Kentucky State Mandated
Domestic Violence/Intimate Partner
Violence and Elder Abuse:
Applying Best Practice Guidelines
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Answer Sheet: Kentucky State Mandated Domestic Violence/Intimate Partner Violence and Elder Abuse: Applying Best Practice Guidelines

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Objectives

Upon completion of this course, the learner will be able to:

- Define intimate partner violence/domestic violence/elder abuse, particularly in the state of Kentucky.
- Discuss the statistics related to intimate partner violence/domestic violence and elder abuse.
- Describe the effects of intimate partner violence/domestic violence on adult and child victims.
- Discuss the dynamic of intimate partner violence/domestic violence and elder abuse.
- Identify risk factors related to being a victim of violence and for being a perpetrator of violence.
- Describe how to initiate the topic of intimate partner violence/domestic violence and/or elder abuse with your patients.
- Discuss interventions for intimate partner violence/domestic violence identified in the Best Practice Guidelines described in this course.
- Describe reporting requirements related to intimate partner violence/domestic violence and elder abuse in Kentucky.
- Identify victim services and other resources in Kentucky related to intimate partner violence/domestic violence and elder abuse.

Introduction

Case Study 1. Roseanne

Roseanne is rushing to get ready for work. She finishes helping 3 year old Matthew get dressed and gives him some breakfast. She grabs the baby from her crib and a shooting pain stabs her in the right shoulder. With the pain comes the memory of last night. Roseanne’s husband Jack got home late last night—he had been drinking and he was in a foul mood. He finally went to bed—but not before berating Roseanne, as usual, and slapping and punching her multiple times. She has bruises on her face that her makeup can barely hide. She touches up her makeup one last time before dropping off both Matthew and the baby with her mother.

Her mother knows that it’s been difficult for Roseanne, but she doesn’t know how bad it’s gotten. Since Roseanne was pregnant with 5 month old Tara, she has been punched, kicked and sexually victimized repeatedly by her husband. It has become a routine part of her life. While driving to work, Roseanne starts crying. She tries to reapply some makeup to cover the bruises, as she rushes onto the unit. Roseanne is a neonatal nurse.

Roseanne is like so many American women, she is the victim of intimate partner violence/domestic violence (IPV/DV). IPV/DV is actual or threatened physical or sexual violence or psychological and emotional abuse directed toward a spouse, ex-spouse, current or significant other, or current or former dating partner. Intimate partners may be heterosexual or of the same sex; sexual intimacy is not a requirement in this definition (CDC, 2002).

Up to 25 percent of U.S. women have been the victims of IPV/DV, which can result in immediate injury and/or chronic health problems. When victims seek medical care, clinicians often do not screen for and identify IPV/DV. In fact, the U.S. Preventive Services Task Force indicates that very few research studies exist that can help guide clinicians on how to screen for IPV/DV and manage care for identified victims. Once identified, healthcare providers need to be able to refer victims to programs and counseling that will be effective in helping them end the violence in their lives.

Kentucky has established a long tradition of protecting its most vulnerable citizens. In 1976, KRS Chapter 209 was enacted by the General Assembly to protect adults from abuse, neglect and
exploitation. Subsequent Legislative and Executive Branch actions have broadened the scope of protections and services to this population and have brought the plight of adults to the attention of the general public.

While the Commonwealth of Kentucky has had a continuing education requirement for some healthcare providers related to domestic violence, in KRS 194A.540, passed in 2005, the law was expanded to include additional professions taking, at a minimum, 3 hours of domestic violence/elder abuse training. The course must include the dynamics of domestic violence, effects of domestic violence on adult and child victims, legal remedies for protection, lethality and risk issues, model protocols for addressing domestic violence, available community resources and victim services, and reporting requirements.

Professions included in this law are:

- Mental Health professions licensed or certified under KRS Chapter 309, 319 and 334;
- Alcohol and Drug Counselors certified under KRS Chapter 309;
- Primary Care Physicians, defined in KRS 164.925, and Psychiatrists KRS 202A.011, who are licensed under KRS Chapter 311;
- Nurses licensed under KRS Chapter 314.
- Paramedics certified under KRS Chapter 311.
- Emergency Medical Technicians certified under KRS Chapter 211;
- Coroners, defined in KRS 72.405 and Medical Examiners, KRS 72.240.

**Defining the Problem**

Domestic violence is a broad term that indicates violence in close or intimate interpersonal relationships. This violence is known by many names: intimate partner violence, wife abuse, wife battering, spousal abuse, woman abuse, etc. Some define the term domestic violence even broader to include child abuse, elder abuse, or abuse that occurs in any close interpersonal relationship. Put simply it is when one person purposely causes either physical or mental harm to another, when they are in a close personal relationship. For the purposes of this course the term intimate partner violence/domestic violence (IPV/DV) will be used. The course will also use the pronouns “she” and “her”, but the learner is reminded that although statistically more women are abused by men, this violence can also occur at the hands of women towards their male partners, and among same-gender partners.

It is also important to remember that abuse rarely occurs in just one form; more frequently forms of abuse occur in combinations. A woman who is physically abused is also likely isolated and controlled by her partner; a woman who is abused sexually may also be stalked and emotionally abused. The elderly woman who is being neglected by her caretaker who is also stealing her money.

**Intimate Partner Violence/Domestic Violence (IPV/DV)**

IPV/DV is a serious, preventable public health problem affecting more than 32 million Americans (Tjaden & Thoennes, 2000). IPV/DV can vary in frequency and severity. It occurs on a continuum, ranging from one hit that may or may not impact the victim to chronic, repeated abuse which is also known as battering (CDC, 2005b).

There are four main types of IPV/DV (Saltzman, et al., 2002):

**Physical violence** is the intentional use of physical force with the potential for causing death, disability, injury, or harm. Physical violence includes, but is not limited to, scratching; pushing; shoving; throwing; grabbing; biting; choking; shaking; slapping;
punching; burning; use of a weapon; and use of restraints or one’s body, size, or strength against another person.

**Sexual violence** is divided into three categories:

1) use of physical force to compel a person to engage in a sexual act against his or her will, whether or not the act is completed;
2) attempted or completed sex act involving a person who is unable to understand the nature or condition of the act, to decline participation, or to communicate unwillingness to engage in the sexual act, e.g., because of illness, disability, or the influence of alcohol or other drugs, or because of intimidation or pressure; and
3) abusive sexual contact.

**Threats of physical or sexual violence** use words, gestures, or weapons to communicate the intent to cause death, disability, injury, or physical harm.

**Psychological/emotional violence** involves trauma to the victim caused by acts, threats of acts, or coercive tactics. Psychological/emotional abuse can include, but is not limited to, humiliating the victim, controlling what the victim can and cannot do, withholding information from the victim, deliberately doing something to make the victim feel diminished or embarrassed, isolating the victim from friends and family, and denying the victim access to money or other basic resources. It is considered psychological/emotional violence when there has been prior physical or sexual violence or prior threat of physical or sexual violence.

**Stalking** is often included among the types of IPV/DV. Stalking generally refers to repeated behavior that causes victims to feel a high level of fear (Tjaden & Thoennes, 2000). Stalking can be very traumatic and cause emotional stress. Victims of stalking may have nightmares; feel out of control; have trouble sleeping, eating, and concentrating; or feel vulnerable or depressed. Stalking can also cause financial stress if the victim loses time from work or can’t go to work (USDHHS, 2005c).

One out of every 12 women has been stalked at some time in her life. The National Center for Victims of Crime defines stalking as “virtually any unwanted contact between two people that directly or indirectly communicates a threat or places the victim in fear….” Examples may include (USDHHS, 2005c):

- Following a person;
- Appearing at a person’s home or place of business;
- Making harassing phone calls;
- Leaving written messages or objects;
- Vandalizing a person’s property.

