Florida: Domestic Violence

2 contact hours: $19

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This course meets the domestic violence continuing education requirement for healthcare providers in the state of Florida.

Course Summary: The scope of domestic violence includes violence against women, children, and elders. Describes best practices for screening, assessment, and documenting signs of violence when seen in the healthcare setting. Outlines Florida reporting requirements and discusses state programs to reduce incidence.

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Off-Product Label Use: No off-product label use was discussed or recommended in this course.

Criteria for Successful Completion: 80% or higher on the post test, a completed evaluation form, and payment where required. No partial credit will be awarded.

This course will be reviewed every two years. It will be updated or discontinued on Apr 1, 2013.

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1. Read the course material and then complete the following forms:
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Course Objectives

When you finish this course, you will be able to:

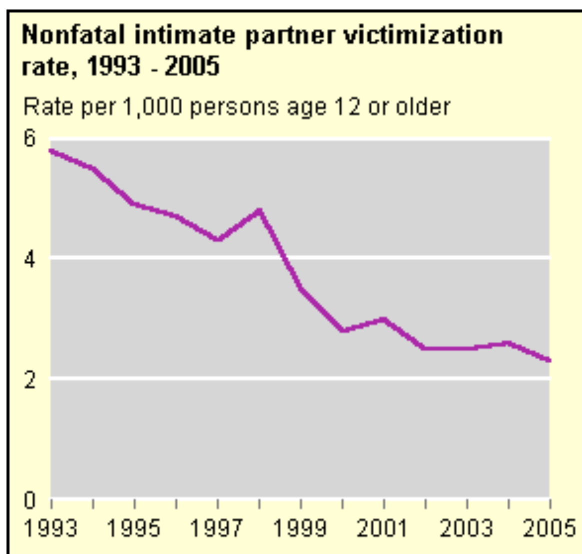
- Describe the scope of domestic violence in the United States and Florida.
- List the five main categories of domestic violence.
- Explain the prevalence of violence against women and how it relates to domestic violence.
- Define the significance of the co-occurrence of child maltreatment and domestic violence.
- Discuss the relationship of elder abuse to domestic violence.
- Outline the economic and societal costs of domestic violence.
- Identify best practices for screening, assessment, and documentation of domestic violence in the healthcare setting.
- Outline Florida legislation relating to domestic violence, including reporting requirements for healthcare professionals.
- Discuss Florida prevention and education programs designed to reduce the incidence of domestic violence.

Intimate Partner Violence

Intimate partner violence (IPV) is defined as physical, sexual, or psychological harm by a current or former partner or spouse. It can occur among heterosexual or same-sex couples and does not require sexual intimacy. IPV is a serious, preventable public health problem that affects millions of people in the United States and throughout the world. In many societies this type of violence is considered “normal.” It varies in frequency and severity and occurs on a continuum, ranging from one hit that may or may not impact the victim to chronic, severe battering (CDC, 2010).

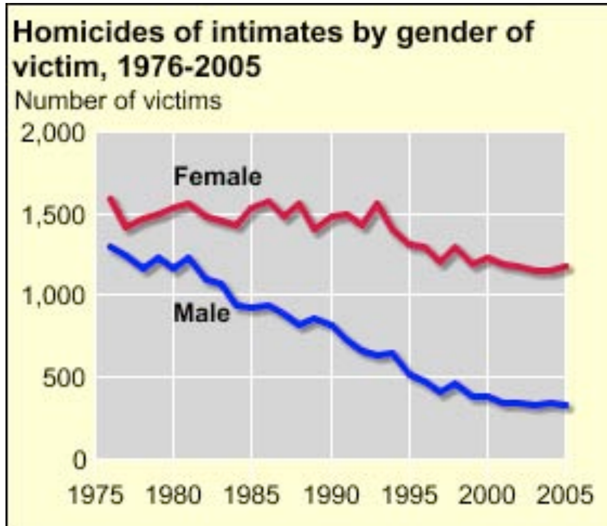
The terms “domestic violence,” “family violence,” “wife beating,” “battering,” “spouse abuse,” and “dating violence” are often used interchangeably. However, in an effort to facilitate the collection of data and make comparisons among jurisdictions an effort is being made to use a consistent definition and the CDC advocates the definition of IPV as noted above (CDC, 2010).

Although women can be violent to men, the vast majority of intimate partner violence is perpetrated by men against women. From 1976 to 2005, U.S. Department of Justice statistics showed that about 96% of women who experienced intimate partner violence were victimized by a man while only about 3% reported that the offender was another woman (Catalano, 2007).



Source: U.S. Dept of Justice. (http://bjs.ojp.usdoj.gov/content/intimate/overview.cfm)

Fatal incidents of intimate partner violence—sometimes referred to as “intimate homicide”—have also declined in the United States since 1976. Between 1976 and 2005 the number of white females killed by intimates rose in the mid-1980's, then declined after 1993 reaching the lowest recorded in 2002. The number of intimate homicides for all other race and gender groups declined over the same period; the number of black males killed by intimates dropped by 83%, white males by 61%, black females by 52%, and white females by 6% (Catalano, 2007).



Source: U.S. Dept of Justice. (http://bjs.ojp.usdoj.gov/content/intimate/overview.cfm)

Describing trends based on law enforcement statistics can be problematic however. In the United States less than one-fifth of the women raped by an intimate partner reported their most recent rape to the police. In a National Violence against Women Survey, most women and men who were physically assaulted failed to file a complaint, although women were more likely than men to report their victimization to the police (26.7% and 13.5%, respectively) (Tjaden and Thoennes, 2000).

This reluctance to report intimate partner violence to authorities is a problem internationally as well as in the United States. According to a World Health Organization (WHO) survey of more than 24,000 women in 10 countries, more than half of the physically abused women surveyed reported that they had never sought help from a health service, shelter, legal service, or from anyone in any position of authority such as police, religious leaders, or other government organization (WHO, 2005).

Despite growth in research over the last two decades, there is still a lack of reliable information on the amount and frequency of IPV, SV, and stalking victimization at the national and state levels. To help address this lack the CDC's National Center for Injury Prevention and Control (NCIPC), in collaboration with the National Institutes of Justice (NIJ), and the Department of Defense (DoD), has developed the National Intimate Partner and Sexual Violence Surveillance System (NISVSS). Beginning in 2010, NISVSS will collect ongoing population-based surveillance among English and/or Spanish-speaking male and female adults (18 years and older) living in the United States. In addition, over-sampling for American Indian and Alaska Natives will provide important information on these underserved and understudied populations. During the first year, data will also be collected from female active duty US Armed Forces members and female spouses of married male service members. The data gathered will help generate accurate and reliable incidence and prevalence estimates for IPV, SV, and stalking victimization that can inform public policies and prevention strategies at both the national and state levels and help guide and evaluate progress toward reducing the substantial health, social, and economic burdens associated with these behaviors (CDC, 2010a).

Domestic Violence in Florida

In Florida reported domestic violence incidents declined overall since 1996 when there were 136,382 reported incidents. With the exception of a small increase in 2005 over 2004 the decline has been steady and in 2008 reported incidences reached a low of 113,123. However, in fiscal year 2008-2009 a total of 115,976 domestic violence crimes were reported in Florida. This was a 2.5% increase over the 2007-2008 total of 113,123 and, when comparing the first half of 2009 with the same period in 2008, actually reflects a 5.2% increase. Among the startling numbers for this same period were a rise of 8.9% in Florida's domestic violence homicides, a rise of 100% in domestic violence manslaughter homicides, and a 36% rise in aggravated stalking. Domestic violence crimes are believed by experts to still be seriously underreported, suggesting an even worse problem than the statistics represent and women still account for the majority of deaths related to domestic violence. While many experts believe the increase is related to current economic problems the connection is complex and merits further research (FDCF, 2009).

