Domestic Violence CME
with a Special Focus on Human Trafficking
DOMESTIC VIOLENCE WITH A SPECIAL FOCUS ON HUMAN TRAFFICKING

The Florida Medical Association Council on Medical Education & Science and the Committee on CME & Accreditation is pleased to offer this first CME Supplement to the Florida Medical Magazine, Domestic Violence with a Special Focus on Human Trafficking. Although the idea of mandatory CME topics for all physicians regardless of specialty is problematic at best, I think we can all agree that these issues deserve our time and attention.

Based on input from the Florida Department of Health, the FMA Council on Public Health and other community organizations, this course was recently updated and refreshed by the inclusion of the most current statistics and information about the emerging threat of human trafficking. We are particularly grateful for the efforts of Florida Surgeon General Ana Viamonte Ros, MD, and John Lanza, MD, Chair of the Council on Public Health.

The timing of this piece coincides with the requirement that Florida-licensed physicians must complete two (2) credits in Domestic Violence during every third licensure term. This means that all physicians who were first licensed in Florida prior to Aug. 1, 2006, must now complete the course.

This CME supplement is offered to allow you to fulfill a licensure obligation, and as a reminder that sometimes the little things we do in everyday practice, such as detailed documentation and simple screenings, can make a huge impact in the lives of our patients. While we physicians cannot solve every problem our patients face, we can serve as a link to connect the most vulnerable to community resources and services. As James E. Harrell, MD, says, if we at least ask the question, the door is opened and a dialogue can begin.

Please remember that the FMA Education Department stands ready to serve as your primary source for current information about CME, accreditation and licensing requirements. This is only one of the many benefits of membership.

Finally, I encourage you to contact us if you have an idea for CME, want to be more involved with the educational activities of the FMA and/or have suggestions for improving our current offerings. Together, we can continue to strengthen the FMA’s educational services.

Sincerely,

Vincent A. DeGennaro, MD
FMA Vice President
Chair, FMA Council on Medical Education & Science

Melissa Carter
FMA Director of Education
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CME Information and Instructions for Claiming Credit

CME OBJECTIVES:
This course is intended to fulfill the following objectives:

1. Compare and contrast the similarities and differences between domestic violence and human trafficking.
2. Increase healthcare professionals' awareness and identification of victims of domestic violence and human trafficking.
3. Clarify the behavioral dynamics related to domestic violence and human trafficking.
4. Encourage routine screening procedures for the possibility of patient history of domestic violence or trafficking.
5. Identify the best options for referral to community resources.
6. Encourage the establishment of documentation policies in domestic violence and trafficking cases.
7. Increase advocacy within the healthcare community for victims of domestic violence and trafficking.

AUTHORS:

JAMES E. HARRELL, MD
Dr. Harrell is a past Chair of the FMA Committee on Continuing Medical Education. He is an obstetrician-gynecologist from Stuart, Florida, where he was a member of the medical staff of Martin Memorial Hospital. In addition to being a member of the FMA and the American Medical Association (AMA), he is a Life Fellow of the American College of Obstetricians and Gynecologists, and the Florida Obstetric and Gynecologic Society. Dr. Harrell has provided continuing education courses on domestic violence throughout the State of Florida.

ROBIN HASLLER THOMPSON, MA, JD
Ms. Thompson served as the Executive Director for the Florida Governor’s Task Force on Domestic and Sexual Violence. At the request of the U. S. Department of Justice, Ms. Thompson served on the National Advisory Council on Violence Against Women. She graduated from the Florida State University College of Law in Tallahassee, Fla., in 1984. In addition to her law degree, she holds an MA from Florida State University and a BA from American University in Washington, D.C., where she graduated summa cum laude in 1981.

DISCLOSURE INFORMATION:
This information is being provided to CME learners in compliance with ACCME policies for disclosure and commercial support. The information below identifies planner and faculty financial relationships with any commercial interest that produces health care goods or services related to the content of the educational material. As an accredited CME provider, the FMA is obligated to resolve to the best of its abilities any potential conflicts of interest that may arise from a planner’s or speaker's financial relationships with commercial interests that produce health care goods or services related to the content of the educational presentation in which that speaker is involved.

• Dr. Harrell has no relevant financial relationships.
• Ms. Thompson has no relevant financial relationships.
• The planners of this educational material have no relevant financial relationships.
ACCREDITATION/CREDIT STATEMENT
The Florida Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical educational activities for physicians.

The Florida Medical Association designates this educational activity for a maximum of two (2) AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

INSTRUCTIONS FOR OBTAINING CME CREDIT

• Read all of the educational articles included in this monograph.
• Complete the post-test using the answer sheet provided. Participants must correctly answer at least 70% of the questions to receive credit.
• Complete the evaluation questions on the bottom of the answer sheet.
• Fax the answer sheet to (850) 224-6627 or email to education@medone.org
  
  FMA Mailing address:
  Florida Medical Association
  ATTN: Nancy Wisham
  123 South Adams Street
  Tallahassee, FL 32301

• Call the FMA Education Department at (800) 762-0233 or email education@medone.org if you have questions.
• Once the answer sheet is graded and a score of at least 70 percent is achieved, a certificate of credit will be emailed to you. Retain a copy of your certificate for your records.

ESTIMATED TIME TO COMPLETE THIS EDUCATIONAL ACTIVITY: Two Hours

EXPIRATION DATE FOR THE ACTIVITY: March 31, 2012
Even though domestic violence is understood much more by the public at large as well as the medical community, sadly, this has not yet resulted in a significant decrease in the incidence of such violence. In contrast, societal and health care community awareness and understanding of human trafficking is very low and, many say, compares to where domestic violence was decades ago.

One of the most important things that physicians need to realize about domestic violence is that it is present in the practice of every physician who sees patients. The identification of victims of domestic violence among your patients depends on two factors:

1. How many patients you see, and
2. How many times you ask the question.

While physicians are very likely to encounter domestic violence in their workplace or among their colleagues, human trafficking is different. It is not as commonly seen in the health care setting as is domestic violence. Despite this, knowledge and understanding about domestic violence will help physicians to better respond to patients who are trafficking survivors. Domestic violence and human trafficking sometimes overlap, such as in cases of sex trafficking or servile marriages (“mail order bride” schemes) where the patient is abused by an intimate partner who is also her trafficker. There are also important differences between the two. Completing this course and developing a greater understanding of domestic violence and human trafficking are important because there remain many domestic violence and human trafficking victims who are unrecognized and unassisted when they visit a physician.

A team effort is necessary in every community to help address both of these problems and the physician plays a vital role. By screening for victims and perpetrators, physicians have the ability to offer help and direct the patients to resources, which can help victims to free themselves of abuse and violence. Every physician should be involved with efforts to screen patients and refer them to proper resources. In addition, physicians should support their community’s efforts to end domestic violence and human trafficking.

The terms “victim” and “survivor” are used interchangeably in this course. These terms reflect the perspectives of the harmed individual as well as the attitudes of society, service providers and others who support the victim. It is important to note that many “victims” do not fit the stereotype of a victim as someone who is passive or helpless; many are very active in seeking help and escaping from their situations.

DEFINITIONS

Florida law defines domestic violence as “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.”
**Intimate partner violence** is a pattern of assaultive and coercive behaviors that may include inflicted physical injury, psychological abuse, sexual assault, progressive social isolation, stalking, deprivation, intimidation and threats. These behaviors are perpetrated by someone who is, was, or wishes to be involved in an intimate or dating relationship with an adult or adolescent, and are aimed at establishing control by one partner over the other.\(^3\)

**Human trafficking**, also called “modern-day slavery,” is the recruitment, harboring, transporting, providing or obtaining, by any means, any person for labor or services involving forced labor, slavery or servitude in any industry, such as forced or coerced participation in agriculture, prostitution, manufacturing, or other industries or in domestic service or marriage.\(^2\)

Under Florida law, the definition of domestic violence includes violence between others besides intimate partners who may be “family or household members” such as brother against sister and child against parent violence. Likewise, the statistics collected in Florida include this wider definition of violence. When the phrase “domestic violence” is used in this course, it refers only to “intimate partner violence” as defined above.

**THE GOVERNOR’S TASK FORCE ON DOMESTIC AND SEXUAL VIOLENCE**


In an introductory letter to the Report, Judge Linda Dakis indicated that “many of the recommendations address the single greatest obstacles to curbing domestic violence: exposing it and understanding its dynamics. By surveying professionals whose work brings them into contact with both victims and perpetrators of domestic violence, the Task Force found that many professionals need, and many more would like to receive training on the topic.”