The majority of stalking victims are between 18 and 39 years old. The most common type of stalking is by a person in a former personal or romantic relationship, like an ex-husband—only a small number of women are stalked by strangers (USDHHS, 2005c).
Elder Abuse

According to the National Center on Elder Abuse (NECA) (2003), the number of older Americans that have been abused, neglected or exploited is not known. However, they report that best estimates are between 1 and 2 million Americans age 65 and older have suffered some form of maltreatment at the hands of a care provider.

Each year hundreds of thousands of older persons are abused, neglected, and exploited by family members and others. Many victims are people who are older, frail, and vulnerable and cannot help themselves and depend on others to meet their most basic needs (AOA, 2006).

Legislatures in all 50 states have passed some form of elder abuse prevention laws. Laws and definitions of terms vary considerably from one state to another, but all states have set up reporting systems. Generally, adult protective services (APS) agencies receive and investigate reports of suspected elder abuse.

Elder abuse is an umbrella term referring to any knowing, intentional, or negligent act by a caregiver or any other person that causes harm or a serious risk of harm to a vulnerable adult (AOA, 2006).

- **Physical abuse** is inflicting, or threatening to inflict, physical pain or injury on a vulnerable elder, or depriving them of a basic need.
- **Sexual abuse** is the infliction of non-consensual sexual contact of any kind.
- **Emotional or psychological abuse** is the infliction of mental or emotional anguish or distress on an elder person through verbal or nonverbal acts.
- **Financial or material exploitation** is the illegal taking, misuse, or concealment of funds, property, or assets of a vulnerable elder.
- **Neglect** is the refusal or failure by those responsible to provide food, shelter, health care, or protection for a vulnerable elder.
- **Self-neglect** is characterized as the behavior of an elderly person that threatens his/her own health or safety.
- **Abandonment** is the desertion of a vulnerable elder by anyone who has assumed the responsibility for care or custody of that person.
- **Institutional (Nursing Home) abuse or neglect** occurs when paid or volunteer staff in an institution cause abuse or neglect to the vulnerable elder.

**Commonwealth of Kentucky Definitions**

Kentucky defines **domestic violence and abuse** (KS §403.715 to 403.785) as:

> Physical injury, serious physical injury, sexual abuse, assault, or the infliction of fear of imminent physical injury, serious physical injury, sexual abuse, or assault between family members or members of an unmarried couple.

**Family member** means a spouse, previous spouse, a parent, a child, a stepchild, or any other person related by consanguinity in the second degree. **Member of an unmarried couple** means each member of an unmarried couple which allegedly has a child in common, any children of that couple, or member of an unmarried couple who are living together or have previously lived together.

The state definition of domestic violence only includes persons who are currently living together or who lived together in the past unless they share a common child, regardless of sex. Kentucky is certified to collect and report incident-based data, and law enforcement agencies submit data electronically to the Kentucky State Police.
Definition of adult (KRS 209.020(4) and KRS 209A.020):

A person eighteen (18) years or older, who because of mental or physical dysfunctioning, is unable to manage his own resources or carry out the activity of daily living or protect himself from neglect, or a hazardous or abusive situation without assistance from others, and who may be in need of protective services; or

A person without regard to age who is the victim of abuse or neglect inflicted by a spouse.

Abuse means the infliction of physical injury, sexual abuse, unreasonable confinement, intimidation, or punishment that results in physical pain or injury, including mental injury. These acts, may include, but are not limited to:

- Forced sexual relations, including forced sex with others, animals or foreign objects;
- Unwanted fondling or touching;
- Physical assault, including pushing, kicking, hitting, slapping, punching, choking, strangling, pinching, burning, hair pulling, shoving, stabbing, shooting, beating, battering during pregnancy, striking with an object and complaints of pain as a result of the assault;
- Marks that are or have been observed on an adult that were allegedly inflicted by another individual;
- Rough handling, i.e. forced feeding, roughness when transferring individual from bed to chair, or during bathing, etc; and
- Inappropriate use of physical or chemical restraints.

Mental injury is the infliction of mental anguish caused by actions or verbal assaults against an adult's well being that may result in an adverse change in behavior in the adult. The abuse can be spontaneous, protracted or systematic efforts to debase the adult while instilling fear and may include, but are not limited to:

- Threats of violence against the adult, or others;
- Threats with a weapon(s), including objects used as a weapon;
- Forced isolation or imprisonment, unreasonable confinement;
- Destruction or threats to destroy property and/or pets;
- Forcing to perform degrading acts;
- Controlling activities such as sleep, eating habits, access to money or social relationships;
- Verbal assaults and attacks on the adult's self esteem, including name-calling, insulting, degrading remarks, custody threats or threats to abduct/abscend with the child(ren);
- Stalking: or
- Intimidation.

Neglect is defined as a situation in which an adult is unable to perform or obtain for himself the goods or services that are necessary to maintain his health or welfare, or the deprivation of services by a caretaker that are necessary to maintain the health and welfare of an adult.

Spouse/Partner neglect is the deprivation of services needed for health and welfare and may include, but is not limited to:

- Actively prohibiting the spouse/partner from obtaining needed medical care;
- Controlling the environment to the extent that it prohibits the spouse/partner from carrying out activities of daily living.
**Self-neglect** is a situation in which the adult is unable to perform or obtain goods or services that are necessary to maintain health or welfare. These may include, but are not limited to situations alleging that the adult's health or welfare has suffered or declined as a result of:

- Unmet personal or medical needs, such as bedsores, malnourishment, dehydration, inappropriate clothing, poor hygiene, incorrect use of medication, lack of food or inadequate food;
- Refusing or being unable to access medical or mental health care/treatment;
- Living in an unsafe environment, such as fire/safety hazard, roach/rat/insect infested dwelling, condemned building;
- Living alone and in life-threatening conditions;
- Being unable to manage own resources;
- New onset of confusion and/or disorientation; or
- Attempts to commit suicide.

**Caretaker neglect** is the deprivation by a caretaker of services, which are needed to maintain health and welfare. The caretaker arrangement can be formal (i.e. contractual, institution) or informal (i.e. voluntary agreement with family member, friend). Caretaker neglect can be either "passive" (unintentional) or "active" (intentional) in nature as related to the provision of services (i.e. food, clothing, shelter, social contact, personal needs, medical care) and may include, but is not limited to:

- Lack of adequate food or health related services due to the caretaker's inadequate skills or knowledge;
- Abandonment or lack of supervision;
- Unmet personal or medical needs, such as bedsores, malnourishment, dehydration, inappropriate clothing, poor hygiene, incorrect use of medication, lack of food or inadequate food;
- Withholding or deprivation of food, water or health services;
- Over medication or under medication;
- Forced isolation, unreasonable confinement;
- Not obtaining needed mental health or medical services or permitting unnecessary pain.

A **caretaker** is an individual or institution who has been entrusted with or who has the responsibility for the care of the adult as a result of family relationship, or who has assumed the responsibility for the care of the adult voluntarily or by contract, employment, legal duty, or agreement.

**Exploitation** means obtaining or using another person's resources, including but not limited to funds, assets, or property, by deception, intimidation, or similar means, with the intent to deprive the person of those resources. Indicators of financial, material and sexual exploitation may include:

- Use of force or manipulation through misrepresentation, threats, or coercion;
- Deception, and may include but is not limited to:
  - Creating or reinforcing a false impression, including a false impression as to law, value, intention, or other state of mind;
  - Preventing another from acquiring information that would affect his or her judgment of a transaction; or
  - Failing to correct a false impression that the deceiver previously created or reinforced, or that the deceiver knows to be influencing another to whom the person stands in a fiduciary or confidential relationship;
• Isolation from friends, relatives or important information, such as screening phone calls, denying visitors, or intercepting mail;
• Compelling physical or emotional dependency; and
• Acquiescence of the alleged victim.

Statistics

This alarmingly common problem is a serious public health concern. **One in four women report that they have been physically assaulted or raped by an intimate partner.** These crimes occur in both heterosexual and same-sex relationships.

