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Medical Error Prevention and Root Cause Analysis

This course fulfills the Florida requirement for 2 hours of education on the Prevention of Medical Errors.

Audience
This course is designed for all licensed healthcare professionals.

Course Objective
The purpose of this course is to satisfy the requirement of the Florida law and provide all licensed healthcare professionals with information regarding the root cause process, error reduction and prevention, and patient safety.

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

1. Describe how the Institute of Medicine defines “medical error.”
2. Describe the types of sentinel events the Joint Commission has identified.
3. Discuss what factors must be included in a root cause analysis in order for the Joint Commission to consider it “thorough” and “credible.”
4. Identify what types of adverse incidents must be reported to the Florida Agency for Healthcare Administration.
5. Identify the most common sentinel events reported to the Joint Commission.
6. Evaluate the most common misdiagnoses, as recognized by the Florida Board of Medicine, and outline the safety needs of special populations, including non-English-proficient patients.

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.

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INTRODUCTION

The Institute of Medicine’s (IOM) 1999 publication To Err is Human: Building a Safer Health System, illuminated the unfortunate reality of medical errors in the healthcare industry. The report reviewed the prevalence of medical errors in the United States and highlighted measures that should be taken to prevent them. Specifically, the authors of the report noted that at least 44,000 and perhaps as many as 98,000 Americans were dying in hospitals each year as a result of medical errors and many more were being seriously injured [1]. They further noted that, even when using the lower estimate of 44,000, deaths in hospitals due to medical errors exceeded the annual deaths attributable to motor vehicle accidents (43,458), breast cancer (42,297), or AIDS (16,516) [1]. A 2016 report stated that the average number of annual in-hospital deaths attributable to medical error might actually be much higher, at around 400,000 [2]. This report places medical errors as the third leading cause of death in the United States. Certainly, these numbers must be balanced against the millions of admissions to hospitals in the United States, which is in excess of 35 million annually [1; 3].
It does appear that some progress has been made in the past decade. The Agency for Healthcare Research and Quality found a 17% decline in hospital-acquired conditions between 2010 and 2013, or 1.3 million fewer conditions and 50,000 fewer deaths than if the 2010 rate had remained steady [4]. The precise mechanism(s) responsible for this decline is not clear, it occurred following a concerted effort by federal agencies, organizations, and individual providers to curtail medical errors. However, the statistics indicate that medical errors continue to be an issue. Healthcare professionals should commit to continuing to pay greater attention to evaluating approaches for reducing errors and to building new systems to reduce the incidence of medical errors.

Spurred by a commitment to reducing medical error incidents, the Florida Legislature mandates that all healthcare professionals in Florida complete a two-hour course on the topic of prevention of medical errors [5]. This continuing education course is designed to satisfy the requirements of the Florida law and provide all licensed healthcare professionals with information regarding the root cause analysis process, error reduction and prevention, and patient safety, as well as information regarding the five most misdiagnosed conditions as determined by the Florida Board of Medicine.

### DEFINING “MEDICAL ERROR”

The IOM Committee on Quality of Healthcare in America defines error as “the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim” [1]. It is important to note that medical errors are not defined as intentional acts of wrongdoing and that not all medical errors rise to the level of medical malpractice or negligence. Errors depend on two kinds of failures: either the correct action does not proceed as intended, which is described as an “error of execution,” or the original intended action is not correct, which is described as an “error of planning” [1]. A medical error can occur at any stage in the process of providing patient care, from diagnosis to treatment, and even while providing preventative care. Not all errors will result in harm to the patient. Medical errors that do result in injury are sometimes called preventable adverse events or sentinel events—sentinel because they signal the need for immediate investigation and response [6].

Preventable adverse events or sentinel events are defined as those events that cause an injury to a patient as a result of medical intervention or inaction on the part of the healthcare provider whereby the injury cannot reasonably be said to be related to the patient’s underlying medical condition. Thus, for example, if a patient has a surgical procedure and dies postoperatively from pneumonia, the patient has suffered an adverse event. But was that adverse event preventable; was it caused by medical intervention or inaction? The specific facts of this case must be analyzed to determine whether the patient acquired the pneumonia because of age and comorbidities, which would indicate a nonpreventable adverse event.

Healthcare professionals can learn much by closely scrutinizing and evaluating adverse events that lead to serious injury or death. The evaluation of such events would also enable healthcare professionals to improve the delivery of healthcare and reduce future mistakes. In addition, healthcare professionals should have a process in place to evaluate those instances in which a medical error occurred and did not cause harm to the patient. By reviewing these processes, healthcare professionals are afforded the unique opportunity to identify system improvements that have the potential to prevent future adverse events. The Joint Commission, recognizing the importance of analyzing both preventable adverse events and near-misses, has established guidelines for recognizing these events and requires healthcare facilities to conduct a root cause analysis to determine the underlying cause of the event [7].

### ROOT CAUSE ANALYSIS PROCESS

The Joint Commission is a national organization with a mission to improve the quality of care provided at healthcare institutions in the United States. It accomplishes this mission by providing accredited status to healthcare facilities. Accreditors play an important role in encouraging and supporting actions within healthcare organizations by holding them accountable for ensuring a safe environment for patients. Healthcare organizations should actively engage in a cooperative relationship with the Joint Commission through this accreditation process and participate in the process to reduce risk and facilitate desired outcomes of care.

The Joint Commission defines a sentinel event as “an unexpected occurrence involving the death or serious physical or psychological injury, or the risk thereof. Serious injury specifically includes loss of limb or function. The phrase ‘or the risk thereof’ includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome” [6]. Root cause analysis, as defined by the Joint Commission, is “a process for identifying the basic or causal factors that underlie variation in performance, including the occurrence or possible occurrence of a sentinel event” [6].
The following subsets of sentinel events are subject to review by the Joint Commission [6]:

- The event has resulted in an unanticipated death or major permanent loss of function, not related to the natural course of the patient’s illness or underlying condition

or

- The event is one of the following (even if the outcome was not death or major permanent loss of function unrelated to the natural course of the patient’s illness or underlying condition):
  - Suicide of any patient receiving care, treatment, and services in a staffed around-the-clock care setting or within 72 hours of discharge
  - Unanticipated death of a full-term infant
  - Abduction of any patient receiving care, treatment, and services
  - Discharge of an infant to the wrong family
  - Rape, assault (leading to death or permanent loss of function), or homicide of any patient receiving care, treatment, and services
  - Rape, assault (leading to death or permanent loss of function), or homicide of a staff member, licensed independent practitioner, visitor, or vendor while on site at the healthcare organization
  - Hemolytic transfusion reaction involving administration of blood or blood products having major blood group incompatibilities (e.g., ABO, Rh, other blood groups)
  - Invasive procedure, including surgery, on the wrong patient or wrong site
  - Unintended retention of a foreign object in a patient after surgery or other invasive procedures
  - Severe neonatal hyperbilirubinemia (bilirubin >30 mg/dL)
  - Prolonged fluoroscopy with cumulative dose >1,500 rads to a single field or any delivery of radiotherapy to the wrong body region or >25% above the planned radiotherapy dose
  - Fire, flame, or unanticipated smoke, heat, or flashes occurring during an episode of patient care
  - Any intrapartum (related to the birth process) maternal death
  - Severe maternal morbidity

Alternatively, the following examples are events that are NOT considered reviewable under the Joint Commission's sentinel event policy [6]:

- Any close call (“near miss”)
- Full or expected return of limb or bodily function to the same level as prior to the adverse event by discharge or within two weeks of the initial loss of said function, whichever is the longer period
- Any sentinel event that has not affected a recipient of care (e.g., patient, individual, resident)
- Medication errors that do not result in death or major permanent loss of function
- Suicide other than in an around-the-clock care setting or following elopement from such a setting
- A death or loss of function following a discharge against medical advice
- Unsuccessful suicide attempts unless resulting in major permanent loss of function
- Minor degrees of hemolysis not caused by a major blood group incompatibility and with no clinical sequelae

(For further definition of terms, please refer to the Joint Commission's Sentinel Event Policy and Procedures at https://www.jointcommission.org/sentinel_event_policy_and_procedures.)

As part of the accreditation requirement, the Joint Commission requires that healthcare organizations have a process in place to recognize these sentinel events, conduct thorough and credible root cause analyses that focus on process and system factors, and document a risk-reduction strategy and internal corrective action plan that includes measurement of the effectiveness of process and system improvements to reduce risk [6]. This process must be completed within 45 days of the organization having become aware of the sentinel event.

The Joint Commission will consider a root cause analysis acceptable for accreditation purposes if it focuses primarily on systems and processes, not individual performance [6]. In other words, the healthcare organization should minimize the individual blame or retribution for involvement in a medical error. In addition, the root cause analysis should progress from special causes in clinical processes to common causes in organizational processes, and the analysis should repeatedly dig deeper by asking why, then, when answered, why again, and so on. The analysis should also identify changes that can be made in systems and processes, either through redesign or development of new systems or processes, which would reduce the risk of such events occurring in the future. The Joint Commission requires that the analysis be thorough and credible. To be considered thorough, the root cause analysis must include [6]:
• A determination of the human and other factors most directly associated with the sentinel event and the process(es) and systems related to its occurrence
• Analysis of the underlying systems and processes through a series of “why” questions to determine where redesign might reduce risk
• Inquiry into all areas appropriate to the specific type of event
• Identification of risk points and their potential contributions to this type of event
• A determination of potential improvement in processes or systems that would tend to decrease the likelihood of such events in the future, or a determination, after analysis, that no such improvement opportunities exist

To be considered credible, the root cause analysis must meet the following standards [6]:

• The organization’s leadership and the individuals most closely involved in the process and systems under review must participate in the analysis.
• The analysis must be internally consistent; that is, it must not contradict itself or leave obvious questions unanswered.
• The analysis must provide an explanation for all findings of “not applicable” or “no problem.”
• The analysis must include consideration of any relevant literature.

Finally, as previously discussed, after conducting this root cause analysis, the organization must prepare an internal corrective action plan. The Joint Commission will accept this action plan if it identifies changes that can be implemented to reduce risk or formulate a rationale for not undertaking such changes, and if, where improvement actions are planned, it identifies who is responsible for implementation, when the action will be implemented, and how the effectiveness of the actions will be evaluated [6].

FLORIDA LAW
Healthcare professionals have an obligation to report adverse events to leadership and ensure that organizations have processes in place to satisfy the Joint Commission requirement. In Florida, certain serious adverse incidents must also be reported to Florida’s Agency for Health Care Administration (AHCA). Florida law requires that licensed facilities, such as hospitals, establish an internal risk management program. As part of that program, licensed facilities must develop and implement an incident reporting system, which requires the development of appropriate measures to minimize the risk of adverse incidents to patients, as well as imposes an affirmative duty on all healthcare providers and employees of the facility to report adverse incidents to the risk manager or to his or her designee. The risk manager must receive these incident reports within 3 business days of the incident, and depending on the type of incident, the risk manager may have to report the incident to AHCA within 15 days of receipt of the report.

Florida Statute 395.0197 specifically defines an adverse incident as [8]:

For purposes of reporting to the agency pursuant to this section, the term “adverse incident” means an event over which health care personnel could exercise control and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred, and which:

a) Results in one of the following injuries:
   1. Death;
   2. Brain or spinal damage;
   3. Permanent disfigurement;
   4. Fracture or dislocation of bones or joints;
   5. A resulting limitation of neurological, physical, or sensory function which continues after discharge from the facility;
   6. Any condition that required specialized medical attention or surgical intervention resulting from nonemergency medical intervention, other than an emergency medical condition, to which the patient has not given his or her informed consent; or
   7. Any condition that required the transfer of the patient, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the patient’s condition prior to the adverse incident

b) Was the performance of a surgical procedure on the wrong patient, a wrong surgical procedure, a wrong-site surgical procedure, or a surgical procedure otherwise unrelated to the patient’s diagnosis or medical condition;

c) Required the surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage was not a recognized specific risk, as disclosed to the patient and documented through informed-consent process; or

d) Was a procedure to remove unplanned foreign objects remaining from a surgical procedure.

In 2018, the Florida AHCA reported that a total of 131 deaths occurred as a result of hospital error, 20.6% of 636 adverse incidents reported for the year. The next most common incidents during this period were surgical procedure to remove foreign object from a previous surgical procedure (16.5%), transfer of the patient to a unit providing a more acute level of care due to the adverse incident (14.2%), surgical procedures unrelated to the patient’s diagnosis or medical needs (10%), and surgical procedure performed on...
the wrong site (5.3%) [9]. The following adverse incidents must be reported to the AHCA within 15 calendar days after their occurrence [8]:

- The death of a patient
- Brain or spinal damage to a patient
- The performance of a surgical procedure on the wrong patient
- The performance of a wrong-site surgical procedure
- The performance of a wrong surgical procedure
- The performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient’s diagnosis or medical condition
- The surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage is not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process
- The performance of procedures to remove unplanned foreign objects remaining from a surgical procedure

Each incident will be reviewed by the AHCA, who will then determine the penalty to be imposed upon the responsible party [8]. All Florida healthcare professionals who practice in licensed facilities should familiarize themselves with these requirements and ensure that the facility in which they practice has processes in place to ensure compliance.

Unlike Florida’s mandatory reporting of serious adverse incidents, the Joint Commission recommends that healthcare organizations voluntarily report sentinel events, and it encourages the facilities to communicate the results of their root cause analyses and their corrective action plans. As a result of the sentinel events that have been reported, the Joint Commission has compiled Sentinel Event Alerts. These alerts are intended to provide healthcare organizations with important information regarding reported trends and, by doing so, highlight areas of potential concern so an organization may review its own internal processes to maximize error reduction and prevention with regard to a particular issue [7].

UNINTENDED RETENTION OF A FOREIGN BODY

In 2017–2018, the most frequently reported sentinel event reported to the Joint Commission was unintended retained foreign objects [11]. The prevalence of these events has remained relatively stable since 2009, indicating that preventing these errors remains difficult for practitioners and facilities. The most commonly retained items are sponges, followed by catheter guidewires and other (a broad category encompassing a wide variety of items) [10].

In addition to harming patients and contributing to distrust in the medical system, the unintended retention of foreign objects significantly contributes to patient care costs [13]. The average total cost of care related to unintended retained foreign objects is $166,000 to $200,000 [13].

According to the sentinel event data, the most common root causes of unintended retained foreign objects reported to the Joint Commission are [13]:

- The absence of policies and procedures
- Failure to comply with existing policies and procedures
- Problems with hierarchy and intimidation
- Failure in communication with physicians
- Failure of staff to communicate relevant patient information
- Inadequate or incomplete education of staff

WRONG-SITE SURGERY

Operating on the wrong part of a patient’s body is an obvious sign that there is a problem in the operating room system. Interestingly, wrong-site surgery occurred more commonly in orthopedic procedures than in all other surgical specialties combined. The American Academy of Orthopaedic Surgeons takes this issue seriously, and it has taken special steps to eliminate the problem. For example, it recommends that a surgeon sign their initials at the correct site of surgery with an indelible pen. Unless the initials are visible, the surgeon should not make an incision [12]. Writing “NO” in large black letters on the side not to be operated on was suggested in the past, but this is discouraged due to possible confusion with the surgeon’s initials. In spinal surgery, the Academy recommends that an intraoperative radiograph and radiopaque marker be used to determine the exact vertebral level of spinal surgery [12]. Whatever the mechanism used to prevent and reduce the incidence of this error, it is clear that this is not just the surgeon’s problem. All of the operating room personnel, including physicians, nurses, technicians, anesthesiologists, and other preoperative allied health personnel, should monitor procedures to ensure verification procedures are followed, especially for high-risk procedures.

ERROR REDUCTION AND PREVENTION

Between 2005 and 2018, the Joint Commission reviewed 11,622 sentinel events [11]. Some events, such as fire, impacted multiple patients. Sentinel event reviews during this time period were frequently conducted for unintended retention of a foreign body; wrong-patient, wrong-site, wrong-procedure surgery; delay in treatment; operative and postoperative complications; patient suicide; patient fall; and medication error [11].
Due to the prevalence of wrong-site, wrong-procedure, and wrong-person surgeries, the Joint Commission, along with more than 50 professional healthcare organizations, convened two summits to help reduce the occurrence of these errors. The first summit, convened in 2003, developed a Universal Protocol that consisted of the following: a preprocedure verification process; marking the operative/procedure site with an indelible marker; taking a “time-out” with all team members immediately before starting the procedure; and adaptation of the requirements to all procedure settings, including bedside procedures. However, the incidence of wrong-site surgeries continued to increase, and in 2007 and 2010, additional summits were organized to pinpoint barriers in compliance and discover new strategies to eliminate these errors [14]. As of 2019, the Universal Protocol has been incorporated into the National Patient Safety Goal chapter of the Joint Commission accreditation manual [15].

**DELAYS IN TREATMENT**

According to the Joint Commission, more than half of all reported delays in treatment sentinel events in 2010–2014 resulted in patient death [16]. It is important to keep in mind that delays in treatment can occur in any healthcare setting. The most common reason for a delay in treatment is misdiagnosis; however, delays can also result from delayed test results, physician availability, delayed administration of ordered care, incomplete treatment, and even inability to get an initial appointment or follow-up appointment in a timely manner [16]. The main root causes contributing to delays in treatment are inadequate assessments, poor planning, communication failures, and human factors. Recommendations from the Joint Commission include avoiding cognitive shortcuts, improving health information technology, incorporating diagnostic checklists into the electronic record, promoting provider-to-provider communication, engaging leadership in developing solutions, focusing organization attention on the scheduling process and on ordering tests and reporting test results, improving access to care, implementing a standardized communications method, maintaining adequate staffing levels, and increasing patient and family engagement/activation [16].

**OPERATIVE AND POSTOPERATIVE COMPLICATIONS**

Many of the sentinel events reported to the Joint Commission regarding operative and postoperative complications occurred in relation to nonemergent procedures, such as interventional imaging and/or endoscopy, tube or catheter insertion, open abdominal surgery, head and neck surgery, orthopedic surgery, and thoracic surgery [17]. The majority of the reporting healthcare facilities cited miscommunication as the primary root cause. Other identified causes include failure to follow established procedures, incomplete preoperative assessment, inconsistent postoperative monitoring procedures, and failure to question inappropriate orders. In order to reduce the risk, reporting facilities have identified a number of strategies, including improving staff orientation and training, increasing educational opportunities for physicians, clearly defining expected channels of communication, and monitoring consistency of compliance with procedures. Healthcare facilities should review postoperative patient monitoring procedures to ensure an adequate level appropriate to the needs of the patient, regardless of the setting (e.g., operating room, endoscopy suite, radiology department) [17]. Based upon these findings, it is clear that direct communication among healthcare providers is key to preventing operative and postoperative complications. Healthcare facilities should provide more staff education regarding preventative measures, and healthcare providers can do their part by engaging in a healthy and mutual respect for all of the members of the healthcare team [17].

**PATIENT SUICIDE**

It is estimated that between 48 and 65 hospital inpatient suicides occur per year in the United States. Most of these cases (31 to 52) occur in psychiatric units or involve psychiatric inpatients. The most common method is hanging [50]. Times of care transition are particularly risky, with a 200% increase in risk in the week after discharge from a psychiatric facility; the elevated risk continues for four years [18]. Other risk factors include previous suicide attempt or self-injury, mental or emotional disorders, history of trauma or loss, serious illness or chronic pain, substance use disorder, social isolation, and access to lethal means.

The most common root cause documented for patient suicide reported between 2010 and 2014 was shortcomings in assessment, most commonly psychiatric assessment [18]. In addition, nearly 25% of behavioral health facilities accredited by the Joint Commission were found noncompliant with the requirement to conduct an adequate suicide risk assessment in 2014. The Joint Commission has recommended a number of suicide risk reduction strategies, including [18]:

- Review each patient’s personal and family medical history for suicide risk factors.
- Screen all patients for suicide ideation, using a brief, standardized, evidence-based screening tool.
- Review screening questionnaires before the patient leaves the appointment or is discharged.
- Establish a collaborative, ongoing, and systematic assessment and treatment process with the patient involving the patient’s other providers, family, and friends, as appropriate.
- To improve outcomes for at-risk patients, develop treatment and discharge plans that directly target suicidality.
• Educate all staff in patient care settings about how to identify and respond to patients with suicide ideation.

• Document decisions regarding the care and referral of patients with suicide risk.

A simple review of these measures demonstrates that healthcare providers can avoid the devastating impact of an inpatient suicide by implementing fairly routine preventative strategies, such as removing harmful items and careful screening through the admission and discharge processes.

PATIENT FALLS
Patient falls are a constant challenge in healthcare facilities. Patients who are at highest risk include the elderly, those who have an altered mental status due to chronic mental illness or acute intoxication, and those who have a history of prior falls. It is obvious from these factors that a thorough and complete patient history may be the key to identifying those at risk. The root causes of those patient falls that healthcare facilities identified as sentinel events and reported to the Joint Commission included inadequate assessment, communication failures, lack of adherence to protocols and safety practices, inadequate staff orientation, supervision, staffing levels or skill mix, deficiencies in the physical environment, and lack of leadership [19]. Risk reduction strategies to these root causes are fairly straightforward, although in practice, preventing falls is difficult. The most important are the use of a standardized assessment tool to identify fall and injury risk factors, assessing an individual patient’s risks that may not have been captured through the tool, and interventions tailored to an individual patient’s identified risks [19].

Because patient falls often result in morbidity, mortality, immobility, and early nursing home placement for patients, it is imperative that healthcare facilities initiate adequate fall prevention programs, which will ultimately reduce injuries. Failure to do so will result in a spiraling increase in the number of falls in healthcare facilities, particularly among the elderly who are at highest risk. As more Americans live beyond 65 years of age, the need to develop mobility protocols and programs to reduce the risk of falls and injuries for the older adult grows more urgent.

MEDICATION ERRORS
Unquestionably, medication errors are one of the most common causes of avoidable harm to patients. These errors may occur at three critical points: when ordered by a physician, dispensed by a pharmacist, or administered by a nurse.

The National Coordinating Council for Medication Error Reporting and Prevention defines a medication error as [20]:

Any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the healthcare professional, patient or consumer. Such events may be related to professional practice, healthcare products, procedures, and systems, including prescribing; order communication; product labeling; packaging, and nomenclature; compounding; dispensing; distribution; administration; education; monitoring; and use.

A number of medication errors can be linked to the prescriber who continually uses potentially dangerous abbreviations and dose expressions. Despite repeated warnings by the Institute for Safe Medication Practices about the dangers associated with using certain abbreviations when prescribing medications, this practice continues. To eliminate this factor, there are fairly simple steps that can eliminate much confusion. Prescribers should [21]:

• Avoid the use of the symbol “U” or “u” but rather spell “units” when ordering drugs, such as insulin.

• Spell out medication names completely rather than using abbreviations and acronyms.

• Avoid using abbreviations for “daily” (QD), “every other day” (QOD), or “four times daily” (QID), which are easily confused.

• Use leading zeros before a decimal point (e.g., 0.2 mg instead of .2 mg), and do not use trailing zeros (e.g., 2 mg instead of 2.0 mg).

• Write out “morphine sulfate” and “magnesium sulfate” instead of using the abbreviations (MS, MSO₄, MgSO₄).


Other factors contributing to prescriber errors are illegible or confusing handwriting and, a frequently cited cause of many adverse and sentinel events, the failure of healthcare providers to assess risk and prevent errors. Addressing illegibility may include developing appropriate policies and procedures, tracking and trending patterns, and evaluating results through peer review committees. Improving communication might include developing protocols for the use of verbal orders to assure that those from an onsite practitioner would be limited to an emergency situation only. No verbal orders should be taken for certain medications, such as for chemotherapy, and all verbal orders should be repeated for clarification and, whenever possible, reiterated to a third person. Another method of improving communication might involve reviewing the hospital formulary in collaboration with the Pharmacy and Therapeutics Committee of the medical staff to limit, where appropriate, the number of therapeutically and generically equivalent products [22].
It has been estimated that between 0.2% and 10% of prescriptions are dispensed incorrectly [23]. The most common type of medication error is wrong drug (43.8%), followed by wrong dose (31.5%), failure to consult with prescriber (4.9%), and compounding error (3.7%) [24]. Safe medication dispensing practices may include a number of risk reduction strategies to reduce the incidence of errors that may cause harm to patients [22; 25; 54]:

- Ensure that appropriate and current drug reference texts and/or online resources are immediately available to pharmacy personnel.
- Ensure that essential patient information, such as allergies, age, weight, current diagnoses, pertinent lab values, and current medication regimen, is available to the pharmacist prior to the dispensing of a new medication order.
- Require clarification of any order that is incomplete, illegible, or otherwise questionable using an established process for resolving questions.
- Whenever possible, dispense dosage units in a ready-to-administer form.
- Dispense single-dose vials and ampoules rather than multidose vials.
- Select oral rather than injectable routes, when possible.
- Require that a pharmacist double-check all mathematical calculations for neonatal and pediatric dilutions, parenteral nutrition solutions, and other compounded pharmaceutical products.
- Create an environment for the dispensing area that minimizes distractions and interruptions, provides appropriate lighting, air conditioning, and air flow, safe noise levels, and includes ergonomic consideration of equipment, fixtures, and technology.
- Require that a second pharmacist double-check the accuracy of order entry and dose calculations for all orders involving antineoplastic agents and other high-risk drugs dispensed by the pharmacy.
- Enhance the awareness of look-alike and sound-alike medications, and use warning signs to help differentiate medications from one another, especially when confusion exists between or among strengths, similar looking labels, or similar sounding names.
- Separate look-alike and sound-alike medications in pharmacy dispensing areas or consider repackaging or using different vendors.
- Follow-up and periodically evaluate the need for continued drug therapy for individual patients.

Once again, communication is likely the key to avoiding dispensing errors. Pharmacists should work closely with their staff to ensure that proper protocols are followed, and most importantly, when questions arise regarding a prescription, the pharmacist should take the time to contact the prescriber directly to obtain clarification.

The healthcare provider who has the responsibility to administer a medication has the final opportunity to avoid a mistake. In most cases, particularly in inpatient settings, this responsibility falls to the nurse. Nurses are often taught in nursing school to review the five “rights” prior to administering any medication: the right patient is given the right drug in the right dose by the right route at the right time [26]. Medication errors generally fall into four categories, which mimic these five “rights.” The first is the failure to follow procedural safeguards, such as ensuring that essential patient information, including allergies, age, weight, and current medication regimen, is available. The second is unfamiliarity with a drug. In one case, a jury determined that a nurse was negligent for giving a drug without having reviewed the literature, which stated that the necessary precautions for the administration of the drug required the specialized skill of an anesthesiologist. The third category of drug administration is failure to use the correct mode of administration. A nurse in Delaware was held liable for administering a medication by injection after an order had been written to change the route to oral. The final category involves failure to obtain clarification if an order is incomplete, illegible, or otherwise questionable. In a case tried in Louisiana, a nurse was held liable for administering a medication that a physician ordered, notwithstanding that the dose was excessive. The nurse's administration of the drug led to the patient's death [27].

In addition, healthcare facilities should implement appropriate guidelines, policies, and procedures to ensure safe medication administration practice. These policies should require that staff members who administer medications [25; 54]:

- Are knowledgeable about the drug's uses, precautions, contraindications, potential adverse reactions, interactions, and proper method of administration
- Resolve questions prior to medication administration
- Only administer medications that have been properly labeled with medication name, dose to be administered, dosage form, route, and expiration date
- Utilize a standard medication administration time schedule and receive education on how and when to incorporate newly started medication orders safely into the standardized schedule
- Have a second person verify a dosage calculation if a mathematical calculation of a dose is necessary
- Receive adequate education on the operation and use of devices and equipment used for medication administration (for example, patient-controlled anesthesia pumps and other types of infusion pumps)
• Have another person double-check infusion pump settings when critical, high-risk drugs are infused
• Document all medications immediately after administration

Finally, healthcare facilities should have proper quality assurance measures in place to monitor medication administration practices. Included among these would be protocols and guidelines for use with critical and problem-prone medications to help optimize therapies and minimize the possibility of adverse events and to integrate “triggers” to indicate the need for additional clinical monitoring [25]. It is important to note that the pediatric population is especially vulnerable to medication errors. When children are prescribed adult medications, care must be taken to adjust dosage according to weight, requiring the physician to use pediatric-specific calculations. Also, many healthcare settings are not trained to care for the pediatric patient. Intolerance due to physiologic immaturity is also a factor in adverse response to medications, and in many cases, this population cannot communicate their discomfort due to adverse reactions. Risk reduction strategies include standardizing and effectively identifying medications and processes for drug administration, ensuring pharmacy oversight, and using technology, such as medication dispensing programs, infusion pumps, and bar-coding, judiciously [28].

COMMON MISDIAGNOSES
As Florida healthcare professionals, it is important to be aware that in addition to wrong-site/wrong-procedure surgery, several medical conditions also continue to be misdiagnosed. As of 2019, the Florida Board of Medicine has determined the five most misdiagnosed conditions to be [29]:
• Cancer-related conditions
• Surgery complications
• Cardiac-related issues
• Obstetric/gynecologic conditions
• Respiratory-related issues

It is important to be aware of the possibility of misdiagnosis and incorporate this knowledge into practice.

Cancer
The early detection and diagnosis of cancers is crucial for selecting the appropriate treatment approach and to ensure an optimum outcome. However, an estimated 12% of cancer patients are initially misdiagnosed, and the missed or delayed diagnosis of cancers remains a significant cause of medical malpractice claims [30; 31]. The causes of missed diagnoses vary widely among cancers in different parts of the body. In many cases, patients who do not fit the typical profile for a specific cancer (e.g., young age) may be under-diagnosed, and it is important that cancer is considered as part of the differential diagnosis in ambiguous cases [31; 32; 33]. In order to prevent missed or delayed cancer diagnosis, practitioners may take steps to ensure adherence to clinical guidelines for screening and diagnosis, use tools to facilitate communication, and engage strategies to ensure appropriate follow-up [55].

Surgery Complications
Over the past few decades, the number of inpatient procedures has increased, and with this increase in procedures comes an increase in complications. According to one study, postoperative complications accounted for up to 22% of preventable deaths among patients [34]. The good news is that it is possible to anticipate who is at risk and institute risk reduction measures earlier in the course of care. Reducing the risk of postoperative complications can be accomplished with a thorough assessment of the patient both pre-surgery and upon arrival in the post-anesthesia care unit. Risk reduction measures should be instituted early on in the course of care to decrease the incidence of complicating factors that can lead to prolonged disability and even death. Awareness of patients who are at risk can alert staff to potential complications. Awareness of complication development is the first step in risk reduction. Complications can occur at various periods in the recovery phase. Risk of developing hypotension, myocardial infarction, and respiratory depression is greatest in the first postoperative day. Between days 1 and 3, the risk of congestive heart failure, pulmonary embolus, and respiratory failure increases. Pneumonia generally occurs between days 4 and 7, while cerebrovascular accident and sepsis occur most commonly between 8 and 30 days postoperatively. Other complications, such as cardiac arrhythmias and gastrointestinal tract bleeding, occur throughout the postoperative period at an equal rate [35].

Cardiac-Related Issues
The clinical presentation of chest pain has many possible etiologies, ranging from benign (e.g., panic/anxiety, pneumonia, peptic ulcer, gastroesophageal reflux disease, and pericarditis) to life-threatening (e.g., pulmonary embolism, acute coronary syndrome [ACS], aortic dissection, and pneumothorax). In many cases, it is best to rule out the more urgently threatening possibilities before testing for other causes. Of the potentially life-threatening causes of chest pain, ACS is the most prevalent. Although a large percentage of individuals with suspected ACS will be seen initially in emergency departments, patients in any healthcare setting, regardless of other diagnoses, may abruptly develop chest pain suspicious for ACS. When a patient presents with clinical signs suspicious for myocardial infarction, immediate medi-
cal intervention is directed at confirming a diagnosis and stratifying the person’s risk for adverse events such as cardiac arrest and severe/significant damage to the myocardium [41]. It is important to note that while some patients will present with classic ACS-related chest pain (tightness, sensation of pressure, heaviness, crushing, vise-like, aching pain in the substernal or upper left chest), many patients, particularly women and older patients, will present with “atypical” ACS-related chest pain [45; 46]. Words commonly used to describe “atypical” chest pain associated with ACS include numbness, tingling, burning, stabbing, or pricking. Atypical chest pain location includes any area other than substernal or left sided, such as the back, area between shoulder blades, upper abdomen, shoulders, elbows, axillae, and ears [43; 44; 45; 46]. Aside from atypical clinical presentation, other possible causes of missed ACS diagnosis include failure of interpretation of the history, failure to correctly interpret the electrocardiogram, failure to perform an electrocardiogram when necessary, and lack of proper use of cardiac enzyme test [47].

**Obstetric/Gynecologic Conditions**

A study describing the implementation of mandatory day-of-surgery human chorionic gonadotropin (hCG) pregnancy testing in women undergoing elective orthopedic surgery found that it was an effective method of identifying unrecognized pregnancies [36]. Although the American Society of Anesthesiologists has concluded that the evidence is inadequate to recommend routine pre-anesthesia pregnancy testing, they do state that, “pregnancy testing may be offered to female patients of childbearing age and for whom the result would alter the patient’s management” [37]. It is important that testing be completed with informed consent, in order to protect the patient’s autonomy and right to privacy, and that the findings of testing or decline to test are recorded in the patient’s record [38].

Ectopic pregnancy, or the implantation and growth of fetus and placenta outside the uterine cavity, is the leading cause of pregnancy-related deaths in the first trimester, accounting for 9% to 15% of all maternal deaths in early pregnancy [39; 40]. A woman’s reproductive future also may be compromised by ectopic pregnancy. Ectopic pregnancy may present with symptoms similar to other conditions, and the differential diagnoses may include appendicitis, salpingitis, spontaneous abortion, ovarian cyst, ovarian torsion, urinary tract infections, degenerating uterine fibroids, and normal pregnancy. Early detection can ensure that treatment is begun prior to tubal rupture, reducing the risk of major complications and future infertility. Missed diagnoses are associated with intra-abdominal hemorrhage, need for laparotomy, blood transfusion, and death [42].

**Respiratory-Related Issues**

Respiratory issues can be difficult to diagnose, as the presenting symptoms tend to be similar and in some cases definitive diagnostic tests are unavailable or underutilized. One example is pulmonary hypertension, which, depending on the severity of symptoms, may have a similar presentation to obstructive sleep apnea, hypothyroidism, scleroderma, mitral stenosis, or dilated cardiomyopathy. In one study, half of patients referred to pulmonary hypertension centers were referred late in the course of the disease, when treatment is unlikely to be effective [48]. Improved clinician education regarding the signs/symptoms of pulmonary hypertension as well as appropriate testing and treatment is necessary.

**OTHER CONSIDERATIONS FOR PATIENT SAFETY**

The most important issue to improving patient safety is being aware of the particular safety hazards that may exist for various patient populations and on particular specialty units. In addition, education of the patient and the family should be a priority.

Infants and young children are not developmentally or cognitively able to participate in care and decision making, thus putting them at higher risk, especially for medication errors. In addition, when a medication error occurs in this population, infants and young children are at higher risk because of their physical immaturity and increased sensitivity to the effects of drugs. The family or guardian of a pediatric patient should be encouraged to ask questions, especially if something seems wrong. In addition, a meta-analysis found that computerized provider order entry with clinical decision support reduced pediatric medication errors by 36% to 87% [51]. As such, the adoption of electronic support systems may help to reduce or eliminate these errors.

An estimated 30% of individuals 65 years of age or older who are living in the community fall each year [52]. Older patients may have poor vision, as a result of cataracts, glaucoma, and/or macular degeneration, and cardiovascular problems, which might result in syncpe or postural hypotension. These conditions may affect patients’ balance and stability. Bladder dysfunction, such as nocturia, may cause an elderly patient to have to ambulate more during the night in an unfamiliar environment, thereby increasing the risk of a fall. Lower extremity dysfunctions, such as arthritis, muscle weakness, or peripheral neuropathy, may make it more difficult to ambulate at any time. In addition to being at greater risk for falls, the elderly are also more prone to medication errors as their ability to understand instructions or to recognize an unfamiliar medication may be affected by dementia or other cognitive disorders. Interventions that can help prevent falls in the elderly include exercise programs, tai chi, vision improvement (e.g., first cataract surgery), and multifactorial assessment and intervention [52].
There are also unique factors that increase the risk of medical errors on specialty units. For instance, in critical care units, patients may be suffering from environmental psychosis, which could inhibit participation in their care. This is also true of lethargic and comatose patients. These patients are at particular risk because they cannot participate in the identification process. On psychiatric wards, patients may be suicidal or depressed, which may cause them to act out or attempt to harm themselves or others. Psychiatric patients may also experience orthostatic side effects due to antidepressants, which may increase the incidence of falls. Obstetric patients are at higher risk for falls because they may have decreased sensation and mobility due to administration of epidural anesthesia, and they may also suffer from excessive blood loss, which could lead to postural hypotension [49]. Again, the key is identifying the unique needs of the particular population.

With regard to education, a number of organizations have developed guidelines to facilitate the role of patients as their own safety advocates. These guidelines are not intended to shift the burden of monitoring medical error to patients. Rather, they encourage patients to share responsibility for their own safety. As healthcare professionals, we should ensure that all of our patients are familiar with these guidelines. The Agency for Healthcare Research and Quality has developed a “Patient Fact Sheet” that outlines 20 tips for patients to help prevent medical errors [53]. Although some of these suggestions may seem extreme, many patients now desire to have a more active role in their care. Some of these items have become routine or are currently required, such as consultations by pharmacists when a patient picks up a prescribed medication.

**USE OF AN INTERPRETER**

As a result of the evolving racial and immigration demographics in the United States, interaction with patients for whom English is not a native language is inevitable. Because patient education is such a vital aspect of preventing medical errors, it is each practitioner’s responsibility to ensure that information and instructions are explained in such a way that allows for patient understanding. When there is an obvious disconnect in the communication process between the practitioner and patient due to the patient’s lack of proficiency in the English language, an interpreter is required.

Interpreters are more than passive agents who translate and transmit information back and forth from party to party. They should be professionally trained in ethics, accuracy, completeness, and impartiality. Furthermore, it is the interpreter’s role to negotiate cultural differences and promote culturally responsive communication and practice. When they are enlisted and treated as part of the interdisciplinary clinical team, they serve as cultural brokers, who ultimately enhance the clinical encounter. In any case in which information regarding diagnostic procedures, treatment options, or medication/treatment measures is being provided, the use of an interpreter should be considered.

**CONCLUSION**

Although the United States has one of the top 40 healthcare systems in the world, it is apparent that the numbers of medical errors are at unacceptably high levels. The consequences of medical errors are often more severe than the consequences of mistakes in other industries. They may lead to death or to serious and long-term disability, which underscores the need for aggressive action in this area. As a starting point, we should become an active part of the solution. This will only happen if all healthcare professionals voice their concerns when they identify problems in a system or process. In addition, we should actively participate in the root cause analysis process, understanding that the goal is not to assign blame, but rather to identify how we can improve the process to provide the best quality care to our patients. Medical errors are costly, not only because patients may lose their lives or livelihoods, but also because patients lose trust in the system and colleagues lose faith in each other. To preserve the integrity of our system, we must correct this problem, and the solution begins with each of us.
1. The Institute of Medicine's (IOM) Committee on Quality of Healthcare in America defines error as the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim.
   A) True  
   B) False

2. Patient rape is an example of a sentinel event subject to review by the Joint Commission.
   A) True  
   B) False

3. A “thorough” root cause analysis is one in which the participants identify risk points and their potential contributions to this type of event.
   A) True  
   B) False

4. A credible root cause analysis must be based upon a survey of everyone employed at the healthcare institution.
   A) True  
   B) False

5. A wrong-site surgical procedure that did not result in the death of the patient must be reported to the risk manager within three business days according to Florida law.
   A) True  
   B) False

6. The Joint Commission prepares and distributes Sentinel Event Alerts in order to recommend ways in which the healthcare facility can terminate employees whose actions result in a sentinel event.
   A) True  
   B) False

7. Infant abduction is among the most common sentinel events reported to the Joint Commission.
   A) True  
   B) False

8. The most common root cause documented for patient suicide was shortcomings in assessment, most commonly psychiatric assessment.
   A) True  
   B) False

9. A medication error may occur when ordered by a physician, administered by a nurse, or dispensed by a pharmacist.
   A) True  
   B) False

10. Approximately 32% of patients with cancer are initially misdiagnosed.
   A) True  
   B) False

Be sure to transfer your answers to the Answer Sheet insert located between pages 88–89.

PLEASE NOTE: Your postmark or facsimile date will be used as your test completion date.
Domestic Violence: The Florida Requirement

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

Have you already completed your Domestic Violence requirement? You can skip this course and still receive 26 hours of continuing education.

Audience
This course is designed for all Florida healthcare professionals required to complete domestic violence education.

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. Define domestic violence and its impact on health care.
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 and assess individuals who may be victims or perpetrators of domestic violence, including the importance of conducting a culturally sensitive assessment.
4. 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.

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. (A complete biography appears at the end of this course.)

Alice Yick Flanagan, PhD, MSW, received her Master’s in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families. (A complete biography appears at the end of this course.)

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

Contributing faculty, Alice Yick Flanagan, PhD, MSW, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Division Planner
Jane C. Norman, RN, MSN, CNE, PhD

Division Planner Disclosure
The division planner has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Accreditations & Approvals
In support of improving patient care, NetCE is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.
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 should 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, psychologic, 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 should educate himself or herself to enhance awareness of the presence of abuse victims in his or her particular practice or clinical setting.
Specifically, healthcare professionals should 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 spousal abuse, battering, or intimate partner violence (IPV), 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 Centers for Disease Control and Prevention (CDC) defines IPV as, “violence or aggression that occurs in a close relationship” [1]. According to the Florida Department of Children and Families, domestic violence is “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” [2]. 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” [3]. Family or household members, according to Florida definition, must “be currently residing or have in the past resided together in the same single dwelling unit” [3]. Domestic violence knows no boundaries. It occurs in intimate relationships regardless of race, religion, culture, or socioeconomic status [2].

Whatever the definition, it is important for healthcare professionals to understand that domestic violence, in the form of emotional and psychologic abuse, sexual abuse, and physical violence, is prevalent in our society. Because of the similar nature of the definitions, this course will use the terms “domestic violence” and “IPV” interchangeably.

### NATIONAL AND STATE STATISTICS AND LEGISLATION

Domestic violence is one of the most serious public health problems in the United States [4]. More than 36.4% of women and 33.6% of men have a lifetime history of IPV [4]. In Florida, the weighted lifetime prevalence of IPV (including rape, physical violence, and/or stalking) is 37.3% among women and 30.9% among men [5]. Although many of these incidents are relatively minor and consist of pushing, grabbing, shoving, slapping, and hitting, IPV resulted in approximately 1,300 deaths in the United States in 2017, with 162 deaths reported in Florida [7; 8]. One of the difficulties in addressing the problem is that abuse is prevalent in all demographics, regardless of age, ethnicity, race, religious denomination, education, or socioeconomic status [2].

Victims of abuse 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 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 [9]. The 2003 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 healthcare services; and how many women lost time from paid work and household chores. The estimated total annual cost of IPV against women in the 1995 survey was more than $5.8 billion [9]. When updated to 2017 dollars, the amount was more than $9.3 billion annually. The costs associated with IPV at this time would be considerably more, but no further studies have been conducted [10]. It should be noted that the costs of any one victimization may continue for years; therefore, these statistics most likely underestimate the actual cost of IPV [9].

The national rate of nonfatal domestic violence against women declined 72% between 1993 and 2011 [11]. The rate of overall violent crime fell by nearly 60% in this same time period [11]. Studies reveal that several factors may have contributed 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 [13; 14]. Of note, declines in the economy and stress associated with financial hardship and unemployment are significant contributors to IPV in the United States. Following the economic downturn in late 2008, there was a significant increase in the use of the National Domestic Violence Hotline in 2009, with more than half of victims reporting a change in household financial situation in the last year [15].
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 available to victims in Florida, made legislative and budgetary suggestions for needed changes, 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 [19]. 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 [18]. 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 [19]. 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 [20]. 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 [19]. Due to budgetary constraints, responsibility of compiling this data transferred to the Department of Children and Families in 2008 [21].

As part of Governor Jeb Bush’s initiative, the “Family Protection Act” was signed into law in 2001. The act requires a 5-day mandatory jail term for any crime of domestic battery in which the perpetrator deliberately injures 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 [22].

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 the Domestic Violence in Florida 2010–2011 Annual Report to the Legislature, this has strengthened domestic violence services provided by streamlining the process of allocating funds [23].

In 2007, the Domestic Violence Leave Act was signed into law by Governor Charlie Crist [21]. This law requires employers with 50 or more employees to provide guaranteed leave for domestic violence issues.

In 2017, the FDLE reported 106,979 domestic violence offenses [6]. In general, domestic violence rates have been declining since 1998. An estimated 20.2% of domestic violence incidents involved spouses and 28.4% involved cohabitants; 11.5% of the victims were parents of the offenders. Domestic violence offenses resulted in the death of 162 victims in Florida in 2017, a number that has been decreasing since 2014 [6]. Domestic violence accounted for more than 15% of the state’s murders in 2017 [6].

In their 2018 Annual Report, Fatality Review Teams summarized 32 cases of domestic violence fatalities and near fatalities [49]. The most significant findings included the following observations [49]:

- The perpetrators were predominantly male (90%) with female victims (84%) and had prior criminal histories, generally (55%) and for domestic violence specifically (48%).
- In 32% of fatalities, the perpetrators had a known “do not contact” order filed against them, and 32% of perpetrators had a known permanent injunction for protection against them filed by someone other than the victim.
- Substance abuse histories by the perpetrator was identified in 62% of the cases and diagnosed mental health disorders in 30%.
- In most cases, neither the decedent nor perpetrator sought help from the various intervention programs available to them.

IDENTIFYING GROUPS AT RISK FOR DOMESTIC VIOLENCE

Healthcare professionals are in a critical position to identify domestic violence victims in a variety of clinical practice settings. Nurses are often the first healthcare provider a victim of domestic violence will encounter in a healthcare setting and should therefore be prepared to provide care and support for these victims. Although women are most often the victims, domestic violence extends to others in the household as well. For example, domestic violence includes abused men, children abused by their parents or parents abused by their children, elder abuse, and abuse among siblings [3].

Many victims of abuse sustain injuries that lead them to present to hospital emergency departments. Research has found that 49.6% of women seen in emergency departments reported a history of abuse and 44% of women who were ultimately killed by their abuser had sought help in an emergency department in the two years prior to their death [25; 50]. Another study of 993 police-identified female victims of IPV found that only 28% of the women were identified in the emergency department as being victims of IPV [26]. These alarming statistics demonstrate that healthcare professionals who work in acute care, such as hospital emergency rooms, should maintain a high index of suspicion for battering of the patients that they see. Healthcare professionals who work in these settings should work with hospital administrators to establish and institute assessment 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 should likewise be aware that seemingly supportive family members may, in fact, be abusers.

PREGNANT WOMEN

Because a gynecologist or obstetrician is frequently a woman’s primary care physician, the American College of Obstetricians and Gynecologists (ACOG) recommends that all women be routinely assessed for signs of IPV (i.e., physical and psychologic abuse, reproductive coercion, and progressive isolation), including during prenatal visits, and providers should offer support and referral information for those being abused [28]. According to the ACOG, IPV affects as many as 324,000 pregnant women each year [25]. A meta-analysis of 92 independent studies found that the average reported prevalence of emotional abuse during pregnancy was 28.4%, physical abuse was 13.8%, and sexual abuse was 8% [51]. As with all domestic violence statistics, these estimates are presumed to be lower than the actual incidence as a result of under-reporting 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 pre-eclampsia and gestational diabetes [25]. Because 96% of pregnant women receive prenatal care, this is an optimal time to assess for domestic violence and develop trusting relationships with the women. Possible factors that may predispose pregnant women to IPV include being unmarried, lower socioeconomic status, young maternal age, unintended pregnancy, delayed prenatal care, lack of social support, and use of tobacco, alcohol, or illegal drugs [25; 51].

The overarching problem of violence against pregnant women cannot be ignored, especially as both mother and fetus 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 ensure that therapeutic opportunities are available to the pregnant woman and will reduce the potential negative outcomes [29]. Healthcare professionals should also be aware of the possible psychologic 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 fetus from tobacco, drugs, and alcohol and a loss of interest on the part of the mother in her or her baby’s health [16; 30]. Possible direct injuries to the fetus may result from maternal trauma [25].

Control of reproductive or sexual health is also a recognized trend in IPV. This type of abuse includes trying to impregnate or become pregnant against a partner’s wishes, refusal to use birth control (e.g., condoms, oral contraceptives), or stopping a partner from using birth control [4].

CHILDREN

Children exposed to family violence are at high risk for abuse and for emotional damage that may affect them as they grow older. The Department of Justice estimates that of the 76 million children in the United States, 46 million will be exposed to some type of violence during their childhood [52]. Results of the National Survey of Children’s Exposure to Violence indicated that 11% of children were exposed to IPV at home within the last year, and as many as 26% of children were exposed to at least one form of family violence during their lifetimes [31]. Of those children exposed to IPV, 90% were direct eyewitnesses of the violence; the remaining children were exposed by either hearing the violence or seeing or being told about injuries [31]. Of note, according to Florida criminal law, witnessing domestic violence is defined as “violence in the presence of a child if an offender is convicted of a primary offense of domestic violence, and
that offense was committed in the presence of a child under age 16 who is a family or household member with the victim or perpetrator” [32].

A number of studies indicate that child witnesses are at increased risk for post-traumatic stress disorder, impaired development, aggressive behavior, anxiety, difficulties with peers, substance abuse, and academic problems than the average child [33; 54; 55]. Children exposed to violence may also be more prone to dating violence (as a perpetrator or a victim), and the ability to effectively cope with partnerships and parenting later in life may be affected, continuing the cycle of violence into the next generation [34; 56].