This group was so successful in confronting the problems associated with domestic violence that Gov. Chiles chose to extend and rename the group on Feb. 2, 1996. The name of this group was changed to The Governor’s Task Force on Domestic and Sexual Violence. He charged this group with the following responsibilities:

1. Assist in the implementation of the 225 recommendations contained in the first and second reports of the Governor’s Task Force on Domestic Violence.

2. Direct policies and monitor the state’s activities under the Violence Against Women Act.

3. Increase enforcement activities in the area of sexual violence and to reach our underserved populations.

**Continuing Medical Education Requirement in Florida**

In 1995, the Florida State Legislature enacted a law to require all persons licensed as physicians, osteopathic physicians, nurses, dentists, midwives, psychologists, clinical counselors and psychotherapists to complete a one-hour continuing education course on domestic violence by Jan. 31, 1996. That law changed to now require two hours of continuing medical education (CME) about domestic violence every third biennium (or every six years) as part of the 40 hours of CME required by physicians to maintain their license. The law, as it applies to physicians, is administered by the Florida Board of Medicine and the Florida Board of Osteopathic Medicine.

This law mandates that the following will be included in any course:

1. Information on the number of patients in that professional’s practice who are likely to be victims of domestic violence and the number who are likely to be perpetrators of domestic violence.

2. Screening procedures for determining whether a patient has any history of being a victim or a perpetrator of domestic violence.

3. Instructions on how to provide such patients with information on, or how to refer such patients to, resources in the local community such as domestic violence centers and other advocacy groups that provide legal aid, shelter, victim counseling, batterer counseling or child protective services.\(^4\)

While human trafficking and many other issues concerning domestic violence are not addressed in the above requirements, the final post-test will cover the mandatory objectives as well as these other issues the FMA recognizes as important.

**Statistics about Victims and Perpetrators**

Intimate partner violence is primarily a crime against women. In 2001, a Department of Justice report found that women accounted for approximately 85 percent of the victims of intimate partner violence in the U.S. (588,490 total) and men accounted for approximately 15 percent of the victims (103,220 total).\(^5\) That ratio is consistent with findings throughout the years in which records have been kept.

Since the vast majority of the victims of domestic and sexual violence are female, the term “she” will be used in this course to refer to the victims or survivors. This is not meant to minimize
the experiences of males who are abused and/or raped. They, along with the elderly and children, are included in the generic “she.” Although violence can occur from either partner, the motives of males and females generally are different. Most male abusers batter their partners as a means of power and control; women who are violent are most often reacting in self-defense or retaliation. Domestic violence is also seen in gay and lesbian relationships.

According to the U.S. government, between 14,500 and 17,500 people are trafficked into the U.S. annually, with over 27 million people enslaved as human trafficking victims around the world at any given moment. U.S. citizens as well as those who are foreign born are trafficked in the U.S. As human trafficking is a clandestine operation, it is impossible to know the full extent of human trafficking in the U.S. or in Florida. However, many have said that Florida is third in the nation as a “destination state” for human trafficking victims. About 80 percent of human trafficking victims are women and children; approximately 20 percent are adult males.

Approximately 1/3 of injured female rape and physical assault victims receive medical treatment: 35.6 percent of the women injured during their most recent rape and 30.2 percent of the women injured during their most recent physical assault received medical treatment. Most experts agree that statistics about domestic violence and human trafficking in our society are vastly understated.

Domestic violence is one of the largest epidemics the United States has ever faced.

* Nearly one-third of American women (31 percent) report being physically or sexually abused by a husband or boyfriend at some point in their lives.

* Seventeen percent of adult pregnant women are battered. Women experiencing abuse in the year prior to and/or during a recent pregnancy are 40 to 60 percent more likely than non-abused women to have high-blood pressure, vaginal bleeding, severe nausea, kidney or urinary tract infections and hospitalization during pregnancy and are 37 percent more likely to deliver preterm.

* Children born to abused mothers are 17 percent more likely to be born underweight and more than 30 percent more likely than other children to require intensive care upon birth.

* Leaving the abuser (or taking any act of separation such as obtaining an injunction for protection from the court) significantly increases the danger of being seriously harmed or killed by the abuser.

* 21.7 percent of pregnant teens experience abuse as opposed to 15.9 percent of pregnant adults.

* In Florida, there is at least one death at the hands of a family member every 48 hours.

* In 2008, the Florida Department of Law Enforcement reported a total of 113,123 incidents of domestic violence.

* In addition to injuries sustained during violent episodes, physical and psychological abuse are linked to other adverse physical consequences including arthritis, chronic neck or back pain, migraine or other frequent headaches, stammering, problems seeing, sexually transmitted infections, chronic stomach pain and ulcers.

* Children who witness domestic violence are more likely to show behavioral and physical health problems such as anxiety, depression and violence toward peers. They also are more likely to attempt suicide, abuse drugs and alcohol, run away from home, engage in teenage prostitution and commit sexual assault crimes.

* Domestic violence is the leading cause of injury to women, causing more injuries than muggings, stranger rapes, and car accidents combined.

<table>
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<th>Year</th>
<th>Total Number of Victims</th>
<th>Total Number of Deaths</th>
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<td>194</td>
</tr>
<tr>
<td>2007</td>
<td>115,150</td>
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<td>2004</td>
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<table>
<thead>
<tr>
<th>Primary Offense</th>
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<th>2008</th>
<th>Percent Change</th>
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</thead>
<tbody>
<tr>
<td>Murder</td>
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<td>180</td>
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</tr>
<tr>
<td>Manslaughter</td>
<td>25</td>
<td>14</td>
<td>-44.0</td>
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<tr>
<td>Forcible Rape</td>
<td>979</td>
<td>931</td>
<td>-4.9</td>
</tr>
<tr>
<td>Forcible Sodomy</td>
<td>353</td>
<td>290</td>
<td>-17.8</td>
</tr>
<tr>
<td>Forcible fondling</td>
<td>919</td>
<td>744</td>
<td>-19.0</td>
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<tr>
<td>Aggravated Assault</td>
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<td>20,462</td>
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<td>Aggravated Stalking</td>
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<tr>
<td>Simple Assault</td>
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<td>Threat/Intimidation</td>
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<td>2,655</td>
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<td>351</td>
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<tr>
<td>Total</td>
<td>115,150</td>
<td>113,123</td>
<td>-1.8</td>
</tr>
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</table>

Florida Law on Mandatory Reporting

Florida law does not require the specific reporting of “domestic violence” or “human trafficking.” However, Chapter 790.24, Florida Statutes, requires that a physician who is “knowingly treating any person suffering from a gunshot wound or life-threatening injury indicating an act of violence, or receiving a request for such treatment, shall report the same immediately to the sheriff’s department of the county in which said treatment is administered or request therefore received.” The physician must have had actual knowledge of the violence as opposed to mere suspicion. This means that if a domestic violence or human trafficking victim has a gunshot or life threatening injury as described, physicians must report that injury, just as they would for any other person suffering the same injury. Should the physician knowingly treat such a wound, he or she is obligated to report this fact to the sheriff’s department.

One of the important things to remember is that it is critical for a physician to screen for and identify domestic violence. If a physician does not feel comfortable responding in detail to a patient who discloses domestic violence, a staff person should be trained to work with that patient, to support her, and to provide her with information about the local domestic violence center, where counseling and other services are available.

Regarding the reporting for child, elder or vulnerable person abuse, Chapter 415, Florida Statutes, states that any physician “who knows or has reasonable cause to suspect” that a child or elderly person is abused must report this fact to the Department of Children and Families. (The number for reporting is 800-96-ABUSE.) An elderly person is defined as anyone aged 60 or older. The physician’s name will not be given to the accused but may only be used by the Department of Children and Families and the State Attorney as they investigate the allegations of abuse. Again, it is possible that a domestic violence or human trafficking victim will be reported in these cases, too. For instance, many victims of human trafficking are minors and if a physician suspects that a child under his/her care is being trafficked, he/she must call that abuse into the Hotline.

One case was successfully settled by a domestic violence survivor/plaintiff who sued the hospital after a physician and the hospital failed to properly screen the domestic violence victim and, among other things, notice evidence of repeated physical abuse. She also alleged that they failed to assess the abusive behavior of her boyfriend while at the hospital which would have allowed them to see that she was in imminent risk of danger. After the hospital discharged her, the boyfriend doused her with gasoline and set her on fire. She suffered severe injuries, and lived. In short, she alleged that the hospital neither met numerous safety standards nor did it comply with appropriate domestic violence hospital protocols. Also, in a 2009 case, the court determined that a suit could proceed against a hospital for discharging a husband who killed his wife soon after being discharged. The hospital had potential liability for failing to screen or stabilize the husband in violation of the Emergency Medical Treatment and Active Labor Act.