In Florida, domestic violence crimes include:

- Murder
- Manslaughter
- Forcible rape
- Forcible sodomy
- Forcible fondling
- Aggravated assault
- Aggravated stalking
- Simple assault
- Simple stalking
- Threat/intimidation

Types of Intimate Partner Violence

According to Florida law 741.28, "domestic violence" means

> . . . any assault, aggravated assault, battery, aggravated battery, sexual assault, sexual battery, stalking, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death of one family or household member by another family or household member.
>
> "Family or household member" means spouses, former spouses, persons related by blood or marriage, persons who are presently residing together as if a family or who have resided together in the past as if a family, and persons who are parents of a child in common regardless of whether they have been married. With the exception of persons who have a child in common, the family or household members must be currently residing or have in the past resided together in the same single dwelling unit. (Florida Legislature, 2009)

The Centers for Disease Control and Prevention (CDC) describes four types of intimate partner violence—physical violence, sexual violence, threats of physical or sexual violence, and psychological/emotional violence. Stalking and cyberstalking are increasingly being included as another type of intimate violence.

Physical Violence

Physical violence is the intentional use of physical force with the potential for causing death, disability, injury, or harm. Physical violence includes, but is not limited to:

- Scratching, pushing, or shoving
- Throwing, grabbing, or biting
- Choking, shaking, slapping, punching, or burning
- Use of a weapon
- Use of restraints or one's body, size, or strength against another person.

Physical violence also includes coercing other people to commit any of the above acts (CDC, 2010).

Research has shown that physical violence is often accompanied by psychological abuse and in one-third to one-half of cases, by sexual abuse (Heise and Garcia-Moreno, 2002). The violence is usually not limited to one instance. A National Violence against Women (NVAW) survey found that women who were physically assaulted by an intimate partner averaged 6.9 physical assaults by the same partner, while men averaged 4.4 assaults.

Women experience more chronic and injurious physical assaults at the hands of intimate partners than do men. The National Violence against Women survey found that more than 40% of women who were physically assaulted by an intimate partner were injured during their most recent assault, compared with about 20% of the men (Tjaden and Thoennes, 2000).

Most injuries, such as scratches, bruises, and welts, were minor. More severe physical injuries may occur depending on severity and frequency of abuse. Physical violence can lead to death. In 2005 in the United States, 329 males and 1181 females were murdered by an intimate partner.

Between 2001 and 2005, for nonfatal intimate partner violence:

- 27% of female victims and 15% of male victims reported that the offender threatened to kill them.
- 23% of male victims were threatened with a weapon and 7% had an object thrown at them.
- About 1 in 10 female and male victims reported that the offender tried to hit, slap, or knock them down (USDOJ, 2007).

Injuries to female victims, nonfatal intimate partner violence, 2001–2005

	Average annual	
	Number	**Percent**
Total intimate partner victims	510,970	100%
Not injured	248,805	48.7%
Injured	262,170	51.3%
Serious injury (gunshot wound, knife wounds, internal injuries, broken bones, knocked unconscious)	25,710	5.0 %
Rape/sexual assault without additional injuries	13,350	2.6%
Minor injuries only	222,670	43.6%
Injuries unknown	435	*0.1%

*Based on 10 or fewer sample cases
Source: Catalano, 2007.

Injuries to male victims, nonfatal intimate partner violence, 2001–2005

	Average annual	
	Number	**Percent**
Total intimate partner victims	104,820	100%
Not injured	61,285	58.5%
Injured	43,540	41.5%
Serious injury	4,335	*4.1%
Minor injuries	38,050	36.3%
Rape/sexual assault without other injuries	580	*0.6%
Injuries unknown	570	*0.5%

*Based on 10 or fewer sample cases
Source: Catalano, 2007.

Children are sometimes injured during incidents of intimate partner violence between their parents; a large overlap exists between IPV and child maltreatment. One study found that children of abused mothers were 57 times more likely to have been harmed because of IPV between their parents, compared with children of non-abused mothers (Parkinson et al, 2001).

Sexual Violence

A sexual act is defined as contact between the penis and the vulva or the penis and the anus involving penetration, however slight; contact between the mouth and the penis, vulva, or anus; or penetration of the anal or genital opening of another person by a hand, finger, or other object (Saltzman, 2001).

Abusive sexual contact is intentional touching directly, or through the clothing, of the genitalia, anus, groin, breast, inner thigh, or buttocks of any person against his or her will, or of any person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to be touched (Saltzman, 2001).

Sexual violence involves:

1. Use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed
2. Attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act, for example, because of illness, disability, or the influence of alcohol or other drugs, or because of intimidation or pressure
3. Abusive sexual contact (CDC, 2010)

Sexual and physical abuse is often accompanied by controlling behaviors. In a World Health Organization survey of more than 24,000 women in ten countries, those who experienced one or more of the following controlling behaviors ranged from 20% in Japan to 90% in urban United Republic of Tanzania:

- Keeping her from seeing friends
- Restricting contact with her family of birth
- Insisting on knowing where she is at all times
- Ignoring or treating her indifferently
- Getting angry if she speaks with other men
- Often accusing her of being unfaithful
- Controlling her access to health care (WHO, 2005)

Threats of Physical or Sexual Violence

Threat of physical or sexual violence is defined as the use of words, gestures, or weapons to communicate the intent to cause death, disability, injury, or physical harm. This includes the use of words, gestures, or weapons to communicate the intent to compel a person to engage in sex acts or abusive sexual contact when the person is either unwilling or unable to consent. A person threatening physical or sexual violence may use words such as:

- "I'll kill you."
- "I'll beat you up if you don't have sex with me."

Or actions such as:

- Brandishing a weapon
- Firing a gun into the air
- Making hand gestures
- Reaching toward a person's breasts or genitalia (Saltzman, 2001)

Psychological and Emotional Violence

Psychological/emotional violence involves trauma to the victim caused by acts, threats of acts, or coercive tactics. It is considered psychological/emotional violence when there has been prior physical or sexual violence or prior threat of physical or sexual violence. Psychological and emotional abuse involves trauma to the victim caused by acts, threats of acts, or coercive tactics, such as those listed below (CDC, 2010).

Psychological/emotional abuse can include:

- Deliberately humiliating, diminishing, or embarrassing the victim
- Controlling what they can and cannot do
- Withholding information
- Getting annoyed if they disagree with you
- Using money that is the victim's
- Taking advantage of or disregarding what the victim wants
- Isolating the victim from friends or family
- Prohibiting access to transportation, telephone, money, or basic resources
- Getting the victim to engage in illegal activities
- Using the victim's children to control their behavior
- Threatening loss of custody of children
- Smashing objects or destroying property
- Tarnishing the victim's reputation (Saltzman, 2001)

Coercive control and intimidation by the abusive partner is considered an underlying component of all of these types of violence. The abusive partner's ability to control relies on the abused person's belief that if she or he does not comply with the abusive partner's demands, the victim, the victim's children, or other persons or things the victim cares about will be harmed. Often, threats are alternated with acts of kindness from the perpetrator, making difficult for the victim to break free of the cycle of violence (CDC, 2009).

The ten-country World Health Organization survey and other research have consistently shown that emotional abuse can have a more profound and negative effect than physical violence. Between 20% and 75% of women across all the countries surveyed reported being the recipient of emotional abuse within the previous 12 months (WHO, 2005).

Stalking and Cyberstalking

In addition to the four types of intimate partner violence described above, stalking and cyberstalking have become increasingly common. Stalking generally refers to "harassing or threatening behavior that an individual engages in repeatedly, such as following a person, appearing at a person's home or place of business, making harassing phone calls, leaving written messages or objects, or vandalizing a person's property" (CDC, 2010).