Statistics about IPV/DV vary widely for a number of reasons. It is estimated that cases of IPV/DV are highly underreported, so that the statistics do not reflect the actual occurrence. Statistics about IPV/DV vary because of differences in how different data sources define IPV/DV and collect data. For example, some definitions include stalking and psychological abuse, and others consider only physical and sexual violence. Legal definitions vary from state to state. Data on IPV/DV usually come from police, clinical settings, nongovernmental organizations, and survey research (CDC, 2005).

### Case Study 2. Rita

Rita is a 29 year old woman, who works as an administrative assistant at her county’s office building. She has an 8 year old son, the product of a 10 year relationship with her ex-boyfriend, Cliff. Cliff has problems with cocaine and this is why Rita and Cliff are no longer together; she had finally had enough of his abuse. When they lived together Cliff would belittle Rita for the slightest “infraction”; he did this in the presence of her family, the few friends they had left and out in public. Cliff would criticize whatever she did; he would call her “stupid” and “fat”. Rita had learned to keep her head down and not do anything to further irritate Cliff. But when they were alone, that was the worst time. Cliff wouldn’t just embarrass her, he degraded her, calling her filthy, terrible names in front of their son, Toby. Cliff would beat Rita so badly that she could not go to work, out of shame and pain. Toby would often try to intervene when his father would beat his mother, but Cliff would always scream at him to stay out of it. Rita had felt like she was barely alive. She just wanted Cliff to go away, but she had always been too scared of him to take any action. She had hoped he would find another girlfriend and leave. But she couldn’t wait; three days ago she took Toby and went to live with her sister.

Most IPV/DV incidents are not reported to the police. About 20% of IPV/DV rapes or sexual assaults, 25% of physical assaults, and 50% of stalking incidents directed toward women are not reported. Even fewer IPV/DV incidents against men are reported (Tjaden & Thoennes, 2000a). The reported data greatly underestimates the true magnitude of the problem.

### National Statistics

The following represents **national** information on the occurrence of IPV/DV. In many cases, the severity of the IPV/DV behaviors is not known (CDC, 2005). Additionally, because of the differences in the definitions of IPV/DV and how statistics are gathered, there are some discrepancies in the statistics.

- IPV/DV results in nearly 2 million injuries and 1,300 deaths nationwide every year (CDC, 2003).
- Nearly 5.3 million incidents of IPV/DV occur each year among U.S. women ages 18 and older, and 3.2 million occur among men. Most assaults are relatively minor and consist of pushing, grabbing, shaving, slapping, and hitting (Tjaden & Thoennes, 2000a).
• In the United States every year, about 1.5 million women and more than 800,000 men are raped or physically assaulted by an intimate partner. This translates into about 47 IPV/DV assaults per 1,000 women and 32 assaults per 1,000 men (Tjaden & Thoennes, 2000a).
• Estimates indicate more than 1 million women and 371,000 men are stalked by intimate partners each year (Tjaden & Thoennes, 2000a).
• IPV/DV accounted for 20% of nonfatal violence against women in 2001 and 3% against men (Rennison, 2003).
• From 1976 to 2002, about 11% of homicide victims were killed by an intimate partner (Fox & Zawitz, 2004).
• In 2002, 76% of IPV/DV homicide victims were female; 24% were male (Fox & Zawitz, 2004).
• The number of IPV/DV homicides decreased 14% overall for men and women in the span of about 20 years, with a 67% decrease for men (from 1,357 to 388) vs. 25% for women (from 1,600 to 1,202) (Fox & Zawitz, 2004).
• One study found that 44% of women murdered by their intimate partner had visited an emergency department within 2 years of the homicide. Of these women, 93% had at least one injury visit (Crandal, et al., 2004).
• Previous literature suggests that women who have separated from their abusive partners often remain at risk of violence (Campbell, et al., 2003; Fleury, Sullivan & Bybee, 2000).
• Firearms were the major weapon type used in intimate partner homicides from 1981 to 1998 (Paulozzi, et al., 2001).
• A national study found that 29% of women and 22% of men had experienced physical, sexual, or psychological IPV/DV during their lifetime (Coker, et al., 2002).
• Between 4% and 8% of pregnant women are abused at least once during the pregnancy (Gazmararian, et al., 2000).
• The National Crime Victimization Survey found that 85% of IPV/DV victims were women (Rennison, 2003).
• Prevalence of IPV/DV varies among race. Among the ethnic groups most at risk are American Indian/Alaskan Native women and men, African-American women, and Hispanic women (Tjaden & Thoennes, 2000b).
• Young women and those below the poverty line are disproportionately victims of IPV/DV (Tjaden & Thoennes, 2000b).
• Studies show that for low levels of physical violence, men and women self-report perpetrating physical IPV/DV at about the same rate. However, a common criticism of these studies is that they are generally lacking information on the context of the violence (e.g., whether self-defense is the reason for the violence) (Archer, 2000).
• Nationally, women report a life-time prevalence of IPV/DV at 25.5%, or 1 of 4 women (Tjaden & Thoennes, 2000a).

The 2004 Survey of State Adult Protective Services, funded by AoA, found the following (AOA, 2006):

• A 19.7 percent increase from 2000 – 2004 in the combined total of reports of elder and vulnerable adult abuse and neglect;
• A 15.6 percent increase from 2000 – 2004 in substantiated cases;
• In 20 of the states, more than two in five victims (42.8%) were age 80 or older;
• Most alleged perpetrators in 2003 were adult children (32.6%) or other family members (21.5%), and spouses/intimate partners accounted for 11.3% of the total (11 states responding).

Statistics for Kentucky

The lifetime prevalence for IPV/DV among women in Kentucky is 36.6%, or 1 in 3 women (KCHS, 2005).

The Kentucky Domestic Violence Association (KDVA) reports that in Kentucky in Fiscal Year 2005:
• Kentucky domestic violence programs received 27,095 crisis-related calls.
• Kentucky domestic violence programs sheltered 3,884 survivors and their dependent children and provided non-residential services to an additional 21,470 individuals.
• The Kentucky State Police reported that there were 38,170 Emergency Protective Orders issued and 26,959 Domestic Violence Order petitions filed in Kentucky.

The National Coalition Against Domestic Violence (NCADV) reports that in 2004:

• 22,269 IPV/DV allegations were investigated by the Kentucky State Police in FY2004.
• The Kentucky State Police reported that there were 29,779 Emergency Protective Orders and 15,444 Domestic Violence Orders issued in Kentucky courts during FY 2004.
• Kentucky Spouse Abuse Programs received 32,422 domestic violence related calls in FY 2004.
• 3,916 victims of IPV/DV were sheltered in FY 2004.
• The state of Kentucky was unable to shelter 2,087 individuals in FY 2004.

Women in Kentucky continue to be at risk for IPVDV at levels that exceed national statistics.

Table 1. Comparison of State and National IPV Prevalence Findings (a)

<table>
<thead>
<tr>
<th>Type of IPV and Abuse</th>
<th>Lifetime IPV Prevalence</th>
<th>12-Month IPV Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NVAWS ( n = 8,000 )</td>
<td>KY IPVS ( n = 4,059 )</td>
</tr>
<tr>
<td>Physical</td>
<td>22.1%</td>
<td>34.3%</td>
</tr>
<tr>
<td>Sexual (a)</td>
<td>7.7%</td>
<td>8.7%</td>
</tr>
<tr>
<td>Physical or Sexual</td>
<td>24.8%</td>
<td>34.8%</td>
</tr>
<tr>
<td>Stalking, Very Frightened</td>
<td>4.8%</td>
<td>14.5%</td>
</tr>
<tr>
<td>IPV</td>
<td>25.5%</td>
<td>36.6%</td>
</tr>
</tbody>
</table>

(a) The lifetime and 12-month IPV prevalence for Kentucky women are significantly higher than NVAW Survey findings, except for sexual IPV, which is higher but not significant.

