

INTIMATE PARTNER VIOLENCE AGAINST WOMEN IN NEW YORK CITY



2008 Report from the
New York City
Department of Health
and Mental Hygiene

Letter from the Commissioners

Dear Fellow New Yorkers,

Intimate partner violence (IPV) threatens the physical and mental health of New Yorkers and their families. In extreme instances, intimate partner violence leads to severe injury and death. Every day New York City Police Officers respond to hundreds of 911 calls for assistance, including IPV fatalities.

While men can be victims of IPV, most documented cases are against women. This report uses a range of data sources to describe the health impacts of IPV on women in New York City. It also highlights the disruption intimate partner violence creates in the lives of victims' friends and family members. Findings and recommendations are presented here to enhance the ability of individuals, policy-makers and program planners to prevent intimate partner violence and reduce the harms of violence when it does occur.

Violence within a relationship is most often a hidden occurrence. We encourage victims of intimate partner violence to come forward and seek the assistance that is available. Victims can reach the New York City Domestic Violence Hotline through 311 or 1-800-621-HOPE, 24 hours a day, 7 days a week. Help is available in 150 languages. Victims who experience IPV in Brooklyn and Queens can also go to the New York City Family Justice Centers for comprehensive assistance. In an emergency, calling 911 can reduce the risk of escalating violence and serious injury. After responding to a call, New York Police Department Domestic Violence Officers make follow-up visits to ensure the safety of victimized family members.

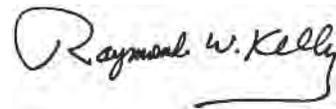
We hope this report, prepared by the New York City Department of Health and Mental Hygiene, is a useful resource as we all work toward making NYC homes safer.



Thomas R. Frieden,
Commissioner
Department of Health
and Mental Hygiene



Yolanda B. Jimenez,
Commissioner
Mayor's Office to
Combat Domestic Violence



Raymond W. Kelly,
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Key Health Findings

While the true extent of intimate partner violence (IPV) among women in New York City (NYC) is unknown, data presented in this report indicate a high burden.

- From 2003 to 2005, nearly half of fatal violence against women (44%) was confirmed to be the result of IPV.
- In 2005, nearly 4,000 NYC women were treated in emergency departments for injuries that they acknowledged were due to IPV. Many more were treated for assault injuries of unknown origin.
- According to anonymous surveys conducted in 2004 and 2005, an estimated 69,000 NYC women ages 18 years and older (2.2% of all adult women) reported fearing an intimate partner.
- Since 1999, physical dating violence reported by public high school females in NYC has risen almost 50%. High school survey data indicate that reported physical dating violence increased from 7.1% in 1999 to 10.6% in 2005.

Women at higher risk of death or injury due to IPV include young women, black and Hispanic women and women who live in neighborhoods with very low median income.

- Compared to teens and older women, women between 20 and 29 years of age were twice as likely to be killed by an intimate partner, to be treated at the hospital or to visit an emergency department for an IPV-related assault.
- Black and Hispanic women were more than twice as likely as women of other racial/ethnic groups to be killed or injured by an intimate partner.
- Women living in neighborhoods with very low median household income had at least twice the IPV-related death, hospitalization and emergency department visit rates compared to women living in higher income neighborhoods.

The type of weapon used varies greatly between fatal and non-fatal IPV.

- Two thirds of IPV-related deaths were the result of assaults by guns or knives.
- Physical force accounted for at least half of IPV-related hospitalizations and emergency department visits; guns and knives were involved in approximately one quarter of IPV-related hospitalizations and in 7% of emergency department visits.

Public high school females who report dating violence and women who report fearing an intimate partner experience more physical and mental health problems than female teens and women who do not.

- Public high school females reporting dating violence were three times more likely to attempt suicide than those who did not report dating violence.
- Women who report fearing an intimate partner had higher levels of asthma and psychological distress than women who do not.
- Binge drinking was twice as high among women reporting fear of a partner.
- Women reporting fear and teens reporting dating violence had much higher levels of risky sexual behaviors, such as having multiple sex partners.

Few women killed by an intimate partner had criminal justice system protections.

- Only 15% of women killed by an intimate partner had a court-issued active Order of Protection.
- Forty-nine percent had a prior Domestic Incident Report.

Introduction

OVERVIEW

In 2004, the New York City Department of Health and Mental Hygiene (DOHMH) established its *Take Care New York* health agenda, which outlines 10 priority health areas. Among these health goals, “Make your Home Safe and Healthy” underscores the importance of living in a home free of intimate partner violence (IPV).

This report, *Intimate Partner Violence Against Women in New York City*, uses multiple health data sources to describe the scope of one type of domestic

violence among NYC women, specifically violence perpetrated by an intimate partner. It details the type of violence against women, highlights the characteristics of IPV victims and examines IPV’s consequences. This report also examines the unique case of IPV among pregnant women. The final section outlines recommendations that stem from the findings. The report aims to inform public health-oriented, IPV-related policies and programs in New York City that focus on awareness, prevention, identification and referral to appropriate services.

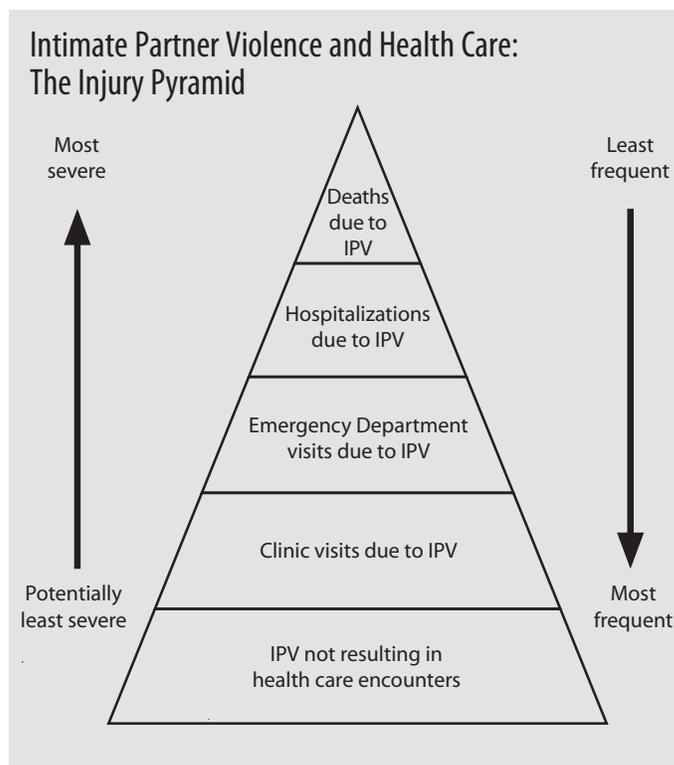
IN THIS REPORT

Intimate partner violence is defined as any violent or coercive behavior, including physical, sexual and psychological abuse, perpetrated by someone who is or was involved in an intimate relationship with the victim. Examples of physical IPV include the use of weapons, slapping, kicking and pushing. Sexual IPV includes forced or unwanted sexual acts. Threatening to hit or to use weapons, continually criticizing and controlling access to family, friends, work and money are examples of psychological IPV.

Men can be victims of IPV. Men and women may perpetrate violence against their partners with similar frequency. However, most documented cases of IPV are perpetrated against women; men are more likely than women to inflict injury on their partners.

Monitoring the health effects of IPV over time is important for tracking the scope of the problem and directing resources to address it. If properly identified and documented, deaths, hospitalizations, emergency department visits, and clinic visits due to IPV can be tracked over time.

The potential severity and frequency of IPV is illustrated by an injury pyramid. At the top of this pyramid is the smallest, most devastating category of women who have been killed by an intimate partner. The next category, more frequent but with less severe, non-fatal outcomes, includes women who, after being injured badly by an intimate partner, are hospitalized for observation, surgery, or other medical care. The third level represents



emergency department visits of women who are treated and released. These women often present to emergency departments with physical injuries such as contusions, broken bones, sprains or stab wounds. Visits to outpatient clinics form the fourth level of the pyramid. Here women often present with chronic conditions, such as gastrointestinal distress or headaches, the underlying cause of which may be IPV. The pyramid’s base marks the most common

but typically least visible category — violence that does not result in encounters with health care systems; it is also the hardest to measure.

This report brings together multiple data sources that roughly correspond to the segments of the injury pyramid just described. It does not include IPV identified in clinic settings, for which data are not readily available. In all data sources, only cases documented as IPV can be studied. Lack of documentation, however, does not necessarily mean lack of violence.