In addition to witnessing violence, various studies have shown that these children may also become direct victims of violence, and children who both witness and experience violence are at the greatest risk for adverse psychosocial outcomes [53]. Research indicates that between 30% and 60% of husbands who batter their wives also batter their children [35]. Moreover, victims of abuse will often turn on their children; statistics demonstrate that 85% of domestic violence victims abuse or neglect their children. The 2017 Crime in Florida report found that more than 16% of domestic homicide victims were children killed by a parent [6]. Teenage children are also victimized. According to the U.S. Department of Justice, between 1980 and 2008, 17.5% of all homicides against female adolescents 12 to 17 years of age were committed by an intimate partner [36]. Among young women (18 to 24 years of age), the rate is 42.9%. Abused teens often do not report the abuse. Individuals 12 to 19 years of age report only 35.7% of crimes against them, compared with 54% in older age groups [37]. Accordingly, healthcare professionals who see young children and adolescents in their practice (e.g., pediatricians, family physicians, school nurses, pediatric nurse practitioners, community health nurses) should 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, or other relatives, are among the most isolated of all victims of family violence. In a national study conducted by the National Institute of Justice in 2010, 4.6% of participants (community dwelling adults 60 years of age or older) were victims of emotional abuse in the past year, 1.6% physical abuse, 0.6% sexual abuse, 5.1% potential neglect, and 5.2% current financial abuse by a family member [38]. The estimated annual incidence of all elder abuse types is 2% to 10%, but it is believed to be severely under-measured. According to one study, only 1 in 14 cases of elder abuse are reported to the authorities [39].

The prevalence rate of elder abuse in institutional settings is not clear. However, in a 2019 review of nine studies, 64% of elder care facility staff disclosed to having perpetrated abuse against an elderly resident in the past year [40]. In a random sample survey, 24.3% of respondents reported at least one incident of elder physical abuse perpetrated by a nursing home staff member [57].

As healthcare professionals in Florida, which leads the nation in percentage of older residents, it is important to 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 should 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 [39].

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 in which 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 [39]. 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 should 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 [4]. Studies demonstrate approximately 5% of murdered men are killed by intimate partners [36]. 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 [42]. Approximately 512,770 women were raped and/or physically assaulted by an intimate partner in 2008, compared to 101,050 men [58]. In addition, 1 in 4 women has been physically assaulted, raped, and/or stalked by an intimate partner, compared with 1 out of every 10 men [1]. Of all homicides committed against men between 1980 and 2008, 7.1% were committed by an intimate partner [36]. Although women are more often victims of IPV, healthcare professionals should always keep in mind that men can also be victimized and assess accordingly.

LESBIAN, GAY, BISEXUAL, AND TRANSGENDER VICTIMS
Domestic violence exists in lesbian, gay, bisexual, and transgender (LGBT) communities, and the rates are thought to mirror those of heterosexual women—approximately 25% [43]. However, women living with female intimate partners experience less IPV than women living with men [6]. Conversely, men living with male intimate partners experience more IPV than do men who live with female intimate partners [6]. In addition, 78% of IPV homicide victims reported in 2017 were transgender women or cisgender men [24]. This supports other statistics indicating that IPV is perpetrated primarily by men. A form of abuse specific to the gay community is for an abuser to threaten or to proceed with “outing” a partner to others [41; 43].

Transgender individuals appear to be at particular risk for violence. According to a large national report, transgender victims of IPV were 1.9 times more likely to experience physical violence and 3.9 times more likely to experience discrimination than other members of the LGBT community [24]. In 2017, an annual national report recorded 52 incidences of hate violence-related homicides of LGBT+ people, the highest incident number recorded in its 20-year history [24]. This increasing prevalence of anti-LGBT+ violence can exacerbate IPV in LGBT+ communities. For example, a person who loses their job because of anti-trans bias may be more financially reliant on an unhealthy relationship. An abusive partner may also use the violence that an LGBT+ person experiences from their family as a way of isolating that person further [24].

Because of the stigma of being LGBT, victims may be reticent to report abuse and afraid that their sexual orientation or biologic sex will be revealed. In one study, the three major barriers to seeking help were a limited understanding of the problem of LGBT IPV, stigma, and systemic inequities [41]. Many in this community feel that support services (e.g., shelters, support groups, crisis hotlines) are not available to them due to homophobia of the service providers. Unfortunately, this results in the victim feeling isolated and unsupported. Healthcare professionals should strive to be sensitive and supportive when working with homosexual patients.

CHARACTERISTICS OF PERPETRATORS OF DOMESTIC VIOLENCE
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 [44]. Domestic violence assessment questionnaires should include questions that explore social drinking habits of both victims and their mates.

Other studies demonstrate that abusive mates are generally possessive and jealous. Another characteristic related to the abuser’s dependency and jealousy is extreme suspiciousness. This characteristic may be so extreme as to border on paranoia [12]. Domestic violence victims frequently report that abusers are extremely controlling of the everyday activities of the family. This domination is generally all encompassing and often includes maintaining complete control of finances and activities of the victim (e.g., work, school, social interactions) [12].

In addition, abusers often suffer from low self-esteem and their sense of self and identity is directly connected to their partner [12]. Extreme dependence is common in both abusers and those being abused. Due to low self-esteem and self-worth, emotional dependence often occurs in both partners, but even more so in the abuser. Emotional dependence in the victim stems from both physical and psychologic abuse, which results in a negative self-image and lack of self-worth. Financial dependence is also very common, as the abuser often withholds or controls financial resources to maintain power over the victim [27].
SCREENING FOR DOMESTIC VIOLENCE AND ABUSE

There is no universal guideline for identifying and responding to domestic violence, but it is universally accepted that a plan for screening, assessing, and referring patients of suspected abuse should be in place at every healthcare facility. Guidelines should review appropriate interview techniques for a given setting and should also include the utilization of assessment tools. Furthermore, protocols within each facility or healthcare setting should include referral, documentation, and follow-up. This section relies heavily on the guidelines outlined in the Family Violence Prevention Fund’s National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings; however, protocols should be customized based on individual practice settings and resources available [35]. The CDC has provided a compilation of assessment tools for healthcare workers to assist in recognizing and accurately interpreting behaviors associated with domestic violence and abuse, which may be accessed at https://www.cdc.gov/violenceprevention/pdf/ipvandvscreening.pdf [45].

The U.S. Preventive Services Task Force recommends that clinicians screen women of childbearing age for intimate partner violence, such as domestic violence, and provide or refer women who screen positive to intervention services. This recommendation applies to women who do not have signs or symptoms of abuse. (https://annals.org/aim/fullarticle/1558517/screening-intimate-partner-violence-abuse-elderly-vulnerable-adults-u-s. Last accessed July 26, 2019.)

Strength of Recommendation: B (There is high certainty that the net benefit is moderate or there is moderate certainty that the net benefit is moderate to substantial.)

Several barriers to screening for domestic violence have been noted, including a lack of knowledge and training, time constraints, lack of privacy for asking appropriate questions, and the sensitive nature of the subject [35]. Although awareness and assessment for IPV has increased among healthcare providers, many are still hesitant to inquire about abuse [46]. At a minimum, those exhibiting signs of domestic violence should be screened. Although victims of IPV may 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 physical. 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 and musculoskeletal injuries. These are often distinguishable from accidental injuries, which are more likely to involve the extremities of the body. Abuse victims are also more likely to have multiple injuries than accident victims. When this pattern of injuries is seen, particularly in combination with evidence of old injury, physical abuse should be suspected [44].

In addition to physical signs and symptoms, domestic violence victims also exhibit psychologic cues that resemble an agitated depression. As a result of prolonged stress, various psychosomatic symptoms that generally lack an organic basis often manifest. For example, complaints of headaches, digestive problems are common. Often, there are reports of fatigue, restlessness, insomnia, or loss of appetite. Great amounts of anxiety, guilt, and depression or dysphoria are also typical. Women who experienced IPV are also more likely to report asthma, irritable bowel syndrome, and diabetes [4]. Healthcare professionals should look beyond the typical symptoms of a domestic violence victim and work within their respective practice settings to develop appropriate assessment mechanisms to detect victims who exhibit less obvious symptoms.

The unique relationship dynamics of the abuser and abused are not easily detected under the best of circumstances. They may be especially difficult to uncover in circumstances in which the parties are suspicious and frightened, as might be expected when a victim presents to the emergency department. The key to detection, however, is to establish a proper assessment tool that can be utilized in the particular setting and to maintain a keen awareness for the cues described in this course. Screening for IPV 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) [35].

The key to an initial assessment is to obtain an adequate history. Establishing that a patient’s injuries are secondary to abuse 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. After such treatment is rendered, however, it is important that healthcare professionals not ignore the reasons that brought the victim to the emergency department [35].
ASSESSING DOMESTIC VIOLENCE AND ABUSE

Healthcare providers have reported that even if routine screening and inquiry results in a positive identification of IPV, the next steps of assessing and referring are often difficult, and many feel that they are not adequately prepared [46]. According to the Family Violence Prevention Fund, the goals of the assessment are to create a supportive environment, gather information about health problems associated with the abuse, and assess the immediate and long-term health and safety needs for the patient to develop an intervention [35].

Assessment of domestic violence victims should occur immediately after disclosure of abuse and at any follow-up appointments. Assessing immediate safety is priority. Having a list of questions readily available and well-practiced can help alleviate the uncertainty of how to begin the assessment (Table 1). If the patient is in immediate danger, referral to an advocate, support system, hotline, or shelter is indicated [35].

If the patient is not in immediate danger, the assessment may continue with a focus on the impact of IPV on the patient’s mental and physical health and the pattern of history and current abuse [35]. These responses will help formulate an appropriate intervention.

CULTURALLY SENSITIVE ASSESSMENT

During the assessment process, a practitioner should be open and sensitive to the patient’s worldview, cultural belief systems and how he/she views the illness [47]. 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 [48]. The first component of Pachter's model calls for the practitioner to take responsibility for cultural awareness and knowledge. The professional should 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 [48]. 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 patient and the professional [48]. 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. 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.

<table>
<thead>
<tr>
<th>ARE YOU IN IMMEDIATE DANGER?</th>
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<tbody>
<tr>
<td>IS YOUR PARTNER AT THE HEALTH FACILITY NOW?</td>
</tr>
<tr>
<td>DO YOU WANT TO (OR HAVE TO) GO HOME WITH YOUR PARTNER?</td>
</tr>
<tr>
<td>DO YOU HAVE SOMEWHERE SAFE TO GO?</td>
</tr>
<tr>
<td>HAVE THERE BEEN THREATS OR DIRECT ABUSE OF THE CHILDREN (IF S/HE HAS CHILDREN)?</td>
</tr>
<tr>
<td>ARE YOU AFRAID YOUR LIFE MAY BE IN DANGER?</td>
</tr>
<tr>
<td>HAS THE VIOLENCE GOTTEN WORSE OR IS IT GETTING SCARIER? IS IT HAPPENING MORE OFTEN?</td>
</tr>
<tr>
<td>HAS YOUR PARTNER USED WEAPONS, ALCOHOL OR DRUGS?</td>
</tr>
<tr>
<td>HAS YOUR PARTNER EVER HELD YOU OR YOUR CHILDREN AGAINST YOUR WILL?</td>
</tr>
<tr>
<td>DOES YOUR PARTNER EVER WATCH YOU Closely, FOLLOW YOU OR STALK YOU?</td>
</tr>
<tr>
<td>HAS YOUR PARTNER EVER THREATENED TO KILL YOU, HIM/HERSELF OR YOUR CHILDREN?</td>
</tr>
</tbody>
</table>

Source: [35] Table 1
INTERVENTIONS FOR DOMESTIC VIOLENCE AND ABUSE

After the assessment is complete, the patient may or may not want immediate assistance or referral. It is important for healthcare providers to assure patients in a nonjudgmental manner that the decision of what they would like in terms of assistance is their choice and that the provider will help regardless of the decisions they are currently ready to make [35].

If the patient would like to immediately implement a plan of action, information for referral to a local domestic violence shelter to assist the victim and the victim's family should be readily available. 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. After 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 those who are unsure of their options [35].

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 her or his local domestic violence center. A list of Florida certified domestic violence centers organized by county and city may also be found on the Florida Coalition Against Domestic Violence website at https://www.fcadv.org/local-center-services. As of 2018, Florida had 72 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.

DOCUMENTATION AND FOLLOW-UP

It is imperative that healthcare professionals document all findings and recommendations regarding domestic violence in the victim’s medical record, including a patient's denial of abuse, if applicable. If domestic violence is disclosed, documentation should include relevant history, results of the physical examination, findings of laboratory and other diagnostic procedures, and results of the assessment, intervention, and referral. The medical record can be an invaluable document in establishing the credibility of the victim's story when seeking legal aid [35].

Healthcare professionals should offer a follow-up appointment if disclosure of past or current abuse is present. Reassurance that assistance is available to the patient at any time is critical in helping to break the cycle of abuse [35].

FACULTY BIOGRAPHIES

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, Hulse & Basy 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.

Alice Yick Flanagan, PhD, MSW, received her Master's in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families.

Previously acting as a faculty member at Capella University and Northcentral University, Dr. Yick Flanagan is currently a contributing faculty member at Walden University, School of Social Work, and a dissertation chair at Grand Canyon University, College of Doctoral Studies, working with Industrial Organizational Psychology doctoral students. She also serves as a consultant/subject matter expert for the New York City Board of Education and publishing companies for online curriculum development, developing practice MCAT questions in the area of psychology and sociology. Her research focus is on the area of culture and mental health in ethnic minority communities.
1. Most healthcare professionals will encounter patients in their practice who are victims of domestic violence.
   A) True
   B) False

2. The Florida Department of Children and Families’ definition of domestic violence may include pet abuse, physical abuse, and/or emotional abuse.
   A) True
   B) False

3. Florida law defines domestic violence exclusively as spouse abuse or battering.
   A) True
   B) False

4. House Bill 1099 strengthened domestic violence services by streamlining the process of allocating funds.
   A) True
   B) False

   A) True
   B) False

6. The majority of children exposed to intimate partner violence are direct eyewitnesses.
   A) True
   B) False

7. Domestic violence injury patterns are more likely than accidental injuries to involve the extremities of the body.
   A) True
   B) False

8. In addition to physical signs and symptoms, domestic violence victims may also exhibit psychologic cues that resemble an agitated depression.
   A) True
   B) False

9. Assessment of domestic violence victims should occur immediately after disclosure of abuse and at any follow-up appointments.
   A) True
   B) False

10. Florida does not presently have a toll-free domestic violence hotline, although this was a recommendation of the Governor’s Task Force on Domestic Violence.
    A) True
    B) False

Be sure to transfer your answers to the Answer Sheet insert located between pages 88–89.

PLEASE NOTE: Your postmark or facsimile date will be used as your test completion date.
**Laws and Rules for Florida Nurses**

This course fulfills the Florida requirement for 2 hours of education on Laws and Rules.

**Audience**  
This course is designed for all nurses licensed in Florida.

**Course Objective**  
The purpose of this course is to provide basic knowledge of the laws and rules governing the practice of nursing in Florida in order to increase compliance and improve patient care. Florida nurses are legally obligated to be aware of standards that govern professional accountability. Information contained in this course is not intended to be used in lieu of lawful guidelines, but as a learning tool that increases the understanding of some regulations as they apply to nurses who are licensed within the state of Florida.

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

1. Describe the legislative purpose for the Nurse Practice Act.
2. Identify specific laws and rules related to the practice of nursing and nursing assisting.
3. Outline the pertinent levels of nursing practice in the State and the general scope of practice of each.
4. Discuss the general requirements for continuing licensure in the State.
5. Differentiate between ethical and legal practice.
6. Discuss the process for discipline related to nursing practice.
7. Create a professional plan for career maintenance and development within the limits of the law.

**Faculty**  
Jane C. Norman, RN, MSN, CNE, PhD, received her undergraduate education at the University of Tennessee, Knoxville campus. There she completed a double major in Sociology and English. She completed an Associate of Science in Nursing at the University of Tennessee, Nashville campus and began her nursing career at Vanderbilt University Medical Center. Jane received her Masters in Medical-Surgical Nursing from Vanderbilt University. In 1978, she took her first faculty position and served as program director for an associate degree program. In 1982, she received her PhD in Higher Education Administration from Peabody College of Vanderbilt University. In 1988, Dr. Norman took a position at Tennessee State University. There she has achieved tenure and full professor status. She is a member of Sigma Theta Tau National Nursing Honors Society. In 2005, she began her current position as Director of the Masters of Science in Nursing Program.

**Faculty Disclosure**  
Contributing faculty, Jane C. Norman, RN, MSN, CNE, PhD, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

**Division Planner**  
Sharon Cannon, RN, EdD, ANEF

**Division Planner Disclosure**  
The division planner has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

**Accreditations & Approvals**  
In support of improving patient care, NetCE is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

**Designations of Credit**  
NetCE designates this continuing education activity for 2 ANCC contact hours.

AACN Synergy CERP Category B.

**Individual State Nursing Approvals**  
In addition to states that accept ANCC, NetCE is approved as a provider of continuing education in nursing by: Alabama, Provider #ABNP0353 (valid through 11/21/2021); Arkansas, Provider #50-2405; California, BRN Provider #CEP9784; California, LVN Provider #V10662; California, PT Provider #V10842; District of Columbia, Provider #50-2405; Florida, Provider #50-2405; Georgia, Provider #50-2405; Kentucky, Provider #7-0054 (valid through 12/31/2021); South Carolina, Provider #50-2405; West Virginia, RN and APRN Provider #50-2405.
INTRODUCTION

Nursing practice acts have a long history in the United States, with the first standards being enacted in the early 1900s. In Florida, a period of major growth and expansion during this period resulted in an increase in the number of hospitals and training schools, which spurred the formation of professional nurses’ associations and an interest in establishing standards for the delivery of nursing care [1]. The first practice act passed the Florida Legislature and was signed into law on June 7, 1913 [1].

The Florida Nurse Practice Act was legislated to safeguard the public, and the purpose of the Act is to ensure that minimum safety requirements are met by every nurse practicing in the state. The Nurse Practice Act, Chapter 464 of the Florida Statutes, includes laws governing scope of practice, licensure and certification, and violations and penalties [3]. Chapter 464 established the Florida Board of Nursing as an authority to adopt rules, develop standards for nursing programs, and discipline nurses who violate regulations [2]. Nurses who fall below Florida’s required minimum competency or who present a danger to patients, coworkers, or others are prohibited from working in the state.

In addition to Chapter 464, nurses in Florida are regulated by Chapter 456, which includes general provisions for all health professions, and Title 64B9 of the Florida Administrative Code. Together, these laws and rules form the basis for the legal practice of nursing and the regulation of nursing by the state of Florida.

This course fulfills the education requirement on the laws and rules that govern the practice of nursing in Florida for all levels of nursing, including registered nurses (RNs), licensed practical nurses (LPNs), and advanced practice registered nurses (APRNs) [3]. While this course will provide an overview of the pertinent sections of the laws and rules, all nurses are encouraged to review them in their entirety in order to ensure compliance.

STANDARDS OF PRACTICE

The basic standards of competent practice directly impact how all nurses in Florida provide care. Not only must a nurse possess the knowledge of lawful and current care standards, but the knowledge must be demonstrated through consistent practice and intervention to prevent unauthorized, inappropriate, erroneous, illegal, contraindicated, or intentional nonperformance of care.
The Nurse Practice Act governs the practice of RNs, LPNs, and APRNs. LPNs are those persons licensed to practice practical nursing, while RNs and APRNs are licensed to practice professional nursing, with various levels of specialization [3]. Both professional and practical nurses are responsible and accountable for making decisions that are based upon their educational preparation and experience in nursing.

According to the Nurse Practice Act, the practice of practical nursing means [3]:

- The performance of selected acts, including the administration of treatments and medications, in the care of the ill, injured, or infirm; the promotion of wellness, maintenance of health, and prevention of illness of others under the direction of a licensed practitioner.
- The observation, assessment, nursing diagnosis, planning, intervention, and evaluation of care; health teaching and counseling of the ill, injured, or infirm; and the promotion of wellness, maintenance of health, and prevention of illness of others.
- The administration of medications and treatments as prescribed or authorized by a duly licensed practitioner.
- The supervision and teaching of other personnel.

A practical nurse is responsible and accountable for making decisions that are based upon the individual's educational preparation and experience in nursing.

The practice of professional nursing is defined by the Act as “the performance of those acts requiring substantial specialized knowledge, judgment, and nursing skill based upon applied principles of psychosocial, biological, physical, and social sciences” [3]. The Florida Statutes further define the scope of practice of professional nursing as [3]:

- The observation, assessment, nursing diagnosis, planning, intervention, and evaluation of care; health teaching and counseling of the ill, injured, or infirm; and the promotion of wellness, maintenance of health, and prevention of illness of others.
- The administration of medications and treatments as prescribed or authorized by a duly licensed practitioner.
- The supervision and teaching of other personnel in the theory and performance of any of the above acts.

ADVANCED PRACTICE REGISTERED NURSES

In addition to the practice of professional nursing, APRNs are certified in advanced or specialized nursing practice. This umbrella term includes certified nurse midwives, certified nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists, and psychiatric nurses [3]. In accordance with the Act, APRNs may perform acts of nursing diagnosis and treatment of alterations of the health status as well as medical diagnosis and treatment, prescription, and operation as authorized within the framework of an established supervisory protocol [3]. Specifically, within the established framework, an APRN may [3]:

- Prescribe, dispense, administer, or order any drug; however, an APRN may prescribe or dispense a controlled substance only if she or he has graduated from a program leading to a Master's or doctoral degree in a clinical nursing specialty area with training in specialized practitioner skills.
- Initiate appropriate therapies for certain conditions.
- Perform additional functions as may be determined by rule.
- Order diagnostic tests and physical and occupational therapy.

All APRNs are required to obtain and maintain malpractice insurance or demonstrate proof of financial responsibility prior to licensure, with some exceptions [10]. Proof of compliance with this rule or exemption must be provided to the Board of Nursing at least 60 days of certification and at each biennial renewal.

Rule 64B9-4.011 states, “APRNs whose protocols permit them to dispense medications…must register with the Board of Nursing by submitting a completed Dispensing Application for Advanced Practice Registered Nurse (APRN), form number DH-MQA 1185” [10]. The APRN dispensing practitioner must comply with all applicable state and federal laws and regulations.

CONTINUING LICENSURE IN FLORIDA

The Florida Board of Nursing is responsible for adopting rules establishing the procedure for the biennial renewal of nursing licenses. All Florida nurses are required to renew their licenses and complete mandated continuing education every two years. The Act stipulates that up to 30 hours of continuing education may be required each biennium [3]. Initial licenses that were issued for less than 24 months are required to complete one hour for each month for which the license was valid. As part of this requirement, all licensees must complete an approved two-hour course on the prevention of medical errors and a two-hour course on the laws and rules that govern the practice of nursing in Florida. Starting in 2019, licensees must also complete a two-hour course on human trafficking every renewal period. Beginning with 2018 renewals, a two-hour course on recognition of impairment in the workplace must be completed every other biennium. Every third renewal (or every six years), licensees must successfully complete two hours of continuing education on domestic violence in addition to the 24-hour requirement. A one-hour course on HIV/AIDS must be completed prior to a licensee’s first renewal. In addition to these requirements, beginning in 2017, all APRNs must complete at least three hours of continuing education on the safe and effective prescription of controlled substances for each biennial renewal.
Completion of all mandated continuing education must be reported to the Board. Failure to document compliance with the continuing education requirements or furnishing false or misleading information regarding compliance is grounds for disciplinary action.

A nurse may maintain his or her license in inactive status if there is no intent to practice nursing in the upcoming biennium. However, this requires that the licensee apply for inactive status and renew the license as inactive every two years; completion of continuing education is not required for these renewals. A license to practice nursing that is not renewed at the end of the biennium shall automatically revert to delinquent status.

In accordance with Rule 64B9-1.013 of the Florida Administrative Code, all licensed nurses must maintain on file with the Board of Nursing the current address at which any notice required by law may be served. If a nurse moves, even out of state, he or she must notify the Board in writing of the new address within 60 days. In addition, all licensed nurses must alert the Board to their current place of practice. Place of practice is defined as one of the following:

- Acute care facility
- Long-term care facility
- Rehabilitation facility
- Clinic
- Physician’s office
- Home health care agency
- Educational institution
- Office of independent nursing practice
- Correctional facility
- Mental health facility
- Occupational health facility
- Managed health care organization or insurance company
- Community health facility
- Other

If a nurse wishes to activate an inactive license, he or she may do so by applying to the Department and paying a reactivation fee. As part of the application process, the licensee must disclose convictions or findings of guilt and/or disciplinary action(s) in or out of state. In addition, the nurse must provide proof of completion of all continuing education for all biennial licensure periods for which the individual was inactive.

Completion of a Board-approved nursing refresher course is required to activate a license that has been inactive for more than two consecutive biennial licensure cycles if the licensee has not been practicing nursing in any jurisdiction for the two years immediately preceding the application for reactivation. The refresher course must include at least 80 hours of classroom instruction and 96 hours of clinical experience in medical/surgical nursing and any specialty area of practice of the licensee.

ETHICAL AND LEGAL ISSUES IN NURSING PRACTICE

In addition to their legal obligations, nurses have ethical obligations to their patients. The practice of nursing is primarily one of caring, and the ethical theories for nursing are often referred to as “the ethics of caring.” Nurses are expected to address both ethical and legal issues in their practice, which can be complex. As medical advancements and new technology progress, these must be incorporated into established ethical standards. The American Nurses Association has established the Code of Ethics for Nurses, which is intended to act as “a guide for nurses to use in ethical analysis and decision-making.” The full text of this Code is available at https://www.nursingworld.org/practice-policy/nursing-excellence/ethics/code-of-ethics-for-nurses. Major ethical issues that may arise in the practice of nursing are related to the provision of patient-centered care, confidentiality, advocacy, delegation, self-care, and supporting colleagues and the profession.

There are also a variety of legal issues that affect the provision of nursing care and maintenance of a nursing license. It is important to note that, although possibly related, the laws governing nursing practice are different from the ethical framework(s) that nurses use to guide decision making. Laws pertaining to documentation, licensure, and standards of care have been established to ensure that nurses practice within a defined scope of practice and are aware of the boundaries of independent nursing action and responsibilities. These laws also act to hold nurses accountable for maintaining an acceptable standard of patient care. However, perhaps the greatest concern for nurses is the threat of negligence or malpractice claims.

According to tort law, four elements must be established for a ruling of malpractice:

- Duty: The nurse owed a duty to meet a particular standard of care. Breach of duty: The nurse failed to perform the owed duty.
- Causation: There is a causal connection between the nurse’s failure and the patient’s injury.
- Damages: An injury occurred for which monetary compensation is adequate relief.

These elements must be shown by a “preponderance of the evidence,” defined as more than 50% probability, a lower standard than the “beyond a reasonable doubt” used in criminal law. Malpractice cases are decided on the basis of what a “jury is likely to think is fact” rather than actual fact.
DISCIPLINARY ACTIONS

The Board of Nursing was created to assure protection of the public from nurses who do not meet minimum requirements for safe practice or who pose a danger to the public [3]. Violations of the laws established by the Board to ensure safe nursing practice are punishable by disciplinary action. These penalties are in addition to the results of any legal or civil proceedings that may be brought by the State or by patients or affected parties.

Acts requiring disciplinary or legal action are outlined in sections 464.016, 464.017, and 464.018 of the Nurse Practice Act [3]. According to section 464.016, the following acts are considered felonies in the third degree [3]:

- Practicing advanced or specialized, professional, or practical nursing unless holding an active license or certificate to do so
- Using or attempting to use a license or certificate that has been suspended or revoked
- Knowingly employing unlicensed persons in the practice of nursing
- Obtaining or attempting to obtain a license or certificate by misleading statements or knowing misrepresentation

In addition, the following acts constitute misdemeanors in the first degree [3]:

- Using the name or title “Nurse,” “Registered Nurse,” “Licensed Practical Nurse,” “Clinical Nurse Specialist,” “Certified Registered Nurse Anesthetist,” “Certified Nurse Practitioner,” “Certified Nurse Midwife,” “Advanced Practice Registered Nurse,” or any other name or title that implies that a person was licensed or certified as same, unless such person is duly licensed or certified
- Knowingly concealing information relating to violations of this part

These actions are punishable by law according to sections 775.082, 775.083, and 775.084 of the Statutes, Constitution, and Laws of Florida [3].

Several actions are also considered grounds for denial of a license or disciplinary action. According to section 464.018, this includes [3]:

- Procuring, attempting to procure, or renewing a license to practice nursing by bribery, by knowing misrepresentations, or through an error of the Department or the Board
- Having a license to practice nursing revoked, suspended, or otherwise acted against, including the denial of licensure, by the licensing authority of another state, territory, or country
- Being convicted or found guilty of, or entering a plea of nolo contendere to, regarding of adjudication, a crime in any jurisdiction that directly relates to the practice of nursing or to the ability to practice nursing
- Being convicted of or found guilty of, or entering a plea of guilty or nolo contendere (no contest) to, regardless of adjudication, any of the following offenses:
  - A forcible felony
  - Theft, robbery, and related crimes
  - Fraudulent practices
  - Lewdness and indecent exposure
  - Assault, battery, and culpable negligence
  - Child abuse, abandonment, and neglect
  - Abuse, neglect, and exploitation
  - For an applicant for a multistate license or for a multistate license-holder, a felony offense under Florida law or federal criminal law
- Having been found guilty of, regardless of adjudication, or entered a plea of no contest or guilty to, any offense prohibited under Section 435.04 or similar statute of another jurisdiction; or having committed an act which constitutes domestic violence
- Making or filing a false report or record, intentionally or negligently failing to file a report or record required by state or federal law, or willfully impeding or obstructing such filing or inducing another person to do so
- False, misleading, or deceptive advertising
- Unprofessional conduct
- Engaging or attempting to engage in the possession, sale, or distribution of controlled substances for any other than legitimate purposes
- Being unable to practice nursing with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, or chemicals or any other type of material or as a result of any mental or physical condition
- Failing to report to the Department any person who the licensee knows is in violation of this part or of the rules of the Department or the Board
- Knowingly violating any provision of this part, a rule of the Board or the Department, or a lawful order of the Board or Department previously entered in a disciplinary proceeding or failing to comply with a lawfully issued subpoena of the Department
- Failing to meet minimal standards of acceptable and prevailing nursing practice, including engaging in acts for which the licensee is not qualified by training or experience
For a full list of punishable acts, please refer to Chapter 464.018 of the Florida statutes.

Sexual misconduct is considered a breach of mutual trust and can irreparably damage the nurse-patient relationship. According to section 464.017, “Sexual misconduct in the practice of nursing means violation of the nurse-patient relationship through which the nurse uses said relationship to induce or attempt to induce the patient to engage, or to engage or attempt to engage the patient, in sexual activity outside the scope of the practice or the scope of generally accepted examination or treatment of the patient” [3]. Sexual misconduct in the practice of nursing is prohibited and is grounds for disciplinary action.

Disciplinary actions encompass a wide range of possible punishments, and the action chosen will depend on the individual circumstances (e.g., the severity of the violation, the number of past offenses). The Board may take the following actions in response to violations listed above [4]:

- Refusal to certify, or to certify with restrictions, an application for a license
- Suspension or permanent revocation of a license
- Restriction of practice or license
- Imposition of an administrative fine not to exceed $10,000 for each count or separate offense
- Issuance of a reprimand or letter of concern
- Placement of the licensee on probation for a period of time and subject to such conditions as the Board may specify
- Corrective action
- Imposition of an administrative fine for violations regarding patient rights
- Refund of fees billed and collected from the patient or a third party on behalf of the patient
- Requirement that the practitioner undergo remedial education

Nurses who have been found guilty on three separate occasions of violations relating to the use of drugs or narcotics or involving the diversion of drugs or narcotics from patients to personal use or sale are not eligible for reinstatement of licensure [3].

In the annual report of fiscal year 2017–2018, more than 550 nurses licensed in Florida had received disciplinary actions. The most common orders are suspension of the nursing license (36%), limitations/obligations of a nursing license (13%), and voluntary surrender of a nursing license (11%) [11]. In most cases, nurses are also responsible for paying any costs associated with their order (e.g., investigation, court costs).

Certain offences may be resolved by mediation. Rule 64B9-8.012 states that mediation is an acceptable resolution for the first instance of the following violations [10]:

- Issuance of a worthless bank check to the Department or the Board for initial licensure or renewal of license, provided the licensee does not practice on a delinquent license
- Failure to report address changes, provided the failure does not constitute failure to comply with an order of the Board
- Failure to pay fines and investigative costs by the time ordered
- Failure to timely submit documentation of completion of continuing education imposed by Board order
- Failure to update a practitioner profile within 15 days

**EXCEPTIONS**

In addition to the limitations listed in this course, it is important to note that there are exceptions to the Nurse Practice Act. The law expressly states that the Act does not prohibit [3]:

- The care of the sick by friends or members of the family without compensation, the incidental care of the sick by domestic servants, or the incidental care of noninstitutionalized persons by a surrogate family
- Assistance by anyone in the case of an emergency
- The practice of nursing by students enrolled in approved schools of nursing
- The practice of nursing by graduates of prelicensure nursing education programs, pending the result of the first licensing examination for which they are eligible following graduation, provided they practice under direct supervision of a registered professional nurse
- The rendering of services by nursing assistants acting under the direct supervision of a registered professional nurse
- Any nurse practicing in accordance with the practices and principles of the body known as the Church of Christ Scientist
- The practice of any legally qualified nurse or licensed attendant of another state who is employed by the U.S. Government, or any bureau, division, or agency thereof, while in the discharge of official duties
• Any nurse currently licensed in another state or territory of the United States from performing nursing services in this state for a period of 60 days after furnishing to the employer satisfactory evidence of current licensure in another state or territory and having submitted proper application and fees to the Board for licensure prior to employment. If the nurse licensed in another state or territory is relocating to this state pursuant to his or her military-connected spouse’s official military orders, this period shall be 120 days after furnishing to the employer satisfactory evidence of current licensure in another state or territory and having submitted proper application and fees to the Board for licensure prior to employment. The Board may extend this time for administrative purposes when necessary.

• The rendering of nursing services on a fee-for-service basis or the reimbursement for nursing services directly to a nurse rendering such services by any government program, commercial insurance company, hospital or medical services plan, or any other third-party payor

• The establishment of an independent practice by one or more nurses for the purpose of rendering to patients nursing services within the scope of the nursing license

• The furnishing of hemodialysis treatments in a patient’s home, using an assistant chosen by the patient, provided that the assistant is properly trained (as defined by the Board by rule) and has immediate telephonic access to a registered nurse who is licensed pursuant to this part and who has dialysis training and experience

• The practice of nursing by any legally qualified nurse of another state whose employment requires the nurse to accompany and care for a patient temporarily residing in this state for not more than 30 consecutive days, provided the patient is not in an inpatient setting, the Board is notified prior to arrival of the patient and nurse, the nurse has the standing physician orders and current medical status of the patient available, and prearrangements with the appropriate licensed healthcare providers in this state have been made in case the patient needs placement in an inpatient setting

• The practice of nursing by individuals enrolled in board-approved remedial courses

CONCLUSION

It is the responsibility of the Florida Board of Nursing to enforce the laws and rules regulating the practice of nursing as the law is currently stated—not how individuals may wish the law to be. However, as nurses are affected by these rules and regulations, they have the responsibility to keep informed of regulatory changes and provide public comment regarding regulations. Board meetings are held every two months, generally during the first week of every even month, and are open to the public. The full board meetings include disciplinary cases, application review, committee reports, rule discussions, and other necessary Board actions. For more information, please contact the Board at 850-488-0595 or https://floridasnursing.gov/.

Customer Information/Answer Sheet insert located between pages 88–89.
1. The purpose of the Nurse Practice Act is to encourage the growth and expansion of hospitals and training schools.
   A) True
   B) False

2. The Nurse Practice Act is Chapter 464 of the Florida Statutes.
   A) True
   B) False

3. The Nurse Practice Act governs the practice of registered nurses, licensed practical nurses, and advanced practice registered nurses.
   A) True
   B) False

4. According to the Nurse Practice Act, the practice of practical nursing may be conducted under the direction of a registered nurse, licensed dentist, or licensed physician.
   A) True
   B) False

5. Ordering diagnostic tests and physical and occupational therapy is a part of the scope of practice for licensed practical nurses.
   A) True
   B) False

6. At least 40 hours of continuing education must be completed every biennium in order to maintain a nursing license in Florida.
   A) True
   B) False

7. Apology is one of the elements that must be established for a ruling of malpractice.
   A) True
   B) False

8. Using the name or title “Registered Nurse” without being duly licensed or certified is considered a misdemeanor in the first degree under the Nurse Practice Act.
   A) True
   B) False

9. Nurses who have been found guilty on three separate occasions of violations relating to the use of drugs or narcotics involving the diversion of drugs or narcotics from patients to personal use or sale are not eligible for reinstatement of licensure.
   A) True
   B) False

10. Board meetings are held annually.
    A) True
    B) False

Be sure to transfer your answers to the Answer Sheet insert located between pages 88–89.

PLEASE NOTE: Your postmark or facsimile date will be used as your test completion date.
Recognizing Impairment in the Workplace: The Florida Requirement

This course fulfills the Florida requirement for 2 hours of education on Recognizing Impairment in the Workplace.

Have you already completed your Impairment in the Workplace requirement? You can skip this course and still receive 26 hours of continuing education.

Audience
This course is designed for nurses in Florida who may intervene to prevent or identify impairment in the workplace.

Course Objective
The purpose of this course is to provide nurses with an appreciation of the impact of impairment on the provision of nursing care and on patient health as well as the skills to identify and report instances of workplace impairment.

Learning Objectives
Upon completion of this course, you should be able to:
1. Outline the epidemiology and scope of impairment in the healthcare workplace.
2. Discuss unique risk factors for substance abuse in nurses.
3. Identify the signs of impairment in the nursing workplace.
4. Analyze the process and legal obligations involved in reporting an instance of impairment in the workplace.
5. Describe the treatment programs available for nurses who have been impaired in the workplace.

Faculty
Nancy Campbell, RN, BSN, PHN, received her Bachelor of Science in Nursing degree from California State University, Bakersfield in 1987. She has nursing experience in a variety of clinical settings, including medical/surgical, community health, and preschool health. She was a nurse case manager for a community program supporting teen parents and a public health nurse focusing on communicable disease management. Her primary focus and passion is on direct patient care and patient education. She is presently employed as a registered nurse for the Head Start program in Tulare County, California.

Faculty Disclosure
Contributing faculty, Nancy Campbell, RN, BSN, PHN, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Division Planner
Jane C. Norman, RN, MSN, CNE, PhD

Division Planner Disclosure
The division planner has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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INTRODUCTION

Impairment of a healthcare professional can place everyone in a workplace at risk for injury. First and foremost is the risk to patients, who trust healthcare professionals to provide safe, reliable, and effective care. The ethical duty to not harm patients is a cornerstone of nursing, yet impaired healthcare workers injure patients daily. Another concern is the potential for impaired nurses to harm other professionals in the workplace, either directly or indirectly. Direct harm falls on a spectrum ranging from serious, injury-causing accidents to excessive absenteeism, which puts additional strain on staff. Presenteeism (i.e., reporting for work while impaired) places colleagues in the difficult position of having to work harder as a result of another's impairment, working in a potentially dangerous environment, and facing the dilemma of reporting a coworker, colleague, or friend.

Reporting impairment can be a difficult ethical situation for healthcare professionals, who often cover for impaired colleagues out of friendship or loyalty and who fear that reporting may ruin the nurse's career or their own. The truth is that the circumstances causing impairment have already eroded a nurse's professional abilities to some degree, and in most states, including Florida, good-faith reporters (i.e., those with sincere and honest intentions) are protected from retaliation by whistleblower laws. Conversely, not reporting a known impaired nurse is a violation of the Nurse Practice Act that can lead to disciplinary action by the Florida Board of Nursing.

Injury to patients and coworkers is increasingly likely when a worker is impaired, but impairment also gravely affects the individual nurse, whose health, safety, career, and social and financial standing are at risk if interventions are not undertaken. The American Nurses Association (ANA) definition of impairment describes a broad array of conditions that can interfere with workplace functioning, including mental or physical illness, fatigue, substance abuse, and other personal circumstances that adversely affect job performance [2]. Though fatigue and certain personal circumstances may be more easily resolved, these types of impairment still pose a danger. Fatigue, acute physical illness, and personal issues (e.g., stress, relationship problems) are generally dealt with in a different manner than impairment related to chemical dependence, other psychologic disorders, and chronic physical conditions. It should be remembered that alcohol and/or substance abuse is a type of medical and psychologic disorder, and helping the nurse obtain treatment so she or he can get healthy and return to work is the ultimate goal of reporting and intervention. Nearly all states, including Florida, now offer nurses found to be impaired at work an alternative to criminal prosecution, the chance to retain their license, and a return to nursing if they agree to enter and participate in an intervention program.
This course presents information on recognizing the signs and symptoms of emotional-, mental health-, and substance-related workplace impairment. Strategies for intervention and reporting (e.g., how and to whom impairment should be reported) are also outlined, particularly within the context of the Florida Nurse Practice Act. Treatment of impairment, including intervention programs, employer initiatives for impaired nurses, and returning to work, will be discussed. In the state of Florida, the Intervention Project for Nurses (IPN) is the Department of Health's contracted program to address nurse impairment; this program will be discussed in detail.

SCOPE OF THE PROBLEM

Historically, the rate of alcohol and drug dependency among healthcare professionals was thought to be much higher than in the general public, due to job stress and easy access to pharmaceutical drugs. However, the rate among nurses and physicians is now estimated to be only slightly higher than or equal to the rate found in the general public (10% to 15%) [3; 4; 5; 6; 9]. The ANA has reported that approximately 15% of all nurses abuse substances to the point at which interference with vocational practice can be expected [13]. Based on these data, up to 300,000 of the 3 million nurses in the United States have alcohol and/or drug use disorders, and job performance may be affected in more than 200,000 nurses [6]. Nurses make up the greatest proportion of healthcare workers in the country; therefore, substance-related impairment among nurses is a major healthcare problem, despite similar rates of abuse and dependency among other healthcare professionals [9].

One study found that while the rate of drug dependence was similar among female nurses and women in the general population, the rate of prescription drug abuse was much higher (more than double) among nurses; use of street-type drugs (e.g., cocaine, cannabis) was found to be lower in nurses than in the general population [5]. Reasons cited for the higher rates of prescription drug abuse included easier access, familiarity with dosages and effects, and comfort experimenting with drugs commonly prescribed to patients [6]. This phenomenon, referred to as “pharmacologic optimism,” is based on the ingrained belief that pharmaceutical drugs cause profound healing with few to no negative effects, an idea that is established early in some nurses [9]. Aside from alcohol, which is the most commonly abused substance among nurses, one study identified the classes of drugs most often abused, in order of frequency, as amphetamines, opioids, sedatives, tranquilizers, and inhalants. In this study, abuse was defined as prescription drug use without a script, using greater than the prescribed dosage, or using a drug for indications other than those prescribed [9]. In many instances of abuse, drugs were obtained through diversion. Drugs are diverted in several different ways [6; 11]:

- A physician writes a prescription for the nurse in the absence of a true indication.
- The nurse steals scripts and falsifies prescriptions for him- or herself.
- A whole dose of an injectable drug ordered for a patient is used by the nurse and replaced with saline, or the nurse retains the correct (drug-filled) syringe and replaces it with another filled with saline.
- Partial doses of medications are administered to patients while the nurse saves or uses the remainder.
- A nurse applies a skin patch to him- or herself before transferring it to the patient.
- A nurse removes syringes or ampules from a sharps waste container to scavenge any remaining drugs.
- The nurse has a colleague who, without actually witnessing the disposal, cosigns a record indicating waste while the nurse actually retains or takes the drug dose.
- The nurse obtains medications for patients who have not asked for them or who refused them.
- The nurse signs out medications for a patient who has been transferred.

All of these examples of diversion techniques have been documented, including cases in which patients have been infected with hepatitis C when a nurse used a syringe of opioid narcotic intended for them before replacing the missing contents with saline and injecting the patient [11]. One study found that 65% of nurses addicted to a pharmaceutical drug were diverting medication from their workplace [19]. Most addicted nurses in this study admitted to treating patients while impaired.

UNIQUE RISK FACTORS

In addition to the common risk factors for substance abuse in all individuals, several unique risk factors have been identified for nurses, including [9; 15]:

- Positive attitudes toward drugs and drug use (i.e., “pharmacologic optimism”)
- Relaxed physician prescribing practices in the facility
- Lack of pharmaceutical controls in a facility
- Little or no education regarding substance use disorders
- Enabling by peers and managers
- Role strain
The prevalence of substance abuse varies by nurse specialty. Critical care, psychiatric, emergency room, and oncology nurses have been found to have the highest rates of substance abuse, but alcohol abuse (five or more drinks per occasion) in particular is a significant problem among oncology nurses [9; 19]. Another study found that binge drinking was more common among all nurses than in the general population 35 years of age or older [10].

Gender is another factor for substance abuse in nursing professions. Male nurses are more likely to abuse substances and are over-represented in treatment programs [9]. However, the majority of RNs (90.9%) and LPNs (92.4%) in the United States are women; therefore, the vast majority of nurses with substance use disorders are women [9; 12]. Studies have shown that men's addiction runs a more acute course, with less pronounced physical and mental effects; men also tend to seek help sooner for the actual addiction. In contrast, women's addiction tends to be prolonged, with a greater mental and physical toll. Women typically seek help for the manifestations of addiction, such as depression, anxiety, and insomnia, which can delay treatment for the root cause [9].

**IDENTIFYING IMPAIRMENT IN THE WORKPLACE**

It is important that nurses have the ability to recognize signs and symptoms of impaired practice and be able to differentiate a pattern of impairment from isolated incidents that may be caused by job stress. Studies have shown that most nurses are not able to accurately identify impairment in the workplace because they have little education on signs and symptoms of impairment in a professional setting and among other professionals [3; 17; 18]. This is compounded by the fact that some individuals, particularly experienced healthcare providers, may be able to function at a high level while under chemical influence. Failure to identify impairment or a belief that reporting is unnecessary because an individual is able to function normally despite alcohol/drug abuse may result in a failure to document and report suspected impairment, inadvertently enabling the substance abuse [3]. On the other hand, nurses who have the knowledge and confidence to identify impairment are empowered to confront colleagues and report their peers according to employer protocol.

**DEFINITION OF IMPAIRMENT**

According to the IPN, “impairment is a condition that results from the use of mind/mood-altering substances, distorted thought processes found in the psychologically impaired, or a physical condition that prevents the nurse from providing safe patient care. Impairment is characterized by the inability to carry out the professional duties and responsibilities in a reasonable manner consistent with nursing standards” [21]. It should be remembered that impaired practice is not strictly related to substance abuse disorders. Common mental health disorders, such as depression and anxiety, have the potential to interfere with nurses’ ability to provide adequate patient care [24]. In a meta-analysis of research related to the impact of mental disorders on the work performance of nurses and other healthcare professionals, strong evidence was found to support a relationship between mental disorders and general errors, medication errors, near errors, impaired patient safety, and decreased patient satisfaction [26]. This is a particular concern given the fact that nurses are at greater risk for certain mental health issues (e.g., depression) than the general public [24].

Physical disability may also impede nurses’ performance, and steps should be taken to create disability inclusive workplaces [27]. Some nurses may be hesitant to disclose disabilities or known limitations for fear of losing their jobs [28]. Physical limitations are not grounds for dismissal, and failure to disclose poses a greater safety risk than working with healthcare professionals with known disabilities.

**SIGNS OF IMPAIRMENT**

Signs of impairment related to substance abuse among healthcare professionals fall into three general categories: job performance issues, emotional and mental status, and workplace drug diversion [7]. Impairment specifically related to substance abuse may present differently in nurses than in the general public. Signs of impairment related to job performance include [7; 8; 22]:

- An excessive number of mistakes at work (e.g., frequent medication errors, errors of judgment in patient care)
- "Job shrinkage" (i.e., the nurse progressively performs the minimal amount of work necessary)
- Increased difficulty meeting deadlines or adhering to schedules
- Frequent or unexplained disappearances
- Implausible and/or elaborate excuses for unusual behavior
- Dishonesty over trivial matters
- Illegible or sloppy charting
- Tremors or shaking
- Extended breaks or lunch hours
- Excessive absence due to alleged illness, particularly following scheduled days off
- Last-minute requests for time off
- Absence without notice
- Smell of alcohol or cannabis
- Excessive use of breath mints, chewing gum, mouthwash, or perfume
Signs of changes in emotional and mental status include [7; 8; 22]:

- Inappropriate or uncharacteristic responses to criticism (e.g., crying, uncontrolled anger, snapping at or arguing with colleagues)
- Emotional lability (e.g., becoming uncommonly gregarious or quiet, withdrawn, or irritable; has recurrent mood swings and is unpredictable)
- Reduced alertness (e.g., forgetfulness, preoccupation, appearing dazed and confused, slow reaction time)
- Increasing isolation from coworkers (e.g., avoiding informal staff gatherings, eating or taking breaks alone, requesting transfer to another shift)
- Increased and uncharacteristic problem with authority
- Change in dress and/or appearance

Signs that a healthcare professional is diverting drugs for personal use include [7; 8; 22]:

- Volunteering to work with patients who receive regular or large amounts of pain medication
- Consistently volunteering to be the medication administrator
- Often signing out more controlled drugs than coworkers
- Failing to obtain co-signatures
- Frequently reporting medication spills or other waste
- Reports reflecting excessive use of pain medications on patients
- Discrepancies in end-of-shift medication counts
- Evidence of tampering with vials, other drug containers, or medication counts
- Waiting until alone to open the narcotics box or cabinet, or disappearing after opening it
- An increase in patients’ complaints of unrelieved pain
- Defensiveness when questioned about medication errors
- Consistently coming to work early and staying late

Nurse supervisors and managers should maintain an active role in identifying impairment in the workplace by refusing to allow personal manipulation by another nurse or to fear confronting a nurse if patient safety is in jeopardy. It is important to reduce or change a nurse’s role or patient assignment and not accept excuses for or ignore poor performance [16]. Several tools have been developed to assess nurses’ job performance and fitness for work [24; 25]. These measures may be completed by supervisors or individual nurses (i.e., self-report). One such tool is the Common Risky Behaviors Checklist, which assesses five dimensions: absence/tardiness, cognitive impairment, unprofessional communication/boundaries, physical impairment, and drug diversion. A copy of the checklist is available online at https://www.ncsbn.org/ChrisONeil_Checklist.pdf.

