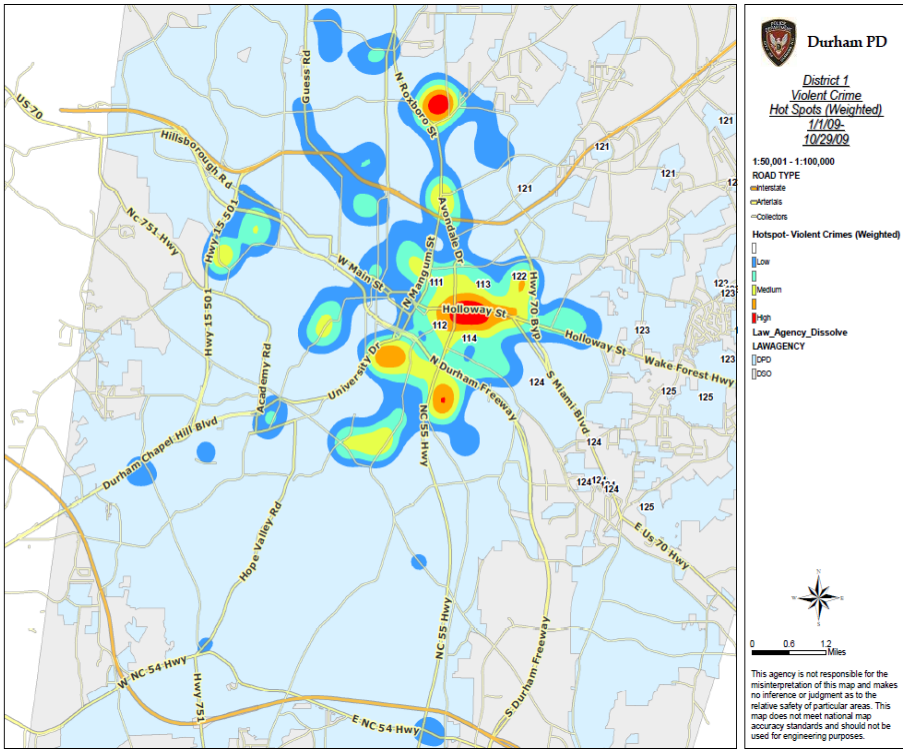


Figure 9.06(c) District 1: Violent Crime Hot Spots (Weighted), 1/1/09 -10/29/09

Figure 9.06(d) displays the average homicide rate over a 5-year period among the most populous counties in North Carolina. The counties with the highest homicide rates that are above the state rate of 6.8 per 100,000 population are Robeson, Durham, Cumberland, Mecklenburg and Guilford counties.

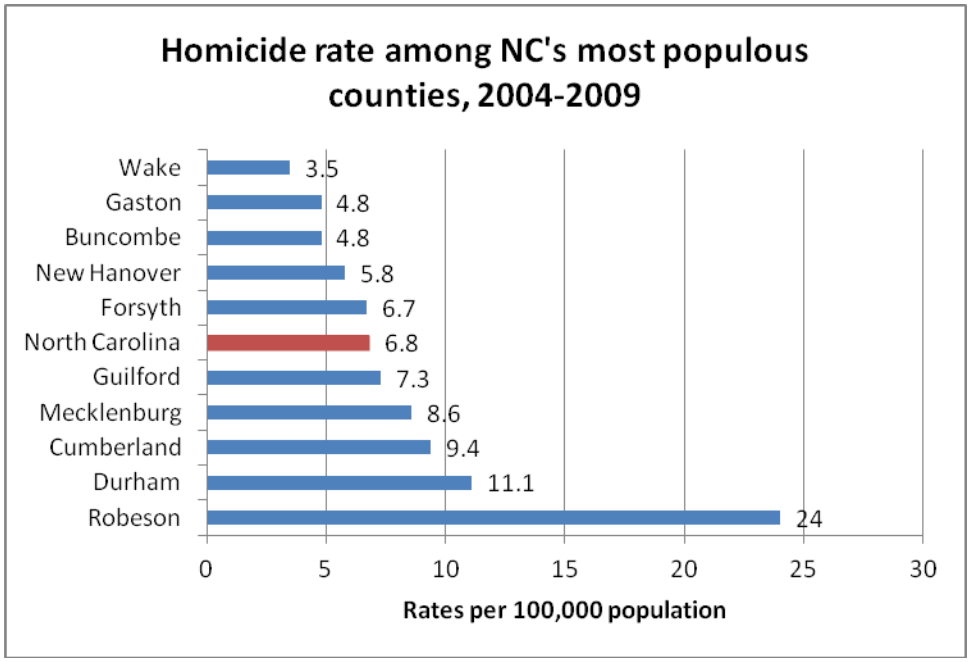


Figure 9.06(d) Homicide rate among NC's most populous counties, 2004-09

Primary Data

Durham County Community Health Opinion Survey

The 2010 Durham County Community Health Opinion Survey randomly selected Durham County households. (Details on survey data collection are in Chapter 1 and all survey results are in Appendix G.) One section of the survey asked respondents to look at several lists and rank their top three neighborhood concerns. For example, one question had a list of 23 community issues. Respondents were told, *"Keeping in mind yourself and the people in your neighborhood, pick the community issues that have the greatest effect on the quality of life in Durham County. Please choose up to 3."* The third most popular response was "gang involvement" (45%) while "violent crime" was chosen by 9% of residents. When residents were asked to choose the top three *health* concerns in their neighborhood, 11.4% of residents chose "gun-related injuries." When residents were asked to choose from a list of 16 *risky behaviors* that had the largest impact on the community, three injury-related topics were in the top four responses. A selection of the injury-related responses from the *risky behaviors* question is summarized by Figure 9.06(e).

Finally, residents were asked, *"What one thing would make Durham County or your neighborhood a healthier place to live?"* The fourth most common response (7.8%) to this open-ended question related to "police presence, reduced crime, neighborhood watch, and gun safety."

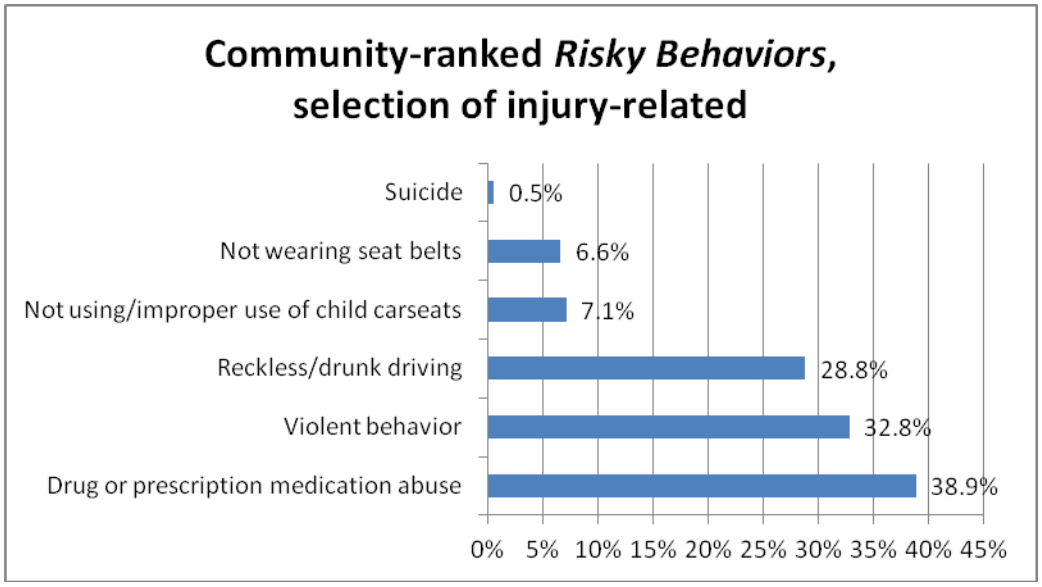


Figure 9.06(e) Community-ranked Risky Behaviors, selection of injury-related

Interpretations: *Disparities, gaps, emerging issues*

Specific groups of individuals are at greater risk of being the victims of a homicide. In general, males and young people ages 24-34 and African Americans are disproportionately impacted. However, race is generally thought to be a marker for other unmeasurable factors related to homicide.

North Carolina: Of all racial/ethnic groups in North Carolina, African Americans and American Indians are at greater risk of homicide, with rates of 15.9 and 20.8 deaths per 100,000 population, respectively, versus 4.4 deaths per 100,000 population for whites. The highest homicide rates are among individuals aged 15-34 years.[156]

Durham County: In Durham County (2004-2007) 86.7% of homicide victims were male.7 African Americans had a homicide rate that was 4.7 higher than whites: 22.6 per 100,000 population compared to 4.8 homicides per 100,000. 8 Young people ages 15-34 accounted for 65.9% of the victims.[157]

Project Safe Neighborhoods (PSN) has been able to identify community educational gaps and emerging issues and respond to those community needs quickly. For example, celebratory gun fire was becoming more common, so PSN began an educational campaign on the dangers of this.