In this report, “women” refers to female teens and adults ages 12 years and older unless otherwise specified. DOHMH defines “intimate” to be either a current or former partner (including husbands,

common-law husbands, boyfriends, girlfriends, lovers, dating partners, etc.), and designates “homicide” as death resulting from injuries sustained through an act of violence committed by another person aimed at causing fear, harm or death. NYPD definitions for “intimate” and “homicide” differ slightly, but are described in the Technical Notes.

All comparisons discussed in the text of this report are statistically significant, unless prefaced with the text, “data suggest.” All rates are age-adjusted to allow for comparisons. Case descriptions drawn from hospital records are integrated throughout the report to augment the quantitative descriptions of IPV.

Intimate Partner Violence in New York City Multiple Data Sources

Agency	Data source	Cases/Population studied	Years for which data are available	
New York City Department of Health and Mental Hygiene (DOHMH)	Female Homicide Surveillance System	Assault-related death records	1999-2005	Data sources are described in full in each section. Additional information is available in the Technical Notes.
	Injury Surveillance System: Hospitalizations	Convenience sample of assault-related hospital records	2002-2003	
	Injury Surveillance System: Emergency Department visits	Convenience sample of assault-related emergency department visits	1999-2005	
	Community Health Survey (CHS)	Population-based sample of adult women residents	2004-2005	
	Youth Risk Behavior Survey (YRBS)	Population-based sample of public high school girls	1999-2005	
Pregnancy Risk Assessment Monitoring System (PRAMS)	Population-based sample of women who delivered a live-born infant	2004-2005		
New York Police Department (NYPD)	Uniform Crime Reports and Murder and Non-negligent Manslaughter Data Domestic Homicide* Data	Female murders Domestic homicides among females	2003-2005	

* NYPD defines domestic homicide as the death of a family member or household member resulting from violence by another family member or household member.

Demographic Characteristics of Women in New York City

Approximately 3.5 million teens and women aged 12 years and older live in New York City. Almost one third live in Brooklyn. The age distribution of women in NYC is similar to the national distribution. Eleven percent are between the ages of 12 and 19; one third (34%) are 50 years of age or older. Compared to the national profile of women, women in NYC are more likely to be non-white, foreign-born and poor.

Number of NYC Women (12+ years): 3,565,773

Borough of Residence

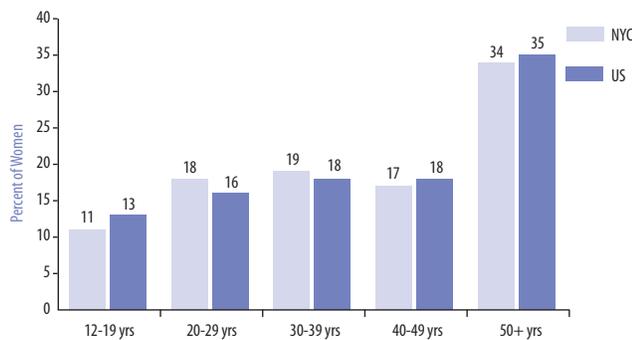
Brooklyn is home to the greatest proportion of women in New York City.

	%	#
Brooklyn	31	1,089,886
Queens	28	986,568
Manhattan	20	720,027
Bronx	16	577,079
Staten Island	5	192,213

Source: US Census 2000/NYC Department of City Planning

Age

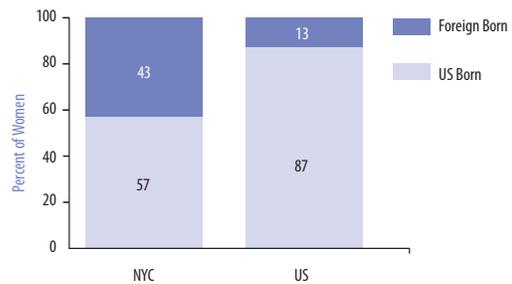
Women (12+ years) in the US and NYC have comparable age distributions.



Source: US Census 2000/NYC Department of City Planning

Immigration Status

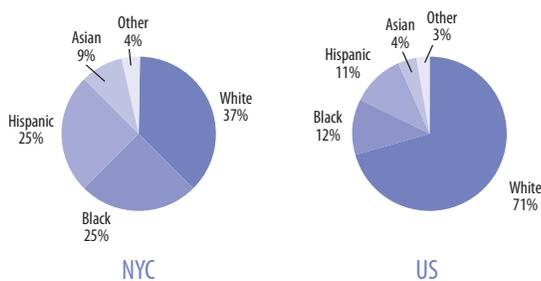
A greater proportion of NYC women (18+ years) are foreign born compared to women nationwide.



Sources: US Census 2000/NYC Department of City Planning

Race

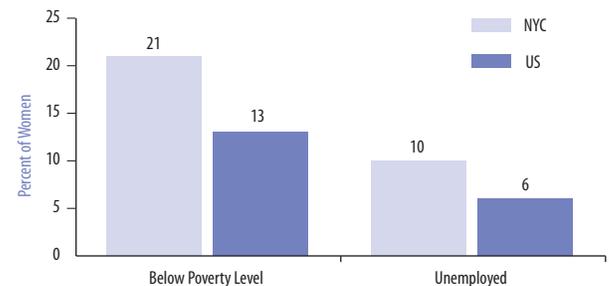
Compared to the US female population, women (12+ years) in NYC are more likely to be black, Hispanic or Asian.



Source: US Census 2000/NYC Department of City Planning

Socioeconomic Indicators

Compared to the US female population, NYC women (16+ years) are more likely to live below the poverty level and to be unemployed.



Sources: US Department of Commerce & US Census 2000/NYC Department of City Planning

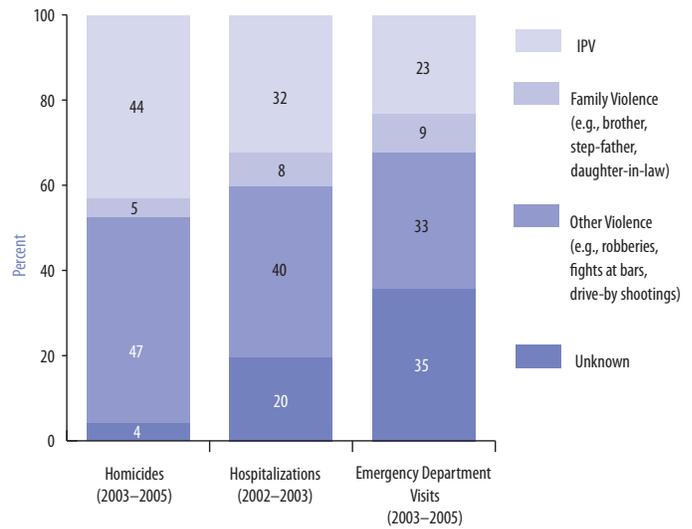
Burden of Intimate Partner Violence-Related Injuries

TYPE OF VIOLENCE

Not all violence against women is perpetrated by an intimate partner. According to recent data, nearly half (44%) of female homicides are intimate partner homicides. Only a small proportion (4%) of female homicides is of an unknown type, where the motive and relationship between the perpetrator and victim are still under investigation by the police.

Health data show that approximately 1 in 3 assault-related hospitalizations among women and 1 in 5 assault-related emergency department visits were identified to be the result of IPV. These are almost certainly underestimates, as one-fifth of assault-related hospitalizations and approximately one-third of assault-related emergency department visits were of an unknown type, where the perpetrator's relationship to the victim was unclear. There are several reasons why a large proportion of violent assault cases are "unknown" in hospitalization and emergency department records: providers may not ask the patient who perpetrated the violence; they may ask but not document the patient's response; or lastly, providers may ask, but the patient may choose not to disclose.

Type of Violence Against Women by Injury Severity, New York City



Sources: DOHMH Female Homicide Surveillance System supplemented with NYPD Homicide Data; DOHMH Injury Surveillance System

Case description: IPV disclosure

Intimate partner violence often remains hidden and undisclosed until a health care encounter. Victims may not label their experiences as IPV until outside observers raise concerns. Alternatively, victims may recognize that they are victims of violence, but they may not disclose it because of fear of retribution or other vulnerabilities (e.g., child custody concerns or undocumented immigration status). The following two hospitalization cases illustrate how violence often remains hidden until a prolonged health encounter or serious injury.

Sources: DOHMH Injury Surveillance System, Hospital Record Review

Patient A delivered a healthy baby girl. During her hospital stay, she revealed that she was sexually and physically abused before and during pregnancy. She reported that her boyfriend would hit her every week during pregnancy, leaving bruises on her face. The patient explained that she never sought help or called the police because "it's not really fighting." She added that her boyfriend had not used any weapons.

