FL: Domestic Violence

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Contact hours: 2

Course price: $18

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

Course Objectives

When you finish this course you will be able to:

- Define forms of intimate partner violence/domestic violence and explain the scope of the problem in the United States and in Florida.
- List risk and protective factors for domestic violence.
- Describe best practices for screening, assessment, and documentation of domestic violence in the healthcare setting.
- Discuss Florida domestic violence legislation, programs, reporting requirements for healthcare professionals, and prevention and education programs.
- Outline the economic and societal costs and consequences of domestic violence.
- Identify social approaches to prevention and education.

Intimate Partner Violence

Intimate partner violence (IPV) describes physical violence, sexual violence, stalking and psychological aggression (including coercive acts) by a current or former intimate partner (CDC, 2016). 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, 2016; WHO, 2016).

There are four main types of IPV:

- **Physical violence**, the intentional use of physical force with the potential for causing death, disability, injury, or harm
- Sexual violence (has five categories)
  - Rape or penetration of victim
  - Victim was made to penetrate someone else
  - Non-physically pressured unwanted penetration
  - Unwanted sexual contact
  - Non-contact unwanted sexual experiences
- **Stalking**, a pattern of repeated, unwanted, attention and contact that causes fear or concern for one's own safety or the safety of someone else (eg, family member or friend).

- **Psychological aggression**, the use of verbal and non-verbal communication with the intent to harm another person mentally or emotionally, and/or to exert control over another person (CDC, 2016, 2015, 2014b).

The CDC advocates use of a consistent definition of IPV (as above) to facilitate systematic data collection and meaningful comparisons and analysis of trends (CDC, 2016, 2015).

Just as intimate partner violence can be thought of as a continuum, domestic violence may also encompass child abuse when children are physically and psychologically harmed when IPV occurs, and elder abuse when the perpetrator is an intimate partner.

Although women can be violent to men, the vast majority of intimate partner violence is perpetrated by men against women. From 1994 to 2010, U.S. Department of Justice statistics showed that IPV declined by more than 60% for both males and females (Catalano, 2012), but a study of nonfatal domestic violence for 2003–2012 shows that females (76%) still experienced more domestic violence victimizations than did males (24%) (Morgan & Truman, 2014; CDC, 2014).

The rate of fatal incidents of intimate partner violence—sometimes referred to as "intimate homicide"—fluctuated during the period from 1980 to 2008 in the United States. The rate for both black and white males remained about 5% after 2002, while for females it rose from all-time lows in 1995 to 43% for black females and 45% for white females in 2008 (Cooper & Smith, 2011).

Violent crime statistics gathered in 2013 and 2014 reflect a continuing decrease since 2005 in violent crime overall, including domestic violence and intimate partner violence (Truman & Langton, 2015). However, while the overall rate of homicide has declined, women continue to be 64% of the victims of intimate partner homicide, and, considering all murder victims, "women are 6 times more likely than men to be killed by a current or former partner" (Zweig, 2014).

Statistics gathered in the first Centers for Disease Control and Prevention (CDC) National Intimate Partner and Sexual Violence Survey (NISVS) in 2010 showed that 35.6% of women and 28.5% of men in the United States have experienced rape, physical violence, and/or stalking by an intimate partner at some point in their lifetime. In Kentucky it is 37.5% of women and 31% of men, while percentages in other states range from 26% to 48% for women and 17% to 40% for men (CDC, 2011). The NISVS is being administered annually and will be used to track trends in IPV as well as sexual violence and stalking (CDC, 2014).

Broad national survey data can be more telling than law enforcement statistics because of the reluctance of both women and men to report intimate partner violence. In the National Violence Against Women Survey (NVAWS) completed in 1996, 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 & Thoennes, 2000). However, a later review of studies found that reluctance to report can have many reasons, varies with the type of violence and the details of a given situation, and is not always correlated in the way people expect (Felson & Paré, 2005).

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

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, 2016)

CDC identifies four types of intimate partner violence—**physical violence**, **sexual violence**, **stalking**, and **psychological aggression**. Information about the important revisions in definition can be found in the CDC's *Intimate Partner Violence Surveillance: Uniform Definitions and Recommended Data Elements, Version 2.0*, which was published in 2015. The CDC strongly advocates for coherent and uniform definitions to improve the collection and analysis of data.

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, aggressive hair pulling, slapping, punching, hitting 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, 2016).