According to the National Violence against Women Survey, stalking by intimates is more prevalent than previously thought. Almost 5% of surveyed women and 0.6% of surveyed men reported being stalked by a current or former spouse, cohabiting partner, or date at some time in their lifetime; 0.5% of surveyed women and 0.2% of surveyed men reported being stalked by such a partner in the previous 12 months (Tjaden and Thoennes, 2000).

According to these estimates, more than 500,000 women and 185,000 men are stalked by an intimate partner annually in the United States. These estimates exceed previous estimates of stalking prevalence in the general population. The findings suggest that intimate partner stalking is a serious criminal justice problem, and each state should develop constitutionally sound and effective anti-stalking statutes and intervention strategies (Tjaden and Thoennes, 2000).

Florida law (784.048) defines cyberstalking as "engaging in a course of conduct to communicate, or to cause to be communicated, words, images, or language by or through the use of electronic mail or electronic communication, directed at a specific person, causing substantial emotional distress to that person and serving no legitimate purpose (Florida Legislature, 2009).

Cyberstalking is a form of stalking. Stalkers have at their fingertips a wide array of computers and equipment including the Internet, global positioning systems, cell phones, and tiny digital cameras. In many states, general stalking statues have not kept up with these new technologies.

Violence Against Women

Violence against women has been the focus of international attention for more than 20 years. In 1993 the World Conference on Human Rights published the Declaration on the Elimination of Violence against Women. It established that according to international human rights law, "states have a duty to exercise due diligence to prevent, prosecute, and punish violence against women" (WHO, 2005).

Recognizing the need for research in the area of intimate partner violence, in 2005 the World Health Organization (WHO) completed a ten-country population-based survey of 24,000 women called the *WHO Multi-country Study on Women's Health and Domestic Violence against Women*. The WHO researchers asked participants a series of questions about physical and sexual violence, emotional abuse, and controlling behaviors.

Overall, the proportion of women who had ever suffered physical violence by a male partner ranged from 13% in Japan to 61% in provincial Peru. Japan had the lowest level of sexual violence at 6%, while Ethiopia had the highest figure of 59%. The majority of settings were between 10% and 50% (WHO, 2005).

It is well-known that violence perpetrated against women by an intimate partner is often accompanied by emotionally abusive and controlling behavior. The National Violence against Women survey found that women whose partners were jealous, controlling, or verbally abusive were significantly more likely to report being raped, physically assaulted, or stalked by their partners, even when other sociodemographic and relationship characteristics were controlled.

Having a verbally abusive partner was the variable most likely to predict that a woman would be victimized by an intimate partner. These findings support the theory that violence perpetrated against women by an intimate partner is often part of a systematic pattern of dominance and control (Tjaden and Thoennes, 2000).

Violence against women incorporates intimate partner violence, sexual violence, and other forms of violence against women such as physical violence committed by acquaintances or strangers (Saltzman, 2001). The victims are often emotionally involved and economically dependent upon the person victimizing them. In contrast, men are more likely to be victimized by someone outside their close circle of relationships (Heise and Garcia-Moreno, 2002).

Intimate Partner Violence during Pregnancy

Depending on the population, setting, or frequency of asking, between 0.9% and 20.1% of women in the United States reported they have experienced violence during pregnancy. Violence during pregnancy may be more common than some conditions for which pregnant women are routinely screened. As with screening for gestational diabetes, neural tube defects, preeclampsia, and behavioral risk factors such as smoking and alcohol use, screening for intimate partner violence should be incorporated into routine prenatal care (CDC, 2006).

Women who report violence around the time of pregnancy have reported higher prevalence of other demographic and psychosocial risk factors that also may have an effect on pregnancy. These include:

- Young maternal age/adolescence
- Unintended pregnancy
- Delayed prenatal care
- Smoking
- Alcohol and drug use
- Lack of social supports
- STD/HIV/AIDS (CDC, 2006)

Child Abuse

Intimate partner violence is often associated with the abuse of children. This is an important public health issue because witnessing violence in the home as a child is a strong risk factor for involvement in abusive relationships as an adult. In addition, experiencing abuse as a child has been associated with other risk factors such as depression, substance abuse, poor school performance, and high-risk sexual activity (CDC, 2009).

The Federal Child Abuse Prevention and Treatment Act (CAPTA) defines child abuse and neglect as, at minimum:

- Any recent act or failure to act on the part of a parent or caretaker which results in death, serious physical or emotional harm, sexual abuse or exploitation; or
- An act or failure to act that presents an imminent risk of serious harm (Child Welfare Information Gateway, 2010)

This definition of child abuse and neglect refers specifically to parents and other caregivers. A "child" under this definition generally means a person who is under the age of 18 or who is not an emancipated minor (Child Welfare Information Gateway, 2010).

CAPTA provides definitions for sexual abuse and the special cases related to withholding or failing to provide medically indicated treatment but does not provide specific definitions for other types of maltreatment such as physical abuse, neglect, or emotional abuse. While Federal legislation sets minimum standards, each state is responsible for providing its own definition of maltreatment within civil and criminal contexts (Child Welfare Information Gateway, 2010).

Florida statute (39.01 and 39.32) defines child abuse as “any willful act or threatened act that results in any physical, mental, or sexual injury or harm that causes or is likely to cause the child's physical, mental, or emotional health to be significantly impaired. Abuse of a child includes acts or omissions.” Harm to a child’s health or welfare can occur when any person inflicts or allows to be inflicted upon the child physical, mental, or emotional injury, and can include:

- Purposely giving a child poison, alcohol, drugs, or other substances that substantially affect the child’s behavior, motor coordination, or judgment or that result in sickness or internal injury.
- Inappropriate or excessively harsh discipline.
- Exposure to a controlled substance or alcohol.
- Engaging in violent behavior that demonstrates a wanton disregard for the presence of a child and could reasonably result in serious injury to the child (Florida Legislature, 2009).

Co-Occurring Domestic Violence and Child Maltreatment

Children exposed to domestic violence may be the victims of co-occurring maltreatment. In particular, domestic violence is a significant risk factor for verbal abuse, physical punishment, and physical abuse of children. Although high rates of co-occurring domestic violence and child maltreatment have been noted in the general population, this co-occurrence has most commonly been investigated in clinical samples of abused women and of physically abused children, with the majority of studies indicating rates of co-occurrence ranging from 30% to 60% (Kelleher, 2006).

There is evidence that children who are exposed to domestic violence and also experience maltreatment are at risk for poor development. There also is a growing concern that children's exposure to domestic violence constitutes a type of psychological or emotional abuse in and of itself (Kelleher, 2006).

Although domestic violence and child maltreatment commonly occur together, policy makers and planners of services lack a nationally representative study that examines the prevalence of this co-occurrence. Equally as important is the need for information on state and local policies and practices around services for families with co-occurring domestic violence and child maltreatment (Kelleher, 2006).

Domestic Violence and the Child Welfare System

Domestic violence is a significant problem for 30% to 40% of families in the child welfare system. Because co-occurring domestic violence and child maltreatment are so prevalent, many communities have implemented policies and practices to protect women and children from domestic violence, and provide services, especially as it relates to interactions with the child welfare system. Many of these initiatives have arisen out of local advocacy through domestic violence centers and services while others come from national movements promulgated by the National Council of Juvenile and Family Court Judges such as its Model Code or its more recent policy and practice recommendations, sometimes referred to as the "Greenbook" (Kelleher, 2006).