It has been consistently shown that the rate of safely stored firearms increases when a health care provider informs patients and their parents of the risks of having an unlocked gun in the home. By adding unnecessary regulations on health care providers that govern what they can and cannot confidentially discuss in the course of preventive care counseling with patients and their parents, as in the bill No Firearm Questions During Health Exams (Brock and Daniel), tragedies that could have been prevented by a simple conversation will, instead, occur.

Recommended Strategies

Project CeaseFire (Chicago):

CeaseFire is a unique, interdisciplinary, public health approach to violence prevention. We maintain that violence is a learned behavior that can be prevented using disease control methods. Using proven public health techniques, the model prevents violence through a three-prong approach:

1. Identification & detection
2. Interruption, Intervention, & risk reduction
3. Changing behavior and norms

Boston Gun Project and Project Safe Neighborhoods in Durham:

The Boston Gun Project is a recommended evidence-based project; however, Project Safe Neighborhoods in Durham emulates many of the program's facets, such as:

- *STARS (Strategies to Abate and Reduce Senseless Violence) Notifications* identify repeat offenders with a history of violence and gun possession. These felons are called in quarterly for notification sessions, where they hear from both the community and law enforcement. The message is simple: Put down illegal guns, stop the violence, and stop involving juveniles in crime. The community offers assistance to those willing to make a change. Notified offenders who continue to engage in violent behavior are targeted for Federal prosecution.

- *The Community Response to Violent Acts* consists of a door-to-door canvassing of the neighborhood where the crime occurred that is conducted by the Durham Police Department, partnering agencies organizations, and concerned citizens.

- *Gun Crime Reviews* analyze all arrests involving possession of a firearm by a team of law enforcement officers and prosecutors to determine the best venue for prosecution.

- *Youth and Parent Workshops* are coordinated by Project Safe Neighborhoods to educate parents and young people about the dangers of at-risk lifestyles and the dangers of gang involvement.

- *Youth and Family Support* is provided to Durham families in need of accessing appropriate community resource services. The Project Safe Neighborhoods Outreach Coordinator connects families to service providers and serves as an advocate for them.

- *The NC Child Response Initiative Team* is a community collaborative program of police officers and mental health clinicians, dedicated to reducing the effects of violence and

trauma for children and their families in Durham County.

Operation Bulls Eye:

In May 2006, the densest two square mile area in the city was analyzed for "Sound of Shots" calls for service. When police data was analyzed for a one-year period from May 1, 2006 to April 30, 2007 it was discovered there was a spatial correlation between shots fired calls, violent gun crimes and validated gang members, and a disproportionate number in all three categories was located in a similar area of East Durham. In response, the Police Department embarked on a year-long initiative from August 1, 2007 to July 31, 2008 called "Operation Bull's Eye." The primary goal of the initiative was to reduce the occurrence of violent activity in the area. Although shots fired calls were relatively unchanged, violent crime dropped 28.3 percent overall from 339 to 243 incidents. In 2010, the Crime Analysis Unit issued the Bull's Eye Year 3 progress report. Shots fired calls in the target area dropped 50 percent from the 1-year period prior to the initiative, and violent gun crimes declined 57 percent.

Current Initiatives & Activities

- ***Project Safe Neighborhoods***

Law enforcement and the community work to change the norms that make gun violence acceptable through targeted outreach efforts and public awareness campaigns.

Website: www.durhampolice.com/psn
Phone Number: (919) 560-4438, ext. 29230

- ***Gang Resistance Education and Training (GREAT)***

Programs addressing gang violence and teaches resistance and positive alternative to gangs.

Website: http://www.great-online.org
Phone Number: (919) 201-6029

- ***Durham County Gun Safety Team***

Established by the Durham County Board of Health in 1999. The mission is to reduce death and injury related to firearms through education and outreach and promote safe (violence free) environment for our children.

Website: www.durhamcountync.gov
Phone Number: (919) 560-7765

- ***North Carolinians Against Gun Violence***

Educate the public in preventing gun violence and keeping North Carolinians safe from gun violence through education, enforcement, and enactment.

Website: www.ncgv.org
Phone Number: (919) 403-7665

Section 9.07 *Harassment and bullying*

While there are laws that provide protections against workplace and sexual harassment, this section focuses on youth. It is from the perspective of the public school system and references matters of school age children in Durham's Local Education Agency.

Overview

Harassment and bullying include, but are not limited to, acts reasonably perceived as being motivated by any actual or perceived differentiating characteristic, such as race, color, religion, ancestry, national origin, gender, socioeconomic status, academic status, gender identity, physical appearance, sexual orientation, or mental, physical, developmental, or sensory disability, or by association with a person who has or is perceived to have one or more of these characteristics.

Bullying or harassing behavior can occur in the form of:

- physical acts
- threatening communications,
- a pattern of gestures or written, electronic, or verbal communications

Harassment and bullying are often seen as a part of the school environment and are relegated to the school community and not the general community. Bullying, however, can impact the larger community with violence and acts of suicide. North Carolina is one of 45 states with anti-bullying legislation. The North Carolina School Violence Prevention Act gives students, parents, teachers, school administrators and community partners the strength of state law to address harassment and bullying. The School Violence Prevention Act was signed into law in June 2009 and took effect at the start of the 2009-2010 school year. It aims to reduce incidences of "bullying and harassing behaviors" in public schools by:[158]

> (1) Establishing a general prohibition on such activity; and
>
> (2) Requiring all school boards to adopt a policy providing procedures for reporting and investigating, and consequences for "bullying and harassing behaviors.

More specifically:

- No student or school employee shall be subjected to bullying or harassing behavior by school employees or students.
- No person shall engage in any act of reprisal or retaliation against a victim, witness, or a person with reliable information about an act of bullying or harassing behavior.
- A school employee who has witnessed or has reliable information that a student or school employee has been subject to any act of bullying or harassing behavior shall report the incident to the appropriate school official.
- A student or volunteer who has witnessed or has reliable information that a student or school employee has been subject to any act of bullying or harassing behavior should report the incident to the appropriate school official.

In Durham Public Schools, policies 4411 & 5126 (Bullying and Harassment Policy) shall be distributed annually in the Durham Public Schools Student Handbook and the Durham Public Schools Employee Handbook. At the beginning of each school year principals shall provide copies of these policies to school personnel and parents or guardians of all students.[159],[160]

Harassment and Bullying are defined broadly by the statute as activities that either:
(1) place a student or school employee in fear of harm to him/herself or his/her property or
(2) create (or is certain to create) a hostile environment by substantially interfering with a student's educational performance or opportunities or benefits.

Impact on health

Victims of harassment and bullying may experience stress-related illness, physical and emotional symptoms, including depression, anxiety, fatigue, pain and frequent colds. Youth who are subjected to bullying often receive poor grades, have lower self-esteem, more health problems, use alcohol and drugs, and struggle with weight management issues. Mental health services may be required and these also impact families, friends, and agencies that aim to serve youth and their families.

Healthy NC 2020 Objective

There is not a Healthy NC 2020 Objective on harassment or bullying.

Secondary data: *Major findings*

Many school districts collect data on office discipline referrals and the reason for the referral, which may involve harassment and bullying. Durham Public Schools Policy requires investigations of all reported incidents. According to district data office, discipline referrals reflect very few reported cases related to harassment and bullying behaviors. In 2008, there were more than 5,000 incident reports for suspension at all school levels. However, fewer than 3% are related to bullying and harassment.

There is data to support that many of the youth suicides nationwide are often connected to the results of victimization through acts of harassment and bullying. Suicide is the third leading cause of death for young people ages 12–18.[161] In a typical 12-month period, nearly 14% of American high school students seriously consider suicide; nearly 11% make plans about how they would end their lives; and 6.3% actually attempt suicide.[162] Both victims and perpetrators of bullying are at a higher risk for suicide than their peers. Children who are both victims and perpetrators of bullying are at the highest risk.[163]

Primary Data

Nationally:

During the 2007–2008 school year, 32% of the nation's students ages 12–18 reported being bullied.[164] Of these students:

- 21 percent said they were bullied once or twice a month.
- 10 percent reported being bullied once or twice a week.
- 7 percent indicated they were bullied daily.
- Nearly 9 percent reported being physically injured as a result of bullying.

