

Domestic Violence in the United States: Screening, Detection and Intervention

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Abstract:

Domestic Violence/intimate partner abuse is prevalent throughout the United States (U.S.), as well as the rest of the world. More than one in three U.S. women reported unwanted sexual contact (e.g., groping) in their lifetime and nearly one in four men in the U.S. experienced some form of contact sexual violence in their lifetime.¹ Contact sexual violence is a combined measure that includes rape, being made to penetrate someone else, sexual coercion, and/or unwanted sexual contact.¹ It is therefore critically important for healthcare providers to be aware of the prevalence of domestic violence and become familiar with appropriate screening and referral tools in order to identify victims and provide resources.

Introduction

News feeds and newspapers seem to be filled with tragic stories of children, women, and men who have lost their lives because of an abusive partner who often then takes their own life as well. The media draws our attention to the issue of domestic violence/intimate partner violence (IPV), but it is not a recent societal phenomenon. In the U.S., assault did not become a legally recognized reason for divorce until the late 1800s, and as late as the 1980s, many states carried an exception to the rape statute that exempted from prosecution a man who raped his legally married spouse. Today, every state holds a partner legally liable for marital rape. IPV has been identified and studied as a social problem with serious consequences to individual health and well-being. Healthcare providers should be aware of the issues of domestic violence, including elder abuse, and the risk of abuse to the children in homes where domestic violence occurs.

Definition of Domestic Violence or Intimate Partner Violence

Florida statutes (Sections 741.28-741.316) define domestic violence as any assault, aggravated assault, battery, aggravated battery, sexual assault, sexual battery, stalking, aggravated stalking, kidnapping, false imprisonment, or any criminal offense resulting in physical injury or death of one “family or household member” by another who is or was residing in the same single dwelling unit. A family or household member includes spouses, former spouses, persons related by blood or marriage, persons who

are presently residing together as if a family, or who have resided together in the past as if a family, and persons who have a child in common regardless of whether they have been married or have resided together at any time. The American Medical Association defines domestic violence as the abuse of power or the domination and victimization of a physically less powerful person by a physically more powerful person.

Epidemiology:

Intimate partner violence is disturbingly prevalent throughout the United States and the world. More than one in three women (36.4 percent) and one in three men (33.6 percent) report experiencing “contact sexual violence” which includes rape, sexual coercion or unwanted sexual contact, as well as physical violence, and/or stalking by an intimate partner during their lifetime.¹ Although both men and women can experience IPV, women are far more likely to experience severe sexual and physical violence from a partner or to be killed by one.² According to the National Center for Injury Prevention and Control’s survey on intimate partner and sexual violence over 1 in 3 women (36.4 percent or 43.6 million) have experienced sexual violence an intimate partner during their lifetime.³ Most assaults are minor and include pushing, grabbing, slapping, and hitting; however, intimate partner violence can lead to death. 25.1 percent of women will report this intimate partner violence. By contrast, about 1 in 3 men (33.6 percent or 37.3 million) have experienced sexual violence by an intimate partner in their lifetime, but only 10.9 percent have reported the violence.³ It is difficult to estimate the percentage of perpetrators because victims historically underreport given the consequences of admitting to such actions. These statistics are alarming since most acts of domestic violence are not reported, likely making the actual numbers much higher. In part, this is because they capture victimization that the victim may not interpret as a crime because it is an intimate partner.³ In Florida alone in 2020, 106,615 domestic violence incidents were reported.⁴ The majority of those, specifically 84,547 incidents, were simple assault, followed by aggravated assault, rape and threat/intimidation. There were 198 murders and 19 cases of manslaughter, a minimal decrease from the 200 murders and 21 cases of manslaughter in 2019, related to domestic violence.⁴ Researchers in one major metropolitan city examined murder/suicide by cop and found that 39 percent of incidents involved domestic violence.⁵

The Florida Department of Children and Families reported that during the fiscal year 2021-2022, Florida’s 41 certified domestic violence centers provided 532,825 nights of emergency shelter to 11,811 survivors of domestic abuse and their children.⁶ Advocates created 171,008 tailored safety plans, provided a total of 206,093 hours of advocacy and counseling services, and received 81,357 domestic violence hotline calls from individuals seeking emergency services, information, and safety planning assistance. Not only are lives disrupted due to domestic violence but the estimated lifetime cost related to intimate partner violence, including healthcare, lost productivity, and criminal justice expenses is estimated to be \$3.6 trillion.⁷