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 & Garcia-Moreno, 2002). The violence is usually not limited to one instance. The National Violence Against Women Survey (NVAWS) found that women who were physically assaulted by an intimate partner averaged 6.9 physical assaults by the same partner, while men who were assaulted averaged 4.4 assaults.

Women experience more chronic and injurious physical assaults at the hands of intimate partners than do men. The NVAWS 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. 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 (Tjaden & Thoennes, 2000).

Sexual Violence

Sexual violence is divided into five categories, any of which constitute sexual violence, whether attempted or completed. Additionally, all of these acts occur without the victim's consent, including cases in which the victim is unable to consent due to being too intoxicated (eg, incapacitation, lack of consciousness, or lack of awareness) through their voluntary or involuntary use of alcohol or drugs (CDC, 2016).

- **Rape or penetration of victim**. This includes completed or attempted, forced or alcohol/drug-facilitated unwanted vaginal, oral, or anal insertion. Forced penetration occurs through the perpetrator's use of physical force against the victim or threats to physically harm the victim.
- **Victim was made to penetrate someone else**. This includes completed or attempted, forced or alcohol/drug-facilitated incidents when the victim was made to

sexually penetrate a perpetrator or someone else without the victim's consent.

- **Non-physically pressured unwanted penetration**. This includes incidents in which the victim was pressured verbally or through intimidation or misuse of authority to consent or acquiesce to being penetrated.
- **Unwanted sexual contact**. This includes intentional touching of the victim or making the victim touch the perpetrator, either directly or through the clothing, on the genitalia, anus, groin, breast, inner thigh, or buttocks without the victim's consent
- **Non-contact unwanted sexual experiences**. This includes unwanted sexual events that are not of a physical nature that occur without the victim's consent. Examples include unwanted exposure to sexual situations (eg, pornography); verbal or behavioral sexual harassment; threats of sexual violence to accomplish some other end; and/or unwanted filming, taking or disseminating photographs of a sexual nature of another person (CDC, 2016).

Sexual and physical abuse is often accompanied by controlling behaviors. In a World Health Organization (WHO) survey of more than 24,000 women in ten countries, the percentage of those who had 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 healthcare (WHO, 2005)

Stalking

Stalking is a pattern of repeated, unwanted, attention and contact that causes fear or concern for one's own safety or the safety of someone else (eg, family member or friend). Some examples include repeated unwanted phone calls, emails, or texts; leaving cards, letters, flowers, or other items when the victim does not want them; watching or following from a distance; spying; approaching or showing up in places when the victim does not want to see them; sneaking into the victim's home or car; damaging the victim's personal property; harming or threatening the victim's pet; and making threats to physically harm the victim (CDC, 2016).

In the United States 7.5 million people are stalked in one year, with 85% of the victims being stalked by someone they know. Sixty-one percent of female victims and 44% of male victims are stalked by an intimate partner. Among women who have been murdered, 76% were stalked by their intimate partner and 67% had been abused by them. Stalking victims may become fearful and anxious, and their physical and mental health can suffer as a result (National Center for Victims of Crimes, 2012).

Today, stalkers have at their fingertips a wide array of computers and equipment including the Internet, global positioning systems (GPS), cell phones, and tiny digital cameras. In many states, general stalking statues have not kept up with these new technologies for cyberstalking.

Florida law (784.048) defines **cyberstalking** as "engag[ing] 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, 2016).

Psychological Aggression

Psychological aggression is the use of verbal and non-verbal communication with the intent to harm another person mentally or emotionally, and/or to exert control over another person. Psychological aggression can include expressive aggression (eg, name-calling, humiliating); coercive control (eg, limiting access to transportation, money, friends, and family; excessive monitoring of whereabouts); threats of physical or sexual violence; control of reproductive or sexual health (eg, refusal to use birth control; coerced pregnancy termination); exploitation of victim's vulnerability (eg, immigration status, disability); exploitation of perpetrator's vulnerability; and presenting false information to the victim with the intent of making them doubt their own memory or perception (eg, mind games) (CDC, 2016).

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 it difficult for the victim to break free of the cycle of violence.

The ten-country WHO 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).

Violence Against Women

Violence against women has been the focus of international attention for more than twenty 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 WHO completed a ten-country population-based survey (cited earlier) 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). A review study published by WHO in 2013 found substantially similar data. It shows the global average of prevalence of intimate partner violence of ever-partnered women to be 26.4%, and ranging from a low of 8.9% in some areas of East Asia to a high of 77.7% in central Sub-Saharan Africa (WHO, 2013).