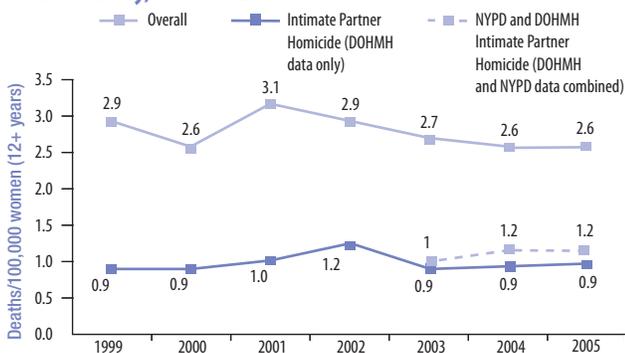
Patient B was at her apartment with her new boyfriend when her former boyfriend broke in and beat both of them. At the hospital, the patient explained that her ex-boyfriend had physically and sexually abused her in the past. She had not mentioned anything to anyone due to threats from her ex-boyfriend. This recent act, however, marked a threshold for her. She consented to photos to document the injuries, and intended to press charges.

FEMALE HOMICIDE TRENDS

Between 1999 and 2005, the overall female homicide rate, irrespective of whether IPV-related, was largely stable. In 2005, there were 94 female homicides, corresponding to a rate of 2.6 deaths per 100,000 women. IPV-related homicides were also unchanged from 1999 to 2005.

Beginning in 2003, we used NYPD data as a supplement to DOHMH data, to clarify the relationship between the perpetrator and the victim when such information was previously missing. As a result of NYPD's more complete information, IPV-related homicide rates for 2003 through 2005 appear higher than when only DOHMH data were examined. Nonetheless, both data sources suggest a stable trend. In 2005, according to combined NYPD and DOHMH data, there were 43 IPV-related homicides, corresponding to a rate of 1.2 deaths per 100,000 women.

Trends in Homicide Rates Among Women, New York City, 1999 to 2005



Rates are age-adjusted.

Sources: DOHMH Female Homicide Surveillance System supplemented with NYPD Homicide Data; US Census 2000/NYC Department of City Planning

DOHMH Female Homicide Data Source

DOHMH reports homicides using the International Classification of Diseases, Version 10 coding system. Data on all female homicide victims, ages 12 years and older, were obtained from the Office of the Chief Medical Examiner (OCME) records, which include autopsy, crime scene and police reports, as well as demographic characteristics of the victim. Trained data collectors use standardized coding techniques to abstract information on assault circumstances and the relationship between the victim and the perpetrator. Data were available through 2005 at the time of this report.

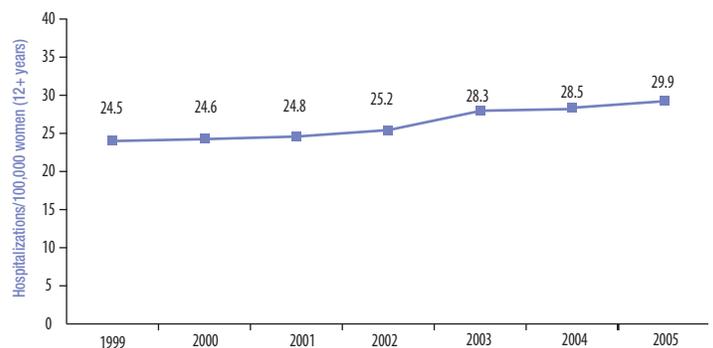
NYPD Female Homicide Data Source

NYPD reports homicides using the Federal Bureau of Investigation's Uniform Crime Reporting System. Data on all NYPD homicides for 2003 through 2006 were obtained from the Crime Analysis and Program Planning Section and the Domestic Violence Unit of the NYPD. NYPD data provide information on the relationship between the victim and the perpetrator and on the victim's prior contact with the police and courts. NYPD information on the victim-perpetrator relationship was matched with DOHMH homicides to create a more complete picture of IPV-related homicides.

ASSAULT-RELATED HOSPITALIZATION TRENDS

The overall female assault hospitalization rate, irrespective of whether IPV-related, was also steady from 1999 to 2002, followed by a 19% increase from 2002 to 2005. In 2005 there were 1,048 assault hospitalizations, corresponding to 29.9 hospitalizations per 100,000 women.

Trend in All Assault-Related Hospitalization Rates Among Women, New York City, 1999 to 2005



Rates are age-adjusted.

Sources: New York Statewide Planning and Research Cooperative System (SPARCS) & US Census 2000 NYC Department of City Planning

Hospitalization databases do not routinely maintain information on the type of perpetrator for assault-related admissions. The trend in IPV-related hospitalizations is not available. However, to establish the current burden of IPV-related hospitalizations, we reviewed a sample of 2002 and 2003 hospital charts. In this two-year sample of 1,112 assault-related hospitalizations, 32% of the hospital charts had documentation of IPV, and 20% contained no information on the perpetrators. From this sample, we project the citywide annual average to be 243 hospitalizations for IPV-related injuries. This estimate corresponds to an average annual hospitalization rate of 6.7 IPV-related hospitalizations per 100,000 women.

DOHMH Hospitalization Data Source

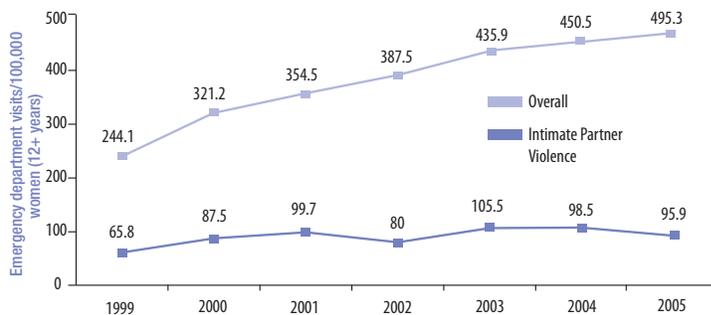
Hospitalizations due to assault among women ages 12 years and older were identified through the New York Statewide Planning and Research Cooperative System (SPARCS) database. The trend analysis was based on SPARCS data through 2005.

Corresponding assault-related case medical records were obtained from a sample of hospitals for two years only – 2002 and 2003. All identified medical records were reviewed by trained data collectors for assault circumstances and the relationship between the victim and the perpetrator. Citywide assault hospitalization counts and rates were then estimated from this sample. See Technical Notes for information on hospital selection and estimation procedures.

EMERGENCY DEPARTMENT VISIT TRENDS

In contrast to the generally stable trend seen in female homicides and the recent slight rise in assault-related hospitalizations, emergency department visits resulting from assaults against women have risen steeply over the past seven years. From 1999 to 2005, the rate increased 103% to 495.3 assault-related emergency department visits per 100,000 women, or a total of 7,343 visits. The rise could be due to actual increases in assaults against women that do not require hospitalization, but it could also reflect increased emergency department utilization, improved documentation, or a combination of all three explanations. While most of this increase was due to a rise in assaults perpetrated by non-intimate partners, IPV-related emergency department visits increased as well. From 1999 to 2005, the rate increased 46% to 95.9 IPV-related ED visits per 100,000 women, or 3,637 visits.

Trends in Assault-Related Emergency Department Visit Rates Among Women, New York City, 1999 to 2005



Rates are age-adjusted

Sources: DOHMH Injury Surveillance System & US Census 2000/NYC Department of City Planning

DOHMH Emergency Department Data Source

One week per quarter each year, trained data collectors review emergency department records to abstract assault circumstances and the relationship between the victim and the perpetrator. From this sample, citywide assault-related emergency department counts and rates were estimated using standard sampling techniques. See Technical Notes for additional information on data collection, emergency department and week selection and estimation procedures. Data were available through 2005 at the time of this report.