Intimate partner abuse often starts or escalates during pregnancy or the postpartum period.⁸ Physical abuse is estimated to occur in 324,000 pregnancies each year, making it more prevalent than preeclampsia or gestational diabetes for which women are screened. Pregnancy may lead the woman to focus her attention on her unborn child and thus less attention may be given to her partner. When the pregnancy is unintended, the risk of domestic violence is three times greater.⁹ Even more alarming is that abused pregnant women have a threefold higher risk of becoming a victim of homicide or attempted homicide.¹⁰ There is intimate partner violence among the LGBT community as well. One study found that, although intimate partner violence is higher among bisexual respondents than gay respondents, among bisexuals, intimate partner violence is perpetrated more often by an opposite-sex partner.¹¹

Pathophysiology of IPV-Power and Control

To better understand the relationship between a victim and their abuser, it is important to understand the pathophysiology of IPV. Abusive relationships develop because one individual in the relationship exerts their power over the other. The Duluth Wheel of Power and Control exhibits the methods of abuse used by an abusive individual (Figure 1). The use of these methods of power and control by the abuser are unpredictable. A tension building phase may begin with threats, intimidation, fear, and guilt (described in the wheel), followed by physical or sexual abuse.¹² The abuser may blame their abusive behavior on the victim and the victim may ignore or deny the abuse until it recurs. Because the abusive behavior is unpredictable, the victim may feel as though they are “walking on eggshells.”¹³

The Affected Individuals

I. Elders:

Elder abuse is included in domestic violence and is prevalent world-wide. Often overlooked, it does not receive the same prevention and screening awareness as intimate partner abuse. The prevalence of elder abuse ranges from 10 percent of cognitively-intact elders to 45-50 percent of those elders who suffer from dementia. Per the National Elder Abuse Incidence Study, 19 percent of the population in the U.S. is over the age of 80, and over half of all reports of abuse are within this age range.¹⁴ Elder abuse includes physical, mental, emotional/psychological, sexual abuse, neglect, abandonment, poor and improper medical care, and financial exploitation. Risk factors that can predispose an elderly individual to abuse include disability, depression, dementia, social isolation, poor socioeconomic status, external family stressors and substance abuse.

Elder abuse can occur in any setting. In the home, usually an adult child becomes progressively more frustrated “parenting their parent.” In a nursing home, it could be caused by burnout among the nursing or ancillary staff. A European study published in September 2017 looked at several hundred nursing staff employees, and analyzed three facets: emotional exhaustion, depersonalization, and personal accomplishment. Emotional exhaustion was observed in almost 50 percent of nurses, depersonalization in over 20 percent, and a feeling of low personal accomplishment in almost 40 percent.¹⁵ These numbers are a cause for concern, particularly if these numbers were to remain similar in larger scale studies. Recognition and prevention of burnout in both caregivers and nurses can reduce elder abuse.¹⁵

Although there is insufficient evidence that screening for elder abuse leads to reduced harm, the U.S. Preventive Services Task Force specifically advises that screening individuals is helpful to detect abuse and also uncover other conditions that may mimic abuse. One approach is to utilize the Elder Abuse Suspicion Index (EASI), which recommends asking your elderly patients five questions:

Within the last 12 months:

- 1) Have you relied on people for any of the following: bathing, dressing, shopping, banking, or meals?
- 2) Has anyone prevented you from getting food, clothes, medication, glasses, hearing aides or medical care, or from being with people you wanted to be with?

- 3) Have you been upset because someone talked to you in a way that made you feel shamed or threatened?
- 4) Has anyone tried to force you to sign papers or to use your money against your will?
- 5) Has anyone made you afraid, touched you in ways that you did not want, or hurt you physically?