Elder Abuse and Abuse of Vulnerable Adults

Abuse of a vulnerable adult is defined in Florida law (415.102) as the abuse, neglect, or exploitation of a person age 18 years or older who has a disability or is suffering from the infirmities of aging.

Abuse of a vulnerable includes:

> . . . any willful or threatened act or omission that causes or is likely to cause significant impairment to a vulnerable adult's physical, mental or emotional health.

Neglect of a vulnerable adult includes:

> . . . the failure or omission on the part of the caregiver to provide the care, supervision and services necessary to maintain the physical and mental health of the vulnerable adult. The failure of a caregiver to make reasonable efforts to protect a vulnerable adult from abuse, neglect or exploitation by others.

Exploitation of a vulnerable adult includes:

> . . . actions of deception or intimidation, for the purpose of personal gain or benefit by a person in a position of trust, that deprives a vulnerable adult of the use, benefit or possession of funds, assets or property. Exploitation also occurs when the Possible Responsible Person knows or should know that the vulnerable adult lacks the capacity to consent and who obtains or uses, or endeavors to obtain or use, their funds, assets or property for personal gain or benefit (Florida Legislature, 2009).

According to the best available estimates, between 1 and 2 million Americans age 65 or older have been injured, exploited, or otherwise mistreated by someone on whom they depended for care or protection (NCEA, 2005).

Complicating these estimates, however, is the difficulty in defining and quantifying elder abuse. Available data indicate that the highest rates of elder abuse are among women and those aged 80 and older. In 90% of cases, the perpetrator is a family member, most often a spouse or adult child (Nelson, 2004).

Abuse of vulnerable adults is an important issue in Florida because it leads the nation in the percentage of the state's population aged 60 or over. That percentage is expected to continue to grow, from 23% in 2009 to 35% by 2030 (FDEA, 2010). In June 2008, Florida's governor signed into law SB 366, which "increased the penalty for aggravated abuse of Florida's elderly and disabled populations from a second-degree felony to a first-degree felony." In its press release the Florida Department of Elder Affairs observed that elder abuse was increasing and that in 2008 alone, in the state of Florida, there had been 42,800 reports of elder abuse and neglect, almost 15% more than in the previous year (FDEA, 2008).

Risk and Protective Factors for IPV

A combination of individual, relational, community and societal factors contribute to the risk of becoming a victim or perpetrator of intimate violence. Risk factors are contributing factors and may or may not be direct causes. Not everyone who is identified as "at risk" becomes involved in violence.

Some risk factors are the same and some are associated with one another. For example, childhood physical or sexual victimization is a risk factor for both future perpetration and victimization. Understanding these multilevel factors can help identify various opportunities for prevention.

The termination of a relationship poses an increased risk for, or escalation of, intimate partner violence. This assumption is based on two types of evidence: divorced or separated women report more intimate partner violence than do married women. Also, interviews with men who have killed their wives indicate that either threats of separation by their partner or actual separation are most often the precipitating events that lead to the murder (Tjaden and Thoennes, 2000).

The National Violence against Women Survey found that married women who lived apart from their husbands were nearly four times more likely to report that their husbands had raped, physically assaulted, and/or stalked them than were women who lived with their husbands (20% and 5.4%). Similarly, married men who lived apart from their wives were nearly three times more likely to report that their wives had victimized them than were men who lived with their wives (7.0% and 2.4%) (Tjaden and Thoennes, 2000).

These findings suggest that termination of a relationship poses an increased risk of intimate partner violence for both women and men. However, it should be noted that the survey data do not indicate whether the violence happened before, after, or at the time the couple separated. Thus, it is unclear whether the separation triggered the violence or the violence triggered the separation (Tjaden and Thoennes, 2000).

Adolescents are at increased risk for violence—from either their partner or from a family member. Women with HIV or AIDS are also at increased risk for violence (CDC, 2009).

Factors Associated with a Man's Risk for Abusing His Partner	
Individual Factors	Young age Heavy drinking Depression Personality disorders Low academic achievement Low income Witnessing or experiencing violence as a child
Relationship Factors	Marital conflict Marital instability Male dominance in the family Economic stress Unhealthy family relationships and interactions
Community Factors	Poverty Low social capital Weak community sanctions against IPV
Societal Factors	Traditional gender norms Social norms supportive of violence

The World Health Organization population survey investigated which factors might protect a woman from intimate partner violence and which factors put her at greater risk. As in other studies, this survey looked at individual and partner factors as well as factors related to the woman's immediate social context (WHO, 2005).

The survey found that in all but two settings (Japan and Ethiopia), younger women (aged 15 to 19 years) were at higher risk for physical or sexual abuse within the last 12 months. In all but two settings (Bangladesh and Ethiopia), women who had been separated or divorced reported much more partner violence during their lifetime than currently married women. Higher education was associated with less violence in many settings (WHO, 2005).

Cost to Society

In 2003 dollars, costs associated with intimate partner violence exceeded $8.3 billion, which included $460 million for rape, $6.2 billion for physical assault, $461 million for stalking, and $1.2 billion in the value of lost lives. Victims of severe intimate partner violence lose nearly 8 million days of paid work—the equivalent of more than 32,000 full-time jobs—and almost 5.6 million days of household productivity each year (CDC, 2003). This is generally considered an underestimate because the costs associated with the criminal justice system were not included.

The U.S. medical community treats millions of intimate partner rapes and physical assaults annually. Of the nearly 5 million intimate partner rapes and physical assaults perpetrated against women annually, approximately 2 million will result in an injury to the victim, and more than half a million will result in some type of medical treatment to the victim (Tjaden and Thoennes, 2000).

Of the estimated 2.9 million intimate partner physical assaults perpetrated against men annually, 581,391 will result in an injury to the victim, and 124,999 will result in some type of medical treatment to the victim. Many medically treated victims receive multiple forms of care—ambulance services, emergency room care, or physical therapy—and multiple treatments, such as several days in the hospital, for the same victimization (Tjaden and Thoennes, 2000).

Consequences

In general, victims of repeated violence experience more serious consequences than victims of one-time incidents. Women with a history of intimate partner violence are more likely to display behaviors that lead to further **health risks** such as substance abuse, alcoholism, and suicide attempts. Intimate partner violence is also associated with a variety of negative **health behaviors**; studies show that the more severe the violence, the stronger its relationship to negative health behaviors by victims.

Some victims may engage in high-risk sexual behaviors such as unprotected sex, decreased condom use, early sexual initiation, choosing unhealthy or multiple sexual partners, or trading sex for food, money, or other items. There is often an increased use of harmful substances and illicit drug use, alcohol abuse, and driving while intoxicated. Victims of intimate partner violence may also engage in unhealthy diet-related behaviors such as smoking, fasting, vomiting, overeating, and abuse of diet pills. They may also overuse health services.

Women who experience severe aggression by men such as not being allowed to go to work or school, or having their lives or their children's lives threatened are more likely to have been unemployed in the past and be receiving public assistance (CDC, 2003). They may have restricted access to services, strained relationships with healthcare providers and employers, and be isolated from social networks.

Psychological Consequences of Intimate Partner Violence

- Depression
- Antisocial behavior
- Suicidal behavior in females
- Anxiety
- Low self-esteem
- Inability to trust men
- Fear of intimacy
- Symptoms of post-traumatic stress disorder
- Emotional detachment
- Sleep disturbances
- Flashbacks
- Replaying assault in mind

Screening and Assessment

The number of medical personnel treating injuries annually is in the millions. To better meet the needs of intimate partner violence victims, medical professionals should receive training in screening and assessment, learn to recognize the physical consequences of intimate partner violence, and initiate appropriate medical intervention strategies.