Even though these cases were not in Florida, physicians must be aware of potential legal problems associated with the failure to comply with a legal obligation to report domestic violence.

Some states have passed laws that require a physician to report domestic violence when he or she becomes aware of it in a relationship. However, mandatory reporting of suspected or confirmed abuse is strongly opposed by many and can have unintended consequences, including the following:

1. Deterring a woman from confiding in her physician or from seeking care.
2. Inhibiting providers from screening patients for abuse.
3. Impairing a woman’s ability to plan and negotiate a safe exit for herself and her children.

For contact information about Domestic violence resources in your area, go to www.fmaonline.org/domestic_violence_info.aspx
Characteristics of domestic violence

Up to 90 percent of battered women do not inform their physician of their problem and until recently, few physicians routinely asked patients direct questions about abuse in a relationship. This is inconsistent with the physician’s responsibility to provide comprehensive care.

Many physicians feel they do not have to be concerned because they believe that they do not see victims of domestic violence in their practices. However, the prevalence of domestic violence seen in a practice is determined by how many patients are seen and how often the physician asks about the problem. In fact, “the federal Agency for Healthcare Research and Quality (AHRQ) estimates that 2 percent to 4 percent of all women seen in hospital emergency departments have acute trauma associated with domestic violence and another 10 percent to 12 percent of women have a recent history of domestic violence.”[22] The AHRQ further notes that even though most domestic violence injuries are classified as “superficial,” they estimate that 73,000 hospitalizations and 1,500 deaths among women are attributed to domestic violence each year[22] In other words, the percentages of women who are there because of acute or immediate trauma on account of domestic violence is relatively small; however, a much larger percentage of women seeking emergency care have recent histories of domestic violence but are not there because of an immediate domestic violence related injury. For example, a domestic violence victim seeking emergency care due to a stroke is there for treatment of that condition, even though she is also a victim of domestic violence whose health and ability to access care were directly related to abuse. This study also raises the question about whether domestic violence is being evaluated correctly as domestic violence-related injuries are classified as “superficial” even though serious injury, and sometimes death, result.

EVIDENCE OF DOMESTIC VIOLENCE IN FLORIDA’S MEDICAL PRACTICES

A woman who is abused suffers emotionally, psychologically, physically and financially, which can result in physical and mental illness and injury. However, most women who are victims of domestic violence continue to go unrecognized by the medical profession.

CHARACTERISTICS OF DOMESTIC VIOLENCE VICTIMS

Victims of domestic violence are found in every socioeconomic level of society and in all educational, racial, ethnic and age groups. Every survivor is different and the patient you are seeing may not always exhibit these characteristics, although these are the most common.

Victims:

• Are often fearful of their partners
• Are often not allowed access to family, friends, or other support networks
• Often experience reduced autonomy and/or when they exercise autonomy, there are negative or abusive consequences
• Often feel guilty or wonder if they are to blame for their partner’s violence
• May experience problems sleeping, chronic pain, GI disorders, nervousness, depression, or signs of Post-Traumatic Stress Disorder (PTSD)
• Are more likely to have more serious injuries (injuries to the head, neck and torso)
• Can often articulate what precipitated specific incidents or the progression of violence, or
• Others (family, friends, etc.) have expressed concern for the patient’s safety [23]

CHARACTERISTICS OF DOMESTIC VIOLENCE PERPETRATORS
Abusers or perpetrators are also found in all socioeconomic levels of society, in all educational, racial, ethnic and age groups. Abusers:
• Often control access to money, property and other shared commodities
• Are often notably jealous of friends, family, co-workers, and others
• Are often scornful of their partner’s perspective
• Can use various forms of status to claim authority, knowledge or power. (e.g., profession, citizenship, age, family background, education, etc.)
• Often minimize or explain their behavior, make excuses, or become defensive
• Are often vague about violent incidents
• May have a documented prior use of violence
• Often have offensive wounds (i.e. scratches or bite marks when injuries are present), or
• Use physical force against people or property. [24]

• Vulnerable. Victims may have a host of vulnerabilities including age (either very young or very old), disabilities (developmental, physical, mental), or economic status (most are desperately poor, in search of work to support their families).
• Isolated by language and culture. Many trafficking victims do not speak English and do not understand American culture. Traffickers lure their victims into the United States with promises of good work but then force them into prostitution, menial service jobs, sweatshops or farm work. Victims often have no friends and have no idea what city or country they are in because they are moved frequently to escape detection.
• Distrustful of government and law enforcement. The risk of being deported leads victims to fear and distrust government and the police especially when these systems are corrupt in their country of origin. Also, rarely does the government provide any help or assistance to those in need. As a coping or survival skill, victims may even develop loyalties and positive feelings toward their trafficker – a kind of traumatic bonding – and protect them from authorities.
• Unable to see themselves as “victims.” Unlike homeless people or drug addicts who rely on shelters and public assistance, abused individuals do not see themselves as victims because they have a place to live, food to eat, medical care and what they think is a paying job.

Like victims of domestic violence, confidentiality is paramount in human trafficking cases. Victims’ lives and those of their families are often at great risk if they try to escape their servitude or aid in criminal investigations of their captors. Therefore, physicians should minimize the number of staff members who come in contact with the victim. Ensure that all staff members who have contact with the victim, including interpreters and advocates, understand the importance of confidentiality for the safety of the patient. Physicians also should ensure that interpreters do not know the victim or the trafficker and do not otherwise have a conflict of interest. [25]

CHARACTERISTICS OF TRAFFICKED PERSONS
“As I learned more about trafficking, I realized in retrospect, I saw folks who were trafficked (in my practice) and I didn’t know to identify them as such. I saw situations with ‘mail order brides’ and their husbands or overbearing employers that refused to leave the exam room, answering questions for the patients. When I learned more about trafficking, it seemed clear that this is another source of adverse lifetime experiences that we (physicians) have an obligation to help in the same way we help child abuse and domestic violence victims.”
David McCollum, MD, Chair of the American Medical Association’s National Advisory Council on Violence and Abuse (March 2005) [25]

It is more difficult to construct a similar set of descriptors for the likely characteristics of a victim of human trafficking. It is most common that trafficked persons are:

• Vulnerable. Victims may have a host of vulnerabilities including age (either very young or very old), disabilities (developmental, physical, mental), or economic status (most are desperately poor, in search of work to support their families).
• Isolated by language and culture. Many trafficking victims do not speak English and do not understand American culture. Traffickers lure their victims into the United States with promises of good work but then force them into prostitution, menial service jobs, sweatshops or farm work. Victims often have no friends and have no idea what city or country they are in because they are moved frequently to escape detection.
• Distrustful of government and law enforcement. The risk of being deported leads victims to fear and distrust government and the police especially when these systems are corrupt in their country of origin. Also, rarely does the government provide any help or assistance to those in need. As a coping or survival skill, victims may even develop loyalties and positive feelings toward their trafficker – a kind of traumatic bonding – and protect them from authorities.
• Unable to see themselves as “victims.” Unlike homeless people or drug addicts who rely on shelters and public assistance, abused individuals do not see themselves as victims because they have a place to live, food to eat, medical care and what they think is a paying job.

OTHER IMPORTANT LAWS AND RESOURCES
ADDRESS CONFIDENTIALITY
The 1998 Florida Legislature passed an address confidentiality law. This created a program in the Florida Attorney General’s Office to grant certain domestic violence victims a confidential address so that they cannot be stalked through public records. The Attorney General’s office forwards all first class mail to the victim at a new address, thus providing an extra layer of protection to victims of abuse.
**BATTERER INTERVENTION PROGRAMS**

Florida law provides for the establishment and certification of “batterer intervention programs” and describes when a court must require a domestic violence offender to attend one of these 26-week programs. The programs are designed to address the violence and “power and control” tactics that a perpetrator has used toward his intimate partner. They exist throughout Florida and are used by the courts with varying levels of consistency and success. The Department of Children and Families administers the batterer intervention program and more information can be found at www.dcf.state.fl.us/domesticviolence/bip/index.shtml.