And as a final question posed to the physician:

- 6) Doctor: Elder abuse may be associated with findings such as: poor eye contact, withdrawn nature, malnourishment, hygiene issues, cuts, bruises, inappropriate clothing, or medication compliance issues. Did you notice any of these today or in the last 12 months?^{16,17}

Another approach used by law enforcement in field, also named the elder abuse suspicion index (EASI), was described in a publication in September 2017. Data was collected by officers in Connecticut to help better identify their perceptions and knowledge of elder abuse, barriers of detecting elder abuse in the field, characteristics officers deem most valuable as a detection tool, and the potential to use the EASI score in the field. Eighty percent of officers reported they would use the index score long term as it was shown to more easily and reliably help discern unknowing victims of elder abuse.¹⁸

II. Adult Victims

Anyone is a potential victim; however, women between the ages of 18-24 are most commonly abused by an intimate partner.¹⁹ Additional risk factors for IPV can be found in Table 1.²⁰⁻²⁵

Certain groups have a higher prevalence of IPV including trauma victims, emergency room patients, patients with chronic abdominal pain, patients with chronic headaches, pregnant patients with injuries, patients with sexually transmitted infections (STIs), and elderly individuals with injuries.²⁶ Women living in non-industrialized countries have a higher incidence of IPV than those living in industrialized countries.²⁷

III. The Littlest Victims – Children

Nationwide, more than three million children are living in homes where IPV occurs. Among these children, studies estimate that the prevalence of child abuse may be as high as 60 percent.^{28,29} The U.S. Department of Health & Human Services reported that in 2021 alone over 3 million children received an investigation for suspected child abuse. Of these, 588,229 children were victims of child abuse and neglect, including 1,820 fatalities. Based on this data, 8.1 in 1,000 children are affected.³⁰

The long-term effects of a child witnessing or being a victim of domestic violence are numerous. They include increased risk for perpetuation of domestic violence in their future relationships along with psychological effects such as depression and vague somatic complaints.^{31,32} These children may also display increased rebellious behavior with an increased tendency for truancy, dropping out of school, drug and alcohol use, and episodes of running away. Because of the direct effects on children who

witness domestic violence, some researchers have called for a strengthening of professional responses to them as direct victims, not as passive witnesses to violence.³³

IV. The Batterer:

An abuser may lead what appears to be a “normal” life outside the home. The violent behavior may only occur behind closed doors. The abuser may have been a victim of abuse as a child. Men who lived in violent homes as children are more likely to be violent with their adult partners than men who were reared in non-violent homes.²⁷ For the batterer, casting blame and guilt on the victim can elevate their own sense of worth. Batterers are often abusers of alcohol and drugs.

Clinical Presentation:

A patient experiencing intimate partner violence may present in a variety of manners. Often, they present with inconsistent injuries or vague explanations of injuries. Victims may also have poor follow-up, frequently miss appointments, be non-compliant with treatments or may be reluctant to comply with a physical examination. Their partner may be present and reluctant to leave the room during the history or examination. It is estimated that between two and seven percent of acute emergency room visits are from IPV.³⁴ Victims will seek care in the emergency department because they are likely to see different healthcare providers each time and there is less follow-up. The patient’s social history may include substance abuse disorders, tobacco abuse, anxiety and depression. Higher rates of previous abuse as a child and suicide attempts are also observed.^{34,35,36} According to Medical and Psychosocial Diagnoses in Women with a History of Intimate Partner Violence, published in 2009, several signs and symptoms are associated with intimate partner violence and are noted in Figure 2.³⁷ Signs and symptoms with the highest relative risk include anxiety, substance abuse, tobacco abuse, depression, headache, sexually transmitted infections, contusions/abrasions, lower back pain, and lacerations (Figure 2).³⁷ Persons suffering from IPV and/or sexual/physical abuse also have a 1.5 to 2 times greater risk of having functional gastrointestinal symptoms.³⁴ Victims of intimate partner violence also reported worse physical and mental health and increased chronic pain and disability preventing employment or absence from work. Physical examination is often unremarkable. However, the physician may discover old fractures, cigarette burns or bites in areas that are not readily visible.

The Role of the Healthcare Provider:

Screening

All healthcare providers should remain alert for the presence of IPV, even in asymptomatic patients. The United States Preventive Services Task Force states that screening asymptomatic females for IPV may provide benefits with minimal adverse effects.³⁸ As of 2018, the U.S. Preventive Services Task Force had a grade B recommendation for the screening of IPV. The Affordable Care Act, passed in August 2012, required insurance companies to cover IPV screening and counseling as part of eight essential health services for women at no additional cost to the patient.³⁹ Based on this information, all primary care providers should screen females 12 years of age and older for IPV. Additional red flags that suggest screening is necessary include but are not limited to: trauma, chronic or recurrent sexually transmitted

infections and injuries in the elderly. In a 2014 meta-analysis looking at screening for IPV in the healthcare setting, moderate evidence was found that screening led to an increase in identification of IPV, particularly in the antenatal setting; however, there was no evidence that identification led to more referrals to support services.⁴⁰

