

Domestic Violence: The Florida Requirement

This course fulfills the Florida requirement for 2 hours of Domestic Violence Education.

Faculty

Marjorie Conner Allen, BSN, JD, received her Bachelor of Science in Nursing degree from the University of Florida, Gainesville, in 1984. She began her nursing career at Shands Teaching Hospital and Clinics at the University of Florida, Gainesville. While practicing nursing at Shands, she gave continuing education seminars regarding the nursing implications for dealing with adolescents with terminal illness. In 1988, Ms. Allen moved to Atlanta, Georgia where she worked at Egleston Children's Hospital at Emory University in the bone marrow transplant unit. In the fall of 1989, she began law school at Florida State University. After graduating from law school in 1992, Ms. Allen took a two-year job as law clerk to the Honorable William Terrell Hodges, United States District Judge for the Middle District of Florida. After completing her clerkship, Ms. Allen began her employment with the law firm of Smith, Hulsey & Busey in Jacksonville, Florida where she has worked in the litigation department defending hospitals and nurses in medical malpractice actions. Ms. Allen resides in Jacksonville and is currently in-house counsel to the Mayo Clinic Jacksonville.

Faculty Disclosure

Contributing faculty, Marjorie Conner Allen, BSN, JD, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Division Planners

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Division Planners Disclosure

The division planners have disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Audience

This course is designed for all Florida healthcare professionals required to complete Domestic Violence education.

Accreditation

CME Resource is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

CME Resource is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

CME Resource, #1092, is approved as a provider for continuing education by the Association of Social Work Boards 400 South Ridge Parkway, Suite B, Culpeper, VA 22701. www.aswb.org. ASWB Approval Period: 3/13/2007 to 3/13/2010. Social workers should contact their regulatory board to determine course approval.

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Designation of Credit

CME Resource designates this educational activity for a maximum of 2 AMA PRA Category 1 Credit(s)[™]. Physicians should only claim credit commensurate with the extent of their participation in the activity.

CME Resource designates this continuing education activity for 2 ANCC contact hours.

AACN Synergy CERP Category B.

Social workers will receive 2 continuing education clock hours in participating in this intermediate to advanced course.

CME Resource designates this continuing education activity for 1 NBCC clock hour.

This course meets the qualifications for 2 hours of continuing education credit for MFTs and/or LCSWs as required by the California Board of Behavioral Sciences.

This course meets the requirements for 2 Clinical hours as required by the New Jersey Board of Social Work Examiners.

Individual State Nursing Accreditations

In addition to states that accept ANCC, CME Resource is accredited as a provider of continuing education in nursing by: Alabama, ABNP0353; California, CEP9784; California BVNPT Provider #V10662; Florida Provider #50-2405; Iowa, #295; Kentucky, 7-0054, Kentucky Board of Nursing approval of an individual nursing continuing education provider does not constitute endorsement of program content; Texas, ANCC/Type I Provider.

Additional Approval

CME Resource is approved as a provider of continuing education for Florida Nursing Home Administrators. Provider number FNHAP-17.

Special Approval

This course fulfills the Florida requirement for 2 hours of Domestic Violence Education every third renewal period.

This activity is designed to comply with the requirements of California Assembly Bill 1195, Cultural and Linguistic Competency.

About the Sponsor

The purpose of CME Resource is to provide challenging curricula to assist healthcare professionals to raise their levels of expertise while fulfilling their continuing education requirements, thereby improving the quality of healthcare.

Our contributing faculty members have taken care to ensure that the information and recommendations are accurate and compatible with the standards generally

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Disclosure Statement

It is the policy of CME Resource not to accept commercial support.

Course Objective

The purpose of this course is to enable healthcare professionals in all practice settings to define domestic violence and identify those who are affected by domestic violence in the United States. This course describes how a victim can be accurately diagnosed and identifies the community resources available in the state of Florida for domestic violence victims.

Learning Objectives

Upon completion of this course, you should be able to:

1. Describe how the state of Florida defines “domestic violence.”
2. Cite the general prevalence of domestic violence on a national and state level and identify state laws pertaining to the issue.
3. Describe how to screen for patients who have a history of being a victim of domestic violence.
4. Describe how to screen for patients and/or family members who have a history of being perpetrators of domestic violence.
5. Discuss the importance in conducting a culturally sensitive assessment when screening for domestic violence.
6. Identify community resources presently available for domestic violence victims and their perpetrators throughout Florida concerning legal aid, shelter, victim and batterer counseling, and child protection services.



Sections marked with this symbol include evidence-based practice recommendations. The level of evidence and/or strength of recommendation, as provided by the evidence-based source, are also included so you may determine the validity or relevance of the information. These sections may be used in conjunction with the course material for better application to your daily practice.