**REPORTING COLLEAGUES AND MANDATORY REPORTING LAW**

Florida law requires that a Board-licensed nurse make a good faith report of another individual’s known workplace impairment, whether the situation is acute or there is growing suspicion. But, reporting a colleague is a decision with which many nurses struggle [3]. Experienced, older nurses are more likely to report impairment because they have likely witnessed the negative effects in coworkers at some point; younger and less experienced nurses are less likely to report. Many professionals choose to ignore the problem because they think someone else will or is already handling the situation [1; 3]. One study identified several factors that contribute to failure to report by coworkers, including feeling like a “tattle-tale,” fear of revenge or retaliation, fear the colleague might react in a violent manner, not wanting to be responsible for jeopardizing a colleague’s job, not being confident enough in one’s own observations or instincts to confront a colleague, not being an expert in chemical dependence, and believing the intervention would be better dealt with by an expert [3]. Although these concerns may be valid, nursing is a profession that holds patient safety and healing as the highest duty—and not one of these concerns seems related to protecting patients. Furthermore, few of the reasons for non-reporting show any regard for helping a coworker to heal. Nursing is about action, and there is no excuse for failing to act.

**FLORIDA LAW**

Reporting known impairment in Florida is mandatory, not optional. Failure to report an impaired individual who is providing health care can lead to disciplinary action by the Board of Nursing. The Florida Statutes Chapter 464.018 Disciplinary Actions defines nursing impairment and describes the conditions and actions an impaired nurse will face. The section states that the following constitutes grounds for disciplinary action or denial of a license [14]:

Being unable to practice nursing with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, or chemicals or any other type of material or as a result of any mental or physical condition. In enforcing this paragraph, the department shall have, upon a finding of the State Surgeon General or the State Surgeon General’s designee that probable cause exists to believe that the licensee is unable to
practice nursing because of the reasons stated in this paragraph, the authority to issue an order to compel a licensee to submit to a mental or physical examination by physicians designated by the department. If the nurse refuses to comply with such order, the department's order directing such examination may be enforced by filing a petition for enforcement in the circuit court where the nurse resides or does business. The nurse against whom the petition is filed shall not be named or identified by initials in any public court records or documents, and the proceedings shall be closed to the public…A nurse affected by this paragraph shall at reasonable intervals be afforded an opportunity to demonstrate that she or he can resume the competent practice of nursing with reasonable skill and safety to patients.

The Florida Statutes Chapter 464.018 Disciplinary Actions also contains the mandatory reporting law. The following act constitutes grounds for denial of a license or disciplinary action [14]:

Failing to report to the department any person who the nurse knows is in violation of this part or of the rules of the department or the board. However, a person who the licensee knows is unable to practice nursing with reasonable skill and safety to patients by reason of illness or use of alcohol, drugs, narcotics, chemicals, or any other type of material, or as a result of a mental or physical condition, may be reported to a consultant operating an impaired practitioner program…rather than to the department.

HOW TO REPORT AN IMPAIRED NURSE

Nurses should be familiar with their organization's policies and procedures for reporting employee substance abuse or other impairment and those regarding assistance programs [16]. When aware of the resources available to an impaired nurse, including the process, programs, and benefits of employee assistance programs or alternative-to-discipline programs, nurses are better prepared and more likely to report impairment. In 1983, the Florida legislature established the IPN as a contact point for nursing impairment reporting, as a treatment and rehabilitation facilitator, and as a monitoring program for impaired nurses within the state [20]. Florida nurses are required to report suspected impaired practice to the IPN and/or the Florida Department of Health [21]. Reporting to either of these entities fulfills the mandatory reporting obligation. With the knowledge that recovery, nonpunitive rehabilitation, and returning to work are the goals of such programs, nurses should feel confident that their colleagues will receive the help they need to overcome their impairment [3]. In the long-term, the report will be beneficial to the impaired nurse, and in the short-term, patients are being protected from harm.

Before making a report, documenting changes in the suspected nurses' behavior and work performance is recommended [16]. The signs and symptoms listed in the previous section of this course are a good starting point. Taking note of specific actions or behaviors will help when making the report and/or confronting a colleague or supervisee.

In the past, professional organizations recommended confronting the impaired individual directly, but this strategy was found to be unrealistic and is no longer endorsed [2; 3; 16; 22]. The ANA Code of Ethics no longer recommends confronting colleagues as the initial course of action before notifying a supervisor [3]. The 2015 ANA Code of Ethics states that “the nurse’s duty is to take action to protect patients and to ensure that the impaired individual receives assistance. This process begins with consulting supervisory personnel, followed by approaching the individual in a clear and supportive manner and by helping the individual access appropriate resources” [2]. The Code further states that “nurses must follow policies of the employing organization, guidelines outlined by the profession, and relevant laws to assist colleagues whose job performance may be adversely affected by mental or physical illness, fatigue, substance abuse, or personal circumstances” [2]. The Florida Nurse Practice Act clearly states that the IPN or the Department of Health must be notified, but does not specify how an intervention must proceed [21].

Some sources suggest that the best outcomes are achieved when a professional interventionist or personnel trained in intervention confronts the individual [22]. Many facilities have employee assistance or human resources personnel who are trained to intervene. The IPN offers intervention training [23].

The ANA Code of Ethics also provides the following additional advice regarding intervening in cases of suspected workplace impairment [2]:

- The nurse should extend compassion and caring to colleagues throughout the processes of identification, remediation, and recovery.
- Care must also be taken in identifying impairment in one's own practice and in seeking immediate assistance.
- In instances of impaired practice, nurses within all professional relationships should advocate for appropriate assistance, treatment, and access to fair institutional and legal processes. Advocacy includes supporting the return to practice of individuals who have sought assistance and, after recovery, are ready to resume professional duties.
• If impaired practice poses a threat or danger to patients, self, or others, regardless of whether the individual has sought help, a nurse must report the practice to persons authorized to address the problem.

• Nurses who report those whose job performance creates risk should be protected from retaliation or other negative consequences.

• If workplace policies for the protection of impaired nurses do not exist or are inappropriate—that is, they deny the nurse who is reported access to due legal process or they demand resignation—nurses may obtain guidance from professional associations, state peer assistance programs, employee assistance programs, or similar resources.

TREATMENT PROGRAMS

When a nurse is reported to either the IPN or the Department of Health, the referral triggers a consultation with the reporter and/or the employer of the impaired nurse [1]. This is followed by an intervention and evaluation. The intervention typically occurs one to three days after a report (whereas a standard disciplinary process typically takes 9 to 12 months to remove a nurse from practice) [1]. If a nurse self-reports to the IPN, the intake and evaluation process begins immediately. In Florida, the IPN is charged with accepting reports, evaluating referrals, determining the proper course of action, monitoring the nurse's progress in treatment, and case managing all individuals returning to work [23]. The IPN program objectives are to [23]:

• Ensure public health and safety through a program that provides close monitoring of nurses who are unsafe to practice due to the use of drugs, including alcohol, and/or psychiatric, psychologic, or physical condition

• Require the nurse to withdraw from practice immediately, and until such time that the IPN is assured that he/she is able to safely return to the practice of nursing

• Facilitate early intervention, thereby decreasing the time between the nurse's acknowledgment of the problem and his/her entry into a recovery program

• Provide a program for affected nurses to be rehabilitated in a therapeutic, non-punitive, and confidential process

• Provide an opportunity for retention of nurses within the nursing profession

• Provide a cost-effective alternative to the traditional disciplinary process

• Develop a statewide resource network for referring nurses to appropriate services

• Provide confidential consultations for nurse managers

Although the IPN assesses referrals to the program to decide the best course of action for the individual, the program does not actually provide treatment for addiction or other diseases/disorders. Rather, the IPN directs individuals to approved treatment programs and providers [1]. Additional services provided by the IPN include advocacy for participants; tracking meeting attendance and discussing recovery progress with group facilitators; comprehensive monitoring of nurses following discharge from treatment; providing random drug screening of participants and detecting relapse; and reporting compliance issues to the proper authority [1; 23]. If at any time during the process the nurse refuses to participate in the program or fails to comply with program guidelines, including after returning to work, she or he is referred to the Department of Health for discipline, which entails investigation, hearings, and disciplinary action.

RETURNING TO WORK

Following completion of approved treatment, the IPN determines if nurses in the program are ready to return to practice based on several criteria, including the individual's stability in recovery, cognitive functioning, decision-making/problem-solving ability, use of good judgment, ability to deal with stressful situations, and development of a support system [1]. A signed advocacy contract and completed relapse prevention workbook must also be submitted. Stability in recovery is crucial and is indicated by advocacy contract compliance, consistently negative random urine drug screens, regular attendance at support and monitoring groups, and favorable monitoring reports [1]. Progress reports are generated by treatment providers, nurse support group facilitators, and by the nurses in recovery (i.e., self-reports).

The support system for nurses returning to work includes a weekly support group for ongoing self-care and relapse prevention. A coworker is also established as a workplace monitor to provide feedback to the IPN on the nurse's job performance [1]. If a nurse was referred to the IPN due to pharmaceutical use or diversion, it is recommended that the nurse be assigned a labor exchange colleague assigned to handle patient medication duties. Other restrictions for these individuals may include no overtime or floating; no multiple employers; and no agency, hospice, or home care employment [1].

The Florida Board of Nursing allows nurses two opportunities to return to work after referral for diversion of drugs or narcotics [14]. A nurse will not have their license reinstated after a third violation of drug diversion for sale or personal use.
PROMOTING SAFETY IN THE WORKPLACE AND PROVIDING ASSISTANCE

Employers should have clear policies and procedures for fostering and maintaining a drug- and alcohol-free workplace and ensuring that nurses are fit to practice. When system deficiencies are found to exist, these should be remedied. Employees benefit from a sense that policies are enforced equally and without exception; otherwise, uncertainty will exist as to whether poor behavior is overlooked or ignored if an employee is well liked or has perceived seniority. The National Council of State Boards of Nursing (NCSBN) recommends several employer policies to promote safety, including drug testing before employment, testing when there is suspicion of drug use, and conducting regular fitness-to-practice evaluations [9].

All employees should be familiar with and abide by their facility’s policies, guidelines, and procedures. The NCSBN recommends that nurses be familiar with procedures (internal and external) related to how to document concerns, how and when to report impairment, return to practice after treatment, and relapse management [9]. Nurses should also be provided with information about employee assistance programs (if applicable), including a clear understanding of the confidentiality of such programs.
1. The rate of alcohol and drug dependency among nurses and physicians is estimated to be slightly higher than or equal to the rate found in the general public (10% to 15%).
   A) True
   B) False

2. Use of street-type drugs (e.g., cocaine, cannabis) is higher in nurses than in the general population.
   A) True
   B) False

3. A positive attitude toward drugs and drug use (i.e., “pharmacologic optimism”) is a unique risk factor for substance use in nurses.
   A) True
   B) False

4. Male nurses are more likely than female nurses to abuse substances and are over-represented in treatment programs.
   A) True
   B) False

5. Impaired nursing practice is defined as isolated incidents that may be caused by job stress.
   A) True
   B) False

6. Frequently reporting medication spills or other waste may be a sign that a healthcare professional is diverting drugs for personal use.
   A) True
   B) False

7. Experienced, older nurses are more likely to report impairment because they have likely witnessed the negative effects in coworkers at some point.
   A) True
   B) False

8. Reporting suspected impaired practice to Florida’s Intervention Project for Nurses does not fulfill the mandatory reporting obligation.
   A) True
   B) False

9. The American Nurses Association Code of Ethics recommends confronting potentially impaired colleagues as the initial course of action, before notifying a supervisor.
   A) True
   B) False

10. When a nurse is reported for suspected impairment at work, intervention typically occurs within one to three days.
    A) True
    B) False
Recognizing and Reporting Human Trafficking in Florida

This course fulfills the Florida requirement for 2 hours of education on Human Trafficking.

Audience
This course is designed for all health and mental health professionals in Florida who may identify and intervene in cases of human trafficking and exploitation.

Course Objective
The purpose of this course is to provide physicians, nurses, and other healthcare professionals an in-depth, practical review of human trafficking, including the definition and scope of the problem, the means of identification and assessment of individuals who may be victims, guidance on reporting of cases, and interventions and resources available to victims.

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

1. Define human trafficking.
2. Identify the forms of human trafficking.
3. Identify economic, political, social, and cultural factors that contribute to human trafficking.
4. Analyze the trafficking experience, including how traffickers recruit and the financial implications of trafficking.
5. Explain the psychologic, health, and social consequences of human trafficking.
6. Utilize interviewing strategies to assess and identify victims and promote the ethical treatment of trafficking victims.
7. Describe the appropriate steps for reporting suspected cases of trafficking.
8. Describe various interventions and resources for human trafficking victims.

Faculty
Alice Yick Flanagan, PhD, MSW, received her Master’s in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families. (A complete biography appears at the end of this course.)

Faculty Disclosure
Contributing faculty, Alice Yick Flanagan, PhD, MSW, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Division Planner
Jane C. Norman, RN, MSN, CNE, PhD

Division Planner Disclosure
The division planner has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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Special Approvals
This course meets the Florida requirement for Human Trafficking education.

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SCOPE OF HUMAN TRAFFICKING
As the issue of human trafficking is so complex, it is difficult to determine the scope of the problem. Many scholars and researchers believe that published estimates are just educated guesses. On a global level, the International Labour Organization has estimated that there are 40.3 million human trafficking victims [6]. The estimates for the United States are not totally clear, but there were approximately 78,000 human trafficking victims reported to the U.S. State Department in 2016; only an estimated 0.2% are rescued [7]. According to Polaris, which founded and runs the National Human Trafficking Hotline, there have been a total of 40,200 cases of human trafficking reported since 2007 [7].

INTRODUCTION
Although human trafficking has always existed, it has begun to receive increased attention as a result of awareness and outreach efforts. All social problems compete for attention, and various groups will make compelling claims about social problems using persuasive rhetoric and dramatic statistics [1]. More than just a human rights issue, it has garnered attention from feminists, religious conservatives, labor activists, immigration specialists, and the mental health professions [2]. Furthermore, attention will be drawn from the media, politicians, organizations, and public, all of whom will respond to the gravity of the condition. It is through this process of claims-making and counter claims-making that “conditions” that may not necessarily have initially attracted attention can develop into a recognized social problem [1]. How the problem is described or constructed will influence public opinion, which will then ultimately facilitate action from governmental agencies, social service organizations, and international agencies [3; 4; 5].

This course will provide a basic overview of human trafficking (e.g., the scope, definitions and frameworks, contributing factors, different forms). The course will attempt to provide practitioners a glimpse of the lives of human trafficking victims, including physical, psychologic, social, and sexual abuse that human trafficking victims experience and the types of control tactics perpetrators use. Specific interventions and responses will be covered, including mental health, social services, educational, prevention, and legal efforts. Finally, for practitioners who do work with human trafficking victims, the emotional toll that it takes upon practitioners as well as the importance of self-care will be discussed. The course will end by offering an array of resources. Practitioners will be encouraged to view films and documentaries about human trafficking, as this is one way to “enter the lives” of human trafficking victims and better understand the dynamics of the complex world of human trafficking.
Weitzer's content analysis of websites and publications about human trafficking found that human trafficking is portrayed as an epidemic, growing at alarming rates, with some government reports estimating 40,000 to 50,000 individuals trafficked in the United States each year [8]. Weitzer argues that many of the reports have overestimated the scope of the problem and points out that the estimates fluctuate drastically year to year [9]. Sex trafficking tends to be portrayed more frequently due to its sensationalism. In a study of 50 human trafficking campaigns in Spain between 2004 and 2017, 40 (80%) depicted sex trafficking and exploitation involving women [10]. The U.S. Department of Justice reported 1,045 convictions for human trafficking-related crimes in 2017, including forced labor and sex trafficking of adults and minors. This was an increase of more than 78% over the number reported in 2015 [6]. In 2016, the International Labour Organization stated that there were 4.8 million victims of sex trafficking, and 15.4 million in forced marriages. The majority (62%) of those trafficked are in Asia and Pacific regions [11]. In 2017, it is estimated that there are 24.9 million people around the world who are in forced labor [11].

Florida ranks third in the United States in terms of destinations for trafficked persons [12]. In 2018, the National Human Trafficking Hotline received 1,885 contacts e.g., phone calls, texts, e-mails) and 767 human trafficking cases reported in Florida. The most common type was sex trafficking (68%), followed by labor trafficking (16.5%) and combined sex/labor trafficking (7.5%) [12]. The majority of victims were female (69%) and adult (55.8%).

DEFINITIONS OF HUMAN TRAFFICKING

The United Nations defines human trafficking as [13]:

The recruitment, transportation, transfer, harbouring or receipt of persons, by means of threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability, or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude, or the removal of organs.

In essence, this definition involves three elements: the transport of the person, the force or coercion of the victim, and the abuse and exploitation [14]. The United Nations Office on Drugs and Crime divides the definition of human trafficking into three sections: the act, means, and purpose [15]. The act, or what is done, generally refers to activities such as recruitment, transportation, transfer, harboring, or receipt of persons. The means of trafficking consists of threats or use of force, abduction, fraud, deception, abuse of power or vulnerability, or giving payments or benefits to a person in control of the victim. Finally, these acts are carried out for the purpose of exploitation, which includes prostitution, sexual exploitation, forced labor, slavery or forced servitude, and the removal of organs [15]. It is important to remember that human trafficking is not human smuggling. Human smuggling involves an individual being brought into a country through illegal means and is voluntary. The individual has provided some remuneration to another individual or party to accomplish this goal [16].

Watch the 12-minute video clip The Top 10 Facts About the “S” Word at https://www.youtube.com/watch?v=TJID8KzMrE.

This video provides a snapshot of modern slavery, including the economics of slavery and the various types of slavery worldwide.

The Trafficking Victims Protection Act (TVPA) defines human trafficking to include both sex trafficking and labor trafficking [17]. Sex trafficking is the recruitment, harboring, transportation, provision, obtaining, patronizing, or soliciting of a person for the purposes of a commercial sex act, in which the commercial sex act is induced by force, fraud, or coercion, or in which the person induced to perform such an act has not attained 18 years of age. Labor trafficking is the recruitment, harboring, transportation, provision, or obtaining of a person for labor or services, through the use of force, fraud, or coercion for the purposes of subjection to involuntary servitude, peonage, debt bondage, or slavery. A victim need not be physically transported from one location to another for the crime to fall within this definition.

In many cases, women and children are considered the typical victims of human trafficking. Hart posits that women are more vulnerable to trafficking due to the lack of social safety nets in many developing countries [18]. Coupled with women’s subordinate social statuses in many cultures, this leads to the “feminization of poverty.” Although the social conditions may make women and children more vulnerable to human trafficking, the reality is that men are also victims of human trafficking.
Overall, the definition of human trafficking is ambiguous because of the many intersections with other issues (e.g., sexual abuse, domestic violence, forced marriage, forced labor) [19]. It occurs both domestically and internationally, but is primarily a hidden problem. This makes research efforts, the prosecution of perpetrators, and policy and community efforts to protect victims even more challenging [19].

**FORMS OF TRAFFICKING**

**SEX TRAFFICKING**
The TVPA of 2000 is a U.S. federal statute passed by Congress to address the issue of human trafficking and offers protection for human trafficking victims [17]. This statute defines sex trafficking as, “the recruitment, harboring, transportation, provision, or obtaining of a person for the purpose of a commercial sex act” [17]. A commercial sex act is, “any sex act on account of which anything of value is given to or received by any person” [17]. In other words, it usually involves the illegal transport of humans into another country to be exploited in a sexual manner for financial gains [20]. However, it does not always involve the transport of victims from one region to another; such cases are referred to as “internal trafficking” [21]. Victims of sex trafficking could be forced into prostitution, stripping, pornography, escort services, and other sexual services [22]. Victims may be adult women or men or children, although there is a higher prevalence of women and girls. The term “domestic minor sex trafficking” has become a popular term used to connote the buying, selling, and/or trading of children younger than 18 years of age for sexual services within the country, not internationally [22; 23]. An element of force, fraud, or coercion is not necessary, as the victims are children and inherently vulnerable [23]. In the United States, the children most vulnerable to domestic minor sex trafficking are those who are homeless, abused, runaways, and/or in child protective services [22].

Although highly controversial, it is said that sex trafficking victims differ from prostitutes in that sex trafficking victims are forced to involuntarily perform sexual services and are often not paid for their “work.” Sex trafficking involves the use of force and coercion and can encompass other forms of criminal sexual activities, including forced erotic dancing, “mail-order brides,” and pornography [21]. On the other hand, individuals involved in prostitution make a decision to provide sex services for a fee. The decision to enter prostitution does not eliminate the possibility of being a victim of trafficking if one is held against his/her will through physical and/or psychologic abuse [24]. It is also important to remember that this does not necessarily mean prostitution is a choice these individuals would have made if other options were available or that they have a choice in selecting their sexual partners and/or sexual activities [25].

**BONDED LABOR/FORCED LABOR**
The United Nations has defined debt bondage as [26]:

> The status or condition arising from a pledge by a debtor of his personal services or of those of a person under his control as security for a debt, if the value of those services as reasonably assessed is not applied towards the liquidation of the debt or the length and nature of those services are not respectively limited and defined.

Essentially, because the individual does not have money as collateral for the debt owed, the individual pledges his/her labor or, in some cases, the labor of a child or another individual for an unspecified amount of time [27]. These individuals may be transported or trafficked into another country for the purpose of forced labor.

In many cases of bonded labor, the initial loan may be welcomed by the individual. However, the victims do not realize that with the low wages, unspoken high interest rates and other continually accruing fees, and the perpetrator’s manipulation of the “accounts,” laborers can never repay the loans. Some estimate that half of all persons in forced labor are bonded laborers. The majority of bonded labor cases occur in India, Bangladesh, and Pakistan [28]. Some families find themselves in a cycle of poverty as the debt cannot be paid off and is passed down from generation to generation [27]. Bonded labor can involve laborers in brick kilns, mines, stone quarries, looming factories, agricultural farms, and other manufacturing factories [27]. In the United States, individuals may be trafficked to work long hours in garment factories, restaurants, and other manufacturing sectors. Frequently, the employer/captor will take away victims’ identifications, monitor their movements, socially isolate them, and/or threaten deportation if they do not comply [29]. Migrant workers are at high risk of forced labor [24].

In the United States, forced labor is predominantly found in five sectors [29]:

- Prostitution and sex industry (46%)
- Domestic servitude (27%)
- Agriculture (10%)
- Sweatshops and factories (5%)
- Restaurant and hotel work (4%)

Visit the PBS Frontline website (https://www.pbs.org/wgbh/pages/frontline/slaves/map) and read the transcripts of interviews with a sex trafficker and five Eastern European female victims who were deceived into sexual slavery.

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**Note:**

The information provided is for educational purposes only and should not be considered complete or exhaustive. It is intended to raise awareness about human trafficking and related issues. For more detailed information, please consult relevant legal and professional resources.
It is speculated that most of the forced labor occurs in California, Florida, New York, and Texas, all major routes for international travel [29].

Domestic servitude refers to a category of domestic workers (usually female) who work as servants, housekeepers, maids, and/or caregivers, often in private homes. In some cases, young women are lured with the promise of a good education and work, and when they arrive in the United States, they are exploited economically, physically, and/or sexually. Their passports or identification papers are taken away, and they are told they have to pay off the debt incurred for their travel, processing fees, and any other bogus expenses. Because they do not speak English, they find they have no other recourse but to endure exploitive working conditions [30]. Unfortunately, as in many sectors of forced labor, there are no regulations to monitor the conditions under which domestic servants operate [29].


CHILD LABOR

Child labor can be viewed as a specific form of bonded labor or forced labor. However, not all child laborers have been trafficked. Child labor is defined by International Labour Organization (ILO) as economic labor performed by a child younger than 15 years of age or hazardous labor done by a child 18 years of age or younger. Child labor is deeply rooted in poverty and the infrastructure and political stability of the country as well as market forces [31]. The ILO estimates that there are 152 million child laborers in the world [32]. Between 2000 and 2016 there was a nearly 38% decrease in the number of children in child labor. The reduction was greater for girls (43%) than for boys (34%). The largest numbers of child laborers are found in Asia and the Pacific region; however, there is evidence that the number of child laborers in Africa is increasing [32].

The definition of child labor is controversial because the definitions for "work" and "childhood" are ambiguous and often culturally defined [33]. On a conceptual level, work may be beneficial for the socialization and educational processes of children [33; 34]. So, it is important to differentiate between child work and child labor. Child work has been defined as activities that are supervised by an adult and that promote the development and growth of the child, while child labor does not benefit the child [31]. Many definitions of child labor create a dichotomy whereby child work is considered not harmful while child labor has negative emotional, intellectual, and social consequences [35]. Work that is exploitive for children has been defined as working long hours at a young age, work that is poorly compensated, and work that produces physical, social, and psychologic stress that will hamper development, access to education, and self-esteem [36]. The ILO adds that child labor is work that interferes, deprives, and interrupts schooling and places children in the position of trying to balance school and long work hours [34].

It is important to remember that child labor occurs in the United States. Runaway and homeless youths are at greatest risk, often lured by promises of work and housing [37]. The Polaris Project found that the top three forms of child labor trafficking in the United States were begging, peddling, and traveling sales crews [37].

CHILD CONSCRIPTION

In some cases of trafficking, children are kidnapped and trafficked to serve as soldiers. Other times, children are coerced by a narrative indicating they will be serving a higher purpose and avenge the deaths of family and friends; this is known as comradeship [38]. Some children are actively recruited and may be promised a small salary to “voluntarily” join. In a study of 132 cases of child conscription in Colombia, 18% of the children were motivated by perceived economic rewards [39]. Many children lack educational opportunities or hope for a better future, perceiving soldiering as the only option [38]. Conscripted girls often cite educational opportunities as a motive [38]. In Nepal, former female soldiers also indicated they were driven to volunteer in the armed groups by a fear that if they stayed with their families they would be married away as children or raped [38].

It is estimated that at any one time 250,000 to 300,000 children younger than 18 years of age are currently serving as child soldiers [40; 41]. Traffickers prefer to recruit children to serve as soldiers because they are inexpensive and more easily molded and shaped to comply and obey without question [42]. They are also more likely to kill fearlessly and recklessly. Child soldiers are treated as adults, without any regard to how the physical and psychologic rigors of war will affect them psychologically and developmentally. In Uganda, where children are kidnapped or recruited as child soldiers relatively often, the Lord’s Resistance Army has been known to initiate new child soldiers in brutal ritualized killings of others so as to terrorize them into submission and annihilate any moral conscience they may have about killing [42]. In Afghanistan, children have been recruited by the Taliban and have served as suicide bombers [28].
It can be difficult to comprehend the atrocities that these children witness and experience. Bayer, Klasen, and Adam conducted a study involving 169 former Ugandan and Congolese child soldiers who were an average of 15.3 years of age [43]. Almost all (92.9%) reported having witnessed a shooting, 89% witnessed someone wounded, and 84% witnessed someone seriously beaten. A total of 54.4% reported having killed someone, and 27.8% reported that they were forced to engage in sexual activity [43]. In another study, the researchers found that the experience of conscription among children produced significant emotional and psychologic traumas and a host of cognitive and behavioral problems [24]. In this study of 19 child soldiers, 18 had volunteered to join the army and one had been abducted. Although most of the children volunteered into the army, their participation became involuntary. Some tried to run away or disobey, which resulted in beatings and imprisonment. If captured, they were told to commit suicide [24]. The reintegration of child soldiers is not easy. Many are stigmatized when they return to their home villages, as their families and friends fear that these former child soldiers may be violent [41; 44].


FACTORs THAT CONTRIBUTE TO HUMAN TRAFFICKING

GLOBALIZATION

Human trafficking has been called one of the “darkest sides of globalization” [45]. Globalization is the term used to describe the interconnectedness of countries and nations, which facilitates easy communication, exchange of ideas, and flow of goods, capital, and services [45]. Crimes such as human trafficking are affected by globalization just as legitimate businesses are [46]. Furthermore, the ideals of Western capitalism may reinforce human trafficking as a business or industry, with its emphasis on the free market and the flow of goods and services across international borders [46].

Globalization has also created the need for cheaper labor [28; 47]. A study involving 160 countries examined the effects of globalization and human trafficking trends [48]. Researchers found a positive relationship between globalization and trafficking for forced labor, prostitution, and debt bondage.

POVERTY

Poverty and incessant economic stressors caused by civil wars, natural disasters, and collapses of government systems all contribute to human trafficking [18; 23; 49]. Families entrenched in deep poverty may feel they have no other recourse but to sell a child or may be more easily lured with promises of money and a better future [49; 50; 51]. In one study, the odds of being trafficked were nine times greater for those who felt extremely hopeless about upward mobility compared with those with lower levels of hopelessness [49].

SOCIAL AND FAMILIAL DISORGANIZATION

Community factors (such as high social disorganization characterized by violence, unemployment, and high crime) contribute to higher risk of trafficking [23]. In addition, families marked by instability (e.g., domestic violence, child abuse, continual unemployment) are also at higher risk of having a member trafficked [23].

CORRUPTION

Human trafficking cannot occur without the existence of corruption within existing infrastructures. Public officials, police officers, and local leaders in many developing countries have been known to take bribes to provide protection to parties involved in various aspects of human trafficking [45; 48; 52].

DIGITAL TECHNOLOGY

The rampant use of digital technology, such as the Internet, greatly facilitates sex trafficking. The relative anonymity of online contact can empower traffickers to recruit or sell victims. Graphic images of women and children engaged in sexual acts can be easily disseminated over the Internet [53]. Traffickers may employ the Internet for advertising, marketing to those interested in making pornography [53]. In addition, social media sites such as Facebook, Craigslist, and Instagram have been used as a means of facilitating trafficking (e.g., by connecting and grooming potential victims) [54; 55; 56]. Newsgroups offer opportunities for those interested in locating women and children for sexual exploitation.

In a qualitative study, smartphones were found to be integral in the business of trafficking [54]. Researchers indicated the phones were used “to maintain contact with each other, in order to facilitate the business ‘transactions’ and stay in touch with transnational ‘partners’ and other traffickers who remained in the country of origin” [54; 55].

RACIALIZED SEXUAL STEREOTYPES

Race and ethnicity have been inextricably linked to sexual violence and victimization. Myths regarding sexuality in certain cultures or racial fetishization may affect trafficking patterns. For example, there is an over-representation of Asian women on American Internet pornography sites in part due to popular myths sexualizing, eroticizing, and exoticizing Asian women. This has translated into trafficking, as
traffickers respond to the demand for young Asian women and girls in part fueled by these stereotypes of exotic, docile, submissive, and eager-to-please Asian women [30]. These stereotypes devalue and dehumanize people, which is the underlying core of human trafficking. This contributes to the acceptability of the exploitation of individuals, particularly members of marginalized groups [57].

These racial stereotypes go beyond simply framing the victims in a particular manner [58]. They raise implicit questions regarding how the powers of state are depicted. In other words, the patriarchal attitudes of certain countries lead to “bad” or “backward” cultural practices or ways of being that then cause trafficking—setting up is a dichotomy of the “West” and “others” [58].

CULTURE

Although many are careful in linking cultural factors to the etiology of human trafficking for fear of imposing judgment on a particular culture, many maintain that cultural ideologies that tolerate sexual trafficking, bonded labor, and child labor may be a stronger factor than poverty in predicting trafficking rates [30; 36]. For example, some cultures emphasize collectivism and prioritizing the needs of the family and group first before the needs of the individual. Some children may feel they have to sacrifice themselves for their family when traffickers promise money [30]. Traffickers also know that they can threaten to hurt victims’ families to keep them from escaping [30].

Furthermore, in many cultures, boys are more highly valued than girls, and as a result, girls are considered more dispensable [30]. Sons are considered the family's social security, staying with the family while daughters marry into other families. Therefore, girls may be more likely to be sold into slavery than boys.

Child labor is also inextricably tied to cultural factors. In India, for example, child labor is common because it is believed that children in the lower levels of caste system (i.e., the “untouchables”) should be socialized early to understand their positions in society [36]. It has been observed that when traditional cultural and societal norms about women's roles were relaxed in some European countries and more women entered the labor force, child labor decreased [36]. Ultimately, it is difficult to unravel the effects of poverty and culture because the pressures of poverty can lead families to use tradition as a justification to sacrifice young men, women, and children [36].

Ultimately, the conversation about human trafficking is complex, and to attempt to isolate the causes is beyond challenging. Multiple factors have been suggested as possibly predicting human trafficking, including macroeconomic factors (e.g., gross domestic product per capita), unemployment rates, female inequality, cultural oppression, and lack of protection of women’s rights [59; 60]. In one study, ease of land access to the destination country appeared to be a powerful predictor in terms of the number of individuals trafficked [59].

THE TRAFFICKING EXPERIENCE

Five stages of the trafficking experience have been identified [61; 62; 63]:

- Pre-departure stage: The period before the victim becomes involved in the trafficking situation. This may include recruitment and preparing for travel.
- Travel and transit stage: The time after recruitment during which the victim “agrees” or is coerced into the trafficked situation. This phase also includes the journey whereby the trafficker(s) brings the victim(s) to their work destination. It is important to remember that this stage can be very dangerous and can involve numerous transit points.
- Destination stage: This is the period during which the victim arrives at the intended destination. This stage is marked by exploitation, abuse, victimization, and coercion. One way to control the victims is to continually inflate their debt so they have to constantly work to pay it off. Another is to confine and isolate victims.
- Detention, deportation, and criminal evidence stage: If a victim is arrested by the police or immigration authorities, victims are held in legal proceedings and they often fear deportation, and/or retaliation from the trafficker(s).
- Integration and re-integration stage: During this stage, government and nongovernment agencies provide services to victims that involve a long process of attempting to reintegrate the victim back into his/her community.

TRAFFICKERS: AN OVERVIEW

Much attention has been focusing on victims of trafficking; however, it is important to also understand the perpetrators.

Methods of Recruitment

It has been suggested human traffickers employ five general strategies to recruit and traffic victims [64; 65; 66; 67]:

- Kidnapping: Traffickers may kidnap their victims. They may lure them with food or treats or take them by force. Victims with few if any social ties are highly vulnerable, as no one will miss them or report their disappearance.
• Targeting poor families: Traffickers may convince families to sell their children (often daughters). Because many families in developing countries live in abject poverty, traffickers will stress to victims’ families how the money will help them to survive. Other traffickers may tell families that selling their daughter will provide her with more promising opportunities.

• Developing a false romantic relationship with victim: A tactic often used with young girls, perpetrators pose as boyfriends by romancing victims, buying gifts, and proclaiming their love. Victims have a difficult time believing that their boyfriends would hurt or deceive them, making them easy targets for trafficking.

• Fake storefronts: Some employment, modeling, or marriage agencies are fronts for illegal trafficking operations. A potential victim might be lured with the promise of employment, a lucrative modeling contract, or an arranged marriage in the United States. After victims have been lured in, traffickers come to assess their “product.” Perpetrators may be family members or friends.

• Legal storefronts: Some legal businesses in the tourism, entertainment, and leisure industries integrate trafficking activities into their business structure.

• Recruiting local prostitutes: Traffickers might purchase prostitutes working in local night clubs from brothel owners or simply lure prostitutes by promising them a more affluent future. Women working as prostitutes may later recruit younger victims.

The Financial Profits

Unfortunately, human trafficking can be a lucrative business. According to the ILO, profits from forced labor, trafficking, and modern slavery are estimated to be $150 billion annually [68]. The majority of this total is attributable to commercial sexual exploitation ($99 billion) followed by construction/manufacturing/mining ($34 billion), agriculture ($9 billion), and domestic work ($8 billion) [68].

The receiving country and location of trafficking will affect the profits. For example, if a girl is kidnapped from a village in Nepal and taken to India, she can be sold in India for $1,000 [64]. If she is then trafficked to the United States, she could be sold for $20,000.

Interestingly, the “cost” of a slave has not risen over time. According to Bales, the cost of obtaining a slave to work in the agriculture sector in 2007 was about $100; in 1850, this same slave would cost the equivalent of $40,000 in 2007 currency [69]. In one study, it was approximated that in the United States, a trafficker can make an average of about $300,000 per victim lifetime, which would total $32 billion annually [70]. Income in larger cities (e.g., Atlanta, San Diego, Washington, DC) may be even greater.

CONSEQUENCES OF HUMAN TRAFFICKING: IMPACT ON VICTIMS

The social realities of victims of human trafficking are difficult to comprehend, and some may wonder why victims remained silent and complied with their traffickers. The Silence Compliance Model was created to explore the factors that promote victims’ seeming willingness to comply to their traffickers’ demands [71]. This model has three categories: coercion, collusion, and contrition. Victims are coerced, brutalized, threatened, and threatened, and basic necessities of life are withheld from them. Methods of psychologic coercion include isolation, induced exhaustion, threats, degradation, and monopolizing perception [72]. This serves to silence victims and create a sense of helplessness. By isolating and controlling victims’ movements and limiting their exposure to the outside world, traffickers have complete monopoly of their attention and perception of reality [72]. Victims are then forced to collude with the traffickers as a result of their relative isolation, fear, false sense of belonging, and complete dependence on the trafficker. Finally, victims feel contrite, ashamed, stigmatized, and remorseful of the things they have been made to do [71].

PSYCHOLOGIC AND MENTAL HEALTH CONSEQUENCES

Victims of trafficking experience a host of psychologic, mental health, and emotional distress. Depression, suicidal ideation, substance use, and anxiety are typically cited mental health problems [23]. Post-traumatic stress disorder (PTSD) is also common given the trauma many victims experience, including physical and/or sexual violence and abuse; victims forced into prostitution experience continual, daily sexual assault [73]. In a study of 192 European women who were trafficked but who managed to escape, the overwhelming majority (95%) disclosed that they experienced physical and sexual violence during the time of their trafficked experience [74]. More than 90% reported sexual abuse, and 76% reported physical abuse.

Trafficked victims experience fear from the start of their capture through the transit phase and after they arrive at their destination. During the transit stage, many victims experience dangerous border crossings, risky types of transports, injury, beatings, and sexual assault [61]. Upon arrival to their destination, many trafficking victims have been socially isolated, held in confinement, and deprived of food [75]. All sense of security is stripped from them— their personal possessions, identity papers, passports, visas, and other documents [61; 75]. The continual fear for their personal safety and their families’ safety and the perpetual threats of deportation ultimately breed a sense of loss of control and learned helplessness. It is not surprising that depression, anxiety, and PTSD are common symptoms experienced by trafficked victims.
In a study of 164 survivors of human trafficking who returned to Nepal, the authors examined the extent to which they experienced PTSD, depression, and anxiety [76]. All of the survivors experienced some level of these disorders, but the survivors who were trafficked for sex experienced higher levels of depression and PTSD compared to those who were not trafficked for sex. In a study with Moldovan survivors of human trafficking, researchers found that six months after their return, 54% had diagnosable mental health issue. Specifically, 35.8% met the diagnostic criteria for PTSD, 12.5% met the criteria for major depression, and 5.8% were diagnosed with an anxiety disorder [77].

There is also some evidence that trafficked victims may experience complex PTSD, a type of PTSD that involves an acute change of the victims’ sense of self, their relationship with others, and their relationship with God or higher being [78]. These persons direct anger inwardly (toward themselves) in addition to toward their perpetrators, which results in a loss of faith in themselves and the world [63; 75; 78]. Perhaps due to self-directed anger and shame, some will engage in risky sexual behaviors, self-harm, and substance abuse. Some victims also have difficulty managing and expressing how they are feeling, while others experience dissociation [75].

Substance abuse is also common among victims. In interviews, trafficked women discussed how traffickers forced them to use substances like drugs and/or alcohol so they could work longer hours, take on more clients, and/or perform sexual acts that they could not normally [61]. Other victims used substances as a means to cope with their situations. Trafficked individuals who are gender and/or sexual minorities report shame, confusion, and sexual identity issues if forced into heterosexual relationships [63].

Children forced into conscription will also experience a host of psychologic symptoms. In a study comparing former Nepalese child soldiers and children who were never conscripted, former child soldiers experienced higher levels of depression, anxiety, PTSD, psychologic difficulties, and functional impairments [80]. In another study of former children soldiers from the Congo and Uganda, one-third met the criteria for PTSD [43]. The researchers found there was a relationship between greater levels of PTSD symptoms and higher levels of feelings of revenge and lower levels of openness to reconciliation [43]. In-depth narrative interviews of former child soldiers from northern Uganda found that the children spoke of the violence and atrocities they witnessed without any emotion, as if they had removed themselves from their experiences [81]. This speaks to how the victims have to numb themselves psychologically in order to cope. The researchers also found that the children who lost their mothers were more traumatized by this experience than the violence they witnessed as soldiers.

Some have argued that the diagnostic criteria of PTSD may not be easily applied to those from different cultures. As a result, it is important to assess for other psychiatric disorders, such as depression. Japan, for example, never used the PTSD diagnosis prior to 1995, despite the fact that they have a large and intricate mental health system [82]. Ultimately, PTSD cannot be universally applied to every culture and for every humanitarian crisis; therefore, if a human trafficking victim does not necessarily fall within the Diagnostic and Statistical Manual of Mental Disorders criteria for PTSD, one cannot necessarily conclude that they have not experienced trauma or are not traumatized [82].

SOCIAL CONSEQUENCES

When rescued and attempting to reintegrate into their communities, victims of human trafficking often experience stigma, ostracism, and marginalization [80; 83]. For example, in Nepal, community members perceived returning child soldiers who had performed acts such as carrying dead bodies or coed sleeping as in violation of Hindu cultural norms [80]. One documentary following former child soldiers living in a refugee camp in northern Uganda found that preconceived notions and myths about children soldiers often led to ridicule and ostracism after they were liberated from the army and returned home.

However, girls who were recruited as soldiers, who were forced to have sex, or who return with children appear to be the most marginalized group [84]. In a qualitative study of former girl soldiers in Sierra Leone, researchers found that, compared to returning boy soldiers, girls were perceived to have violated gender norms and values about sexuality. Although psychologically and developmentally they were still children, the community perceived and treated them as “damaged” or “unclean” women. Their communities were not able to integrate them back in despite the victimization they experienced. These girls lacked voice and experienced shame, marginalization, poverty, and powerlessness upon their return [84]. In a study of former child soldiers in Uganda, the children reported having difficulty finding jobs or getting married when they returned home. Girls who had been raped were stigmatized and made to feel unwelcome in their communities. Others stated that their community perceived them as murderers [44].
HEALTH CONSEQUENCES

In studies of trafficked women, headaches, fatigue, dizziness, back pain, pelvic pain, stomach pain, sexually transmitted infections (STIs), unwanted pregnancies, and gynecologic infections were common, generally the result of continual physical, psychologic, and sexual abuse [23; 74]. Victims of labor trafficking also experience health issues related to the type of work, workplace conditions, malnutrition, and violence [85]. It is important to remember that some of these somatic complaints, such as headaches, fatigue, and gastrointestinal problems, may be underlying symptoms of anxiety, depression, and stress [74]. Some cultural groups might not use the terms “depression,” “sad,” or “anxious,” but may use metaphors and somatic symptoms to describe their pain, all of which are embedded within cultural ideologies. The most common culture-based idioms of distress are somatic symptoms. Some groups tend not to psychologize emotional problems; instead, they experience psychologic conflicts as bodily sensations (e.g., headaches, bodily aches, gastrointestinal problems, and dizziness).

Using an in-depth, direct interview survey designed to explore each stage of the trafficking experience, a multicountry European study identified a range of aversive health, sexual, and reproductive consequences common among women and adolescent victims of human trafficking [61]:

- Pre-departure stage: All victims reported having had limited knowledge of the health implications of having sex with strangers, and only 1 in 25 felt well-informed regarding the risks of acquiring HIV or other STIs.
- Travel and transit stage: Half of those interviewed reported having been confined, beaten, and/or raped during the journey.
- Destination stage: A large majority reported having been “intentionally hurt” (as evidenced by contusions, lacerations, loss of consciousness, and signs of head trauma); subjected to solitary confinement and deprived of human contact and adequate food and nutrition; subject to a variety of physical ailments, including headache, fever, undiagnosed pelvic pain, urinary tract infection, STIs, rash/scabies, and oral/dental health issues. All had experienced repeated sexual abuse or coercion, and 1 in 4 reported at least one unintended pregnancy (often involving negative outcomes of abortions performed in unsafe and unhealthy conditions).

In the context of forced prostitution among trafficked victims, safeguards against infection (e.g., regular condom use), early diagnosis, and adequate antimicrobial treatment are inconsistently employed or absent entirely [61]. Consequently, in addition to unwanted pregnancy, the risk for pelvic inflammatory disease and subsequent infertility is relatively high. Moreover, the relationship between forced prostitution and HIV infection is stronger when sexual violence is involved. Women who are forced into prostitution are 11 times more likely to become HIV-infected than women who entered prostitution voluntarily [86]. Sexual violence may increase the transmission risk as a result of open abrasions and injuries to the vagina. Furthermore, sexual violence can negatively impact self-esteem, which could then deter victims from advocating more strongly for condom use [86].

Among child victims of human trafficking, healthy growth and development is especially problematic. Malnourishment and poor hygiene often lead to delayed bone growth, poorly formed teeth, and early dental caries [87]. The intense nature of child labor also has severe negative physical and health consequences. Children working in unsafe conditions without protection, such as in mines or mills, can lead to respiratory problems such as asthma and bronchitis [88]. A study of adult and child laborers on tobacco farms in Kazakhstan found that the workers were unaware that exposure to tobacco and pesticides could affect their health. Protective garments were also rare, with many children not even having gloves [89].

Under normal circumstances, young children are still developing physically; however, such adverse conditions can halt their development. The lungs of adolescent boys typically experience the most rapid growth around 13 to 17 years of age; working in conditions characterized by excessive toxic dust or unclean air makes them more vulnerable to developing silicosis and fibrosis [88]. In the United States, young children participating in agricultural work are at risk of the major traumas associated with farm work, such as injuries caused by tractors or falling from heights, in addition to those injuries associated with repetitive stress and exposure to toxins. Children have thinner layers of epidermis, which make them more vulnerable to the toxicity of pesticides, and this can ultimately increase their risks for certain cancers [88]. Children working in gold mines do intensive digging,...
lifting, and transporting and mix mercury with the crushed ore, often with their bare hands. Mercury toxicity can lead to neurologic symptoms such as loss of vision, tremors, and memory loss [89].

IDENTIFICATION AND ASSESSMENT

Healthcare providers are often the most likely to encounter a victim of human trafficking under circumstances that provide an opportunity to intervene. Yet, many providers lack the training and confidence to identify and assist victims. In a survey of 110 emergency department physicians, nurses, and physician assistants, the majority (76%) reported having a knowledge of human trafficking, but only 13% felt equipped to identify a trafficking victim and only 22% were confident in their ability to provide satisfactory care for such patients [90]. Less than 3% had ever received any training on this topic. In a separate survey of healthcare and social service providers, only 37% had ever received training on identification of trafficking victims [91].

Because human trafficking and exploitation are, by nature, covert processes, the identification and rescue of the victim can be difficult. Traffickers move victims from one area to another to reduce the risk of identification, and one of the main problems with the assessment of such individuals is that practitioners may only have a one-time encounter with the victim [92].

POTENTIAL RED FLAGS

Bruises, scars, and other signs of physical abuse may be missed on examination, as victims are often beaten in areas hidden by clothing (e.g., the lower back) so as not to affect the victim's outer appearance. Physical trauma symptoms may be present, commonly on the torso, breast, and/or genital areas [70]. Burns, broken bones, pelvic pain, and/or STIs (particularly in children) may also be red flags [93]. However, more common physical injuries are also typical with other circumstances, making physical exam of limited value. The entire clinical picture should be considered.

It may also be helpful to assess for tattoos and/or other modifications (e.g., branding, piercings). Some perpetrators use tattoos to identify victims or to signify “ownership” [56].

With regard to episodic clinical encounters, recommendations for providing safe assessments in a culturally sensitive manner are lacking. The Department of Health and Human Services Administration for Children and Families maintains a useful website that addresses practical issues of human trafficking for allied professional groups, known as the Rescue and Restore Campaign [87]. Included are diagnostic and interviewing tips to help healthcare providers recognize, intervene, and refer trafficking victims. Emergency and primary care providers should be cognizant of clues that a patient may be the victim of trafficking and prepared to engage in greater depth of inquiry with special attention to the following indicators [87; 93; 94; 95]:

- Does someone, other than family, who behaves in a controlling manner, accompany the patient? Traffickers attempt to guard and control most every aspect of the victim’s life, while maintaining isolation from family, friends, and other common forms of human interaction.
- Are there inconsistencies in answers to basic questions (e.g., name, age, address)?
- Does the patient speak English? If not, has he or she recently been brought to this country, and from where? Many victims of human trafficking have recently been trafficked from other countries. As discussed, common sending countries/regions include Eastern Europe, Asia, Latin America, Africa, India, and Russia.
- If the patient is accompanied by someone other than a family member, who does the talking, and why? Attempt to interview and examine the patient separately and alone, using an interpreter if necessary. Probe in a sensitive manner for detailed information on the situation and relationship.
- Does the patient show signs of psychosocial stress (e.g., appears withdrawn, submissive, fearful, anxious, depressed)? Can the individual account for this?
- Are there visible signs of physical abuse (e.g., bruises, lacerations, scars)? How does the individual explain these?
- Does the patient lack a passport or other immigration and identification documentation (e.g., driver's license, social security number, visa)? If so, what explanation is given? To control victims’ movements, traffickers often take away passports and any legal identification documents.
- What is the patient's home and work situation? Basic questions about what they eat, where they live and sleep, who else lives with them, and what work they do can be revealing. For example, “Can you leave your work or job situation if you wish?” or “When you are not working, can you come and go as you please?”