Primary care providers can include screening questions in their initial assessment. Asking questions in a non-threatening and non-judgmental manner is imperative. Using phrases such as, ‘I ask all of my patients about violence in the home’ allows the provider to ask the necessary questions without singling out the patient.⁴¹ The healthcare provider should never ask the patient why they have allowed the abuse to happen or why they have not left the situation as this re-victimizes the patient. Raising questions about potential abuse should occur only if the patient is alone. If the questions are asked when the partner is present, the patient may deny that abuse occurs and the potential for escalation of violence at home is increased. Victims should be assured that information shared will be kept confidential unless there is a lethal weapon involved. Providing resources in restrooms or other private areas of the clinical setting allows women to obtain information without directly speaking to someone. Reasons cited for the lack of routine screening for IPV by healthcare providers include physician comfort levels, awareness of the various techniques, fear of offending the patient, and perceived lack of effective interventions.⁴²

Several effective screening tools for intimate partner violence have been developed. A widely utilized screening tool is the HITS (Hurt, Insult, Threaten, Scream) Screening Tool for Domestic Violence (Table 2). HITS consists of four questions scored on a 5-point scale ranging from never to frequently.⁴³ This test has a 30-100 percent sensitivity and 55-99 percent specificity. Physicians may also consider simply asking the patient if they are afraid of their partner or anyone else. A positive response can lead to further questioning.

A recent study from 2020 reported on the development of a new tool that can be used to assess the risk of repeated incidences of IPV.⁴⁴ The study reviewed random court files and found common characteristics among the perpetrators, including unemployment, other violent criminal history, and their own victimization in a domestic setting. These relationships were also likely to have partners of different ethnicity, poverty, difference in incomes, living in a rental property, alcohol and drug use, and prior history of physical violence.

Secondary and Tertiary Prevention: Four Steps to Take Once Intimate Partner Violence is

Detected

Step 1: Be supportive. Physicians can best support their patients by acknowledging the patient’s admission of abuse and the difficulty the patient must have faced in disclosing this information. In addition, the physician can also ask the victim how they can best support them.

Step 2: Assess the patient’s safety. Clinicians should employ open-ended questions to ask victims of IPV about their concerns and fears.⁴⁵ A validated 20-item Danger Assessment Tool (Figure 3) is also available to predict the likelihood of lethality or near-lethality in a relationship afflicted by domestic violence.⁴⁶ Although the majority of patients are not in imminent danger and are not planning to leave their current abusive relationship, clinicians should not lose sight of the fact that IPV can result in death.

Physicians should work closely with the patient to formulate a safety plan. A Safety Packing List (Figure 4) highlights items that should be included in the safety plan. Essential items include a set of keys, important documents such as birth certificate(s), additional cash and clothes, as well as emergency numbers and the number of someone that the victim trusts and can call in an emergency.⁴⁷ Patients should be educated on the course of domestic violence and the potential for escalation of violence if the victim chooses to leave the relationship.

Step 3: Know onsite, local and national resources. The best resource for IPV victims is IPV advocacy services as they are well trained in IPV intervention and can most adequately assist the patient in dealing with IPV. Additionally, the National Domestic Violence Hotline is a valuable resource as are others listed in Table 3. Physicians and patients should ensure that any provided resources are hidden or concealed from the abuser. References can be small (thereby easily concealed in a shoe, etc.), obscure (hidden on the back of the physician's card along with other useful numbers). Technology also provides opportunities to discreetly pass along resources. The Aspire News App, for example, appears to be a news website when downloaded, but actually offers a way to call for help and can be downloaded onto a phone or other electronic device.⁴⁸

Step 4: Determine whether or not Child Protective Services should be involved. If any child is thought to be unsafe in the home, it is mandatory for the clinician to report this. However, the IPV victim and parent of the child should be encouraged to report on his or her own as this may assist in custody decision making.

Documentation:

Careful documentation is imperative in cases of domestic violence, especially when the patient is contemplating pursuing legal intervention. Documentation should include direct quotes from the patient regarding time, nature and other details regarding the abuse; physical exam findings; photography or sketches of the sustained injuries (photographs to include the patient's face in case of necessity for evidence), and comments on comorbidities and degree of disability.^{42,45} If necessary, rape kits should be obtained, completed and documented. Physicians should not use words such as "denies" or "claims" as this may suggest disbelief in the patient especially in a court of law. More appropriate language includes "patient reports" rather than "patient denies or claims."