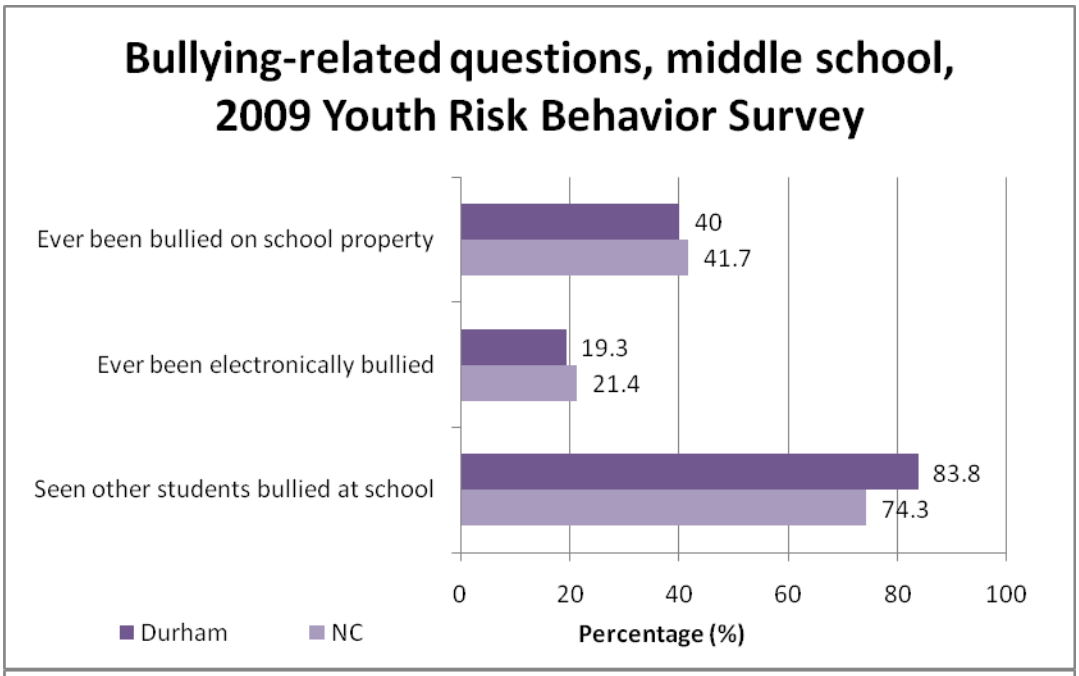
2009 Youth Risk Behavior Survey (YRBS): [165]

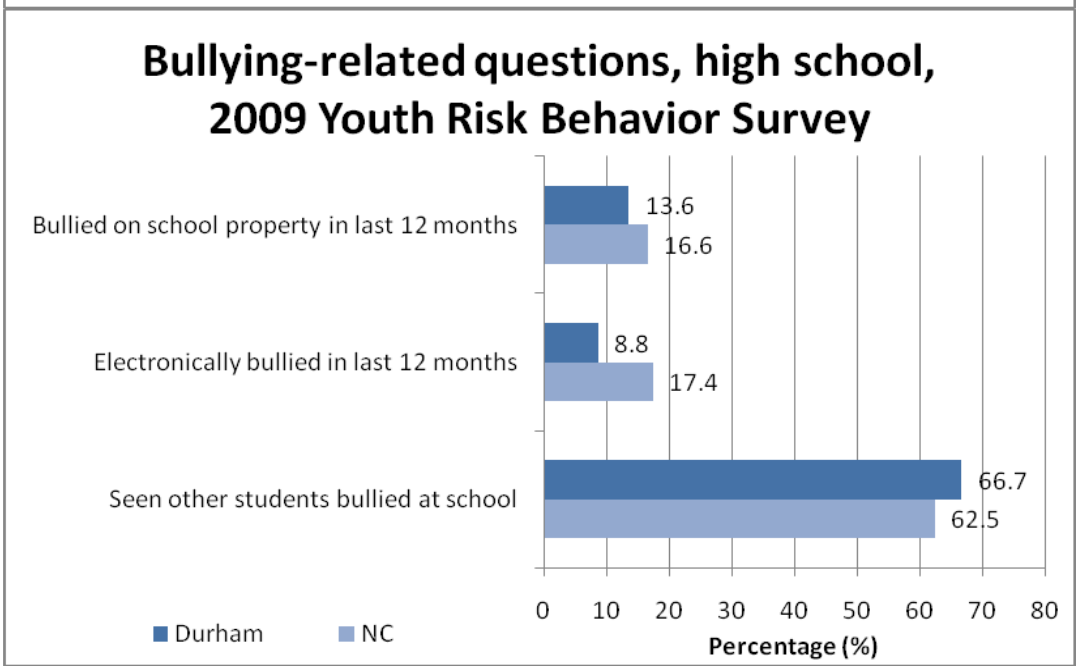
The Youth Risk Behavior Survey (YRBS) was given to randomly selected classrooms of middle and high school students in Durham Public Schools. The YRBS is a CDC survey designed to monitor priority risk behaviors related to tobacco use, unhealthy diet, inadequate physical activity, alcohol and other drug use, unintended pregnancy and sexually transmitted diseases, and unintentional injuries and violence. The full results are available at www.healthydurham.org or at these links: full report summary reports

The YRBS data shows that Durham's middle school students were less at-risk for behaviors related to weapons, bullying at school, abuse of prescription drugs, and sex education. Moreover, Durham middle school students, when compared with statewide results, perceived that teachers and other school personnel cared and offered encouragement. However, since 2007, Durham middle school students have regressed with regard to seat belts, bullying, and cigarette smoking.

The two charts below summarize the results from questions given to middle and high school students related to bullying and harassment. This topic was introduced on the survey with the following text, "The next 3 questions ask about bullying. Bullying is when 1 or more students tease, threaten, spread rumors about, hit, shove, or hurt another student over and over again. It is not bullying when 2 students of about the same strength or power argue or fight or tease each other in a friendly way." The following are the statistically significant results:

- Female middle school students were more likely than expected to have been electronically bullied
- Durham middle school students were more likely to report *seeing other students* bullied at school compared to North Carolina middle school students
- Male middle school students were more likely than expected to have been threatened or injured with a weapon on school property
- Durham high school students were less likely to report being bullied at school compared to students in the Central Region of North Carolina.





Figures 9.07(a) and (b) YRBS Results

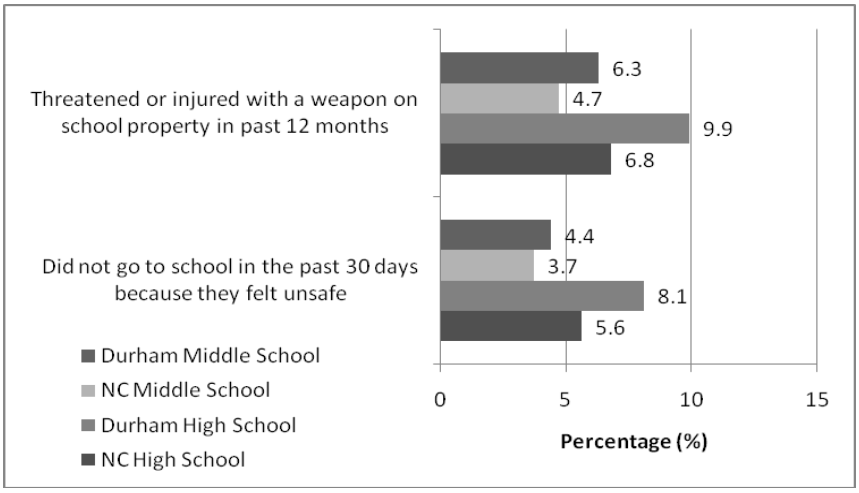


Figure 9.07(c) YRBS Results

Community Health Opinion Survey:[166]

The 2010 Durham County Community Health Opinion Survey randomly selected Durham County households. Of the 207 households surveyed, 45, or 21.8%, had children between the ages of 9 and 19 living in them. Of these households with children, 35.6% of respondents felt that their children could benefit from more information about violence prevention, such as bullying and gang violence.

Interpretations: *Disparities, gaps, emerging issues*

Cyberbullying has become a new method of harassing and bullying individuals. While traditional modes of bullying often occur face to face in the school environment and have witnesses, cyber-bullying uses technology such as computers, cell phones and other electronic devices. Studies have shown that cyberbullying peaks around the end of middle school and the beginning of high school. Victims of cyber-bullying are also at risk for depression. One study found that victims of cyber-bullying had higher levels of depression than victims of face-to-face bullying.[167]

North Carolina has legislation prohibiting cyberbullying.