**CELL PHONES**

In some locations, battered women may receive free cell phones, many of which are programmed to dial 911 only. These cell phones are donated by individuals and phone companies. Again, local domestic violence centers can provide more information about this service.

**CHILDREN**

Many of the local domestic violence centers are not funded adequately to provide critically needed services to children who need help. These are some of the most at-risk children in the state. Services needed include screening and identification of child abuse, case management focusing on child safety, individual and group counseling and education about alternatives to violence.

**DOMESTIC VIOLENCE CENTERS**

The Florida Coalition Against Domestic Violence (FCADV) and the state’s 42 certified domestic violence centers are at the heart of domestic violence services in the State of Florida. These domestic violence centers provide emergency shelter, counseling, case management and a whole range of services to domestic violence survivors and the community. FCADV is the statewide organization for these centers and works on public awareness, policy development, creation of standards, provision of funding, and support for Florida’s domestic violence centers.

FCADV operates Florida’s toll-free domestic violence hotline (800-500-1119), maintains a resource library, and develops posters, brochures, safety plans, and other resources. Visit www.fcadv.org.

There has been a growing demand for services for victims of domestic violence, particularly in the area of outreach counseling and children’s programs. In fiscal year 2007-2008, Florida’s domestic violence shelters:

- Answered 113,323 crisis calls
- Provided counseling services to 63,058 individuals
- Provided emergency shelter to 14,504 individuals, primarily women and children

**FIREARMS AND DOMESTIC VIOLENCE**

Nationally, and in Florida, firearms are used overwhelmingly in domestic violence homicides. In 2008, 70 percent of the domestic violence homicides reported by local fatality review teams were committed with firearms. In 2004, firearms accounted for 58 percent of the 68 weapon types used to commit domestic violence homicides. A national study found that women who were threatened or assaulted with a gun or other weapon were 20 times more likely than other women to be murdered. When a gun was in the house, an abused woman was six times more likely than other abused women to be killed.

Both federal and Florida law make it a crime for anyone who has an injunction for protection against domestic violence to possess a firearm and many courts specifically require respondents to surrender firearms when the protection order is issued. There are some exceptions for on duty law enforcement (if permitted by their agency) and military personnel.

**HUMAN TRAFFICKING REFERRALS AND SERVICES**

In contrast to domestic violence and sexual violence programs and resources, Florida does not have a network of anti-trafficking services or shelters. However, there are some important resources available for both reporting human trafficking and for getting help to victims.

At the federal level, the Department of Health and Human Services has a 24-hour hotline. This national, multi-lingual hotline provides referrals for services in the victim’s area. (888-373-7888 or www.acf.hhs.gov/trafficking). To report human trafficking to the federal authorities, the U.S. Department of Justice also has a toll-free number (888-428-7581 voice and TTY). However, it is best to first report human trafficking to local law enforcement.

Florida has several resources to assist victims of trafficking. These include:

- Florida State University, Center for the Advancement of Human Rights, 850-644-4550, www.cahr.fsu.edu
- Florida Immigrant Advocacy Center, 305-573-1106, lucha Project, www.fiacfla.org
RAPE CRISIS SERVICES
The Florida Council Against Sexual Violence (FCASV) is a statewide nonprofit organization committed to victims and survivors of sexual violence and the sexual assault crisis programs who serve them. Further information about FCASV can be found at www.fcasv.org. A list of rape service programs located in Florida can be accessed from this site or by calling (888) 856-RAPE (7273).

SUPERVISED VISITATION NETWORK
Very often, the court will order supervised visitation or exchange of children in domestic violence cases, either when there is an injunction for protection or as part of a separation and dissolution of marriage. In order for custody visitation and exchanges to be conducted safely, all twenty judicial circuits in Florida have established supervised visitation centers. These centers work with the court and the parents to provide a safe place for the drop-off and pickup of children and supervision of the entire parent-child visit. Supervised visitation programs are critical in preventing violence when the children are transferred from one parent to the other.

Information is available about local visitation centers through the circuit court, or by contacting the Clearinghouse on Supervised Visitation at the Florida State University School of Social Work. The Clearinghouse can be contacted at (850) 644-6303 or via email at familyviolencestudies@fsu.edu or http://familyvio.csw.fsu.edu/IFVSP.php. Local supervised visitation centers are listed at http://familyvio.csw.fsu.edu/phpBB3/viewtopic.php?f=12&t=86.

WELFARE-RELATED SOCIAL SERVICES
Florida law provides help for victims of domestic violence so that they can become economically independent. It helps with special relocation benefits so they can move to a safer place and find work, and temporarily exempts them from some work requirements. It also assists non-U.S. citizen victims if they have petitioned for protection under federal law.

A physician should have all of these statewide phone numbers and the phone numbers of the local domestic violence centers and rape crisis programs available for immediate referral.

FEDERAL LAWS
The Violence Against Women Act (VAWA) and its subsequent reauthorizations created new laws relating to domestic violence, sexual violence, stalking and dating violence and established a wide array of services for survivors, including the National Domestic Violence Hotline, which has helped thousands of women get assistance through local programs. VAWA also created new protections for battered immigrant women and improved the awareness and responses of law enforcement, prosecution, the courts and others in communities around the U.S. (www.ovw.usdoj.gov/regulations.htm.) Florida receives funding under the federal Violence Against Women Act for a wide range of service providers, justice system agencies and has helped expand services and outreach to traditionally underserved populations.

Strong federal laws also exist at the federal level to assist survivors of human trafficking. The Victims of Violence and Trafficking Protection Act of 2000 (VTVPA) and its subsequent reauthorizations also provides stronger penalties for trafficking, increases support for victims through providing social services benefits and immigration relief, and institutes prevention efforts in the US and abroad among other provisions. (www.ovw.usdoj.gov/regulations.htm)

For contact information about Domestic violence resources in your area, go to www.fmaonline.org/domestic_violence_info.aspx
Victims of domestic violence are competent individuals who understand better than anyone else their benefit/risk safety ratio and the practical realities of their own personal situation.

Common reasons not to reveal problems include:

- Shame and humiliation about what is happening to her.
- Feeling that she deserves the abuse.
- Fear of retribution if the abuser learns the violence has been disclosed.
- Unfamiliarity with help that is available in the community to assist her in dealing with the problem.
- Feeling that a physician is too busy to spend time talking about her problems.

**WHY DOESN’T THE VICTIM JUST LEAVE?**

The most dangerous time for the battered woman is when she finally decides on separation or divorce. As many as 75 percent of domestic violence calls made to police and 73 percent of the emergency room domestic violence visits occur after separation. Of women killed by their abuser, 70 percent are killed during the process of trying to leave their abuser especially if jealousy is part of the relationship. It is important to understand that there are many reasons why victims of domestic violence and human trafficking do not just leave their abusive situations.

First, they do leave. It is a myth that abused women stay in abusive relationships. Jacobson and Gottman point out that abused women actually divorce their abusive husbands at a much higher divorce rate than the general public. They found that two years after the participants in their study were first interviewed, 38 percent of the wives in violent relationships had left their abusive husbands.

Reasons women do not leave include, but are not limited to, the following:

1. They may feel they deserve the abuse. Some women feel the violence directed toward them or their children is deserved and may represent just punishment. The abuser, with verbal abuse, tends to make the victim or victims believe this is true.

2. They can’t afford to leave. Financial considerations are one of the primary reasons a woman will remain in a relationship with an abuser. She may not have a job that will enable her to support herself or her children. The abuser will often cause a woman to lose her job by making her miss work (not provide transportation, or batter her when she is expected to work). An example of this is when the batterer beats his victim in the head and face the day before she plans to start work. Needless to say, she will miss work for some days. Housing and transportation are also major problems facing a woman trying to make a decision to leave a relationship.

**PATIENTS’ RELUCTANCE TO DISCLOSE DOMESTIC VIOLENCE**

There are many reasons why a patient may not want to reveal domestic violence to her physician or other health care providers. The same is true of victims of trafficking who may be afraid, ashamed or unaware that they are even victims. It should remain their own personal decision to talk about their problem whenever they feel comfortable.
3. Fear. These women are often concerned for their own safety and the safety of their children, particularly if they leave the relationship. When a batterer tells the victim that he is going to kill her, she and others helping her must take this threat seriously. A woman is at greatest risk of violence at the time that she decides to leave her batterer. She is five times more likely to be killed after separation or after divorce than when she was still in the relationship. The chance of being murdered increases significantly if jealousy is a problem with the abuser.