According to the Kentucky Cabinet for Health and Family Services (2005) the majority of IPV/DV victims in Kentucky reported multiple rather than single IPV episodes over 12 months; three-fourths (76.7%) of them experienced psychological stress or physical injuries (74.1%), and more than one-fourth (29.8%) of abused, injured women sought medical treatment or counseling.

Statewide Data for SFY 2002 - SFY 2005 *

| Table 2. Total Adult Protective Services for 60-Plus Population |
|-------------------------|-------------------------|-------------------------|-------------------------|
|                         | 2002 | 2003 | 2004 | 2005 |
| Total # of Reports      | 7,304| 7,361| 7,676| 9,136|
| Total # of Investigations| 5,245| 5,270| 5,043| 5,179|
| Total # of Investigations Substantiated | 1,115| 1,180| 1,471| 1,543|
| Total # of Information & Referral Services | 724 | 677 | 1010 | 2333 |
| Total # of General Adult Services | 1,335| 1,414| 1,623| 1,624 |
| Table 3. Total # of Allegations by Type within an Investigation for 60-Plus Population |
|---------------------------------------------|-------|-------|-------|-------|
|                                             | 2002  | 2003  | 2004  | 2005  |
| Adult Abuse                                 | 1,536 | 1,400 | 1,281 | 1,145 |
| Spouse Abuse                                | 327   | 304   | 399   | 360   |
| Partner Abuse                               | 63    | 59    | 81    | 89    |
| Neglect by Caretaker                        | 2,241 | 2,197 | 1,942 | 2,031 |
| Self Neglect                                | 1,653 | 1,645 | 1,719 | 1,733 |
| Exploitation                                | 722   | 77    | 858   | 945   |

| Table 4. Total # of Investigations Substantiated by Type for 60-Plus Population |
|---------------------------------------------|-------|-------|-------|-------|
|                                             | 2002  | 2003  | 2004  | 2005  |
| Adult Abuse                                 | 201   | 191   | 229   | 240   |
| Spouse Abuse                                | 62    | 45    | 85    | 93    |
| Partner Abuse                               | 10    | 10    | 17    | 24    |
| Neglect by Caretaker                        | 275   | 304   | 300   | 323   |
| Self Neglect                                | 455   | 481   | 620   | 623   |
| Exploitation                                | 112   | 149   | 220   | 240   |

| Table 5. Criminal Charges Filed Related to KRS 209 |
|-------------------------------------------|-------|-------|-------|-------|
| Number of Criminal Charges Filed Related to KRS Chapter 209 (60-plus population) | 2002   | 2003   | 2004   | 2005   |
| Data Unavailable                          | Data Unavailable | 181    | 238    |

*Kentucky State Fiscal Year: July 1st – June 30th*

| Table 6. 60 Plus Reports as Percentage of 60 Plus Population* |
|---------------------------------------------|-------|-------|
| Region                                      | 60+ Population* | Reports |
| Barren River                                | 43,775 | 568   |
| Big Sandy                                   | 26,265 | 624   |
| Bluegrass Rural                             | 67,860 | 937   |
| Bluegrass Fayette                           | 33,783 | 569   |
| Cumberland Valley                           | 40,403 | 420   |
| FIVCO                                       | 26,199 | 329   |
| Gateway/Buffalo                             | 10,191 | 191   |
| Green River                                 | 37,377 | 569   |
| KIPDA Jefferson                             | 121,210| 2,053 |
| KIPDA Rural                                 | 22,195 | 175   |
| Kentucky River                              | 20,049 | 260   |
| Lake Cumberland                             | 38,663 | 365   |
| Lincoln Trail                               | 36,919 | 491   |
| Northern Kentucky                           | 56,202 | 810   |
| Pennyrile                                   | 38,776 | 299   |
| Purchase                                    | 40,555 | 476   |

*K* Kentucky State Data Center, School of Urban & Public Affairs, University of Louisville, US Census Bureau 2000 Website, [http://KSDC.Louisville.edu/1census.htm](http://KSDC.Louisville.edu/1census.htm).
Table 7. Total Adult Protective Services for 18 to 59 Population

<table>
<thead>
<tr>
<th></th>
<th>2002</th>
<th>2003</th>
<th>2004</th>
<th>2005</th>
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</thead>
<tbody>
<tr>
<td>Total # Reports for 18-59 Population</td>
<td>30,231</td>
<td>30,001</td>
<td>32,733</td>
<td>38,660</td>
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<tr>
<td>Total # Investigations for 18-59 Population</td>
<td>23,805</td>
<td>22,448</td>
<td>21,876</td>
<td>22,477</td>
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<tr>
<td>Total # Investigations Substantiated for 18-59 Population</td>
<td>5,251</td>
<td>4,854</td>
<td>5,942</td>
<td>5,968</td>
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<tr>
<td>Total # Information &amp; Referral Services</td>
<td>4,720</td>
<td>5,431</td>
<td>8,115</td>
<td>14,671</td>
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<tr>
<td>Total # General Adult Services</td>
<td>1,706</td>
<td>2,122</td>
<td>2,742</td>
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</tbody>
</table>

Identifying Abuse

Behavioral Signs

Some signs of abuse are clear: physical injuries, repeated injuries, injuries that are explained in a manner unlikely to occur, bilateral injuries, injuries that appear in a pattern left by the object used in the assault. In addition to the physical injuries, there are behavioral indicators that IPV/DV may be occurring.

Case Study 3. Rhoda

Rhoda and Jim have been married for 38 years. Rhoda has been suffering from severe headaches for about 10 years. At a recent holiday dinner, Rhoda’s niece Hannah notices, once again, how Jim always accuses Rhoda of flirting with one of her 4 brothers-in-law. Inevitably, at every family get together, after a few drinks, Jim starts this behavior. Hannah has always liked her aunt Rhoda, despite not seeing her very often, and her shy, self-effacing manner. But Jim has always been jealous. Hannah knows that he also doesn’t allow Rhoda to spend much money. She turns over her paycheck to him and he gives her a small allowance. That is all she’s allowed to spend. Jim has not allowed Rhoda go to the have the headaches evaluated. Jim does all the shopping in the home. Besides work and the occasional family occasion, Rhoda doesn’t really get out much. Hannah is curious and asks Rhoda if she’s ok. Rhoda begins to cry and tells Hannah that Jim has been physically abusing her ever since he started drinking—about 10 years ago—after Jim had been laid off from his high level management position with a Fortune 500 company. That was about the same time that her headaches started.

Hannah offers to take Rhoda to see her primary care provider, a nurse practitioner, for her headaches. When the NP screens for IPV/DV, this time, Rhoda admits to the abuse.

Sometimes it is hard to identify an abusive relationship, or to admit to it, if it is happening to you. There are clear signs to help in the identification of abuse. Consider IPV/DV when faced with the following (USDHHS, 2005a):

- Monitoring how the partner spends all of her time;
- Criticism of even little things;
- Constant accusations of unfaithfulness;
- Prevention or discouragement of partner seeing friends or family, or going to work or school;
- Anger when drinking alcohol or using drugs;
- Controls how any money is spent;
- Controls the use of needed medicines;
- Humiliates the partner in front of others;
• Destroys property or things that the partner cares about;
• Threatens to hurt the partner, the children, or pets, or does cause hurt (by hitting, beating, pushing, shoving, punching, slapping, kicking, or biting);
• Uses or threatens to use a weapon against the partner;
• Forces sex against the partner’s will;
• Blames the partner for his/her own violent outbursts.

Consider elder abuse when the following occurs (APA, 2007):

**Physical Abuse**

• Bruises or grip marks around the arms or neck.
• Rope marks or welts on the wrists and/or ankles.
• Repeated unexplained injuries.
• Dismissive attitude or statements about injuries.
• Refusal to go to same emergency department for repeated injuries.

**Emotional/Psychological Abuse**

• Uncommunicative and unresponsive.
• Unreasonably fearful or suspicious.
• Lack of interest in social contacts.
• Chronic physical or psychiatric health problems.
• Evasiveness.