State	Cyber-stalking	Cyber-harassment	Cyber-bullying
North Carolina	N.C. Gen. Stat. §§ 14-196.3	N.C. Gen. Stat. §§ 14-196(b)	N.C. Gen. Stat. §§ 14-458.1, 115C-407.15-17

AN ACT PROTECTING CHILDREN OF THIS STATE BY MAKING CYBER-BULLYING
A CRIMINAL OFFENSE PUNISHABLE AS A MISDEMEANOR
14-458.1. Cyber-bullying; penalty.
(a) Except as otherwise made unlawful by this Article, it shall be unlawful for any person to use a computer or computer network to do any of the following:
(1) With the intent to intimidate or torment a minor:
a. Build a fake profile or Web site;
b. Pose as a minor in an Internet chat room; an electronic mail message; or an instant message;
c. Follow a minor online or into an Internet chat room; or
d. Post or encourage others to post on the Internet private, personal, or sexual information pertaining to a minor.

Special populations

Research indicates that harassment and bullying behaviors often disproportionately impact special populations such as gay, lesbian, bisexual and transgender (GBLT) individuals, students with disabilities and those with conditions affecting their appearance.

GLBT youth experience more bullying (including physical violence and injury) at school than their heterosexual peers. GLBT youth also attempt suicide at a rate two to four times higher than that of their heterosexual peers.[168] In the words of one expert, GLBT adolescents "must cope with developing a sexual minority identity in the midst of negative comments, jokes, and often the threat of violence because of their sexual orientation and/or transgender identity."[169] While trying to deal with all the challenges of being a teenager, GLBT teens have to also deal with harassment, threats, and violence directed at them on a daily basis. They hear anti-gay slurs such as "homo", "faggot" and "sissy" about 26 times a day or once every 14 minutes. The mental health and education, not to mention physical well-being, may be at-risk for GLBT students.

Recommended Strategies

Harassment and bullying are serious issues that every school in the nation confronts. Research indicates that more than half of all school-aged children nationwide will be involved in bullying this year as a victim or a perpetrator and that many more witness bullying acts on a regular basis. Parents, schools and community organizations must take active roles to work collaboratively to educate and create messages of anti-harassment and bullying prevention. The best approach is a comprehensive effort that helps end physical, verbal and technological harassment and adds violence prevention with anti-bullying measures.

The following action steps are quoted directly from the Suicide Prevention Resource Center's fact sheet on suicide and bullying:[170]

- Start prevention early. Bullying begins at an age before many of the warning signs of suicide are evident. Intervening in bullying among younger children, and assessing both bullies and victims of bullying for risk factors associated with suicide, may have significant benefits as children enter the developmental stage when suicide risk begins to rise.

- Keep up with technology. Bullying often takes place in areas hidden from adult supervision. Cyberspace has become such an area. At the same time, young people may also use social media and new technologies to express suicidal thoughts that they are unwilling to share with their parents and other adults. Both bullying prevention programs and suicide prevention programs need to learn how to navigate in this new world.
- Pay special attention to the needs of LGBT youth and young people who do not conform to gender expectations. These youth are at increased risk for both bullying victimization and suicidal behavior. It is essential to respond to the needs of these young people, especially the need for an environment in which they feel safe, not just from physical harm, but from intolerance and assaults upon their emotional well-being.
- Use a comprehensive approach. Reducing the risk of bullying and suicide requires interventions that focus on young people (e.g., mental health services for youth suffering from depression) as well as the environment (especially the school and family environments) in which they live.

The important thing to remember is bullying prevention is not just for the schools, but the entire community. Community activists at every opportunity can create events that encourage peer leaders to become trained in how to recognize, stop and report bullying.

Current Initiatives & Activities

- ***Durham Public Schools***

Durham Public Schools has several initiatives that aim to address bullying and harassment in the schools. Some of these are listed below.

Website: http://www.dpsnc.net/
Phone Number: (919) 560-2000

- A Bullying Tips and Hotline is planned for the 2011-2012 school year. School Security and Student Support Services will partner to ensure that acts of harassment and bullying can be reported anonymously.
- Year-long district level Anti-Bullying Campaign
- Annually school counselors (or counselor teams) complete Anti-Bullying projects which can consist of one or several of the following: a school event (assembly presentation, PTA program, etc), students, grade or team projects, contests, and/or instructional programs. Project efforts will be reported to the Office of Student Support Services.
- G.R.E.A.T. Gang Resistance Education and Training
  Our school-based, law enforcement officer-instructed classroom curriculum. With prevention as its primary objective, the program is intended as an immunization against delinquency, youth violence, and gang membership. It targets students in grades 4 and 6.
- Conflict Resolution/Peer Mediation/Bullying Instructional program where students are trained in ways to handle conflict peacefully and to combat bullying. Peer mediation is used to settle conflicts between students. Resources and strategies are provided to school staff in an effort to reduce the number of fights and batteries.

- *SAVE* Students Against Violence Everywhere (SAVE) is an after school club, which focuses on planning and implementing violence prevention activities at the school. Middle Schools are given opportunities to help youth start early with campus leadership and identification of program and school efforts that improve the school climate and culture.
- School Support Staff Professional Development In-service training is provided to social workers, counselors, instructional coaches and administrators on prevention topics. These topics include substance use prevention, violence prevention, gang awareness, teen issues, communication skills, conflict resolution, peer mediation, anti-bullying, health education and character education.
- Reconnecting Youth *A Peer Group Approach to Building Life Skills* and helping high-risk youth in grades 9-12 raise grades and manage their anger, while decreasing drug use, depression, and suicide risk. The research-based *RY* curriculum is divided into four major units: Self-Esteem Enhancement, Decision-Making, Personal Control, and Interpersonal Communications.
- Suicide Intervention Training for all counselors, social workers and school psychologist; ASIST (Applied Suicide Intervention Skills Training) for counselors and social workers

Additional Information and Resources

Stop Bullying.gov is an official U. S. government Website managed by the Department of Health and Human Services in partnership with the Department of Education and Department of Justice. www.stopbullying.gov.

Special Edition on Bullying at School and Online gives parents the tools they need to intervene in informed and effective ways. It includes more than 30 original articles, video clips, quizzes, online workshops, community forums and quick-fact lists, all available free-of-charge http://www.education.com/special-edition/bullying/ .

Addressing Bullying in Schools: An Introduction to the Olweus Bullying Prevention Program Susan P. Limber, Ph.D.Clemson University. Retrieved from: http://www.dropoutprevention.org/downloads/docs/webcast/20080527/slides_20080527.pdf.

The ABCs of Bullying Addressing, Blocking, and Curbing School Aggression. Retrieved from: http://pathwayscourses.samhsa.gov/bully/bully_1_pg1.htm.

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9.06	Homicide	Jennifer Snyder, MA	Durham Police Department, Project Safe Neighborhoods Coordinator
9.06	Homicide	Jackie Kaufman, ANP	Durham County Gun Safety Team, North Carolinians Against Gun Violence Education Fund
9.06	Homicide	Scott Proescholdbell, MPH	NC Division of Public Health, Chronic Disease and Injury Section, Head, Injury Epidemiology and Surveillance Unit
9.06	Homicide	Tamera Coyne-Beasley, MD, MPH, FAAP, FSAHM	NC Child Health Research Network, Director; Community Engagement NC TraCS Institute - Child Health Core, Associate Director; UNC-CH, Professor of Pediatrics and Internal Medicine
9.06	Homicide	Joanie Ross, R.H.Ed.	Durham County Health Department, Health Promotion, Injury Prevention

9.06	Homicide	Gail Neely	North Carolinians Against Gun Violence, Assistant Director
9.07	Harassment and bullying	Michelle H. Smith	Durham Public Schools, Student Services Office