In terms of human trafficking, similar reasons: fear, economic factors and acceptance of the situation, may keep a trafficking victim enslaved. In addition, she may be so poor that she may feel compelled to stay and work to feed her family in her home country, or a woman forced into sex trafficking may feel tremendous shame and be unable to return to her family who believed she had legitimate work in the United States. These severe economic and work-related factors are prevalent in human trafficking cases, as opposed to domestic violence situations. Battered immigrant women and human trafficking victims also share a host of reasons why they might stay in an abusive relationship, including isolation, inability to speak English, lack of community or family support, distrust of government and law enforcement, and a lack of awareness of their rights and the resources available to help them.

THE USE OF VIOLENCE IN THE FAMILY

POWER AND CONTROL

An abuser primarily uses domestic violence or the threat of violence as a means of maintaining power, control and domination over his partner. It is also true that domestic violence usually becomes more severe over time. Abuse will not spontaneously go away. It often begins with verbal abuse including remarks intended to belittle the victim or make her lose confidence in her actions. It then progresses from bad language and shouting to physical and sexual violence. A perpetrator may be physically abusive only once, but the memory of that violence and the threat to use violence again may be all that is necessary to keep the victim compliant and fearful. Perpetrators are often obsessively or morbidly jealous and will limit the ability of the woman to contact friends, family or others in the public, where she might seek help. (See Appendix C) Power and Control Wheel. This abuse can also include financial abuse before and after a divorce when the abuser withholds funds from the victim. Even after a divorce when the court requires the abuser to make certain payments to the victim on a timely basis, the abuser can still attempt to control a woman by not making payments on time. This can have serious consequences when her rent or other bills are due and she does not have funds to make her payments.

ABUSIVE BEHAVIORS

Abusers have different ways of expressing their abuse. However, to those who care for victims of domestic abuse, there appears to be a repetitive pattern. Abusive behaviors are noted in Appendix E.

NON-VIOLENT ALTERNATIVES

There are methods for dealing with problems in a relationship that do not involve abuse. For the most part, this involves confronting the specific problems that are present in a given relationship. It is important to note that “couples counseling” or other joint interventions rarely work to stop violence, and in many instances can increase the danger to the victim and her children. This is because a perpetrator may retaliate against a victim for her honesty in sessions or may continue to intimidate her so she cannot speak openly in session. The equality wheel depicts qualities of non-violent relationships. (See Appendix F: Equality Wheel.)

DOMESTIC VIOLENCE AND ITS POTENTIAL EFFECT ON CHILDREN

The effects of domestic violence on children can be devastating. The physician should be alerted to look for domestic violence when certain problems occur with young children and children through their teens.

Child abuse and domestic violence frequently exist simultaneously. The most obvious and potentially dangerous risk for children who live in a home in which there is domestic violence is that they become direct victims of abuse. In 30 to 60 percent of families affected by intimate partner violence, children are also physically abused.[31]

DOMESTIC VIOLENCE: IN DATING RELATIONSHIPS AND AFTER DIVORCE

Abuse and tendencies to control often become evident in a dating relationship. They are frequently overlooked because the victim “loves” her abuser and unrealistically believes or hopes that he will change once they are married and have children. A perpetrator’s controlling behavior continues throughout the relationship. Even after divorce, many men continue to control the lives of their ex-spouses through litigation, child custody/visitation manipulation, or through third parties. A perpetrator also can continue to exert control over his ex-spouse by delaying court-ordered payments (child support and/or alimony). This will often result in late payments and large fees and penalties being assessed against her, ultimately damaging her credit rating. A woman will respond differently to direct questions about violence in her relationship depending upon her present stage of response to the abuse. Therefore, even after divorce, it is still important to continue to ask about her safety and about the safety of her children during follow up visits.
Physician Involvement

DOMESTIC VIOLENCE CANNOT BE DISTINGUISHED BY CLASS, RACE, AGE, MARITAL STATUS, EDUCATIONAL STATUS OR RELIGION AND IT EXISTS WITHIN EVERY GROUP IN OUR SOCIETY. Violence exists in wealthy, middle class and disadvantaged groups. It is often advisable to remember that domestic violence and human trafficking can occur among the elderly, immigrants, people with disabilities and other groups that may not fit the stereotype of a victim. Violence perpetrated on the elderly is an especially important issue in Florida as our state continues to have a large population of retired and older residents.

Universal screening for domestic violence very likely will also increase the number of trafficked persons identified in the physician’s practice. Physicians can also identify domestic violence by simply asking a question or two of each patient. This is the one way that domestic violence can be identified before the justice system is involved. If this is identified, it may prevent another episode of beating of the victim or her children and possibly prevent their murder.

SCREENING FOR DOMESTIC VIOLENCE – ASK EVERY PATIENT

Women who have been abused often respond positively about their involvement in domestic violence when questioned directly. Over one-third of abused women will speak to a physician or nurse about their abuse if a direct inquiry is made. In four different studies of survivors of abuse, 70 to 81 percent of the patients studied reported that they would like their physicians and other health care providers to ask them privately about intimate partner violence. Asking about violence can improve the outcome for domestic violence survivors. Clinical studies have proven the effectiveness of a two minute screening for early detection of abuse of pregnant women. Abuse will usually not be the patient’s primary complaint and it is important to ask about domestic violence even if the first time you bring it up, she says no or offers explanations that are inconsistent with her injuries. Also remember that injuries are likely to be on body parts that are hidden by clothing or on other parts of the body, such as the scalp, that are not easily seen.

How should a physician ask the question? Direct questions that can be asked include:
• “Are you currently in a relationship with someone who threatens or physically hurts you?”
• “Mrs. Smith, when I see people with injuries of this type, it is often because someone hit them. Is that what happened to you?”
• “What happens when your spouse loses his temper?”
• “Who hit you?” (Ask this if the patient has obvious bruises, especially facial.)
• “Has your partner ever harmed or threatened to harm you or someone you love?”
• “Have you ever been forced to have sex when you did not want to?”
• “Have you ever been afraid for the safety of your children?”

You may want to make this kind of statement: “We now know that violence in the home is a very common problem and can be very serious. I routinely ask all of my patients whether they are experiencing domestic violence because no one should have to live in fear and because there is help available.”

The American College of Obstetricians and Gynecologists has done a great deal of work on domestic violence and the physician’s role, particularly on the issue of universal screening. The following site is especially helpful to assist with screening questions:


Additionally, another tool, RADAR[39] is an acronym created by the Massachusetts Medical Society that many find useful to systematically screen patients. The acronym stands for:

- Routine screening
- Ask direct questions
- Document your findings
- Assess patient safety
- Review patient options and referrals

Another option would be to have the following hand-stamped on the chart:

- DV* Screen Yes ___ No ___
- DV* Referral Yes ___ No ___

(*DV is the abbreviation used for domestic violence.)

In Florida, there was concern that if a physician documented the domestic violence in a patient’s chart, some insurance companies would not pay the insurance benefits because they would consider the problem a “pre-existing condition.” This was resolved with the passage of a law in Florida which prohibits the denial of medical or life insurance coverage for victims of domestic violence.[40]

Finally, hospitals and other health care facilities should consider adopting a facility-wide tool to help screen for domestic violence. In 2002, the Agency for Healthcare Research and Quality (AHRQ) released an evaluation tool that hospitals can use to assess the quality and effectiveness of their domestic violence programs. Dr. Jeffrey H. Cohen, Director of the Center for Violence and Injury Control at Allegheny General Hospital in Pittsburgh, Pennsylvania, and AHRQ’s former Domestic Violence Senior Scholar-in-Residence, said the tool has been “well received by the research community and hospital domestic violence programs.” It can be downloaded at the Agency’s Website at www.ahrq.gov/research/domesticviol.[41] This tool details a range of activities that providers can use to address domestic violence. This includes discreetly placing information about local domestic violence shelters in the bathroom so the patient has access to it without her abuser knowing that the information has been provided.

SCREENING FOR HUMAN TRAFFICKING

In human trafficking cases, screening for human trafficking is also important. However, because it is not as prevalent as domestic violence, the physician should screen when human trafficking is suspected.