**Sexual Abuse**

• Unexplained vaginal or anal bleeding.
• Torn or bloody underwear.
• Bruised breasts.
• Venereal diseases or vaginal infections.

**Financial Abuse or Exploitation**

• Life circumstances don’t match with the size of the estate.
• Large withdrawals from bank accounts, switching accounts, unusual ATM activity.
• Signatures on checks don’t match elder’s signature.

**Neglect**

• Sunken eyes or loss of weight.
• Extreme thirst.
• Bed sores.

**Consequence of Violence**

In the past it was a common belief that domestic violence/intimate partner violence was a family problem. Over the decades, public opinions and laws have changed that make domestic violence a crime. However, in addition to the criminal aspect, domestic violence is also a public health problem. Because of its alarming frequency, its significant impact on the individual, the family, the community, IPV/DV is a serious problem that is common in our society. Violence by an intimate partner is linked to both immediate and long-term health, social, and economic consequences. Factors at all levels—
individual, relationship, community, and societal—contribute to the perpetration of IPV/DV. Preventing IPV/DV requires a clear understanding of those factors, coordinated resources, and empowering and initiating change in individuals, families, and society (CDC, 2005).

Each year in the United States, about 2 million women are physically assaulted by their intimate partners. These assaults result in injuries that lead to over 73,000 hospitalizations and 1,500 deaths. In addition to the physical injuries domestic violence causes, it is also a major risk factor for mental health disorders. For example, one study found that 61 percent of women diagnosed with depression had also experienced domestic violence—a rate two times that of the general population (Kass-Bartlemes, 2004).

In general, victims of repeated violence over time experience more serious consequences than victims of one-time incidents (Johnson & Leone, 2005). The following list describes just some of the consequences of IPV (CDC, 2005).

**Case Study 4. Jenna**

Jenna is 34 years old; she has 5 children, only 2 of her children have the same father. Her children have been in and out of foster homes for years, mainly because of neglect. Jenna has an addiction to crack cocaine and crystal methamphetamine. Jenna's current boyfriend is a dealer of methamphetamine. When he uses methamphetamine, he becomes verbally, physically and sexually abusive to Jenna. But in order to get meth for herself, she tolerates his behavior. Jenna’s last boyfriend is currently in prison for drug offenses. He was also abusive to her. The father of 2 of her children is also in prison, for aggravated assault of Jenna and her oldest child, who is hearing impaired and in special education as a result of head trauma sustained during that beating. Jenna grew up watching her father beat her mother and enduring sexual abuse at the hands of 2 different uncles for most of her childhood.

Jenna’s never held a job more than 2 weeks; she has a great deal of anxiety that often comes out as anger and irritability, making it difficult for her to get along with coworkers. Jenna is on welfare.

Her children have a variety of difficulties. In addition to special education services, her children see a variety of other specialists. This includes mental health and behavioral specialists; several of her children take psychotropic medications. Two of the children have had psychiatric hospitalizations. The family continues to have an open case with the Florida Department of Children and Families.

A social worker comes out to visit Jenna every few weeks. Jenna wishes they would all just leave her alone.

In general, victims of repeated violence over time experience more serious consequences than victims of one-time incidents (Johnson & Leone, 2005). The following list describes just some of the consequences of IPV (CDC, 2005).

Women who are victims of abuse suffer long-term consequences such as poor health status; decreased quality of life and high use of healthcare services (Campbell, 2002). Campbell (2002) reported that often those who have been abused to not present to emergency departments or primary or urgent care offices with overt trauma or injury, despite their significant injuries.

Indeed, among physicians who treat patients who are victims of abuse, success in treatment was not viewed as disclosure of the abuse, but rather success was seen as the development of a longitudinal trust relationship. That was necessary before women will admit that their injuries, often discovered during care for some other healthcare problem, are a result of IPV/DV (Campbell, et. al, 2002).

**Physical Consequences of Violence**

Each year in the United States, about 2 million women are physically assaulted by their intimate
partners. These assaults result in injuries that lead to over 73,000 hospitalizations and 1,500 deaths. Victims of domestic violence have more physical problems, including headaches, chronic pain, sleep problems, vaginal infections, digestive problems, sexually transmitted diseases, and urinary tract infections, and they are more likely to rate their health as only fair or poor (Kass-Bartlesme, 2004).

At least 42% of women and 20% of men who were physically assaulted since age 18 sustained injuries during their most recent victimization. Most injuries were minor such as scratches, bruises, and welts (Tjaden & Thoennes, 2000a).

More severe physical consequences of IPV may occur depending on severity and frequency of abuse (Campbell et al., 2002; Heise & Garcia-Moreno, 2002; Plichta, 2004; Tjaden & Thoennes, 2000a). These include:

- Bruises.
- Knife wounds.
- Pelvic pain.
- Headaches.
- Back pain.
- Broken bones.
- Gynecological disorders.
- Pregnancy difficulties like low birth weight babies and perinatal deaths.
- Sexually transmitted diseases including HIV/AIDS.
- Central nervous system disorders.
- Gastrointestinal disorders.
- Symptoms of post-traumatic stress disorder:
  - Emotional detachment.
  - Sleep disturbances.
  - Flashbacks.
  - Replaying assault in mind.
- Heart or circulatory conditions.

Children may become injured during IPV incidents between their parents. A large overlap exists between IPV and child maltreatment (Appel & Holden, 1998). One study found that children of abused mothers were 57 times more likely to have been harmed because of IPV between their parents, compared with children of non-abused mothers (Parkinson et al., 2001).

Unhealthy/Risky Behaviors Related to Violence

Women with a history of DV/IPV are more likely to display behaviors that present further health risks. These behaviors may be a result of force by the abuser, an inability to negotiate for protection due to limited power within the relationship, a means of numbing oneself, already feeling that there is no point in trying to be healthy within the context of abuse, and perhaps an attempt to seek help from healthcare providers through the overuse of health services.

DV/IPV is associated with a variety of negative health behaviors (Heise & Garcia-Moreno, 2002; Plichta, 2004; Roberts, Auinger, & Klein, 2005; Silverman et al., 2001). Studies show that the more severe the violence, the stronger its relationship to negative health behaviors by victims.

- Engaging in high-risk sexual behavior – This can be the result of force on the part of the abuser. But it is important to remember that abused persons are not generally able to negotiate safer sex practices, which can keep them safe from bloodborne pathogens and other sexually transmitted diseases. Since the perpetrator is motivated by power and control, women who are abused by their partners do not generally have enough power in their
relationships to insure their own safety from their abusers in many ways, including safety during sex. Some of the high risk sexual behaviors can include:
  o Unprotected sex.
  o Decreased condom use.
  o Early sexual initiation.
  o Choosing unhealthy sexual partners.
  o Having multiple sex partners.
  o Trading sex for food, money, or other items, either by choice or by force.
  o Unwanted pregnancies.
• Using or abusing harmful substances – A way of numbing oneself the trauma of an abusive life include:
  o Smoking cigarettes.
  o Drinking alcohol.
  o Driving after drinking alcohol.
  o Using drugs.
• Unhealthy diet-related behaviors:
  o Fasting.
  o Vomiting.
  o Abusing diet pills.
  o Overeating.
• Overuse of health services.

Psychological Consequences of Violence

Physical violence is typically accompanied by emotional or psychological abuse (Tjaden & Thoennes, 2000a). IPV/DV—whether sexual, physical, or psychological—can lead to various psychological consequences for victims. Campbell’s (2002) review of the literature revealed that the most common forms of mental health disorder arising from IPV/DV are:

• Depression
• Post-traumatic Stress Disorder – In addition to the symptoms of PTSD such as intrusive thoughts, nightmares, flashbacks, anxiety, hyperarousal, avoidance, etc., some women may turn to drugs and alcohol to numb themselves against those symptoms (Campbell, 1999).