Is the explanation given for the clinical visit consistent with the patient’s presentation and clinical findings?
• Does the victim appear fearful when asked questions about citizenship, country of origin, immigration status, or residence? This may indicate a fear of deportation.
• If the victim is a minor, is s/he in school? Living with parents or relatives? If not, what reasons are given for these circumstances?

SCREENING QUESTIONS
Examples of questions to screen for human trafficking include [96; 97; 98]:
• Can you tell me about your living situation?
• Has anyone ever threatened you with violence if you attempted to leave?
• Does anyone force/require you to have sexual intercourse for your work?
• Has anyone ever threatened your family if you attempted to leave?
• Does anyone make you feel scared at work?
• Are you free to come and go as you wish?
• Does your home have bars on windows, blocked windows/doors, or security cameras?
• How many hours do you work?
• Have you ever worked without receiving payment you thought you would get?
• Do you owe your employer money?
• Do you have to ask permission to eat, sleep, use the bathroom, or go to the doctor?

The Polaris Project has developed a flow chart for the assessment of potential trafficking victims, available at https://www.traffickingresourcecenter.org/sites/default/files/Assessment%20Tool%20-%20Medical%20Professionals.pdf. If a person is thought to be a victim, one should follow workplace protocols and/or contact the National Human Trafficking Resource Center at (888) 373-7888 for next steps.

INTERVIEWING TRAFFICKED VICTIMS: BEST PRACTICE GUIDELINES
Service providers should repeatedly weigh the risks and benefits of various actions when interviewing human trafficking victims [65; 99; 100]. The following interviewing recommendations were published by the World Health Organization to encourage service providers to continually and ethically promote human trafficking victims’ safety during every phase of the interviewing process [93; 101]:
• Each victim and trafficking situation should be treated as unique; there are no standard templates of experiences. Listen carefully to the victim’s story. Each story told is unique, and each patient will voice distinctive concerns. Believe each story, no matter how incredible it may seem. As rapport and trust build (perhaps very slowly), accounts may become more extensive.
• Always be safe and assume the victim is at risk of physical, psychologic, social, and legal harm.
• Evaluate the risks and benefits of interviewing before starting the interviewing process. The interviewing process should not invoke more distress. In other words, the interviewing process should not end up re-traumatizing the victim.
• Provide referrals for services where necessary; however, it is necessary to be realistic and not make promises that cannot be kept. Trust is vital because it has been severed on so many levels for trafficking victims.
• Victims’ readiness to change will not be based on what societal defines as “ready” or social expectations. Some victims will eagerly grasp new opportunities, while others may be fearful of potential traffickers’ threat and be less receptive to help.
• Determine the need for interpreters and if other service providers should be present during the interviewing phase. Ensure that everyone involved is adequately prepared in their knowledge about human trafficking, how perpetrators control their victims, and how to ask questions in a culturally sensitive manner. Keep in mind that often times, traffickers will offer to help with the interpreting. Using interpreters from the same community of the victim should be avoided to prevent breaches in confidentiality.
• All involved should be prepared for an emergency plan. For example, is there a set plan for a victim who indicates he/she is suicidal or in danger of being hurt?
• Always be sure to obtain informed consent. Remember the informed consent process is going to be unfamiliar to many victims. In addition, self-determination and autonomy have been compromised by continual threats and being forced to commit dehumanizing acts. Avoid using legal and technical jargon.

It is important to use a trauma-informed approach when assessing and caring for potential victims, which requires that practitioners understand the impact of trauma on all areas of an individual’s life [102]. Physical, emotional, and psychologic safety is at the heart of trauma-informed care. Providers should assume that human trafficking victims are describing their reality to the best of their ability, given the trauma they have experienced. Responses and behaviors (e.g., being guarded, defensive, belligerent) may be coping mechanisms [102].
REPORTING

If screening and assessment findings indicate that an individual may be a victim of human trafficking, one should contact the National Human Trafficking Hotline at 1-888-373-7888. A text telephone (TTY) option for people who are deaf, hard of hearing, or speech impaired can be accessed by dialing 711. Reporting by text is available by texting the National Human Trafficking Hotline at 233733. Online chat is also accessible at https://humantraffickinghotline.org.

The National Human Trafficking Hotline collects information about the location of the trafficking case and the name of the suspected trafficker. The hotline will also request non-personally identifying information, such as the city and state of the reporter and how he or she learned of the hotline; reporting can be done anonymously. Reporters and/or victims are only asked to provide information they feel comfortable sharing, and the hotline does not share information with external agencies unless permission is given or when required by law. Hotline calls are managed by anti-trafficking hotline advocates, who are specifically trained. After receiving a report of suspected human trafficking, the National Human Trafficking Hotline will assess each case individually to determine if a case should be reported to a local, state, or federal investigative and/or service agency equipped to investigate the tip and/or respond to the needs of the potential victim.

Under the child abuse laws, practitioners who are mandated reporters and who are suspicious that a minor is being abused should immediately report the abuse. Persons in Florida who know, or have reasonable cause to suspect, that a child is abused, neglected, or abandoned must immediately report the abuse. Persons in Florida who are suspicious that a minor is being abused should immediately report the abuse. Practitioners who are mandated reporters and who are suspicious that a minor is being abused should immediately report the abuse.

INTERVENTIONS AND RESOURCES

EDUCATION AND PREVENTION

Education is believed to be a key ingredient in the prevention of human trafficking. Raising awareness through advertisements, campaigns, and other creative vehicles regarding recruitment threats, the various deception techniques employed, the different forms of human trafficking, and the consequences of human trafficking can decrease the incidence [64; 103]. Because the general public often believes human trafficking is a problem that only occurs in developing countries, there is a clear need for public education about trafficking and safety for young children and women in and outside the United States [22]. The Campaign to Rescue and Restore Victims of Human Trafficking provides brochures and posters about human trafficking, which are available to be ordered (at no cost) from https://www.acf.hhs.gov/archive/otip/resource/about-rescue-restore [87]. Posting these brochures or posters increases the possibility that a trafficked victim will self-report [100].

Education about human trafficking has become a higher international priority. Innovative and creative approaches are being implemented to disseminate information about human trafficking, particularly how perpetrators recruit high-risk groups (e.g., youths with disabilities, runaways) [67]. For example, groups have used street plays to educate communities about child labor dangers in India [104].

Watch a video produced by the ILO exploring the use of street plays to educate communities about child labor in India at https://www.netce.com/courseoverview.php?courseid=1851.

Although the topic of human trafficking has become more common in public discourse, service providers and law enforcement authorities remain under-educated about human trafficking. They are not sure what to look for, what to ask, and what to do if they do identify individuals who are victims of human trafficking [103]. Law enforcement officials require training to identify and assess potential victims at various borders and ports of entry. If a minor is accompanied by an adult who is not the child’s parent or legal guardian, this should raise a red flag [103]. Furthermore, to work effectively to identify human trafficking victims, there is a need for service providers to navigate and collaborate with a complex host of government, social service, mental health, and nongovernment legal entities [103].

MENTAL HEALTH AND SOCIAL SERVICES

Care and services provided to victims can be organized into three distinct categories: immediate and concrete services at the time of rescue; services related to recovery; and long-term services pertaining to reintegration [105]. When trafficking victims are rescued, a great deal of counseling services and practical, day-to-day assistance will be required. Housing, transportation, food, clothing, medical care, dental care, financial assistance, educational training, reunification (for those who wish to return to their homeland), and legal aid are some of the concrete services needed [71]. Practitioners should connect, coordinate, and case manage these services as much as possible. During this stage, it is also important to understand victims’ needs, their strengths, and their risks and vulnerabilities [75].
Safety planning is also crucial in the immediate rescue stage. Traffickers may be continuing to try to locate some victims; placing victims in safe houses may be necessary [63]. The National Human Trafficking Hotline encourages that safety planning be based on the unique needs and circumstances of the individual.

During the recovery and reintegration stages, as discussed, human trafficking victims experience an array of mental health and psychologic issues. Mental health counseling is vital, but it is important to remember that the concept of counseling or talk therapy may be foreign to victims from non-Western cultures [65]. The expression of emotions may be in opposition to cultural values of emotional restraint, which can be intensified by feelings of shame and guilt resulting from experiences with sexual and physical assault. Beyond the paramount importance of the practitioner taking the patient’s trust, practitioners may educate patients about the counseling process and explore their patients’ expectations about counseling, healing, and recovery [106]. As noted, victims’ symptoms may not only be a manifestation of the trauma but also coping mechanisms to cope with self-blame, shame, and trauma [56].

Given differing cultural beliefs about healing, it is crucial that practitioners be open to alternative treatment and explore with patients the use of traditional healing methods [65]. There are many indigenous healing interventions victims may be using, including cultural rituals, faith healing, therapeutic touch, herbal remedies, and spiritual practices [107]. These interventions are multi-layered, taking into account the physical, psychologic, communal, and spiritual [107]. These healing methods are historically rooted in specific cultures, and therefore, practitioners should become familiar with traditional healing methods and how they can be integrated with Western counseling techniques [106]. For example, given many cultural groups’ beliefs that unmarried girls are defiled if raped, a cultural cleansing ritual may be needed as a first step to help a community accept a returning victim who was sexually assaulted during her trafficking experience [30]. After this ritual is performed, it is possible that both the patient and her family may be more open to counseling and other services.

Other trauma interventions that might be beneficial include cognitive-behavioral therapies, eye movement and desensitization reprocessing therapies, mindfulness techniques, and expressive therapies [56; 63].

Physicians, social workers, nurses, therapists, and counselors must be familiar with legal, case management, educational, job and life skills training, and housing services in the community. Human trafficking victims are not only unfamiliar with navigating the social service system, but many are also not proficient in English. Therefore, practitioners will serve as coordinators and advocates, linking necessary services. In one study, the majority of agencies had to rely on collaboration in order to refer clients [108]. Social workers and practitioners relied on word-of-mouth and community meetings to learn about services in order to better meet the needs of human trafficking victims. Furthermore, because many community organizations and agencies are not familiar with human trafficking, practitioners must take a primary role in educating colleagues about the complex dynamics of human trafficking.

It is important to remember that the evidence supporting interventions and therapies for victims of human trafficking is in its infancy [105]. Most efficacy studies of therapies and interventions do not involve experimental designs, which makes it difficult to draw definitive conclusions regarding efficacy. Future work is needed to develop and evaluate interventions that address the multilayered and complex needs of human trafficking survivors.

For more information on how to identify and assist victims, watch the information video Look Beneath the Surface, produced by Rescue & Restore Victims of Human Trafficking public awareness campaign, an initiative of the U.S. Department of Health and Human Services, at https://www.youtube.com/watch?v=bqyzW8413Dc.

**ADVOCACY**

Physicians, social workers, nurses, allied health professionals, counselors, and psychologists will find themselves in multiple roles when working with victims of human trafficking. Advocacy is one of these roles and involves the practitioner being an agent for change. This consists of engaging in activities that alter the social conditions at the individual, family, community, and institutional levels [109]. One way to advocate on behalf of human trafficking victims is by signing petitions or joining credible organizations concerned with changing the circumstances that lead to human trafficking. Many organizations have petitions established on their websites for individuals to persuade policymakers, legislators, and government officials to advocate for the protection of human trafficking victims, create greater awareness of the issue, and prosecute traffickers, including:

- https://www.freetheslaves.net
- https://polarisproject.org
- https://www.stopthetraffik.org
Justice for Victims of Trafficking Act
In 2015, the Justice for Victims of Trafficking Act (JVTA) became law, allowing survivors formal input in federal anti- trafficking policy and providing incentives for states to enact laws to prevent the prosecution of child victims for crimes committed as a direct result of being subjected to trafficking. The JVTA provides additional bases of criminal liability for those who patronize or solicit trafficking victims for commercial sex and creates a new offense prohibiting the advertising of sex trafficking activity. It also clarifies that traffickers in child sex trafficking cases who had a reasonable opportunity to observe the victim can no longer claim ignorance about a victim's age as a defense [24]. Some provisions of this law are scheduled to expire in 2019 and 2020 [110].

Victims of Trafficking and Violence Protection Act
A wide range of laws have been established to protect human trafficking victims and to prosecute perpetrators. A general knowledge of these laws is helpful when caring for victims and seeking appropriate social services. The TVPA was enacted in 2000 and reauthorized in 2003, 2005, 2008, 2013, and 2018 by the Trafficking Victims Protection Reauthorization Acts [24]. It emphasizes the three Ps: prevention, protection, and prosecution [111]. The prevention component consists of training and awareness; the protection dimension gives trafficked victims the ability to receive services using federal funds like other refugees; and the prosecution component focuses on laws and policies for the prosecution of traffickers.

Because victims of trafficking are often viewed as criminals, this law states that victims of severe trafficking should not be penalized for any illegal behaviors or acts they engaged in as a result of being trafficked, including entering the United States with false documents or no documentation or working without appropriate paperwork [64]. This law also allows T Nonimmigrant Status (T visas) to be granted to victims of trafficking so they may remain in the United States with the purpose of collaborating with the federal authorities to prosecute the perpetrators. During this time, victims are offered a range of benefits and services, including access to the Witness Protection Program [64]. After three years, victims can apply for permanent resident status [16].

One of the criticisms of the Act is that it places the burden of demonstrating innocence and coercion on the victim [112]. The Act also fails to recognize the complex dynamics of human trafficking. For example, it focuses more on sex trafficking versus other forms [113]. Many victims have been abused and terrorized by the perpetrators, who they must now provide information and evidence against to stay in the country. Victims are continually fearful that they will be deported [112].

Victims who are of minor age are eligible for Unaccompanied Refugee Minors programs, the Children’s Health Insurance program, and Temporary Assistance to Needy Families [103]. Furthermore, victims between 16 and 24 years of age are eligible for work permits and can apply for the Job Corps program [103]. However, it is important to remember that the key to this law is that the victim must have experienced a “severe form” of trafficking and the victim must be willing to assist in the apprehension and prosecution of the perpetrator to receive services [114].

Preventing Sex Trafficking and Strengthening Families Act
The Preventing Sex Trafficking and Strengthening Families Act was signed into law in 2014. In accordance with this law, child welfare agencies are required to monitor and report the number of child sex trafficking victims. Cases of suspected or known child sex trafficking must also be reported to law enforcement [37].

Trafficking Victims Protection Reauthorization Act
The Trafficking Victims Protection Reauthorization Act was introduced and signed into law in 2013. It allocated $5 million in 2009, $7 million in 2010, $7 million in 2011, and $8 million annually through 2017 to provide services to victims and to prevent human trafficking [22; 115; 116]. It amends the TVPA and assists foreign governments to implement programs to prevent human trafficking. Victims of human trafficking in other countries are also eligible for assistance through organizations that have grants from the U.S. government [115]. Greater monitoring of trafficking trends through databases will also be implemented. The Act also declares that it is not a defense that a defendant is not criminally liable or is subject to reduced criminal liability due to acceptance of the illicit conduct in the foreign jurisdiction.

The Prosecutorial Remedies and Other Tools to End the Exploitation of Children Today Act
The Prosecutorial Remedies and Other Tools to End the Exploitation of Children Today Act was enacted in 2003. This law maintains that all sexual activity with minors, within or outside the United States, is illegal. American citizens who engage in sex with minors in any country and who are caught will be prosecuted in the United States [64].

As of 2017, all 50 states have enacted criminal anti-trafficking laws. In addition, every state has a law on labor trafficking, and all have passed criminal statutes for sex trafficking [117].
SOAR to Health and Wellness Act
The SOAR (Stop, Observe, Ask, and Respond) to Health and Wellness Act was signed into law in 2018. It directs the Department of Health and Human Services to develop a program to train healthcare providers and practitioners to identify possible human trafficking victims, to work with law enforcement agencies, and to refer victims to services [7].

Florida House Bill 369
In 2015, The Florida Legislature passed House Bill 369, which mandates the display of a human trafficking public awareness sign in a wide range of locations, including [118]:

- Every public rest area, turnpike service plaza, weigh station, primary airport, passenger rail station, and welcome center in the state
- Emergency rooms at general acute care hospitals
- Strip clubs or other adult entertainment establishments
- A business or establishment that offers massage or bodywork services for compensation that is not owned by a healthcare professional

The sign must contain text, in both English and Spanish, regarding the steps to take if you or someone you know is the victim of trafficking, exploitation, and/or forced labor.

RESOURCES
For more information and to become involved in advocacy movements, please utilize the following resources. In some cases, the tools provided may be valuable for patient and/or peer training. In particular, the National Human Trafficking Hotline provides free, downloadable awareness materials for victims, first responders, and healthcare and mental health professionals, including a flyer available in 20 languages.

Alliance for Children in Trafficking
https://www.napnappartners.org/provider-public-resources

Coalition to Abolish Slavery & Trafficking
https://castla.org

Coalition Against Trafficking in Women
http://www.catwinternational.org

Futures Without Violence
https://www.futureswithoutviolence.org

HEAL Trafficking
https://healtrafficking.org

Human Rights Watch
https://www.hrw.org

International Justice Mission
https://www.ijm.org

International Labour Organization
https://www.ilo.org

Office of Refugee Resettlement
https://www.acf.hhs.gov/orr

National Human Trafficking Hotline
https://humantraffickinghotline.org

Polaris Project
https://polarisproject.org

Salvation Army
https://www.salvationarmyusa.org

Sex Workers Project
http://sexworkersproject.org

United Nations Office on Drugs and Crime
Human Trafficking Knowledge Portal

U.S. Department of Health and Human Services
Administration for Children and Families
https://www.acf.hhs.gov

U.S. Department of Health and Human Services
Administration for Children and Families
SOAR to Health and Wellness Training
https://www.acf.hhs.gov/otip/training/soar-to-health-and-wellness-training

Services Available to Victims of Human Trafficking: A Resource Guide for Social Service Providers

U.S. Department of Justice
Bureau of Justice Assistance
https://www.bja.gov

U.S. Department of Justice
Office for Victims of Crime
https://ojp.gov/ovc

U.S. Department of Labor
Bureau of International Labor Affairs
https://www.dol.gov/agencies/ilab

U.S. Department of State, Office to Monitor and Combat Trafficking in Persons
CONCLUSION

Human trafficking is a severe human rights violation. Because the roots of human trafficking are multifaceted, no one solution exists to eliminate this problem. Unfortunately, as the problem grows, practitioners will be confronted with the issue in their patient populations. Practitioners should be committed to the collaboration amongst disciplines to address poverty, racism, discrimination, and oppression in order to reduce the vulnerable positions of human trafficking victims and their families. Because of the social justice component in the codes of ethics of professionals such as physicians, nurses, social workers, psychologists, and counselors, all practitioners can play a key role in the individual, community, and systemic levels to help address this gross abuse of power. One way to begin is to educate oneself and one’s respective disciplines about the global nature of human trafficking and the complex dynamics of the problem.

FACULTY BIOGRAPHY

Alice Yick Flanagan, PhD, MSW, received her Master’s in Social Work from Columbia University, School of Social Work. She has clinical experience in mental health in correctional settings, psychiatric hospitals, and community health centers. In 1997, she received her PhD from UCLA, School of Public Policy and Social Research. Dr. Yick Flanagan completed a year-long post-doctoral fellowship at Hunter College, School of Social Work in 1999. In that year she taught the course Research Methods and Violence Against Women to Masters degree students, as well as conducting qualitative research studies on death and dying in Chinese American families.

Previously acting as a faculty member at Capella University and Northcentral University, Dr. Yick Flanagan is currently a contributing faculty member at Walden University, School of Social Work, and a dissertation chair at Grand Canyon University, College of Doctoral Studies, working with Industrial Organizational Psychology doctoral students. She also serves as a consultant/subject matter expert for the New York City Board of Education and publishing companies for online curriculum development, developing practice MCAT questions in the area of psychology and sociology. Her research focus is on the area of culture and mental health in ethnic minority communities.

To view an excerpt of California Senator Kamala Harris’s keynote address at Examining the Roots of Human Trafficking and Exploitation, the 2014–2015 UCLA School of Law Symposium, visit http://www.netce.com/coursecontent.php?courseid=1851.
1. The United Nations Office on Drugs and Crime divides the definition of human trafficking into three sections: the act, means, and purpose.
   A) True
   B) False

2. Domestic servitude refers to a category of domestic workers (usually female) who work as servants, housekeepers, maids, and/or caregivers, often in private homes.
   A) True
   B) False

3. Digital technology, such as the Internet, greatly inhibits sex trafficking.
   A) True
   B) False

4. Myths that certain races or ethnicities are more erotic and exotic do not affect sex trafficking patterns.
   A) True
   B) False

5. Developing a false romantic relationship with a victim is a method of recruitment used by human traffickers.
   A) True
   B) False

   A) True
   B) False

7. Child laborers who work in agricultural fields might be more susceptible to certain cancers due to their rapid growth.
   A) True
   B) False

8. When interviewing a victim of human trafficking, it is important to assess if an interpreter is needed and ensure the interpreter is knowledgeable about the dynamics of human trafficking.
   A) True
   B) False

9. If a practitioner suspects an individual is a victim of human trafficking, he/she should contact the National Human Trafficking Hotline.
   A) True
   B) False

10. One of the criticisms of the Trafficking Victims Protection Act of 2000 is that it places the burden of demonstrating innocence and coercion on the victim.
    A) True
    B) False

Be sure to transfer your answers to the Answer Sheet insert located between pages 88–89.

PLEASE NOTE: Your postmark or facsimile date will be used as your test completion date.
Strategies for Appropriate Opioid Prescribing: The Florida APRN/PA Requirement

This course fulfills the Florida APRN requirement for 3 hours of education on the Prescribing of Controlled Substance Medications. RNs and LPNs will receive general hours for completing this course.

Audience
This course is designed for all nurses and physician assistants who may alter prescribing practices or intervene to prevent drug diversion and inappropriate opioid use.

Course Objective
The purpose of this course is to provide clinicians who prescribe or distribute opioids with an appreciation for the complexities of opioid prescribing and the dual risks of litigation due to inadequate pain control and drug diversion or misuse in order to provide the best possible patient care and to prevent a growing social problem.

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

1. Define opioid prescribing and opioid misuse.
2. Apply epidemiologic trends in opioid use and misuse to current practice so at-risk patient populations can be more easily identified, assessed, and treated.
3. Create comprehensive treatment plans for patients with chronic pain that address patient needs as well as drug diversion prevention.
4. Identify state and federal laws governing the proper prescription and monitoring of controlled substances.
5. Evaluate behaviors that may indicate drug seeking or diverting as well as approaches for patients suspected of misusing opioids.

Faculty
Mark Rose, BS, MA, is a licensed psychologist and researcher in the field of alcoholism and drug addiction based in Minnesota. He has written or contributed to the authorship of numerous papers on addiction and other medical disorders and has written books on prescription opioids and alcoholism published by the Hazelden Foundation. He also serves as an Expert Advisor and Expert Witness to various law firms on matters related to substance abuse, is on the Board of Directors of the Minneapolis-based International Institute of Anti-Aging Medicine, and is a member of several professional organizations.

Faculty Disclosure
Contributing faculty, Mark Rose, BS, MA, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Division Planner
Jane C. Norman, RN, MSN, CNE, PhD

Division Planner Disclosure
The division planner has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

Accreditations & Approvals
In support of improving patient care, NetCE is jointly accredited by the Accreditation Council for Continuing Medical Education (ACCME), the Accreditation Council for Pharmacy Education (ACPE), and the American Nurses Credentialing Center (ANCC), to provide continuing education for the healthcare team.

Designations of Credit
NetCE designates this continuing education activity for 3 ANCC contact hours.

NetCE designates this continuing education activity for 3 pharmacotherapeutic/pharmacology contact hours.

AACN Synergy CERP Category A.

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Individual State Nursing Approvals
In addition to states that accept ANCC, NetCE is approved as a provider of continuing education in nursing by: Alabama, Provider #ABNP0353 (valid through 11/21/2021); Arkansas, Provider #50-2405; California, BRN Provider #CEP9784; California, LVN Provider #V10662; California, PT Provider #V10842; District of Columbia, Provider #50-2405; Florida, Provider #50-2405; Georgia, Provider #50-2405; Kentucky, Provider #7-0054 (valid through 12/31/2021); South Carolina, Provider #50-2405; West Virginia, RN and APRN Provider #50-2405.

Special Approvals
This course fulfills the Florida requirement for 3 hours of education on prescribing of controlled substance medications.

About the Sponsor
The purpose of NetCE 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 accepted at the time of publication. The publisher disclaims any liability, loss or damage incurred as a consequence, directly or indirectly, of the use and application of any of the contents. Participants are cautioned about the potential risk of using limited knowledge when integrating new techniques into practice.

Disclosure Statement
It is the policy of NetCE not to accept commercial support. Furthermore, commercial interests are prohibited from distributing or providing access to this activity to learners.

INTRODUCTION
Pain is the leading reason for seeking medical care, and pain management is a large part of many healthcare professionals’ practice. Opioid analgesics are approved by the U.S. Food and Drug Administration (FDA) for moderate and severe pain and are broadly accepted in acute pain, cancer pain, and end-of-life care, but are controversial in chronic noncancer pain. In response to the long-standing neglect of severe pain, indications for opioid analgesic prescribing were expanded in the 1990s, followed by inappropriate prescribing and increasing abuse, addiction, diversion, and overdose through the 2000s. In tandem with the continued under-treatment of pain, these practice patterns led to needless suffering from uncontrolled pain, opioid analgesic addiction, and overdose.

Opioid analgesic prescribing and associated overdose peaked in 2011 with both now in multi-year decline, but information on these important trends is largely absent in the medical literature and media reporting.

Patients show substantial opioid response variations in analgesia and tolerability and may exhibit a range of psychologic, emotional, and behavioral responses that reflect inadequate pain control, an emerging opioid use problem, or both. Clinician delivery of best possible care to patients with pain requires appreciation of the complexities of opioid prescribing and the dual risks of inadequate pain control and inappropriate use, drug diversion, or overdose. A foundation for appropriate opioid prescribing is the understanding of factual data that clarify the prevalence, causality, and prevention of serious safety concerns with opioid prescribing.

DEFINITIONS
Definitions and use of terms describing opioid analgesic misuse, abuse, and addiction have changed over time, and their current correct use is inconsistent not only among healthcare providers, but also by federal agencies reporting epidemiologic data such as prevalence of opioid analgesic misuse, abuse, or addiction. Misuse and misunderstanding of these concepts and their correct definitions have resulted in misinformation and represent an impediment to proper patient care.

Inappropriate opioid analgesic prescribing for pain is defined as the non-prescribing, inadequate prescribing, excessive prescribing, or continued prescribing despite evidence of ineffectiveness of opioids [1]. Appropriate opioid prescribing is essential to achieve pain control; to minimize patient risk of abuse, addiction, and fatal toxicity; and to minimize societal harms from diversion. The foundation of appropriate opioid prescribing is thorough patient assessment, treatment planning, and follow-up and monitoring. Essential for proper patient assessment and treatment planning is comprehension of the clinical concepts of opioid abuse and addiction,
their behavioral manifestations in patients with pain, and how these potentially problematic behavioral responses to opioids both resemble and differ from physical dependence and pseudo-addiction. Prescriber knowledge deficit has been identified as a key obstacle to appropriate opioid prescribing and, along with gaps in policy, treatment, attitudes, and research, contributes to widespread inadequate treatment of pain [2]. For example, a 2013 survey measuring 200 primary care physicians’ understanding of opioids and addiction found that [3]:

- 35% admitted knowing little about opioid addiction.
- 66% and 57% viewed low levels of education and income, respectively, as causal or highly contributory to opioid addiction.
- 30% believed opioid addiction “is more of a psychologic problem,” akin to poor lifestyle choices rather than a chronic illness or disease.
- 92% associated prescription analgesics with opioid addiction, but only 69% associated heroin with opioid addiction.
- 43% regarded opioid dependence and addiction as synonymous.

This last point is very important because confusion and conflation of the clinical concepts of dependence and addiction has led to accusations of many non-addicted patients with chronic pain of misusing or abusing their prescribed opioid and in the failure to detect treatment-emergent opioid problems [4]. Knowledge gaps concerning opioid analgesics, addiction, and pain are related to attitude gaps, and negative attitudes may interfere with appropriate prescribing of opioid analgesics. For example, when 248 primary care physicians were asked of their prescribing approach in patients with headache pain with either a past or current history of substance abuse, 16% and 42%, respectively, would not prescribe opioids under any circumstance [5]. Possibly contributing to healthcare professionals’ knowledge deficit in pain treatment is the extent of educational exposure in school. A 2011 study found that U.S. medical school students received a median seven hours of pain education and Canadian medical students a median 14 hours, in contrast to the median 75 hours received by veterinarian school students in the United States [6]. Additionally, less than 3% of medical schools incorporate pain management into their curriculum, yet chronic pain is the most common reason patients see a provider, accounting for 40% of all visits in primary care [7].

The terms related to addiction are often inconsistent, inaccurate, and confusing, partially reflecting the diverse perspectives of those working in the related fields of health care, law enforcement, regulatory agencies, and reimbursement/payer organizations. Changes over time in the fundamental understanding of addiction have also contributed to the persistent misuse of obsolete terminology [8]. The Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association, is the standard reference for the diagnosis of addiction and all other psychiatric disorders. Prior to the 2013 release of the DSM-5, versions of the DSM eschewed the term “addiction” in favor of “substance dependence,” with a separate diagnostic entity of “substance abuse” representing a less severe version of dependence [9]. Also, in earlier DSM versions, physiologic dependence, manifesting as substance tolerance and withdrawal, was considered a diagnostic criterion of substance dependence. The result was the perpetuation of patient and healthcare professional confusion between physical and substance dependence and the belief that tolerance and withdrawal meant addiction. This confusion also enhanced provider and patient fears over addiction developing from opioid analgesics and contributed to the undertreatment of pain. The DSM-5 has eliminated substance dependence and substance abuse by combining them into the single diagnostic entity of substance use disorder. The disorder is measured on a continuum from mild to severe [9].

In 2011, the American Society of Addiction Medicine (ASAM) published their latest revision in defining the disease of addiction. In the abbreviated version, the ASAM states [10]:

Addiction is a primary, chronic disease of brain reward, motivation, memory, and related circuitry. Dysfunction in these circuits leads to characteristic biologic, psychologic, social, and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.

According to the ASAM, the five characteristics of addiction are [10]:

- Inability to consistently abstain
- Impairment in behavioral control
- Craving or increased “hunger” for drug or reward experiences
- Diminished recognition of significant problems with one’s behaviors and interpersonal relationships
- A dysfunctional emotional response

The ASAM emphatically states this summary of addiction should not be used as diagnostic criteria for addiction because the core symptoms vary substantially among addicted persons, with some features more prominent than others [10].
EPIDEMIOLOGY OF CHRONIC PAIN AND OPIOID MISUSE

Chronic pain affects about 100 million American adults—more than the total affected by heart disease, cancer, and diabetes combined [2]. It also costs the nation up to $635 billion each year in medical treatment and lost productivity and is the leading reason for receiving disability insurance [3; 11]. The lifetime prevalence of chronic pain ranges from 54% to 80%, and among adults 21 years of age and older, 14% report pain lasting 3 to 12 months and 42% report pain that persists longer than one year [2]. While 5 to 8 million Americans receive long-term opioids for the management of chronic pain, an estimated 41% of patients with chronic pain report their pain is uncontrolled, and 10% of all adults with pain suffer from severe, disabling chronic pain [11].

The increasing prevalence of chronic pain is the result of multiple factors, including the aging population; rising rates of obesity and obesity-related pain conditions, such as joint deterioration; advances in life-saving trauma interventions; poorly managed post-surgical pain; and greater public awareness of pain as a condition warranting medical attention [2]. In addition, many armed forces veterans have been returning from military action in Afghanistan and Iraq with traumatic injuries and chronic pain, and veterans’ care clinicians have been reporting the perception that long-term pain management is lacking support in the veteran healthcare infrastructure [12].

There is a widespread misperception that opioid analgesic prescribing and overdose continues to grow, fueling an opioid epidemic [13; 14; 15; 16; 17]. Data from a 2018 Centers for Disease Control and Prevention (CDC) surveillance report show that between 2006 and 2017, the annual prescribing rate per 100 persons decreased from 72.4 to 58.5 for all opioids, an overall reduction of 19.2% [18]. (Opioid prescriptions, including codeine, fentanyl, hydrocodone, hydromorphone, methadone, morphine, oxycodone, oxymorphone, propoxyphene, tapentadol, tramadol, and buprenorphine, were identified using the National Drug Code. Cough and cold formulations containing opioids were not included.) The rate for all opioid prescriptions initially increased annually by 3.0% from 2006 to 2010, but then decreased annually by 1.6% from 2010 to 2014, and continued to decrease annually by 8.2% from 2014 to 2017 [18].

Although the epidemic of drug overdoses that began in the 1990s primarily involved prescription opioids prescribed for analgesia, the rapid increase in overdose deaths in 2010 was primarily attributed to heroin, and in 2013, to synthetic opioids, particularly illicitly manufactured fentanyl [18]. A record number (63,632) of drug overdose deaths occurred in 2016, a rate of 19.8 per 100,000 persons. Although deaths might have involved more than one drug, prescription and/or illicit opioids were involved in 66.4% of these drug overdose fatalities. Among opioid-involved deaths, the most commonly involved drugs were synthetic opioids other than methadone (primarily illicitly manufactured fentanyl [19,413 deaths]), prescription opioids (17,087 deaths), and heroin (15,469 deaths). Prescription opioid deaths included those involving natural and semisynthetic opioids (14,487 deaths) and methadone (3,373 deaths). Cocaine was involved in 10,375 deaths. The increase in overdose deaths in 2016 was attributed to heroin, synthetic opioids other than methadone (mostly illicitly manufactured fentanyl), cocaine, and psychostimulants with abuse potential [18].

There is nearly universal agreement that opioid analgesics were injudiciously overprescribed during the 2000s. Interpretation of the broader trend of increased prescribing from 1990 might be viewed by public health professionals as entirely problematic and by pain medicine professionals as necessary in part, given the past neglect of patients in pain. This reflects the polarized nature of pain care and opioid analgesic prescribing in particular. Efforts to reduce opioid analgesic overprescribing and associated overdose have been successful but have come at a cost to patients who have faced increasing barriers to access, including stigma and abuse in a healthcare system, tapering of opioids without consideration for pain or functional improvements, and difficulty finding a physician [14; 19; 20].

Worldwide consumption of opioid analgesics increased dramatically over the past few decades, driven primarily by U.S. consumption. For example, the global consumption of oxycodone was 3 tons (2,722 kg) in 1990 and 77 tons (69,853 kg) in 2009, with 62 tons (81%) consumed in the United States [21]. However, in line with a decrease in global manufacture of the drug, global consumption of oxycodone also decreased, from 79.7 tons in 2016 to 62.6 tons in 2017. Consumption remained concentrated in the United States, which consumed 42.4 tons (67.7%) of the world total [22]. In 2017, the United States had 4.3% of the world population but consumed 80% of global opioid supplies and 99.2% of hydrocodone supplies [22]. This is partially because access to opioid analgesics is virtually or entirely non-existent for much of the world's population. An estimated 3.6 billion people (50% of the global population who reside in the poorest countries) receive less than 1% of the distributed opioids [23]. Other countries with adequate opioid access prefer dihydrocodeine or low-dose morphine over hydrocodone for use in moderate or moderately severe pain [24].

Many prescribed opioid analgesic fatalities result from the co-ingestion of central nervous system (CNS)/respiratory depressants (especially benzodiazepines) or prescribed methadone. The National Institute on Drug Abuse reported benzodiazepines contributed to 24% of opioid analgesic fatalities in 2017 (compared with 18.4% in 2004), but this may underestimate the true contribution [25]. A Canadian study evaluated 607,156 adults prescribed opioids for noncancer pain, and of those whose deaths were related to opioids, co-prescribed benzodiazepines were detected in 84.5% [26].
In another study of 2,182,374 North Carolina residents receiving one or more opioid analgesics in 2010, benzodiazepines were present in 61.4% who fatally overdosed [27]. A cross-sectional study of 386,457 ambulatory care visits in the United States from 2003 through 2015 found that the use of benzodiazepines increased substantially from 3.8% to 7.4% of visits, including co-prescribing with other sedating medications [28]. Use for back and chronic pain increased more significantly than for anxiety and insomnia, which remained relatively unchanged. This increase likely reflects not only a growing number of individuals receiving benzodiazepines, but also an increase in those receiving them on a long-term basis, despite the lack of evidence supporting their use past 8 or 10 weeks [28].

**OPIOID MISUSE IN FLORIDA**

In Florida, misuse of prescription opioids became a serious problem in the 1990s and 2000s, but efforts to stem the problem appear to be working. The rate of drug overdose deaths increased 58.9% during 2003–2010, and in 2009, one in eight deaths in Florida was attributable to drug overdose [29; 30]. As of 2017, 6% of all deaths in Florida were found to have a drug present [31]. Oxydodone-caused deaths accounted for 2.9% of all drug-related deaths (8,646) in 2017 [29]. These trends resulted in the enactment of several measures to address prescribing that was inconsistent with best practices, and partnership with the U.S. Drug Enforcement Administration (DEA) to close and prevent “pill mills” from introducing millions of opioid dose units into illicit markets [32; 33]. In May 2017, former Florida Governor Rick Scott signed an executive order declaring the opioid epidemic a public health emergency, providing additional funding and empowering state health professions to take steps to address this pressing issue [33]. As part of this order, the State Health Officer has issued a standing order for opioid antagonists to ensure emergency responders have access [33]. The order has been extended several times and, as of August 2019, is still in place [34].

Drug overdose fatalities in Florida have continued rising from increased use of heroin, synthetic cannabinoids, and novel psychoactive substances such as alpha-PVP (“flakka”). An influx of clandestine fentanyl into Florida in early 2014, and several fentanyl analogs and other novel non-pharmaceutical opioids more recently, has largely driven the increases in opioid overdose fatalities. Several overdose fatalities in Florida were linked to counterfeit alprazolam, oxycodone, and hydrocodone tablets that contained fentanyl [35]. The decrease in prescription opioid fatalities, offset by increasing overdose fatalities from other opioid and non-opioid agents, reflects the intervention focus on the supply side (“pill mill laws”) and neglect of treatment funding that would address the demand side of problematic drug use [36].

In Florida, fatalities with benzodiazepines present peaked in 2010 with 6,188, falling to 5,064 in 2017 (37% were alprazolam) [31]. Of the 28,031 deaths investigated by Florida authorities, toxicology results determined that drugs were present at the time of death in 12,439 individuals, with the vast majority revealing more than one drug occurrence [31]. Other primary contributors to opioid analgesic-related fatalities include alcohol and prescribed methadone [37; 38].

In addition to the executive order issued in 2017, several new state laws were passed in 2018 to impose additional legal requirements on controlled substance prescribers [39]. These laws will be discussed in detail later in this course.

**INITIATION AND MANAGEMENT OF THE PATIENT WITH PAIN**

In 2016, the CDC issued updated opioid prescribing guidelines for chronic pain that address when to initiate or continue opioids for chronic pain; opioid selection, dosage, duration, follow-up, and discontinuation; and assessing risk and addressing harms of opioid use [40]. Some of the recommendations are standard risk mitigation approaches, but others have been criticized by pain medicine physicians and patient advocates. A common criticism is the sole focus on curtailing prescribing and patient access [41; 42; 43; 44].

It can be difficult to balance the benefits and harms of prescription opioids. This is exacerbated by inadequate education and by opioid prescribing guidelines based on expert opinion instead of scientific evidence. This has resulted in wide variation in clinical practice, inconsistent prescriber guidance, and clinician confusion [45]. For instance, the CDC and other opioid guidelines state that opioids should be considered only after non-opioid therapy fails. However, when pain is severe and patients require powerful analgesic control, there is little choice because no other pain medications are as effective as opioids with lower addiction risk [46].

However, many guidelines do share common recommendations. These represent the current “conventional wisdom” in opioid analgesic prescribing and can inform healthcare professionals of the best clinical practices in opioid prescribing that include approaches to the assessment of pain and function and pain management modalities. Pharmacologic and nonpharmacologic approaches should be used on the basis of current evidence or best clinical practice. Patients with moderate-to-severe chronic pain without adequate pain relief from non-opioid or nonpharmacologic therapy can be considered for a trial of opioid therapy [40; 47]. Initial treatment should always be considered individually determined and as a trial of therapy, not a definitive course of treatment [48].
Long-term opioid use often begins with treatment of acute pain. When opioids are used for acute pain, clinicians should prescribe the lowest effective dose of immediate-release opioids in a quantity no greater than that needed for the expected duration of severe pain. In most cases, three days or less will be sufficient; more than seven days will rarely be needed [40]. Florida law dictates that, for the treatment of acute pain, a prescription for an opioid drug may not exceed a three-day supply; an exception may be made for a seven-day supply if [49]:

- The prescriber, in his or her professional judgment, believes that more than a three-day supply of such an opioid is medically necessary to treat the patient's pain as an acute medical condition.
- The prescriber indicates “ACUTE PAIN EXCEPTION” on the prescription. (For the treatment of pain other than acute pain, a practitioner must indicate “NONACUTE PAIN” on a prescription.)
- The prescriber adequately documents in the patient's medical records the acute medical condition and lack of alternative treatment options that justify deviation from the three-day supply limit.

With postoperative, acute, or intermittent pain, analgesia often requires frequent titration, and the two- to four-hour analgesic duration with short-acting hydrocodone, morphine, and oxycodone is more effective than extended-release formulations. Short-acting opioids are also recommended in patients who are medically unstable or with highly variable pain intensity [50; 51; 52].

As part of House Bill 21, passed in 2018, the Florida Board of Medicine and the Board of Osteopathic Medicine are required to establish guidelines for prescribing controlled substances for acute pain; these guidelines are forthcoming [49].

### PATIENT EVALUATION AND ASSESSMENT OF ADDICTION RISK
Information obtained by patient history, physical examination, and interview, from family members, a spouse, or state prescription drug monitoring program (PDMP), and from the use of screening and assessment tools can help the clinician to stratify the patient according to level of risk for developing problematic opioid behavioral responses (Table 1). Low-risk patients receive the standard level of monitoring, vigilance, and care. Moderate-risk patients should be considered for an additional level of monitoring and provider contact, and high-risk patients are likely to require intensive and structured monitoring and follow-up contact, additional consultation with psychiatric and addiction medicine specialists, and limited supplies of short-acting opioid formulations [40; 53].

Anxiety disorders, major depressive disorder, and intense emotional distress alter pain perception and response. Intensity and perception of reported pain is also influenced by factors such as mood, cultural background, social supports, and financial resources. A biopsychosocial model is required to inform pain assessment in order to address the biologic basis of pain and presence of social and psychologic contributors [46].

Before deciding to prescribe an opioid analgesic, clinicians should perform and document a detailed patient assessment that includes [1]:

- Pain indications for opioid therapy
- Nature and intensity of pain
- Past and current pain treatments and patient response
- Comorbid conditions
- Pain impact on physical and psychologic function
- Social support, housing, and employment
• Home environment (i.e., stressful or supportive)
• Pain impact on sleep, mood, work, relationships, leisure, and substance use
• Patient history of physical, emotional, or sexual abuse

Depression is perhaps the single most important comorbidity in patients with chronic pain and is vastly underdiagnosed and untreated. Patients with unrecognized and untreated depression are unlikely to respond to opioids and other pain therapies, but successful treatment of depression can promote analgesia [57].

If substance abuse is active, in remission, or in the patient’s history, consult an addiction specialist before starting opioids [1]. In active substance abuse, do not prescribe opioids until the patient is engaged in treatment/recovery program or other arrangement made, such as addiction professional co-management and additional monitoring. When considering an opioid analgesic (particularly those that are extended-release or long-acting), one must always weigh the benefits against the risks of overdose, abuse, addiction, physical dependence and tolerance, adverse drug interactions, and accidental exposure by children [40; 58].

Screening and assessment tools can help guide patient stratification according to risk level and inform the appropriate degree of structure and monitoring in the treatment plan. It should be noted that despite widespread endorsement of screening tool use to help determine patient risk level, most tools have not been extensively evaluated, validated, or compared to each other, and evidence of their reliability is poor [59].

Despite limited evidence for reliability and accuracy, screening for opioid use is recommended by the American Society of Interventional Pain Physicians, as it will identify opioid abusers and reduce opioid abuse.


Level of Evidence: Limited (Evidence is insufficient to assess effects on health outcomes because of limited number or power of studies, large and unexplained inconsistency between higher-quality trials, important flaws in trial design or conduct, gaps in the chain of evidence, or lack of information on important health outcomes.)

Opioid Risk Tool (ORT)
The Opioid Risk Tool (ORT) is a five-item assessment to help predict aberrant drug-related behavior. The ORT is also used to establish patient risk level through categorization into low, medium, or high levels of risk for aberrant drug-related behaviors based on responses to questions of previous alcohol/drug abuse, psychologic disorders, and other risk factors [60].

Screening and Opioid Assessment for Patients with Pain-Revised (SOAPP-R)
The Screening and Opioid Assessment for Patients with Pain-Revised (SOAPP-R) is a patient-administered, 24-item screen with questions addressing history of alcohol substance use, psychologic status, mood, cravings, and stress. Like the ORT, the SOAPP-R helps assess risk level of aberrant drug-related behaviors and the appropriate extent of monitoring [61].

CAGE and CAGE-AID
The original CAGE (Cut down, Annoyed, Guilty, and Eye-opener) Questionnaire consisted of four questions designed to help clinicians determine the likelihood that a patient was misusing or abusing alcohol. These same four questions were modified to create the CAGE-AID (adapted to include drugs), revised to assess the likelihood of current substance abuse [62; 63].

Diagnosis, Intractability, Risk, and Efficacy (DIRE) Tool
The Diagnosis, Intractability, Risk, and Efficacy (DIRE) risk assessment tool is a clinician-rated questionnaire that is used to predict patient compliance with long-term opioid therapy [64; 65]. Patients scoring lower on the DIRE tool are poor candidates for long-term opioid analgesia.

Mental Health Screening Tool
The Mental Health Screening Tool is a five-item screen that asks about a patient’s feelings of happiness, calmness, peacefulness, nervousness, and depression in the past month [66]. A lower score on this tool is an indicator that the patient should be referred to a specialist for pain management.

Creating a Treatment Plan
Opioid therapy should be presented as a trial for a pre-defined period (e.g., ≤30 days). The goals of treatment should be established with all patients prior to the initiation of opioid therapy, including reasonable improvements in pain, function, depression, anxiety, and avoidance of unnecessary or excessive medication use [1; 40]. The treatment plan should describe therapy selection, measures of progress, and other diagnostic evaluations, consultations, referrals, and therapies. All patients prescribed an opioid for pain related to a traumatic injury (severity score ≥9) should be concurrently prescribed an antagonist (e.g., naloxone) [49].

In opioid-naïve patients, start at the lowest possible dose and titrate to effect. Dosages for opioid-tolerant patients should always be individualized and titrated by efficacy and tolerability [1]. The need for frequent progress and benefit/risk assessments during the trial should be included in patient
education. Patients should also have full knowledge of the
warning signs and symptoms of respiratory depression.

Prescribers should be knowledgeable of federal and state
opioid prescribing regulations. Issues of equianalgesic dosing,
close patient monitoring during all dose changes, and
incomplete cross-tolerance with opioid conversion should be
considered. If necessary, treatment may be augmented, with
preference for non-opioid and immediate-release opioids
over long-acting/extended-release opioids. Taper opioid dose
when no longer needed [58].

Non-Opioid Pain Management Options
Nonpharmacologic Approaches
Several nonpharmacologic approaches are therapeutic com-
plements to pain-relieving medication, lessening the need
for higher doses and perhaps minimizing side effects. These
interventions can help decrease pain or distress that may
be contributing to the pain sensation. Approaches include
palliative radiotherapy, complementary/alternative methods,
manipulative and body-based methods, and cognitive/behav-
ioral techniques. The choice of a specific nonpharmacologic
intervention is based on the patient's preference, which, in
turn, is usually based on a successful experience in the past.

Methods to provide distraction from pain come in a wide
variety, including reciting poetry, meditating with a calm
phrase, watching television or movies, playing cards, visiting
with friends, or participating in crafts. Music therapy and art
therapy are also becoming more widely used as nonpharma-
cologic options for pain management.

Non-Opioid Analgesics
Non-opioid analgesics, such as aspirin, acetaminophen (Tyle-
nol), and nonsteroidal anti-inflammatory drugs (NSAIDs),
are primarily used for mild pain and may also be helpful as
cosanalgics for moderate and severe pain. Acetaminophen is
among the safest of analgesic agents, but it has essentially no
anti-inflammatory effect. Toxicity is a concern at high doses,
and the maximum recommended dose is 3–4 g per day [67].
Acetaminophen should be avoided or given at lower doses
in people with a history of alcohol abuse or renal or hepatic
insufficiency [67].

NSAIDs are most effective for pain associated with inflamma-
tion. Among the commonly used NSAIDs are ibuprofen
(Motrin, Advil), naproxen (Aleve, Naprosyn), and indo-
methacin (Indocin). There are several classes of NSAIDs,
and the response differs among patients; trials of drugs for
an individual patient may be necessary to determine which
drug is most effective [68]. NSAIDs inhibit platelet aggrega-
tion, increasing the risk of bleeding, and also can damage the
mucosal lining of the stomach, leading to gastrointestinal
bleeding. There is a ceiling effect to the non-opioid analge-
sics; that is, there is a dose beyond which there is no further
analgesic effect. In addition, many side effects of non-opioids
can be severe and may limit their use or dosing.