Mandatory Reporting:

In the state of Florida, physicians are not required to report domestic abuse unless serious injury or gunshot wounds were inflicted. Similarly, Florida Statute § 877.155 requires any person who treats for second or third-degree burns affecting 10 percent or more of the body, to report such treatment to the authorities if they determine the burns were caused by a flammable substance and if they suspect the injury is a result of violence or other unlawful activity. Reporting of domestic abuse without the informed consent of the patient is illegal even if the patient admits to the violence.⁴⁹

If there is a suspicion of child abuse or an admission of such, the child abuse must be reported to the Florida Department of Children and Families.

As of 2012, only a minority of states had mandatory reporting of IPV which is largely due to the concern that mandatory reporting requirements threaten patient-physician confidentiality and may deter women from seeking needed medical attention or discussing abuse.^{50,51} In surveys of victims presenting to emergency departments, most victims do not support mandatory reporting.⁵² This is likely due to the fact that these victims recognize that the reporting of an incident may lead to an escalation of the violence by their abuser. Nonetheless, it is important that healthcare providers be familiar with their state requirements for mandatory reporting of IPV.

Intervention:

Randomized control trials studying IPV are not feasible because of the nature of the “disease.” However, in recent years, many meta-analyses have been performed to further investigate the effectiveness of intervention in IPV. In 2013, the World Health Organization issued guidelines stating that, except for women who have spent one or more nights in a shelter or pregnant women, there was insufficient evidence that interventions for IPV improved health outcomes.^{53,54} Another recent meta-analysis was published suggesting that women-centered advocacy and home-visitation programs reduce a woman’s risk of further violent abuse.⁵⁵ Women experiencing IPV in rural areas face distinct barriers in obtaining help, as the number of shelters, social services, and healthcare services are often limited. Compared with women in urban areas, rural women have reported greater barriers to obtaining protective orders, and violations of orders occur more often.⁵⁶

The effectiveness of batterer’s intervention is also not completely understood. The Florida Department of Children and Families has designed and monitors a program that is required for defendants as a mandatory condition of their probation. Therapy for batterers includes counseling and group therapy. The duration of treatment in the state of Florida is 26 weeks. In this setting, batterers with previous abusive behavior challenge other batterers about their unacceptable behavior. Many batterers are court ordered into these intervention programs and for those who do complete at least a six-month program, there is some data to show that the recidivism rate is low.⁵⁷

Experiencing the Legal System

Matters involving abuse and IPV fall under the jurisdiction of the Family Court within each legal jurisdiction in Florida. The Family Court has the authority to review those matters that deal with civil domestic, repeat violence, dating violence, stalking, and sexual violence injunctions. These same matters may also result in or stem from criminal actions which would be reviewed by the Criminal Court, usually within the same legal jurisdiction.

If the alleged IPV does not meet the requirements for mandatory reporting referenced above, the patient may also petition the court to provide a temporary injunction if there is an immediate and present danger of domestic violence. The petition for temporary injunction can be filed where the patient currently or temporarily resides, as well as where the abuser resides, or where the domestic violence occurred. The court may consider a number of factors when determining whether to grant the temporary injunction, including the abuser’s past history of violence against the patient and others.

These proceedings are usually first filed as an *ex parte* temporary injunction, meaning that the other party, or the abuser, is not present. If the *ex parte* temporary injunction is granted, it is effective for 15 days, and the court must set a full hearing to take place no later than the 15-day period to determine

whether it will grant a permanent injunction. During this temporary injunction period, the court may restrain the abuser from contact with the patient, provide the patient exclusive occupancy of any shared dwelling, or specify places that the abuser must stay away from, like places of employment, children's schools, or other family homes. The court may also order the abuser to surrender any firearms to the law enforcement, as well as any other relief the court believes is necessary.