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 socio-demographic 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 & Thoennes, 2000). 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 & Garcia-Moreno, 2002).

Intimate Partner Violence During Pregnancy

Approximately 324,000 women are abused during pregnancy every year in the United States. Worldwide the prevalence of IPV during pregnancy in one study ranged from a low of 1% in urban Japan to 28% in Peru Province (WHO, 2005). Other studies have found even higher percentages (WHO, 2011).

More research is critical to understand the details of IPV during pregnancy but what is known so far indicates many negative effects for both mother and unborn child. Effects can be seen in negative health behaviors such as tobacco, alcohol, and drug use or delayed prenatal care. Reproductive health may be affected by many things including poor pregnancy weight gain, low birth weight, or obstetric complications. Physical and mental effects can include injury of all kinds—up to and including death; depression; poor attachment of mother to child; and others (ACOG, 2012; WHO, 2011).

Research has demonstrated that being pregnant does not protect women from IPV, but the evidence is conflicting as to whether or not violence increases or decreases during pregnancy. All of the usual triggers for IPV will be in play but the additional stresses that surround unplanned or unwanted pregnancies appear to be an additional risk factor for violence during pregnancy (WHO, 2011).

Pregnancy (at all stages) can present opportunities for health care professionals to inform and advise women regarding IPV and offer choices for assistance if a woman is being abused (ACOG, 2012). These professionals can become knowledgeable on the recognition and documentation of abuse, applicable laws in their locale, and the variety of resources available for victims of IPV.

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, 2016a, 2014a).

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 which presents an imminent risk of serious harm (Child Welfare Information Gateway, 2013, n.d.)

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, 2013, n.d.).

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 its civil and criminal laws (Child Welfare Information Gateway, 2013, n.d.).

Florida statute [39.01(2) and 39.01(30)] defines **child abuse** as

> any willful act or threatened act that results in any physical, mental, or sexual abuse, 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," which can include:

- Willful acts that produce certain specific injuries
- 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

- Leaving a child without adult supervision or arrangement appropriate for the child's age or mental or physical condition.
- Inappropriate or excessively harsh discipline
- Exposure to a controlled substance or alcohol (Florida Legislature, 2016)

Domestic Violence with 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 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, policymakers and planners of services lack a nationally representative study that examines the prevalence of this co-occurrence. Equally 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; NIJ, 2011).

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 to provide services, especially as they relate 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; NIJ, 2011).

Elder Abuse and Abuse of Vulnerable Adults

> Florida's future is linked to the financial health and physical security of its elder population.
>
> DOEA, 2016

Abuse of a vulnerable adult is defined in Florida law (415.102) as "any willful act or threatened act by a relative, caregiver, or household member which causes or is likely to cause significant impairment" to a vulnerable adult's physical, mental, or emotional health."

A **vulnerable adult** is a "person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a mental, emotional, sensory, long-term physical, or developmental disability or dysfunction, or brain damage, or the infirmities of aging" Abuse includes acts and omissions (Florida Legislature, 2016).

Exploitation of a vulnerable adult includes breaches of fiduciary relationships, unauthorized taking of personal assets, misappropriation of money, and intentional or negligent failure to use the vulnerable adult's assets for their support and maintenance.

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. Neglect also means the failure of a caregiver to make reasonable efforts to protect a vulnerable adult from abuse, neglect, or exploitation by others (Florida Legislature, 2016).

While much more research is needed, what we have so far suggests that there are more than 41 million Americans age 65 and older and they are a growing proportion of the population. One in 10 Americans 60 and older experienced abuse over one year, and some experienced more than one form of abuse. Almost 50% of people with dementia experience some form of abuse (NCEA, 2013).

A recent elder abuse prevalence study conducted in New York State found that for every known case of elder abuse there were 23.5 unknown cases, and in the case of financial exploitation it was 44 unknown cases for each known one (NCEA, 2013).

Elder abuse results in financial losses for victims, and often in increased rates of hospitalization, risks of dying sooner, and significantly higher rates of psychological distress (NCEA, 2013).

Florida has approximately 4.9 million residents age 60 and older. That is a greater number of elders as a percentage of population than in any other state and it is expected to grow—from 23% in 2010 to 35% in 2030. With a large, growing, and physically and culturally diverse elder population, the state faces many challenges (DOEA, 2016).