INTRODUCTION

Domestic violence continues to be a prevalent problem in the United States today. Because of the number of individuals affected, it is likely that most healthcare professionals will encounter patients in their practice who are victims. Accordingly, it is essential that healthcare professionals are taught to recognize and accurately interpret behaviors associated with domestic violence. It is incumbent upon the healthcare professional to establish and implement protocols for early identification of domestic violence victims and their abusers. In order to prevent domestic violence and promote the well-being of their patients, healthcare professionals in all settings must take the initiative to properly assess all women for abuse during each visit and, for those women who are or may be victims, to offer education, counseling, and referral information.

Victims of domestic violence suffer emotional, psychological, and physical abuse, all of which can result in both acute and chronic signs and symptoms of physical and mental disease, illness, and injury. Frequently, the injuries sustained require abused victims to seek care from healthcare professionals immediately after their victimization. Subsequently, physicians and nurses are often the first healthcare providers that victims encounter and are in a critical position to identify domestic violence victims in a variety of clinical practice settings where victims receive care. Accordingly, each healthcare professional must educate himself or herself to enhance awareness of the presence of battered women in his or her particular practice or clinical setting.

Specifically, healthcare professionals must be aware of the signs and symptoms associated with domestic violence. In addition, when family violence cases are identified, there should be a plan of action that includes providing information on, and referral to, local community resources related to legal aid, sheltering, victim counseling, batterer counseling, advocacy groups, and child protection.

DEFINING DOMESTIC VIOLENCE

Domestic violence, which is sometimes also referred to as “spouse abuse,” “battering,” or “intimate partner violence,” refers to the victimization of an individual with whom the abuser has or has had an intimate or romantic relationship. Researchers in the field of domestic violence have not agreed on a uniform definition of what constitutes violence or an abusive relationship. The prevailing perception about domestic violence is that assaults are “physical, frequent, and life-threatening” [1]. The Centers for Disease Control and Prevention (CDC), in their publication *Costs of Intimate Partner Violence Against Women in the United States*, define intimate partner violence (IPV) as, “violence committed by a spouse, ex-spouse, or current or former boyfriend or girlfriend. It occurs among both heterosexual and same-sex couples and is often a repeated offense” [2]. The Florida Department of Children and Families defines domestic violence as, “a pattern of behaviors that adults or adolescents use against their intimate partners or former partners to establish power and control. It may include physical abuse, sexual abuse, emotional abuse, and economic abuse. It may also include threats, isolation, pet abuse, using children and a variety of other behaviors used to maintain fear, intimidation and power over one’s partner” [48]. 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 who is or was residing in the same single dwelling unit” [12]. Domestic violence knows no boundaries. It occurs in intimate relationships, regardless of race, religion, culture, or socioeconomic status [3].

Whatever the definition, it is important for healthcare professionals to understand that domestic violence, in the form of emotional and psychological abuse and physical violence, is prevalent in our society. Unfortunately, domestic violence and abuse has become a fact of life for many Americans [4]. This course will use the terms “domestic violence” and “IPV” interchangeably.

NATIONAL AND STATE STATISTICS

Since the 1980s, domestic violence has emerged as one of the most serious public health problems facing women in this country [5]. In the United States, more than 26% of women 18 years of age and older and 15.9% of men have a lifetime history of IPV [49]. Although many of these incidents are relatively minor and consist of pushing, grabbing, shoving, slapping, and hitting, IPV resulted in 1544 deaths in 2004 [26; 50]. One of the difficulties in addressing the problem is that the abuse of women cannot be predicted by any demographic feature related to age, ethnicity, race, religious denomination, education, socioeconomic status, or class [7].

Women who are abused often suffer severe physical injuries and will likely seek care at a hospital or clinic. The health and economic consequences of domestic violence are significant. Statistics vary from report to report, and due to the lack of recent studies on the national cost of domestic violence, the U.S. Congress funded the CDC to conduct a study to determine the cost of domestic violence on the healthcare system [2]. The CDC report, which relied on data from the National Violence Against Women Survey conducted in 1995, estimated the costs of IPV by measuring how many female victims were nonfatally injured; how many women used medical and mental health care services; and how many women lost time from paid work and household chores. The estimated total cost of IPV against women in 1995 was more than \$5.8 billion. It must be noted that the costs of any one victimization may continue for years; therefore, this estimate most likely underestimates the actual cost of IPV [2].

The rate of domestic violence against women has declined from 1993 to 2004, dropping from 1.1 million violent crimes against women in 1993 to 627,400 in 2004 [9]. The rate of overall family violence also fell by more than one-half in this time period [10]. Studies reveal that several fac-

tors may be contributing to the reduction in violence, including a decline in the marriage rate and decrease of domesticity, better access to federally funded domestic violence shelters, improvements in women's economic status, and demographic trends, such as the aging of the population [21; 39].

FLORIDA

In response to troubling domestic violence statistics, Governor Lawton Chiles appointed a Task Force on Domestic Violence on September 28, 1993 to investigate the problems associated with domestic violence in Florida and to compile recommendations as to how the problems should be approached and ultimately resolved. On January 31, 1994, the Task Force issued its first report on domestic violence. This report recommended standards to accurately measure the extent of domestic violence and strategies for increasing public awareness and education. It identified programs and resources that are presently available to victims in Florida, made legislative and budgetary suggestions for needed changes and provided a methodology for implementing these changes, and identified areas of domestic violence that require further study.