A victim of trafficking may look like many of your patients and be brought in by an existing patient. In one case, a wealthy family member brought a young woman they were subjecting to domestic servitude to see their family physician. The wife/mother/trafficker thought her children would be infected by the trafficking victim’s illness. Traffickers often bring victims into emergency rooms, clinics and other health care settings, posing as relatives, caring friends or legitimate employers. Here are some indicators for both U.S. citizen and foreign-born victims of trafficking:

- Evidence of being controlled
- Evidence of an inability to move or leave job
- Bruises or other signs of battering
- Fear or depression
- Non-English speaking
- Recently brought to this country from Eastern Europe, Asia, Latin America, Canada, Africa or India
- Lack of passport, immigration or identification documentation[42]
According to a recent article posted in JAMA online:\(^{13}\):

“...trafficked persons are often isolated from the public, so they have little opportunity to see their situation in a different light, according to the Campaign to Rescue and Restore Victims of Human Trafficking of the U.S. Department of Health and Human Services.”

Trafficking survivors who need health care may have an opportunity to escape their captivity, but only if physicians and others who treat them are able to recognize and reach out to them. The agency suggests that clinicians ask the following set of questions of persons who do not seem to be able to move to a different location or change jobs, who appear fearful or depressed, lack identification documents, or who seem reluctant or unable to speak for themselves:

- What type of work do you do?
- Are you being paid?
- Can you leave your job if you want to?
- Can you come and go as you please?
- Have you or your family been threatened?
- What are your working and living conditions like?
- Where do you sleep and eat?
- Do you have to ask permission to eat/sleep/go to the bathroom?
- Are there locks on your doors/windows so you cannot get out?
- Has your identification card or documentation been taken from you?”

**DOCUMENTATION**

It is important for the physician to document in the patient’s chart evidence of the violence and to be accurate in their documentation. It is important to use direct quotes from the patient. Appropriate photographs or detailed drawings or a sketch of a body are important. (See the Injury Location Chart at Appendix A).

This documentation is needed when the justice system becomes involved. If the victim seeks an injunction for protection against domestic violence or if the state is going to prosecute a person accused of domestic violence and the victim cannot testify, accurate medical records describing the abuse are critical evidence. Medical records are so valuable that many abusers will accept a plea bargaining arrangement rather than go to trial when they are presented with this evidence. This information also is valuable when legal custody of the children is being determined by the court or if the violence escalates to the point where the abuser is killed by the spouse or one of the children. Medical records that substantiate violence may keep the victim from going to jail should she defend herself and kill the abuser because they validate her claim of self-defense. It is important to think of the children in these situations who may lose one parent to death only to be separated from the other parent who may be forced to spend years in jail if convicted of a crime.

The same rules regarding documentation apply in cases of human trafficking. The justice system could intervene in the same ways: prosecuting the offender, providing relief for the victim with an injunction for protection or through a civil action against the trafficker or with child custody and support issues. Particularly in these cases, medical records would be crucial to corroborating the victim’s story to convict the trafficker, setting restitution for her and for deciding sentencing.

**ABUSE IN THE PHYSICIAN’S PERSONAL LIFE**

Physicians experience domestic violence in their personal lives just as often as anyone else. They may develop a working relationship with others in their profession (physicians, nurses, office personnel) in which the physician is “never wrong.” Remember, when you are treating a patient, there may be multiple ways to treat a given diagnosis. Your education and experience lead you to choose one of those ways to treat the patient to the exclusion of the others. This means that you have decided that the other treatments for that problem are not as good as the one that you have chosen and that the one you have chosen is the right treatment. The development of this type of attitude may lead to an abusive relationship if the behavior pattern is carried into the physician’s own home. No one is right all of the time!

A physician who reviews the Power and Control Wheel (Appendix C) or the Patterns of Behaviors (Appendices D and E) and finds some of his/her own personal behavior represented there should consider seeking professional help to deal with this problem.

Any health care professional may contact the Professionals Resource Network (PRN) at (800) 888-8776.
ROLE OF THE PHYSICIAN

It is important for the physician to validate the patient’s feelings, which may include confusion, worry, anger and sometimes rage. It is critical that the physician understand that the patient is the one to make the decision to seek help according to her wishes and needs.

Even if the patient does not want to talk about it at a certain time, there are messages that can be given to help when the time is appropriate. The patient needs to hear from the physician that:

• You believe her and will listen to her.
• She does not deserve to be abused for any reason.
• Abuse is a common problem affecting millions of women.
• She is not alone.
• Help is available from you and your staff, as well as from other resources in the community.\textsuperscript{[44]}

These statements are true for both domestic violence and human trafficking victims.

FOUR STEPS FOR RESPONDING TO DOMESTIC VIOLENCE IN THE HEALTH CARE SETTING

The Family Violence Prevention Fund’s National Consensus Guidelines on Identifying and Responding to Domestic Violence in Health Care Settings provides a helpful template for physician responses to domestic violence in their practice.\textsuperscript{[45]}

1. Provide validation:
   • Listen non-judgmentally.
   • “I am concerned for your safety (and the safety of your children).”
   • “You are not alone and help is available.”
   • “You don’t deserve the abuse and it is not your fault.”
   • “Stopping the abuse is the responsibility of your partner not you.”

\textbf{Treatment Options
2. Provide information:
   • “Domestic violence is common and happens in all kinds of relationships.”
   • “Violence tends to continue and often becomes more frequent and severe.”
   • “Abuse can impact your health in many ways.”
   • “You are not to blame.”
   • “Exposure to violence in the home can emotionally and physically hurt your children or other dependent loved ones.”

3. Respond to safety issues:
   • Offer the patient a brochure about safety planning and review it with her.
     (See Appendix H for a Sample Safety Plan) or visit www.endabuse.org/userfiles/file/HealthCare/consensus.pdf to view a specific Safety Plan and Discharge Instructions Template.
   • Review ideas about keeping information private and safe from the abuser.
   • Offer the patient immediate and private access to an advocate in person or via phone.
   • Have a provider or advocate discuss safety of the children and the patient at that time.
   • If the patient wants immediate police assistance, offer to place the call.
   • Reinforce the patient’s autonomy in making decisions regarding her/his safety.
   • If there is significant risk of suicide, the patient should be kept safe in the healthcare setting until an emergency psychiatric evaluation can be obtained.

4. Make referrals to local resources:
   • Describe any advocacy and support systems within the health care setting.
   • Refer patient to advocacy and support services within the community.
   • Refer patients to organizations that address their unique needs such as organizations with multiple language capacities, or those that specialize in working with specific populations (i.e. teen, elderly, disabled, deaf or hard of hearing, particular ethnic or cultural communities or lesbian, gay, transgender or bisexual clients).
   • Offer a choice of available referrals including on-site advocates, social workers, Florida domestic violence centers (800)500-1119 or the National DV Hotline (800) 799-SAFE, TTY (800) 787-3224.

The physician should know about the resources available for help in his or her community. You may want to meet with the director of a local shelter. Even a telephone call to a local shelter would provide a great deal of information about the resources available in your local community.

COUNSEL THE PATIENT?
It is important to realize that the physician and the health care setting are links to services and are not the service providers for victims of trafficking or domestic violence. Even if physicians or staff are trained and able to provide some introductory and supportive counseling, they should nonetheless make referrals to local domestic violence and human trafficking programs for further assistance. If the physician is concerned that when he or she identifies a patient who is involved in a violent relationship, counseling for that patient can take a long time in a busy schedule. The physician should consider rescheduling the patient if it is safe and convenient for that patient, or have a trained nurse, social worker or other staff person spend needed time with the patient.

ESTABLISHING A SAFETY PLAN WHEN VIOLENCE IS IDENTIFIED
One of the first tasks of a domestic violence or human trafficking advocate is to make sure that the victim is safe. The first and best task the physician can accomplish is to give the patient a referral to a local domestic violence center. (Visit www.fcadv.org/centers.php for a list of all certified domestic violence centers in Florida.)

The domestic violence center advocate will conduct a full safety plan. This includes:
   • Inquiring about the safety of any children in the home.
   • Determining if there is an immediate threat to the woman’s safety, including death threats.
   • Helping the victim plan for an emergency escape so that she and her children can safely get out of the situation, if necessary.

THE ROLE OF THE EMERGENCY ROOM
Emergency rooms are now alerted to ask questions about domestic violence routinely, because as many as one-third of ER visits by women are related to domestic violence. Research has shown that the number of women treated in an emergency room for problems related to domestic violence exceeds the
number of women treated by emergency rooms for muggings, rapes and automobile accidents combined.[46]

Continuing education of emergency department personnel, including doctors and nurses, has been effective in identifying the women suffering from abuse who report to the emergency room complaining of multiple problems, from exacerbation of previous emotional problems to actual treatment of physical problems caused by her batterer. Written protocols designed to identify victims of domestic violence have increased dramatically since the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) expanded their requirements to include these protocols, effective in 1992. [47] It is critical that victims receive referrals to domestic violence centers prior to their discharge from the emergency room.