Other mental health issues include (Bergen, 1996; Coker et al., 2002; Heise & Garcia-Moreno, 2002; Roberts, Klein, & Fisher, 2003):

• Suicidal behavior in females.
• Anxiety.
• Low self-esteem.
• Antisocial behavior.
• Inability to trust men.
• Fear of intimacy.

Social Consequences of Violence

Victims of IPV/DV sometimes face the following social consequences (Heise & Garcia-Moreno 2002; Plichta, 2004):

• Isolation from social networks, including family, friends, work and/or school.
• Restricted access to services.
• Strained relationships with healthcare providers.
• Poor work performance or stained relationships with employers.
**Economic Consequences of Violence**

- Costs of IPV/DV against women in 1995 exceed an estimated $5.8 billion. These costs include nearly $4.1 billion in the direct costs of medical and mental health care and nearly $1.8 billion in the indirect costs of lost productivity (CDC, 2003).
- When updated to 2003 dollars, IPV/DV costs exceed $8.3 billion, which includes $460 million for rape, $6.2 billion for physical assault, $461 million for stalking, and $1.2 billion in the value of lost lives (Max, et al., 2004).
- Victims of severe DV/IPV lose nearly 8 million days of paid work—the equivalent of more than 32,000 full-time jobs—and almost 5.6 million days of household productivity each year (CDC, 2003).
- Women who experience severe aggression by men (e.g., not being allowed to go to work or school, or having their lives or their children’s lives threatened) are more likely to have been unemployed in the past, have health problems, and be receiving public assistance (Lloyd & Taluc, 1999).
- The health-related costs of rape, physical assault, stalking, and homicide by intimate partners exceed $5.8 billion each year. Of this total, nearly $4.1 billion are for direct medical and mental health care services and productivity losses account for nearly $1.8 billion (CDC, 2003).

**Pregnancy and IPV/DV**

Pregnancy is a high risk period for abuse. According to the Surgeon General’s Office, 15-20% of pregnant women are physically abused while pregnant and the abuse often results in birth defects (Saddock & Saddock, 2004).

In a review of the literature, Jasinski (2004) found that there were a number of consequences for women who were victimized during pregnancy:

- Late entry into prenatal care;
- Low birth weight babies;
- Premature labor;
- Unhealthy maternal behaviors (such as smoking, drinking, drug use, etc.);
- Fetal trauma;
- Health issues for the mother.

Gazmarian, et al. (2000) found, in a review of the literature, that abuse during pregnancy resulted in:

- Sexually transmitted diseases, including HIV-1;
- Urinary tract-infections;
- Substance abuse;
- Depression; and
- Other mental health conditions.

**Dynamics of IPV/DV Victimization and Perpetration**

**Risk Factors for IPV/DV**

Risk factors are associated with a greater likelihood of IPV/DV victimization or perpetration. Risk factors are not necessarily direct causes of IPV/DV—these may be contributing factors to IPV/DV (Heise & Garcia-Moreno, 2002). Not everyone who is identified as “at risk” becomes involved in violence.
Some risk factors for IPV/DV victimization and perpetration are the same. In addition, some risk factors for victimization and perpetration are associated with one another; for example, childhood physical or sexual victimization is a risk factor for future IPV/DV perpetration and victimization.

The public health approach aims to moderate and mediate those contributing factors that are preventable, and to increase protective factors, which reduce risk of victimization and perpetration.

A combination of individual, relational, community, and societal factors contribute to the risk of being a victim or perpetrator of IPV. Understanding these multilevel factors can help identify various points of prevention intervention.

Risk Factors for Victimization

Multiple factors impact on the risk of becoming a victim of IPV/DV (Crandall, et al., 2004; Heise & Garcia-Moreno, 2002; Stith, et al., 2004; Tjaden & Thoennes, 2000a, Sadock & Sadock, 2004):

Individual Factors

- Prior history of DV/IPV.
- Being female.
- Young age.
- Heavy alcohol and drug use.
- High-risk sexual behavior.
- Witnessing or experiencing violence as a child.
- Being less educated.
- Unemployment.
- For men, having a different ethnicity from their partner’s.
- For women, having a greater education level than their partner’s.
- For women, being American Indian/Alaska Native or African American.
- For women, having a verbally abusive, jealous, or possessive partner.

Relationship Factors

- Couples with income, educational, or job status disparities.
- Dominance and control of the relationship by one partner.

Community Factors

- Poverty and associated factors (e.g., overcrowding).
- Low social capital—lack of institutions, relationships, and norms that shape the quality and quantity of a community’s social interactions.
- Weak community sanctions against DV/IPV (e.g., police unwilling to intervene).

Societal Factors

- Patriarchal gender norms (e.g., women should stay at home, not enter workforce, should be submissive).

Risk Factors for Perpetration of Violence

Multiple factors influence the risk of perpetrating IPV/DV (Black, et al., 1999; Heise & Garcia-Moreno, 2002; Kantor & Jasinski, 1998; Stith, et al., 2004; Tjaden & Thoennes, 2000a, Kaplan & Saddack, 2004):
**Individual Factors**

- Low self-esteem.
- Low income.
- Low academic achievement.
- Involvement in aggressive or delinquent behavior as a youth.
- Heavy alcohol and drug use.
- Depression.
- Anger and hostility.
- Personality disorders.
- Prior history of being physically abusive.
- Having few friends and being isolated from other people.
- Unemployment.
- Economic stress.
- Emotional dependence and insecurity.
- Belief in strict gender roles (e.g., male dominance and aggression in relationships).
- Desire for power and control in relationships.
- Being a victim of physical or psychological abuse (consistently one of the strongest predictors of perpetration).

**Relationship Factors**

- Marital conflict—fights, tension, and other struggles.
- Marital instability—divorces and separations.
- Dominance and control of the relationship by the male.
- Economic stress.
- Unhealthy family relationships and interactions.

**Community Factors**

- Poverty and associated factors (e.g., overcrowding).
- Low social capital—lack of institutions, relationships, and norms that shape the quality and quantity of a community’s social interactions.
- Weak community sanctions against IPV (e.g., unwillingness of neighbors to intervene in situations where they witness violence).

**Societal Factors**

- Patriarchal gender norms (e.g., women should stay at home, not enter workforce, should be submissive to their male relatives, etc.).

Men who abuse tend to be immature, dependent, non-assertive and to suffer from strong feelings of inadequacy (Saddock & Saddock, 2004). In humiliating the woman, the man builds up his own low self-esteem. Men who are impatient, impulsive and abusive widely use the defense mechanism of displacement. The abuse occurs when a man feels threatened or frustrated at home, at work or among family and friends in social settings. The aggression that they experience as a result of this frustration, provoked by others, is displaced onto the woman.

According to Saddock & Saddock (2004), dynamics of abuse include:

- Identification with the aggressor (the father, boss, etc.);
- Testing behaviors (will she stay with me, no matter how I treat her?);
• Distorted desire to express manhood; and
• The dehumanization of women, the objectification of women and the perception that the woman is property.

The abusive act itself is reinforcing; once a man has beaten a woman, he is likely to do it again (Saddock & Saddock, 2004).

Dependence is the most common trait among battered women (Saddock & Saddock, 2004).

Power and Control

A significant component of dynamics of IPV/DV is the power and control the perpetrator has on the victim. The Power and Control wheel was developed by the Duluth Violence Prevention Program.

The Power and Control Wheel was developed by battered women in Duluth who had been abused by their male partners and were attending women’s education groups sponsored by the women’s shelter. The Wheel used in the curriculum is for men who have used violence against their female partners. The Duluth Project recognizes that there are women who use violence against men, and that there are men and women in same-sex relationships who use violence, this wheel is meant specifically to illustrate men’s abusive behaviors toward women.