As a result of this report, Florida enacted legislation during the 1995 session implementing various suggestions of the Task Force. Specifically, the Legislature amended Section 455.222 of the Florida Statutes to require that all physicians, osteopaths, nurses, dentists, dental hygienists, midwives, psychologists, and psychotherapists obtain, as part of their biennial continuing education requirements, a one-hour continuing education course on domestic violence [11]. In June of 2006, Governor Jeb Bush signed into law House Bill 699. The bill, which went into effect July 1, 2006, changed the domestic violence continuing education requirement from one hour every renewal period to two hours every third renewal period.

In 1997, at the request of the Governor's Task Force, a workgroup was established by the Florida Department of Law Enforcement (FDLE) to evaluate the feasibility of tracking incidents of domestic violence in the state [13]. This resulted in the creation of

the Domestic Violence Data Resource Center (DVDRC). The original mission of the DVDRC was to collect information related to domestic violence and to report and maintain the information in a statewide tracking system [14]. Domestic Violence Fatality Review Teams were established to examine those cases of domestic violence that resulted in a fatality and identify potential changes in policy or procedure that might prevent future deaths. The teams were comprised of representatives from law enforcement, the courts, social services, state attorneys, domestic violence centers and others who may come into contact with domestic violence victims and perpetrators [15]. In 2000, the creation of Florida Statute 741.316 required the FDLE to annually publish a report based on the data gathered by the Fatality Review Teams [14]. Due to budgetary constraints, responsibility of compiling this data transferred to the Department of Children and Families in 2008 [16].

In 2001, Governor Jeb Bush signed into law the "Family Protection Act." The act requires a 5-day mandatory jail term for any crime of domestic battery in which the perpetrator deliberately injured the victim. The law also makes a second battery crime a felony offense, treating offenders as serious criminals. Additional legislation, signed into law in 2002, includes Senate Bills 716 and 1974. Senate Bill 716 protects domestic violence victims by including dating relationships of six months in the definition of domestic violence laws. Senate Bill 1974 requires judges to inform victims of their rights, including the right to appear, be notified, seek restitution, and make a victim-impact statement. Governor Bush also created the Violence Free Florida campaign to increase public awareness of domestic violence issues [17].

In 2003, Governor Bush signed House Bill 1099, which transferred funding authority of the Florida Domestic Violence Trust Fund from the Department of Children and Families to the Florida Coalition Against Domestic Violence. According to those supporting the bill, this will strengthen services to battered women and their children by streamlining the process of allocating funds.

In 2007, the FDLE reported 115,150 domestic violence offenses [16]. In general, domestic violence rates have been declining since 1998. Forty-four percent of domestic violence incidents involved spouses and 44% involved cohabitants. Four percent of the domestic violence offenses involved violence by parents against children less than eighteen years of age, and 4% of the victims were parents of the offenders. In 2007, domestic violence offenses resulted in the death of 189 victims in Florida, a 15% increase since 2006 [16; 53]. Domestic violence accounted for 16% of the state's murders in 2007 [16].

In their 2008 Annual Report, Fatality Review Teams summarized 27 cases of domestic violence that resulted in death [16]. The most significant findings included the following observations [16]:

- In most cases, family and friends were aware of the violence but did not know how to intervene.
- Alcohol/drug abuse, separation issues, employment/monetary problems, and mental capacity were significant factors in accelerating the abuse.
- In most cases, neither the decedent nor perpetrator sought help from the various intervention programs available to them.
- Victim safety would benefit from domestic violence provider, law enforcement, and judicial access to a centralized database containing civil and criminal case information.
- There is a need for more education and awareness to the public on domestic violence issues.

To obtain a copy of the Executive Summary of the 2008 Florida Domestic Violence Fatality Review Team Annual Report, please visit <http://www.fdle.state.fl.us/publications/2008DomesticFatalityReviewExecutiveSummary.pdf>.

IDENTIFYING DOMESTIC VIOLENCE/GROUPS AT RISK

Healthcare professionals are in a critical position to identify domestic violence victims in a variety of clinical practice settings where women receive care. Nurses are often the first healthcare provider a victim of domestic violence will encounter in a healthcare setting and must therefore be prepared to provide care and support for these victims [6]. Although women are most often the victim of domestic violence, domestic violence extends to others in the household as well. For example, domestic violence occurs when children are abused by their parents or when parents are abused by their children, when the elderly are abused, and when siblings abuse each other [19].

As previously described, statistics demonstrate that large numbers of trauma victims presenting to hospital emergency rooms are domestic violence victims. In one study, 49.6% of women seen in emergency departments reported a history of abuse [52]. Another study found that 1.4 million individuals were treated in a hospital emergency department for injuries resulting from confirmed or suspected interpersonal violence [40]. Alarming statistics certainly demonstrate that healthcare professionals who work in acute care, such as hospital emergency rooms, must maintain a high index of suspicion for battering of the patients that they see. Nurses who work in these settings should work with emergency room physicians and hospital administrators to establish and institute screening mechanisms to accurately detect these victims.