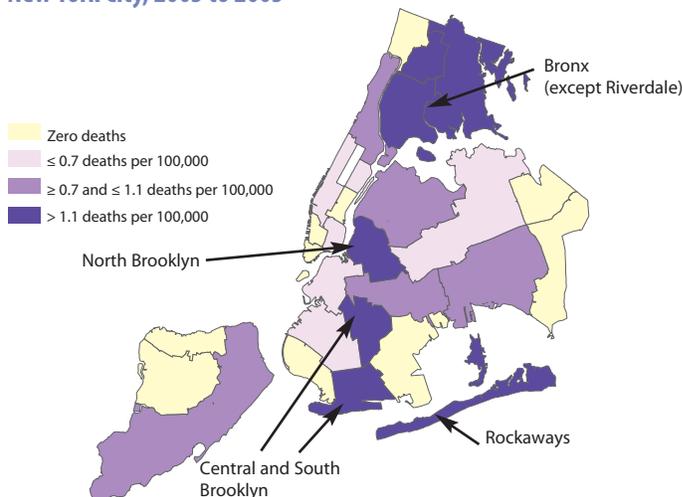
Characteristics of Intimate Partner Violence-Related Injuries

Using the data sources described above, we reviewed demographic and socioeconomic characteristics of women who were killed or injured by an intimate partner. Women in younger age groups, black and Hispanic women and those living in neighborhoods with very low median household income were at increased risk for fatal and non-fatal IPV in NYC. Data are presented on the next page; the main findings include:

- Women in their 20s experienced higher rates of intimate partner homicide, hospitalizations and emergency department visits than women in other age groups.
- Black and Hispanic women had higher rates of intimate partner homicide, hospitalizations and emergency department visits compared to women in other racial/ethnic groups.
- Women living in the Bronx had higher rates of IPV-related hospitalization and emergency department visits than women living in other boroughs.
- Women living in neighborhoods with very low median household income experienced higher rates

of intimate partner homicide, hospitalization and emergency department visits than women living in higher income neighborhoods. Intimate partner homicides were concentrated in the South Bronx; neighborhoods in North, Central and South Brooklyn; and the Rockaways.

Intimate Partner Homicide Among Women by Neighborhood, New York City, 2003 to 2005



Sources: DOHMH Female Homicide Surveillance System supplemented with NYPD homicide data; US Census 2000/NYC Department of City Planning

Characteristics of Intimate Partner Violence-related Injuries

	Female homicides due to IPV (DOHMH and NYPD data combined) per 100,000 women (2003–2005)	IPV-related hospitalizations per 100,000 women (2002–2003)	IPV-related emergency department visits per 100,000 women (2003–2005)
Citywide	1.1	6.7	100.0
Age			
12–19 years	0.4	6.1	96.5
20–29 years	2.2	11.0	201.6
30–39 years	1.8	10.5	147.2
40–49 years	1.5	7.9	106.3
50+ years	0.4	2.1	23.7
Race/ethnicity			
Black	1.7	12.2	150.7
Hispanic	1.5	7.7	219.6
White	0.5	3.0	28.5
Asian/Other	0.6	1.8	31.7
Borough			
Bronx	1.8	10.8	203.0
Brooklyn	1.2	6.5	81.6
Queens	0.8	5.1	71.8
Manhattan	0.8	4.8	75.5
Staten Island	0.9	5.8	76.5
Neighborhood median household income			
Very low	1.5	10.7	183.4
Low	1.1	5.7	72.2
Moderate	0.4	4.4	73.3
High	0.3	3.9	31.4
Foreign-born status[§]			
Foreign born	0.9	3.9	*
US born	0.8	4.4	*

§ Information on foreign-born status was missing for 22% of homicides and 37% of hospitalized IPV-related assault cases.

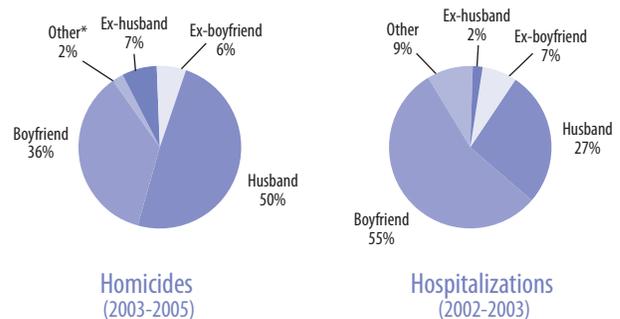
* Foreign-born status was not consistently available in emergency department records.

Sources: DOHMH Female Homicide Surveillance System supplemented with NYPD Homicide Data; Injury Surveillance System; US Census 2000/NYC Department of City Planning

INTIMATE PARTNER VIOLENCE PERPETRATORS

According to medical examiner and medical record reviews, most IPV was perpetrated by current partners — either boyfriends or husbands. Husbands were more frequently the perpetrator in fatal assaults (50%) than in non-fatal assaults (27%). In contrast, boyfriends were more frequently identified as IPV perpetrators in non-fatal assaults (55%) than in fatal ones (36%). Data also suggest that a higher proportion of fatal IPV was perpetrated by ex-partners (13%) compared to non-fatal IPV (9%).

Who Commits IPV?



Proportions are age-adjusted.

* Other includes baby/child's father or same-sex partner. There was one documented same-sex partner in the female homicides, and five in the assault-related hospitalizations.

Sources: DOHMH Female Homicide Surveillance System supplemented with NYPD Homicide Data; DOHMH Injury Surveillance System

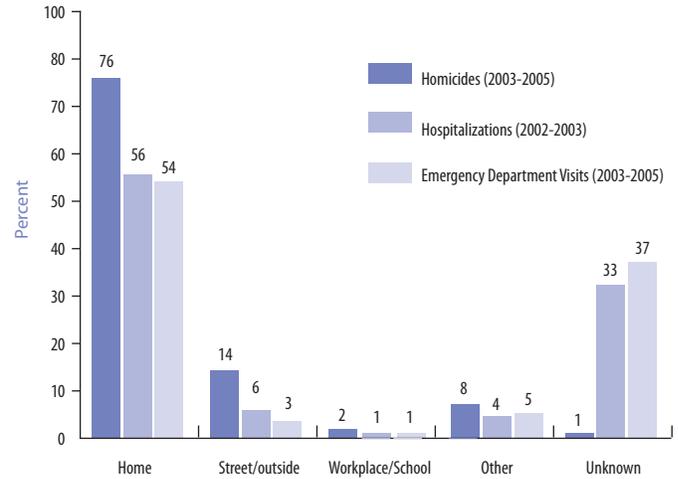
ASSAULT LOCATION

Most fatal (76%) and more than half of non-fatal IPV (54% – 56%) occurred in the home of the victim or the perpetrator, where few people other than family members were likely to witness the abuse. Less frequent locations were on the street or outside, and at other locations, such as bars, stores, restaurants or motels. At least one third of hospital and emergency department records did not provide information on the location where the assault occurred.

Given that much of the reported violence occurs in the home, children are at risk for witnessing IPV. Records were examined to ascertain whether a child witnessed the assault. Information was missing in slightly less than one third of female homicide records (30%). Approximately 12% of IPV-related homicide records indicated that at least one child under 18 years of age witnessed the assault, and 57% indicated no children witnessed the assault.

Information on children witnessing the assault was missing in 70% of hospital records. Six percent of hospital records indicated children witnessed the assault, and 24% indicated no children witnessed

Place Where Fatal and Non-Fatal Intimate Partner Violence Occurred, New York City



Sources: DOHMH Female Homicide Surveillance System supplemented with NYPD Homicide Data; DOHMH Injury Surveillance System

* Other locations include bars, stores, restaurants, or motels.

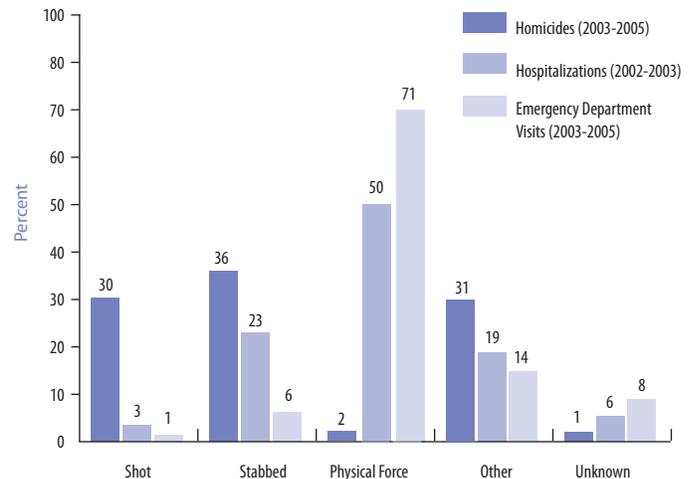
the assault. In emergency department records the presence of children witnesses was not systematically recorded.

METHODS OF ASSAULT

Most fatal IPV (66%) was caused by shootings or stabbings. Firearms were used in approximately one third of all IPV female homicides (30%); in contrast firearms were rarely used in IPV-related assaults resulting in hospitalization (3%) or in emergency department visits (1%). Stabbings accounted for more than one third of IPV female homicides (36%), approximately one quarter of IPV-related hospitalizations (23%) and 6% of IPV-related emergency department visits.

Physical force, where hands and feet are usually the weapon, was the most frequent cause of IPV-related hospitalizations (50%) and emergency department visits (71%). Injuries resulting from bludgeoning by objects, strangulation, and burns are included in 'other.' Six percent of hospital charts and 8% of emergency department records did not provide information on the method of the assault.