The Power and Control Wheel identifies how the perpetrator utilizes a number of strategies to gain and maintain power and control over the victim.
Some men feel remorse and guilt after an episode of violent behavior and become loving and caring. This behavior can give the woman hope and allows her to stay in the relationship until the next episode. This perpetuates the cycle (Saddock & Saddock, 2004).

Contributing Factors to Elder Abuse

According to the American Psychological Association (2007), there is no one explanation for elder abuse and neglect. It occurs as a complex problem, emerging from multiple factors, including: family situations, caregiver issues, and cultural issues. Saddock & Saddock (2004) suggest that family conflicts and other problems underlie elder abuse.

Violence that occurs in IPV/DV often persists as the couple ages. Elder abuse is often a continuation of the abuse that has been occurring for many years. Women who have been abused by their spouses will likely continue to be abused as they age. Violence in families tends to be intergenerational. In families that have used violence as a means of managing stress will likely continue this pattern. However, women who have been abused for years may become the
aggressors when their husbands’ health fails. Adults, who were victims of child abuse may now be in a position to provide care for the very parents, now frail and elderly, who once abused them. Regardless of the pre-existence of violence in the home, each person makes the choice about his or her own behavior. Many former child victims become attentive, loving caretakers; formerly abused spouses do not necessarily retaliate when an opportunity arises (APA, 2007).

### Case Study 5. Jean and Frank

Jean is an 83 year old woman who has been married to Frank, 85, for 62 years. For almost all of the years of their marriage Frank emotionally and physically abused Jean. In the past 5 years, Frank has stopped physically assaulting Jean, but he continues to belittle and berate Jean. In fact, since his stroke almost a year ago, Frank has become even more verbally and emotionally abusive to Jean. Frank is no longer ambulatory and requires almost complete care.

As his primary caretaker, Jean is becoming less and less inclined to provide the care that Frank needs. When Frank refuses his medication, Jean no longer insists. When he struggles with her when she is bathing or feeding him, she stops. Frank rails about Jean almost constantly. Jean now just goes downstairs and turns up the television.

When Frank falls from bed one day and is taken to the hospital by paramedics, Jean and her daughter Rhoda (see Case Study 3), are approached by a worker from Adult Protective Services. During the discussion with Jean and Rhoda the APS worker recognizes the pattern of abuse that has been occurring throughout the life of this family. Jean admits that she is resentful now about having to care for Frank after all the years of abuse she suffered at his hands. She doesn’t feel she can take care of him any longer. After discussion with Jean and Rhoda, the decision is made to place Frank in a nursing home. Jean, although feeling guilty, is relieved.

Family stress is often identified as a factor that can trigger elder abuse. When a frail or disabled older parent moves into a family member’s home, the lifestyle adjustments can be overwhelming. The older person’s presence in the home can present financial burdens, overcrowding can result from the addition of another, particularly needy individual. Relationships can become strained. Caregivers may lack the knowledge or skills needed to provide care to the elderly person (APA, 2007).

Social isolation can increase the potential for abuse. Social isolation can be a strategy for keeping the abuse secret, or it can be a result of the stresses of caring for a dependent older family member. Isolation is dangerous because it cuts off family members from outside help and support they need to cope with the stresses of caregiving. Isolation also makes it harder for outsiders to see and intervene in a volatile or abusive situation to protect the older person and to offer help to the abuser (APA, 2007).

Caregivers can have a range of personal problems that impact their ability to provide care and can lead to abuse. Such issues as stress level, mental or emotional illness, addiction to alcohol and other drugs, job loss or other personal crises, financial dependency on the older person, and the tendency to use violence to solve problems. Sometimes the person being cared for may be physically abusive to the caregiver, especially when the older person has a form of dementia (APA, 2007).

The demands of daily care for an elder without appropriate training and without information about how to balance the needs of the older person with their own needs, they frequently experience intense frustration and anger that can lead to a range of abusive behaviors (APA, 2007).

When the caregiver is responsible for an older person who is sick or is physically or mentally impaired, the stress level can increase tremendously. Caregivers may feel trapped and hopeless and are unaware of available resources and assistance. If they have no skills for managing difficult
behaviors, caregivers can find themselves using physical force. Particularly with a lack of resources, neglectful situations can arise (APA, 2007).

Caretakers sometimes believe that to even consider respite or residential care is a betrayal of the elder’s trust; the caretaker believes that the older person only wants their care. This sense of loyalty can also contribute to abuse and neglect (APA, 2007).

According to the American Psychological Association (2007), dependency is a contributing factor in elder abuse. When the caregiver is dependent financially on an impaired older person, there may be financial exploitation or abuse. When the reverse is true, and the impaired older person is completely dependent on the caregiver, the caregiver may experience resentment that leads to abusive behavior.

Our culture also contributes to the abuse and neglect of the elderly. As a society, we tend toward the devaluation and lack of respect for older adults. Additionally, there is still a belief that what goes on in the home is a private, family matter. Sensitivity to cultural factors and differences is important when there is a suspicion of elder abuse or neglect. Language barriers, ethnic rituals, religious or ethical belief systems can be difficult to interpret. Sometimes there seems to be mistreatment of family members, especially women, wherein their basic human rights are not honored. Definitions of what is considered abuse and neglect varies across diverse cultural and ethnic communities. Those who participate in these behaviors do not consider them abusive; the “abused” may not realize they are being abused (APA, 2007).

Date Rape/Sexual Assault/Drugs used in Sexual Assault

These are drugs that are sometimes used to assist a sexual assault. Sexual assault is any type of sexual activity that a person does not agree to. It can include inappropriate touching, vaginal penetration, sexual intercourse, rape, and attempted rape. Because of the effects of these drugs, victims may be physically helpless, unable to refuse sex, and can't remember what happened. The drugs often have no color, smell, or taste and are easily added to flavored drinks without the victim's knowledge. There are at least three date rape drugs (USDHHS, 2004):

- GHB (gamma hydroxybutyric acid).
- Rohypnol (flunitrazepam).
- Ketamine (ketamine hydrochloride).

Although the term "date rape" is commonly used, most experts prefer the term "drug-facilitated sexual assault." These drugs have been used to help people commit other crimes, like robbery and physical assault, and have been used on both men and women (USDHHS, 2004).

Case Study 5. Tiffany

Tiffany is 20 year old college student. Last year at a dorm party (where Tiffany knew almost all of the people who attended the party) she awoke in a friend's room, under a pile of coats with no clothes on. She doesn't remember at all what happened that night, except when she awoke, there were others sleeping in the room on the floor and her genital area was sore, wet and sticky. She got dressed and ran back to her own room to find her best friend and roommate. Tiffany cried with her roommate and together they called the police. The police officers brought her to the emergency room. In talking with the nurse in the emergency department, Tiffany learned that she had probably been victimized through the use of so-called "date rape drugs".

Since that night, Tiffany has had a number of emotional responses; some of them very distressing. She started therapy because of difficulty with trust. She knew all the people at the party; someone she knew had drugged her and raped her; she just was so depressed when she thought about it.
The drugs can affect you quickly. The length of time that the effects last varies. It depends on how much of the drug is taken and if the drug is mixed with other substances, like alcohol. Alcohol can worsen the drug's effects and can cause more health problems. Also, one drug — GHB — can be made in a home laboratory, so the exact ingredients are unknown (USDHHS, 2004).

**GHB**

GHB can cause the following:

- Relaxation.
- Drowsiness.
- Dizziness.
- Nausea.
- Problems seeing.
- Unconsciousness (black out).
- Seizures.
- Can't remember what happened while drugged.
- Problems breathing.
- Tremors.
- Sweating.
- Vomiting.
- Slow heart rate.
- Dream-like feeling.
- Coma.
- Death.

**Rohypnol**

Rohypnol can cause the following:

- Can't remember what happened while drugged.
- Lower blood pressure.
- Sleepiness.
- Muscle relaxation or loss of muscle control.
- Drunk feeling.
- Nausea.
- Problems talking.
- Difficulty with motor movements.
- Loss of consciousness.
- Confusion.
- Problems seeing.
- Dizziness.
- Confusion.
- Stomach problems.