For every victim of abuse, there is also a perpetrator. Like their victims, perpetrators of domestic violence come from all socioeconomic backgrounds, races, religions, and walks of life [27]. Accordingly, healthcare professionals must likewise be aware that seemingly supportive family members may, in fact, be abusers. Perpetrators and their victims in lower socioeconomic groups are more likely to turn up in hospital emergency rooms and local community clinics. Conversely, people of higher socioeconomic status are more able to turn to the private clinician for assistance [27].

PREGNANT WOMEN

Because a gynecologist or obstetrician is frequently a woman's primary care physician, these healthcare providers must be particularly sensitive to domestic violence issues [19]. According to the CDC, IPV affects as many as 324,000 pregnant women each year [52]. This represents approximately 8% of all pregnant women in the United States. As with all domestic violence statistics, this number is presumed to be lower than the actual incidence as a result of underreporting and lack of data on women whose pregnancies ended in fetal or maternal death. This makes IPV more prevalent among pregnant women than some of the health conditions included in prenatal screenings, including preeclampsia and gestational diabetes [52]. Because 96% of pregnant women receive prenatal care, this is an optimal time to screen for domestic violence and develop trusting relationships with the women. Possible factors that may predispose pregnant women to IPV include young maternal age, unintended pregnancy, delayed prenatal care, lack of social support, and use of tobacco, alcohol, or illegal drugs [52].

The overarching problem of violence against women cannot be ignored, especially as both mother and unborn child are at risk. At this particularly vulnerable time in a woman's life, an organized clinical construct leading to immediate diagnosis and medical intervention will insure that therapeutic opportunities are available to the pregnant woman and will reduce the potential negative outcomes [20; 56]. Healthcare professionals should also be aware of the possible psychological consequences of abuse during pregnancy. There is a higher risk of stress, depression, and addiction to alcohol and drugs in abused women. These conditions may result in damage to the unborn baby from drugs and alcohol and a loss of interest on the part of the mother in her or her baby's health [22]. Possible direct injuries to the fetus may result from maternal trauma [52].

CHILDREN

Children who are raised in violent homes are also in danger. These children are at high risk for abuse and for emotional damage that may affect them as they grow older. As many as 70% of children from violent homes have witnessed their fathers battering their mothers. Interestingly, studies demonstrate that children who witness domestic violence are more likely to grow into a perpetrator or victim of domestic violence than a child who was himself or herself abused, thereby creating a “cycle of violence.” For example, male adolescents who witness domestic violence are many times more likely to batter their mates later in life [23]. A meta-analysis of 118 studies of the psychosocial outcomes of children exposed to domestic violence found that 63% of child witnesses exhibited more aggression, anxiety, difficulties with peers, and academic problems than the average child [42]. In addition to witnessing violence, these children may also become direct victims of violence, as between 50% and 70% of husbands who batter their wives also batter their children [6]. Moreover, victims of abuse will often turn on their children; statistics demonstrate that 85% of domestic violence victims abuse or neglect their children. The 2007 Crime in Florida report found that 11.6% of domestic homicide victims were children [53]. Teenage children are also victimized. According to the U.S. Department of Justice, between 1976 and 2005, 5% of all homicides against females 12 to 17 years of age were committed by an intimate partner [55]. Among young adults (18 to 24 years of age) the rate is 29%. Abused teens often do not report the abuse. Individuals 12 to 19 years of age report only 35.7% of crimes against them as compared to 54% in older age groups [43]. Accordingly, healthcare professionals who see young children and adolescents in their practice, i.e., pediatricians, family physicians, school nurses, pediatric nurse practitioners, and community health nurses, must have the tools necessary to detect these “silent victims” of domestic violence and to intervene quickly to protect young children and adolescents from further abuse. Without such critical intervention, the cycle of violence will never end.

ELDERLY

Abused and neglected elders, who may be mistreated by their spouses, partners, children, and other relatives, are among the most isolated of all victims of family violence. In a national study conducted by the National Center on Elder Abuse, there was a total of 472,813 reports of elder abuse to Adult Protective Services in the United States in 2000. This was a 160% increase from the 293,000 reports in 1996 [44]. The prevalence rate of elder abuse in institutional settings is not clear. However, in one nonprobability study, 36% of nursing and aide staff disclosed to having witnessed at least one incident of physical abuse by other staff members in the preceding year. When asked whether they themselves perpetrated physical abuse against an elderly resident, 10% admitted they had [45].

As healthcare professionals in Florida, which leads the nation in percentage of older residents, we must understand that the needs of older Floridians will increase as will the numbers of elder victims of domestic violence. Because elder abuse can occur in family homes, nursing homes, board and care facilities, and even medical facilities, healthcare professionals must remain keenly aware of the potential for abuse. When abuse occurs between elder partners, it is primarily manifested in one of two ways, either as a long-standing pattern of marital violence or as abuse originating in old age. In the latter case, abuse may be precipitated by issues related to advanced age, including the stress that accompanies disability and changing family relationships [6].