At the hearing for final injunction, both the patient and the abuser are permitted to have advocates present from the State Attorney's Office, law enforcement, or a domestic violence center. The court may also consider relevant evidence of abuse and violence from the patient's medical records. If the court approves a final injunction, it may also order temporary support of any minor children, temporary alimony, and refer the patient to a domestic violence center. Though the patient cannot be ordered to attend counseling, the abuser can be ordered to undergo a substance abuse or mental health evaluation and any treatment that is recommended. The abuser may also be ordered to enroll in and complete a certified batterer intervention program. Any violations of these injunctions are treated as criminal matters, and the Florida Department of Law Enforcement maintains a Domestic, Dating, Sexual and Repeat Violence Injunction Statewide Verification System that will communicate these injunctions between state criminal agencies. Violation of a final injunction may result in arrest and charge of a first-degree misdemeanor for each violation with a maximum sentence of one year. The Domestic Violence Case Flow in Table 4 provides an example of the possible course of a case.⁵⁸

Conclusion:

Domestic violence is prevalent and impacts the psychological and physical well-being of the victims, as well as the children in homes where the abuse occurs. It is associated with financial and societal ramifications. Health care providers should pursue a better understanding of victims and their perpetrators, the clinical presentation, who and how to screen for IPV, and the resources that are available to victims. Be your patient's advocate!

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Figure 1- The Duluth Wheel of Power and Control

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DOMESTIC ABUSE INTERVENTION PROJECT

202 East Superior Street
Duluth, Minnesota 55802
218-722-2781
www.duluth-model.org

Figure 2: Common Presenting Symptoms in Victims of Intimate Partner Violence

Adapted from reference 37

Signs/symptoms associated with IPV	Relative Risk Ratio
Substance abuse	6.33
STDs	3.30
Depression	3.24
Anxiety	2.73
Tobacco abuse	2.34
Lacerations	2.15
Contusions/abrasions	1.72
Low back pain	1.58
Headache	1.56

Table 1: Risk Factors for Domestic Violence

Adapted from references 21-26

Risk Factors for Domestic Violence
• Prior exposure to intimate partner violence
• History of heavy alcohol or drug use
• Female sex
• Young age (< 24 years of age)
• History of depression or chronic mental illness
• Lower level of education

- Residence in lower socioeconomic neighborhood

Table 2: The HITS Screening Tool for Domestic Violence⁴²

How Often Does Your Partner	Never	Rarely	Sometimes	Fairly Often	Frequently
Physically hurt you	1	2	3	4	5
Insult or talk down to you	1	2	3	4	5
Threaten you with harm	1	2	3	4	5
Scream or curse at you	1	2	3	4	5

A total score of more than 10 is suggestive of intimate partner violence.

The HITS Tool is a first screen and not a diagnostic test. A score of > 10 is strongly suggestive of domestic violence and requires more in depth diagnostic assessment and a safety profile and plan. See Florida domestic violence CME training requirements for safety and referral protocols from the Florida Medical Association. Experts suggest providing the patient with partner violence safety and referral information and knowledge of local shelters and contacts and documenting the patient education. For immediate risk, help arrange for an advocate to assist the patient immediately. The HITS Tool is reprinted with permission from Kevin Sherin, MD, MPH, MBA and is copyright protected.

Figure 3: The Danger Assessment is an instrument that helps to determine the level of danger an abused woman has of being killed by her intimate partner.⁴⁴

DANGER ASSESSMENT

Jacquelyn C. Campbell, Ph.D., R.N.
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Several risk factors have been associated with increased risk of homicides (murders) of women and men in violent relationships. We cannot predict what will happen in your case, but we would like you to be aware of the danger of homicide in situations of abuse and for you to see how many of the risk factors apply to your situation.

Using the calendar, please mark the approximate dates during the past year when you were abused by your partner or ex partner. Write on that date how bad the incident was according to the following scale:

1. Slapping, pushing; no injuries and/or lasting pain
2. Punching, kicking; bruises, cuts, and/or continuing pain
3. "Beating up"; severe contusions, burns, broken bones
4. Threat to use weapon; head injury, internal injury, permanent injury
5. Use of weapon; wounds from weapon

(If any of the descriptions for the higher number apply, use the higher number.)

Mark **Yes** or **No** for each of the following. ("He" refers to your husband, partner, ex-husband, ex-partner, or whoever is currently physically hurting you.)