Method Used in Fatal and Non-Fatal Intimate Partner Violence Assaults, New York City



Sources: DOHMH Female Homicide Surveillance System supplemented with NYPD Homicide Data; DOHMH Injury Surveillance System

* Other includes bludgeoning, strangulations or burns.

CRIMINAL JUSTICE INVOLVEMENT AND OTHER ASSISTANCE

NYPD data from 2003 to 2005 provide information on the proportion of NYPD-designated intimate partner homicides that had prior Domestic Incident Reports (DIRs) or Orders of Protection (see box.) Approximately half (49%) of NYPD-designated cases had prior DIRs on record. At the time of the incident, approximately 15% of cases had an active Order of Protection, a request for formal, ongoing court protection against the alleged perpetrator.

For women hospitalized for an IPV-related injury, social work notes in medical records can provide some information on criminal justice system involvement, although such information was missing for 70% of records examined. Missing information does not necessarily indicate a lack of police involvement. It also could indicate a lack of provider documentation or patient disclosure. Medical records noted police involvement in almost one quarter of all cases (23%). An additional 3% reported already having an Order of Protection. Few patients (4%) indicated they had not yet contacted the police, but that they intended to.

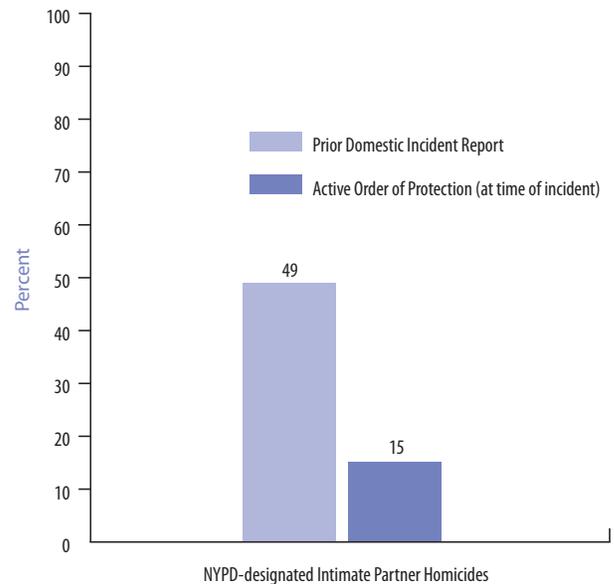
In addition to criminal justice involvement, social services provided to hospitalized victims was examined. Approximately half of IPV cases (47%) had documented social work involvement during the hospitalization. This suggests that half of women hospitalized for a known IPV incident did not receive formal social work services despite disclosing abuse. This figure could reflect service offerings, patient preferences, incomplete documentation practices or a combination of these factors.

A DIR is a report completed by law enforcement officers in the State of New York when responding to a domestic incident call.

An Order of Protection is a court-issued document that helps protect a victim from harassment or abuse through judicial limits on the perpetrator's behavior.

In 2008, New York State expanded protections to allow a person who is or was in an intimate relationship with an abuser to seek an Order of Protection in family court, even if no legal relationship or common child exists.

Criminal Justice Involvement in Fatal Intimate Partner Violence Cases, New York City, 2003-2005



Source: NYPD Homicide Data

Domestic Incident Reports, Complaints against Intimate Partners, 2002 to 2005

A review of Domestic Incident Reports by a female complainant against an intimate partner shows a decline in recent years. There were 41,725 DIRs in 2005, a 24% decline from 2002.

Year	# of DIRs
2002	54,728
2003	48,287
2004	44,042
2005	41,725

Source: Domestic Violence Research Unit, New York State Division of Criminal Justice Services

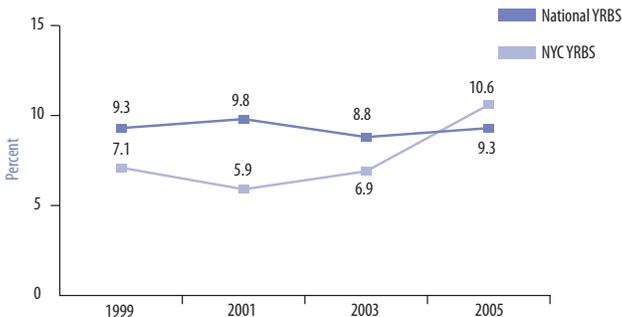
Survey Results: Self-Reported Intimate Partner Violence and Health Status

TREND AND BURDEN

Fear of an intimate partner is one consequence of IPV. Findings from representative telephone surveys conducted in 2004 and 2005 show that approximately 2.2% of NYC's women ages 18 and older – 69,000 women – reported they were afraid of an intimate partner during the past year. Survey data show no increase in this component of IPV. Women between 20 and 29 years of age, black and Hispanic women and women living in neighborhoods with very low median household income reported a higher prevalence of fear of an intimate partner compared to women in other groups. These at-risk groups are similar to those with higher rates of emergency department visits, hospitalizations and homicides.

Every two years since 1999, the Youth Risk Behavior Survey (YRBS), a self-administered survey on a range of risk behaviors, has assessed physical dating violence among NYC public high school students. While national estimates among female teens have been stable over time, NYC estimates indicate a recent rise in prevalence. An estimated 7.1% of teenage girls in NYC reported physical dating violence in 1999. In 2005, the estimate had risen almost 50% to 10.6% (approximately 15,000 students). The prevalence of physical dating violence among NYC high school girls did not vary by student age or borough of school. Multi-race, non-Hispanic girls had a significantly higher prevalence (25.2%) than girls in other racial/ethnic groups.

Trends in Physical Dating Violence Among Girls, 1999 to 2005



Sources: NYC Youth Risk Behavior Survey and the National Youth Risk Behavior Survey

Survey Methods:

Adults: The NYC Community Health Survey (CHS) is an annual random-digit-dial cross-sectional survey of approximately 10,000 NYC adults ages 18 and older. It is administered by the DOHMH. The survey question described here is: *In the past 12 months, have you been frightened for the safety of yourself, your children or friends because of the anger or threats of an intimate partner?*

Teens: The NYC Youth Risk Behavior Survey (YRBS) is a cross-sectional survey of randomly selected public high school students. It is administered every two years by the DOHMH and the NYC Department of Education. The survey question described here is: *In the past 12 months, did your boyfriend or girlfriend ever hit, slap or physically hurt you on purpose?*

Prevalence of Self-Reported IPV in Public High School Girls and Adult Women in NYC

	Self-reported fear of intimate partner CHS (2004–2005)	Physical dating violence YRBS (2005)
Citywide (%)	2.2	10.6
Age groups, teens (%)		
15 years or younger	—	11.5
16–17 years	—	9.4
18+ years	—	11.4
Age groups, adults (%)		
18–29 years	3.8	—
30–39 years	2.5	—
40–49 years	2.5	—
50+ years	1.0	—
Race/ethnicity (%)		
Black	2.3	13.3
White	1.3	8.0
Hispanic	3.0	9.4
Asian	1.6*	7.5
Multi-race (non-Hispanic)	N/A	25.2
Other	3.2*	7.3
Neighborhood median household income (%)		
Very low	3.2	N/A
Low	1.9	N/A
Moderate	1.8	N/A
High	1.7	N/A
Borough (%)		
Bronx	3.1	10.3
Brooklyn	2.0	11.8
Queens	2.0	8.0
Manhattan	2.0	12.6
Staten Island	1.3*	10.6
Foreign-born status (%)		
Foreign born	1.8	N/A
US born	2.5	N/A

Sources: Community Health Survey (2004–2005) and NYC Youth Risk Behavior Survey (2005)
N/A refers to data not available.

* Relative standard error (RSE) >30%; estimate should be interpreted with caution.

HEALTH CORRELATES OF INTIMATE PARTNER VIOLENCE

According to survey results, women who feared a partner contended with a wide array of physical, behavioral, and mental health concerns. Specifically, they were more likely to report asthma and psychological distress than women who did not fear a partner. Women reporting fear were also more likely to report being current smokers and less likely to report getting the medical care they needed. Substance use and sexual risk behaviors, such as having three or more sex partners in the past year, were also more common among women who reported fearing a partner.

Data on public high school females reflect patterns seen among adults. Female teens experiencing physical dating violence reported a higher prevalence of feeling sad and hopeless and suicidal thoughts and behavior. Affected teens also reported at least twice the frequency of alcohol and drug use and smoking compared with teens not experiencing dating violence. Several indicators of sexual risk behavior also were elevated among female teens experiencing dating violence. For instance, these teens reported at least twice the frequency of having four or more sexual partners in their lifetimes and at least twice the frequency of ever having been pregnant compared to teens who did not experience dating violence.