It is important to understand that the domestic violence dynamic involves not only a victim but a perpetrator as well. For example, an adult son or daughter who lives in the parents’ home and depends on the parents for financial support may be in a position to inflict abuse. This abuse may not always manifest itself as violence, but can lead to an environment where the elder parent is controlled and isolated. The elder may be hesitant to seek help because the abuser’s absence from the home may leave the elder without a caregiver [6].

Because these elderly victims are often isolated, dependent, infirm, or mentally impaired, it is easy for the abuse to remain undetected. Healthcare professionals in all settings must remain aware of the potential for abuse and keep a watchful eye on this particularly vulnerable group.

MEN

Statistics confirm that domestic violence is predominantly perpetrated by men against women; however, there is evidence to suggest that women also exhibit violent behavior against their male partners [24]. Studies demonstrate approximately 5% of murdered men are killed by intimate partners [9]. It is persuasively argued that the impact on the health of female victims of domestic violence is generally much more severe than the impact on the health of male victims [25]. Approximately 1.5 million women are raped and/or physically assaulted by an intimate partner each year, compared to 834,700 men [26]. In addition, 1 out of every 4 women has been physically assaulted or raped by an intimate partner, compared to 1 out of every 14 men [26]. IPV accounted for 22% of nonfatal violence against women between 2001 and 2005 and 4% against men [9]. Nevertheless, healthcare professionals must always keep in mind that males can also be victimized.

SAME SEX COUPLES

Domestic violence exists in the gay and lesbian community and the rates are thought to mirror those of heterosexual women, approximately 25% [28]. It is interesting to note, however, that women living with female intimate partners experience less intimate partner violence than women living with men [26]. Conversely, men living with male intimate partners experience more intimate partner violence than do men who live with female intimate partners [26]. This supports other statistics indicating that intimate partner violence is perpetrated primarily by men. Because of the stigma of being gay, victims may be reticent to report abuse and afraid that their sexual orientation will be revealed. Many in this community feel that support services are not available to them due to homophobia of

the service providers. Unfortunately, this results in the victim feeling isolated and unsupported. Healthcare professionals must strive to be sensitive and supportive when working with homosexual patients.

HOW TO SCREEN FOR DOMESTIC VIOLENCE AND ABUSE

A tremendous barrier to diagnosing and treating domestic violence is a lack of knowledge and training. Healthcare workers are trained to recognize and accurately interpret behaviors associated with domestic violence and abuse. However, healthcare professionals are hesitant to inquire about abuse [29; 30]. Studies indicate that a small minority of pediatricians and family physicians screen parents for IPV during well-child care visits as is recommended [18; 41]. The American College of Obstetricians and Gynecologists indicates that only 6% of its membership of over 33,000 physicians routinely ask their patients about abuse [32]. Approximately 10% of primary care physicians routinely screen for intimate partner abuse during new patient visits, and 9% routinely screen during periodic checkups [31]. Less than half of the physicians studied had recent training on intimate partner abuse, and only 17% routinely screened patients during their first prenatal visit [31].

It is imperative that healthcare professionals work together to establish specific guidelines that will facilitate identification of batterers and their victims. These guidelines should review appropriate interview techniques and should also include the utilization of screening tools, such as intake questionnaires. The following is a review of certain signs and symptoms that may indicate the presence of abuse. Although battered women do not display typical signs and symptoms when they present to healthcare providers, there are certain cues that may be attributed to abuse. The obvious cues are the physical ones. Injuries range from bruises, cuts, black eyes, concussions, broken bones, and miscarriages to permanent injuries such as damage to joints, partial loss of hearing or vision, and scars

from burns, bites, or knife wounds. Typical injury patterns include contusions or minor lacerations to the head, face, neck, breast, or abdomen. These are often distinguishable from accidental injuries, which are more likely to involve the periphery of the body. In one hospital-based study, domestic violence victims were thirteen times more likely to sustain injury to breast, chest, or abdomen than accident victims. Abused women are also more likely to have multiple injuries than accident victims. When this pattern of injuries is seen in a woman, particularly in combination with evidence of old injury, physical abuse should be suspected [20].



The Institute for Clinical Systems Improvement (ICSI) recommends that staff should have heightened awareness of a possible domestic violence situation when the patient presents with: somatic complaints without diagnosis (chronic

pain, fatigue, headache), post-traumatic stress symptoms, gastrointestinal pain, unexplained neurological changes, depression, and/or multiple or erratic visits with a series of vague complaints.

(http://www.icsi.org/domestic_violence/domestic_violence_2589.html. Last accessed August 29, 2008.)