Data Sources

[1] Centers for Disease Control and Prevention (CDC). Web-based Injury Statistics Query and Reporting System (WISQARS™). Centers for Disease Control and Prevention website. http://www.cdc.gov/ncipc/wisqars/default.htm. Accessed May 12, 2011.
[2] North Carolina Institute of Medicine. *Healthy North Carolina 2020: A Better State of Health*. Morrisville, NC: North Carolina Institute of Medicine; 2011. http://publichealth.nc.gov/hnc2020/docs/HNC2020-FINAL-March-revised.pdf. Accessed September 15, 2011.
[3]Finkelstein EA, Corso PS, Miller TR. Incidence and Economic Burden of Injuries in the United States. New York: Oxford University Press; 2006.
[4] North Carolina Institute of Medicine. *Healthy North Carolina 2020: A Better State of Health*. Morrisville, NC: North Carolina Institute of Medicine; 2011. http://publichealth.nc.gov/hnc2020/docs/HNC2020-FINAL-March-revised.pdf. Accessed September 15, 2011.
[5] North Carolina Institute of Medicine. *Healthy North Carolina 2020: A Better State of Health*. Morrisville, NC: North Carolina Institute of Medicine; 2011. http://publichealth.nc.gov/hnc2020/docs/HNC2020-FINAL-March-revised.pdf. Accessed September 15, 2011.
[6]Bureau of Labor Statistics. *Table B-1: Fatal occupational injuries by metropolitan area, 2009*. Washington, DC: US Department of Labor, Bureau of Labor Statistics; 2009. http://www.bls.gov/iif/oshwc/cfoi/cfoi_msa_2009.pdf. Accessed October 24, 2011.
[7] North Carolina Injury and Violence Prevention Branch. *10 Leading Causes of Injury Death (All Races, Both Sexes) by Age Groups, North Carolina : 2010*. Raleigh, NC: North Carolina Department of Health and Human Services; 2010. http://www.injuryfreenc.ncdhhs.gov/DataSurveillance/LeadingCausesofInjuryDeathbyAge.pdf. Accessed June 7, 2011.
[8]North Carolina Injury and Violence Prevention Branch. *All Ages: Top 5 Causes of Injury Death, Hospitalization and ED Visits by County, 2007-2009*. Raleigh, NC: North Carolina Department of Health and Human Services; 2009. http://www.injuryfreenc.ncdhhs.gov/DataSurveillance/Top5TablesByCounty2007-2009AllAges.pdf. Accessed June 7, 2011.
[9] Ibid.
[10] Ibid.
[11] North Carolina State Center for Health Statistics. *2007 NC Vital Statistics, Volume 2: Leading Causes of Death. Tables A-F*. Raleigh, NC; North Carolina Department of Health and Human Services; 2008. http://www.schs.state.nc.us/SCHS/deaths/lcd/2007/pdf/TblsA-F.pdf. Accessed August 10, 2009.
[12] Centers for Disease Control and Prevention. Injury Prevention & Control: Traumatic Brain Injury. Centers for Disease Control and Prevention website. http://www.cdc.gov/TraumaticBrainInjury/. Accessed June 12, 2011. Updated October, 2011.
[13] Ibid.
[14] Ibid.
[15] Centers for Disease Control and Prevention (CDC). Bridged-Race Resident Population Estimates United States, State and County
for the years 1990 – 2009. CDC WONDER website. http://wonder.cdc.gov/wonder/help/bridged-race.html. Accessed June 11, 2011.
[16] Ibid.
[17] Harmon, K. *The Burden of Unintentional Poisonings in North Carolina*. Raleigh, NC: North Carolina Department of Health and Human Services, Division of Public Health; 2010. http://www.ncdoi.com/OSFM/Safekids/Documents/OMD/NC_UnintentionalPoisoningData.pdf. Accessed June 11, 2011.
[18] Simons T. *Drug Take- back Programs: Safe Disposal of Unused, Expired or Unwanted Medications in North Carolina*. Coastal Coalition for Substance Abuse Prevention; 2010. http://www.ncdoi.com/OSFM/Safekids/Documents/OMCWhitePaper.pdf. Accessed July 1, 2011.
[19] Ford, M. Unintentional Poisoning in North Carolina: An Emerging Public Health Problem. *North Carolina Medical Journal*. 2010; 71(6): 544

[20] Proescholdbell S, Harmon K.. Epidemiology of Injury and Violence in North Carolina. *North Carolina Medical Journal*. 2010; 71(6):539. http://www.ncmedicaljournal.com/wp-content/uploads/2010/12/71611-web.pdf. Accessed July 1, 2011.
[21] Ibid.
[22] Centers for Disease Control and Prevention (CDC). Web-based Injury Statistics Query and Reporting System (WISQARS™). Centers for Disease Control and Prevention website. http://www.cdc.gov/ncipc/wisqars/default.htm. Accessed May 12, 2011.
[23] North Carolina Poison Center. *Carolinas Poison Center Biennial Report 2008-2009*. Charlotte, NC: North Carolina Poison Center; 2010. http://www.ncpoisoncenter.org/workfiles/CarolinsPoisonCenterReport2010_for%20WEB.pdf . Accessed June 3, 2011.
[24] Ibid.
[25] Centers for Disease Control and Prevention (CDC). Bridged-Race Resident Population Estimates United States, State and County
for the years 1990 – 2009. CDC WONDER website. http://wonder.cdc.gov/wonder/help/bridged-race.html. Accessed June 11, 2011.
[26] Ibid.
[27] Woody J. *The Burden of Unintentional Falls in N.C.* Raleigh, NC: North Carolina Department of Health and Human Services, Injury and Prevention Branch; 2009. http://www.injuryfreenc.ncdhhs.gov/DataSurveillance/2009NCBurdenUnintFallInjury.pdf. Accessed June 11, 2011.
[28] Fuller G. Falls in the Elderly. *Am Fam Physician.* 2000 Apr 1;61(7):2159-2168. American Academy of Family Physicians website. http://www.aafp.org/afp/2000/0401/p2159.html. Accessed June 11, 2011.
[29] Stevens JA, Corso PS, Finkelstein EA, Miller TR. The costs of fatal and non-fatal falls among older adults. *Inj Prev.* 2006 Oct;12(5):290-5.
[30] Ibid.
[31] Centers for Disease Control and Prevention (CDC). Bridged-Race Resident Population Estimates North Carolina State and County Residents only for the years 1990 – 2009. CDC WONDER website. http://wonder.cdc.gov/wonder/help/bridged-race.html. Accessed June 11, 2011.
[32] Ibid.
[33]Russell V, Woody J. *Building for Strength: North Carolina's Strategic Plan for Preventing Injuries and Violence: 2009-2014.* Raleigh, NC: Department of Health and Human Services, Division of Public Health, Injury and Violence Prevention Branch; 2010. http://www.injuryfreenc.ncdhhs.gov/FullIVPStrategicPlan.pdf. Accessed July 7, 2011.
[34] North Carolina State Center for Health Statistics. 2011 County Health Data Book. North Carolina Department of Health and Human Services website. http://www.schs.state.nc.us/SCHS/data/databook/. Accessed August 1, 2011. Published November 2010. Updated March 25, 2011.
[35] 2010 Durham County Community Health Opinion Survey. Partnership for a Healthy Durham website. http://www.healthydurham.org/index.php?page=health_recent. Accessed September 15, 2011.
[36] Ibid.
[37] Russell V, Woody J. *Building for Strength: North Carolina's Strategic Plan for Preventing Injuries and Violence: 2009-2014.* Raleigh, NC: Department of Health and Human Services, Division of Public Health, Injury and Violence Prevention Branch; 2010. http://www.injuryfreenc.ncdhhs.gov/FullIVPStrategicPlan.pdf. Accessed July 7, 2011.
[38] Ibid.
[39] Office of National Drug Control Policy. *Fact Sheet: A Response to the Epidemic of Prescription Drug Abuse*. Washington, DC: Office of National Drug Control Policy; 2010. http://www.whitehouse.gov/sites/default/files/ondcp/Fact_Sheets/prescription_drug_abuse_fact_sheet_4-25-11.pdf. Accessed June 19, 2011.
[40] North Carolina State Center for Health Statistics. 2007 Minority Health data. North Carolina Department of Health and Human Services website. http://www.schs.state.nc.us/SCHS/data/minority.cfm. Accessed June 19, 2011.
[41] Office of Healthy Carolinians and Health Education. Evidence-based Resources and Promising Practices (Draft). North Carolina Department of Public Health. Updated April 20, 2011.