Informed Consent and Treatment Agreements
The initial opioid prescription is preceded by a written
informed consent or “treatment agreement” [1]. This
agreement should address potential side effects, tolerance
and/or physical dependence, drug interactions, motor skill
impairment, limited evidence of long-term benefit, misuse,
dependence, addiction, and overdose. Informed consent
documents should include information regarding the risk/
benefit profile for the drug(s) being prescribed. The pre-
scribing policies should be clearly delineated, including the
number/frequency of refills, early refills, and procedures for
lost or stolen medications.

The treatment agreement also outlines joint physician
and patient responsibilities. The patient agrees to using
medications safely, refraining from “doctor shopping,” and
consenting to routine urine drug testing (UDT). The pre-
scriber’s responsibility is to address unforeseen problems and
prescribe scheduled refills. Reasons for opioid therapy change
or discontinuation should be listed. Agreements can also
include sections related to follow-up visits, monitoring, and
safe storage and disposal of unused drugs.

PERIODIC REVIEW AND MONITORING
When implementing a chronic pain treatment plan that
involves the use of opioids, the patient should be frequently
reassessed for changes in pain origin, health, and function
[1]. This can include input from family members and/or the
state PDMP. During the initiation phase and during any
changes to the dosage or agent used, patient contact should
be increased. At every visit, chronic opioid response may be
monitored according to the “5 As” [1]:

- Analgesia
- Activities of daily living
- Adverse or side effects
- Aberrant drug-related behaviors
- Affect (i.e., patient mood)

Signs and symptoms that, if present, may suggest a problem-
atic response to the opioid and interference with the goal of
functional improvement include [69]:

- Excessive sleeping or days and nights
turned around
- Diminished appetite
- Short attention span or inability to
concentrate
- Mood volatility, especially irritability
- Lack of involvement with others
- Impaired functioning due to drug effects
- Use of the opioid to regress instead of
re-engaging in life
- Lack of attention to hygiene and appearance

[67]
The decision to continue, change, or terminate opioid therapy is based on progress toward treatment objectives and absence of concerning adverse effects and risks of overdose or diversion [1]. Satisfactory therapy is indicated by improvements in pain, function, and quality of life. It is important to remember that for some patients with severe chronic pain, improved function may take longer than pain control. Either pain or function (not both) will improve. In some cases, preventing worsening pain/functional impairment is the best achievable outcome. Brief assessment tools to assess pain and function may be useful, as may UDTs. Treatment plans may include periodic pill counts to confirm adherence and minimize diversion.

**Involvement of Family**

Family members or the partner of the patient can provide the clinician with valuable information that better informs decision making regarding continuing opioid therapy. Family members can observe whether a patient is losing control of his or her life or becoming less functional or more depressed during the course of opioid therapy. They can also provide input regarding positive or negative changes in patient function, attitude, and level of comfort. The following questions can be asked of family members or a spouse to help clarify whether the patient's response to opioid therapy is favorable or unfavorable [69]:

- Is the person's day centered around taking the opioid medication? Response can help clarify long-term risks and benefits of the medication and identify other treatment options.
- Does the person take pain medication only on occasion, perhaps three or four times per week? If yes, the likelihood of addiction is low.
- Have there been any other substance (alcohol or drug) abuse problems in the person's life? An affirmative response should be taken into consideration when prescribing.
- Does the person in pain spend most of the day resting, avoiding activity, or feeling depressed? If so, this suggests the pain medication is failing to promote rehabilitation. Daily activity is essential, and the patient may be considered for enrollment in a graduated exercise program.
- Is the person in pain able to function (e.g., work, do household chores, play) with pain medication in a way that is clearly better than without? If yes, this suggests the pain medication is contributing to wellness.

**Assessment Tools**

**VIGIL**

VIGIL is the acronym for a five-step risk management strategy designed to empower clinicians to appropriately prescribe opioids for pain by reducing regulatory concerns and to give pharmacists a framework for resolving ambiguous opioid analgesic prescriptions in a manner that preserves legitimate patient need while potentially deterring diverters. The components of VIGIL are:

- Verification: Is this a responsible opioid user?
- Identification: Is the identity of this patient verifiable?
- Generalization: Do we agree on mutual responsibilities and expectations?
- Interpretation: Do I feel comfortable allowing this person to have controlled substances?
- Legalization: Am I acting legally and responsibly?

The foundation of VIGIL is a collaborative physician/pharmacist relationship [70; 71].

**Current Opioid Misuse Measure (COMM)**

The Current Opioid Misuse Measure (COMM) is a 17-item patient self-report assessment designed to help clinicians identify misuse or abuse in patients with chronic pain. Unlike the ORT and the SOAPP-R, the COMM identifies aberrant behaviors associated with opioid misuse in patients already receiving long-term opioid therapy [53]. Sample questions include: In the past 30 days, how often have you had to take more of your medication than prescribed? In the past 30 days, how much of your time was spent thinking about opioid medications (e.g., having enough, taking them, dosing schedule)?

**Pain Assessment and Documentation Tool (PADT)**

Guidelines by the Federation of State Medical Boards (FSMB) and the Joint Commission stress the importance of documentation from both a healthcare quality and medical-legal perspective. Research has found widespread deficits in chart notes and progress documentation for patients with chronic pain who are receiving opioid therapy, and the Pain Assessment and Documentation Tool (PADT) was designed to address these shortcomings [72]. The PADT is a clinician-directed interview, with most sections (e.g., analgesia, activities of daily living, adverse events) consisting of questions asked of the patient [73]. However, the potential aberrant drug-related behavior section must be completed by the physician based on his or her observations of the patient.

**The Brief Intervention Tool**

The Brief Intervention Tool is a 26-item, “yes-no,” patient-administered questionnaire used to identify early signs of opioid abuse or addiction. The items assess the extent of problems related to drug use in several areas, including drug use-related functional impairment [66].

**Urine Drug Tests**

UDTs may be used to monitor adherence to the prescribed treatment plan and to detect unsanctioned drug use. They should be used more often in patients receiving addiction therapy, but clinical judgment is the ultimate guide to testing frequency (Table 2) [74]. The CDC recommends clinicians...
should use UDT before starting opioid therapy and consider UDT at least annually to assess for prescribed medications as well as other controlled prescription drugs and illicit drugs [40]. However, this recommendation was based on low-quality evidence that indicates little confidence in the effect estimate.

Initially, testing involves the use of class-specific immunoassay drug panels [1]. If necessary, this may be followed with gas chromatography/mass spectrometry for specific drug or metabolite detection. It is important that testing identifies the specific drug rather than the drug class, and the prescribed opioid should be included in the screen. Any abnormalities should be confirmed with a laboratory toxicologist or clinical pathologist. Immunoassay may be used point-of-care for “on-the-spot” therapy changes, but the high error rate prevents its use in major clinical decisions except with liquid chromatography coupled to tandem mass spectrometry confirmation.

Urine test results suggesting opioid misuse should be discussed with the patient using a positive, supportive approach. The test results and the patient discussion should be documented.

CONSULTATION AND REFERRAL
It is important to seek consultation or patient referral when input or care from a pain, psychiatry, addiction, or mental health specialist is necessary. Clinicians who prescribe opioids should become familiar with opioid addiction treatment options (including licensed opioid treatment programs for methadone and office-based opioid treatment for buprenorphine) if referral is needed [1].

Ideally, providers should be able to refer patients with active substance abuse who require pain treatment to an addiction professional or specialized program. In reality, these specialized resources are scarce or non-existent in many areas [1]. Therefore, each provider will need to decide whether the risks of continuing opioid treatment while a patient is using illicit drugs outweigh the benefits to the patient in terms of pain control and improved function [75].

MEDICAL RECORDS
As noted, documentation is a necessary aspect of all patient care, but it is of particular importance when opioid prescribing is involved. All clinicians should maintain accurate, complete, and up-to-date medical records, including all written or telephoned prescription orders for opioid analgesics and other controlled substances, all written instructions to the patient for medication use, and the name, telephone number, and address of the patient’s pharmacy [1]. Good medical records demonstrate that a service was provided to the patient and that the service was medically necessary. Regardless of the treatment outcome, thorough medical records protect the prescriber.

PATIENT EDUCATION ON THE USE AND DISPOSAL OF OPIOIDS
Patients and caregivers should be counseled regarding the safe use and disposal of opioids. As part of its mandatory Risk Evaluation and Mitigation Strategy (REMS) for extended-release/long-acting opioids, the FDA has developed a patient counseling document with information on the patient’s specific medications, instructions for emergency situations and incomplete pain control, and warnings not to share medications or take them unprescribed [58]. A copy of this form may be accessed online at https://www.fda.gov/media/79776/download.

When prescribing opioids, clinicians should provide patients with the following information [58]:

- Product-specific information
- Taking the opioid as prescribed
- Importance of dosing regimen adherence, managing missed doses, and prescriber contact if pain is not controlled
- Warning and rationale to never break or chew/crush tablets or cut or tear patches prior to use
- Warning and rationale to avoid other central nervous system depressants, such as sedative-hypnotics, anxiolytics, alcohol, or illicit drugs
- Warning not to abruptly halt or reduce the opioid without physician oversight of safe tapering when discontinuing
- The potential of serious side effects or death
- Risk factors, signs, and symptoms of overdose and opioid-induced respiratory depression, gastrointestinal obstruction, and allergic reactions
- The risks of falls, using heavy machinery, and driving
Patients should be reassured that opioid withdrawal is managed by the prescribing physician or referral to an addiction specialist. Patients should be reassured that opioid discontinuation is not the end of treatment; continuation of pain management will be undertaken with other modalities through direct care or referral.

As a side note, cannabis use by patients with chronic pain receiving opioid therapy has traditionally been viewed as a treatment agreement violation that is grounds for termination of opioid therapy. However, some now argue against cannabis use as a rationale for termination or substantial treatment and monitoring changes, especially considering the increasing legalization of medical use at the state level [75]. Cannabis use for chronic pain in patients receiving opioid therapy continues to receive increased interest and support; however, experts caution that more evidence of improved patient outcomes is needed [78; 79; 80].

CONSIDERATIONS FOR NON-ENGLISH-PROFICIENT PATIENTS

For patients who are not proficient in English, it is important that information regarding the risks associated with the use of opioids and available resources be provided in their native language, if possible. When there is an obvious disconnect in the communication process between the practitioner and patient due to the patient’s lack of proficiency in the English language, an interpreter is required. Interpreters can be a valuable resource to help bridge the communication and cultural gap between patients and practitioners. Interpreters are more than passive agents who translate and transmit information back and forth from party to party. When they are enlisted and treated as part of the interdisciplinary clinical team, they serve as cultural brokers who ultimately enhance the clinical encounter. In any case in which information regarding treatment options and medication/treatment measures are being provided, the use of an interpreter should be considered. Print materials are also available in many languages, and these should be offered whenever necessary.

CRISIS INTERVENTION: MANAGEMENT OF OVERDOSE

Individuals who have first contact with persons suspected of experiencing an opioid-related overdose are in the position to intervene to prevent the potentially devastating consequences. In these cases, care begins with crisis intervention directed at immediate survival by reversing the potentially lethal effects of overdose with an opioid antagonist.
Opioid antagonists have obvious therapeutic value in the treatment of opioid overdose. A 2012 study found that wider distribution of naloxone and training in its administration might have prevented numerous deaths from opioid overdoses in the United States [81]. Since the first community-based opioid overdose prevention program began distributing naloxone in 1996, more than 10,000 overdoses have been reversed [81].

In Florida, licensed healthcare providers may prescribe and pharmacists may dispense opioid antagonists (even as a standing order) for at-risk individuals, these individuals’ relatives or other caregivers, and emergency responders to be used in their course of duties [82]. Emergency responders include (but are not limited to) law enforcement officers, paramedics, and emergency medical technicians [82]. As noted, there is a statewide standing order for naloxone for all emergency responders in Florida [33].

**OPIOID ANTAGONISTS**

Relatively minor changes in the structure of an opioid can convert an agonist drug into one with antagonistic actions at one or more opioid receptor types. Opioid antagonists include naloxone, naltrexone, and nalmefene. Interestingly, naloxone also appears to block the analgesic effects of placebo medications and acupuncture. These agents have no abuse potential [83].

In response to acute overdose, the short-acting opioid antagonist naloxone is considered the gold standard, and it remains the most widely used opioid antagonist for the reversal of overdose and opioid-related respiratory depression. It acts by competing with opioids at receptor sites in the brain stem, reversing desensitization to carbon dioxide, and reversing or preventing respiratory failure and coma. There is no evidence that subcutaneous or intramuscular use is inferior to intravenous naloxone. This has prompted some states to pass laws allowing opioid antagonists to be available to the general public for administration outside the healthcare setting to treat acute opioid overdose [84].

When used for opioid overdose, a dose of 0.4–2 mg of naloxone is administered intravenously, intramuscularly, or subcutaneously [85]. If necessary, the dose may be repeated every two to three minutes for full reversal. For ease of use, naloxone is also available in a pre-filled auto-injection device. It is important that standard Advanced Cardiac Life Support (ACLS) protocols be continued while naloxone is being administered and that medical treatment (at a healthcare facility) be given immediately.

**COMPLIANCE WITH STATE AND FEDERAL LAWS**

In response to the rising incidence in prescription opioid abuse, addiction, diversion, and overdose in the late 1990s and 2000s, the FDA has mandated opioid-specific REMS to reduce the potential negative patient and societal effects of prescribed opioids. Other elements of opioid risk mitigation include FDA partnering with other governmental agencies, state professional licensing boards, and societies of healthcare professionals to help improve prescriber knowledge of appropriate and safe opioid prescribing and safe home storage and disposal of unused medication [69].

Several regulations and programs at the state level have been enacted in an effort to reduce prescription opioid abuse, diversion, and overdose, including [86]:

- Physical examination required prior to prescribing
- Tamper-resistant prescription forms
- Pain clinic regulatory oversight
- Prescription limits
- Prohibition from obtaining controlled substance prescriptions from multiple providers
- Patient identification required before dispensing
- Immunity from prosecution or mitigation at sentencing for individuals seeking assistance during an overdose

**CONTROLLED SUBSTANCES LAWS/RULES**

The DEA is responsible for formulating federal standards for the handling of controlled substances. In 2011, the DEA began requiring every state to implement electronic databases that track prescribing habits, referred to as PDMPs. Specific policies regarding controlled substances are administered at the state level [87].

According to the DEA, drugs, substances, and certain chemicals used to make drugs are classified into five distinct categories or schedules depending upon the drug's acceptable medical use and the drug's abuse or dependency potential [88]. The abuse rate is a determinate factor in the scheduling of the drug; for example, Schedule I drugs are considered the most dangerous class of drugs with a high potential for abuse and potentially severe psychologic and/or physical dependence.

In Florida, the prescribing, dispensing, and consumption of certain controlled substances are governed by Chapter 893 of the Florida Statutes [89]. This law establishes the standards for controlled substance prescribing, including reporting system requirements, for prescribers and pharmacists in Florida. As of 2019, the Florida schedule of controlled substances aligns with the DEA schedule [39].
THE ELECTRONIC FLORIDA ONLINE REPORTING OF CONTROLLED SUBSTANCES EVALUATION PROGRAM

Emerging trends and patterns of prescription opioid abuse, addiction, and overdose are monitored by several industry and government agencies through data collection from a variety of sources. These include health insurance claims; the Automation of Reports and Consolidated Orders System, a DEA-run program that monitors the flow of controlled substances from manufacturing through distribution to retail sale or dispensing; the Treatment Episode Data Set, which monitors treatment admissions; the National Center for Health Statistics state mortality data; and the Research Abuse, Diversion, and Addiction-Related Surveillance System, which monitors prescription drug abuse, misuse, and diversion [90].

Almost all states, including Florida, have enacted PDMPs to facilitate the collection, analysis, and reporting of information on controlled substances prescribing and dispensing [1]. All prescribers must consult the Electronic Florida Online Reporting of Controlled Substances Evaluation (E-FORCSE) to review a patient's controlled substance dispensing history before prescribing or dispensing a controlled substance to a patient 16 years of age or older [39; 91]. This is mandated even for existing patients and should be done each time a controlled substance is prescribed or dispensed [39]. If the system is nonoperational or cannot be accessed due to a temporary technologic or electrical failure, the prescription may be issued (with documentation of the exception) for up to a maximum three-day supply.

All clinicians who prescribe or dispense controlled substances are required to report the action to E-FORCSE as soon as possible, but no later than the close of the next business day [39]. This should be repeated each time the substance is dispensed. This reporting requirement is waived in certain circumstances, including for [92]:

- The dispensing of a controlled substance in the healthcare system of the Department of Corrections
- The dispensing of a controlled substance to a person younger than 16 years of age

IDENTIFICATION OF DRUG DIVERSION/SEEKING BEHAVIORS

Research has more closely defined the location of prescribed opioid diversion into illicit use in the supply chain from the manufacturer to the distributor, retailer, and the end user (the patient with pain). This information carries with it substantial public policy and regulatory implications. The 2016 National Survey on Drug Use and Health asked 11.5 million non-medical users of prescription opioids how they obtained their most recently used drugs [93]. Among persons 12 years of age or older, 53% obtained their prescription opioids from a friend or relative. Of this 53%, 40.4% got the prescription opioids from a friend or relative for free, 8.9% bought them from a friend or relative, and 3.7% took them from a friend or relative without asking; 35.4% got them through a prescription from one doctor (vs. 19.7% in 2012) [93]. Less frequent sources included a drug dealer or other stranger (6%); multiple doctors (1.4%); theft from a doctor's office, clinic, hospital, or pharmacy (0.7%) (vs. 0.8% in 2012); and some other way (3.4%) [93].

As discussed, UDTs can give insight into patients who are misusing opioids. A random sample of UDT results from 800 patients with pain treated at a Veterans Affairs facility found that 25.2% were negative for the prescribed opioid while 19.5% were positive for an illicit drug/unreported opioid [94]. Negative UDT results for the prescribed opioid do not necessarily indicate diversion, but may indicate the patient halted his/her use due to side effects, lack of efficacy, or pain remission. The concern arises over the increasingly stringent climate surrounding clinical decision-making regarding aberrant UDT results and that a negative result for the prescribed opioid or a positive UDT may serve as the pretense to terminate a patient rather than guide him/her into addiction treatment or an alternative pain management program [95].

In addition to aberrant urine screens, there are certain behaviors that are suggestive of an emerging opioid use disorder. The most suggestive behaviors are [75; 96; 97]:

- Selling medications
- Prescription forgery or alteration
- Injecting medications meant for oral use
- Obtaining medications from nonmedical sources
- Resisting medication change despite worsening function or significant negative effects
- Loss of control over alcohol use
- Using illegal drugs or non-prescribed controlled substances
- Recurrent episodes of:
  - Prescription loss or theft
  - Obtaining opioids from other providers in violation of a treatment agreement
  - Unsanctioned dose escalation
  - Running out of medication and requesting early refills

Behaviors with less association with opioid misuse include [75; 96; 97]:

- Aggressive demands for more drug
- Asking for specific medications
- Stockpiling medications during times when pain is less severe
- Using pain medications to treat other symptoms
INTERVENTIONS FOR SUSPECTED OR KNOWN DRUG DIVERSION

There are a number of actions that prescribers and dispensers can take to prevent or intervene in cases of drug diversion. These actions can be generally categorized based on the various mechanisms of drug diversion.

Prevention is the best approach to addressing drug diversion. As noted, the most common source of nonmedical use of prescribed opioids is from a family member or friend, through sharing, buying, or stealing. To avoid drug sharing among patients, healthcare professionals should educate patients on the dangers of sharing opioids and stress that “doing prescription drugs” is the same as “using street drugs” [76]. In addition, patients should be aware of the many options available to treat chronic pain aside from opioids. As stated, to prevent theft, patients should be advised to keep medications in a private place and to refrain from telling others about the medications being used.

Communication among providers and pharmacies can help to avoid inappropriate attainment of prescription drugs through “doctor shopping.” Prescribers should keep complete and up-to-date records for all controlled substance prescribing. When possible, electronic medical records should be integrated between pharmacies, hospitals, and managed care organizations [76]. It is also best practice to periodically request a report from the E-FORCSE to evaluate the prescribing of opioids to your patients by other providers [76].

When dealing with patients suspected of drug seeking/diversion, first inquire about prescription, over-the-counter, and illicit drug use and perform a thorough examination [76; 98]. Pill counting and/or UDT may be necessary to investigate possible drug misuse. Photo identification or other form of identification and social security number may be required prior to dispensing the drug, with proof of identity documented fully. If a patient is displaying suspicious behaviors, consider prescribing for limited quantities [98].

If a patient is found to be abusing prescribed opioids, this is considered a violation of the treatment agreement and the clinician must make the decision whether or not to continue the therapeutic relationship. If the relationship is terminated, it must be done ethically and legally. The most significant issue is the risk of patient abandonment, which is defined as ending a relationship with a patient without consideration of continuity of care and without providing notice to the patient. The American Medical Association Code of Ethics states that “physicians' fiduciary responsibility to patients entails an obligation to support continuity of care for their patients” [99]. While physicians have the option of withdrawing from a case, they cannot do so without giving notice to the patient, the relatives, or responsible friends sufficiently long in advance of withdrawal to permit another medical attendant to be secured or to facilitate the transfer of care, when appropriate [99]. The notice of termination should be sent in writing, should specifically note the cause(s) for the termination, and should give a period of time prior to termination, usually 30 days [100]. Patients may also be given resources and/or recommendations to help them locate a new clinician.

Patients with chronic pain found to have an ongoing substance abuse problem or addiction should be referred to a pain specialist for continued treatment. Theft or loss of controlled substances is reported to the DEA. If drug diversion has occurred, the activity should be documented and a report to law enforcement should be made [101].

CASE STUDY

An unemployed man, 64 years of age, is brought to an emergency department by ambulance, after his wife returned from work to find him lying on the couch, difficult to arouse and incoherent. He has a past history of hypertension, diabetes (non-insulin dependent), mild chronic obstructive pulmonary disease, and chronic back and shoulder pain, for which he has been prescribed hydrocodone/acetaminophen for many years. His wife reports that while he seemed his usual self when she left for work that morning, he had, in recent weeks, been more withdrawn socially, less active, and complained of greater discomfort from the back and shoulder pain. She knows little about his actual medication usage and expresses concern that he may have been taking more than the prescribed amount of “pain medicine.”

On evaluation, the patient is somnolent and arouses to commands. His blood pressure is normal, he is afebrile, and there are no focal neurologic deficits. Oxygen saturation, serum glucose, and routine laboratory studies (blood counts and metabolic profile) are normal except for mild elevation in blood urea nitrogen (BUN) and creatinine; the urine drug screen is negative except for opioids. Additional history from the family indicates that the patient has been admitted to other hospitals twice in the past three years with a similar presentation and recovered rapidly each time “without anything being found.”
Following admission, the patient remains stable-to-improved over the next 12 to 18 hours. By the following day, he is awake and conversant and looks comfortable. On direct questioning, he reports recent symptoms of depression but no suicidal ideation. The patient describes an increased preoccupation with his pain syndrome, difficulty sleeping at night, and little physical activity during the day, in part because of physical discomfort. He is vague about his medication regimen and admits to taking “occasional” extra doses of hydrocodone for pain relief.

The family is instructed to bring in all his pill bottles from home, which they do. In addition to the hydrocodone prescribed by his primary care physician, there is a recent refill of a prescription for the medication given to the patient at the time of his last hospital discharge six months earlier.

**ASSESSMENT**

A full evaluation, including radiographic studies and consultation with psychiatry and physical therapy, is completed. The working diagnosis for the patient’s acute illness is toxic encephalopathy caused by the sedative side effects of opioid medication on the CNS. It is explained that the combination of his advancing age and diabetes likely reduced the efficiency of his kidneys in clearing the medication and its metabolites, making him more susceptible to CNS sedation. It is noted that the patient and his wife have little understanding of the rationale, proper use and safeguards, potential side effects, and limited effectiveness of opioid use for chronic pain.

In addition, the patient is diagnosed with poorly controlled chronic pain syndrome secondary to osteoarthritis and degenerative disc disease; exacerbating factors include deconditioning and reactive depression. The use of an opioid analgesic, at least for the near term, is considered appropriate, if dosed properly, monitored closely, and integrated into a comprehensive, multidisciplinary plan that includes treatment of depression and the use of adjunctive, nonpharmacologic modalities of care. In the setting of possible early diabetic nephropathy, the option of utilizing an NSAID, except for very brief periods of break-through pain, is not considered to be a safe option.

At discharge, and in consultation with his primary care physician, a written treatment and management plan addressing all aspects of the patient’s care is presented to the patient and his wife for discussion and consent. Among the key issues addressed are:

- Goals: Improvement in subjective pain experience; improved function of daily living manifested by regular walking exercise and improved social interaction with family and friends; relief of depression; and in the long-term, anticipated withdrawal of opioid medication and resumption of part-time work and/or volunteer community activity
- Outpatient physical therapy and back exercise program to increase core muscular strength, improve flexibility, reduce pain, and increase exercise tolerance
- Patient and family counseling regarding the safe use, dosage regulation, side effects, and proper disposal of opioid medication
- Joint patient-physician responsibilities as regards to regular follow-up, monitoring of goals and treatment effectiveness, avoidance of “doctor-shopping,” and assent to single provider for prescription medication

**FOLLOW-UP**

On follow-up six weeks after discharge, the patient is noticeably improved. He reports that he feels stronger and is sleeping better. His affect is brighter, and he is getting out more. He has maintained his physical therapy and exercise routine and is compliant with his medication. Though he still has pain, it is noticeably less and he is coping better. He and his wife are encouraged by his progress, particularly in regard to his improved functional status.

**CONCLUSION**

For patients suffering from pain, prescribed opioid analgesics may substantially lessen pain, distress, and impairment. Inappropriate overprescribing and overdose related to opioid analgesics increased dramatically in the 2000s. These trends are in multi-year reversal, but patient safety and risk mitigation remains no less important, and clinical tools, guidelines, and recommendations are available for use when prescribing opioids to patients with pain. By implementing these tools, the clinician can effectively address issues related to the clinical management of opioid prescribing, opioid risk management, regulations surrounding the prescribing of opioids, and problematic opioid use by patients. In doing so, healthcare professionals are more likely to achieve a balance between the benefits and risks of opioid prescribing, optimize patient attainment of therapeutic goals, and avoid the risk to patient outcome, public health, and viability of their own practice imposed by deficits in knowledge.
1. Inappropriate opioid analgesic prescribing for pain is defined as the non-prescribing, inadequate prescribing, excessive prescribing, or continued prescribing despite evidence of ineffectiveness of opioids.
   A) True
   B) False

2. The aging population contributes to the increasing prevalence of chronic pain in the United States.
   A) True
   B) False

3. In the absence of other risk factors, a patient prescribed opioids for chronic pain who has no personal or family history of alcohol or substance abuse is considered at medium risk for developing problematic opioid behavioral responses.
   A) True
   B) False

4. The Screener and Opioid Assessment for Patients with Pain-Revised (SOAPP-R) consists of five items.
   A) True
   B) False

5. When implementing a chronic pain treatment plan that involves the use of opioids, the patient should be frequently reassessed for changes in pain origin, health, and function.
   A) True
   B) False

6. For patients considered at medium risk for misuse of prescription opioids, urine drug testing should be completed every month.
   A) True
   B) False

7. There are no universal recommendations for the proper disposal of unused opioids.
   A) True
   B) False

8. The Office of National Drug Control Policy is responsible for formulating federal standards for the handling of controlled substances.
   A) True
   B) False

9. All clinicians who prescribe or dispense controlled substances are required to report the action to the Electronic Florida Online Reporting of Controlled Substances Evaluation (E-FORCSE) within one business day.
   A) True
   B) False

10. Injecting medications meant for oral use is suggestive of an emerging opioid use disorder.
    A) True
    B) False
Mass Shooters and Murderers: Motives and Paths

Audience
This course is designed for all healthcare professionals who may intervene to identify persons at risk for committing acts of mass violence.

Course Objective
The purpose of this course is to provide health and mental health professionals with the knowledge and skills necessary to identify persons on paths to extreme violence and to intervene to prevent mass shooting events.

Learning Objectives
Upon completion of this course, you should be able to:
1. Outline the history of mass violence and media coverage of these events in the United States.
2. Identify psychopathology that is uncommon in mass shooters.
3. Describe psychopathology that is common in mass shooters and discuss how different pathologies act synergistically.
4. Analyze cultural factors that influence perpetrators of mass violence.
5. Distinguish targeted and affective violence and the role of pathways in identifying persons at risk for mass violence.
6. Evaluate components of the Pathways to Violence Model.
7. Describe the proximal warning behaviors outlined in the Warning Behaviors Model.
8. Discuss the distal characteristics of targeted violence as defined in the Warning Behaviors Model.
9. Define core concepts associated with perpetration of extremist violence, including radicalization and terrorism.
10. Analyze current and historic extremist ideologies common in the United States.
11. Outline the role of Islamist and far-rightist violence in the United States, including media and cultural narratives.
12. Evaluate models used to describe the common pathways to extremist violence.
13. Review general gun violence trends and data.
14. Describe the barriers to and rationale for gun safety discussions with patients.
15. Discuss considerations for avoiding stigmatizing patients with mental illness and appropriately meeting the needs of non-English-proficient patients in conversations regarding gun safety.

Faculty
Mark Rose, BS, MA, is a licensed psychologist and researcher in the field of alcoholism and drug addiction based in Minnesota. He has written or contributed to the authorship of numerous papers on addiction and other medical disorders and has written books on prescription opioids and alcoholism published by the Hazelden Foundation. He also serves as an Expert Advisor and Expert Witness to various law firms on matters related to substance abuse, is on the Board of Directors of the Minneapolis-based International Institute of Anti-Aging Medicine, and is a member of several professional organizations.

Faculty Disclosure
Contributing faculty, Mark Rose, BS, MA, has disclosed no relevant financial relationship with any product manufacturer or service provider mentioned.

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

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INTRODUCTION

Mass shootings at schools and other public settings are distressingly familiar, but their close relationship to extremist violence and domestic homicide is largely unknown. Mass shootings are part of a larger public health concern of gun violence that includes homicide, suicide, and gunshot injury. These violent acts are not impulsive, but are endpoints of a pathway beginning with grievance and alienation. Interaction with other factors influences movement on a pathway to mass violence (usually, but not always, involving guns) and whether the culmination is fueled by personal or ideologic motive; the marked similarities of perpetrators and pathways in both erase many previous distinctions.

Extreme beliefs drive ideologic mass violence, but it is important to remember that few with extreme beliefs progress to extreme behaviors (violence). Hate is an extreme belief that can lead to extremist violence and motivate intergroup violence when cultural or economic changes perceived as threats are blamed on another group. In the United States, ideologic violence is primarily perceived as a problem from Muslims, but more acts of fatal mass violence are committed by far-right extremists than Islamist extremists [108].

More than half of mass shootings (generally defined as at least four persons killed in an incident) are domestic homicide events. During domestic violence, the risk of homicide increases 500% when a gun is present, and gun access is also a factor in public mass shootings [176].
Mass shootings, extremist violence, and domestic homicides are closely related. Gun violence, gun rights, and gun control are contentious subjects, but also require attention. Health and mental health providers play a key role in preventing gun violence by initiating conversations with patients, but they often lack training and guidance. Understanding the beliefs and perspectives of gun culture allows for effective gun safety counseling.

Clinicians are not immune to the false narratives surrounding mass shooting and extremist violence (a more accurate term than “terrorism”) and benefit from understanding the evidence on mass and domestic violence, gun violence in general, their aggravating and mitigating factors, and preventive approaches.

Please note that all information contained in this course is specific to the United States, except when explicitly stated.

HISTORICAL OVERVIEW

Discussions of mass shootings and extremist violence may give the impression of an American public in an era of unique and unprecedented threat, but these phenomena are not recent. The following overview describes the historical antecedent events and perpetrators of personal and ideologically motivated mass violence. Over the past 140 years, the patterns and themes are recurrent, while cultural framing of individuals as predisposed to mass violence has changed over time [253].

ANARCHISTS: THE FIRST VIOLENT EXTREMISTS

The anarchist wave of extremist violence spread from Europe to the United States in the later 1800s. Similarities to recent Islamist extremist violence are evident. Borne of extreme income inequality, anarchist ideology advocated class warfare against capitalism and government oppression through violent revolution, including bombing and assassination [1; 2].

The United States in the later 1800s was described as the Gilded Age. The richest 2% owned 60% of the wealth, 35,000 workers died in industrial accidents every year, and striking for better work conditions resulted in violent reprisals. Under these conditions, anarchism spread to the industrial hubs of the United States [1; 2].

Chicago became a center of anarchism and anarchist leaders who endorsed violence to fight capitalist oppression. A Chicago newspaper printed instructions on how to use dynamite and other terrorism-related pieces. In 1886, 40,000 workers went on strike for an eight-hour workday in Chicago. Riots ensued, a bomb thrown at a group of policemen killed seven officers, and several anarchists were prosecuted and convicted [2; 3].

The level of population-level terror caused by anarchists was substantial. Bomb attacks ripped through underground subways, theaters, cafes, parades, and other crowded settings in London, Barcelona, Paris, Moscow, Melbourne (Australia), and other major cities. Between 1894 and 1900, the heads of state in Russia, France, Spain, Austria, and Italy were assassinated [4; 5].

In the United States, an anarchist assassinated President William McKinley in 1901. Industrialists were targeted for murder. In 1920, a bomb exploded on Wall Street, killing 38 people and seriously wounding 143, the most destructive act of terrorism on American soil until the Oklahoma City bombing in 1995. In 1908, President Theodore Roosevelt stated that “compared with the suppression of anarchy, every other question sinks into insignificance” [4; 5].

Anarchist terrorism coincided with the onset of mass journalism, and a mutually reinforcing relationship developed. Tabloid-style reporting that sensationalized the terrorist acts and vilified the anarchists drove sales and profits. This attracted new recruits, ignorant of anarchist theory but interested in the notoriety and publicity. Media coverage fed into anarchists’ grandiosity and vanity, and many were obsessed with their press. The nature of reporting elevated and spread public fears and perceptions of threat disproportionate to their true levels [2; 4].

The racist anarchist profile popularized by the media fueled ethnic tensions, triggering indiscriminate deportation programs that targeted immigrant communities and other vicious backlashes against immigrants that went far beyond the perpetrators. Ethnic tensions peaked in 1927 when Sacco and Vanzetti, recent Italian immigrants, were put on trial for anarchism [2; 4]. A presidential commission warned this crackdown only validated anarchist rhetoric about a police state and made violent resistance against police brutality seem necessary to young, disaffected men in targeted immigrant communities. Instead, the commission stressed the importance of addressing severe income inequality and other root structural causes of the violence [2; 4].

Following the onset of the Great Depression in the early 1930s, severe civil unrest and frequent, violent clashes between foreclosed farmers and unemployed industrial workers and strikebreakers, police, and the National Guard were common.

On February 15, 1933, anarchist Giuseppe Zangara attempted to assassinate President-elect Franklin D. Roosevelt (FDR). Standing 30 feet away, Zangara fired five shots at FDR, hitting persons next to FDR, one of whom died [6]. By the mid-1930s, the mass unrest dissipated as social and economic policies began addressing the root causes [5].
MASS MURDER AT A SCHOOL

The deadliest school attack killed 44 and wounded 58 in Bath, Michigan, in 1927, but this event is regularly missing from depictions of mass murder in America. The Bath Consolidated School (BCS) was attacked by Andrew Kehoe, who moved to Bath in 1912 and later became treasurer of the local school board. The BCS opened in 1922, vehemently opposed by Kehoe because its funding required property tax increases. This led to conflicts with other board members. In a public defeat, he lost his seat on the school board in 1926 [7; 8].

Kehoe stopped paying the mortgage on his farm and received a letter of foreclosure. His wife was severely ill with tuberculosis. Neighbors thought Kehoe had become suicidal or was planning murderous revenge. Kehoe, a mechanic, had keys to access the BCS for repairs and rigged explosives throughout the school in the months before the attack [7; 8].

The morning of the attack, Kehoe murdered his wife, firebombed his farm, and then detonated the first bomb at BCS. The timer to the second 500-lb bomb failed, so he drove his truck into rescuers and detonated dynamite inside it, killing himself and several others. His motive was vengeance against the school board and community for increasing his taxes to pay for the BCS [7; 8]. He left a final communication, “Criminals are made, not born,” reflecting externalized blame and long-held grievance [9].

The story made national headlines, but quickly disappeared. Men of Northern European heritage in small towns, like Kehoe, did not fit the prevailing terrorist narrative during a period when the public greatly feared bombing by “anarchist foreigners”; Sacco and Vanzetti were executed three months after the Bath bombing. Without an obvious political motive, the media quickly reached for mental illness to rationalize the incomprehensible, and news headlines widely described Kehoe as a “maniac.” Then, as now, this approach stigmatizes people with mental illness, but serves to comfort a public that wants to see mass murderers and terrorists as insane, because viewing them as rational actors makes them a far greater threat [10].

MASS SHOOTINGS

The First Public Shooting Incident

Many reviews of mass shooting events in the United States cite the 1966 incident perpetrated by Charles Whitman at the University of Texas at Austin (UTA) as the first such offense. This is true of the modern era, but the first true mass murder took place in Winfield, Kansas, in 1903.

In 1889, the 19-year-old Twigg moved to Winfield with an uncle. He was reportedly viewed as bright and good-looking, with a favorable future. In 1894, a woman broke off an engagement to him. Demoralized, he joined the army in 1896, and was sent to fight in the Philippines for three years during a bloody insurrection that saw excessive brutality by both sides. During this period, an ongoing conflict with two superior officers developed into a severe grievance [11].

Returning to Winfield in 1903, his deterioration was obvious. Twigg’s former employer, and other businesses, refused to hire him. Others noted that he muttered of plots against him and of being jilted. A search of his belongings after the massacre found a rambling, paranoid note warning that vengeful annihilation of all who conspired against him was imminent [11].

The University of Texas at Austin and South Chicago Community Hospital in 1966

On August 1, 1966, 25-year-old student Charles Whitman climbed to the top of the high campus tower at UTA and began shooting at people below, killing 15 and wounding 31 before the police shot and killed him. His horrific event occurred just two weeks after Richard Speck committed one of the most notorious mass murders in American history when he gained entrance to a dormitory at night and killed eight nursing students at the South Chicago Community Hospital [12].

Both murders were thought to profoundly influence the public’s fear of crime, with Speck shattering people’s perceptions of safety in their own homes and Whitman having an equally damaging effect on beliefs of safety in public places. The two crimes significantly shaped the perception of mass murder [12].

Head injury and brain dysfunction are thought to be highly prevalent among mass murderers, with 10% a conservative estimate and considerably higher than in the general population. Brain injury may interact with adverse psychosocial factors to increase individual predisposition, suggested in the histories of Richard Speck, who sustained a head injury falling from a tree; Andrew Kehoe, who was in a coma for two weeks from a severe head injury sustained in a fall in early adulthood; and Charles Whitman, with severe headaches, changes in personality, and violent, intrusive ideation possibly from a large brain tumor found at autopsy [9; 13].

The 2017 Las Vegas Mass Murder

Detailed case analyses of mass violence perpetrators show similar distal and proximal patterns leading to the incident; this will be discussed later in this course. The Las Vegas mass murderer Stephen Paddock has remained an enigma. In the worst mass shooting in U.S. history, 59 people were killed and more than 420 were wounded by gunshots on October 1, 2017. Paddock erased his digital trail leading to the meticulously planned attack [14; 15].
The first hint of possible motivation came in documents released seven months later. Multiple witnesses gave statements of their contacts with Paddock shortly before the attack. These described his angry, agitated tirades about the deadly standoffs at Ruby Ridge, Idaho, in 1992, Waco, Texas, in 1993, and the involved agencies (Federal Bureau of Investigation [FBI], Bureau of Alcohol, Tobacco, Firearms, and Explosives [ATF]); the federal government in general, gun control, and the Federal Emergency Management Agency (FEMA) “camps” for gun owners; the 25th anniversary of Ruby Ridge; and that “sometimes sacrifices have to be made” [16; 17]. While not conclusive, the statements align with the beliefs of anti-government extremists, a segment of the far-right [18].

In the 11 months before the attack, Paddock purchased more than 55 guns (mostly assault weapons). Found in the hotel room where he shot into the crowd were 24 weapons, mostly AR-15 rifles or variants with 100-round magazines and bump stocks to enable high firing rates. Hundreds of child pornography images were found on his laptop computer. Paddock’s father was a bank robber once on the FBI’s Most Wanted List, whom the FBI classified as a “psychopath.” Psychopathic traits can be inherited, and while they do not account for the motivation, they may explain the detachment and cruelty necessary to commit such an act [14; 15].

THE MEDIA AND PUBLIC PERCEPTION

As mentioned, public perceptions of mass murder and murderers have changed over time. The framing of individuals and subgroups as predisposed to mass violence is shaped by culturally prevailing political, race, and class anxieties, which are propagated by the media. This is bidirectional, as the media also shapes prevailing political, race, and class anxieties. The stigma linked to gun violence and mental illness is itself complex, politicized, and influenced by changing views of race, gender roles, violence, and conceptions of psychiatric illness [19].

News media depictions have long been the primary information source of mass murder for the public, journalists, academics, interest group activists, and criminal justice professionals. The media has fundamentally influenced the narratives and perceptions of mass murder/murderers, and research has consistently shown that the news media presents a distorted image of crime. The need to attract a larger audience and greater advertising revenue has shaped media selection and presentation of violent crime [12; 20].

Mass shootings and murders in public spaces naturally evoke horror and outrage. The nature of media coverage and commentary amplifies public fears of their safety and promotes anger and blame directed at individuals portrayed as predisposed to mass violence. Oversimplified discussions often reduce complex phenomena to a single factor. False information can also spread by media efforts to lead the reporting in breaking news situations. Within hours of the Parkland, Florida, shooting in February 2018, Republic of Florida leader Jordan Jereb claimed credit for training perpetrator Nikolas Cruz as a joke that he posted online in alt-right fora. The media began reporting that Cruz was a violent white supremacist, and the spread of this hoax made Jereb a celebrity in trolling subcultures [21; 22]. (Trolling is defined as deliberately trying to disrupt, upset, attack, or offend others online.) Following mass shootings, alt-right trolls also float the names of innocent individuals to “bait” mainstream media uptake. After the Parkland shooting, a hoax of this nature was re-posted on Twitter by prominent figures, including the President of the United States [21].

Some widespread misperceptions and erroneous beliefs discussed in this course include [9; 23; 24; 25; 26]:

The perpetrator “snapped.”

In this case, the premise is that nobody who reflected on such an act would engage in behavior so horrifying. Unlike impulsive violence, which is the most prevalent type overall, mass shootings almost always reflect targeted, or instrumental, violence. This subtype of violence is planned and methodically prepared over time.

The perpetrator must have been Muslim.

The catastrophic attack on September 11, 2001, by violent Islamist extremists continues to shape public and law enforcement perception of Muslims as uniquely terrorism-prone. As discussed later in this course, Islamist extremist violence has become infrequent in the United States and other extremist subgroups present a higher level of threat.

The assailant must have been mentally ill.

In mass shootings that capture media attention, perpetrators are often depicted as schizophrenic, psychotic, or “psycho.” Mental illness has long been used to explain why these rampages occur, in part because it rejects the idea that a sane person could do something so horrific. Mass violence is very rare by persons experiencing serious mental illness (as it is among those without mental illness).

Mass shootings are just a fact of life.

The randomness of these events and inability to predict their perpetration can promote the view that future victims, law enforcement, and society are helpless and powerless. This is challenged by research showing that mass violence cannot be predicted but may be prevented.
MASS SHOOTERS: CHARACTERISTICS

A variety of psychopathologic, social, and interpersonal factors interact to increase the likelihood an individual will move to a path to mass violence.

PSYCHOPATHOLOGY OF MASS SHOOTERS/MURDERERS

In mass shooters with psychiatric diagnoses, perpetration is motivated by long-standing, pervasive feelings of extreme anger, persecution, violent revenge, and severe narcissism, and not by formal symptoms of the psychiatric disorder [27]. These abnormalities reflect character pathology traits or symptoms of personality disorders, which differ from serious mental illness [26].

Personality disorders are enduring, pervasive, inflexible patterns of behaviors. With typical onset in adolescence or early adulthood, these disorders of maladaptive attitudes, behaviors, and thought patterns remain stable over time. Such individuals may conclude that violence is an acceptable or necessary response to their problems, but they are not disengaged from reality and are capable of logistical and rational processes necessary for long-term planning [26].

Mass shooters frequently feel compelled to leave some type of final communication; others have been caught and extensively evaluated. Nearly all “leak” their pre-attack intent or thought process. These sources provide a more complete understanding of perpetrator motives, mental state, and psychologic disturbances [24; 28; 29; 30].

Psychiatric Disorders Not Associated with Mass Shooting

Schizophrenia/Serious Mental Illness

The umbrella term “serious mental illness” refers to psychoses, schizophrenia (including paranoid type), bipolar disorder, and severe major depression. Active delusions and psychotic symptoms, such as command hallucinations, acutely elevate the risk of violent behavior, especially if substance abuse or cognitive impairments are present. Some persons with serious mental illness who are non-adherent to their medication have a higher risk of violence, either against others or self-directed (e.g., suicidal behavior) [31]. Overall, however, persons with serious mental illness and other psychiatric disorders are not more violent than individuals without psychiatric conditions. Importantly, mass shootings committed during episodes of serious mental illness are rare [9].

Despite this, mass shootings that capture media attention are often followed by depictions of the perpetrator as mentally ill and by calls for improved mental health care [32]. For example, following the 1999 Columbine and the 2012 Newtown school massacres came high-profile warn-

ings—some by psychiatrists—that half of mass shooters/murderers were experiencing serious mental illness, mostly schizophrenia, and their treatment would have prevented such incidents [19]. The criminology literature contributes to these misperceptions by recycling obsolete and incorrect statistics on mass shooters/murderers [20].

Since 1950, the public perception of persons with mental illness as violent or frightening have increased; persons with serious mental illness are more feared today than they were half a century ago [9; 33]. In a 2013 Gallup poll designed to assess public perception of factors associated with mass shootings, 80% of respondents attributed a “great deal” (48%) or “fair amount” (32%) of blame to the failure of the mental health system to identify individuals who are a danger to others [34]. This opinion, often echoed by researchers, may appear supported by evidence that many mass shooters had received a psychiatric diagnosis at some point [25; 28]. However, these assertions of causality or heightened risk are overwhelmingly discredited by evidence that persons with serious mental illness commit less than 3% of all violence. Most of this violence does not involve guns. The relationship between psychiatric disorders and violence in any form is minimal when substance abuse is absent, and suicide—not homicide—is the most significant public health concern with mental illness and guns [9; 35; 36].

Although mass shooters with active serious mental illness are rare, they do occur. In 2009, a 41-year-old man killed 13 people and wounded another 4 in Binghamton, New York. In the two weeks before the incident, the man’s father reported that his son had stopped eating dinner and became withdrawn. A local news station received a letter from the offender, mailed the day of the shootings, that reflected chronic paranoid, persecutory delusions with the shooter describing resentment over his perceived persecution by “undercover cops” who destroyed his chances of assimilating and working in the United States. The case material suggested active psychosis and severe depression [9; 29].

Substance Use Disorders

Mass shooters seldom use substances, probably to avoid impairing effects on planning, preparation, and maximizing the casualty rate. The exceptions were two cases in which therapeutic amounts of sedating drugs were ingested [37]. In contrast, other violence commonly involves substance use, especially alcohol. With intimate partner homicide, the victim, perpetrator, or both are often intoxicated [37]. Alcohol and drug use increase the risk of violent crime as much as seven-fold, even in persons without a history of mental illness [38]. This is especially concerning in states with laws that allow persons to bring loaded handguns into bars and nightclubs. A history of childhood abuse, binge drinking, and male sex are predictive factors for serious (but not mass) violence [19; 39].

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Limitations of the Standard Diagnostic Systems

Limitations of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) have interfered with efforts to identify the psychopathology of mass shooters [40]. The DSM-5 uses a categorical diagnostic system, whereby personality and other psychiatric disorders are determined as present or absent, based on whether the number of diagnostic criteria meets the diagnostic threshold [41]. Dimensionality is a truer measure of personality pathology, because personality traits fall on a spectrum of trait dimensions that may be present in differing degrees. Destructive narcissistic or paranoid traits may be present in an individual, but when the number of symptom criteria are insufficient to meet DSM-5 diagnostic criteria, important dimensional aspects of the psychopathology are missed [24].

Extremes of character and temperamental traits do not fit easily into the categorical diagnostic system of the DSM-5 and can require more complicated formulations and assessments. The DSM has also contributed to checklist-style psychiatric examinations that may blur important diagnostic distinctions [41].

The DSM-5 classifies psychiatric disorders by symptom-based criteria and not by underlying cause. This modern DSM system increases diagnostic reliability, but some argue at the expense of validity. This is most relevant in pathologic personality traits; the dimensional aspects of mental structure and functioning and pathologic disturbances in cognition, ideation, fantasy, affect, psychologic defenses, object relating, moral functioning, and impulse control are better understood and evaluated using psychodynamic concepts [40].

Media and behavioral health specialists commonly (but usually erroneously) ascribe mass shootings and terrorist attacks to delusional, psychotic beliefs [42]. The DSM-5 classification of psychotic disorders invites interpretation of rigid but non-delusional beliefs as psychotic-spectrum conditions [41].

An extreme overvalued belief is a core concept in understanding ideologic violence and mass shootings. Extreme overvalued beliefs are rigidly held, non-delusional beliefs shared by one’s subgroup. The belief is often defended, becoming more dominant, refined, and resistant to challenge over time. The individual develops an intense emotional commitment to the belief and may act violently in its service—justified by a sense of moral superiority [42].

Extreme overvalued beliefs are not psychotic delusions, which are defined as fixed, false idiosyncratic beliefs not shared by others. Extreme overvalued beliefs also are not obsessional beliefs, recognized by an individual as their own but resisted due to the intrusive unpleasant nature. The DSM-5 adds confusion by describing overvalued ideas as not shared by others in one’s subcultural group, which is often not the case [42].