Level of Evidence: A (randomized, controlled trial), B (cohort study), C (Non-randomized trial with concurrent or historical controls, case-control study, study of sensitivity and specificity of a diagnostic test, and/or population-based description study), D (cross-sectional study, case series, case report), and R (consensus statement, consensus report, or narrative review)

In addition to physical signs and symptoms, battered women also exhibit psychological cues that resemble an agitated depression. As a result of prolonged stress, these women often manifest various psychosomatic symptoms that generally lack an organic basis. For example, they may complain of backaches, headaches, and digestive problems. Often, they will complain of fatigue, restlessness, insomnia, or loss of appetite. Great amounts of

anxiety, guilt, and depression or dysphoria are also typical [20; 33]. In many women, this constellation of symptoms has been labeled “Battered Women’s Syndrome.” Unfortunately, physicians may respond to these women by diagnosing the patient to be neurotic or irrational [25]. Healthcare professionals must cast aside these misperceptions of abused victims and work within their respective practice settings to develop screening mechanisms to detect women who exhibit these symptoms.

Abuser characteristics have been studied far less frequently than victim characteristics. Some studies suggest a correlation between the occurrence of abuse and the consumption of alcohol. A man who abuses alcohol is also likely to abuse his mate, although the abuser may not necessarily be inebriated at the time the abuse is inflicted [34]. Screening questionnaires should include questions that explore social drinking habits of both the victims and their mates.

Other studies demonstrate that abusive mates are generally possessive and jealous. Another characteristic related to the batterer’s dependency and jealousy is extreme suspiciousness. This characteristic may be so extreme as to border on paranoia [27]. In addition, battered women have frequently reported that abusers are extremely controlling of the everyday activities of the family. This domination is generally all encompassing. One battered woman gave the following examples of her controlling husband: “He insisted that no one (including guests and their toddler children) wear shoes in the house, that the furniture be in the same indentations in the carpet, that the vacuum marks in the carpet be parallel, and that any sand that spilled from the children’s sandbox during their play be removed from the surrounding grass” [35]. In addition, healthcare professionals should be on the lookout for men who have low self-esteem, are frequently angry and depressed, and are “very dependent on their partners as the sole source of love, support, intimacy, and problem solving” [33].

Both batterers and battered partners are noted for being extremely dependent upon each other. It appears that each member of the couple believes that he or she will perish without the other and that the survival of each can only occur if the conjugal relationship remains intact. This belief ostensibly arises from their negative self images, which cause the couple to doubt both their ability to live independently and to find other partners who will accept them. Both tend to deny or minimize the scope and severity of the violence in their relationship. This denial makes the conjugal relationship appear more viable and desirable to both [36].

These particular relationship dynamics are not easily detected under the best of circumstances. They may be especially difficult to uncover in circumstances where the parties are suspicious and frightened, as might be expected when a victim presents to an emergency room. The key to detection, however, is to establish a proper screening tool that can be utilized in the particular setting and to maintain a keen awareness for the cues described in this course. Screening should be carried out at the entry points of contact between victims and medical care (e.g., primary care, emergency services, obstetric and gynecologic services, psychiatric services, and pediatric care) [20].

The key to an initial screening is to obtain an adequate history. Establishing that a patient's injuries are secondary to battering is the first task. Clearly, there will be times when a victim is injured so severely that treatment of these injuries becomes the first priority [37]. After such treatment is rendered, however, it is important that healthcare professionals not ignore the reasons that brought the victim to the emergency room.



The ICSI recommends that the following should be done immediately when domestic violence is confirmed by the patient:

- Validate the patient's feelings (e.g., fear, shame, etc.)
- Support the patient's right not to be hurt
- Acknowledge the potential for further harm

(http://www.icsi.org/domestic_violence/domestic_violence_2589.html. Last accessed August 29, 2008.)

Level of Evidence: R (Consensus statement, consensus report, or narrative review)

Of female trauma patients, 16% to 30% will report that they have been battered when asked directly about how the injury occurred. Obviously, however, some women will not admit to a history of battering. Any trauma or burn that seems incompatible with a history of the injury is suggestive of battering and indicative of the need for gentle probing regarding how things are at home. Information must also be collected to facilitate a comprehensive assessment of the victim's needs, resources, and priorities in order to develop immediate and long-range plans designed to minimize and eliminate future abusive episodes. A structured interview that can be used to obtain the necessary information for treatment planning is outlined in **Figure 1** [37].

After the history is obtained and initial treatment is started, it is imperative that healthcare professionals document all findings and recommendations in the victim's medical record. The medical record can be an invaluable document in establishing the credibility of the battered woman's story when she seeks legal aid [37].

**STRUCTURED INTERVIEW
FOR TREATMENT PLANNING**

1. How were you hurt?
2. Has this happened before?
3. When did it first happen?
4. How badly have you been hurt in the past?
5. Was a weapon involved?
Is there a weapon in the house?
6. What kind of weapon?
7. Who lives in the home?
8. What are the children's ages?
9. Are the children in danger?
10. Have they been hit or hurt by him?
11. How badly have they been hit or hurt by him?
12. Have you ever told anyone about this before?
If so, who?
13. What have you done in the past to protect yourself?
14. What have you done in the past to get help?
15. Have you ever called the police?
16. If yes, when, and what did they say/do?
17. Did you report this incident to the police?
If not, why not?
18. If yes, what precinct?
19. What did they say/do?
20. Have you ever obtained a protective order?
21. Have you tried to press charges this time or before?
22. Does your boyfriend/husband have a criminal record?
23. Has he beaten or hurt other people?
24. Has he threatened to kill you?
25. Has he tried to kill you?
26. If so, what did he do?
27. Are you afraid to go home?
28. Where can you go?
29. Have you ever called a crisis center for help?
30. If so, who is your contact person there?
31. If not, why not?
32. Do you know the phone number of the local crisis center?