Clinicians have an opportunity to identify and intervene on behalf of abused women and men and to assist in breaking the intergenerational cycle that could affect their children. Whenever possible, at the point of detection, clinicians should communicate with the family's other health care providers, such as pediatricians. Clinicians should also be aware of and follow state reporting requirements related to domestic violence or child abuse and neglect (CDC, 2006).

Training in the use of efficient assessment methods can increase the percentage of providers that screen for intimate partner violence. When providers are asked why they do not screen for violence, they commonly indicate four major barriers:

- Time constraints
- Discomfort with the topic
- Fear of offending the patient or partner
- Perceived powerlessness to change the problem (CDC, 2006)

Health care organizations and individual providers can increase competency in and commitment to screening for violence. One such screening and intervention method can be summarized in the acronym RADAR, which was developed by the Massachusetts Medical Society (CDC, 2006).

Use Your RADAR:

- **R**outinely screen every patient
- **A**sk directly, kindly, nonjudgmentally
- **D**ocument your findings
- **A**ssess the patient's safety
- **R**eview options and provide referrals (CDC, 2006)

The first step in the RADAR process is to routinely screen for violence. Assume that all patients are at risk for violence and ask every patient as part of his or her routine health assessment. Screening requires that the provider ask directly for information at multiple visits. In cases where violence is identified, document your findings in the patient's chart. Assess your patient's safety—is the patient or are her or his children in immediate danger? Finally, review the patient's options and provide him or her with referrals (CDC, 2006).

A woman's behavior during office visits can provide warning signs for possible intimate partner violence. Abused women may present with a flat affect or as frightened, depressed, or anxious. Severe cases may be characterized by symptoms of post-traumatic stress disorder (PTSD), such as dissociation, psychic numbing, or startle responses to touch. Abused women may appear overly compliant. Most patients have a number of questions, but an abused woman may have "learned" not to question authority. Conversely, an abused woman may exhibit excessive distrust of healthcare providers, possibly because of the fear and shame associated with the abuse and the possibility of its detection (CDC, 2006).

Possible Signs of IPV in Women

- Flat affect
- Fright, depression, anxiety
- Post-traumatic stress disorder (PTSD) symptoms (dissociation, psychic numbing, startle responses to touch)
- Over-compliance
- Excessive distrust

Source: CDC, 2006.

Documentation

Medical records are often used as evidence in domestic violence cases. Clear, concise, and factual documentation can help establish that abuse has occurred. Medical professionals may not be aware that subtle differences in how they document cases of domestic abuse can affect the usefulness of their records if there is a hearing. For example, "excited utterances" or "spontaneous exclamations" should be carefully documented because they have exceptional credibility due to their proximity to the event and because they are not likely to be premeditated. The victim or the victim's attorney can use a medical record to obtain a restraining order, qualify for special status or exemptions in public housing, welfare, health and life insurance, victim compensation, and immigration relief related to domestic violence and in resolving landlord-tenant disputes (Isaac & Enos, 2001).

According to a number of studies, many medical records are not sufficiently well-documented to provide adequate legal evidence of domestic violence. A study of 184 visits for medical care in which an injury or other evidence of abuse was noted revealed major shortcomings in the records (Isaac & Enos, 2001):

- For the 93 instances of an injury, the records contained only 1 photograph. There was no mention in any records of photographs filed elsewhere (eg, with police).
- A body map documenting the injury was included in only 3 of the 93 instances. Drawings of the injuries appeared in 8 of the 93 instances.
- Doctors' and nurses' handwriting was illegible in key portions of the records in one-third of the patients' visits in which abuse or injury was noted.
- Criteria for considering a patient's words an "excited utterance" were met in only 28 of the more than 800 statements evaluated (3.4%). Most frequently missing was a description of the patient's demeanor, and often the patient was not clearly identified as the source of the information.

Medical records could be more useful to domestic violence victims in legal proceedings if some minor changes were made in documentation. Clinicians can do the following (Isaac & Enos, 2001):

- Take photographs of injuries known or suspected to have resulted from domestic violence.
- Write legibly. Computers can also help overcome the common problem of illegible handwriting.
- Set off the patient's own words in quotation marks or use such phrases as "patient states" or "patient reports" to indicate that the information recorded reflects the patient's words. To write "patient was kicked in abdomen" obscures the identity of the speaker.
- Avoid such phrases as "patient claims" or "patient alleges," which imply doubt about the patient's reliability. If the clinician's observations conflict with the patient's statements, the clinician should record the reason for the difference.
- Describe the person who hurt the patient by using quotation marks to set off the statement. The clinician would write, for example: The patient stated, "My boyfriend kicked and punched me."
- Avoid summarizing a patient's report of abuse in conclusive terms. If such language as "patient is a battered woman," "assault and battery," or "rape" lacks sufficient accompanying factual information, it is not admissible.
- Do not place the term "domestic violence" or abbreviations such as "DV" or "IPV" in the diagnosis section of the medical record. Such terms do not convey factual information and are not medical terminology. Whether domestic violence has occurred is determined by the court.
- Describe the patient's demeanor, indicating, for example, whether she is crying or shaking or seems angry, agitated, upset, calm, or happy. Even if the patient's demeanor belies the evidence of abuse, the clinician's observations of that demeanor should be recorded.
- Record the time of day the patient is examined and, if possible, indicate how much time has elapsed since the abuse occurred. For example, the clinician might write, "Patient states that early this morning his boyfriend hit him."

Florida Legislation

In 2008–2009 the Florida legislature adopted the following bills related to domestic violence (FCDF, 2009):

- Confidential Records of Children (Chapter No. 2009-34). This bill authorizes the sharing of confidential and exempt information among all state and local agencies and programs that provide services to children or are responsible for the children's safety, if the information is reasonably necessary to assure access to services or the safety of the child. However, the bill specifically excludes information relating to clients and records of certified domestic violence centers from the sharing provision. Effective July 1, 2009.

- Service of Process (Chapter No. 2009-215). This bill allows sheriffs to serve a facsimile copy of a protective injunction instead of a certified copy in domestic violence and sexual violence cases. Thus, faster service of process could be accomplished in these cases. The bill also amends current law to provide that law enforcement may arrest a person who has violated a condition of pretrial release when the original arrest was for an act of dating violence. Effective July 1, 2009.

- Parental Responsibility and Time-Sharing (Chapter 2009-180). This bill amends current law to provide that the rebuttable presumption for domestic violence apply to a first-degree misdemeanor or higher rather than to third-degree felony or higher. The bill also prohibits the court from referring parents to parenting coordination if there has been a history of domestic violence, unless both parties have given consent freely and voluntarily. This bill provides qualifications for the parenting coordinator to include a minimum of four hours of domestic violence training, and disqualifications to include offenses of child abuse, child neglect, domestic violence, parental kidnapping, or interference with custody. Effective October 1, 2009.

- Sexual Battery Victim Services (Chapter 2009-184). This bill creates a new statute that requires the investigating law enforcement officer to notify sexual battery victims of their legal rights and remedies, assist them in obtaining any necessary medical treatment resulting from the incident, and advise sexual battery victims that they can contact a certified rape crisis center about services. (This new statute is comparable to the existing domestic violence statute providing these same protections for domestic violence victims.) Effective July 1, 2009.

- State Judicial System (Chapter 2009-61). This bill allows the clerk of courts to charge fees up to $295 in all cases in which the party is instituting any civil action, suit or proceeding. This law would have impacted domestic violence victims seeking injunctions for protection by requiring in some instances the victim to pay for the protection order. In a June 19, 2009 opinion issued by the State's Attorney General, this law "does not require a clerk of court to assess a filing fee for the filing of a petition for a domestic violence injunction," based on conflict with existing law F.S. 741.30, which mandates fees may not be assessed.