The 9/11 terrorists, Unabomber Ted Kaczynski, the Oklahoma City bomber, and perpetrators of Islamist and anti-abortion violence all possessed extreme overvalued beliefs that promoted a view of their moral superiority that justified violence [41]. During the criminal responsibility evaluations of Anders Breivik (the Norwegian mass shooter responsible for the deaths of 77 people), the initial team of psychiatrists erroneously concluded his beliefs reflected paranoid schizophrenia. A second team correctly defined his bizarre, extreme beliefs as extreme overvalued beliefs shared by other right-wing extremist groups in Norway [42].

One subgroup with shared extreme overvalued beliefs are “sovereign citizens.” Believing the U.S. government is illegitimate, they wage war against it and those in authority through harassment, refusal to pay taxes, intimidation, and occasionally violence. When challenged, sovereign citizens espouse idiosyncratic legal theories and political beliefs that may appear delusional but are shared by these adherents and are best understood as an extremist political philosophy and not as a psychotic belief system [41].

Psychopathology Associated with Mass Shooters

As discussed, psychiatric disorders alone do not cause individuals to commit mass shootings. But psychiatric symptoms may exacerbate other problems, making it more difficult to deal with family, work or school problems, peer relationships, or personal crises [43]. Mass shooters may report their acts of violence were precipitated by anger over blocked goal achievement (e.g., being expelled from school or fired from work) or negative social interactions (e.g., peer bullying, rejection, humiliation) [43]. The disproportionality and perceived basis of their rage and vengeance is not adequately explained by psychologic conditions (e.g., depression, psychosis, antisocial personality) or social experiences (e.g., being bullied) [44; 45].

Instead, this requires contribution from other conditions. With narcissism, psychopathy, or paranoia present, one’s perspective and interpretation of the world readily distorts, which promotes irrational and exaggerated perceptions of one’s victimization and persecution, ultimately leading to the targeting of those perceived to represent their persecutors [25; 43]. The interaction of paranoid ideation and narcissistic pathology captures the psychopathology of mass shooters.

Paranoia

Paranoia begins as a profound disturbance in the sense of trust—a sense of self under attack. This develops from an intense insecurity related to some deep sense of inferiority. The intensity of this perceived insecurity and constant intrusion into awareness generates anxiety. Convinced the defect is perceived by others and cannot be disguised, chronic feelings of shame and humiliation develop [45]. A belief one is special enough to be singled out for persecution reflects the narcissistic dimensions of paranoia [46].
Individuals with paranoia are hypersensitive to perceived slights. Obsessed with revenge, they justify the revenge as “payback” for a perceived injustice. They often react disproportionately to perceived slights, and their “mistrustment” by others may not have been extreme or unusual. Eric Harris (one of the Columbine killers) left a diary describing a hatred of his bullying, persecutory peers; this was unsubstantiated after extensive interviewing of Columbine students [47]. The final writings of Virginia Tech shooter Seung-Hui Cho portrayed other students (whom he barely knew) as having “raped my soul” and having “crucified” him [46].

Rejection or “disrespect” is perceived as showing others are on attack, consider them inferior, or expect them to submit to external control. Paranoid persons become obsessed with social rank and status in social settings and despise weakness. Self-justifying and entitled, they view their behavior as necessitated by their unique plight caused by the ill will of others [45].

The nature of paranoia self-exacerbates, because the paranoid individual withdraws and his or her thought processes are not amenable to corrective feedback. The individual ruminates angrily on his or her humiliation by others. This becomes magnified with isolation, explaining the build-up of rage and planned annihilation and how the personality pathology of mass shooters devolves over time [45; 48].

The obsession with rejection or “disrespect” that progresses into rage and planned annihilation usually stems from paranoid thinking and not psychopathy [49]. Purely psychopathic individuals do not form or desire to form emotional bonds, are unlikely to obsess about rejection by others, and are likely to dismiss the others out of hand. While Harris and some other mass shooters possessed prominent psychopathic traits, their psychopathy was not the main driver of murderous vengeance over perceived social rejection [45].

Studies of mass murderers describe paranoid conditions as pervasive, falling on a spectrum from traits to delusion. Paranoid themes seldom rise to the level of psychosis in these offenders, but virtually all share common themes of preoccupation with feelings of social persecution, alienation, and/or perceived injustice; severe envy; and fantasies of revenge against their perceived tormentors for the cumulative perceived maltreatment [9; 24; 50]. It is important to remember that feeling persecuted and being persecuted are not the same thing [45].

Narcissistic Pathology
Narcissism is a dimensional personality trait that, in more pronounced cases, involves an inflated and grandiose regard of self, extremely low regard of others, and inability to experience empathy, concern, or compassion for others’ suffering [51]. With a grandiose and unstable sense of self, hypersensitivity to ego threats results in retaliatory aggression and violence to perceived social rejection and insult [52]. In pathologic narcissism, destructive rage is an externalized defense reaction against intolerable feelings of shame or powerlessness and aversive self-awareness of defect [23].

Narcissistic injury occurs when the pathologic narcissist perceives a threat to their self-esteem that reveals to others their hidden, “true” defective self [44]. Narcissistic injury can provoke narcissistic rage, an ego preservation response that serves to restore a sense of safety and power by destroying a threat, to satisfy the need for revenge, and to right a wrong by inflicting pain on another [13; 53]. When present with paranoid traits, the interaction can produce a severe reaction with excessive retaliation and disproportionate transfer of pain to perceived persecutors believed to be the only resolution [23; 24].

The interaction of paranoid cognition with narcissistic traits over time increases the propensity for targeted violence. This is most evident in the diaries or “manifestos” of mass shooters discovered post-event. A central theme is feeling rejected, dismissed, disrespected, and devalued by an “in-group” and of wanting vengeance for this mistreatment. The in-group is despised for being “superficial” and for their undeserved status. The “rejecting” peer group becomes an obsession; the shooter cannot let go and move on [45].

Malignant narcissism, a syndrome with core components of pathologic narcissism, antisocial features, paranoid traits, and unconstrained aggression, may also be present. Malignant narcissism is psychoanalytically described as a level of personality fracture or disorganization—a disturbance of object relations—whereby a profoundly fragile sense of self is compensated by antisocial grandiosity (“I am above the rules”) and preoccupation with mistreatment and disrespect by others [52; 53].

Autism Spectrum Disorder
The role of autism spectrum disorder (ASD) in mass shooters is controversial but significant and only recently identified [54]. ASD encompasses the neurodevelopmental disorders previously termed autism and Asperger syndrome. The range of potential symptoms and severities makes ASD a spectrum disorder [55].

ASD is not a mental illness or personality disorder in the usual sense, but is considered an impairment of early brain development leading to personal, social, academic, or occupational difficulties [55]. ASD is usually identified in early childhood by pervasive deficits in social communication and interactions, restricted and repetitive patterns of behavior or activities, and intense but non-bizarre special interests [54].

Marked social impairment and anxiety, lack of empathy, highly rigid thought processes, and very literal interpretation of written and verbal material typify ASD [43]. Persons with ASD can have good technical skills and may be drawn to computers, which are logical and syntax-guided, unlike social interactions, which are guided by semantics and can be confusing and anxiety-provoking [56].
ASD is differentiated from other disorders that may present with social-interaction abnormalities and restricted interests. Unlike schizoid personality disorder, persons with ASD often have a desire to make friends or have intimate relationships, but profound social-skills deficits make them unable to appropriately engage, empathize with, or respond to others. Unlike schizotypal personality disorder, social-interaction impairments in ASD are rooted in empathic and perspective-taking deficits [57].

Core problems faced by individuals with ASD include impairments in interpersonal reciprocity and understanding the effects of their actions on others [54]. Common comorbidities of anxiety, mood, and personality disorders or attention-deficit/hyperactivity disorder (ADHD) may intensify impaired coping ability. Early comorbidity may further impair later social adjustment in youths with ASD, highlighting the importance of early diagnosis and treatment [43].

ASD alone does not increase the risk for mass violence; this requires the presence of additional factors that interact with ASD features, such as deficits in social cognition and empathy, emotion-regulation deficits, and intense restricted interests [57; 58]. History of childhood neglect or abuse correlate with later criminal behavior. Comorbid psychopathy with ASD is rare but potentially very serious and a significant violence risk and threat assessment issue. At first assessment, it may be difficult to distinguish between the two because lack of empathy is characteristic of both disorders, but the underlying reasons differ [54; 57; 59; 60]. An increased intensity of preoccupations with disturbing or violent content is a possible warning sign [43].

Research suggesting ASD may be over-represented in mass shooters was investigated using the Mother Jones database of mass shootings (as noted, defined as at least four deaths in a single event). Evidence of ASD was evaluated in 75 cases, and 8% of perpetrators had a pre-event ASD diagnosis; this increased to 9% after adding Elliot Rodger, the Santa Barbara mass shooter [43]. An additional 21% of the cases had ASD traits or symptoms [43].

CULTURAL INFLUENCES

Mass shooting incidents have increased since the 2000s. With mental disorders alone negligibly related to mass shooting and not useful for predicting violent acts, researchers have looked to other explanations in the culture.

Culture of Celebrity, Narcissism, and Perverse Incentive

Since the 1990s, mass murders have not just increased, but have arguably taken on a different quality, especially mass shootings. With an American culture that promotes an influential value system centered on celebrity and fame, narcissism has been described as the classic American pathology. An upswing in the narcissistic values of American culture since the 1990s has also been documented [61; 62; 63]. Some critics have suggested that media attention makes mass killers into celebrities. A comparison of media coverage given to celebrities versus seven perpetrators of mass killings during 2013–2017 found the murderers received roughly $75 million in media coverage value. Some received more high-value coverage during their attack months than some of the most famous American celebrities, and media coverage exceeded the public interest, as reflected in online searches and Twitter use [64].

Contagion, Copycat, and Columbine as Cultural Script

The idea of a “cultural script” has also been examined. A “cultural script” describes a schema, or a prescription, for behavior. Media and sociocultural factors have propagated a “script” of mass shootings that points to armed attack as a model for problem-solving—a “masculine” solution to lessen an inferior social position, especially for altering the shooter’s reputation from a socially marginalized loser to a notorious antihero [27; 50]. Media attention to mass murder may perversely glamorize the act in the eyes of subsequent perpetrators; the instant notoriety feeds narcissistic pathology [9; 65].

Social media is an important contributing factor to this disturbing finding, given the appeal of fame, or rather infamy, without achievement other than successfully killing innocents [66]. Performative violence, a related concept, describes the construction of identity or position through a violent act that, by demanding audience attention and compelling the audience to look intently at the perpetrator and his or her act, fulfills perpetrator needs for recognition and acknowledgment of their existence and uniqueness [67].

Contagion and copycat effects are related but distinct. Contagion is imitation of the violent act, an effect active over days or weeks. Copycat is identification with the actor, an effect that may remain active for months or even years. Copycats can aggregate over time to become a cultural script [50]. School shooters are more likely than other types of mass murderers to commit copycat violence for achieving notoriety [28].

Perpetrators and plotters looked to past attacks for inspiration and operational details to cause even greater damage [68; 69]. The FBI examined 160 mass shootings committed after Columbine and found a copycat effect that was stronger and more pervasive than previously understood.

The 1999 Columbine shooting was a landmark event; the planning of this mass shooting was driven by rage and narcissistic desire for immortality. The perpetrators, Eric Harris and Dylan Klebold, uploaded videos of themselves firing guns, yelling into the camera about killing hundreds and starting a “revolution,” and other content fantasizing about Hollywood directors fighting over their story. At the dawn of the Internet era, the Columbine offenders created a script for mass shooting [68; 69].
Mother Jones analyzed 74 plots and attacks by perpetrators claiming inspiration by Columbine. Of these, 53 plots were thwarted and 21 were completed and resulted in the deaths of 89 victims and injury of 126. Of these [68; 69]:

- The suspects often planned the attack on the anniversary of Columbine (≥21 cases).
- The goal was to outdo the Columbine body count (13 cases).
- The suspects referred to Harris/Klebold as heroes, idols, martyrs, or God (at least 10 cases).
- At least three suspects made pilgrimages to Columbine High School, two of which carried out rampages after returning home.

The “Columbine effect” describes this cultural script of aggregated copycats; mass shootings are ritualized and self-referential, with perpetrators identifying with past shooters. This expands beyond the Columbine legacy, with mass shooters citing many others before them. The Internet has propagated this script by increasing the ease by which perpetrators can study and idolize previous mass killers [27].

A universal reporting code has been recommended for appropriately covering these incidents and reducing “copycat” effects. This media guidance suggests avoiding emphasis on perpetrators and neither glorifying nor demonizing them, and emphasizing victim and community recovery efforts [9; 70].

**Violent Video Game Consumption**

The consumption of violent media, in particular violent first-person shooter video games, has been suggested as a factor contributing to a likelihood of committing violent acts. The shoot-to-kill style of first-person shooter games is considered highly arousing and violent.

This theory can be traced back to Columbine shooters Harris and Klebold, whose writings indicated they had used the video game *Doom* to prepare for their attack. Similarly, Anders Breivik claimed to have used the video game *Modern Warfare 2* during his preparation phase [71]. There is some evidence that exposure to media violence is a risk factor for aggressive behavior in youth, including violent criminal behavior [72]. However, other studies have found no link between video game violence and aggressive behaviors or reduced empathy in youth [73]. There is even less evidence of effects on adults, including adults with ASD [74].

It is important to note that most video game players do not commit violence, and most mass shooters have no documented history of violent media consumption. It has been suggested that player motivations, frustration, and the social context of play may influence the possible risks associated with violent video games [75].

**Hegemonic Masculinity**

It is important to note that masculinity, like all expressions of gender, is fluid, and each culture may have many types of masculinity available [252]. Hegemonic (“toxic”) masculinity has not been clinically defined, but it is generally understood to mean “a set of values, established by men in power, that functions to include and exclude, and to organize society in gender unequal ways. It combines several features: a hierarchy of masculinities, differential access among men to power (over women and other men), and the interplay between men’s identity, men’s ideals, interactions, power, and patriarchy” [252]. This conceptualization of masculinity, based on the idea that men are inherently more powerful than women and some other men, is common in alt-right and far-right ideologies.

**MASS SHOOTERS: PATHS TO VIOLENCE**

Mass shootings are followed by a collective frustration, even anguish, over the inability to stop these incidents from recurring. Evidence from research on suicide and violence prediction and prevention can help explain why standard methods fail in thwarting mass shooters.

Suicide reduction has long relied on suicide prediction using risk factors to place patient suicide potential as low, moderate, or high. However, this approach fails to consider the fluidity of proximal factors that drive acute suicide behaviors. Today, experts believe suicide cannot be predicted but can be prevented, and this paradigm shift has transformed suicide prevention efforts [76].

Predicting future violence is likewise difficult. Predictive methods of assessing violent antisocial behavior rely on risk assessment, whereby risk factors are measured and used to statistically predict future violence. To examine the value of risk assessment, 409 patients detained for violent criminal behavior were evaluated and followed 12 months after discharge to the community. Risk assessment had little value in predicting future violence and could not identify essential risk factors that should be targeted to prevent violence [77].

Thus, predictive methods fail to identify future violence in mass shooters because predictor risk variables (e.g., criminal history, psychiatric diagnosis, drug history) are static factors that are causally and temporally unrelated to violence [77]. Standard prediction and profiling methods cannot identify individuals posing a high, increasing, or imminent threat. Profiling is helpful in identifying perpetrators who have already acted violently, such as serial murderers, but is not useful with future mass shooters [66; 78].
One approach, based on the concept that targeted violence is distinct from affective violence, is already showing promise in interrupting mass shooters before they act [69; 78; 79; 80; 81; 82]. Targeted violence (also referred to as instrumental or predatory violence) is methodically planned against individuals, groups, or locations. Affective violence (also referred to as impulsive or emotional violence) is emotionally charged, impulsive, and reactive and typifies intimate partner violence (IPV). While affective violence is the most common subtype of violence, it does not accurately describe mass shootings. Mass shootings are considered an example of targeted violence, the endpoint of an understandable process of thinking and behavior that is neither spontaneous nor impulsive. Potential offenders on a pathway to targeted violence can be identified and prevented, but not usually predicted.

The National Collaborating Centre for Mental Health recommends using a multidisciplinary approach that reflects the care setting when assessing and managing the risk of violence and aggression. Take into account previous violent or aggressive episodes, because these are associated with an increased risk of future violence and aggression.


**Level of Evidence:** Expert Opinion/Consensus Statement

Two models have been developed and applied to describe, identify, and impede those on a pathway to acts of targeted violence. The Pathway to Violence Model was developed by the U.S. Secret Service from studying assassins and school shooters [78]. It describes a progression from grievance to violent attack and helps differentiate individuals who threaten and menace a target from those truly intent on committing violence. This model describes the underlying interaction of emotional and psychosocial factors [83; 84].

The Warning Behaviors Model uses pattern recognition of dynamic variables proximally related to violence that reveal pre-attack behaviors and violent intent. Unlike static risk factors, dynamic proximal factors are the best short-term indicators of targeted violence, because they point to intrapersonal behavioral, cognitive, and emotional processes that signify decreasing, increasing, or imminent threat [40; 82; 85].

The Warning Behaviors Model captures superordinate behavioral and psychologic patterns that may represent changing or accelerating risk. This model is used extensively in targeted violence of school shooters and other public mass shooters, including violent extremists [40; 79; 80; 81; 85; 86].

Both models are complementary and overlapping, because state of mind and outward behaviors are inextricably intertwined. Understanding the pathways to targeted violence of mass shooters facilitates their disruption and prevention [26; 78; 79; 80; 81]. As discussed, prevention does not require prediction.

**THE PATHWAY TO VIOLENCE MODEL**

The Pathway to Violence Model does not suggest that all, or even many, people with a grievance will move to violent action [87]. However, the FBI states that among threat-management models, Pathway to Violence is best-suited to address the question of why persons perpetrate targeted violence [26].

**Stages of the Pathway to Violence Model**

**Grievance**

The first stage of the Pathway to Violence Model is a perceived injustice, threat, or loss of a highly personal significance. In this context, grievance refers to the cause of the offender’s distress or resentment—a perception of having been wronged or treated unfairly or inappropriately. More than a feeling of anger, grievance can result in a desire, even a sense of mission, to right the wrong and achieve a measure of deserved justice. Grievance is more than a feeling of discontent or a short-lived, even explosive, expression of anger or frustration; it is a conclusion reached about the reason for the offender’s suffering. A grievance is external to the offender, and by externalizing blame, the offender creates a target for retribution. The grievance becomes an organizing principle as the offender seeks to address the unjust treatment causing the anguish [87].

The grievance is exacerbated by a robust narcissism laced with an inflated sense of entitlement, privilege, or ability that, when perceived as unrecognized or insulted by others, results in an intolerable state, whereby the only compensatory relief to their sense of humiliation comes from rage and violent fantasy (i.e., ideation) [78]. However, few who are aggrieved progress to committing targeted violence.

**Ideation**

Those who become violent move from grievance to ideation as they realize violence is the appropriate means to address their grievance and make a conscious choice to violently harm others [83; 87].

Unable to find satisfaction or repair outside of violent fantasy, a “pseudocommando” warrior mentality may consume their thinking while simultaneously inflaming their narcissistic grandiosity. Revenge fantasies become inflexible and persistent because they provide desperately needed nourishment to injured self-esteem. A sense of (pseudo) power and control is gained by ruminating on vengeance [29]. Subjects often begin a fascination with previous attacks and attackers during the ideation stage, underscoring the notoriety and attention that often accompanies high-profile targeted violence [88].
Many persons who harbor profound grievances and violent revenge fantasies do not progress to violence and withdraw into an omnipotent fantasy of violent retribution [24]. Others become so enthralled by violent ideation and psychologically consumed by the compensatory relief it affords their fractured ego that they lose the desire or ability to pursue nonviolent means of resolution [78].

**Research and Planning**

Eventually, fantasy may escalate beyond ideation into action; research and planning bridges the gap between idea and action. During this stage, the offender takes concrete steps toward an attack and dedicates effort and energy toward the goal, which can include selecting and gathering information on the target, stalking the target, photographing targeted areas (e.g., classrooms, hallways, theaters), and charting out areas for explosive devices. Other behaviors can include Internet searches and conversing with like-minded others on social media or online [26; 78].

**Preparation**

During the preparation stage, the individual is accumulating the necessary weapon(s), ammunition, clothing, or other practical materials needed for an attack; the offender is also becoming psychologically prepared [78]. Other behaviors can include assembling equipment, confirming transportation routes, and/or attack rehearsal [26]. Kimveer Gill played a video game that re-enacted Columbine (considered a rehearsal) before killing one person and injuring 19 at Dawson College in Montreal in 2006 [45].

**Breach**

The offender assesses the level of security and barriers that must be defeated to gain close physical proximity to the target in the breach stage. Without normal access to a targeted facility, the offender may breach by conducting a “dry run” penetration test, intruding into a facility where he or she does not have legitimate access to identify security countermeasures. Breaching can also involve the smuggling of weapons into a classroom or theater, and then waiting to attack, or dressing as a security guard or package delivery person for a non-forcible entry [78; 89].

**Attack**

The final stage is the attack. The offender launches a destructive, nihilistic assault, attempting to completely dominate the targeted institution or person. The attack typically represents the manifestation of two desired states [78; 90]:

- Perceived infamy and notoriety from the inevitable media coverage
- A sense of omnipotent—but transient—control

The offender’s depleted narcissism fuels an overwhelming desire for omnipotent control over the target. The offender may realize the attack will result in his or her arrest or death, but the fleeting experience of control is perceived as transformative [78; 90].

**The Pathway to Violence Model in Research**

The initial Pathway to Violence stages have been applied to analysis of the progression of paranoid cognitions observed in mass murderers. Threat perception occurs when perceived...
personal inadequacy interacts with real or imagined perception of threat and expectations of persecution. Threats typically involve some form of social or peer rejection (i.e., a grievance). Whether delusional or not, this perception triggers feelings of humiliation and anger, if not hatred, contempt and disgust for the perceived persecutors [24].

Manifestos and other written communications of mass shooters show recurrent themes of persecution, alienation, envy, and vengefulness. These were identified by psycholinguistic analysis of pre-attack communications from 12 mass shooters (Table 1) [28; 46].

THE WARNING BEHAVIORS MODEL

The Warning Behaviors Model has two components: proximal warning behaviors and distal characteristics. Some proximal and distal items reflect the original development for use in terrorism, but the model has been applied to all forms of mass violence.

Proximal Warning Behaviors

Pathway Behavior

Any behavior described in the Pathway to Violence Model is defined in the Warning Behaviors Model as a pathway behavior, including research, planning, preparation, or implementation of a targeted attack [83].

Sirhan Sirhan assassinated Senator Robert F. Kennedy on June 5, 1968, the first anniversary of the Six-Day War. Sirhan was not Muslim but identified closely with the Palestinians and saw Kennedy’s vote to sell 50 combat jets to Israel in January 1968 as a betrayal of his people. In the five months leading to the attack, Sirhan secured a handgun, practiced at a shooting range, and made at least four approaches to Kennedy in public venues before shooting him in the pantry at the Ambassador Hotel in Los Angeles, California. This assassination began the U.S. Secret Service’s practice of protecting aspiring presidential candidates [79]. Each of the actions he took would be categorized as a pathway behavior.

Fixation

Fixation is defined as an extreme preoccupation with another person, activity, or idea, often involving a grievance and a personal cause. With increasingly pathologic preoccupation comes social and occupational deterioration. Fixation is observed by increasing perseveration on persons or cause; increasingly strident opinion, negative characterization of the object of fixation, and angry emotional undertone; and impact on family or associates of the object of fixation, if present and aware [50].

In 2007, during his psychiatric residency, Nidal Hasan, the 2009 Fort Hood, Texas, mass killer, gave a psychiatric presentation titled, “The Koranic World View as it relates to Muslims in the Military.” Note the disconnect between topic and context of the lecture in some of these quotes [79]:

- “We love death more than you love life!”
- “Fighting to establish an Islamic state to please God, even by force, is condoned by Islam.”
- “Muslim soldiers should not serve in any capacity that renders them at risk to hurt/kill believers unjustly.”

Hasan became increasingly vocal in his opposition to the Afghanistan and Iraq wars and gave a subsequent psychiatric presentation titled, “Why the War on Terror is a War on Islam.” In late 2008, Hasan sent 18 emails to Anwar al-Awlaki in Yemen asking whether killing American soldiers and officers was religiously legitimate. His fixation was a cause, but it became deeply personal because his grievance against the wars in the Middle East went unheeded [79].

Identification

Mass shooters often have behavior demonstrating a warrior mentality or psychologic desire to be a pseudocommando. These individuals identify with military or law enforcement weapons, uniforms, or paraphernalia, or with previous attackers. They may self-proclaim as agents to advance a cause or belief system [79].

Fixation is what one constantly thinks about, and identification is what one becomes. Fixation and identification are key warning behaviors; the evolution from preoccupation to self-identity distinguishes (with a large effect size) attackers from persons of concern without violent intent [50].

An example of this type of behavior is Anders Breivik, who in 2011 bombed several Norwegian government buildings (killing 8 people) and hours later shot and killed 69 young people. Breivik identified himself as a reincarnated Knights Templar, the militant spear of the 12th-century Christian Crusades against the Muslims, and saw himself as a soldier fighting to free his people from Muslim immigrants and multiculturalism. In photos, Breivik wore homemade uniforms emblematic of his identification. He developed an affinity for American terrorists Ted Kaczynski (and plagiarized his writings) and Timothy McVeigh, writing that McVeigh probably felt as he did when making his bombs [79].

As noted, school shooters recurrently identify with the Columbine perpetrators. This is exemplified by the assailant who killed 10 victims and injured at least another 10 at his high school in Santa Fe, Texas, in 2018. On the day of the attack, he wore a black trench coat in 90-degree weather [91].

Novel Aggression

Novel aggression is an act of violence that appears unrelated to any pathway behavior and is committed for the first time. This behavior tests the perpetrator’s ability to become violent and can be thought of as experimental aggression [37].
Energy Burst

Mass shooters often display an increase in frequency, duration, or variety of warning behaviors related to a target, even if the behaviors appear innocuous, in the days or weeks before an attack [37]. For example, Jared Loughner, in the 12 hours before his attack on U.S. Representative Gabrielle Giffords and bystanders in a supermarket in 2011, engaged in the following, according to police reports [79]:

- Drops off 35-mm film at Walgreen’s before midnight, checks into motel shortly after midnight… searches web for ‘assassins’ and ‘lethal injection’… at 02:19 picks up photos, makes a purchase, leaves telephone message with friend… at 04:12 posts to Myspace page a photo of his Glock pistol and the words ‘Goodbye friends.’
- At 06:00, visits Walmart and Circle K stores, unable to purchase ammunition at first Walmart, purchases 9-mm full metal jacket ammo and diaper bag at 07:27… stopped by police officer for running a red light… went home but was confronted by father, runs away… returns to Circle K, gets a cab, goes to supermarket where he insists on getting correct change for cab ride to the shopping center where Congresswoman Giffords was speaking… 16 minutes later at 10:10, opens fire, killing 6 and wounding 13 people. Tackled by three senior citizens when he attempts to reload.

Leakage

Leakage is defined as intentions or plans of violence expressed to another person or posted on the Internet that raise concern. Leakage may be overt (e.g., “I’m going to kill my supervisor and his cohorts tomorrow.”) or covert (e.g., “Don’t come to work tomorrow, but watch the news.”) [37].

This warning behavior is one of the strongest warning signs an individual intends to commit targeted violence [40]. Leakage is nearly ubiquitous across all targeted violence offender groups, including juvenile and adult mass murderers, attackers of public figures, school shooters, and lone actor terrorists. Grievance is strongly correlated with leakage, but no single mass shooter “profile” is more likely than others to leak intent [87]. Threat assessment professionals should not expect leakage based on a subject type (e.g., young, with criminal history) and be reassured by its absence, or be surprised by its presence with a subject type (e.g., well-educated professional, no criminal record) and discount its potential significance [87].

Would-be offenders frequently express threats or intentions to others verbally or in writing, posting a manifesto or on online fora. In most school shootings, at least one person knew about the killers’ intentions [28; 40; 92; 93]. Leakage before a planned attack was acknowledged by Tucson offender Loughner in his writings: “Of course, I kept a journal. Don’t people like me always keep a journal? It’s part of the whole thing. It was me against the world” [28].

On December 20, 2010—19 days before the attack—Loughner wrote on his MySpace page: “I HAVE THIS HUGE GOAL AT THE END OF MY LIFE: 165 rounds fired in a minute!” A week earlier, Loughner wrote: “I’ll see you on National TV! This is a foreshadow… why doesn’t anyone talk to me?” [37].

Numerous mass shootings have been prevented because people reported hearing or observing oral or written threats of violence [69; 94]. In 57 cases of thwarted attacks, manifestos were frequently posted online by the would-be offenders who made highly credible threats [94].

In many other cases, persons aware of the threatened mass violence did not alert anyone in authority. By reporting such advance communications, individuals can help prevent planned acts of mass violence. To encourage adolescents to speak out, many school administrators have provided anonymous avenues for students to make reports without fear of repercussion. The U.S. Department of Homeland Security implemented the “If You See Something, Say Something” campaign as a nationwide means of encouraging citizen reporting and community safety [28; 86; 95; 96; 250].

Many health and mental health professionals are governed by a duty to warn if they are aware that a patient may be a risk to others. This applies to cases of mass shooters just as it does in cases of intimate partner or family violence.

Directly Communicated Threat

Some perpetrators will make an unambiguously stated or written threat to either a target or to law enforcement expressing intent to commit violence. For decades, law enforcement academies taught that explicit threats were a precursor to violence [66]. This is valid in the context of a current or past sexual intimate; in these cases, directly communicated threats indicate heightened risk of violence against the target, referred to as the “intimacy effect.” However, in targeted violence, this is disproven, and directly communicated threats are rare.

Last Resort

Last resorts are communications or actions indicating a “violent-action imperative” or time imperative and increasing desperation or distress, forcing the subject into a position of last resort. No alternative to violence is perceived, and the individual believes the consequences are justified; the subject feels trapped [79; 85].

Days after white supremacist Dylann Roof perpetrated his mass murder in a South Carolina church in 2015, his website and manifesto were discovered. These writings provide a good example of last resort thinking. Roof had written [79]:
I have no choice. I am not in the position to, alone, go into the ghetto and fight. I chose Charleston because it is [the] most historic city in my state, and at one time had the highest ratio of blacks to Whites in the country. We have no skinheads, no real KKK [Ku Klux Klan], no one doing anything but talking on the Internet. Well, someone has to have the bravery to take it to the real world, and I guess that has to be me.

Evidence of Validity

The Terrorist Radicalization Assessment Protocol-18 (TRAP-18) combines the 8 proximal warning behaviors and 10 distal characteristics into a single assessment instrument for mental health providers, law enforcement, and intelligence/security professionals. Developed for threat assessment of violent extremists, use of TRAP-18 has expanded to all potential lone-actor perpetrators of targeted violence [81].

The validity of TRAP-18 was examined in 111 violent Islamist, right-wing, and single-issue extremist cases in 1990–2014 [81]. Researchers found that 70% demonstrated at least half of the 18 TRAP variables and more than 77% showed all four warning behaviors (i.e., pathway, fixation, identification, and leakage). Leakage (85%) was the most frequent proximal warning behavior. Less frequent proximal warning behaviors were directly communicated threat (22%), novel aggression (17%), and energy burst (8%). Few differences were observed among extremist ideology groups. The authors concluded the TRAP-18 appeared useful across the spectrum of ideologies that drive targeted violence [81].

A separate study examined 33 mass murderers in Germany from 2000–2010. An average of 6.11 warning behaviors were present in each perpetrator. The authors concluded a pattern of proximal warning behaviors can be expected to precede targeted mass murder [80; 81].

An FBI analysis found the observable behaviors that are most suggestive of pre-attack planning of targeted mass violence include [26]:

- Novel or greatly increased interest in guns
- Recent, significant real or perceived personal loss or humiliation
- Surveillance behaviors
- Sudden changes in social media behavior
- Statements or farewell writings

Indicators of potential imminence include [26]:

- Energy burst, end-of-life planning, and/or last resort behavior
- Sudden cessation of medications or other substance use
- Sudden withdrawal from routine life pattern

Distal Characteristics of Targeted Violence

While proximal warning behaviors are signs of growing or imminent threat of targeted violence, distal characteristics are long-term psychodynamic and psychosocial factors that may be necessary but not sufficient for targeted violence [66]. The most frequently identified distal characteristics in the TRAP-18 validation study were framed by an ideology (100%), changes in thinking and emotion (88%), failure of sex-pair bonding (84%), and personal grievance and moral outrage (78%) [81].

Personal Grievance and Moral Outrage

Many perpetrators express a personal grievance (typically a major loss in love or work, with anger, humiliation, and blaming others) combined with moral outrage over historical or contemporaneous religious or political events. This characteristic largely overlaps with stage 1 in the Pathway to Violence Model [66].

Moral outrage can develop via vicarious identification with a victimized group when the offender has not personally experienced the victimized suffering. An example of this type of thinking is evidenced by Timothy McVeigh, the Oklahoma City bomber. He displayed superior intelligence, hypervigilant narcissist characteristics, and “ultimate warrior” identification. He was humiliated by rejection from the Special Forces (i.e., the grievance). He was also abandoned by his mother and distrusted women, with a sexualized interest in weapons. McVeigh saw himself as the first hero of a second American revolution. His research, planning, and preparation began following moral outrage over the Branch Davidian compound assault by the FBI and the ATE.

Framed by an Ideology

The presence of an ideology or belief system that justifies the intent to act is a common characteristic of mass shooters [66]. The intent to commit an act of mass violence is framed by an ideology or belief system. Violence is sanctioned by an external moral authority, but the ideology is often selectively evaluated for words and phrases that justify targeted violence. Morality becomes a simplistic choice between good and evil.

Ideologic violence is perpetrated against a perceived enemy to advance a specific belief system and frequently to purify in religious or racial extremism. Purification may not be the only goal for violence, but it is often central to the paranoid belief that one is surrounded by contaminants and toxins, including women as “temptresses.” A consistent theme in the thinking of anti-abortion terrorists (e.g., James Kopp, Eric Rudolph, Robert Dear, Paul Hill) is female sexual promiscuity as the cause of desire for abortion [90].

Failure to Affiliate with an Extremist Group

Rejection by an extremist group the actor wants to join, due to either lifelong interpersonal problems or beliefs seen as too extreme by others in the group, is a distal characteristic of violent extremists. The rejection further isolates and may
harden the belief system and violent intent. In one study, all 10 violent extremists (i.e., Timothy McVeigh, Joseph Franklin, John Salvi, Eric Rudolph, Buford Furrow, Ted Kaczynski, Benjamin Smith, Paul Hill, Michael Griffin, and Terry Nichols) attempted to affiliate with an extremist group, but their rejection led to further hardening of radical position and violent intent [66]. In the specific case of Paul Hill, he was a minister of a Presbyterian Church in Florida, but was excommunicated for his radicalization in the anti-abortion extremist movement. Three years after his excommunication, Hill shot and killed John Britton, MD, and his bodyguard James Barrett.

Dependence on Virtual Communities
In early studies of violent extremists, online support was noted to be greater than off-line contact with other extremists. However, this item is now believed to be obsolete, with online connectivity the norm for much of the population.

Thwarted Occupational Goals
Thwarted success is endemic for many young people. The distinction is that future offenders become disillusioned with the surrounding social order; resentful of narcissistic wounding from a history of slights, rejections, and failures; and find a target for their intense grievance and hatred [40].

Changes in Thinking and Emotion
Over time, the thoughts of mass shooters and their expression become more strident, simplistic, and absolute. Prior to a violent attack, argument, persuasion, and critical thinking cease, and dogmatic preaching and imposition of one’s beliefs on others begins. Beliefs become more rigid, simplistic, and absolute; a “moral authority” is embraced. Violence is cloaked in self-righteousness and the pretense of superior belief.

Fixation warning behavior may be apparent during these changes, but fixation relates to thought content, and this distal characteristic relates to changing interpersonal expression of that content. Expressiveness may suddenly diminish when the subject enters later stages of the pathway [66]. The individual may appear happier and/or more at peace after having made the decision to act.

Failure of Sexual Pair Bonding
The failure to form a sexually intimate relationship from puberty until the violent offense and death or incarceration is a common characteristic [81]. Incels (involuntary celibate men) are individuals who, having failed to find women they can talk or coerce into sex, radicalize their anger into calls of violence [97]. More than believing they are entitled to sex but unable to find a willing partner, their hatred of women stems from believing women are (or should feel) required to give them sex but purposefully withhold it. This distinction is crucial to understanding the disproportionality of rage against women [98]. Several mass shooters/murderers since 2015 have been identified as incels, including Elliot Rodger, Alek Minassian, Chris Harper-Mercer, and Scott Beierle.

In addition to the many school shooters mentioned, the 84% prevalence of failure of sex-pair bonding among 111 violent extremists is striking and may represent a sensitive indicator of distal risk [81]. None of the following perpetrators had any evidence of normal sexually intimate relationships: Anders Breivik, Eric Rudolph, Buford Furrow, Nidal Hasan, Mohamed Atta, Marwan al-Shehhi, Ted Kaczynski, or Timothy McVeigh [40].

Mental Disorder
The presence of a mental disorder by history or at the time of the offense is common. However, with violence and mental illness, it is essential to address the behavior, not the diagnosis [26].

Greater Creativity and Innovation
Operating outside the structure of extremist groups may promote greater innovation [79; 80; 81]. One example of this characteristic is found in Bruce Ivins, a prominent anthrax researcher in the U.S. government. In the Fall of 2001, Ivins killed 5 people and injured 17 in two waves of anthrax attacks. His motives included revenge, need for personal validation, career preservation, and professional redemption. Ivins was also obsessed with a sorority house, which he stalked.

History of Criminal Violence
A history of instrumental criminal violence before the act of targeted violence is considered a distal characteristic of mass violence perpetrators.

Warning Behaviors Model Case Illustration: Nikolas Cruz
In the case documents of Cruz, who perpetrated the 2018 Marjory Stoneman Douglas High School shooting in Parkland, Florida, pre-attack communications or manifestos are not mentioned, but observations by others are replete with distal risk characteristics and proximal warning behaviors of targeted violence [99].

Cruz was diagnosed with developmental delays at 3 years of age and, subsequently, with autism, depression, ADHD, and emotional behavioral disability. Obsessive-compulsive and anger issues were also noted. Over 10 years, the Broward Sheriff’s Office responded to 23 calls by his mother for help when Cruz was violent.

In 8th grade, Cruz was placed in a school for students with emotional problems. In 10th grade, his grades were good, but he was fascinated by guns and death. Weeks after transferring to Marjory Stoneman Douglas High School to begin 11th grade, Cruz posted on social media that he planned to “shoot up” the school. He had become preoccupied with wars, death, and killing. Cruz had trouble making friends, and his peers saw him as peculiar and socially awkward.
Investigated after cutting his arms on social media, Cruz stated he planned on buying a gun. A month after quitting mental health treatment in January 2017, he assaulted a classmate and was expelled from the high school. Cruz purchased the AR-15 used in the massacre one year later. Later that year, he was reported to the FBI after stating he wanted to be a professional school shooter on a YouTube page.

In November 2017, Cruz went to live with neighbors after his mother died. Within weeks, the neighbors called the County Sheriff when kicking Cruz out for violent behavior, stating they feared him because he had eight guns he kept with a friend and that he had put a gun to the head of someone several times. The police received a call the next day that Cruz was collecting guns and knives and could be a “school shooter in the making.”

Another family in Parkland took him in. In early January 2018, a caller told the FBI she wanted to get her fears about Cruz’s potential for violence off her chest. Citing his social media statements and photos and seeing his behaviors with guns, “It’s alarming to see these pictures, to know what he’s capable of doing, and what could happen.”

In the two weeks before the shooting, Cruz told the family he was living with that he was happier than he had ever been before. On February 14, 2018, Cruz arrived at Marjory Stoneman Douglas High with his AR-15 at 2:06 p.m., when school was letting out for the day, and killed 17 classmates and staff and injured at least another 17 before surrendering.

**Discussion:** What risk characteristics and proximal warning behaviors did Cruz exhibit?

**Warning Behaviors in Practice**

The Warning Behaviors Model is used by professionals trained in threat assessment and management to detect and disrupt targeted violence, as shown in the following case summaries [69; 78; 82].

The Threat Assessment and Management Unit of the Los Angeles Police Department (LAPD) described a firefighting recruit, enraged when dismissed from the academy, told another trainee, “When they fire me, I’m coming back here to f***ing massacre everyone.” The trainee informed the academy, which alerted the LAPD, and a search warrant was obtained. Finding an explosive device and a dozen assault-style rifles and handguns, the impression was of “someone absolutely geared to go to war.” The Threat Unit leader stated there had not been rapid intervention, an imminent mass shooting was certain.

Police in Keizer, Oregon, received a tip about a high school junior from another who the student had told he was angry at other students and was bringing a gun to school. The student of concern was interviewed and admitted being unhappy, but denied intent to harm others. Two months later, the student was admitted to a psychiatric facility for a suicide attempt. The school district’s threat assessment and management team of psychologists, counselors, and police interviewed his friends, family, and teachers before the student’s release from the facility and found additional warning signs in notebooks in which he raged about grievances toward a girl who rejected him and students he despised; he included both on a hit list. He had also attempted to buy a gun.

The threat assessment and management team determined the student lacked access to a gun and launched a “wraparound intervention” of counseling, in-home tutoring, and helping him pursue his interests in music and computers. Over the next 18 months, the student’s outlook improved, the warning signs dissipated, he graduated high school, and his case was transferred to the county adult threat assessment and management team. A psychologist on the threat assessment and management team stated they largely helped redirect his focus onto his strengths while maintaining close but casual and supportive contact.

Use of threat assessment and management is demonstrably effective in preventing targeted mass violence. However, threat assessment and management remains largely unknown in mental health, law enforcement, education, and social service professional communities.

Psychiatrist Jerome Knoll, an expert in mass murderers and targeted violence, states that mass shootings will diminish only to the extent that society takes the following meaningful actions [24]:

- Third-party reporting of concerns or leaked intent
- Sensible nationwide gun control laws
- Media responsibility

When a person is believed to be on a path to violence, health and mental health professionals should act decisively. The American Psychological Association (APA) has identified several approaches to effective gun violence prevention at the individual and societal levels [251]. At the individual level, this involves addressing underlying issues that are triggering desperation, including referring the person to or providing mental health services and other sources of support. As discussed, psychiatric hospitalization may be needed to address despondence and suicidality. Nonpsychiatric resources can also help alleviate the individual’s problems or concerns and include conflict resolution, credit counseling, job placement assistance, academic accommodations, veterans’ services, pastoral counseling, and disability services [251]. At the macro, or societal, level, the APA recommends a comprehensive approach that engages the many stakeholders involved, including community and public safety officials, schools, workplaces, neighborhoods, mental health and public health systems, and faith-based groups, to develop laws, policies, and community outreach programs [251].
Warning Behaviors and Impulsivity

In some cases, perpetrators of targeted violence act impulsively in response to a triggering event of loss and humiliation. These precipitous attacks fail to include the often-considerable planning and preparations already carried out. Such cases are the exception, but point to the complexity and fluidity of factors and their interaction that move an individual from grievance to perpetration [100].

PATHWAY TO TARGETED VIOLENCE IN THE WORKPLACE

Mass shooters who target their current or former workplace largely resemble other targeted violence perpetrators. These offenders are almost always aggrieved or disgruntled employees or ex-employees whose explosion of murderous rage is the culmination of a perceived rejection, a felt injustice, and determination to seek revenge. They are typified by paranoid and/or narcissistic traits, blame others for their problems, and feel unjustly wronged. Strong persecutory themes reflect an amplified narcissistic injury [9; 24].

The failed Atlanta day trader Mark Barton, who killed 12 people and injured 13 more in 1999, left a suicide note stating “I don’t plan to live very much longer, just long enough to kill as many of the people that greedily sought my destruction” [9; 24].

Perpetrators of targeted workplace homicide progress through the Pathway and Warning Behaviors stages [79; 80]:

• Begins with a grievance, a thinking pattern that blames everyone else, and an angry, ashamed emotional state.
• The humiliating event (e.g., loss of status, perceived rejection at home or work) is delusional, reality-based or both.
• Vengeful thoughts develop into violent fantasies. Most individuals do not go further; their grievance and vengeful fantasies eventually resolve.
• Very few see violence as the only solution; a decision to act is captured by the acronym JACA:
  – The act is Justified.
  – There is no Alternative.
  – I accept the Consequences.
  – I am Able to do this.
• From this point, the perpetrator progresses to research, planning, and preparation.

EXTREMEIST MASS VIOLENCE: THE PERPETRATORS

Mass violence may be committed for personal or ideologic motive, but many former distinctions between the two have dissolved. The Warning Behaviors Model, initially applied to ideologic terrorism, was later found similarly reliable and valid with non-ideologic targeted mass violence, and mass shootings fueled by personal or ideologic motive often appear identical. The paths to targeted violence of both offender types largely overlap, and both originate from grievance and alienation. Extremist violence purported to advance an ideology is frequently grievance-driven violence cloaked in ideology.

Most persons with extreme beliefs do not commit extremist violence, as can be demonstrated with a pyramid model. The large base represents the masses of aggrieved, alienated individuals; the substantially narrow midpoint represents the aggrieved who develop extreme beliefs; and the tiny tip of the pyramid represents individuals with extreme beliefs who commit extremist violence [101].

CORE CONCEPTS

The way that threat is understood and addressed is profoundly influenced by how the threat is defined. The literature on radicalization, extremism, and terrorism includes inconsistent and incorrect use of key terms and concepts, and no two countries define “radicalization” the same [102; 103].

Radicalism, Extremism, and Violent Extremism

Radicalization is a process that intends to transform thinking, belief, and perception from socially normative to extremist, but this term frequently conflates extremism, radicalism, and terrorism. Radicalism describes intent to overthrow a status quo, not necessarily using illegal or violent means. Extremism refers to deviation from a norm. Radicalism and extremism are not societal threats unless connected to violence or inciting hatred; neither automatically leads to violence, and almost all of those with radical extreme ideas never act on them [101; 102; 104].

Essential distinctions are extremist ideology versus behavior and movement from non-violence to violence [101; 105]. “Violent ideology” and “violent extremist beliefs” are misnomers. Most individuals who harbor extreme beliefs/extremist ideologies do not commit violence to advance the belief or ideology [101]. Individual factors, not ideology, largely influence extremist violence (as will be discussed later in this course).

“Lone actors” self-radicalize without formal terrorist network affiliation, support, or influence. Social movement theory historically viewed lone-actor terrorism as an anomaly, but this long-standing paradigm is mostly obsolete [106]. Radicalization is a distinctly social process, now primarily online.
instead of offline. Predating the Internet, Unabomber Ted Kaczynski is one of few truly self-radicalized terrorists [107].

Terrorism
The terrorist attack on September 11, 2001, murdered 2,969 people in New York, Virginia, and Pennsylvania. Thousands more, including many first responders, lost their lives to health complications from proximity to Ground Zero in New York City. This attack by Islamist extremists caused almost 18 times the fatalities of the 1995 Oklahoma City bombing, America’s second deadliest terrorist attack. From the extreme loss of life and physical destruction, 9/11 has eclipsed all other terrorist events in U.S. history and continues to shape perceptions of terrorism and its perpetrators [108].

Terrorism is defined by the Central Intelligence Agency (CIA) and U.S. State Department as premeditated, politically motivated violence against noncombatant targets by non-state actors, usually intended to influence an audience. Counterterrorism experts consider this definition accurate, in contrast to the description used by other U.S. governmental agencies of “coercion through fear or intimidation” [109].

Islamist terrorists often intend to incite anger, not fear. By provoking aggressive over-reaction that victimizes Muslims previously unsympathetic to Islamist extremist violence, the goal of increasing future support and vulnerability to radicalization is achieved [109]. Solely defining fear as the objective perpetuates the idea that not appearing terrorized by terrorism is to overcome it. This promotes aggressive over-reach and civil rights violations, which feed terrorist propaganda and recruitment efforts [110].

Terrorism is not defined by lethality, and violence includes property destruction. For example, terrorist acts by far-left animal-rights and environmentalist extremists in the 1990s and 2000s targeted property and not people. Horrific mass violence is not terrorism when ideologic goals or motives are absent [111; 112].

The distinguishing feature of terrorism is the mens rea, or intent, of the perpetrated act [113]. Terrorist acts are synonymous with extremist violence, but terrorism is not synonymous with extremist ideology. Acts of terrorism/extremist violence can be motivated or inspired by extremist ideology.

Ambiguous Motivation
Violent attacks with ambiguous or multiple goals are challenging to define. In the 2015 mass shooting in San Bernardino, the perpetrators radicalized to Islamist extremist violence during Mideast travel but were familiar to the victims of this workplace massacre, making personal grievance impossible to rule out as a motive. A hypothetical middle-aged white man attacking a Planned Parenthood clinic could be terrorism inspired by extremist anti-abortion ideology or IPV against his wife employed by the clinic; a hypothetical young Muslim woman attacking an office building could be inspired by radical Islamism or by personal retribution [111].

Assigning terrorist, criminal, or personal motivation to targeted violence is inherently subjective. Research demonstrates that some attackers cloak their motives with political rhetoric to construct a narrative that legitimizes their acts, and so taking statements about political motivation at face value should be avoided. Described as “murderers in search of a cause,” such actors may “upgrade” their violence by flavoring it with a political motive, when in fact it is driven by grudges or other personal motives [67; 114]. Many attacks in 2016–2017 appeared linked to Islamism, but open source reporting indicated the purported religiosity of attackers was suspect [113].