**JUSTICE SYSTEM RESPONSES**

The justice system has made great strides in the past decade in addressing domestic violence. Law enforcement, the judiciary, attorneys, advocates and many others have received training on how to effectively respond to help victims be safe and to hold the perpetrators accountable. Domestic violence is a crime in Florida. In addition to the criminal justice system, the victim can seek relief against the abuser from the civil courts by seeking an injunction for protection and other kinds of civil relief.

An injunction for protection is an order the court issues to provide a range of protections to the victim. The victim must petition the court for this relief by going to the courthouse. It is a good idea for the victim to contact the local domestic violence center so that she can be assisted in filling out the proper paperwork and completing the process. The injunction for protection is sometimes called a restraining order, protection order, or “stay-away” order because most of the time it mandates that the respondent/abuser not contact the victim in any way. It can also provide for exclusive possession of the residence, child custody and support and require the abuser to go to a batterers’ intervention program.

Florida law makes it a crime to commit domestic violence and if the police are called to the scene, Florida law has a “preferred arrest policy.” This means that if the police find probable cause, they should arrest the perpetrator. In the past, some law enforcement officers would require the victim to file charges against the perpetrator before they would/could arrest him. The police would take him to jail after she filed charges against him and he would soon be out of jail (bail or released) and be back in the home in a few hours. It is easy to guess what awaited the victim when he returned to the home. Arrest and prosecution now is neither the prerogative nor the responsibility of the victim; rather it is mandated by Florida law as the sole duty of the state.

The victim has no choice about prosecution of the abuser. Florida law also has a “primary aggressor” law that requires law enforcement to investigate and determine who acted in self-defense (perhaps inflicting injury on the other party) and who was the primary offender. This law was passed in response to a large number of “mutual” arrests that occurred when the responding officers did not fully investigate domestic violence at crime scenes and arrested both the perpetrator and the victim.

It is also a crime for the respondent/abuser to violate the terms of an injunction for protection. As with most legal matters, it can be complicated to deal with the court system, and the physician should advise the patient to contact her local domestic violence center for legal assistance. The Florida Domestic Violence Hotline also has a “legal hotline” at (800) 500-1119, ext 3.

However, Florida has criminalized human trafficking and all law enforcement officers are required by law to be trained on human trafficking. In addition, Florida law enforcement at the state and local levels has proven to be invaluable partners to the federal authorities during the investigation and prosecution of human trafficking crimes. This is because the federal laws have been in place longer and specific training and resources have been directed at the federal level more extensively. Federal laws provide benefits (such as social services and immigration relief) that the state does not or cannot provide and because the federal laws are stronger in terms of criminal penalties.

The justice system responses to human trafficking victims are markedly different. For the most part, this is because human trafficking laws are relatively new and many people in the justice system are not aware of these laws or that human trafficking even exists. Also, unlike domestic violence which is primarily prosecuted at the state level, federal prosecutions are far and away the most common in human trafficking crimes. This is because the federal laws have been in place longer and specific training and resources have been directed at the federal level more extensively. Federal laws provide benefits (such as social services and immigration relief) that the state does not or cannot provide and because the federal laws are stronger in terms of criminal penalties.

MEDICAL COMMUNITY RESPONSES

Many medical organizations have been involved in educating the physicians and the public about the problems associated with domestic violence. The Florida Medical Association published a journal specifically addressing domestic violence, and indeed this course is one of the outgrowths of that publication. [48] At the local level, it is important for people in their community to get involved with their area programs, and to help address domestic violence or human trafficking with others. Physicians are learning that they have a key role in dealing with these problems in their communities. Here are some examples:
• The American College of Obstetricians and Gynecologists (ACOG) devotes a portion of its web site (www.acog.org/departments/dept_web.cfm?recno=17) to communicating specific information about domestic violence including available services, resources, referral information, screening tools, and upcoming educational opportunities for practitioners. To purchase a copy of the 2005 ACOG publication Special Issues in Women’s Health, which includes chapters on Intimate Partner Violence and Domestic Violence and Sexual Assault, as well as Adult Manifestations of Childhood Sexual Abuse, visit the ACOG Bookstore at www.acog.org/bookstore.

• For many years, ACOG has joined local, state, and national organizations in sponsoring October as Domestic Violence Awareness Month to raise awareness about this public health epidemic. Activities often include campaigns encouraging domestic violence awareness in the workplace and in health care settings, charity shopping days and national days of recognition. Call your local domestic violence shelter to find out how you can participate each October.

• ACOG and CDC have developed a slide set on intimate partner violence during pregnancy designed as a training tool for clinicians to increase understanding of the important role they can play in identifying, preventing, and reducing intimate partner violence. The slide set also emphasizes the critical window of opportunity that prenatal care provides for the screening and referral of pregnant women. The slide set is available for download by visiting CDC’s web site: (www.cdc.gov/reproductivehealth/violence/IntimatePartnerViolence/index.htm)

• The American Medical Association, the AMA Alliance, and the Family Violence Prevention Fund observed Stop America’s Violence Everywhere (SAVE) Day and Health Cares About Domestic Violence Day on Wednesday, Oct. 8, 2008. To download free patient education materials, clinical tools and resources by specialty, visit www.ama-assn.org/ama/no-index/physician-resources/20012.shtml.

• The American Medical Association has devoted entire issues of the Journal of The American Medical Association (JAMA) to the problem of domestic violence. The Diagnostic and Treatment Guidelines on Family Violence, which is a set of protocols for physicians, is also available.

• The American Medical Association Alliance has published an activity booklet entitled “Hands Are NOT For Hitting.” Aimed at young children (pre-school through the third grade), it features simple hand-tracing activities, which teach that hitting others is not appropriate. It may be obtained from the AMA Alliance at 515 N. State St., Chicago, Ill. 60610 Phone: (800) 621-8335. Visit www.amaalliance.org/site/epage/40309_625.htm to download the booklet.

• The Florida Medical Association (FMA), the Florida Medical Association Alliance and their component county societies/alliances often work to support domestic violence programs at the local level through a variety of efforts such as organizing fundraisers, adopting abuse shelters, and arranging for volunteer physician services. Contact the FMA, FMA Alliance, or your local county medical society or alliance if you have ideas to support the domestic violence programs in your area. Visit www.fmaonline.org to access a list of all FMA Partners, including county medical societies and county alliances.

• The Family Violence Prevention Fund has significant resources to help improve the healthcare response to domestic violence and they have been cited throughout this course. They will help train individuals in your community about better methods to address domestic violence.

Another example of the efforts undertaken by a local community to help resolve domestic violence involves the Crisis Nursery Project of the Hibiscus House, a private, non-profit shelter for abused children located in Jensen Beach, Florida. This program is designed to help families in a crisis situation receive help before an abusive situation develops, without the involvement of the Florida Department of Children and Families. Children can be cared for at the Hibiscus House facility for up to 30 days while the family receives counseling at Hibiscus House to deal with severe problems within the family. This has been especially helpful when a woman leaves a violent situation before she has time to make arrangements for the care and sheltering of her children. They are successful in preventing 98 percent of the families from being reported for allegations of abuse. Although this program was initially funded by a federal grant, and recently by the local community, the program received $193,000 from the Florida State Legislature in the 1998 legislative session. Other communities are encouraged to contact this group at (772) 334-9311 for more information about their program.
For contact information about Domestic violence resources in your area, go to www.fmaonline.org/domestic_violence_info.aspx
Appendix A

Injury Location Chart

Indicate with arrow to body where injury was observed. Indicate number of injuries of each type in the space provided.

ENCOUNTERS

Cuts ___ Punctures ___
Bites ___ Abrasions ___
Bruises ___ Bleeding ___
Burns ___ Dislocations ___
Bone Fractures ________

Cuts ___ Punctures ___
Bites ___ Abrasions ___
Bruises ___ Bleeding ___
Burns ___ Dislocations ___
Bone Fractures ________

Cuts ___ Punctures ___
Bites ___ Abrasions ___
Bruises ___ Bleeding ___
Burns ___ Dislocations ___

Cuts ___ Punctures ___
Bites ___ Abrasions ___
Bruises ___ Bleeding ___
Burns ___ Dislocations ___
Appendix B

A Battered Woman’s Bill of Rights

- She has the right not to be abused.
- She has the right to be angry over past beatings.
- She has a right to choose to change the situation.
- She has a right to freedom from fear of abuse.
- She has a right to request and expect assistance from police and social agencies.
- She has a right to share her feelings and not to be isolated from others.
- She has a right to want a better role model of communication for her and her children.
- She has a right to be treated like an adult.
- She has a right to leave the battering environment.
- She has a right to privacy.
- She has a right to express her own thoughts and feelings.
- She has a right to develop her individual talents and abilities.
- She has a right to legally prosecute the abuser.
- She has the right not to be perfect.