Women Who Report Fearing an Intimate Partner Have Greater Health Concerns

Health Status (%)	Women who feared a intimate partner	Women who did not fear a intimate partner
Poor self-reported health status	9.3	6.4
Diabetes*	17.2	8.9
Asthma*	16.0	6.2
Overweight	31.5	28.0
Obese	27.0	22.1
Current smoker	28.4	15.4
Told have high blood pressure**	38.3	29.1
Access to Care (%)		
Has health insurance ⁺	79.0	83.9
Needed care but couldn't get it**	36.4	11.8
Has primary care provider	87.3	82.6
Mental Health Indicator (%)		
Serious psychological distress**	30.5	7.0
Substance Use and Other Risk Behaviors (%)		
Had >five drinks in a row on more than one day in past month (binge drinking)	15.3	7.2
Ever used cocaine (including crack or freebase), heroin, PCP, angel dust, or any other street drugs excluding marijuana*	12.3	5.3
Three or more sex partners in past year	8.8	2.7

* 2004 only

** 2005 only

⁺ limited to respondents ages 18-64 years

Source: Community Health Survey, 2004-2005

Female Teens Experiencing Physical Dating Violence Have Greater Health Concerns

Mental health indicators (%)	Female teens reporting physical dating violence	Female teens reporting no physical dating violence
Felt sad or hopeless every day for Two or more weeks (past year)	58.1	38.2
Seriously considered attempting suicide (past year)	39.0	17.8
Planned suicide (past year)	29.6	11.8
Attempted suicide (past year)	27.3	9.8
Substance use, past month (%)		
Had > five drinks in a row on > one or more of the day in past 30 days	27.9	10.8
Used marijuana in past 30 days	23.4	8.9
Engaged in binge drinking and marijuana use in past 30 days	11.9	3.5
Smoking (%)		
Smoked on one or more days in the past 30 days	24.6	10.5
Sexual risk behaviors (%)		
Ever had sex	75.6	39.6
Had > four sex partners in lifetime	24.7	10.1
Had > one sex partner in past month	52.2	27.2
Used condom when last had sexual intercourse	49.7	65.5
Ever been pregnant	14.4	6.0

Source: NYC Youth Risk Behavior Survey, 2005

Pregnancy and Intimate Partner Violence

IPV during pregnancy is a serious public health concern, as harms extend beyond the victim. Studies suggest that pregnancy may be a time of increased risk for IPV.

Between 2002 and 2003, the rate of IPV-related hospitalizations was nearly three times higher among pregnant women than among non-pregnant women. However, this difference might reflect the greater likelihood of hospital admission for assaulted pregnant women who present at emergency departments in order to monitor the overall effects on the fetus more closely. In contrast, data suggest the rate of intimate partner homicide was higher among non-pregnant women.

Counts of pregnant and non-pregnant women:

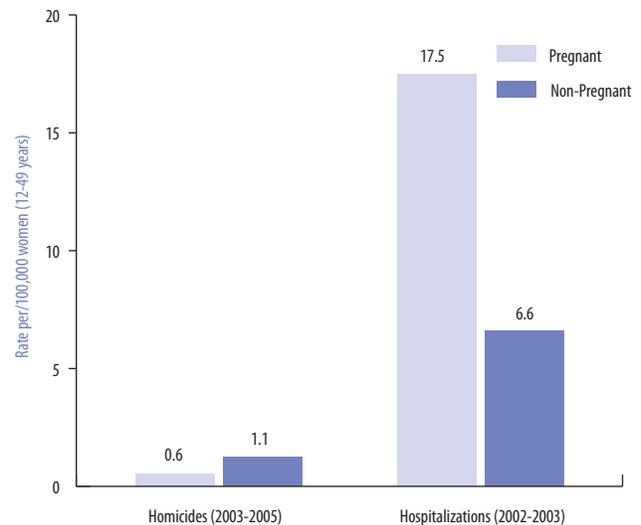
Counts were needed for denominators used in the rate computation. Women ages 15–49 were considered to be of childbearing age. To estimate the number of pregnant women, we totaled counts of live births, spontaneous terminations and induced terminations available through the DOHMH Office of Vital Statistics. We excluded non-residents and women whose residence was unknown. The estimated count of pregnant women in NYC was subtracted from census figures to arrive at an estimated count of non-pregnant women in NYC.

The Pregnancy Risk Assessment Monitoring System (PRAMS) is an ongoing, population-based surveillance system designed to monitor selected maternal behaviors and experiences that occur before, during, and after pregnancy among women who deliver live-born infants. New York City data from 2004-2005 suggest that the prevalence of physical IPV during pregnancy (3.8%) was roughly similar to the level of IPV among respondents before their pregnancy (4.9%).

Survey Methods:

The NYC Pregnancy Risk Assessment Monitoring System (PRAMS) is an ongoing, mail-based survey, with telephone follow-up for non-respondents, of approximately 2,200 NYC women who deliver a live-born infant in New York City. The questions described here begin with: *During the 12 months before you got pregnant, did an ex-husband or*

Intimate Partner Homicide and Intimate Partner Violence-related Hospitalization Rates in Pregnant and Non-Pregnant Women of Childbearing Age, New York City



Rates are age-adjusted.

Sources: DOHMH Female Homicide Surveillance System supplemented with NYPD Homicide Data; DOHMH Injury Surveillance System; US Census 2000/NYC Department of City Planning

Proportion of Women Reporting IPV Before Pregnancy and During Pregnancy, New York City

IPV during 12 months prior to pregnancy by husband/partner or ex-husband/partner	4.9%
IPV during pregnancy by husband/partner or ex-husband/partner	3.8%

Source: NYC PRAMS, 2004-2005

ex-partner push, hit, slap, kick, choke or physically hurt you in any way? The question was repeated with reference to current husbands or partners. Also, questions were asked about IPV during the most recent pregnancy.

Case description: Health and Social Impacts of IPV

IPV victims often contend with health and social problems that extend beyond the immediate injury. These include mental and physical health conditions and somatic complaints. Victims' employment may be jeopardized, and their children may get caught in the crossfire. The following two cases illustrate this point.

Patient A went to the emergency department because she had been punched and kicked by her boyfriend again, an ongoing event almost since they started dating two years ago. At first the violence was not that frequent; then it escalated, to a frequency of two to three times a week. She lost her job at a local grocery store because she could not go to work with all the visible bruises. The night before the patient

was admitted to the hospital, her boyfriend had slammed her on the floor and punched and kicked her in the abdomen. He injured her spleen in the beating. Every time she thought she could not take it anymore, she would try to get help. She had called the police at least four times before, but always ended up dropping the charges.

Patient B was hospitalized after her boyfriend punched her and threw her against a wall at home. The most serious immediate injury was broken facial bones. In recent months the patient had lost her job. Her despair was causing her to engage in self-mutilation; she had been cutting her wrist with a knife.

Sources: DOHMH Injury Surveillance Hospital Record Review

Discussion

LIMITATIONS

IPV is often a hidden practice. Attempts to measure its occurrence often undercount its frequency. For example, at least one quarter of hospitalizations and emergency department visits due to assaults against women do not have documentation on the perpetrator. The burden and trends of non-fatal IPV identified in this report are, therefore, almost certainly underestimates. Since women who disclose IPV in health care encounters may be different from those who do not, the data presented on non-fatal IPV may not be generalizable to all women who experience IPV.

IPV is also likely to be underreported in surveys. The Community Health Survey (CHS), the Youth Risk Behavior Survey (YRBS) and the Pregnancy Risk Assessment Monitoring System (PRAMS) rely on self-reported data, where respondents answer questions without outside verification. For several reasons, including shame, fear and denial, respondents may not disclose their IPV experiences.

While the CHS and the YRBS are population-based, they are not representative of the entire population; some groups are not included. The CHS does not include households without landline telephone service or people living in institutional settings, such as hospitals, nursing homes, prisons and college dormitories. The YRBS is conducted biannually in public high schools. The survey does not reach private school students, homeless youth, incarcerated youth, students who may be schooled at home, those who are chronically absent from school or dropouts. Persons not reached by these surveys may face a different risk level of IPV.

The cause for the dramatic increase seen in emergency department IPV-related visits is unknown and must be interpreted with caution, particularly in light of the lack of evidence of an increase among most other adult data sources shown in this report. An actual increase in violence is not the only explanation for observed upward trends. According to review of supplemental health data sources, neither overall increases in emergency department utilization nor general changes in treat-and-release practices in emergency departments could account for the dramatic rise. Improved documentation by health care providers and increased disclosure by patients could result in an upward shift of assault cases seen in NYC's emergency departments. In fact, the trend coincides with strengthening IPV-related outreach by professional medical associations and advocates locally and nationally — initiatives that were reinforced by the 2001 establishment of NYC's Mayor's Office to Combat Domestic Violence.