Risk and Protective Factors for IPV

People with certain risk factors are more likely to become victims or perpetrators of IPV. Those risk factors contribute to IPV but might not be direct causes. Not everyone who is identified as "at risk" becomes involved in violence.

Some risk factors for IPV victimization and perpetration are the same, while others are associated with one another. For example, childhood physical or sexual victimization is a risk factor for future IPV perpetration and victimization.

A combination of individual, relational, community, and societal factors contribute to the risk of becoming an IPV victim or perpetrator. Understanding these multilevel factors can help identify various opportunities for prevention (CDC, 2015b).

Risk Factors for Intimate Partner Violence	
Individual factors	▪ Low self-esteem ▪ Low income ▪ Low academic achievement ▪ Young age ▪ Aggressive or delinquent behavior as a youth ▪ Heavy alcohol and drug use ▪ Depression ▪ Anger and hostility ▪ Antisocial personality traits ▪ Borderline personality traits ▪ Prior history of being physically abusive ▪ Having few friends and being isolated from other people ▪ Unemployment ▪ Emotional dependence and insecurity ▪ Belief in strict gender roles (e.g., male dominance and aggression in relationships) ▪ Desire for power and control in relationships ▪ Perpetrating psychological aggression ▪ Being a victim of physical or psychological abuse (consistently one of the strongest predictors of perpetration) ▪ History of experiencing poor parenting as a child ▪ History of experiencing physical discipline as a child
Relationship factors	▪ Marital conflict—fights, tension, and other struggles ▪ Marital instability—divorces or separations ▪ Dominance and control of the relationship by one partner over the other ▪ Economic stress ▪ Unhealthy family relationships and interactions

Risk Factors for Intimate Partner Violence	
Community factors	▪ Poverty and associated factors (eg, overcrowding) ▪ Low social capital—lack of institutions, relationships, and norms that shape a community's social interactions ▪ Weak community sanctions against IPV (eg, unwillingness of neighbors to intervene in situations where they witness violence)
Societal factors	▪ Traditional gender norms (eg, women should stay at home, not enter workforce, and be submissive; men support the family and make the decisions) (CDC, 2015b)

The National Violence Against Women Survey found that married women who lived apart from their husbands were nearly 4 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 3 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 & Thoennes, 2000).

These findings suggest that termination of a relationship poses an increased risk of IPV 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 & Thoennes, 2000).

The WHO population survey investigated which factors might protect a woman from IPV 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).

Screening and Assessment for Domestic Violence

Many healthcare and social services professionals are already involved with screening and assessment of clients for domestic violence, including intimate partner violence. Numerous professional associations have taken positions advocating screening of most, if not all, adults. As with all aspects of domestic violence, there are gaps in the research and thus sometimes contradictory findings and positions, and more research is needed.

Screening

In 2011 the Institute of Medicine (IOM) released a report on preventive services with recommendations that were quickly adopted by the U.S. Department of Health and Human Services. One of the recommendations was to provide screening and counseling to women regarding "interpersonal and domestic violence" (ASPE, 2013).

In January 2013 the U.S. Preventive Services Task Force (USPSTF) changed its recommendations regarding screening for IPV in women of childbearing age, and screening for abuse and neglect in elders. The task force

> recommends that clinicians screen women of childbearing age for intimate partner violence (IPV), such as domestic violence, and provide or refer women who screen positive to intervention services.

The task force also

> concludes that the current evidence is insufficient to assess the balance of benefits and harms of screening all elderly or vulnerable adults (physically or mentally dysfunctional) for abuse and neglect. (USPSTF, 2013)

Prior to January 2013 the recommendation regarding IPV had been similar to the current one for abuse and neglect of elders. The research and reasoning that goes into recommendations as well as suggestions for implementation of recommendations are discussed in detail on the USPFSTF website.

In discussing specific tools for screening, the task force notes that several instruments can be used to screen women for IPV. Those with the highest levels of sensitivity and specificity for identifying IPV are:

- Hurt, Insult, Threaten, Scream (HITS)—includes four questions, can be used in a primary care setting, and is available in both English and Spanish. It can be self- or clinician-administered.
- Ongoing Abuse Screen/Ongoing Violence Assessment Tool (OAS/OVAT)
- Slapped, Threatened, and Throw (STaT)—three-item self-report instrument that was tested in an emergency department setting

- Humiliation, Afraid, Rape, Kick (HARK)—self-administered four-item instrument
- Modified Childhood Trauma Questionnaire—Short Form (CTQ-SF)
- Woman Abuse Screen Tool (WAST)

The task force found no valid reliable screening tools to identify abuse of elderly or vulnerable adults in the primary care setting. However, the accompanying discussion reveals that this may be more about a lack of data, many variables, and the need for more research and practice (USPSTF, 2013).