Source: [8]

Figure 1

CULTURALLY SENSITIVE ASSESSMENT

During the assessment process, a practitioner must be open and sensitive to the client's/patient's world-view, cultural belief systems and how he/she views the illness [46]. This may reduce the tendency to over-pathologize or minimize health concerns of ethnic minority patients.

Pachter proposed a dynamic model that involves several tiers and transactions [47]. The first component of Pachter's model calls for the practitioner to take responsibility for cultural awareness and knowledge. The professional must be willing to acknowledge that he/she does not possess enough or adequate knowledge in health beliefs and practices among the different ethnic and cultural groups he/she comes in contact with. Reading and becoming familiar with medical anthropology is a good first step.

The second component emphasizes the need for specifically tailored assessment [47]. Pachter advocates the notion that there is tremendous diversity within groups. For example, one cannot automatically assume that a Cuban immigrant adheres to traditional beliefs. Often, there are many variables, such as level of acculturation, age at immigration, educational level, and socioeconomic status, that influence health ideologies. Finally, the third component involves a negotiation process between the client/patient and the professional [47]. The negotiation consists of a dialogue that involves a genuine respect of beliefs. It is important to remember that these beliefs may affect symptoms or appropriate interventions in the case of domestic violence.

Culturally sensitive assessment involves a dynamic framework whereby the practitioner engages in a continual process of questioning. These components are meant to provide an introduction to help practitioners recognize the range of dimensions, including physical, biological, social, and cultural factors, that affect immigrants and ethnic minorities. By incorporating cultural sensitivity into the assessment of individuals with a history of being victims or perpetrators of domestic violence, it may be possible to intervene and offer treatment more effectively.

RESOURCES AND REFERRALS

After identifying victims and their abusers, health-care professionals should immediately implement a plan of action that includes providing a referral to a local domestic violence shelter to assist the victim and the victim's family. The acute situation should be referred immediately to local law enforcement officials. Other resources in an acute situation include crisis hotlines and rape relief centers. Once a victim is introduced into the system, counseling and follow-up are generally available by individual counselors who specialize in the care of battered women and their spouses and children. These may include social workers, psychologists, psychiatrists, other mental health workers, and community mental health services. The goals are to make the resources accessible and safe and to enhance support for women who are unsure of their options [38].

In Florida, a 24-hour domestic violence hotline is available for toll-free counseling and information. The number is 800-500-1119. The counselors answering the toll-free line may refer the victim to his or her local domestic violence center. Florida currently has 42 certified domestic violence centers that provide information and referral services, counseling and case management services, a 24-hour hotline, temporary emergency shelter for more than 24 hours, educational services for community awareness relative to domestic violence, assessment and appropriate referral of resident children, and training for law enforcement personnel.

An alphabetical listing of the cities in which these centers are located and an alphabetical listing of the domestic violence centers are on the following pages. These pages can be removed and retained for reference. Every effort has been made to insure accuracy in the information provided at the time of publication.

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Florida Directory of Certified Domestic Violence Centers

The following information was verified at the time of publication.

This is not a stated or implied endorsement.

Florida Domestic Violence Hotline
1-800-500-1119

24-Hour Hotlines

Abuse Counseling & Treatment, Inc.	239-939-3112
Aid to Victims of Domestic Abuse, Inc.	800-355-8547 561-265-2900
Another Way, Inc.	352-493-6743
CARE of Charlotte County, Inc.	941-627-6000
CASA (Community Action Stops Abuse)	727-895-4912
Citrus County Abuse Shelter Association	352-344-8111
Dawn Center of Hernando County	352-799-0657
Domestic Abuse Council (DeLand)	386-255-2102 386-738-4080
Domestic Abuse Shelter (Low Keys) (Mid Keys) (Upper Keys) (Key Largo)	305-294-0824 305-743-4440 305-852-6222 305-451-5666
Family Life Center	386-437-3505
FavorHouse of Northwest Florida, Inc.	850-994-3560
Harbor House	407-886-2856
The Haven of R.C.S.	727-442-4128
Haven of Lake and Sumter Counties	352-753-5800
Help Now of Osceola County	407-847-8562
Hope Family Services	941-755-6805
Hubbard House	904-354-3114
Lee Conlee House	386-325-3141
Martha's House	863-763-0202
Miami-Dade Advocates for Victims (Homestead)	305-758-2546 305-247-4249
Micah's Place	904-225-9979
Ocala Rape Crisis – Domestic Violence Center (Creative Services Inc.)	352-622-5919
Peaceful Paths	800-393-7233 352-377-8255