For additional information about these bills and others, go to the Legislature's website at: http://www.leg.state.fl.us. In addition, prior year's *Domestic Violence Annual Reports* prepared by the Florida Department of Children and Families (FDCF) list that session's pertinent bills.

New Background Screening Process

Beginning August 1, 2010, Florida HB 7069 took effect and requires significant changes to the background screening process for those who work with certain vulnerable Floridians, including children, elders, and those with disabilities. Details of the law and the new procedures can be found at: http://www.dcf.state.fl.us/admin/backgroundscreening/ and http://elderaffairs.state.fl.us/english/backgroundscreening.php.

Florida Reporting Requirements

Florida statute 790.24 requires medical professionals and employees of medical facilities to report to the sheriff's office gunshot wounds or any life-threatening injury "indicating an act of violence". There is no specific requirement to report injuries resulting from an act of domestic violence.

Mandatory Reporters

Specific occupations in Florida—called “professionally mandatory reporters”—are required by law to report suspected abuse or neglect of children and vulnerable adults. A mandatory reporter must provide his or her name, which is entered into the record but remains confidential. Healthcare professionals, including staff of care facilities and day care center workers are mandatory reporters (FDCF, 2009a).

Mandatory reporters can make reports by telephone, TTY, fax, or internet. See the Resources section for full contact information. For a complete list of mandatory reporters in Florida call the Florida Department of Children and Families at 850 487 1111 or visit their website: http://www.dcf.state.fl.us/abuse/publications/mandatedreporters.pdf.

Children

Chapter 39 of the Florida Statutes mandates that any person who knows, or has reasonable cause to suspect, that a child is abused, neglected, or abandoned by a parent, legal custodian, caregiver, or other person responsible for the child's welfare shall immediately report such knowledge or suspicion to the Florida Abuse Hotline of the Department of Children and Families (FDCF, 2009a).

Vulnerable Adults

Healthcare workers are required to report suspected abuse of vulnerable adults to the Florida Abuse Hotline. This includes reporting the suspected abuse, neglect, and exploitation of vulnerable adults who, because of their age or disability, may be unable to adequately provide for their own care or protection. Law enforcement takes the lead in all criminal investigations and prosecution (FDCF, 2009a).

Legal Rights of Florida's Victims

In Florida, a person who is a victim or has reasonable cause to believe they are in imminent danger of becoming a victim of intimate partner violence can file an Injunction for Protection. There are four types of injunctions for protection:

- Against domestic violence
- Against repeat violence (used when the parties are not “family or household members”)
- Against dating violence
- Against sexual violence (CASA, 2010)

For more information about Injunctions for protection and other legal rights, call 800 799-SAFE or visit http://www.casa-stpete.org/knowrights.htm, or http://www.fcadv.org/resources.

Prevention and Education

Most of the efforts directed against intimate personal violence center on reducing future additional risk, dealing with the consequences of the violence for the victim, and processing the perpetrators through the judicial system. As with its first agenda in 2002, the National Center for Injury Prevention and Control's new agenda for 2009 to 2018 reiterates the goal for prevention and education: stopping intimate personal violence from happening in the first place (primary prevention). Research efforts are urgently needed surrounding "early risk and protective factors related to perpetration." A better understanding of these factors should lead to more effective prevention programs. As before, prevention must address individual, relationship, community, and societal factors (NCIPC, 2009).

The National Center for Injury Prevention and Control has identified two tiers of research priorities for the next ten years aimed at preventing sexual violence and intimate partner violence. These ambitious goals reflect the strong need for detailed and broad-based data for the formulation and implementation of prevention strategies for sexual violence and intimate partner violence.

Tier 1 includes:

- Develop and evaluate surveillance methods for sexual violence and intimate partner violence victimization and perpetration.
- Examine the etiology of sexual violence and intimate partner violence perpetration to identify modifiable risk and protective factors and optimal times and strategies for prevention.
- Clarify the contexts within which violence occurs and the associations among types and subtypes of sexual violence and intimate partner violence, other types of violence, other risk behaviors, and other health outcomes to determine implications for prevention of perpetration.
- Examine the role of disparities in the occurrence and development of sexual violence and intimate partner violence and determine implications for prevention of perpetration.
- Evaluate the efficacy and effectiveness of programs, strategies, and policies across all levels of the social ecology to prevent and interrupt development of perpetration of sexual violence and intimate partner violence.
- Evaluate the efficacy and effectiveness of programs, strategies, and policies to prevent both sexual violence and intimate partner violence, multiple types of sexual violence and intimate partner violence, and other forms of violence.

Tier 2 includes:

- Assess the cost and health burden of sexual violence and intimate partner violence throughout the life span.
- Evaluate the economic efficiency of programs, strategies, and policies to prevent perpetration of sexual violence and intimate partner violence.
- Evaluate interventions for persons exposed to sexual violence and intimate partner violence to reduce risk for associated negative health consequences.
- Conduct dissemination and implementation research regarding programs, strategies, and policies used in the primary prevention of sexual violence and intimate partner violence.
- Examine when and how to adapt effective programs, strategies, and policies to prevent sexual violence and intimate partner violence for new settings and among diverse populations (NCIPC, 2009).

The World Health Organization, following its ten-country survey of violence against women made the following recommendations for prevention and education:

- Strengthen national commitment and action by promoting gender equality and women's human rights.
- Promote primary prevention including giving higher priority to child sexual abuse.
- Involve educators.
- Strengthen healthcare provider response.
- Provide support services for women living with violence.
- Sensitize the criminal justice system.
- Support research and collaboration and increase donor support. (WHO, 2005)

Florida Programs and Resources

Batterer Intervention Programs

Batterer Intervention Programs (BIP) are community-based programs that receive referrals through the civil and criminal court system, pretrial and diversion programs, the Department of Children and Families, and through self referral. The goal of these programs is to provide standardized training, hold batterers responsible for their violence, and provide tools for establishing and maintaining non-abusive relationships. The basis of the BIP is to identify power and control as the central issue related to abusive behavior. The program is funded through fees from program participants. BIP service providers must be state-certified and conform to a set of state standards (FDCF, 2007, 2009).

Domestic Violence Centers

Domestic violence centers are community-based agencies that provide services to the victims of intimate violence. The majority of adults served by Florida's shelters are between that age of 30 and 45. Minimum services include temporary emergency shelter, information and referrals, safety planning, counseling and case management, a 24-hour emergency hotline, educational services for community awareness, assessment and appropriate referral of resident children, and training for law enforcement and other professionals. Other services include transportation, legal advocacy, relocation assistance, transitional housing, and life skills training.

There are 42 certified domestic violence centers in Florida, the first of which was established in 1974. The Florida Coalition Against Domestic Violence, which was incorporated in 1981, provides leadership and advocacy for Florida's domestic violence centers. The centers are located throughout the state in undisclosed locations and provide free and confidential services to victims. In 2008–2009 Florida's certified domestic violence centers provided services to more than 14,000 women, children, and men—the vast majority women with children (FDCF, 2009).

Services Provided by Emergency Shelters in Florida in 2008–2009	
Individuals served	14,667 people • 7896 Women • 6727 Children • 44 Men
Days of shelter	419,338 days
Individuals provided information and referral	559,206 people

Source: FDCT, 2009.

The Florida Coalition Against Domestic Violence also operates a statewide domestic violence hotline. A survivor can access the nearest domestic violence center for emergency services by dialing (800)500-1119. Legal advice, referrals, and information for victims are also available.