Assessment

The CDC has supported at least two studies to evaluate assessment tools, and their reports can be consulted via the CDC website by anyone looking for more information about available screening tools for varying practice settings. *Intimate Partner Violence and Sexual Violence Victimization Assessment Instruments for Use in Healthcare Settings: Version 1* was published in 2007, and *Measuring Intimate Partner Violence Victimization and Perpetration: A Compendium of Assessment Tools* in 2006.

Healthcare professionals should make sure they understand and are trained to use any procedures, tools, and forms their institution already has in place for screening and assessment. In addition, it is important to be up-to-date on your state's requirements for reporting and documenting domestic violence information.

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 the way 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:

- For the 93 instances of an injury, the records contained only 1 **photograph**. There was no mention in any records of photographs filed elsewhere (for example, with the 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. (Isaac & Enos, 2001)

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:

- 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" (Isaac & Enos, 2001).

Domestic Violence in Florida

In 2014, overall crime in Florida declined by 3.6%, but overall reported domestic violence offenses decreased by only 1% (FCADV, 2015).

In 2014, 106,882 domestic violence offenses were reported to law enforcement. In the same year, 205 people died as a result of domestic violence homicide, almost 21% of homicides in Florida. Domestic violence murder and manslaughter actually increased by 10.2% (FCADV, 2015).

In Florida, domestic violence crimes include:

- assault
- aggravated assault
- battery
- aggravated battery
- sexual assault
- sexual battery
- stalking
- aggravated stalking
- kidnapping
- false imprisonment
- Any criminal offense resulting in physical injury or death of one family or household member by another family or household member

Florida Legislation

During the 2015 Florida Legislative Session several bills were passed that have effects on the 42 certified domestic violence centers in the state and on survivors of domestic violence and their children (FCADV, 2015a):

- **Child Protection Investigation (CPI) Project**. This collaborative program between the FCADV, the Office of the Attorney General, the Department of Children and Families, the certified domestic violence centers, community care agencies, and the criminal justice system received an additional $2 million for program expansion.

- **Sexual Offenses (HB 133).** Extends the statute of limitations governing prosecutions of felony sexual battery offenses from four years to eight years.
- **Tracking Devices or Tracking Applications (HB 197).** Result is that it will be a violation of the law for a batterer to install or hide a GPS tracking device on a survivor's car or phone without that person's consent.
- **Public Records—Audio or Video Recordings (SB 248).** Provides public records exemptions and guidance to law enforcement agencies that will offer a level of protection to domestic violence survivors so that any recordings made by a police officer will be difficult for a member of the general public to access.
- **No Contact Order (SB 342).** Allows courts to impose conditions in a No Contact Order that will better protect victims of domestic violence, make the orders immediately effective, and make them more consistent across the state.

For additional information about bills go to the Legislature's website. Also, the Florida Coalition Against Domestic Violence and Department of Children and Families websites have information and links pertinent to current legislative efforts, as well as legislation and administrative code already in place (FCADV, 2015a).

Background Screening Process

Florida does require a background screening process for those who work with certain vulnerable Floridians, including children, elders, and those with disabilities. In 2012 additional legislative changes to that process were made. Details of the laws and the procedures can be found here.

Florida Department of Childen and Families: Background Screening and

Florida Department of Elder Affairs: Background Screening

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

Although every person has a responsibility to report suspected abuse or neglect, some occupations are specified in Florida law as required to do so. These occupations are considered "professionally mandatory reporters." A professionally mandatory reporter of child abuse/neglect is required by Florida Statute to provide his or her name to the Abuse Hotline Counselor when reporting. A professionally mandatory reporter's name is entered into the record of the report, but is held confidential (§ 39.202, F.S. and 415.107, F.S.) (FDCF, 2013).

Mandatory reporters can make reports by telephone, TDD, fax, or web. 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.

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, 2013).

Vulnerable Adults

Healthcare workers (and others) 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, 2013).