An example is the 2017 murder of a Denver security guard by Joshua Cummings, a white man who had recently converted to Islam. When captured, he stated his allegiance to the Islamic State of Iraq and the Levant (ISIS) but committed the murder for the “pleasure of Allah,” and not on behalf of ISIS [115]. Placed on a terrorism watch list after leaders of a local mosque reported him as suspicious and possibly radicalized, Cummings had a long history of threatening violence to police. No contact or connection with any Islamist group was found. The Denver Chief of Police concluded Cummings was “looking for attention” with his ISIS-related statements [116].

Violence can also be motivated by extreme beliefs that are denied by the assailant. Following his assassination attempt on FDR, Giuseppe Zangara rejected any anarchist influence or inspiration, but repeatedly mentioned his sympathy for poor people everywhere and a bitter resentment of capitalists and heads of state for their money that drove his desire to kill [6].

EXTREMIST IDEOLOGIES
In the post-9/11 era, Islamist extremism has defined public perceptions of terrorism and governmental targeting of counter-terrorism efforts in both the United States and European Union [105]. However, over the last 100 years in the United States, extremist violence has been perpetrated to advance a broad range of extreme ideologies, the nature of which has changed over time. The temporal appearance of extremist violence in Europe and the United States shows that broader political and economic changes have influenced the changing nature of terrorist motivation, with these factors transcending national borders.

Temporal Appearance of Extremism in the United States and Europe
Researchers examining terrorist motivation in response to broader sociocultural and geopolitical changes have identified five terrorism “waves” in the United States and Europe beginning in the 19th century [1; 3; 113].

The evolution of terrorism in the United States began in the 1880s with the anarchist wave, which lasted roughly 40 years, followed in the 1920s by an anti-colonial wave, which lasted to the 1960s, then a new left wave, which in turn faded as the religious wave formed [113].
The Anarchist Wave

The anarchist terrorists and assassins of heads of state in the late 1800s and early 1900s committed extreme acts to advance an ideologic/political goal, but had virtually no interaction with each other, and a shared understanding of a common purpose was improbable. On these dimensions, the anarchists were the precursors of current “lone-actor” violent extremists [113].

The Anti-Colonial Wave (Nationalist-Separatist)

The anti-colonial wave began in the 1920s in reaction to the vast international reorganization and technologic innovation following WWI, described by some as the onset of globalization. Extremist violence during anti-colonial and new left waves was coordinated and group-led [113].

This wave was typified by groups such as Fatah and the Irish Republican Army, joined by members who continued the mission of their parents as minority groups seeking liberation from their colonial oppressors or from ruling majorities in their country [1; 3].

The New Left Wave (Social- Revolutionary)

Extremist groups of the new left wave are typified by groups such as the Weather Underground, the Symbionese Liberation Army, the Red Army Faction in Germany, and other far-left extremist groups in the 1960s and 1970s, who rebelled against their parents’ generation’s loyalty to the regime or ruling structure [1; 3].

The former Soviet Union was the bastion of Communism and backer of many leftist terrorist-sponsor nations. Its collapse substantially contributed to the demise of the new left wave and rise of the religious wave. It also propelled, as an unforeseen consequence of support to the Mujahideen, resistance in Afghanistan [113].

The Religious Extremism Wave

The religious wave of transnational Islamism emerged in the 1980s and can be divided into four sub-waves [113; 117]. The initial sub-wave propagated beliefs of an international oppression of Muslims, which drew religiously inspired fighters to join the Mujahideen in the Afghanistan conflict against the Soviet Union. This sub-wave included Osama bin Laden and other original al-Qaeda members. The second sub-wave involved the Bosnia, Chechnya, and Kashmir conflicts and the 9/11 attacks. These violent Salafi extremists were generally middle class and educated; hardened criminals were nearly absent. The third sub-wave emerged in the wake of the Iraq War as “homegrown” rather than international extremists. The fourth sub-wave emerged in 2010–2014 with ISIS leaders and members substantially lower in education and higher in criminal histories than prior sub-waves, and with sole actors in the United States inspired by violent Salafi extremist leaders.

In each successive sub-wave, the “religiosity” of participants noticeably declined from the preceding sub-wave. Anti-terrorist experts described this pattern as an “extremist social trend,” with individuals radicalized to violence by extremist interpretation of Islam replaced by what are best described as “Islamized radicals.” In the fourth wave, 90% were motivated for personal reasons, including looking for a fight, adventure, or revenge against perceived rejection. Religion was not the primary driver of this movement [118; 119]. Corroboration came from recent interviews of former al-Qaeda members, describing being attracted to terrorism motivated primarily by a pre-existing anger and alienation related to childhood abuse or trauma, lack of integration and assimilation, and/or socioeconomic grievances. Foreign policy grievances were described as a channel for releasing deeply held tensions, instead of a primary motive [113].

This decline in “religiosity” is indicative of a wider change in the “extremist social trend” extending far beyond Islamism. In aggregate, these factors indicate the religious wave is dissipating, with the Western world progressing into terrorism’s fifth wave [113].

The Lone Actor Wave

The emerging terrorist actors are motivated by the rhetoric of extreme ideologies through online exposure, instead of affiliation with extremist groups offline. Lone actors, typified by Dylann Roof and Anders Breivik, have much in common with the first wave Anarchists [1; 3]. The Internet alone is not driving radicalization but serves as a catalyst with wider societal changes the root cause [103].

Individuals with a grievance can find previously inaccessible ideologies that may provide “frame alignment” to their grievances and failures. They may not fully understand the ideology but can latch onto it in ways not previously possible. The far-reaching societal changes echo the conditions during the anarchist wave. It is premature to determine if the next phase of terrorism represents a new wave, or a loop that continues to mirror, at least in part, the anarchist ancestors [113].

Current Extremist Ideologies in the United States

Far-Left Extremism

This group is traditionally class-oriented, with individuals and groups that adhere to anti-imperialist, anarchist, or Marxist beliefs and seek to overthrow the capitalist system, including the U.S. government, for replacement with decentralized, non-hierarchical systems. During the 1960s and 1970s, far-left extremist groups were motivated by anti-war, anti-capitalism, and social justice issues. Far-left extremists were responsible for 68% of terrorist attacks and 58% of fatalities in the United States during the 1970s [120; 121].

Terrorist attacks by violent left-wing groups dissipated in the 1980s. However, environmental activism and terrorism emerged in the 1990s and remains the current ideology associated with the far-left. In the 1990s and 2000s, groups
like the Animal Liberation Front (ALF) and Earth Liberation Front (ELF) have been responsible for many terrorist attacks against property, but all have been non-lethal and non-injurious. Incidents by these groups dropped off during the 2010s [121].

**Single-Issue Extremism**

Individuals motivated primarily by a single issue rather than a broad ideology have beliefs that may fall anywhere on the political spectrum [121]. Examples include members of the Puerto Rican independence movement and the Jewish Defense League in the 1960s and 1970s, and extremists with idiosyncratic ideologies, like Unabomber Ted Kaczynski.

Several armed attacks against law enforcement officers were perpetrated in 2014-2016 by assailants whose stated motivation was deadly use-of-force incidents involving the police and blacks during this period. The deadliest year was 2016, with attacks in Dallas that killed five and wounded nine law enforcement officers; in Baton Rouge that killed three law enforcement officers and injured three; and in Philadelphia that killed one civilian and injured five law enforcement officers. A 2014 attack in New York City killed two officers. In several other incidents, assailants opened fire on police without officer or civilian fatalities. These extremists, perhaps most accurately described as black supremacists, do not neatly fall into other broad groupings [121].

Anti-abortion extremists not motivated by traditional far-right issues (e.g., anti-government, race superiority) are single-issue extremists. Between 1973 (when abortion was nationally legalized) and 2007, more than 200 abortion clinics were bombed or set on fire and more than 4,000 acts of violence were perpetrated (including homicide) or threatened against abortion providers or clinic workers [89; 120].

**Islamist Extremism**

Islamists are violent Salafi Sunni Muslim extremists. Salafism is a highly conservative fundamentalist movement within Sunni Islam that originated in the Arabian Peninsula and is adhered to by a minority of Sunni Muslims [122].

Violent Salafis engage in extremist violence to advance their beliefs against perceived enemies. Influential figures include al-Qaeda leaders Osama bin Laden and Anwar al-Awlaki, an American-born radical Islamic cleric who led al-Qaeda of the Arabian Peninsula. al-Awlaki was killed by a 2011 U.S. military drone strike in Yemen, but his videos persist. ISIS and New York City injuring 31 [123].

The Zebra Killers were a Nation of Islam offshoot of black Muslims who, in San Francisco during 1973–1974, committed more than 1,000. On September 11, 2001, four passenger jets were hijacked by members of al-Qaeda and flown into both World Trade Center towers and the Pentagon, with the fourth plane crashed into an empty field after the passengers gained control. With nearly 3,000 people killed and thousands more injured, the lethality and long-term impact of 9/11 were extraordinary [121].

Following 9/11, attacks perpetrated by foreign Islamist extremists became rare. They were replaced by individuals born or raised from childhood in the United States, whose self-identified radicalization to Islamist extremist violence occurred through Internet exposure to material from al-Qaeda or ISIS [120]. Attacks during the 2010s by al-Qaeda- or ISIS-inspired perpetrators decreased but did not disappear. In 2013, Dzhokhar and Tamerlan Tsarnaev detonated bombs near the finish line of the Boston Marathon, killing three and injuring several hundred others in an attack motivated by extremist Islamic views (although not connected to any group specifically). Ahmad Khan Rahami was arrested for three ISIS-inspired explosive device attacks in New Jersey and New York City injuring 31 [123].

The first Islamist extremist attack in the United States was the 1993 truck bomb in a garage under the World Trade Center in New York, killing 6 people and injuring more than 1,000. On September 11, 2001, four passenger jets were hijacked by members of al-Qaeda and flown into both World Trade Center towers and the Pentagon, with the fourth plane crashed into an empty field after the passengers gained control. With nearly 3,000 people killed and thousands more injured, the lethality and long-term impact of 9/11 were extraordinary [121].

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Following 9/11, attacks perpetrated by foreign Islamist extremists became rare. They were replaced by individuals born or raised in the United States, whose self-identified radicalization to Islamist extremist violence occurred through Internet exposure to material from al-Qaeda or ISIS [120]. Attacks during the 2010s by al-Qaeda- or ISIS-inspired perpetrators decreased but did not disappear. In 2013, Dzhokhar and Tamerlan Tsarnaev detonated bombs near the finish line of the Boston Marathon, killing three and injuring several hundred others in an attack motivated by extremist Islamic views (although not connected to any group specifically). Ahmad Khan Rahami was arrested for three ISIS-inspired explosive device attacks in New Jersey and New York City injuring 31 [123].

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The Alternative Right (“Alt-Right”)

An emerging far-right extremist infrastructure, the term “alt-right” was coined by white nationalist leader Richard Spencer to describe a younger, better-educated movement than traditional white supremacists like the KKK, with right-wing views at odds with the conservative establishment. “Alt-right” re-brands long-standing racist, misogynist, and white nationalist beliefs for appeal to younger people [125; 126].

The sprawling alt-right universe envelops neo-Nazis, white supremacists, male supremacists, misogynists, conspiracy theorists, techno-libertarians, white nationalists, anarchists, and Dark Enlightenment adherents through a loosely affiliated aggregation of blogs, fora, podcasts, Twitter/Gab, and YouTube personalities united by a hatred of feminism, multiculturalism, and liberalism, and the belief that “political correctness” threatens individual liberty [97; 125; 127].

The alt-right movement is largely traced to 2012–2014, with the killing of black teenager Trayvon Martin and the “Gamergate” harassment campaign that targeted female game developers and journalists for entering the male-dominated space. Using 4chan and other platforms to organize, the targets were “doxxed” (i.e., had their personal information published online) and systematically targeted with rape and death by anonymous abusers. Gamergate was formative in the development of the alt-right; young men from right-wing online spaces came together in a shared campaign against liberal “politically correct” culture [126; 127]. Male supremacy was fundamental to the formation of the racist alt-right [97]. Alt-right, white supremacist, and male supremacist circles tightly overlap to reinforce shared narratives of dispossessed, oppressed white men, blamed on minorities, women, and immigrants [97]. Gamergate crystallized the “manosphere” of misogynist websites that encourage harassment of women and launched the incel movement.

Antisemitism is another common belief of far-right and alt-right extremists. In these groups, Jewish persons are commonly blamed for promoting progressive (and perceived anti-white and/or anti-Nationalist) policies such as civil rights, immigration, and diversity. Antisemitic conspiracy theories (e.g., Holocaust denial, banking/Hollywood control) are used to justify violent behaviors. Several shootings committed by far-right or alt-right perpetrators have occurred outside or in synagogues or Jewish community centers over the past 20 years, including in Kansas in 2014 (resulting in three deaths), at the U.S. Holocaust Memorial Museum in 2009 (resulting in one death), and Los Angeles in 1999 (resulting in five injuries). The mass shooting at the Tree of Life (Or L'Simcha Congregation) Synagogue in 2018 resulted in 11 deaths and 6 injuries. The shooter in this case, Robert Gregory Bowers, had a history of participation in alt-right extremist social media. Before entering the Synagogue on October 27, 2018, Bowers posted the following on the website Gab (a Twitter-like social media site frequented by alt-right extremists): “HIAS [Hebrew Immigrant Aid Society] likes to bring invaders in that kill our people. I can’t sit by and watch my people get slaughtered. Screw your optics, I’m going in.” He had also made statements online indicating his desire to “kill Jews” [128].

ISLAMIST AND FAR-RIGHTIST VIOLENCE IN THE UNITED STATES

Attacks and Fatalities

Following 9/11, non-Islamist extremism has often been ignored, but threats posed by far-right extremism are significant. Table 2 shows Islamist and far-rightist violence; 9/11 and the Oklahoma City bombing are excluded as outliers [108; 129; 130].

After 2008, Islamist extremists were responsible for a small number of high-casualty mass shootings, including 49 killed in the 2016 Pulse nightclub attack and 14 killed in the 2015 San Bernardino attack. During that same period, far-right extremists committed more numerous, lower-casualty attacks [115]. After 9/11, deaths from far-right attacks exceeded Islamist attacks in 10 of the 15 years and were the same in 3 of the years [108; 129; 130].

Black supremacists committed 15% of extremist homicides in 2017, including the shooting spree of Kori Ali Muhammad, who killed four white victims in Fresno. This followed eight police officers killed in Dallas and Baton Rouge by black supremacists in 2016, the most homicides perpetrated by this extremist subgroup since the early 1980s. More time is needed to determine if black supremacists represent a durable problem [115].

Law enforcement officers killed or injured in targeted attacks doubled after 9/11 (vs. pre-9/11). Far-rightist attacks on law enforcement officers escalated during 2009–2013, motivated by anti-government and white supremacist anger, some focused on the nation’s first African American president [108; 129; 130].

All Islamist extremist attacks on military personnel occurred during 2009–2011 by offenders motivated by anger over the Iraq and Afghanistan wars. Far-right extremists are sympathetic to the military but often hold anti-government views and have a higher likelihood of escalating routine law enforcement contacts into fatal encounters. These extremists present a unique risk to local law enforcement officers, who are disproportionately targeted [108; 129; 130].

Emerging Trends in Far-Rightist Violence

Analysis of 108 far-rightist homicides from 1990 to 2008 concluded far-right terrorism was primarily a white male phenomenon fueled by a need to re-establish their perceived threatened dominant position in society [131]. In 2015, the FBI issued an intelligence bulletin that Muslims and Islamic

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religious institutions were new targets for harassment and violence by far-right militia groups, and that given the broader trends of Islamophobia and sharp increases in hate crimes targeting Muslims, anti-Muslim violence by militias had the potential to worsen [132].

The FBI forecast was prescient. Looking at events in early 2018, three men were charged with bombing a mosque in Minnesota (no deaths or injuries); a sting operation foiled a planned mass-shooting of a Florida mosque; a Muslim mayoral candidate in Minnesota received death threats from a militia group; and three defendants, disrupted before they detonated four car bombs to demolish a Kansas apartment that housed Somali Muslim immigrants, were all found guilty of conspiring to use a weapon of mass destruction and conspiracy against rights, a hate crime. The bombing was planned for November 9, 2016, the day of the presidential election [133; 134]. Sikhs have also been killed by perpetrators unaware that Sikhs are not Muslims, including a Sikh temple massacre that killed six worshipers in 2012 [135].

The Southern Poverty Law Center identifies the 2014 rampage of Elliot Rodger that killed 7 and injured 14 as the first alt-right-inspired mass murder. As an incel, Rodgers’ grievance against women was amplified to murderous hatred by immersion in violent misogynist fora [126]. In 2018, another deadly incel attack killed 10 Toronto pedestrians and injured 16 more, most of whom were women. Before his vehicular rampage, Alek Minassian posted “All hail the Supreme Gentleman Elliot Rodger!” on social media [98].

Among cases cited by the Southern Poverty Law Center in 2017, the alt-right anti-Muslim radicalization of Alexandre Bissonnette preceded his mass shooting in a Quebec City mosque killing 6 worshipers and injuring 19 others, and Lane Davis, who murdered his liberal father after accusing him of pedophilia, solely from believing the alt-right conspiracy that liberals are secretly operating pedophilia rings (e.g., #Pizzagate) [126].

**Similarities of Far-Right and Islamist Extremists**

The radicalization pathways and outcomes of far-right and Islamist extremists are markedly similar, the issues leading to a path highly overlap, and both should be regarded as similarly problematic [103; 136]. The following case suggests how similar factors may influence radicalization to either extremism.

In 2016, nine young people were fatally shot in Munich by David Sonboly, an 18-year-old man born in Germany to Iranian refugee parents. At first, the attack appeared to be a violent incident by a radicalized Islamist. However, various personal, psychologic, and political motivations led Sonboly (born Ali Sonboly) to embrace a “pure racial identity” that transcended his cultural, immigrant, and minority background, and that of his family and friends. Sonboly idolized far-right terrorist Anders Breivik and timed his mass murder on the fifth anniversary of the Breivik attacks in Norway [103; 137].

The specifics of this case are unusual, but the issues at the margins of society similarly affect young people challenged by their cultural and ethnic identities, leading a few to radicalization and violence. Sonboly did not feel comfortable in his own skin, radicalizing and murdering others over insecurities surrounding his ethnic and cultural identity [103].

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### EXTERMIN IDEOLOGY AND VIOLENCE IN THE UNITED STATES

<table>
<thead>
<tr>
<th>Target and Timeframe</th>
<th>Far-Rightist</th>
<th>Islamista</th>
</tr>
</thead>
<tbody>
<tr>
<td>Civilians fatalities from attacks, 1990–2017</td>
<td>N/A</td>
<td>272</td>
</tr>
<tr>
<td>Civilians fatalities from attacks, 9/12/2001–2017</td>
<td>N/A</td>
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<tr>
<td>Civilians fatalities from attacks, 2008–2018</td>
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<tr>
<td>Attacks on law enforcement officers and fatalities, 1990–2015</td>
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<td>57</td>
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<tr>
<td>Attacks on military personnel and fatalities, 1990–2015</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
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*Excludes September 11 and Oklahoma City attacks

| Source: [108; 115; 129; 130]|

Table 2

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The specifics of this case are unusual, but the issues at the margins of society similarly affect young people challenged by their cultural and ethnic identities, leading a few to radicalization and violence. Sonboly did not feel comfortable in his own skin, radicalizing and murdering others over insecurities surrounding his ethnic and cultural identity [103].
With industrial capitalism ending and being replaced by neoliberal globalization, the pace of de-industrialization has accelerated. The political, religious, and cultural societal changes and broader globalization have left many communities with a sense of alienation. “Left behind” white working classes and Muslim minorities both face social, psychologic, economic, and structural issues that can thwart the formation of identities and realization of individual potential. Both are apprehensive about multiculturalism, dislocation, and identity conflict [103]. Anomie is a term to describe the alienation and instability that can follow rapid social change and an increasing inability to achieve what society appears to promise, which may lead to weakened group ties, non-adherence to social norms, fragmentation of identity, and loss of purpose [125; 138].

The emotional consequences of losing hope leave many of these young men vulnerable, exposed, and pliable to external influences that exploit feelings of marginalization and loss of significance [103]. For example, young white men who feel disenfranchised and alienated are vulnerable to radicalization from exposure to alt-right elements [120; 125].

A crisis of masculinity is an issue faced by youth in marginalized communities and a vulnerability factor to both Islamist and far-right radicalization. It is created by a lack of social mobility, persistent unemployment, anomie, and disenfranchisement. The consequences can encourage young people to prove themselves—to seek recognition and become somebody—using whatever means necessary [103].

MEDIA AND CULTURAL NARRATIVES OF EXTREMIST VIOLENCE

Mass violence is followed by questions of whether the act was terrorism. Public perception of terrorist acts and actors has far-reaching consequences that influence governmental and mental health policy and how citizens treat each other. In essence, media reporting shapes this perception [139].

A 2018 study examined the media attention of terrorist attacks in the United States from 2006 to 2015. All 136 attacks (81.6% non-fatal) were controlled for target, fatalities, and arrests. Attacks by Muslim perpetrators received an average 357% more media coverage than comparable attacks by non-Muslims. During this period, Muslims perpetrated 12.5% of attacks but received 50.4% of all news coverage [135].

Several terrorist attacks received substantially less media coverage than researchers expected. These include attacks on a Sikh Temple in Wisconsin that killed six people in 2012; on a Kansas synagogue that killed three people in 2014; and the 2015 attack that killed nine African Americans in a Charleston church. All three cases had white male perpetrators and religious or ethnic minority targets, highlighting the disparity in media coverage of domestic terrorism [135].

Some terrorist attacks are sensationalized and extensively covered, but most receive little to no media attention [140]. A terrorist attack receives less coverage when framed as a crime, while crime reports of incidents committed by Muslims are more likely to be labeled as terrorism [141]. Events are considered more newsworthy if they can be typed as reflecting current beliefs and social structures and can be scripted in ways that reinforce stereotypes. Media framing of terrorism as a specifically Muslim problem is the dominant narrative [142].

Media coverage increases when terrorist perpetrators are members of an out-group, or “others.” Social identity research highlights in-group and out-group dynamics, whereby people perceived as “others” are portrayed and perceived more negatively. The biased portrayal of Muslims and Arabs as “others” in entertainment and news media may explain why people implicitly connect terrorism and Islam as threats to national security, and an incident as “terrorism” when the perpetrator is Muslim [135; 143; 144; 145]. The substantially greater media attention to extremist attacks by Muslims reinforces the cultural narrative of who should be feared. Framing this type of event as more prevalent helps explain why 42% of Americans are very or somewhat fearful that they or someone they know will be a victim of terrorism and implicitly link terrorism and Islam [145; 146].

Political decisions can reinforce Muslim-terrorist stereotypes. In 2009, the U.S. Department of Homeland Security released an intelligence brief stating the economic downturn and election of the first African American president were fueling a resurgence in far-right extremism. A severe backlash (incorrectly) claiming the report painted conservatives as potential domestic terrorists led to withdrawal of the report and defunding of the DHS unit that produced it [147; 148]. Following the white supremacist mass murder of nine black churchgoers in 2015, the FBI Director stated the offense was not an act of terror [139]. These misperceptions and lack of will to consider extremist violence by non-Muslims fuel prejudice and discrimination, prevent other pressing security threats from being addressed, and invite consequences [135; 149].

EXTREMIST MASS VIOLENCE: PATHWAYS

Distinguishing nonviolent from violent extremists and understanding what generates the difference is a foremost concern that is only recently appreciated [150]. As with mass shooters, terrorist acts have been ascribed to mental illness, which became a focus of terrorist prevention. However, looking to psychologic characteristics and psychopathology to explain extremist violence has been generally unhelpful [151].
Extremist violence, as with all forms of targeted violence, cannot be disrupted using prediction. Realizing terrorist acts are too difficult to predict, the focus turned to radicalization as a proxy for pre-empting terrorism, because radicalized individuals are substantially greater in number and easier to detect than individuals who commit extremist violence [101]. This logic is compelling but flawed, and around 2010, the value of disrupting radicalization became questioned. Viewing ideas as threats can lead to a war on ideas, and government over-reaction to terrorist threat often creates a backlash, with new threats [101]. Decades of social psychology research demonstrates extreme beliefs are largely or mostly unrelated to extreme actions [101; 120].

The Profiles of Individual Radicalization in the United States (PIRUS) database was developed to address these shortcomings [120; 150]. PIRUS contains information on 1,473 violent and nonviolent extremists across the ideologic spectrum from 1948 to 2013 and is the first U.S. extremist database with size and case detail sufficient for longitudinal (pathway) and quantitative analyses [120; 150].

MORAL EMOTIONS AND INTERGROUP VIOLENCE

As discussed, social identity theory distinguishes the group one identifies with and belong in (in-group) from groups one does not identify with nor belong in (out-group). Group members can share emotions about their in-group and out-groups. Group emotions motivate group behaviors and provide the bases for in-group and out-group attributions. Negative attributions of an out-group by leaders of ideologic groups can motivate hostile or violent in-group behaviors against out-group members. Hate crimes, massacre, and genocide against out-groups have been incited by leaders who, from positions of moral superiority, evoke moral outrage, devaluation, and a need to protect in-group “purity” from out-group contamination [90; 152; 153].

The ANCODI Emotions

Anger, contempt, and disgust (ANCODI) are moral emotions associated with violations of ethics, morality, and divinity. Disgust is also an evolved defense to ward off contaminants and purge the environment of toxins [90]. A highly relevant body of research demonstrates how ANCODI emotions can combine to drive ideologically motivated intergroup violence [153; 154; 155].

Research on aggression has focused on anger, but disgust transforms aggression into hostility and anger into hatred. Directed at a despised out-group, anger motivates action, contempt motivates devaluation, and disgust motivates dehumanization and elimination. Thus, the ANCODI emotions work in a sequence (or pathway) that starts with a perceived injustice and evolves to elimination [155]. ANCODI works through serial narrative by in-group leaders. An unjust incident that evokes outrage is attributed to the out-group (anger), re-framed from a position of moral superiority that links similar behaviors to the morally inferior out-group (contempt) that threatens in-group purity with contamination and must be removed (disgust). Cultural narratives can facilitate hatred across generations by propagating ANCODI emotions [152; 155].

The validity of ANCODI emotions as instrumental in inciting ideologically motivated violence has been demonstrated by speech and video analysis of leaders of ideologically motivated groups, and by clinical research involving members of ideologically motivated groups. Hitler, Osama Bin Laden, Slobodan Milošević, and Virginia Tech mass shooter Seung-Hui Cho (among others) showed escalation of disgust preceding mass violence. Studies evaluating ANCODI showed cross-cultural, cross-language, and cross-generational validity [153; 155].

People normatively react to spoiled food, filthy environments, and insects not with anger or contempt, but with disgust and a desire to cleanse, sometimes through violence, so they do not continue to poison [153; 156]. In a mass psychology context, the Nazis equated the Jews with vermin and other contaminants, and thus found an emotional accelerant for the Holocaust. Propaganda in the Rwandan genocide states it was “cockroaches,” and not humans, that were killed. These ideologies argue that purification takes a step forward if toxins and contaminants are obliterated [90; 157].

For ideologic extremists, the path to violence advances when anger, fear, or contempt of the perceived enemy is replaced by equating the enemy with a toxin (disgust). The impulse is to rid the enemy of poison and exterminate, to kill [90]. Far-right groups vehemently defend a sense of identity, the purity of which is seen threatened with destruction or dilution by emerging racial, ethnic, and religious minority groups [103]. Calls by ISIS to violently cleanse society of impure elements incited the annihilation of Shia and moderate Sunni Muslims to rid their “pure” Islamic caliphate of these “contaminants” [105].

Anger, contempt, and disgust compressed together become dangerous in the processes of dehumanization and extremist violence across all languages and cultures. Monitoring communications for expression of ANCODI emotions directed at out-groups may provide an early-warning mechanism of impending violence [153; 155]. The same is true of the language used by individuals encountered in a health or mental health setting.

Dehumanization

Dehumanization is directly related to ANCODI emotions of contempt and disgust, but its valid measurement remained elusive until introduction of a novel scale using the Ascent of (Hu)Man (AoM) diagram. With AoM, a diagram is presented, with five images depicting the evolution of humans, from primitive quadrupedal ancestor to modern human.
The subject places each person/group on a continuum from 0 (primitive pre-human) to 100 (fully human). Lower scores indicate dehumanization, and higher scores represent humanization [158]. For comparison, the average American in 2014 rated ISIS at 54 [158]. The AoM scale and other measures were given to alt-right adherents and a control group to understand the psychologic profile of this emergent group (Table 3) [159].

Supremacists perceived Blacks as half-way between the primitive ape-like human ancestor and “full” human, and similarly dehumanized democrats and the mainstream media, with feminists and Muslims closer to primitive pre-humans than fully human. The combined ratings by supremacists and populists increased somewhat, but these entities were still perceived as less than fully human.

The alt-right group perceived that certain historically advantaged groups are superior to other groups and need their interests protected, with their social positions under threat. They also expressed a level of hostility toward religious/national out-groups and political opposition groups considered extremist [159].

The supremacist subgroup reported very high motivations to express prejudice, extreme dehumanization of out-groups and opposition groups, very high levels of callous and manipulative behavior, and more frequent aggressive behavior. The populist subgroup showed lower extremist tendencies [159].

Radicalization

As discussed, radicalization is a gradual process that intends to change the beliefs, feelings, and behaviors of individuals with the objective of aligning them against the core values of societies they inhabit and preparing them for intergroup conflict against an out-group that must be fought [117]. Social factors influence this process and the progression from extremist beliefs (non-violence) to extremist violence [151]. The radicalization process may be linear or nonlinear, but it starts with social or political grievances and perceived injustices, a subsequent identity crisis, and the search for significance, identity, or purpose that follows [105].

Radicalization should be understood in the context of “push” and “pull” factors. Push factors refer to negative social, political, economic, or cultural root causes that influence individuals to affiliate with extremist organizations. Pull factors are the perceived positive characteristics and benefits of extremist organizations that lure vulnerable individuals, such as feelings of significance and belonging [105].

Mental illness history, although very uncommon in the PIRUS data, may likewise “pull” individuals by increasing their susceptibility to ideologic narratives or extremist group coercion, or “push” individuals labeled, stigmatized, and excluded from conventional society and forced to seek acceptance through antisocial means [150].

Following alienation from the status quo of perceived unjust society, contextual factors set the stage for radicalization. These include political, economic, ideologic, and psychosocial drivers [105].

Significance Quest Theory of Radicalization to Extremist Violence

The Significance Quest Theory, also termed the 3-N (Need, Narrative, and Network) Model, explains radicalization and movement on a path to extremist violence using principles from social psychology and criminology that combine into three core, inter-related components [149; 151; 160].

The Need

The actor, or the ethnic, religious, or national group they identify with, experiences perceived oppression from a regime or social group; systemic discrimination, stigma, and/ or abuse; or personal circumstances of trauma, failure, a significant loss, or reversal. Perceiving themselves as rejected, divested of control, or victimized by injustice, the actor feels belittled, disrespected, and humiliated. The specifics of the experience are less important than the psychologic effects [149; 151; 161].
A feeling of significance is the fundamental human need to feel worthy and to feel important, valued, and respected in the eyes of others. Humiliating and shameful experiences create a discrepancy between the positive way one wishes to view oneself, and the negative self-perception suggested by the circumstances. This discrepancy induces an aversive arousal and motivates action. The actor searches for routes that can remedy this state of insignificance and restore feelings of value and worth [151].

The Narrative
Some individuals with feelings of alienation and perceived injustice will search for the means to improve their condition. Unable to resolve or improve their grievance, feelings of anger and frustration accumulate. Extremist groups exploit these vulnerabilities by convincing the individual his or her frustration is attributable to a specific enemy [105; 162].

Regardless of where it falls on the political spectrum, the task of extremist ideology is to advance radicalization by identifying an entity to blame for the humiliation, justifying aggression against the entity on moral grounds, and indoctrinating the individual into simplistic thinking that sees the world in black and white. This narrative greatly appeals to those striving for significance [151].

Political, economic, or social grievances can lead to a “cognitive opening,” when individuals in crisis become prone to altering their previously held beliefs and perceptions. Instead of relying on individuals’ identity crises to spread their ideology, extremist recruiters actively trigger cognitive openings through different communication strategies intended to create a “moral shock” [105].

Through frame alignment, the individual examines whether the narrative of an extremist group aligns with his or her experiences and views. If frame alignment is not achieved, the process may be abandoned. If the frame makes sense, a process of socialization begins, and the individual adopts the ideology and becomes committed to it [105].

The Network
Through exposure to the extremist network, the realities of the individual undergo reconstruction. Alternative frames through which to interpret one’s grievances are introduced. These frames are variations of existing cultural or religious frames that rework the schemata of interpretation to affect the meaning attached to events [117]. The individual increasingly identifies with the extreme ideology and network, leading to support of, or engagement in, extremist violence [105].

The network makes a violence-justifying narrative cognitively accessible; their support of the narrative validates it and proves its soundness. The network may convince the individual that, under present circumstances, violence is an acceptable and legitimate means. Violence becomes perceived as less extreme and more normative, making it easier to deviate from broad societal norms without the burden of guilt [149; 161].

Radicalization starts with an individual recognizing an unfavorable condition as “not right.” This condition is then framed as “not fair” and attributed to a target entity. The enemy is demonized, and violence is validated. Dehumanization is a key psychosocial factor in extremist violence that contributes to “moral disengagement,” the process which develops a moral justification to use violence [105; 163]. Reinforcement of an “us versus them” mentality brings the individual fully into the extremists’ fold [117].

PIRUS Research and Radicalization Pathways
The PIRUS database was analyzed to identify nonviolent and violent radicalization pathways. (Note: The most recent data entry in PIRUS dates to 2013, which prevents analysis of alt-right extremism and makes some data on Internet activities and group affiliation dated. Nonetheless, studies using PIRUS data advance the understanding of extremist violence and its prevention.) Researchers found that factors that are necessary for nonviolent extremism are not sufficient for moving to violent extremism [120; 150]. A sense of community victimization and cognitive frame realignment are both necessary for radicalization to violent extremism. These factors combine with psychologic and emotional vulnerabilities from lost significance or thwarted efforts to gain significance, personal trauma, and collective crises to produce sufficient pathways to violent extremism. Radicalization to violence is unlikely in the absence of a cognitive frame realignment or the absence of feeling one is a member of a collectively victimized community. When present, neither factor ensures movement to violence, but they set the environment where it is possible.

Pathways that combine loss of significance and other individual-level vulnerabilities with perceptions of community victimization are particularly important for explaining shifts from nonviolent to violent extremism. Personal vulnerabilities can fuel identity-seeking behaviors in individuals who then find direction and meaning in extremist narratives. Individual-level factors interact with social identity dynamics, and individuals are persuaded that their personal deficits largely result from their membership of a collectively victimized or threatened community.

As individuals and groups become more insular, common mechanisms of cognitive bias (e.g., groupthink, rule compliance, dehumanizing rhetoric, diffusion of responsibility) increase, convincing individuals that alleviation of community grievances and threats to community survival can only occur through violent action.
Analysis of historical data from PIRUS identified four correlates of extremist violence [164]:

- Absence of stable employment
- Radical peers
- Mental illness history
- Pre-radicalization criminal record

The correlations were significant and additive. Individuals with none of the characteristics had a 41.3% chance of engaging in extremist violence; those with one factor had a 59.8% chance of violent behavior; with two factors, a 67.0% chance; and with three factors, an 84.8% chance. Documented mental illness was uncommon, and its influence on extremist violence was difficult to identify [164]. Of note, 41.3% of violent extremists lacked all four risk factors, highlighting the limited predictive capacity of static distal factors.

**RADICALIZATION PATHWAYS: THE U.S. DEPARTMENT OF JUSTICE REPORT**

In 2015, the U.S. Department of Justice published their findings of radicalization pathways among post-9/11 extremists unaffiliated with terrorist groups. The pathway was common across Islamist and far-right ideologies [129]. The pathway begins with personal and political grievances combined. This mirrors personal grievance and moral outrage outlined among the distal characteristics of targeted violence discussed previously in this course. These grievances formed the basis for an affinity with online sympathizers and ideologic validation of their beliefs (the second stage).

In the third stage, an “enabler” is identified—someone providing inspiration for terrorism (nearly all are indirect). The most frequent enablers identified were:

**Islamists**
- Osama bin Laden
- Anwar al-Awlaki

**White Supremacists and Anti-Government Extremists**
- William Pierce (National Alliance founder and author of *The Turner Diaries*)
- Internet personality Alex Jones

Nearly all extremists then engaged in broadcasting of terrorist intent. Finally, a triggering event occurs and acts as the catalyst for extremist violence that was personal, political, or some combination. The prompt to violence may be immediate or may accumulate slowly through a series of “escalation thresholds.”

**Example 1**

The triggering event superseded all other facets of radicalization by fusing the personal proclivity for anger and violence with political grievance over the abuse of Muslims by U.S. military forces. This defining event allowed the subject to dehumanize his victims while elevating himself to a position of moral sanctity as a self-identified holy warrior.

**Example 2**

A series of escalation thresholds were influenced by a combination of personal grievances over a lack of employment prospects and paranoid political beliefs that intensified through affinity with online sympathizers. Along this pathway, discharge from military service was the triggering event for his self-identification as an armed warrior that precipitated an assassination.

**SIMILARITIES OF VIOLENT EXTREMISTS AND OTHER MASS SHOOTERS**

A comparison of 115 mass murderers (at least four victims) with 71 lone actor terrorists from 1990 to 2013 concluded both groups were very similar in behaviors, and similar threat assessment frameworks may be applied to both offender types. Instead of prediction based on static factors, prevention identifies patterns of behavior in both offender types that increases or decreases across time in a lead-up to perpetration; these trends statistically differ from random behavior [89].

Severe grievance is a common starting point among mass shooters and violent extremists. Both offender groups share pathologic narcissism, whereby sensitivity to shame and humiliation is activated by actual or perceived loss and public exposure of self as deficient. This, in turn, fuels the development of grievance against the humiliating entity. The path to violence diverges, but finally converges against a persecutory entity and past humiliation is undone through contempt, devaluation, and violence [90].

The National Collaborating Centre for Mental Health cautions against making negative assumptions based on culture, religion, or ethnicity when assessing risk of violence. Unfamiliar cultural practices and customs can be misinterpreted as being aggressive, and clinicians should ensure that the risk assessment is objective and takes into account the degree to which the perceived risk can be verified. (https://www.nice.org.uk/guidance/ng10. Last accessed March 19, 2019.)

**Level of Evidence:** Expert Opinion/Consensus Statement
IMPLICATIONS FOR SUCCESSFUL COUNTERING OF VIOLENT EXTREMISM

In the final report of the PIRUS data analysis, the authors state that erroneous assumptions drive policies to protect against Islamist extremism. These policies are counterproductive and are likely to inflame instead of mitigate the conditions that promote extremism [112; 120].

Complex psychologic and emotional processes, driven by feelings of lost significance and community victimization, play a central role in radicalization. Countering violent extremism programs should take this into account and should not place undue pressure or surveillance on specific communities, because this may amplify feelings of community victimization and alienation.

Efforts to counter extremist narratives and recruitment efforts should address perceptions of community victimization by challenging myths or misperceptions. Legitimate grievances should be acknowledged, with a focus on alternatives to address these grievances. Those countering violent extremism should be aware that cognitive biases make members less responsive to the disconfirming evidence central to counter-narratives.

Successful programs to counter violent extremism address underlying psychologic and emotional vulnerabilities that make individuals open to extremist narratives. These may result from traumatic experiences and losses, or personal and community marginalization. Programs that emphasize the acquisition of job-relevant skills may be effective for promoting sustained employment of at-risk individuals.

FBI statistics show that, in 2001, anti-Muslim hate crime incidents increased 1,600% from 2000. In 2002, hate crimes against Muslims decreased 67%, a drop credited, in part, to the leadership of President George W. Bush [148]. Leaders and advocates should keep this in mind when providing care or doing outreach.

GUN VIOLENCE TRENDS, DATA, AND FACTORS

The identification and interruption of individuals on a pathway to targeted mass violence is often performed by professionals with specialized training in threat assessment and management. However, mass shootings are part of the broader public health concern of gun violence. There is overwhelming recognition that health and mental health professionals can take critically important actions to reduce gun violence and increase the safety of their patients.

Clinician effectiveness in helping prevent gun violence requires understanding the following [32; 165; 166]:

- The nature and extent of mass shootings and the gun violence problem in general, including what it is, whom it affects, where it occurs, how patterns have changed over time, and the factors contributing to these changes.
- The facts on gun safety and risks, gun owner subculture, and how to have gun conversations with patients.

It is vitally important for clinicians to understand the dynamics of domestic violence and victim danger with perpetrator access to a gun. The strong association between domestic violence and mass shootings is largely unappreciated.

AGGRESSION, WEAPONS, AND VIOLENCE

The understanding of gun violence and risk reduction is well-informed by briefly reviewing aggression, aggressive behavior, and potential interaction with gun presence.

General Contributors to Aggression

The I-3 Model, a general framework to understand aggression, identifies three factors that influence the likelihood and intensity of aggressive behavioral response: instigation, impellance, and inhibition [167].

Instigation

Instigation is defined as the immediate environmental provocation that normatively affords an aggressive response. For example, in most contexts, witnessing another man try to seduce one's wife normatively renders aggression. Other normative instigations may include social rejection and verbal/physical provocation.

Impellance

Impellance encompasses the situational or dispositional qualities that influence how strongly the instigator fosters a proclivity to aggress. Factors that increase impellance strength include trait aggressiveness, Dark Tetrad personality traits (i.e., Machiavellianism, narcissism, psychopathy, and sadism), trait anger, hostile rumination, and presence of a weapon.

Inhibition

The situational or dispositional qualities that influence how strongly an individual is likely to enact an aggressive response are over-ridden with disinhibition. Inhibition is weakened by intoxication and strengthened by self-control, frontal lobe functioning, and emotional commitment to the relationship with the potential target of aggression.

Hostile Attributional Bias

Hostile attributional bias describes the tendency to perceive hostility in ambiguous situations. These individuals show a pattern of hypervigilance to threat and reactive aggression to perceived provocation. Hostile attributional bias is connected to personality traits involving hostile beliefs and reactive aggression, including narcissism and psychopathy [168; 169].
Some subcultures promote hostile attributional bias [169]. A unique “culture of honor” in some areas of the United States (particularly in the South) promotes vigilance toward provocateurs, perceptual readiness to attribute hostile intent to others, and retaliatory aggression in response to being dishonored. Violence among urban minority men is promoted by the premium placed on retaliation when disrespected (“dissed”). Recent “stand your ground” laws in some states permit lethal retaliation against a perceived provocateur [170].

The “Weapons Effect”
In the I-3 model of aggression, the presence of a weapon increases the proclivity for aggressive response to provocation [167]. This “weapons effect” was first described more than 50 years ago following observations that the mere presence of a weapon increased aggression, especially in angered individuals. In response to a specific situation, whether a person behaves aggressively is greatly influenced by how they interpret, or appraise, the situation [171].

Research demonstrates that the presence of weapons increases aggressive thoughts and hostile appraisals, which in turn increases the aggressive behavior. These effects are significantly stronger for men than women [171].

Weapons can make people more aggressive even when they are concealed instead of visible. In a nationally representative sample of adults, motorists with a concealed weapon in their car were more likely to drive aggressively (e.g., tailgate, make obscene gestures) than motorists without weapons in their car, even after controlling for other factors related to aggressive driving (e.g., gender, age, urbanization, census region, driving frequency) [171; 172].

DOMESTIC HOMICIDE AND MASS SHOOTINGS
As discussed, mass shootings/murders are generally defined as four or more people killed over a brief duration in close proximity. Many are domestic homicides, excluded from public mass shooting databases because they were not perpetrated in public and/or the perpetrator was known to the victims [173]. Unlike targeted violence, domestic violence homicides are typically impulsive acts perpetrated in highly charged emotional states. The terms “domestic violence” and “intimate partner violence” (IPV) are often used interchangeably.

During the 1920s and 1930s, mass murders (mostly familicides and crime-related gun massacres) were nearly as common as in the post-1960s era. Familicide describes mass murder, typically a man killing his partner (spouse or ex-spouse, girlfriend or ex-girlfriend), their children, relatives, or some combination. Then, as now, these acts were less likely to receive widespread news coverage. The long-standing view of domestic violence as a private family matter has undermined taking domestic violence as seriously as other potentially fatal violence [12; 20]. Public and clinician attention to the lethality of domestic violence is vital.

Domestic Violence as a Driving Factor in Mass Shootings
Some are quick to link Islam or mental illness to the actions of mass shooters, but the strong association with domestic violence/IPV goes largely unaddressed [174]. Domestic violence mass murders comprise more than 50% of all mass murders. Everytown for Gun Safety (Everytown) is a nonprofit organization involved in research, education, and policy related to gun violence prevention. Because domestic mass shootings are often excluded from public mass shooting databases, Everytown examined the prevalence of mass shootings (defined at least four people killed with a firearm, shooter excluded) during 2009–2017 [175; 176]. They found that in 173 mass shooting incidents, 1,001 people were killed and 792 were injured. Fifty-four percent of mass shootings were domestic violence incidents, during which 491 intimate partners or other family members were killed, 39% of whom were children. In these incidents, 65% ended when the perpetrators killed themselves. Women make up 15% of all deaths from gun violence, but 64% of mass shooting victims are women and children [175; 176]. In total, 16% of attackers had previously domestic violence charges, and 59% of incidents took place entirely in private residences.

Women are 16 times more likely to be killed by gunfire in the United States than in other high-income countries [176; 177; 178; 179]. A woman is 500% more likely to be killed in a domestic violence event when a gun is present. Nearly 1 million women alive today have been shot, or shot at, by an intimate partner. Abusers use guns to threaten and control their victims, even if they never pull the trigger. Around 4.5 million American women alive today have been threatened with a gun by an intimate partner [176; 177; 178; 179].

Of female victims of homicide, 90% are killed by a person they know, and half of these offenders are current or former intimate partners [180]. In contrast, a 2017 analysis places the annual risk of being killed by a stranger with severe psychoses at 1 in 14 million [32]. Most suicides that follow homicide occur in the context of IPV; the perpetrators are motivated by dependency on, and/or desire to be reunited with, the victim(s) [181].

Warning Signs
Before the incident, 42% of mass shooters showed “red flag” warning signs for dangerous gun behaviors indicating they posed a danger to themselves or others, including [176]:

- A recent threat of violence
- An act (or attempted act) of violence toward self or others
- A conviction for certain firearms offenses (e.g., unlawful and reckless use, display or brandishing)
- Violation of a protective order
- Ongoing substance abuse
The “red flags” overlap with factors that place women at greatest risk of being killed in abusive relationships, including [80; 178]:

- Perpetrator access to a gun
- Previous threat with a weapon
- Escalation in severity or frequency of violence
- Recent estrangement, especially from a controlling partner
- Being stalked by a former sexual partner

**Domestic Violence Histories of Mass Shooters**

As noted, a history of domestic violence is common among perpetrators of mass violence. One example is Devin Kelley, who killed 26 people and injured 20 in the November 2017 church massacre in Sutherland Springs, Texas. Kelley was consumed by a grievance against his mother-in-law and attacked the church his in-laws attended, although the mother-in-law was not present [182]. In the Air Force during 2012, Kelley was court-martialed and served 12 months in a military jail for assaulting his first wife and infant stepson, fracturing the boy's skull. While awaiting sentencing, he was detained at a mental health clinic for bringing weapons on base and making death threats against his superiors [182; 183]. His domestic violence record never appeared in the background check required of licensed gun dealers because the Air Force did not file the paperwork. Kelley legally purchased the AR-15 used in the massacre. Dishonorable discharges, but not bad conduct discharges, which Kelley received, enter the background check to block gun sales [182].

Other examples include Omar Mateen, who killed 49 people in the Pulse nightclub in 2016 and frequently battered his former wife, and Tamerlan Tsarnaev, one of the Boston Marathon bombers, who had been previously been arrested for domestic assault and battery. Anti-abortion extremist Robert Dear, who killed three people in a Colorado Planned Parenthood clinic in 2015, had an extensive history of violence against women, domestic abuse, and an arrest for rape. Seung-Hui Cho, who killed 32 people at the Virginia Polytechnic Institute in 2007, had a history of stalking and harassing female students [184].

**IPV Dynamics**

IPV describes attempts to harm or control current or former romantic partners against their will through physical violence, psychological aggression, sexual violence, or stalking. Men and women tend to show equivalent rates of IPV perpetration, but women are disproportionately injured and killed by IPV. De-humanization of women (i.e., women viewed as sex objects and not people) has implications for violent behavior directed toward them. The extent to which men objectify women is related to their IPV behaviors toward those women [185].

Domestic violence is driven by a desire by the abuser to exert power and control over the victim. The perpetrator's sense of losing that control is when violence is more likely, including domestic mass murder. The psychology of mass shooters also points to violence as the means to gain power and control [186]. Beyond potential use to kill and wound, batterers use guns in a variety of ways to coerce and control their victims. They may threaten to kill the women, themselves, the children, or a pet. During an argument, other methods of gun intimidation include cleaning, holding or loading a gun, and going outdoors and shooting the gun [187; 188].

Domestic abusers and mass killers often possess patriarchal, highly traditional views of male-female relationships and may use domestic violence to impose traditional gender roles on the female partner [174; 184]. This view also makes fundamentalist belief systems of major religions that advocate restrictive attitudes toward gender appealing and encourage men to punish women for their own failings. ISIS infamously noted this, with promises of young female sex slaves in its recruiting material. An IPV history may help neutralize the natural barriers to attempting mass murder [184].

**MASS SHOOTINGS AND OTHER GUN VIOLENCE**

Firearm injuries encompass fatal and non-fatal outcomes of interpersonal violence, self-directed violence, and accidental discharge. Around 100,000 Americans are injured or killed by guns each year, and since 1968, more civilians have been murdered with guns than American soldiers have been killed in combat by any means in all wars combined [189; 190]. Firearm injuries are disproportionately a problem affecting men and boys, who account for 86% of deaths and 89% of non-fatal injuries; and a problem afflicting the South, where 46% of all gun-related homicides and 45% of suicides occur [165].