Cut Out Domestic Violence

In Florida there are a number of programs that provide training, community outreach, education, and prevention education. One successful program, started in 2004, trains licensed hair stylists, cosmetologists and nail technicians to identify the signs of domestic violence, listen and talk to victims and connect them with appropriate resources and authorities. Although they are not encouraged or required to report suspected cases of abuse, the more than 55,000 salon professionals in 8,000 licensed hair salons are a vital resource for their communities. For more information about this program call 239 939 3112.

The Rural Initiative

The Florida Coalition Against Domestic Violence (FCADV) oversees an array of programs in addition to the state's domestic violence centers and provides technical assistance, referrals, training, and community education throughout Florida. Among its innovative programs are the **Rural Initiative**, which focuses on improving domestic violence services and training in rural Florida communities, and a teen-dating violence program that supports services and training in domestic violence centers and youth agencies throughout the state.

DELTA

In 2002 CDC used Family Violence Prevention Services Act (FVPSA) funding to develop the Domestic Violence Prevention Enhancements and Leadership through Alliances (DELTA) Program whose focus is the primary prevention of IPV at the community level. Through the DELTA Program, CDC provides financial support to fourteen state-level domestic violence coalitions for prevention-focused training and technical assistance. Local coalitions then develop and implement strategies focused on preventing first-time perpetration and victimization.

The Florida Coalition Against Domestic Violence (FCADV) participates in the DELTA program, overseeing six local primary prevention projects focusing on underserved youth, communities of color, and immigrants. The programs involve seven counties: Orange, Pasco, Palm Beach, Okaloosa-Walton, Alachua, and Pinellas. The goal of the DELTA program is to reduce the number of new cases of domestic violence. For more information about DELTA call 850 656 6985 or visit the FCADV website at http://www.fcadv.org/projects-programs/delta-project.

The Economic Justice Initiative

The FCADV also supports the **Economic Justice Initiative**, which addresses economic and housing issues that threaten the safety and economic well being of battered women. For more information about the Economic Justice Initiative call 850 425 2749 or visit http://www.fcadv.org/projects-programs/economic-justice-initiative.

The Disability and Accessibility Project

The **Disability and Accessibility Project** was created to support domestic violence centers in creating accessible services and effectively serving survivors living with disabilities. For more information visit the Florida Coalition Against Domestic Violence website at http://www.fcadv.org/projects-programs/disabilities-program.

The INVEST Program

The Intimate Violence Enhanced Services Team (INVEST) provides intensive assistance to those individuals determined to be in potentially lethal situations, individuals who often do not seek out help. The program allows "law enforcement and domestic violence centers to work together to identify victims at high risk for homicide and to enhance their possibility of receiving safety from further victimization." For more information visit the Florida Coalition Against Domestic Violence website at http://www.fcadv.org/projects-programs/invest-program.

These and other programs have increased our awareness of the effects of intimate partner violence in Florida and throughout the United States. Shedding light on the devastating effects of intimate partner violence, improving training for healthcare workers and law enforcement professionals, and providing ongoing public education will continue to move us towards the goal of the reduction and eventual elimination of this pervasive and expensive public health problem.

(Resources begin on next page)

Resources

Florida Coalition Against Domestic Violence
All calls to FCADV and services provided by FCADV are confidential.
425 Office Plaza Dr.
Tallahassee, FL 32301
Hotline: 800 500 1119
TTY Hotline: 800 621 4202
Phone: 850 425 2749
Fax: 850 425 3091
http://www.fcadv.org

Mandatory Reporters Use:
Phone: 800 96-ABUSE or 800 962 2873
Fax: 800 914 0004
TDD: 800 453 5145
Web reporting, http://www.dcf.state.fl.us

Florida Department of Children and Families
Domestic Violence Program Office
Building 3, Room 325
1317 Winewood Boulevard
Tallahassee, FL 32399
Phone: 850 921 2168
Fax: 850 922 6720
Email: domesticviolence@dcf.state.fl.us
http://www.dcf.state.fl.us/programs/domesticviolence/

For details of the changes to the background screening law that took effect August 1, 2010 visit this website: http://www.dcf.state.fl.us/admin/backgroundscreening/.

Florida Department of Elder Affairs
4040 Esplanade Way
Tallahassee, FL 32399-7000
Phone: 850 414 2000
Fax: 850 414 2004
TDD: 850 414 2001
http://elderaffairs.state.fl.us/index.php
Elder Helpline: 800 96-ELDER or 800 963 5337
Report Elder Abuse: 800 96-ABUSE or 800 962 2873
Statewide Senior Legal Helpline: 888 895 7873

For details of the changes to the background screening law that took effect August 1, 2010 visit http://elderaffairs.state.fl.us/english/backgroundscreening.php.

Florida Long-Term Care Ombudsman Program
4040 Esplanade Way, Suite 280
Tallahassee, FL 32399-7000
Phone: 850 414 2323
Toll Free: 888 831 0404
Fax: 850 414 2377
Email: LTCOPInformer@elderaffairs.org
http://ombudsman.myflorida.com/

Florida Attorney General
Medicaid Fraud Control Unit
866 966 7226 (toll-free in state only)
Phone: 850 414 3935
TTY: 800 955 8771
http://myfloridalegal.com/

Family Violence Prevention Fund
http://www.endabuse.org/section/programs/health_care
The National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings (2004)
"Designed to assist health care providers from multiple settings and in various professional disciplines in addressing domestic violence victimization. Includes assessment, documentation, intervention and referral information."
http://www.endabuse.org/section/programs/health_care/_consensus_guidelines
http://www.endabuse.org/programs/healthcare/files/Consensus.pdf

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Post Test

Use the Answer Sheet following the test to record your answers.

1. Intimate partner violence:
   a. Refers only to relationships that involve sexual intimacy.
   b. Never includes psychological abuse.
   c. Refers to violence that occurs between current or former partners or spouses.
   d. Only happens in the United States.

2. The perpetrators of intimate partner violence are evenly divided between men and women.
   a. True
   b. False

3. Domestic violence in Florida:
   a. Increased by 100% from 2007/8 to 2008/9.
   b. Has declined substantially and is no longer considered a significant problem.
   c. Does not include murder.
   d. Has recently risen after many years of overall decline.

4. The Centers for Disease Control and Prevention describes physical violence as:
   a. The intentional use of physical force with potential for causing death, disability, injury, or harm.
   b. The use of physical force to coerce another person to engage in a sex act.
   c. Abusive language that includes threats of violence.
   d. Stalking and cyberstalking.

5. Choking, shaking, slapping, punching, or burning is an example of:
   a. Psychological violence.
   b. Stalking.
   c. Physical violence.
   d. Sexual violence.

6. Sexual and physical abuse is often accompanied by controlling behaviors. Controlling behaviors include:
   a. Verbal abuse.
   b. Preventing access to health care.
   c. Hitting and slapping.
   d. Cyberstalking.

7. The use of words, gestures, or weapons to communicate the intent to cause death, disability, injury, or physical harm is:
   a. Controlling behavior.
   b. Psychological violence.
   c. Threat of physical or sexual violence.
   d. Stalking.

8. An underlying component of all types of domestic violence is:
   a. Isolating the victim from family and friends.
   b. Withholding information.
   c. Coercive control and intimidation.
   d. Threat of physical violence.

9. Harassing or threatening behavior that an individual engages in repeatedly, such as following a person, appearing at a person's home or place of business, making harassing phone calls, leaving written messages or objects, or vandalizing property is a description of:
   a. Cyberstalking.
   b. Coercive control and intimidation.
   c. Controlling behavior.
   d. Stalking.

10. The variable most likely to predict that a woman will be victimized by an intimate partner is a partner who is:
   a. Verbally abusive.
   b. From a different country.
   c. Of a different race.
   d. Emotionally abusive.