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 IPV 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, 2016, 2013)

"Anyone who has been the victim of domestic violence, or has reasonable cause to believe they are in imminent danger of becoming a victim, can file for an Injunction for Protection. A Repeat Violence Injunction requires two unrelated incidents of violence or stalking, one of which must have occurred within six months of filing for the petition" (CASA, 2013).

"An **Injunction for Protection** may order the abuser to immediately stop the violence or harassment, to leave the shared home, to avoid contact with the victim at home, work, or school, to attend batterer's intervention and/or appropriate counseling. The injunction can also provide for temporary custody, visitation, and child or spousal support" (CASA, 2013).

For more information about Injunctions for Protection and other legal rights, call the National Domestic Violence Hotline at 800 799-SAFE (7233) or visit CASA: Know Your Legal Rights or Florida Coalition Against Domestic Violence: Legal Resources.

Florida Programs and Resources

Batterer Intervention Programs

Batterer Intervention Programs (BIP) are community-based programs intended 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.

Legislation in 2012 removed the requirement that BIP service providers be state-certified and monitored. However, most other requirements regarding program length and content, payment by batterers, and requirements to attend after convictions were not changed. Full information is available from the Department (FDCF, 2014, 2007).

Florida Coalition Against Domestic Violence

The Florida Coalition Against Domestic Violence (FCADV) "serves as the professional association for the state's 42 certified domestic violence centers, and is the primary representative of battered women and their children in the public policy arena" (FCADV, 2016).

FCADV is statutorily responsible for delivering and managing services for the state's domestic violence program. The FCADV provides training and technical assistance for the centers, communities, and organizations, as well as multi-lingual and other resource materials. It also is involved in numerous partnerships to provide assistance to and gather information from survivors of domestic violence (FCADV, 2016, 2015).

The FCADV also operates and manages the statewide Florida Domestic Violence Hotline (800 500 1119). Hotline advocates provide support, advocacy, information, and referral services for survivors of domestic violence, their children, families, and friends. During 2014–2015 the hotline received 31,646 calls, of which 4,091 were handled by the legal hotline (FCADV, 2015).

Domestic Violence Centers

Florida's 42 certified domestic violence centers are community-based agencies that provide services to the victims of intimate violence. Florida Statute 39.905 outlines basic requirements necessary to meet the certification standards to be included as a domestic violence center recognized by the State of Florida. These centers range from 15- to 132-bed facilities and provide more than 2,126 beds statewide for survivors and their children who are in imminent danger (FCADV, 2016a).

During fiscal year 2014–2015, emergency shelter was provided to 15,397 individuals for 546,658 nights, and there was not always a bed available for everyone who needed it. However, in 2013 increased funding appropriated by the state legislature meant that in 2015, 278 additional beds became available across the state (FCADV, 2015).

According to Florida's Administrative Rule 65H-1 Program Standards for Certification, each of the centers must provide a minimum of core services, which include:

- Information and referral
- Counseling
- Case management
- Emergency shelter
- 24-hour hotline services
- Child assessment
- Professional training
- Community education
- Safety planning (FCADV, 2016a)

These centers also provide a host of additional services such as: transportation, rent and utility assistance, transitional housing, legal and court advocacy, work skills and job readiness training and placement, financial literacy education, and training and education programs (FCADV, 2015).

Rural Statewide Initiative Project

The Florida Coalition Against Domestic Violence (FCADV) Rural Statewide Initiative Project "supports direct services for survivors in Florida's most isolated communities." The programs are designed to address the unique situations of rural survivors. The Initiative uses a community organizing model to bring community, judicial, and law enforcement partners together to provide coordinated services to survivors (FCADV, n.d.-1).

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 visit the FCADV Delta Project website (FCADV, n.d.-2).

The Economic Justice Initiative

The FCADV also supports the **Economic Justice Initiative**, which addresses economic and housing issues that threaten the long-term independence and safety of survivors and their children. For more information about the Economic Justice Initiative call 850 425 2749 or visit FCADV: 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 FCADV Disability and Accessibility Project.

The INVEST Program

The Intimate Violence Enhanced Services Team (InVEST) "was created specifically to reduce and prevent domestic violence homicides in Florida." The program has implemented batterer accountability measures and increased advocacy for survivors at high risk of being murdered by their intimate partner. Since the program's inception in 2009 no InVEST program participants have been homicide victims. For more information, visit the FCADV InVEST Program website.