[42] Centers for Disease Control and Prevention (CDC). *Preventing Intimate Partner and Sexual Violence: Program activities guide*. Atlanta, GA: Centers for Disease Control and Prevention; 2010. http://www.cdc.gov/violenceprevention/pdf/IPV-SV_Program_Activities_Guide-a.pdf. Accessed July 1, 2011.
[43] Centers for Disease Control and Prevention (CDC). *Sexual Violence Prevention: Beginning the dialogue*. Atlanta, GA: Centers for Disease Control and Prevention; 2009. http://www.cdc.gov/violenceprevention/pdf/SVPrevention-a.pdf. Accessed July 7, 2011.
[44] U. S. Department of Justice, Office for Victims of Crime. *Breaking the Cycle of Violence: Recommendations to improve the criminal justice response to child victims and witnesses*. Washington, DC: U.S. Department of Justice; 1999. www.ojp.usdoj.gov/ovc/publications/factshts/pdftxt/monograph.pdf . Accessed July 7, 2011.
[45] Macy R. J. *Violence against women in North Carolina* .Morrisville, NC: North Carolina Medical Journal; 2010. www.ncmedicaljournal.com/wp-content/uploads/2010/12/71616-web.pdf. Accessed June 30, 2011.
[46] U. S. Department of Justice, Bureau of Justice Statistics: Selected findings. *Female Victims of Violence*. Washington, DC: U.S. Department of Justice, Bureau of Statistics; 2009. http://bjs.ojp.usdoj.gov/content/pub/pdf/fvv.pdf. Accessed July 9, 2011.
[47] Centers for Disease Control and Prevention (CDC). *Preventing Intimate Partner and Sexual Violence: Program activities guide*. Atlanta, GA: Centers for Disease Control and Prevention; 2010. http://www.cdc.gov/violenceprevention/pdf/IPV-SV_Program_Activities_Guide-a.pdf. Accessed July 1, 2011.
[48] Centers for Disease Control and Prevention (CDC). Intimate Partner Violence During Pregnancy A Guide For Clinicians. Centers for Disease Control and Prevention website. http://www.cdc.gov/reproductivehealth/violence/IntimatePartnerViolence/ipvdp_download.htm. Accessed July 1, 2011.
[49] Centers for Disease Control and Prevention (CDC). Intimate Partner Violence Prevention Scientific Information: Risk and protective factors. Risk Factors for Intimate Partner Violence. Centers for Disease Control and Prevention website. www.cdc.gov/Ncipc/dvp/IPV/ipv-risk_protective.htm. Accessed July 1, 2011.
[50]Catalano S, Smith E, Snyder H, Rand M. *Bureau of Justice Statistics: Selected findings*: *Female Victims of Violence*. Washington, DC: U. S. Department of Justice; 2009. http://bjs.ojp.usdoj.gov/content/pub/pdf/fvv.pdf. Accessed July 1, 2011.
[51] Centers for Disease Control and Prevention (CDC). Intimate Partner Violence: Consequences. Cost to Society. Centers for Disease Control Disease and Prevention website. http://www.cdc.gov/violenceprevention/intimatepartnerviolence/consequences.html. Accessed July 7, 2011.
[52] North Carolina Coalition Against Domestic Violence. Homicides. North Carolina Coalition Against Domestic Violence website. http://www.nccadv.org/homicides.htm. Accessed June 20, 2011. Updated 2011.
[53] Elder, R. (2011). *Domestic Violence Death Toll Rises* in The Herald-Sun Tuesday, May 17, 2011 Page C3.
[54] North Carolina Crime Control. *Domestic Violence Task Forces*. Raleigh, NC: North Carolina Crime Control; 2010. http://www.nccrimecontrol.org/div/GCC/50B%20Enforcement.pdf.
[55] North Carolina Coalition Against Domestic Violence. Homicides. North Carolina Coalition Against Domestic Violence website. http://www.nccadv.org/homicides.htm. Accessed June 20, 2011. Updated 2011.
[56] Ibid.
[57] Durham Police Department. *2009 Annual Report.* Durham, NC: Durham Police Department; 2010. http://www.durhampolice.com/pdf/4Q09_accomplishments.pdf. Accessed July 18, 2011.
[58] North Carolina Council for Women. 2009-2010 County Statistics. North Carolina Council for Women website. http://www.councilforwomen.nc.gov/stats.htm. Accessed July 21, 2011.
[59] Angle M, Sharpe L. *Durham County Schools, Youth Risk Behavior Survey – Spring 2009.* Mars Hill, NC: Richard L. Hoffman Center for Assessment and Research Alliances; 2010. http://www.healthydurham.org/docs/2009_Durham_Report_Final%282%29.pdf.
[60] Durham Crisis Response Center Database
[61] Ashcroft J, Daniels D, Hart S. (2004). *When Violence Hits Home: How Economics and Neighborhood Play a Role*. Washington, DC: US Department of Justice, National Institute of Justice; 2004. http://www.ncjrs.gov/pdffiles1/nij/205004.pdf. Accessed August 1, 2011.
[62] City of Durham. Office of Economic and Workforce Development. Income Characteristics – 2000 Census Samples. City of Durham, Office of Economic and Workforce development website. http://www.ci.durham.nc.us/departments/eed/income_char.cfm. Accessed August 1, 2011.
[63] Pew Hispanic Center. Data and Resources: Durham County, North Carolina. Pew Hispanic Center website. http://pewhispanic.org/states/?countyid=37063. Accessed August 13, 2011.

[64] National Coalition of Anti-Violence Programs. Barriers in Addressing LGBT Domestic Violence. National Coalition of Anti-Violence Programs website. http://www.ncavp.org/issues/DomesticViolence.aspx. Accessed August 13, 2011.
[65] Rand M, Harrell E. *Crime Against People with Disabilities, 2007.* Washington, DC: U.S. Department of Justice, Bureau of Justice Statistics; 2009. http://bjs.ojp.usdoj.gov/content/pub/pdf/capd07.pdf. Accessed August 13, 2011.
[66] National Coalition Against Domestic Violence. *Male Victims of Violence*. Washington, DC: National Coalition Against Domestic Violence; 2008. http://www.ncadv.org/files/MaleVictims.pdf. Accessed August 17, 2011.
[67] Oregon Counseling. About Domestic Violence Against Men. Oregon Counseling website. http://www.oregoncounseling.org/Handouts/DomesticViolenceMen.htm. Accessed July 7, 2011.
[68] YWCA Greater Cincinnati. Elder Abuse Including Domestic Violence in Later Life. YWCA website. http://www.ywca.org/site/pp.asp?c=agLGKXNOE&b=1331659. Accessed July 7, 2011.
[69] Centers for Disease Control and Prevention (CDC). Preventing Intimate Partner and Sexual Violence: Program activities guide. Centers for Disease Control and Prevention website. http://www.cdc.gov/violenceprevention/pub/ipv_sv_guide.html. Accessed July 28, 2011.
[70] Centers for Disease Control and Prevention (CDC). Dating Matters: Understanding teen dating violence prevention. Centers for Disease Control and Prevention website. http://www.cdc.gov/violenceprevention/datingmatters.html. Accessed July 28, 2011.
[71] North Carolina State University Women's Center. Sexual Violence Definitions. North Carolina State University website. http://studentaffairs.ncsu.edu/womens-center/?page_id=477. Accessed June 14, 2011.
[72] WomensLaw.org. North Carolina Statutes: Article 7A. Rape and Other Sex Offenses. WomensLaw.org website. http://www.womenslaw.org/statutes_detail.php?statute_id=2172#statute-top. Accessed October 21, 2011.
[73] Rape, Abuse & Incest National Network (RAINN). Statistics. RAINN website. http://www.rainn.org/statistics. Accessed June 14, 2011. Updated 2009.
[74] Centers for Disease Control and Prevention (CDC). Sexual Violence: Definitions. Centers for Disease Control and Prevention website. http://www.cdc.gov/ViolencePrevention/sexualviolence/definitions.html. Accessed October 21, 2011. Updated November 9, 2009.
[75] North Carolina State University Women's Center. Sexual Violence Definitions. North Carolina State University website. http://studentaffairs.ncsu.edu/womens-center/?page_id=477. Accessed June 14, 2011.
[76] U.S. Department of Justice, Office of Justice Programs. *Sexual Assault on Campus: What colleges and universities are doing about it.* Washington, DC: U.S. Department of Justice, National Institute of Justice; 2005. www.ncjrs.gov/pdffiles1/nij/205521.pdf. Accessed July 14, 2011.
[77] Centers for Disease Control and Prevention (CDC). Sexual Violence: Consequences. CDC website. http://www.cdc.gov/ViolencePrevention/sexualviolence/consequences.html. Accessed June 14, 2011.
[78] Rape, Abuse & Incest National Network (RAINN). Recovering from Sexual Assault: Self Care for Friends and Family Members. RAINN website. http://www.rainn.org/get-information/sexual-assault-recovery. Accessed June 14, 2011. Updated 2009.
[79] U.S. Department of Justice, Federal Bureau of Investigation (FBI). *Data Tables 8 & 10.* FBI website. http://www2.fbi.gov/ucr/cius2009/offenses/violent_crime/index.html. Accessed September 7, 2011. Updated September , 2010.
[80] North Carolina Department of Administration. County Statistics. North Carolina Department of Administration website. http://www.nccfwdvc.com/stats.htm. Accessed October 21, 2011.
[81] Rape, Abuse & Incest National Network (RAINN). Recovering from Sexual Assault: Self Care for Friends and Family Members. RAINN website. http://www.rainn.org/get-information/sexual-assault-recovery. Accessed June 14, 2011. Updated 2009.
[82] Rape, Abuse & Incest National Network (RAINN). Statistics. RAINN website. http://www.rainn.org/statistics. Accessed June 14, 2011. Updated 2009.
[83] North Carolina Department of Administration. County Statistics. North Carolina Department of Administration website. http://www.nccfwdvc.com/stats.htm. Accessed October 21, 2011.
[84] Ibid.
[85] Virginia Commonwealth University. Many Say Schools Underreport Sexual Assault. Virginia Commonwealth University website. http://www.capitalnews.vcu.edu/2010/05/many-say-schools-underreport-sexual-assaults.html. Accessed July 27, 2011. Updated May, 2010.
[86] Farson, K. (2011, April). *Sexual assault reports in Durham County, 2000-2010.* Presented at "It's Time!"…For a Critical Conversation, Durham, NC.