11. The Federal Child Abuse Prevention and Treatment Act (CAPTA):
   a. Provides specific definitions for all types of maltreatment.
   b. Supersedes any similar state law.
   c. Protects any person less than 21 years of age.
   d. Addresses acts or failures to act by parents or other caregivers that result in harm to a child.

12. According to Florida law, any willful act or threatened act that results in physical, mental, or sexual injury or harm that causes or is likely to cause the child's physical, mental, or emotional health to be significantly impaired is defined as:
   a. Child neglect.
   b. Child endangerment.
   c. Coercive control.
   d. Child abuse.

13. Children who are exposed to domestic violence are at risk for poor development. There is evidence that a child's exposure to domestic violence:
   a. May cause autism.
   b. Contributes to physical illness.
   c. Constitutes a type of psychological abuse.
   d. Has no effect on the child's development.

14. Any willful or threatened act or omission that causes or is likely to cause significant impairment to a vulnerable adult's physical, mental or emotional health is:
   a. Exploitation.
   b. Abuse
   c. Coercion.
   d. Neglect.

15. According to available data, the highest rates of elder abuse:
    a. Occur among elderly men.
    b. Occur among women and those age 80 and older.
    c. Are perpetrated by nursing home owners.
    d. Are perpetrated by elderly men.
16. The termination of a relationship poses:
    a. An increased risk of IPV.
    b. No change in risk of IPV.
    c. A decreased risk of IPV.
    d. A 100% increase in risk of IPV.
17. Psychological consequences of intimate partner violence include all of the following except:
    a. Antisocial behavior.
    b. Emotional detachment.
    c. Suicidal behavior in females.
    d. Decreased likelihood of becoming an abuser.
18. A screening and intervention method for healthcare providers that may be used to detect, document and provide referrals to victims of domestic violence is called:
    a. PTSD.
    b. DCBS.
    c. CDC.
    d. RADAR.
19. When documenting a domestic violence occurrence, healthcare professionals should:
    a. Never take photographs.
    b. Write down their own observations, and never use quotation marks.
    c. Describe the patient's demeanor.
    d. Use the term domestic violence, or "DV" or "IPV," in the medical record.
20. Recent laws enacted by the Florida legislature:
    a. Make it optional for an investigating law enforcement officer to notify sexual battery victims of their legal rights and remedies.
    b. Allow sheriffs to serve a facsimile copy of a protective injunction instead of a certified copy in domestic violence and sexual violence cases.
    c. Require those filing for an injunction for protection to pay a $295 fee to the court clerk.
    d. Require courts to refer parents to parenting coordination if there has been a history of domestic violence.
21. Healthcare professionals, including staff of care facilities and day care center workers in Florida are required by law to report suspected abuse and neglect. They are called:
    a. Vulnerable adults.
    b. DELTA.
    c. Professionally mandatory reporters.
    d. Professionally responsible reporters.

22. Any person who knows or has reasonable cause to suspect, that a child or vulnerable adult is abused or neglected is required by Florida law to:
    a. Initiate legal action.
    b. Report the suspected abuse to the Florida Abuse Hotline.
    c. Report the suspected abuse to the Federal Abuse Hotline.
    d. Physically remove the abused person from the location where the abuse occurs.

23. A community-based program that provides training, holds perpetrators of IPV responsible for their violence, and provides tools for establishing and maintaining non-abusive relationships is:
    a. A Domestic Violence Center.
    b. The Florida Coalition Against Domestic Violence.
    c. A Batterer Intervention Program.
    d. The Department of Children and Families.

24. The Florida Coalition Against Domestic Violence operates a statewide domestic violence hotline.
    a. True
    b. False

Answer Sheet

Florida: Domestic Violence
Name (Please print your name): ____
Date: ________________

Passing score is 80%

1. ______
2. ______
3. ______
4. ______
5. ______
6. ______
7. ______
8. ______
9. ______
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19. ______
20. ______
21. ______
22. ______
23. ______
24. ______

Course Evaluation

Please use this scale for your course evaluation. Items with asterisks (*) are required.

- 5 = Strongly agree
- 4 = Agree
- 3 = Neutral
- 2 = Disagree
- 1 = Strongly disagree

*1. Upon completion of the course, I was able to:

a. Describe the scope of domestic violence in the United States and Florida.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

b. List the five main categories of domestic violence.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

c. Explain the prevalence of violence against women and how it relates to domestic violence.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

d. Define the significance of the co-occurrence of child maltreatment and domestic violence.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

e. Discuss the relationship of elder abuse to domestic violence.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

f. Outline the economic and societal costs of domestic violence.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

g. Identify best practices for screening, assessment, and documentation of domestic violence in the healthcare setting.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

h. Outline Florida legislation relating to domestic violence, including reporting requirements for healthcare professionals.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

i. Discuss Florida prevention and education programs designed to reduce the incidence of domestic violence.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

*2. The course was written in a way that facilitated my learning.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

*3. This course was free from commercial bias.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

*4. The course met my continuing education needs.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

*5. The material presented was supported by evidence.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

*6. The author avoided the use of anecdotal information as the main source of material.

❑ 5 ❑ 4 ❑ 3 ❑ 2 ❑ 1

*7. The course was free of product promotion.

❑ Yes ❑ No**

** If you answered no, please answer #8.

8. Was product promotion the sole purpose of the presentation?

❑ Yes ❑ No

*9. It took me 60 minutes per contact hour to complete the course, test, and evaluation.

❑ Yes ❑ No**

** If your answer was no, how long did it take?

____

10. My professional educational level is (check one):

Nursing

❑ Nurse Aide ❑ LVN/LPN ❑ RN (diploma) ❑ RN (AD)

❑ BSN ❑ MSN ❑ Nurse Practitioner / Advanced Practice Nurse

❑ PhD / DNSc

Therapy

❑ OT Aide ❑ COTA ❑ OT ❑ MOT ❑ OTD

❑ PT Aide ❑ PTA ❑ PT ❑ MPT ❑ MSPT ❑ DPT ❑ PhD

Other (please specify): ____

11. I heard about ATrain Education from:

❑ Search engine ❑ Advertisement

❑ Government or Board website ❑ Returning customer

❑ Friend ❑ Publication (Magazine, etc.)

❑ Other ___________________________

12. I found the ATrainCEU.com website easy to use:

❑ Yes ❑ No

13. Comments or suggestions (optional): ____

____

____

____

(Registration on next page)

Registration Information

Please answer all of the following questions (*required).

* Name: ____

* Address: ____

* City: ______________________________State:______ Zip: _________

* Phone: ____

* Professional Designation: ______________________________

* License Number and State: _____________________________

Please email my certificate: ❑ Yes ❑ No
Email (required if you want your certificate sent by email): _______________
(If you request an email certificate we will not send a copy of the certificate by U.S. Mail.)

Payment Options
You may pay by credit card or by check.
Fill out this section only if you are paying by credit card.
2 contact hours: $19

Credit card information:
Name ____

Address (if different from above): ____________________________

City: ________________________________State:____ Zip: ________

Card type: ❑ Visa ❑ MC ❑ American Express ❑ Discover

Card number ___________________________ CVS # ___________

Expiration date ____

Test Completion and Mailing Instructions
1. Complete all forms:
   - ❑ Answer Sheet
   - ❑ Evaluation Learning Activity
   - ❑ Registration Form (this page)
2. If you are paying by check, prepare a check for $19 made out to ATrain Education, Inc.
3. Mail the completed forms and your payment to:

   ATrain Education, Inc
   5171 Ridgewood Rd
   Willits, CA 95490

When we receive your forms and payment, we will mail (or email, if you request it) your certificate of completion. If you have any questions or concerns, please call or contact us at Sharon@ATrainCEU.com. And thanks for taking the ATrain!