These and other programs have increased 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 is designed to achieve the goal of a reduction and eventual elimination of this pervasive and expensive public health problem.

Costs and Consequences of IPV

In 2003 dollars, costs associated with IPV 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. Increased annual healthcare costs for victims of IPV can persist as much as 15 years after abuse ends. Victims of severe IPV 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, 2015a, 2003).

Nearly 1 in 4 women (22.3%) and 1 in 7 men (14.0%) aged 18 and older in the United States have been the victim of severe physical violence by an intimate partner in their lifetime. Nearly 14% of women (13.4%) and 3.54% of men have been injured as a result of IPV that included contact sexual violence, physical violence, or stalking by an intimate partner in their lifetime. In 2010, 241 males and 1095 females were murdered by an intimate partner (CDC, 2015a). All of these crimes mean costs to individuals and society for medical and psychological treatment; law enforcement; social services; lost days of work and school; and so on.

In general, victims of repeated violence experience more serious consequences than victims of one-time incidents. Women with a history of IPV 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 IPV 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, 2015a, 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

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

Source: CDC, 2015a.

Prevention and Education About Domestic Violence

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)

Resources and References

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: https://reportabuse.dcf.state.fl.us/

Florida Department of Children and Families
Phone: 850 921 2168
Fax: 850 922 6720
Email: domesticviolence@dcf.state.fl.us
http://www.myflfamilies.com/service-programs/domestic-violence

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/

- **Elder Helpline**: 800-96-ELDER (800-963-5337)
- **Report Elder Abuse**: 800 96-ABUSE or 800 962 2873
- **Statewide Senior Legal Helpline**: 888 895 7873

Florida Long-Term Care Ombudsman Program
4040 Esplanade Way, Suite 380
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 Florida)
TDD: 800 955 8771
http://myfloridalegal.com/

National Domestic Violence Hotline

800 799 SAFE (7233)

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Post Test

Use the answer sheet following the test to record your answers.

1. Intimate partner violence (IPV):

    a. Refers to violence that occurs between current or former partners or spouses.
    b. Refers only to relationships involving sexual intimacy.
    c. Never includes child abuse or elder abuse.
    d. Never includes violence against men.

2. The victims of intimate partner violence are evenly divided between men and women.:

    a. True
    b. False

3. The CDC describes physical violence as:

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

4. Sexual and physical abuse is often accompanied by controlling behaviors. Controlling behaviors include:

    a. Hitting and slapping.
    b. Verbal abuse.
    c. Cyberstalking.
    d. Preventing a partner from seeing friends.

5. Repeated harassing or threatening behavior, such as following a person or making harassing phone calls, is a description of:

    a. Stalking.
    b. Sexual harassment.
    c. Coercive control and intimidation.
    d. Controlling behavior.

6. Prohibiting access to transportation, money, or friends and family are examples of:

a. Stalking.
b. Psychological aggression.
c. Physical violence.
d. Sexual violence.

7. 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.

8. The variable most likely to predict that a woman will be victimized by an intimate partner is a partner who is:

a. Of a different race.
b. From a different country.
c. Of a different religion.
d. Verbally abusive.

9. The federal Child Abuse Prevention and Treatment Act (CAPTA):

a. Addresses acts or failures to act by parents or other caregivers that result in harm to a child.
b. Provides specific definitions for all types of maltreatment.
c. Supersedes any similar state law.
d. Protects any person less than 21 years of age.

10. According to Florida law, any willful act or threatened act that results in physical, mental, or sexual abuse, 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 abuse.
c. Child endangerment.
d. Coercive control.

11. 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.

12. According to Florida law, any willful or threatened act or omission by a relative, caregiver, or household member that causes or is likely to cause significant impairment to a vulnerable adult's physical, mental or emotional health is:

a. Exploitation.

b. Coercion.

c. Neglect.

d. Abuse.

13. Recent studies indicate that elder abuse is:

a. Chronically underreported.

b. Declining rapidly.

c. Only perpetrated by nursing home owners.

d. Seldom happens to adults with dementia.

14. The termination of a relationship poses:

a. A decreased risk of IPV.

b. An increased risk of IPV.

c. No change in risk of IPV.

d. A 100% increase in risk of IPV.

15. When documenting a domestic violence occurrence, healthcare professionals should:

a. Never take photographs.

b. Write down their own observations, never quoting others.

c. Describe the patient's demeanor.

d. Only report the time of day the patient is being examined, not the time the abuse occurred.