[87] Wisconsin Center for Investigative Journalism. Suffering in Silence: Campus sexual assaults underreported. http://uwcampusassaults.wordpress.com/. Wisconsin Center for Investigative Journalism website. Accessed October 21, 2011.
[88] U.S. Department of Education, Office of Postsecondary Education. *The Handbook for Campus Crime Reporting* Washington, DC: U.S. Department of Education; 2005. www2.ed.gov/admins/lead/safety/handbook.pdf. Accessed August 13, 2011.
[89] Duke Police. Annual Clery Campus Security Report 2010-2011. Duke Police website. http://www.duke.edu/police/news_stats/clery.php. Accessed August 13, 2011.
[90] Durham Technical Community College. *2010-2011 Compliance Information*. Durham, NC: Durham Technical Community College; 2011. www.durhamtech.edu/html/aboutdt/CampusPolice2010-11CleryReport.pdf. Accessed September 1, 2011.
[91] North Carolina Central University. Police and Public Safety Department. Annual Crime & Fire Report 2009-2010. North Carolina Central Universiry website. www.nccu.edu/formsdocs/proxy.cfm?file_id=951. Accessed September 1, 2011.
[92] Durham Technical Community College. *2010-2011 Compliance Information*. Durham, NC: Durham Technical Community College; 2011. www.durhamtech.edu/html/aboutdt/CampusPolice2010-11CleryReport.pdf. Accessed September 1, 2011.
[93] Durham Crisis Response Center Database.
[94] Angle M, Sharpe L. *Durham County Schools, Youth Risk Behavior Survey – Spring 2009.* Mars Hill, NC: Richard L. Hoffman Center for Assessment and Research Alliances; 2010. http://www.healthydurham.org/docs/2009_Durham_Report_Final%282%29.pdf.
[95] Rape, Abuse & Incest National Network (RAINN). Statistics. RAINN website. http://www.rainn.org/statistics. Accessed June 14, 2011. Updated 2009.
[96] Wisconsin Center for Investigative Journalism. Suffering in Silence: Campus sexual assaults underreported. http://uwcampusassaults.wordpress.com/. Wisconsin Center for Investigative Journalism website. Accessed October 21, 2011.
[97] Rape Trauma Services. Rape Statistics. Rape Trauma Services website. http://www.rapetraumaservices.org/rape-sexual-assault.html. Accessed October 21, 2011.
[98] Male Survivor. Survivors. Male Survivor website. http://www.malesurvivor.org/survivors.html. Accessed September 5, 2011.
[99] Pew Hispanic Center. Data and Resources: Durham County, North Carolina. Pew Hispanic website. http://pewhispanic.org/states/?countyid=37063. Accessed September 3, 2011.
[100] U.S. Census Bureau. Race for the Population 18 Years and Over 2010, Hispanic or Latino, and Not Hispanic or Latino for the Population 18 Years and Over 2010, & Profile of General Demographic Characteristics:2000. U.S. Census Bureau website. http://factfinder2.census.gov/faces/nav/jsf/pages/index.xhtml. Accessed September 5, 2011.
[101] *Cook, M. A. (2011, April). Supporting lgbtq survivors on campus*. Presented at Bridging the Gaps: A Focus on Innovations, Durham, NC.
[102] The National Center for Victims of Crime. Access for All: North Carolina Office on Disabilityand Health (NCODH). National Center for Victims of Crime website. http://www.ncvc.org/ncvc/main.aspx?dbName=DocumentViewer&DocumentID=47068. Accessed August 31, 2011.
[103] Wisconsin Coalition Against Sexual Assault. *People with Disabilities and Sexual Assault.* Madison, WI: Wisconsin Coalition Against Sexual Assault; 2003. kyasap.brinkster.net/Portals/0/pdfs/Disabilitiesandsexualassault.pdf. Accessed August 31, 2011.
[104] Abramson, W., Emanuel, E., Gaylord, V., & Hayden, M. (Eds.). (2000). *Impact: Feature Issue on Violence Against Women with Developmental or Other Disabilities, 13*(3) [online]. Minneapolis, MN: University of Minnesota, Institute on Community Integration. Available at http://ici.umn.edu/products/impact/133/.
[105] Centers for Disease Control and Prevention (CDC). Rape Prevention and Education (RPE) Program. CDC website. http://www.cdc.gov/violenceprevention/RPE/. Accessed August 31, 2011. Updated July, 2010.
[106] McCord, J. (1983). *A Forty Year Perspective on Effects of Child Abuse and Neglect.* Child Abuse & Neglect, 7, 265-270.
[107] Orange County Health Department and Healthy Carolinians of Orange County. *2003 Orange County Community Health Assessment.* Chapel Hill, NC: Orange County Health Department; 2003. http://www.co.orange.nc.us/health/documents/2003OCHDCHAReport.pdf. Accessed September 7, 2011.

[108] National Scientific Council on the Developing Child. *Excessive stress disrupts the architecture of the developing brain*, Working Paper No. 3 (2005). National Scientific Council on the Developing Child website. www.developingchild.net. Accessed September 7, 2011.
[109] Ibid.
[110] Felitti V, Anda R, Nordenberg D, Williamson D, Spitz A, Edwards V, et al. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventive Medicine*, 1998:14(4), 245–58.
[111] Runyan D, Wattam C, Ikeda R, Hassan F, Ramiro L. *Child abuse and neglect by parents and caregivers.* In: Krug E, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, editors. World Report on Violence and Health. Geneva, Switzerland: World Health Organization, 2002: 59–86.
[112] Centers for Disease Control and Prevention (CDC). *Understanding Child Maltreatment: Fact Sheet*, Atlanta, GA: Centers for Disease Control and Prevention; 2010. http://www.cdc.gov/violenceprevention/pdf/CM-FactSheet-a.pdf. Accessed July 1, 2011.
[113] United States Government Accountability Office (GAO; www.gao.gov), *African American Children In Foster Care, HHS and Congressional Actions Could Help Reduce Proportion in Care*, Testimony Before the Subcommittee on Income Security and Family Support, Committee on Ways and Means, House of Representatives (2008)
[114] Ibid.
[115] North Carolina Institute of Medicine. *Healthy North Carolina 2020: A Better State of Health.* Morrisville, NC: North Carolina Institute of Medicine; 2011. http://publichealth.nc.gov/hnc2020/docs/HNC2020-FINAL-March-revised.pdf. Accessed August 5, 2011.
[116] Department of Health and Human Services, Sex Trafficking Fact Sheet. Department of Health and Human Services website. www.acf.hhs.gov/trafficking. Accessed July 1, 2011.
[117] Ibid.
[118] U.S. Department of Justice, Civil Rights Division. Anti-Trafficking News Bulletin, July, 2004. Trafficking: Prevention and Intervention in North Carolina and Worldwide. U.S. Department of Justice, Civil Rights Division website. http://www.justice.gov/publications/publications_a.html. Accessed July 1, 2011.
[119] Ibid.
[120] Ibid.
[121] Ibid.
[122] International Labor Organization. *A Global Alliance Against Forced Labor*. Geneva, Switzerland: International Labor Organization; 2005. http://www.ilo.org/wcmsp5/groups/public/@ed_norm/@declaration/documents/publication/wcms_081882.pdf. Accessed August 3, 2011.
[123] U.S. Department of Justice, Civil Rights Division. Anti-Trafficking News Bulletin, July, 2004. Trafficking: Prevention and Intervention in North Carolina and Worldwide. U.S. Department of Justice, Civil Rights Division website. http://www.justice.gov/publications/publications_a.html. Accessed July 1, 2011.
[124] Ibid.
[125] University of North Carolina at Chapel Hill's William and Ida Friday Center for Continuing Education. Combating Sex Trafficking: Prevention and Intervention in North Carolina and Worldwide, April 3-4, 2008. University of North Carolina at Chapel Hill's William and Ida Friday Center for Continuing Education website. http://www.fridaycenter.unc.edu/pdep/trafficking/. Accessed July 7, 2011.
[126] Raymond J, Hughes D, Gomez C. *Sex Trafficking of Women in the United States, International and Domestic Trends*. New York, New York: Coalition Against Trafficking Women-International; 2001. http://www.uri.edu/artsci/wms/hughes/sex_traff_us.pdf. Accessed August 4, 2011.
[127] Ibid.
[128] Fox Latino News. *Human Trafficking of Immigrant Women, Girls on Rise in North Carolina*. January 2011. Fox Latino News website. http://latino.foxnews.com/latino/news/2011/01/21/human-trafficking-immigrant-women-girls-rise-north-carolina/. Accessed September 16, 2011.
[129] Ibid.
[130] Estes, Richard J. and Neil A. Weiner. *The Commercial Sexual Exploitation of Children in the U.S., Canada, and Mexico*. Philadelphia, PA: The University of Pennsylvania School of Social Work; 2001. http://www.sp2.upenn.edu/restes/CSEC_Files/Exec_Sum_020220.pdf. Accessed September 16, 2011.