- ☐ 1. Has the physical violence increased in severity or frequency over the past year?
- ☐ 2. Does he own a gun?
- ☐ 3. Have you left him after living together during the past year?
3a. (If have never lived with him, check here ☐)
- ☐ 4. Is he unemployed?
- ☐ 5. Has he ever used a weapon against you or threatened you with a lethal weapon?
(If yes, was the weapon a gun? ☐)
- ☐ 6. Does he threaten to kill you?
- ☐ 7. Has he avoided being arrested for domestic violence?
- ☐ 8. Do you have a child that is not his?
- ☐ 9. Has he ever forced you to have sex when you did not wish to do so?
- ☐ 10. Does he ever try to choke you?
- ☐ 11. Does he use illegal drugs? By drugs, I mean "uppers" or amphetamines, "meth", speed, angel dust, cocaine, "crack", street drugs or mixtures.
- ☐ 12. Is he an alcoholic or problem drinker?
- ☐ 13. Does he control most or all of your daily activities? For instance: does he tell you who you can be friends with, when you can see your family, how much money you can use, or when you can take the car? (If he tries, but you do not let him, check here: ☐)
- ☐ 14. Is he violently and constantly jealous of you? (For instance, does he say "If I can't have you, no one can.")
- ☐ 15. Have you ever been beaten by him while you were pregnant? (If you have never been pregnant by him, check here: ☐)
- ☐ 16. Has he ever threatened or tried to commit suicide?
- ☐ 17. Does he threaten to harm your children?
- ☐ 18. Do you believe he is capable of killing you?
- ☐ 19. Does he follow or spy on you, leave threatening notes or messages, destroy your property, or call you when you don't want him to?
- ☐ 20. Have you ever threatened or tried to commit suicide?

Total "Yes" Answers _____

Thank you. Please talk to your nurse, advocate or counselor about what the Danger Assessment means for you and your situation.

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Figure 4: Safety Packing List by the U.S. Department of Health and Human Services, Office of Women's Health⁴⁷

SAFETY PLANNING




<http://www.womenshealth.gov>
800-994-9662
TDD: 888-220-5446

Safety Packing List

If you are leaving an abusive situation, take your children and, if possible, your pets. Put together the items listed below. Hide them someplace where you can get them quickly, or leave them with a friend. If you are in immediate danger, though, leave without these items.

Identification for yourself and your children

- ☐ Birth certificates
- ☐ Social Security cards (or numbers written on paper if you can't find the cards)
- ☐ Driver's license
- ☐ Photo identification or passports
- ☐ Welfare benefits card
- ☐ Green card

Important papers

- ☐ Marriage certificate
- ☐ Divorce papers
- ☐ Custody orders
- ☐ Legal protection or restraining orders
- ☐ Health insurance papers and medical cards
- ☐ Medical records for all family members
- ☐ Children's school records
- ☐ Investment papers/records and account numbers
- ☐ Work permits
- ☐ Immigration papers
- ☐ Rental agreement/lease or house deed
- ☐ Car title, registration, and insurance information
- ☐ Records of police reports you have filed or other evidence of abuse

Money and other ways to get by

- ☐ Cash
- ☐ Credit cards
- ☐ ATM card
- ☐ Checkbook and bankbook (with deposit slips)
- ☐ Jewelry or small objects you can sell

Keys

- ☐ House
- ☐ Car
- ☐ Safety deposit box or Post Office box

Ways to communicate

- ☐ Phone calling card*
- ☐ Cell phone*
- ☐ Address book

*It is best not to use a card or phone that you shared with an abuser because he or she may be able to use them to find you.

Medications

- ☐ At least one month's supply for all medicines you and your children are taking
- ☐ A copy of any prescriptions