Patricia C. Ball and Elizabeth Wyman

Appendix C

Domestic Abuse Intervention Project

Dukuth, MN

THE THIRD REPORT OF THE GOVERNOR’S TASK FORCE ON DOMESTIC AND SEXUAL VIOLENCE 1997
Appendix D

Abuser’s Patterns

Abuser may exhibit patterns of behaviors that appear routinely or seem to represent their personal profile. These behaviors are based upon such personal dynamics as behaviors they observed as a child, past episodes within the current or former relationships and their interpretation of what they stand to lose.

- Abuser apologizes
- Makes promises/attempt rehabilitation
- Blames victim
- Denies, rationalizes or minimizes abuse
- Gives gifts
- “Forgets” incident
- No abuse takes place
- Tension rises, Becomes prominent
- Minor incidents begin
- Breakdown of communication
- Victim/Family practices “prevent defense,” begins “walking on eggshells”
- Any type of abuse occurs (physical/sexual/emotional)

Beck Dunn/1997

Appendix E

Abusive Behaviors

Physical Abuse
- Threatens to hurt or kill
- Pushes or shoves
- Prevents from leaving at will
- Kicks or chokes
- Hits, slaps or punches
- Throws objects
- Locks patner out of the house
- Abandons partner in dangerous places
- Refuses to help sick, injured or pregnant family members
- Subject partner to reckless driving
- Rapes or sexually coerces
- Threatens with a weapon
- Abuses pets
- Breaks furniture, belongings or personal effects

Sexual Abuse
- Harasses spouse about imagined affairs
- Tells anti-gender jokes
- Treats partner as sex object
- Is jealous and assumes spouse will have sex with any available person
- Criticizes sexuality
- Insists on unwanted or uncomfortable touching
- Withholds sex and affection
- Calls spouse sexual names like “whore” or “frigid”
- Forces spouse to undress against her will
- Publicly shows interest in other partners
- Forces unwanted sexual acts
- Forces sex when spouse is sick or when it is a danger to health
- Forces sex for the purpose of hurting partner with objects or weapons
- Commits sadistic sexual acts
- Tells spouse about affairs
- Rapes or sexually coerces
**Emotional Abuse**
- Ignores spouse's feelings
- Ridicules or insults with gender characteristics
- Ridicules or insults most valued beliefs, religion, race, heritage or class
- Withholds approval, appreciation or affection as punishment
- Continually criticizes, calls names or shouts
- Humiliates spouse
- Regularly threatens to leave or tells spouse to leave
- Punishes or deprives children when angry at spouse
- Threatens to kidnap the children if spouse leaves
- Manipulates with lies and contradictions
- Keeps spouse on an emotional roller coaster
- Continually finds fault with what spouse does and how it is done
- Calls spouse stupid, incapable, or inadequate
- Tells the children what a bad parent they have
- Tells spouse they are too fat or too thin
- Disallows any success or good feelings

**Social Isolation**
- Doesn’t allow contact with family
- Doesn’t allow spouse to have friends
- If allowed friends, punishes spouse for having them, calls them names, questions or badgers spouse until relationship is stopped
- Suggests or demands a physical move away from a familiar or safe geographic location
- Keeps spouse a prisoner in their own home
- Spouse is forced to live on the abuser’s time clock: to be where the abuser wants when the abuser wants
- Refuses to socialize with spouse
- Denies spouse access to the car

**Dependency**
- Keeps wife pregnant
- Keeps spouse and the family in debt
- If she is employed, causes trouble at spouse’s work; tries to get spouse fired
- Keeps partner unemployed or working at a job they dislike
- Controls the money or resources; everything is in the abuser’s name
- Refuses to work or share money
- Makes partner ask for money

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**Appendix F**

*Domestic Abuse Intervention Project*

Dukuth, MN

*The Third Report of the Governor’s Task Force On Domestic and Sexual Violence 1997*
Appendix G

The Effects of Domestic Violence on Children

**Pre-Natal**
- Increases miscarriages due to increased beatings and/or mother’s stress
- Poor health care due to mother’s stress and lack of proper nutrition

**Infants**
- Crying and irritability
- Sleep disturbances
- Digestive problems

**Toddlers/Preschoolers**
- More aggressive than other children
- More withdrawn than other children
- Impaired cognitive abilities
- Delays in verbal development
- Poor motor abilities
- General fearfulness or anxiety
- Stomachaches
- Nightmares
- Lack of bowel and bladder control after age 3
- Lack of confidence to begin new tasks

**School Age**
- Poor grades or in special classes
- Failure of one or more grade levels
- Poor social skills
- Low self-esteem
- General aggressiveness
- Violent outbursts of anger
- Bullies or withdraws
- Bedwetting
- Nightmares
- Digestive problems, ulcers
- Headaches not related to eye strain or sinus problems

**Teenagers**
- Poor grades, failure in school, quits school
- Low self-esteem
- Refuses to bring friends home
- Stays away from home
- Feels responsible for taking care of home and mother
- Runs away from home
- Violent outbursts of anger or destroying of property
- Poor judgment
- Irresponsible decision making
- Unable to communicate feelings
- Immaturity
- Withdraws from friends or has few friends
- Nightmares
- Ulcers, digestive problems
- Bedwetting
- Headaches
- Severe acne
- Males hitting their girlfriends
- Females being hit by their boyfriends
- Joining in on beatings of mother
Appendix H

Safety Plan

What You Can Do Prior To A Violent Incident

• Know how to identify your partner’s/spouse’s level of violence so that you can assess danger to yourself and to your children.
• When possible, plan to leave before violence occurs and when your partner/spouse is not around.
• Go to a safe place. Make arrangements with a trusted friend or someone not known to your partner or spouse. Ask them not to tell anyone.
• Notify a neighbor to be alert to strange noises and to call the police.
• If you can, get rid of all weapons in your home if your partner/spouse is nearing a violent stage or is in a violent stage of the cycle.
• Know your local battered women’s shelter number.
• Plan where you will go in an emergency or dangerous situation. Consider telling your employer not to talk with your partner/spouse until he or she talks with you first, if you believe your partner/spouse may come to your workplace.

What You Can Do During A Violent Incident

• Leave the physical presence of the batterer, if possible.
• Leave home; locate your escape items.
• Get to a room with a lock on the door and/or a telephone.
• Call 911 for the police or call your local shelter for battered women.
• Have your children call the police.
• Scream so your neighbors can hear and will call the police.
• If you have to leave your children in the home, contact the police immediately.
• If you leave by car, lock your car doors immediately and do not unlock the doors until you arrive safely at your destination.
• Check yourself and children for injuries and go to the hospital, if necessary.
• If you cannot leave, protect yourself to the best of your ability.

What Items You Will Need For A Comfortable, Safe Escape

• MONEY: Always have some hidden. If you cannot keep it in your own home, put it in a place where you can have easy access to it night or day. Plan to have enough money for weekend motel rent, telephone calls, gas and food expenses. Be sure you have change and not just currency.
• KEYS: Have two extra sets of keys made for your car and your home; one set for you to put in a safe place and the other to give to a trusted friend.
• EXTRA CLOTHING: Prepare a bag with extra clothing for you and your children. Consider the fact that your might have to escape in the winter or the summer, so choose clothing suitable for either season.
• IMPORTANT DOCUMENTS: Arrange a plan to gain quick access to important documents or copies and other items. These should include the following:
  - Social Security numbers (his, yours and your children’s)
  - Birth certificates (yours and your children’s)
  - Pay stubs (your husbands and yours)
  - Bank accounts
  - Insurance policies
  - Marriage license
  - Driver’s licenses (yours and a copy of his)
  - Any ownership papers of property
  - Copies of all your monthly bills
  - Valuable jewelry
• IMPORTANT TELEPHONE NUMBERS: Include at least the following numbers:
  - Local police department or 911
  - Shelter
  - Alternative shelter
  - Victim’s assistance
  - Probation officer
  - Social services
  - Your counselor
  - His counselor

ANY OTHER ITEMS OF IMPORTANCE TO YOU AND YOUR CHILDREN