Similarly, the decrease in IPV-related Domestic Incident Reports must be interpreted with caution. It may reflect an actual decline in IPV, a change in outreach to police, improved enforcement or a combination of these factors.

In sum, no single data source can establish the true prevalence of IPV in New York City. Still, bringing together multiple data sources that measure different aspects of IPV expands our understanding of this complex health problem.

SUMMARY

Intimate Partner Violence Against Women in New York City describes the scope of IPV and the health status of those affected by violence. The findings highlight that IPV, according to health data sources, has not decreased over time. While mortality data indicate no significant change from 1999 to 2005, less serious IPV may be on the rise. While these data should be interpreted with caution because of their susceptibility to artifactual influences, such as improved documentation in medical records, recent increases in ED visits and reports of dating violence against female teens are a cause for concern.

In contrast, criminal justice data suggest a downward trend in IPV-related Domestic Incident Reports. Given extensive outreach by media, advocates, service providers and NYPD, it is unlikely that this decline reflects a change in help-seeking by women experiencing IPV and may mark an actual decline in violence at home.

IPV services and preventive efforts should target women at greatest risk. In New York City, young women, black and Hispanic women, and women living in poor neighborhoods face the greatest risk of both fatal and non-fatal IPV. They also report fearing an intimate partner more frequently than women in other groups. The fact that these findings are consistent across all data systems is noteworthy, suggesting that such a pattern is not likely to be an artifact of reporting.

NYC findings are inconclusive regarding pregnancy and IPV risk. Pregnant women have higher IPV-related hospitalization rates than non-pregnant

women. Yet PRAMS data and intimate partner homicide data suggest no increased risk of IPV among pregnant women. It is possible that hospitalization findings reflect a more aggressive practice of treating and admitting pregnant women compared to non-pregnant women, but we cannot rule out a real difference in IPV experiences.

Most IPV resulting in injury or death occurs at home, and gun violence accounts for approximately one third of IPV-related female homicides. This finding underscores the risk of having weapons, such as guns, in the home. It also supports the need for questions about this problem in health care and other service settings since most of the violence is occurring away from the public space.

While IPV's direct injury consequences are substantial, the indirect mental, physical, and behavioral health effects are also quite severe and further compound the health impact of the violence. Girls experiencing dating violence and women reporting fear of a partner reported worse health and higher levels of risky health behaviors. The case descriptions highlight the chronic and escalating nature of physical IPV and its enduring social and health consequences.

Few women killed by their intimate partners had criminal justice system protections, and only half of women hospitalized for IPV-related injuries had documented contact with hospital-based social services. These findings suggest we have more to learn about why IPV victims are reluctant to seek existing services and what facilitates or impedes their help-seeking.

RECOMMENDATIONS

Reducing intimate partner violence and its associated harms requires a coordinated, multi-institutional effort. Health care providers, community-based organizations, city agencies and community residents need to work together to identify victims of intimate partner violence to ensure they get the help they need, and to establish a zero-tolerance culture toward such abuse. Below are key recommendations to improve the identification, documentation and referral of victims of intimate partner violence and to help prevent it.

Health care system and health care providers

While the impact of IPV screening on violence prevention is uncertain, research has shown that screening increases disclosure and facilitates referral. Health care policies, medical training and formal protocols can promote and foster IPV screening, documentation and referral.

- All health care providers should routinely screen for IPV. They are in a unique position to identify violence in their patients' lives and to safely refer patients to appropriate services. To maximize identification of IPV in health care settings, specific screening questions and techniques should be used.
 - Systematic IPV screening in outpatient settings is currently uncommon, but it is an important setting for identification of IPV. Outpatient health care providers can help prevent escalation to more severe injury that might result in an emergency department visit or a hospitalization.
 - Health care providers should initiate a discussion of IPV with statements or questions that frame the problem in a non-judgmental manner, such as:

Since violence is so common in many people's lives, I ask all my patients about it.

This may or may not be a problem for you, but I've found many of my patients are dealing with abusive relationships. Some are uncomfortable or afraid and don't want to talk about it. So, I've started asking all my patients about this.

How are things at home?

- Providers should then inquire directly about violence in patients' lives. An adaptation of the 4-question Abuse Assessment Screen, a widely used, validated approach appears below:

1. *Have you ever been emotionally or physically abused by a partner?*
2. *Within the past year, have you been hit, slapped or otherwise physically hurt by your partner?*
3. *Within the past year has your partner forced you to have sexual activities?*
4. *Are you afraid of your partner?*

(McFarlane et al., 1992)

- ED visits offer limited opportunity because of the visits' short duration, lack of privacy, and fast-paced atmosphere. Nonetheless, violence can be detected here before it escalates to more dangerous levels. Specific questions, such as "Did someone hurt you?" can be delivered in a sensitive manner.
- IPV screening protocols should be implemented in high school-based clinics and adolescent health care providers.
- Documentation is an essential next step after screening. With no documentation, providers can miss an opportunity to link patients to referrals and follow up on their progress. Documentation may aid legal proceedings or the procurement of social services. Limited documentation also compromises public health researchers' and policy-makers' abilities to understand the scope of the problem.
 - Providers should document their findings after discussing IPV with their patients.
 - User-friendly chart formats or electronic health records with IPV check-boxes (present or absent) can facilitate clear medical record documentation of IPV.
- Displaying IPV educational information, including hotline phone numbers, in waiting rooms, exam rooms and bathrooms, can help patients feel comfortable disclosing IPV.
- Patients may not always exhibit physical signs of abuse. Provider education should focus on increasing awareness of how IPV may present

when not injury-related. Behavioral indicators like substance abuse and depressive symptoms may alert a provider to the possibility of underlying IPV.

- Not all health care settings are equipped to provide onsite services for IPV victims. In these instances, community-based organizations can often fill service gaps. Health care providers should be adequately informed about available services in the community and contact information should be accessible (see Resources).
- With the victim's consent, coordination between health care providers and the police might help avoid further escalation of IPV.

Community

- IPV prevention begins with changing social norms. Community-wide messages should emphasize that intimate partner violence is not acceptable, that inaction and silence reinforce the problem and that free services are available. Such outreach can empower IPV victims to get help. Outreach also can empower family, friends, neighbors and co-workers to help those affected by IPV get needed resources.
- Victims can call the police (911), discuss their fears

with their health care providers and/or call the City's Hotline (1-800-621-HOPE or 1-800-621-4673) to find out more about getting help and getting safe.

- While family, friends, neighbors and co-workers cannot take on the role of professional counselors, they can help victims by doing the following:
 - Listen to and talk with a victim in a safe place, without passing judgment.
 - Validate a victim's experiences and take them seriously.
 - Encourage help-seeking and offer support through the help-seeking process.
 - Be aware of domestic violence resources in the community.
 - Learn about safety plans and strategies. One safety strategy, for instance, is to ready personal documents and keep them together, hidden from the perpetrator, in case the victim needs to leave suddenly.
 - Become involved with community actions that raise awareness and help to prevent intimate partner violence in the community.

RESOURCES

The following resources can provide general information on IPV:

- **In emergencies**, where a person's life or physical safety is at risk, always call 911.
- **For information** and help 24-hours-a-day, call the City's toll-free, confidential Domestic Violence Hotline at 1-800-621-HOPE (1-800-621-4673), or call **311** and ask for the Domestic Violence Hotline.
- *How to Keep Yourself Safe: Intimate Partner Violence Health Bulletin*: www.nyc.gov/html/doh/downloads/pdf/public/dohmhnews7-07.pdf
- *Take Care New York. Make Your Home Safe and Healthy*: www.nyc.gov/html/doh/html/tcny/tcny09.shtml/#dv

For health care and social services providers:

- Comprehensive directory of IPV services citywide: www.nyc.gov/html/ocdv/downloads/pdf/ResourceDirectory/pdf

- Getting an Order of Protection: www.nyc.gov/html/ocdv/html/services/courts_help.shtml#orderprotection
- Finding safe housing: www.safehorizon.org/page.php?nav=sb&page=sheltertour
- *Intimate Partner Violence: Encouraging Disclosure and Referral in the Primary Care Setting*, City Health Information: www.nyc.gov/html/doh/downloads/pdf/chi/chi26-2.pdf
- *A Medical Providers' Guide to Managing the Care of Domestic Violence Patients within a Cultural Context*: www.nyc.gov/html/ocdv/downloads/pdf/providers_dv_guide/pdf
- Training is available from the New York State Office for the Prevention of Domestic Violence: www.opdv.state.ny.us/health_humsvc/index.html
- Additional health care provider training materials: www.endabuse.org/programs/healthcare

COORDINATED EFFORTS TO RESPOND TO AND PREVENT IPV:

THE DOHMH IS:

- Instituting systematic IPV screening in DOHMH home visitation programs, such as the Newborn Home Visiting program, and intake screening of female inmates at Rikers Island.
- Developing a Public Health Detailing Program for primary care providers in key low-income neighborhoods to improve patient care around intimate partner violence. Using a strategy modeled after the pharmaceutical sales approach, DOHMH representatives will promote IPV screening, documentation, and referral. "Detailing Action Kits" — containing screening tools and resources for providers and patients — will be distributed to doctors, physician assistants, nurse practitioners, nurses and administrators at their practice sites.
- Launching a clinical decision-making electronic health record tool for roll-out in federally qualified community health centers. The DOHMH Primary Care Information Project is developing a specific module for IPV screening in prenatal care settings.
- Addressing intimate partner violence in the workplace. The DOHMH is coordinating outreach and education efforts focused on IPV prevention for employees. Employees can find continuously updated information and resources on a featured section of the agency's intranet site.
- Engaging teens on several topics including dating violence, managing expectations, risk-taking, depression, and substance use through a public education and awareness campaign called, NYC Teen Mindspace that harnesses the power of social networking sites, MySpace and Facebook (http://www.myspace.com/nycteen_mindspace). The goals of this pilot project are to increase general awareness and understanding of these topics, to encourage teens to forward campaign elements to their friends in order to encourage discussion and ultimately shift social norms and to promote help-seeking.

THE NYPD'S SPECIALLY TRAINED DOMESTIC VIOLENCE PREVENTION OFFICERS ARE:

- Investigating domestic violence incidents, including those related to intimate partner violence, arresting suspects and making follow-up home visits. In 2007, NYPD Officers made over 76,000 follow-up home visits to ensure the safety of victimized family members.
- Making referrals for medical care, legal advice, social services assistance, crisis intervention and counseling support for victims and their family members. NYPD Domestic Violence Prevention Officers also facilitate arrangements for temporary safe lodging.
- Arranging for a security survey of the victim's home to address immediate security needs and for lock changes free of charge.
- Developing a safety plan and providing tips to enhance security at home, work, and during one's commute.

THE MAYOR'S OFFICE TO COMBAT DOMESTIC VIOLENCE IS:

- Improving access to services through the City's Family Justice Center Initiative. This innovative, multi-institutional program enables co-located City agencies and community partners to provide a wide range of services to domestic violence victims and to streamline effective service delivery. NYC's first Family Justice Center, located in Brooklyn, opened in July 2005 and averages over 1,000 client visits per month. A Family Justice Center opened in Queens in 2008, and another is scheduled to open in the Bronx in 2009.
- Monitoring health care utilization and prevalence of health care provider IPV screening among Family Justice Center clients, in consultation with the DOHMH.
- Teaching young people about healthy relationships through the New York City Healthy Relationship Training Academy. Through the Academy young people learn how to recognize the signs of an unhealthy relationship and develop skills to build healthy relationships.
- Coordinating systematic review of all NYC domestic violence homicides, including intimate partner homicides, through the NYC Domestic Violence Fatality Review Committee. Committee membership includes City agency and community-based organization representatives and survivors. Review of aggregate information informs development of policies and programs targeting communities most at risk.

Technical Notes

FATAL INJURY DATA SOURCES

This report's description of IPV-related homicide is based on homicide cases as defined by DOHMH. NYPD defines homicide differently, so NYPD information was used as a supplement only, in order to enhance information on the relationship between the victim and the perpetrator.

DOHMH uses a broader definition of both homicide and intimate partner; as a result DOHMH figures are systematically higher than NYPD figures. Nonetheless, there is substantial overlap between the cases both agencies monitor and agreement in trend assessment.

	Homicide	Intimate
DOHMH	Death resulting from injuries sustained through an act of violence committed by another person aimed at causing fear, harm, or death. Cases are victims who died in NYC.	Current or former partner (including husbands, common-law husbands, boyfriends, girlfriends, lovers, dating partners, etc.)
NYPD	Murder and Non-negligent Manslaughter as per Federal Bureau of Investigation's Uniform Crime Reporting System. Cases are incidents that happened in NYC.	Current and ex-spouse or common-law partner who live/d in a household, and partners with child in common

NON-FATAL INJURY DATA SOURCES

The DOHMH Injury Surveillance System is built on data generated from assault-related hospitalization (2002–2003) and ED (1999–2005) records. (See below for more information on these sources.) Foreign-born status, nature of the intimate relationship between perpetrator and victim and criminal justice information are seldom available in ED records, whereas these factors are often available in hospital records. Pregnancy status has not been routinely collected in the ED record review.

OTHER DATA SOURCES

CHS and PRAMS data collected in 2004 and 2005 were combined to create robust estimates. DIR and Order of Protection data were provided by the NYPD as part of their Murder and Non-negligent Manslaughter data. NYC DIR information was provided by the Domestic Violence Research Unit of the State Division of Criminal Justice Services based upon data originally collected by the NYPD.

EMERGENCY DEPARTMENT AND HOSPITAL SAMPLES

Emergency Department Record Review

Between 20 and 23 hospitals each year (1999 to 2005) that see 70–75% of NYC's assault-related hospitalizations were chosen for emergency department visit surveillance. This approach maximizes data collection yield.

Four times a year, a one-week sample of charts for assault patients treated and released from emergency departments is selected; this strategy minimizes the influence of seasonal trends in IPV. The first week is selected at random; the next three one-week periods are set at equal 13-week intervals. All assault-related cases seen at participating emergency departments during these four weeks are reviewed and IPV-related cases are documented.

Based on these samples, DOHMH researchers estimate citywide IPV-related emergency department visit rates. We assume that emergency department visits reflect assault hospitalizations' volume and distribution, and we compute the proportions of assault hospitalizations captured by the hospitals participating in surveillance. Proportions are specified by patients' age, gender, and borough of residence, and are used to generate citywide estimates of assault-related emergency department visits from the sample data. See www.nyc.gov/html/doh/html/ip/aedv/2005-age.html for further explanation of estimation procedures.

Assault Hospitalization Record Review

In 2005, the DOHMH launched a pilot surveillance program of hospitalized assaults in NYC's women 12 years and older. DOHMH researchers reviewed 2002 and 2003 medical records for female assault-related hospitalizations at the 23 hospitals seeing 70–75% of NYC assault-related admissions.

The universe of assault-related hospitalization records among women 12 years of age and older at the 23 hospitals were reviewed for 2002 and 2003. Estimation procedures for citywide rates are similar to those used with ED data.

RATES AND PROPORTIONS

Rates (except when age-specific) were age-standardized to the National Center for Health Statistics Year 2000 Standard Population. Age-adjusted proportions were computed when appropriate. Confidence intervals were computed for death and injury rates; non-overlapping confidence intervals indicated statistically significant differences. For CHS data, t-tests were conducted. For YRBS data, chi-square tests for differences in proportions were computed. Differences with p-values of 0.05 or less were considered significant. Proportions and rates have been rounded.

NEIGHBORHOOD DEFINITIONS

Neighborhoods were defined using the United Hospital Fund's 42 zip-code aggregations. Neighborhood household income groups were calculated by ranking the 42 UHF neighborhoods by median household income (US Census 2000). The ranked list was divided into four groups, ranging from very low to high. Roughly 25% of NYC's population fell into each neighborhood income group.

MAP

Victim neighborhood of residence was used to create the female homicide map. Health and NYPD homicide data were pooled from 2003 to 2005 and UHF neighborhoods were aggregated to accommodate small counts.

NYPD IPV Homicide Data

For this report NYPD provided homicide data through 2006, a year for which DOHMH data were not yet available. DOHMH and NYPD definitions of intimate partner homicide differ slightly. The following summary of NYPD-defined intimate partner homicides shows an almost 40% decline from 2005 to 2006.

Year	NYPD-defined Intimate Partner Homicides
2003	32
2004	33
2005	32
2006	20

Sources: NYPD Homicide Data

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Deborah J. Chard-Wierschem	Susan Hallinan	Wenhui Li	Susan Resnick
Louise Cohen	Edward Hill	Jenna Mandel-Ricci	Kathy Ryan
Donna Eisenhower	Jennifer James	Philip McGuire	Pia Savino
Michael Farrell	Deborah Kaplan	Candace Mulready	Tracy Weber
Dana Friedman	Elizabeth Kilgore	Leze Nicaj	

With this report we pay tribute to all New York City women who lives were cut short because of intimate partnership violence (IPV) and honor all IPV survivors. Their experiences inspire those affected by IPV to get the help they need and motivate service providers to extend their reach to treat survivors and to prevent future violence.