[131] U.S. Department of Justice: Office of Juvenile Justice and Delinquency Prevention. *Runaway/Thrown-away Children: National Estimates and Characteristics*. Washington, DC: NISMART Series; 2002. https://www.ncjrs.gov/pdffiles1/ojjdp/196469.pdf. Accessed September 16, 2011.
[132] Department of Health and Human Services, Labor Trafficking Fact Sheet. Department of Health and Human Services website. www.acf.hhs.gov/trafficking. Accessed August 31, 2011.
[133] Ibid.
[134]U.S. Department of Justice, Federal Bureau of Investigation . *North Carolina Human Trafficking Task Force*. Washington, DC: U.S. Department of Justice, Federal Bureau of Investigation; 2007. http://humantrafficking.unc.edu/files/2011/03/NCHumanTraffickingTaskForceManual.pdf. Accessed August 31, 2011.
[135]The Polaris Project. Recognizing the Signs of Human Trafficking. The Polaris Project website. http://www.polarisproject.org/human-trafficking/recognizing-the-signs. Accessed August 31, 2011.
[136] Ibid.
[137] U.S. Department of Justice, Federal Bureau of Investigation . *North Carolina Human Trafficking Task Force*. Washington, DC: U.S. Department of Justice, Federal Bureau of Investigation; 2007. http://humantrafficking.unc.edu/files/2011/03/NCHumanTraffickingTaskForceManual.pdf. Accessed August 31, 2011.
[138] WBTV.com. The North Carolina Connection to Human Trafficking, July 2010. WBTV.com website. http://www.wbtv.com/global/story.asp?s=11828239. Accessed August 23, 2011.
[139] Ibid.
[140] Ibid.
[141] Ibid.
[142] U.S. Department of Justice, Federal Bureau of Investigation . *North Carolina Human Trafficking Task Force*. Washington, DC: U.S. Department of Justice, Federal Bureau of Investigation; 2007. http://humantrafficking.unc.edu/files/2011/03/NCHumanTraffickingTaskForceManual.pdf. Accessed August 31,
[143] Ibid.
[144] The Centers of Disease Control and Prevention, US Department of Health and Human Services. Web-based fatal injury data, 2007. http://www.cdc.gov/injury/wisqars/fatal.html. Accessed June 20, 2011.
[145] The Centers of Disease Control and Prevention, US Department of Health and Human Services. Injury violence and control. http://www.cdc.gov/injury/index.html. Accessed June 20, 2011.
[146] Coyne-Beasley, T & Lee, AC. Fatal and Nonfatal Firearm Injuries in North Carolina, *NC Med J*. 2010; 71(6): 565-568. http://www.ncmedicaljournal.com/wp-content/uploads/2010/12/71619-web.pdf.
[147] North Carolina State Center for Health Statistics. 2011 County Health Data Book. North Carolina Department of Health and Human Services website. http://www.schs.state.nc.us/SCHS/data/databook/. Accessed August 1, 2011. Published November 2010. Updated March 25, 2011.
[148] Holland WM. Fire/emergency medical services and coping methods: mitigating traumatic stress symptomatology in emergency services professionals. A dissertation submitted to the faculty of Liberty University in partial fulfillment of the requirements for the degree of doctor of philosophy, June 2008. http://digitalcommons.liberty.edu/cgi/viewcontent.cgi?article=1109&context=doctora. Accessed September 1, 2011.
[149] T. Coyne-Beasley, A. C. Lee. *Fatal and Nonfatal Firearm Injuries in North Carolina*. Morrisville, NC: North Carolina Medical Journal; 2010. http://www.ncmedicaljournal.com/wp-content/uploads/2010/12/71619-web.pdf. Accessed July 17, 2011.
[150] North Carolina Injury and Prevention Branch. *Violent Death in North Carolina: Durham County Incidents: 2004-2008.* Raleigh, NC: North Carolina Department of Health and Human Services; 2010. http://www.injuryfreenc.ncdhhs.gov/About/2008CountyFactSheetDurhamFINAL.pdf. Accessed September 12, 2011.
[151] North Carolina Institute of Medicine. *Healthy North Carolina 2020: A Better State of Health.* Morrisville, NC: North Carolina Institute of Medicine; 2011. http://publichealth.nc.gov/hnc2020/. Accessed August 5, 2011.
[152] North Carolina State Center for Health Statistics. 2011 County Health Data Book. North Carolina Department of Health and Human Services website. http://www.schs.state.nc.us/SCHS/data/databook/. Accessed August 1, 2011. Published November 2010. Updated March 25, 2011.
[153] Ibid.

[154] North Carolina Injury and Prevention Branch, North Carolina Department of Health and Human Services. *The North Carolina Violent Death Reporting System (N.C.VDRS)*: *Durham County 2004-2007*. Raleigh, NC: North Carolina Injury and Prevention Branch; March 2010. http://injuryfreenc.ncdhhs.gov/About/DurhamCountyVDRS%20Report2004-2007.pdf. Accessed August 12, 2011. http://www.injuryfreenc.ncdhhs.gov/About/DurhamCountyVDRS%20Report2004-2007.pdf. Accessed October 21, 2011.
[155] Gang Reduction Strategy Data Committee. *2010 Youth and Crime Community Indicator Report.* Durham, NC: Gang Reduction Strategy; 2010.
[156] North Carolina Institute of Medicine. *Healthy North Carolina 2020: A Better State of Health*. Morrisville, NC: North Carolina Institute of Medicine; 2011. http://publichealth.nc.gov/hnc2020/. Accessed August 5, 2011.
[157] North Carolina Injury and Prevention Branch, North Carolina Department of Health and Human Services. *The North Carolina Violent Death Reporting System (N.C.VDRS)*: *Durham County 2004-2007*. Raleigh, NC: North Carolina Injury and Prevention Branch; March 2010. http://www.injuryfreenc.ncdhhs.gov/About/DurhamCountyVDRS%20Report2004-2007.pdf. Accessed October 21, 2011.
[158] SENATE DRS85179-LE-128A (03/25). School Violence Prevention Act. North Carolina General Assembly website. http://www.ncga.state.nc.us/sessions/2011/bills/senate/pdf/s707v0.pdf. Accessed September 21, 2011.
[159] Durham Public Schools. 4411– Bullying / harassment policy. Durham Public Schools website. http://www.dpsnc.net/about-dps/district-policies/524/4411-bullying-harassment. Accessed September 21, 2011.
[160] Durham Public Schools. 5126 - Bullying / harassment policy. Durham Public Schools website. http://www.dpsnc.net/about-dps/district-policies/525/policy-5126-bullying-harassment. Accessed September 21, 2011.
[161] Suicide Prevention Resource Center. *Suicide and bullying: Issue brief.* Newton, MA: Education Development Center, Inc. http://www.sprc.org/library/Suicide_Bullying_Issue_Brief.pdf. Accessed September 22, 2011. Updated March 2011.
[162] Ibid.
[163] Ibid.
[164] Ibid.
[165] Angle M, Sharpe L. *Durham County Schools, Youth Risk Behavior Survey – Spring 2009.* Mars Hill, NC: Richard L. Hoffman Center for Assessment and Research Alliances; 2010. http://www.healthydurham.org/docs/2009_Durham_Report_Final%282%29.pdf.
[166] 2010 Durham County Community Health Opinion Survey. Partnership for a Healthy Durham website. http://www.healthydurham.org/index.php?page=health_recent. Accessed September 15, 2011.
[167] Suicide Prevention Resource Center. *Suicide and bullying: Issue brief.* Newton, MA: Education Development Center, Inc. http://www.sprc.org/library/Suicide_Bullying_Issue_Brief.pdf. Accessed September 22, 2011. Updated March 2011.
[168] Ibid.
[169] Ibid.
[170]Ibid.