Things to help you cope

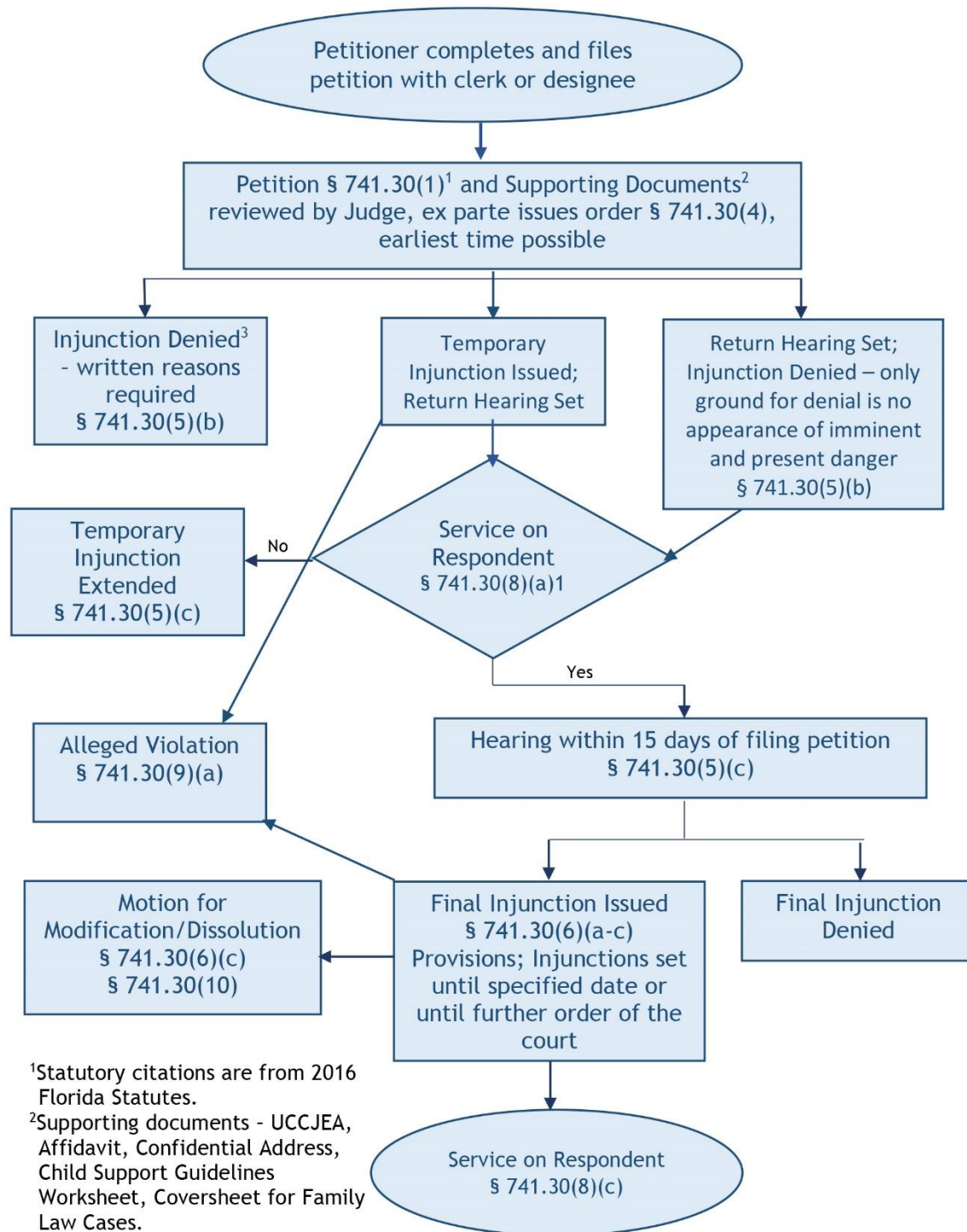
- ☐ Pictures
- ☐ Keepsakes
- ☐ Children's small toys or books

U.S. Department of Health and Human Services, Office on Women's Health

Table 3: Local, State and National Resources

Local Hotlines	
Florida Department of Children and Families Domestic Violence Hotline	1-800-500-1119
Florida Department of Children and Families Abuse Hotline	1-800-96-ABUSE (22873)
Hubbard House, Inc. (Duval, Baker and Nassau Counties)	1-904-354-3114
Quigley House (Clay County)	1-904-284-0061
Betty Griffin Center (St. John's County)	1-904-824-1555
Florida Partnership to End Domestic Violence	1-800-500-1119
National Hotlines	
National Domestic Violence Hotline	1-800-799-SAFE (7233)
National Sexual Assault Hotline	1-800-656-4673
The National Teen Dating Abuse Helpline	1-866-331-9474
Online Resources	
Futures Without Violence	www.futureswithoutviolence.org
National Coalition Against Domestic Violence	www.thehotline.org

Table 4: Domestic Violence Case Flow Chart created by the Florida Courts⁵⁸



¹Statutory citations are from 2016 Florida Statutes.

²Supporting documents - UCCJEA, Affidavit, Confidential Address, Child Support Guidelines Worksheet, Coversheet for Family Law Cases.

³Petitioner may refile/submit supplemental affidavit.