The definitions for mass shooting exclude assailants in counting the death toll, but otherwise vary. In 2005, the FBI defined mass murder as a purposeful homicidal act resulting in the deaths of four or more people. Following the 2012 Sandy Hook shooting, the defining minimum number of lives lost was lowered from four to three during the same event [191].

FBI Supplementary Homicide Reports, widely used for homicide data, rely on voluntary reporting by local law enforcement agencies nationwide. Problems with persistent under-reporting led to several independent homicide research databases, with Mother Jones and Everytown the two most widely cited [20; 28].

Most mass shooting databases exclude murders committed against family members, during robbery or burglary, or resulting from gang or drug activity [192]. This has excluded some of the worst incidents, including [193]:
• A 1983 robbery of a Seattle gambling club, in which 13 victims were executed by gunfire
• The largest family annihilation in U.S. history, when in 1987 an Arkansas man murdered his 14 family members, then drove to other locations to kill a former coworker, and then a woman who had spurned his romantic advances

According to the Mother Jones mass shooting database, during 2007–2013, active shooting and mass murder incidents increased 150% compared with 2000–2006 [66; 194]. Mass shootings occurred, on average, every 200 days in 1982–2010, increasing to every 64 days in 2011–2014. The average victims per year increased more than 200% after the federal ban on assault weapons and large-capacity magazines expired (i.e., 65.7 victims per year in 2005–2016 vs. 21.1 victims per year in 1995–2004) [195].

The Gun Violence Archives (GVA) reported the following numbers of mass shooting incidents annually [196]:

- 2014: 271
- 2015: 333
- 2016: 383
- 2017: 346
- 2018: 340

The FBI examined active shooter incidents, defined as one or more individuals actively engaged in killing or attempting to kill people in a populated area. In total, 200 active shooter incidents were identified between 2000 and 2015 [197; 198]. The average annual frequency increased from 2000–2006 (6.4) and 2007–2013 (16.4) to 2014 and 2015 (20 incidents each). In 2000–2013, there were 160 incidents with 1,043 casualties (486 killed and 557 wounded). In contrast, in 2014–2015 alone, there were 40 incidents with 231 casualties (92 killed and 139 wounded). During 2014–2015, the FBI noted two incidents in which a citizen with a gun permit exchanged gunfire with a shooter before the assailant was restrained and arrested, and a third incident in which a citizen pursued the shooter inside a store, but was shot and killed before he fired his weapon.

In sum, public mass shootings show an increasing frequency since roughly 2007–2010.

### Homicides

As a subtype of homicide, discussion of trends in mass shooting also requires discussion of broader trends in gun homicide. Beginning in 1996, Congress prohibited gun injury research by the Centers for Disease Control and Prevention (CDC), and FBI data are used to analyze gun contribution to total homicides (Table 4) [199; 200].

The National Institute of Justice (NIJ) published an analysis of homicide increases in November 2017 [201]. Homicides increased nationwide from 2014 to 2015 (11.4%) and 2015 to 2016 (8.2%); and in big cities (≥250,000 population) from 2014 to 2015 (15.2%) and 2015 to 2016 (10.8%).

Despite 2016 homicide rates 35.4% lower nationwide and 45.7% lower in big cities than in 1995, the abrupt 2015–2016 increase is concerning. A closer look by NIJ found that most big cities with large homicide increases in 2015 or 2016 saw far smaller increases or large decreases in the opposite (2016 or 2015) year [201]. In all, 10 big cities accounted for 67.5% of homicide increases in 2015 and 95.5% in 2016 [201].

Most homicide increases are concentrated in a fraction of big cities and are time-limited. This suggests factors driving these increases may also be short-lived. The Department of Justice linked homicide increases in 2015–2016 to two proximal factors: the opioid epidemic and the “Ferguson effect.” They did not identify the underlying (root) causal factors [201].

<table>
<thead>
<tr>
<th>Type of Homicide (Weapon Used)</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Firearms</td>
<td>8,897</td>
<td>8,454</td>
<td>8,312</td>
<td>9,778</td>
<td>11,004</td>
</tr>
<tr>
<td>Knives, cutting instruments</td>
<td>1,604</td>
<td>1,490</td>
<td>1,595</td>
<td>1,589</td>
<td>1,604</td>
</tr>
<tr>
<td>Blunt objects</td>
<td>522</td>
<td>428</td>
<td>446</td>
<td>450</td>
<td>472</td>
</tr>
<tr>
<td>Personal weapons (hands, fists, etc.)</td>
<td>707</td>
<td>687</td>
<td>682</td>
<td>659</td>
<td>656</td>
</tr>
<tr>
<td>Weapon type not stated</td>
<td>802</td>
<td>850</td>
<td>872</td>
<td>873</td>
<td>903</td>
</tr>
<tr>
<td>All Homicides</td>
<td>12,888</td>
<td>12,253</td>
<td>12,270</td>
<td>13,750</td>
<td>15,070</td>
</tr>
</tbody>
</table>

Source: [200]  
Table 4
The illicit opioid epidemic concentrates in white populations, but not in big cities. In 2015, fatal heroin overdose rates among whites were 74% higher than Blacks and 135% higher than Hispanics. Racial differences in fatal fentanyl overdoses were even larger [201].

In 2015–2016, there were larger increases in drug-related homicides than all other homicide types involving white offenders and victims. The increasing demand for illicit opioids attains more sellers into the market, which escalates conflicts between sellers over customers and territory; increases disputes between buyers and sellers over price, purity, quantity, or related factors; and draws other criminals who intend to rob sellers or buyers of drugs or money [201].

The “Ferguson Effect”

The “Ferguson effect” describes a cascade of effects that followed a series of high-profile, deadly use-of-force incidents involving the police and black Americans in big cities during 2014–2016, beginning in Ferguson, Missouri [201]. A ripple effect of these incidents activated a police “legitimacy crisis” in urban black communities already experiencing elevated levels of violent crime. With increased community alienation from the police, contact is avoided and violent crime is not reported by witnesses or victims, and violent retaliation increases. Following highly publicized violent police encounters, calls for police assistance significantly decline in nearby black neighborhoods, taking about a year to return to pre-incident levels [201; 202]. Another effect is increasing concerns among police for their safety, resulting in reduced proactive policing, fewer arrests, and reduced stopping and questioning for suspicious behaviors and activities [201].

Cities most troubled by conflict between police and black communities experienced the greatest one-year homicide increases (in either 2015 or 2016), including Cleveland, Chicago, Baltimore, St. Louis, and Milwaukee [201].

Suicide and Suicide Attempts

Suicide is self-directed violence, and it is often overlooked in gun violence discussions. Guns are used in 5% of suicide attempts, but are responsible for more suicide deaths (>50%) than all other methods combined [203]. Around two-thirds of the annual 33,000 gun-related fatalities in the United States are suicide. In 2012, 75% of all gun suicides were white men, with the highest rates among those 70 years of age or older [165; 204; 205; 206].

During an acute suicidal crisis, lethality of the method available can be a critical determinant of fatal or nonfatal outcome. The fatality rate of suicide attempts using guns (85%) is much higher than most other methods (cutting/slashing: 0.7%; intentional overdose: 2.5%; jumping: 20%); hanging is the exception (70%). People usually do not substitute a different method when a highly lethal method is unavailable or difficult to access [165; 207].

Most suicidal impulses are overwhelming but short-lived, and suicidal individuals are often ambivalent about killing themselves [188]. The time between deciding on suicide and attempting suicide can be 10 minutes or less; more people begin a suicide attempt and stop mid-way than continue and complete it [205; 208; 209]. Cutting and overdose, unlike guns, offer a window for rescue [165]. More than 90% of those who attempt suicide and survive do not later die by suicide, but suicide attempts with a gun are usually fatal [205].

DISCUSSING GUN SAFETY AND RISKS WITH PATIENTS

The key role of primary care clinicians in preventing gun-related mortality and morbidity by initiating gun conversations with their patients is established. Clinicians should know what approaches to use and how to speak with patients, especially members of gun culture. Judgemental approaches and telling patients their fears of mass shootings/violent strangers and their urge to defend themselves are irrational are unlikely to be effective [210].

RATIONALE AND BARRIERS

Gun safety counseling is a key component in preventing firearm injury and deaths, including IPV and mass shootings, but healthcare professionals have a longstanding reluctance in addressing gun risks in their patients. Efforts by the American College of Physicians, the American Academy of Pediatrics, the National Association of Social Workers, the APA, and many other health and mental health organizations are helping to overcome this resistance [211; 212]. Asking patients about firearms, counseling them on safe firearm behaviors, and taking further steps with high-risk patients are some critically important actions to help prevent gun violence and accidents [212].

General Barriers

The healthcare team strives to prevent important health and mental health problems at the individual and population levels, but in general, does poorly at gun injury prevention. Members of the team infrequently ask about firearms and counsel poorly, if at all, despite awareness that the high lethality of guns makes prevention efforts particularly important [213].

In a 2014 survey of 573 internal medicine physicians, 58% reported never discussing with their patients whether there were guns in the home, 80% never discussed whether the patient used guns, 77% never discussed ways to reduce the risk for gun-related injury or death, and 62% reported never discussing the importance of keeping guns away from children [214].
In a survey study of 339 psychologists, 78.2% reported having no systems in place for identifying patients with access to firearms [215]. Only 51.6% of those surveyed indicated they would initiate firearm safety counseling if the patients were assessed as at risk for self-harm or harm to others, and 46% reported not receiving any information on firearm safety issues [215].

Many barriers exist. Perhaps the most important is an unfamiliarity with firearms themselves, with the benefits and risks of firearm ownership, and with what to say during firearm safety counseling and how to say it. Some may worry that asking questions that seem intrusive may invite discord or damage the patient relationship. They may feel uncomfortable asking about firearms, even when they are well-informed, or worry that patients will not be truthful. Some may believe that firearm counseling is outside their scope of practice or infringes on patients’ Second Amendment rights [213].

**Gun Culture and Clinician Barriers**

Fully grasping and appreciating the perspectives, beliefs, and values of gun culture members is vital for providers who are not part of the culture (*Appendix: Understanding Gun Culture*). Now considered culture blindness, this may lead to failures in engaging the patient, understanding their interests, and communicating useful information to them or their family [32; 216; 217]. Effective work with gun owners is considered a cross-cultural issue that requires the integration of gun violence evidence with the culture and interests of gun owners [32; 218].

Patient-centered care, a guiding principle in many disciplines, requires cultural competence for patient populations diverse by ethnic heritage, religious beliefs, sexual orientation, and other factors. Cultural competence includes respect for cultural variation, awareness of diverse beliefs and practices, interest in learning about other cultures and skills that enhance cross-cultural communication, and acknowledgment that practicing cultural competence enhances the delivery of quality health care [218]. Healthcare providers should view gun ownership as linked to membership of a subculture, with cultural competence for gun safety counseling requiring the recognition of multiple gun owner subpopulations with differing perspectives and motivations [218].

Health and mental health providers should recognize and work to reduce their knowledge gaps or biases, while taking steps to optimize patient education and communication. This approach is used in counseling patients on other controversial behaviors with potential health consequences, like using helmets and seat belts, accepting childhood vaccinations, and reliance on naturopathic remedies. Clinicians may feel uncomfortable or uninformed when discussing certain subjects and may disagree with patient choices or beliefs, but discomfort or disagreement cannot justify condescension or silent inaction [218].

**Gun Culture and Patient Barriers**

The limited availability and recognized need for healthcare provider training on firearm-related issues has invited patient misunderstanding, as clinicians often enter gun discussions with limited comfort and competence [32]. Some gun-owning patients have interacted with providers who seemed unaware of the issues or intolerant of their perspective and may not view healthcare providers as trustworthy resources for information or concerns about gun safety [218].

Viewpoints of the broader gun owner community have shifted over time, and the current trend shows increased identification and perception as a persecuted group [219]. Some gun owners perceive medical and mental health clinicians as hostile to their interests, values, and rights [32]. This highlights the importance for clinicians to reach across a cultural divide by understanding the perspective of patients in gun culture.

**Prohibitions on Asking About Firearms**

Some states have enacted laws with the stated intent to protect patient privacy and prevent intrusive questioning of gun ownership. Florida passed a law in 2011, the Firearm Owners’ Privacy Act (FOPA), imposing disciplinary sanctions for clinicians who ask about or document patient gun ownership. A clause permitted this when relevant to safety, but many providers believed questioning was illegal under any circumstances and refrained from doing so. Key provisions were overturned in 2017 [32; 220; 221].

While there is presently no state or federal statute that should interfere with initiating gun conversations with patients, the impact of actual or perceived threat of professional sanctions on gun discussions with patients may be substantial [32; 218; 220]. Concerned clinicians can find the status of gun laws in their state by visiting https://lawcenter.giffords.org/search-gun-law-by-state.

**GENERAL GUIDANCE**

Patients are more open to firearm safety counseling that is tailored to their context, focused on well-being and safety, and involves the family in discussions. The following section provides suggestions on how to approach gun discussions [211; 213; 218; 220].

**Individualize and provide health context for questions.** Explain the context for asking about guns when routinely assessing gun safety, such as part of routine household hazard screening for parents of toddlers and risk behaviors for teens. With counseling, use different educational messages for parents of young children, family members of patients with cognitive impairment, and suicidality. Acknowledge local cultural norms.

**Avoid accusatory questions.** If a patient is struggling with suicidal thoughts, instead of asking “Do you have a gun?”, consider “Some of my patients have guns at home, and some gun owners with suicidal thoughts choose to make their guns less accessible. Are you interested in talking about that?”
Start with open-ended questions. To avoid sounding judgmental, instead of starting with, “Is your gun safely secured?”, ask “Do you have any concerns about the accessibility of your gun?”

Avoid being overly prescriptive. Meet patients where they are. When risk is present, instead of prescribing one specific solution, consider brainstorming. Removing the gun may be objectively optimal but when resisted by the patient, turn to making the gun less accessible by discussing various options (e.g., surrendering the gun, disposing of ammunition, storing the gun outside the home). This is consistent with the principles of shared decision-making.

Health and mental health professionals have an opportunity to educate patients about safe storage, household risk factors, and risk mitigation, which is particularly important when increased risk factors apply. Educate patients on firearm safety and include statistics on risks of injury or death, conveyed as less judgmental by written educational material with resources. To refine the patient education approach, professionals should collaborate with gun-owner community members. The suggestion, “Don’t just ask, inform” emphasizes patient education and not just information gathering.

The three basics of gun safety assessment and counseling are [211; 213]:

- Ask
- Assess
- Counsel (regarding safe storage and decreased access)

Ask first, “Are any firearms kept in or around your home?” If “yes,” ask two follow-up questions:

- “Do any of these firearms belong to you personally?”
- “Are any of these firearms stored loaded and not locked away?”

Assess gun access by high-risk household members (e.g., those with history of violence, children or teenagers, suicidal or depressed, IPV survivors or perpetrators, alcohol abuse, cognitive impairment). With guns in the home, ask about the “5 Ls” risk factors (Locked, Loaded, Little children, feeling Low, Learned owner) and ask if the operator has cognitive impairment.

Counsel patients that the safest storage at home is unloaded and securely locked, with ammunition locked in a separate container. To decrease gun access, consider storage at a remote location, ammunition disposal (or stored separately), or deactivation by removing a functional part. Providing an educational handout with information on gun storage devices may also be helpful.

If advisability of having guns at home enters discussion, clinicians can point to the abundant evidence establishing that guns at home, and purchasing a handgun, are associated with a substantial, long-lasting increased risk for violent death [213].

Counseling patients on gun safety and risks may involve advising a patient their safest action is to remove guns from the home. If this is resisted, safe storage practices are introduced as a compromise. The conflict between safest approach and compromise approach may create an ethical challenge [220].

Patients with Safety Concerns

For patients with acute risk of gun violence and/or whose information or behaviors suggests suicidal or homicidal ideation or intent, immediately determine access to lethal means and promptly reduce access with patient cooperation if possible (i.e., lethal means counseling). Temporarily relinquishing guns may be needed; use a gun violence restraining order or red flag law, family members, gun shops, or law enforcement (as allowed by state laws). Disclose to others who can reduce risk (e.g., family, law enforcement, psychiatric services). Hospitalize when necessary; bed availability should be long enough to significantly reduce suicide/homicide risk. Those with prescriptive authority should avoid prescribing disinhibiting medication, such as benzodiazepines [205; 213; 222].

Remember that patient demographics increase the risks of gun-related injury. Middle-aged and older white men and those with children and adolescents in the household are at greater risk. These individuals may be counseled on safe storage and risk reduction [213]. For patients with two or more high-risk factors, counsel on safe storage and risk reduction. In patients with diminished cognitive capacity, disclose to others who can reduce the risk [213].

Laws Addressing Gun Removal from Owner/Possessor

Some laws address individuals at high risk for harming self or others who already possess a gun, by allowing petition for a court order that respondents relinquish their gun(s).

Domestic violence restraining orders (DVROs), with or without gun restrictions, have little effect on intimate partner homicides. DVROs reduce gun intimate partner homicides only when expanded to cover dating partners and ex parte orders (temporary until court hearing with respondent appearance) [224].

Some states have laws that restrict gun purchase and possession from those convicted of misdemeanor crimes of domestic violence and minimally reduce intimate partner homicide. However, misdemeanor crimes of domestic violence laws expanded to restrict gun purchase/possession from those convicted of any violent misdemeanor crime substantially reduce overall intimate partner homicides (-23%) and gun intimate partner homicides (-25%) [224].
Gun violence restraining orders are court orders to temporarily prevent gun access of high-risk individuals in crisis, independent of psychiatric history. Some state gun violence restraining orders allow gun removal if not voluntarily surrendered [225; 226].

Red flag laws (or extreme risk protection orders, in some states) provide a legal means for gun removal when other mechanisms are absent. Two states enacted red flag laws after being powerless to disarm individuals with warning signs of danger before they committed gun massacres. Florida passed its law after the Parkland shooting in 2018, and California passed its law in 2014 after the mass murder by Elliot Rodger [91].

Laws that explicitly require gun surrender or grant law enforcement officers authority to remove guns more effectively reduce gun violence than laws that leave enforcement unaddressed. Gun relinquishment may not occur just because it is ordered. Although enforcement of court orders can be done effectively, efforts to ensure implementation or enforcement by state and local jurisdictions have varied [224; 227].

IPV and Guns
In patients with suspected IPV from a current or former intimate, clinicians should ask about abuser gun ownership regardless of co-habitation status. In addition to lethality threat, the psychologic impact of merely displaying or handling a gun can facilitate coercive control. As a situation of chronic and escalating abuse, coercive control involving a gun portends ill for the woman [179; 223]. Patients injured by, or exposed to, gun violence are at risk for developing post-traumatic stress disorder or risky self-medication [222].

Duty to Warn
Patient disclosures to mental health professionals are typically protected by federal and state laws covering doctor/patient privilege and by practitioners’ ethics rules governing confidentiality. Duty to warn is the exception, summarized to mean that privacy and privilege end where danger to the public begins [26]. This includes potential mass violence.

Tarasoff law states that therapists, clinicians, and other mental health counselors have the duty to protect third parties from harm. As a result of this legislation, clinicians have a duty to protect the third party by warning the targeted victim or others who can then warn the intended victim, notifying law enforcement, and implementing other steps to protect the potential victim [228]. These laws are state-specific and the professions affected vary.

CONSIDERATIONS TO AVOID STIGMATIZING PATIENTS WITH MENTAL ILLNESS
Mental health interventions to prevent mass shootings are based on the supposition that psychiatric evaluations can predict and thus prevent mass shootings. Such proposals are the logical conclusion of ascribing blame to untreated serious mental illness [9; 229]. However, most mass murderers do not have identifiable serious mental illness; most have maladaptive personality configurations. As such, gun access, not serious mental illness, determines most gun homicides [230].

The framing of mass violence as a serious mental illness problem persists, despite the statistically improbable odds of dying from gunshot by a stranger with psychotic illness [32]. The behavior and motives of mass shooters should be distinguished from psychiatric diagnoses [9].

Mass shooters are typified by long-standing, pervasive anger, persecution, violent revenge, and egotism—psychopathology for which the mental health field has no immediate, quick-acting “treatment.” Mental health professionals can help troubled individuals willing to engage in psychotherapy, medication therapy, and/or substance abuse counseling, but the persecutory narcissistic pathology of mass shooters subverts such willingness, and they usually shun mental health treatment [9].

Psychiatric diagnosis is largely an observational tool, not an extrapolative one. A psychiatric diagnosis is not predictive of violence, and predictions of future dangerousness based on psychiatric judgement are not much better than chance alone. Even the overwhelming majority of psychiatric patients who superficially match the profile of mass shooters (i.e., gun-owning, angry, paranoid white men) do not commit crimes [19].

Some mass shooters (e.g., Cho, Harris, Breivik, Holmes, Lanza, Rodger) had been evaluated by psychiatrists prior to committing violence. Their assessments seemed cursory and focused on obvious symptoms, like anger. Without looking further into their personality pathology, the disproportionality of grievances and rage remained undetected and they went on to perpetrate [45]. Expecting psychiatrists, mental health workers, or primary care providers to prevent mass shootings imposes an impossible, ineffective burden [229].

CONSIDERATIONS FOR NON-ENGLISH-PROFICIENT PATIENTS/CLIENTS
As a result of the evolving racial and immigration demographics in the United States, interaction with patients for whom English is not a native language is inevitable. Because patient education is such an important aspect of the care of patients at risk for gun violence, it is each practitioner’s responsibility to ensure that information and instructions are explained in such a way that allows for patient or caregiver understanding. When there is an obvious disconnect in the
communication process between the practitioner and patient due to the patient’s lack of proficiency in the English language, an interpreter is required. (In many cases, the terms “interpreting” and “translating” are used interchangeably, but interpreting is specifically associated with oral communication while translating refers to written text.) Frequently, this may be easier said than done, as there may be institutional and/or patient barriers.

Depending upon the patient’s language, an interpreter may be difficult to locate. Or, an organization may not have the funds to bring in an interpreter. Also, bringing in an interpreter creates a triangular relationship with a host of communication dynamics that must be negotiated [231]. Many view interpreters merely as neutral individuals who communicate information back and forth. However, another perspective is that the interpreter is an active agent, negotiating between two cultures and assisting in promoting culturally competent communication and practice [232; 233]. In this more active role, the interpreter’s behavior is also influenced by a host of cultural variables such as gender, class, religion, educational differences, and power/authority perceptions of the patient [232; 233]. Consequently, an intricate, triangular relationship develops between all three parties. Another factor affecting the communication process is the fact that many interpreters are not adequately trained in the art of interpretation in mental health and general health settings, as there are many technical and unfamiliar terms. An ideal interpreter goes beyond being merely proficient in the needed language/dialect [234]. Interpreters who are professionally trained have covered aspects of ethics, impartiality, accuracy, and completeness [235]. They are also well-versed in interpreting both the overt and latent content of information without changing any meanings and without interjecting their own biases and opinions [235]. Furthermore, knowledge about cross-cultural communication and all the subtle nuances of the dynamics of communicating in a mental health or general health setting is vital [233; 234].

On the patients’ side, they may be wary about utilizing interpreters for a host of reasons. They may find it difficult to express themselves through an interpreter [236]. If an interpreter is from the same community as the patient, the client/patient may have concerns about sharing private information with an individual who is known in the community and the extent to which the information disclosed would remain confidential. In some cases, raising the issue of obtaining an interpreter causes the client/patient to feel insulted that their language proficiency has been questioned. Finally, if an interpreter is from a conflicting ethnic group, the patient may refuse having interpreter services [231]. The ideal situation is to have a well-trained interpreter who is familiar with health and mental health concepts.

If an interpreter is required, the practitioner must acknowledge that an interpreter is more than a body serving as a vehicle to transmit information verbatim from one party to another [236]. Instead, the interpreter should be regarded as part of a collaborative team, bringing to the table a specific set of skills and expertise [236]. Several important guidelines should be adhered to in order to foster a beneficial working relationship and a positive atmosphere.

A briefing time between the practitioner and interpreter held prior to the meeting with the client/patient is crucial. The interpreter should understand the goal of the session, issues that will be discussed, specific terminology that may be used to allow for advance preparation, preferred translation formats, and sensitive topics that might arise [234; 236; 237]. It is important for the client/patient, interpreter, and practitioner to be seated in such a way that the practitioner can see both the interpreter and client/patient. Some experts recommend that the interpreter sit next to the client/patient, both parties facing the practitioner [235].

The practitioner should always address the client/patient directly. For example, the practitioner should query the client/patient, “How do you feel?” versus asking the interpreter, “How does she feel?” [235]. The practitioner should also always refer to the client/patient as “Mr./Mrs. D” rather than “he” or “she” [236]. This avoids objectifying the client/patient.

At the start of the session, the practitioner should clearly identify his/her role and the interpreter’s role [236]. This will prevent the client/patient from developing a primary relationship or alliance with the interpreter, turning to the interpreter as the one who sets the intervention [234]. The practitioner should also be attuned to the age, gender, class, and/or ethnic differences between the client/patient and the interpreter [236]. For example, if the client/patient is an older Asian male immigrant and the interpreter is a young, Asian female, the practitioner must be sensitive to whether the client/patient is uncomfortable given the fact he may be more accustomed to patriarchal authority structures. At the conclusion of the session, it is advisable to have a debriefing time between the practitioner and the interpreter to review the session [234; 236; 237].

In this multicultural landscape, interpreters are a valuable resource to help bridge the communication and cultural gap between clients/patients and practitioners. Interpreters are more than passive agents who translate and transmit information back and forth from party to party. When they are enlisted and treated as part of the interdisciplinary clinical team, they serve as cultural brokers, who ultimately enhance the clinical encounter. In any case in which information regarding diagnostic procedures, treatment options and medication/treatment measures are being provided, the use of an interpreter should be considered.
RESOURCES

American College of Physicians
Commitment to discuss gun safety with patients.
http://go.annals.org/commit-now

American Psychological Association
https://www.apa.org/topics/violence/gun-violence-prevention

American Public Health Association
https://www.apha.org/topics-and-issues/gun-violence

Annals of Internal Medicine
To help healthcare providers become knowledgeable of gun safety and risks, the Annals of Internal Medicine has made gun-related content available for free.
https://annals.org/aim/pages/firearm-related-content

Coalition to Stop Gun Violence
https://www.csgv.org

Everytown for Gun Safety
https://everytown.org

Giffords Law Center to Prevent Gun Violence
Comprehensive information on federal and state gun laws.
https://lawcenter.giffords.org

Office for Victims of Crime
Victims of Mass Violence and Terrorism Toolkit
https://www.ovc.gov/pubs/mvt-toolkit

CONCLUSION

Mass shooting incidents have become overfamiliar to health and mental health providers and the public. The close associations between public mass shooters, extremists who commit mass violence, and domestic mass shooters are largely unknown. Mass shootings are acts of targeted violence fueled by personal or ideologic motive. For both offender types, the pathway to violence begins with grievance and alienation. Contrary to common misperception, mass violence is rarely committed by offenders experiencing serious mental illness or by offenders who “snap.” In addition, most recent victims in the United States have been killed by far-right extremists rather than Islamist extremists. Mass shootings are typically defined as at least four persons killed over a brief period, and a large proportion of public mass violence perpetrators have histories of domestic violence. Mass shootings and domestic homicides are part of the larger public health concern of gun violence. Health and mental health providers are encouraged to initiate gun conversations with their patients. However, knowledge of gun injury statistics and gun culture that many gun owners are a part of are required for clinicians to play an effective role in reducing gun violence.

APPENDIX: UNDERSTANDING GUN CULTURE

Households with guns have demonstrably greater risk for homicide, suicide, and/or accidental firearm death of a household member. For providers devoted to preserving life and promoting health, this can make advising patients in risk situations to remove guns from their home seem ethically self-evident [220; 222].

However, a cultural divide can exist between gun-owning patients and clinicians. For many patients who own guns, gun ownership is a core element of a deeply rooted system of beliefs and values referred to as gun culture. Clinicians who are not part of this culture benefit from an understanding of the perceptions, beliefs, and values of gun culture members before initiating gun safety conversations with their patients. Although difficult for some clinicians, this reflects cross-cultural competence, a core element of patient-centered care. Understanding gun culture can make the difference between reaching versus alienating a patient.

THE LEGAL CONTEXT OF GUN RIGHTS

Ratified into law in 1791, the Second Amendment to the U.S. Constitution reads, “A well-regulated Militia, being necessary to the security of a free State, the right of the people to keep and bear Arms, shall not be infringed.” The U.S. Supreme Court has affirmed the right to bear arms was the right for the individual, attachment to a militia was not relevant, and the protection expressly extended to firearms well-suited for self-defense [32].

MEDIA DEPICTION AND SYMBOLISM

In the United States, guns are bestowed with powerful symbolism that conveys empowerment, self-defense, self-sufficiency, and virility [34; 238]. The extent that guns are literally and symbolically enshrined in American culture is beyond the scope of this course. It is worth mentioning that guns are powerfully associated with masculinity. The images conveyed in American movies of guns as signifiers of virility and power are especially potent for disempowered white, working-class men. Guns figure prominently in the socialization of men from a very early age [239].
Media depictions of guns for self-protection conflict with objective evidence that gun access is more likely to facilitate than prevent violence [188]. The United States is one of very few countries relaxing instead of tightening access to guns. Diverse cultural aspects reinforce the idea that firearms are invaluable for self-defense in a dangerous world, despite evidence that guns heighten the risk of suicide and homicide [188; 204].

GUN CULTURE
Gun culture and its members represent a unique cultural subgroup. Many gun owners intensely resist public policy or clinician efforts that might limit gun access or ownership in some way and perceive such efforts as threats to their culture, values, and way of life. Gun culture and its members can be difficult for outsiders to understand [218]. Formal study of gun culture has been sparse, but recent research has been published to shed light on the values, attitudes, and beliefs of gun culture members. An important point is that research tends to report averages, but the circumstances and experiences of each individual and family are unique [188]. Also, the few available studies may not be representative of the universe of gun culture members.

Firearm ownership and use for recreation and personal defense have long been an integral part of the broader U.S. culture. In many parts of the country, social norms include participation in social activities around gun ownership [240]. In general, there is a sense of identity among gun owners and enthusiasts, often anchored in a shared enjoyment of owning and using firearms and tied to family traditions, personal beliefs, and social relationships [32]. Exposure to gun culture is robustly associated with gun ownership and both are mutually reinforcing [188; 240].

The First-Person Perspective
For those not raised in homes with firearms, gun ownership can begin from an awareness of threat and of one’s vulnerability given the delay in police response that increases in rural areas. The first gun purchase is followed by instructions and practice, which brings an exciting thrill of mastering a powerful tool. The gun at home increases the feeling of confidence and sense of safety from the protection it affords. Wanting that sense of safety and confidence away from home, a concealed-carry permit is obtained. Carrying the weapon feels empowering, and no longer depending on the state for one’s personal security and safety feels liberating. The enthusiasm continues as one enters the social networks of other gun owners. A changing worldview becomes noticeable [241].

Gun owners tend to believe that government regulation should deny guns to the dangerous while protecting the rights of access for the law-abiding. From this perspective, criminals and the dangerously mentally ill are believed to make the nation more violent, while law-abiding gun owners save and protect lives. Gun owners insist the government enforce existing laws, largely support existing background checks, and tend to be open to solutions that specifically target troubled individuals for intervention, such as gun violence restraining orders. Proposals such as bans on assault weapons and large-capacity magazines are opposed, as they are believed to punish the innocent and briefly inconvenience the lawless [241].

Gun Ownership and Empowerment
Guns carry powerful symbolic meaning that can promote gun owner attachment to their weapons extending beyond their self-defense utility. To better understand this relationship, 577 gun owners were administered the Gun Empowerment Scale. White men in economic distress showed greatest attachment to their guns, as a means to re-establish a sense of individual power [242; 243].

With changing economic realities, many working-class white men have lost, or perceive they are losing, their advantage and benefits from previous power and economic hierarchies. With expectation of status and power in their communities frustrated, the gun becomes a symbol through which to regain a lost sense of empowerment, nostalgic masculinity, and sense of self [242; 243].

Gun owners can be emotionally and spiritually attached to the weapon, but owners highly involved in their religious community are less likely to feel empowered by their guns. This suggests that white men most attached to their guns may use firearms to substitute for other cultural sources of meaning and identity. Women and nonwhites who have suffered economic setbacks were not more likely to find empowerment in guns and tended to look elsewhere [242; 243].

Many working-class white men feel embittered over real or perceived economic setbacks. Searching for explanations of their circumstances, some find solace in narratives that cast blame at external forces designed to undermine the white working class. Such narratives reinforce the longstanding media messages that the government is interested in taking their guns and money. In one study, many described feeling highly patriotic through their gun ownership. Owners most attached to their guns were politically conservative and felt that violence against the government is sometimes justified, reflecting beliefs that developed from exposure to these and related narratives [242; 243].

Most gun owners support some gun legislation and do not support the idea of arming everyone. Gun owners who score high on the Gun Empowerment Scale show the strongest pro-gun policy attitudes, viewing that arming teachers and the public would make schools and citizens safer. This is thought to reflect avoidance of cognitive dissonance, an aspect of normal psychology whereby individuals who highly value their benefits from a source are disinclined to objectively examine that source [242; 243].
Beliefs of Self-Defense

Violent crime statistics cannot explain the relationship between threat perception and motivation for owning/carrying guns for self-protection. Instead, a social-cognitive perspective is used to examine how threat perception influences motivations to purchase a handgun and endorse broad gun rights. Long guns (i.e., rifles, shotguns) are owned mainly for hunting, target shooting, and similar activities. Self-protection is typified by handgun ownership [188].

Two distinct types of perceived threats were measured in a nationally representative sample of 899 male gun owners and non-owners [244]:

- Belief in a dangerous world: A diffuse, abstract belief of the world as a dangerous unpredictable place
- Perceived lifetime risk of assault: A specific, concrete threat that one may become a victim of violent assault

Belief in a dangerous world reflects a worldview that sees the world as an inherently dangerous, unpredictable, and threatening place. High belief in a dangerous world is strongly associated with political conservatism and right-wing authoritarianism and correlates with a subtle bias toward minorities (termed symbolic racism) [245; 246; 247; 248].

High belief in a dangerous world was the strongest predictor of need for protection/self-defense. Only handgun owners perceived greater threats than non-owners, with higher perceived lifetime risk of assault and belief in a dangerous world than both non-owners and owners of long guns only. Perceived lifetime risk of assault was influenced by previous victimization experience. Belief in a dangerous world was mainly determined by a politically conservative orientation, but not previous victimization [244].

The belief in a dangerous worldview that motivates handgun purchase also shapes beliefs about how handguns can and should be used. These include the rights of gun owners to shoot or kill other people in self-defense, the fundamentality of Second Amendment rights and opposition to laws infringing on gun rights, strong gun rights advocacy, and belief that a well-armed society is a safe society [244].

The belief in a dangerous world reflects a worldview that forms during early socialization, making it very difficult to influence. Worldviews are coherent belief systems, and changing any one specific belief would make it inconsistent with many other beliefs [249]. Efforts to dissuade handgun owners with a high belief in a dangerous world from needing a gun for self-defense are more likely to alienate than succeed. When specific risk perception drives the need for self-defense, persuasion could be aimed at reducing perceived threat (when inconsistent with actual threat) [244].

Other Sociocultural Factors

Today, efforts to increase gun control have been fiercely resisted primarily by white Americans, but this has not always been the case. During the civil rights movement of the late 1960s, Black Panthers and other black activists exercised their right to carry loaded firearms for protection against the police and other perceived threats (e.g., violent white opponents). Californians responded by demanding stricter gun control, and Governor Ronald Reagan signed a law in 1967 that prohibited carrying loaded firearms in public [248].

The reasons for gun ownership and gun control opposition are complex, but a link is established between racial considerations, gun ownership, and gun control views. Research indicates that racial resentment is integral to National Rifle Association (NRA) discourse and identity of many white gun owners. Among whites, a strong negative correlation was found between racial resentment and endorsement of gun control policy [247; 248].

Symbolic racism is not overt racism but is implicit bias—a subtle, subconscious form usually not linked to consciously held racist attitudes. Symbolic racism develops as a belief structure through early exposure to negative racial stereotypes. Individuals with high levels of symbolic racism respond negatively to issues perceived to involve a racial component, including policy preferences. In a large study of white Americans, higher symbolic racism increased the odds of having a gun in the home and greater opposition to gun control, after crime victimization and other explanatory factors were controlled [248]. However, while some gun ownership experiences are specific to white Americans, especially in rural areas, the enticement of guns to men cuts across racial lines.
1. Head injury and brain dysfunction are thought to be highly prevalent among mass murderers.
   A) True
   B) False

2. Persons with serious mental illness and other psychiatric disorders are more violent than individuals without psychiatric conditions.
   A) True
   B) False

3. The interaction of paranoid ideation and narcissistic pathology captures the psychopathology of mass shooters.
   A) True
   B) False

4. In the Pathway to Violence Model, the escalation from violent ideation to taking concrete action for violent action occurs in the research and planning stage.
   A) True
   B) False

5. Leakage is the most frequent proximal warning behavior among perpetrators of targeted violence.
   A) True
   B) False

6. Most individuals who harbor extreme beliefs/extremist ideologies commit violence to advance the belief or ideology.
   A) True
   B) False

7. The radicalization process starts with social or political grievances and perceived injustices, a subsequent identity crisis, and the search for significance, identity, or purpose that follows.
   A) True
   B) False

8. The “weapons effect” is best described as lethal retaliation against a perceived provocateur.
   A) True
   B) False

9. Fully grasping and appreciating the perspectives, beliefs, and values of gun culture members is vital for providers who are not part of the culture.
   A) True
   B) False

10. The behavior and motives of mass shooters should be distinguished from psychiatric diagnoses.
    A) True
    B) False
MODERATE SEDATION/ANALGESIA
#30462 • 15 ANCC / 15 PhArm hours
By Mail – $66 • Online/eBook – $60
Purpose: The purpose of this course is to provide nurses with the knowledge required for safe drug delivery based on standardized operational guidelines. Preprocedural, intraprocedural, and postprocedural patient care are presented, as well as a thorough review of the drugs used, their advantages and disadvantages, and the safe administration of these agents.
Faculty: Susan Engman Lazear, RN, MN
Audience: This course is designed for all nurses, especially those in procedural and diagnostic areas, such as radiology, endoscopy, cardiac cath, outpatient surgery, intensive care, and emergency departments.
Additional Approval: AACN Synergy CERP Category A, CCMC

LUNG CANCER: DIAGNOSIS AND MANAGEMENT
#30722 • 10 ANCC / 3 PhArm hours
By Mail – $46 • Online/eBook – $40
Purpose: The purpose of this course is to address the various aspects of diagnosis, treatment, disease management and appropriate patient care for healthcare professionals caring for patients with lung cancer.
Faculty: Marilyn Fuller Delong, MA, BSN, RN
Audience: This course is designed for nurses, especially those involved in the care of patients with lung cancer.
Additional Approval: AACN Synergy CERP Category A, CCMC

BURNOUT: IMPACT ON NURSING AND QUALITY OF CARE
#31432 • 5 ANCC hours
By Mail – $26 • Online/eBook – $20
Purpose: Given the integral relationship between work-related stress, job dissatisfaction, burnout, and patient care, properly addressing nursing burnout is essential. The purpose of this course is to provide nurses with information to identify burnout and with effective strategies to manage work-related stress and prevent burnout.
Faculty: Lori L. Alexander, MTPW, ELS, MWC
Audience: This course is designed for nurses and nurse practitioners at all levels and in all settings, especially oncology, palliative care, mental health, and critical care.
Additional Approval: AACN Synergy CERP Category C

RENAL DISEASE AND FAILURE
#34232 • 10 ANCC / 5 PhArm hours
By Mail – $46 • Online/eBook – $40
Purpose: The purpose of this course is to provide primary care clinicians with the information necessary to appropriately identify and treat renal disease, with the objective of minimizing the long-term effects and complications of the disease.
Faculty: Carol Whelan, APRN
Audience: This course is designed for nurses involved in the care of patients with kidney disease or failure.
Additional Approval: AACN Synergy CERP Category A, CCMC

PATHOPHYSIOLOGY: THE IMMUNE SYSTEM
#38430 • 15 ANCC / 5 PhArm hours
Purpose: The purpose of this course is to reinforce the scientific rationales for the interventions nurses perform and the decisions nurses make as patients move through the ever-changing management of their autoimmune or immune system disorder.
Faculty: Jane C. Norman, RN, MSN, CNE, PhD
Audience: This course is designed for nurses working in critical care and general and specialty medical-surgical units in which patients with multiple organ system problems are found.
Additional Approval: AACN Synergy CERP Category A

CARING FOR THE GERIATRIC PATIENT
#39100 • 3 ANCC hours
By Mail – $21 • Online/eBook – $15
Purpose: The purpose of this course is to provide nurses with an overview of the physical and psychosocial considerations necessary when providing care to geriatric patients.
Faculty: Alice Yick Flanagan, PhD, MSW; Allan G. Hedberg, PhD
Audience: This course is designed for nurses in a variety of practice settings who work with older patients.
Additional Approval: AACN Synergy CERP Category A

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## ISCHEMIC STROKE

**#90282 • 10 ANCC / 7 PHARM Hours**

**Purpose:** The purpose of this course is to provide needed information about the roles of diagnosis and screening, evaluation of individuals with suspected stroke, immediate treatment of stroke, and the elements of effective rehabilitation programs so that healthcare professionals may implement the necessary interventions appropriately.

**Faculty:** Lori L. Alexander, MT, FLS, MWC

**Audience:** This course is designed for all physicians, nurses, and other healthcare professionals who have contact with patients who are overweight or obese.

**Additional Approval:** AACN Synergy CERP Category A, CCMC

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## DIAGNOSING AND TREATING OVERWEIGHT AND OBESE PATIENTS

**#91572 • 5 ANCC / 2 PHARM Hours**

**Purpose:** Obesity is an epidemic in the United States. As statistics indicate that the problem is growing, the purpose of this course is to educate healthcare professionals about the epidemiology and treatment of overweight and obese patients. Clinical management, presentation, diagnosis, and behavioral and medical management will be reviewed to assist healthcare professionals in encouraging their patients to lose weight and prevent obesity-related comorbidities.

**Faculty:** John J. Whyte, MD, MPH

**Audience:** This course is designed for all physicians, nurses, and social work/counseling groups involved in the care of patients who are overweight or obese.

**Additional Approval:** AACN Synergy CERP Category A

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## SEIZURES AND EPILEPSY SYNDROMES

**#90423 • 10 ANCC / 5 PHARM Hours**

**Purpose:** The purpose of this course is to expand the understanding of seizure disorders for physicians, nurses, and other healthcare professionals in order to facilitate earlier diagnoses and more effective treatment.

**Faculty:** Kelley M. Anderson, PhD, RN, FNP

**Audience:** This course is designed for all physicians, nurses, and other healthcare professionals who have contact with patients with seizure disorders.

**Additional Approval:** AACN Synergy CERP Category A, CCMC

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## HYPERLIPIDEMIAS AND ATHEROSCLEROTIC CARDIOVASCULAR DISEASE

**#90843 • 10 ANCC / 7 PHARM Hours**

**Purpose:** The purpose of this course is to increase awareness of the crucial role of hyperlipidemias in the development of cardiovascular disease, evaluate the therapeutic benefits of pharmacologic and nonpharmacologic approaches to lipid control, and contribute to a more positive interaction between the healthcare professional and the patient, through fostering patient awareness, implementation of lifestyle changes, and compliance to therapy.

**Faculty:** A. José Lança, MD, PhD

**Audience:** This course is designed for physicians, physician assistants, nurses, and pharmacy professionals who may intervene to limit the effects of hyperlipidemias in their patients, promoting better long-term health and preventing cardiovascular disease.

**Additional Approval:** AACN Synergy CERP Category A

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## SMOKING AND SECONDHAND SMOKE

**#91783 • 10 ANCC / 5 PHARM Hours**

**Purpose:** The purpose of this course is to provide physicians, nurses, behavioral health professionals, and other members of the interdisciplinary team with a formal educational opportunity that will address the impact of tobacco smoking and secondhand exposure in public health and disease as well as interventions to promote smoking cessation among their patients.

**Faculty:** Mark S. Gold, MD, DFASAM, DLFAPA

**Audience:** This course is designed for physicians, nurses, and other healthcare professionals who may intervene to stop patients from smoking.

**Additional Approval:** AACN Synergy CERP Category A, CCMC

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## CARE OF THE PEDIATRIC TRAUMA PATIENT

**#92072 • 15 ANCC Hours**

**Purpose:** As injury remains a leading cause of mortality and morbidity among children, the purpose of this course is to allow healthcare professionals to provide timely care to pediatric trauma patients and to assist parents and caregivers in recognizing measures that prevent this type of injury.

**Faculty:** Susan Engman Lazear, RN, MN

**Audience:** This course is designed for all healthcare professionals involved in the care of pediatric patients, especially those in trauma care centers.

**Additional Approval:** AACN Synergy CERP Category A

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## HEALTH ISSUES DISTINCTIVE TO WOMEN

**#93312 • 15 ANCC / 2 PHARM Hours**

**Purpose:** The purpose of this course is to provide healthcare professionals with updated information related to issues surrounding women across the lifespan to facilitate thorough and appropriate care.

**Faculty:** Gayle Roux, PhD, RN, CNS, FNP

**Audience:** This course is designed for nurses and other healthcare professionals involved in improving health outcomes for women.

**Additional Approval:** AACN Synergy CERP Category A, CCMC

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Course Availability List (Cont’d)

MEN’S HEALTH ISSUES  
**#93763 • 15 ANCC / 5 PHARM HOURS**  
**Purpose:** The purpose of this course is to provide health and mental healthcare professionals with necessary information regarding conditions and health issues that affect men in order to facilitate more effective diagnosis, treatment, and care. As male-specific factors influence the provision and compliance to therapy, tools to ensure effective patient education for men are provided to increase the likelihood of positive outcomes.  
**Faculty:** Lori L. Alexander, MTPW, ELS, MWC  
**Audience:** This course is designed for physicians, physician assistants, nurses, and behavioral health professionals seeking to enhance their knowledge of issues related to men’s health.  
**Additional Approval:** AACN Synergy CERP Category A

SEPSIS: DIAGNOSIS AND MANAGEMENT  
**#94342 • 4 ANCC / 3 PHARM HOURS**  
**Purpose:** The purpose of this course is to provide healthcare professionals with a current review and updated, evidence-based guidance for the diagnosis and management of sepsis and septic shock.  
**Faculty:** Patricia Lea, RN, DNP, MSEd, CRNP; John M. Leonard, MD  
**Audience:** This course is designed for all healthcare professionals who work with patients who present with sepsis, including nurses and physicians.  
**Additional Approval:** AACN Synergy CERP Category A

INFLUENZA: A COMPREHENSIVE REVIEW  
**#94423 • 10 ANCC / 5 PHARM HOURS**  
**Purpose:** The purpose of this course is to provide healthcare professionals with an updated review of influenza, including clinical aspects, public health issues, and strategies for prevention. The goals are to minimize the burden of influenza on patients and communities, prevent complications and hospitalizations, and save healthcare dollars.  
**Faculty:** Elizabeth T. Murane, PHN, BSN, MA  
**Audience:** This course is designed to help healthcare professionals and allied personnel understand influenza and its role in its prevention.  
**Additional Approval:** AACN Synergy CERP Category A

ALZHEIMER DISEASE  
**#95152 • 15 ANCC HOURS**  
**Purpose:** In order to increase and maintain a reasonable quality of life for patients with Alzheimer disease throughout the course of the disease, caregivers must have a thorough knowledge and understanding of the disease. The purpose of this course is to provide clinicians with the skills to care for patients with Alzheimer disease in any setting as part of the interdisciplinary team.  
**Faculty:** Joan Needham, MSEd, RNC  
**Audience:** This course is designed for clinicians who come in contact with patients with Alzheimer disease in hospitals, long-term care facilities, home health care, and the office.  
**Additional Approval:** AACN Synergy CERP Category A

ATTENTION DEFICIT HYPERACTIVITY DISORDER  
**#96212 • 5 ANCC / 2 PHARM HOURS**  
**Purpose:** Attention deficit hyperactivity disorder (ADHD) has a significant effect on day-to-day functioning and quality of life; however, it often goes unrecognized. The purpose of this course is to educate healthcare professionals about the epidemiology, diagnosis, and management of ADHD.  
**Faculty:** John J. Whyte, MD, MPH; Paul Ballas, DO  
**Audience:** This course is designed for all physicians, nurses, and social work/counseling groups involved in the care of patients with attention deficit hyperactivity disorder.  
**Additional Approval:** AACN Synergy CERP Category A

DEPRESSION AND SUICIDE  
**#96402 • 15 ANCC / 2 PHARM HOURS**  
**Purpose:** Although contact with the primary care setting represents a potential opportunity for timely identification and intervention, abundant evidence indicates that many patients with depression are inadequately diagnosed and treated in these settings. The purpose of this course is to provide the information and encouragement necessary to allow primary care providers to properly diagnose, treat, and follow-up with patients with depression.  
**Faculty:** Mark Rose, BS, MA  
**Audience:** This course is designed for physicians, nurses, physician assistants, social workers, therapists, and counselors in the primary care setting who may identify and treat depressed and suicidal patients.  
**Additional Approval:** AACN Synergy CERP Category A

PARKINSON DISEASE  
**#98771 • 10 ANCC / 5 PHARM HOURS**  
**Purpose:** The purpose of this course is to provide physicians, nurses, and other members of the interprofessional healthcare team a review of current concepts of pathogenesis, disease progression, diagnosis, and management of Parkinson disease, in order to improve patient care and quality of life.  
**Faculty:** Mark Rose, BS, MA  
**Audience:** This course is designed for all healthcare providers in the primary care setting who may encounter patients with Parkinson disease.  
**Additional Approval:** AACN Synergy CERP Category A

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