Peace River Center Domestic Violence Shelter (Sebring)	863-413-2700 863-386-1167
Quigley House, Inc.	904-284-0061 TDD 904-284-0424
Refuge House, Inc. (Tallahassee) (Taylor and Madison)	850-681-2111 850-584-8808
Safehouse of Seminole	407-330-3933
SafeSpace Domestic Violence Services, Inc. (St. Lucie) (Indian River) (Martin)	772-464-4555 772-569-7233 772-288-7023
Safe Place and Rape Crisis Center (SPARCC)	941-365-1976
Safety Shelter of St. Johns County (Betty Griffin House)	904-824-1555
Salvation Army Brevard County Domestic Violence Program	321-631-2764
Salvation Army Domestic Violence and Rape Crisis Program	800-252-2597 850-763-0706
Salvation Army Domestic Violence Program of West Pasco	727-856-5797
Serene Harbor, Inc.	321-726-8282
Shelter for Abused Women and Children	239-775-1101
Shelter House, Inc.	800-44-ABUSE 850-863-4777
The Spring of Tampa Bay	813-247-7233
Sunrise of Pasco County, Inc.	352-521-3120
Victims Response, Inc./The Lodge	305-693-0232
Vivid Visions	386-364-2100
Women in Distress of Broward County	954-761-1133
YWCA Harmony House	800-973-9922 561-640-9844

Certified Domestic Violence Centers Listed by County

(See list on previous page for 24-Hour Hotline numbers)

Alachua	Peaceful Paths
Baker	Hubbard House
Bay	Salvation Army Domestic Violence & Rape Crisis Program
Bradford	Peaceful Paths
Brevard	Salvation Army Brevard County Domestic Violence Program Serene Harbor, Inc.
Broward	Women in Distress of Broward County
Calhoun	Salvation Army Domestic Violence & Rape Crisis Program
Charlotte	C.A.R.E. of Charlotte County, Inc.
Citrus	Citrus County Abuse Shelter Assoc.
Clay	Quigley House, Inc.
Collier	Shelter for Abused Women and Children
Columbia	Another Way, Inc.
DeSoto	Safe Place and Rape Crisis Center (SPARCC)
Dixie	Another Way, Inc.
Duval	Hubbard House
Escambia	FavorHouse of Northwest Florida, Inc.
Flagler	Family Life Center
Franklin	Refuge House, Inc.
Gadsden	Refuge House, Inc.
Gilchrist	Another Way, Inc.
Glades	Abuse Counseling & Treatment, Inc.
Gulf	Salvation Army Domestic Violence & Rape Crisis Program
Hamilton	Another Way, Inc.
Hardee	Peace River Center Domestic Violence Shelter
Hendry	Abuse Counseling & Treatment, Inc.
Hernando	Dawn Center of Hernando County
Highlands	Peace River Center Domestic Violence Shelter
Hillsborough	The Spring of Tampa Bay
Holmes	Salvation Army Domestic Violence & Rape Crisis Program
Indian River	SafeSpace Domestic Violence Services, Inc.
Jackson	Salvation Army Domestic Violence & Rape Crisis Program
Jefferson	Refuge House, Inc.
Lafayette	Another Way, Inc.
Lake	Haven of Lake and Sumter Counties

Lee	Abuse Counseling & Treatment, Inc.
Leon	Refuge House, Inc.
Levy	Another Way, Inc.
Liberty	Refuge House, Inc.
Madison	Refuge House, Inc.
Manatee	Hope Family Services, Inc.
Marion	Ocala Rape Crisis-Domestic Violence Center (Creative Services, Inc.)
Martin	SafeSpace, Inc.
Miami-Dade	Miami-Dade Advocates for Victims Victims Response, Inc./The Lodge
Monroe	Domestic Abuse Shelter
Nassau	Micah's Place
Okaloosa	Shelter House, Inc.
Okeechobee	Martha's House
Orange	Harbor House
Osceola	Help Now of Osceola County
Palm Beach	Aid to Victims of Domestic Abuse, Inc. YWCA Harmony House
Pasco	Salvation Army Domestic Violence Program of West Pasco Sunrise of Pasco County, Inc.
Pinellas	CASA (Community Action Stops Abuse) The Haven of R.C.S.
Polk	Peace River Center Domestic Violence Shelter
Putnam	Lee Conlee House
Santa Rosa	FavorHouse of Northwest Florida, Inc.
Sarasota	Safe Place and Rape Crisis Center (SPARCC)
Seminole	SafeHouse of Seminole
St. Johns	Safety Shelter of St Johns County (Betty Griffin House)
St. Lucie	SafeSpace Domestic Violence Services, Inc.
Sumter	Haven of Lake and Sumter Counties
Suwannee	Vivid Visions
Taylor	Refuge House, Inc.
Union	Peaceful Paths
Volusia	Domestic Abuse Council, Inc.
Wakulla	Refuge House, Inc.
Walton	Shelter House, Inc.
Washington	Salvation Army Domestic Violence & Rape Crisis Program