16. Domestic violence in Florida:

a. Does not include kidnapping.
b. Increased by 100% during 2014.
c. Has declined substantially and is no longer a problem.
d. Declined by 1% in 2014.

17. Certain healthcare professionals in Florida are required by law to report suspected abuse and neglect. They are called:

a. Professionally mandatory reporters.
b. Vulnerable adults.
c. DELTAs.
d. Professionally responsible reporters.

18. 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.

19. 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. The Florida Coalition Against Domestic Violence.
b. The Department of Children and Families.
c. A Batterer Intervention Program.
d. A Domestic Violence Center.

20. Possible psychological consequences of intimate partner violence include:

a. Forming unusually strong emotional attachments.
b. Suicidal behavior in men only.
c. Increased self-esteem.
d. Anxiety and depression.

21. The goal of prevention of and education about domestic violence is:

a. Stopping intimate personal violence from happening in the first place.

b. Changing the opinions of law enforcement officers.

c. Putting the perpetrators in jail.

d. Running batterer intervention programs.

Answer Sheet

FL: 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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11. _____
12. _____
13. _____
14. _____
15. _____
16. _____
17. _____
18. _____
19. _____
20. _____
21. _____

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

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

a. Define forms of intimate partner violence/domestic violence and explain the scope of the problem in the United States and in Florida.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

b. List risk and protective factors for domestic violence.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

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

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

d. Discuss Florida domestic violence legislation, programs, reporting requirements for healthcare professionals, and prevention and education programs.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

e. Outline the economic and societal costs and consequences of domestic violence.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

f. Identify social approaches to prevention and education.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

* The author(s) are knowledgeable about the subject matter.

○ 5 ○ 4 ○ 3 ○ 2 ○ 1

* The author(s) cited evidence that supported the material presented.

5 4 3 2 1

* This course contained no discriminatory or prejudicial language.

Yes No

* The course was free of commercial bias and product promotion.

Yes No

* As a result of what you have learned, do you intend to make any changes in your practice?

Yes No

If you answered Yes above, what changes do you intend to make? If you answered No, please explain why.

* Do you intend to return to ATrain for your ongoing CE needs?

- Yes, within the next 30 days.
- Yes, during my next renewal cycle.
- Maybe, not sure.
- No, I only needed this one course.

* Would you recommend ATrain Education to a friend, co-worker, or colleague?

- Yes, definitely.
- Possibly.
- No, not at this time.

* What is your overall satsfaction with this learning activity?

5 4 3 2 1

* Navigating the ATrain Education website was:

- ○ Easy.
- ○ Somewhat easy.
- ○ Not at all easy.

* How long did it take you to complete this course, posttest, and course evaluation?

- ○ 60 minutes (or more) per contact hour
- ○ 50-59 minutes per contact hour
- ○ 40-49 minutes per contact hour
- ○ 30-39 minutes per contact hour
- ○ Less than 30 minutes per contact hour

I heard about ATrain Education from:

- ○ Government or Department of Health website.
- ○ State board or professional association.
- ○ Searching the Internet.
- ○ A friend.
- ○ An advertisement.
- ○ I am a returning customer.
- ○ My employer.
- ○ Other
- ○ Social Media (FB, Twitter, LinkedIn, etc)

Please let us know your age group to help us meet your professional needs.

- ○ 18 to 30
- ○ 31 to 45
- ○ 46+

I completed this course on:

- ○ My own or a friend's computer.
- ○ A computer at work.
- ○ A library computer.
- ○ A tablet.
- ○ A cellphone.
- ○ A paper copy of the course.

Please enter your comments or suggestions here: _____

_____

_____

_____

Registration Form

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

* Name: _____

* Email: _____

* Address: _____

* City: _____ * State: _____ * Zip: _____

* Country: _____

* Phone: _____

* Professional Credentials/Designations:

_____

Your name and credentials/designations will appear on your certificate.

* License Number and State: _____

* Please email my certificate:

○ Yes ○ No

(If you request an email certificate we will not send a copy of the certificate by US 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: $18

Credit card information

* Name: _____

Address (if different from above): _____

* City: _____ * State: _____ * Zip: _____

* Card type:

○ Visa ○ Master Card ○ American Express ○ Discover

* Card number: _____

* CVS#: _____

* Expiration date: _____