**Ketamine**

Ketamine can cause the following:

- Hallucinations.
- Lost sense of time and identity.
- Distorted perceptions of sight and sound.
- Feeling out of control.
• Impaired motor function.
• Problems breathing.
• Convulsions.
• Vomiting.
• Out of body experiences.
• Memory problems.
• Dream-like feeling.
• Numbness.
• Loss of coordination.
• Aggressive or violent behavior.
• Slurred speech.

Barriers to Identification of Intimate Partner Violence/Domestic Violence

Gerbert, et al. (1999) reported that the literature is full of references that victims are reluctant to disclose IPV/DV to healthcare providers and that healthcare providers are reluctant to ask patients about IPV/DV. Most commonly cited reasons that patients do not disclose is (Gerbert, et al., 1999): fear of retaliation by the abuser; shame, humiliation and denial about the seriousness of the abuse; concern about confidentiality, especially related to law enforcement involvement.

In cases when injuries and health problems are apparent and well documented, healthcare providers often do not ask about IPV/DV or intervene on behalf of their patients who experience it. One study found that only 6 percent of physicians ask their patients about possible IPV/DV, yet 88 percent admitted that they knew they had female patients who had been abused. Another study indicated that 48 percent of women supported routine screening of all women, with 86 percent stating it would make it easier to get help (Kass-Bartlesme, 2004).

Healthcare providers have said that they do not screen for IPV/DV because they lack the necessary training and education, time, tools, and support resources, and fear of offending the patient; frustration with the lack of change in the patient’s situation or frustrations with the patient’s unresponsiveness to advice; and they do not feel they can make a difference; feelings of powerlessness to “fix” the situation; and their sense of loss of control over the patient’s decision making (Gerbert, et al., 1999; Tjaden, P. & Thoennes, N., 2002; Borowsky, I.W., Ireland, M., 2002; Elliott, L., Nerney, M., Jones, T., et al., 2002). Recent surveys found that many primary care clinicians, nurses, physician assistants, and medical assistants lack confidence in their ability to manage and care for victims of IPV/DV (Sugg, et al., 1999):

• Only 22 percent had attended any educational program on IPV/DV within the previous year.
• Over 25 percent of physicians and nearly 50 percent of nurses, physician assistants, and medical assistants stated that they were not at all confident in asking their patients about physical abuse.
• Less than 20 percent of clinicians asked about IPV/DV when treating their patients for high-risk conditions such as injuries, depression or anxiety, chronic pelvic pain, headache, and irritable bowel syndrome.
• Only 23 percent of physicians, nurses, physician assistants, and medical assistants believed they had strategies that could assist victims of IPV/DV.

For information regarding the specific studies referred to above, go to http://www.ahrq.gov/research/domviolria/domviolria.htm#more.

An additional factor for nurses in the identification of IPV/DV, is that so many nurses are victims of intimate partner violence. Furniss (1999) reported that 38% of obstetric nurses are or have been the victims of domestic violence. She reported on a study by Janssen, et al. (1998) that:
• 38% of the nurses completing the survey said they had experienced abuse;
• 27.3% said that their partners try to control them;
• 26.9% said they suffer emotional abuse;
• 22.7% are afraid of their partners;
• 14.6% have been battered;
• 8.1% have experienced sexual abuse.

Human Trafficking

Although the crime of human trafficking differs from domestic violence in many ways, there may also be some overlap, as some abusers engage in human trafficking of victims of IPV/DV. According to US Department of Health and Human Services, Office of Children and Families (OCF) (2004), the following are sample questions healthcare providers can ask in screening an individual to determine if he/she is a potential victim of human trafficking. As with domestic violence victims, if you think a patient is a victim of trafficking, you do not want to begin by asking directly if the person has been beaten or held against his/her will. Instead, you want to start at the edges of his/her experience. And if possible, you should enlist the help of a staff member who speaks the patient’s language and understands the patient’s culture, keeping in mind that any questioning should be done confidentially.

Interpreters should be screened in order to ensure they do not know the victim or the traffickers and do not otherwise have a conflict of interest.

Screening For Victims of Human Trafficking

Before asking the person any sensitive questions, try to get the person alone if possible, particularly if the person was accompanied by someone who could be a trafficker posing as a spouse, other family member or employer. However, when requesting time alone, it should do so in a manner that does not raise suspicions.

Suggested screening questions:

• Can you leave your job or situation if you want?
• Can you come and go as you please?
• Have you been threatened if you try to leave?
• Have you been physically harmed in any way?
• What are your working or living conditions like?
• Where do you sleep and eat?
• Do you sleep in a bed, on a cot or on the floor?
• Have you ever been deprived of food, water, sleep or medical care?
• Do you have to ask permission to eat, sleep or go to the bathroom?
• Are there locks on your doors and windows so you cannot get out?
• Has anyone threatened your family?
• Has your identification or documentation been taken from you?
• Is anyone forcing you to do anything that you do not want to do?

If you think you have come in contact with a victim of human trafficking, call the Trafficking Information and Referral Hotline at 1.888.3737.888. This hotline will help you determine if you have encountered victims of human trafficking, will identify local resources available in your community to help victims, and will help you coordinate with local social service organizations to help protect and serve victims so they can begin the process of restoring their lives. For more information on human trafficking visit www.acf.hhs.gov/trafficking.
**Best Practice Guidelines for IPV/DV**

Identifying IPV/DV in healthcare is critical. Many professional organizations recommend routine screening for IPV/DV. Among them are (Horner, 2005): the American Association of Colleges of Nursing, the American Nurses Association, the American Academy of Pediatrics (AAP), American College of Nurse Midwives, and National Association of Pediatric Nurse Practitioners.

With the current focus on evidence-based practice, the Agency for Healthcare Research and Quality (AHRQ) reported that the U.S. Preventive Services Task Force (USPSTF) did not find enough evidence to recommend for or against routine screening for IPV/DV among the general population. However, the USPSTF reinforced the necessity for healthcare providers to be able to identify the signs and symptoms of IPV/DV, document the evidence, provide treatment for victims, and refer victims to counseling and social agencies that can provide assistance (Kass-Bartlesme, 2004).

While there is yet no evidence to recommend routine screening for IPV/DV, many professional organizations recommend it.

A focus on outcomes in healthcare has helped to fuel the work of identifying best practice guidelines or evidence-based practice. Through the work of a panel of content experts, research review and literature review have helped to shape these guidelines. This process has yielded best practice guidelines for a number of different illnesses and conditions (see Resource section of this course for more information on these guidelines).

The federal government’s National Guideline Clearinghouse, identifies guidelines for intervention in IPV/DV. They list The Family Violence Prevention Fund’s 2004 publication of National Consensus Guidelines on Identifying and Responding to Domestic Violence Victimization in Health Care Settings. The full reference appears in the Reference section of this course; the full guidelines can be retrieved from the Family Violence Prevention website at http://endabuse.org/programs/display.php3?DocID=206. These guidelines will be referred to as the Guidelines during this course.

These Guidelines offer a variety of healthcare professionals, working in a variety of healthcare settings the ability to address IPV/DV. Responses to victims are most efficient and effective when coordinated in a multi-disciplinary manner and in collaboration with IPV/DV advocates so that no single provider is responsible for the entire intervention.

In order to effectively be able to identify and respond to IPV/DV, healthcare providers must have information and training on the subject. They need to be able to feel comfortable asking a patient about IPV/DV and they need to feel as though they have something to offer the patient, once IPV/DV is disclosed.

Training sessions funded by AHRQ improved primary care providers' confidence in asking and treating victims of IPV/DV. Providers who participated in the training increased their screening for IPV/DV from 3.5 percent prior to the training program to 20.5 percent after training. Upon completion of the training sessions, participants stated they (Kass-Bartlesme, 2004):

- Felt less fear of offending patients by asking about domestic violence.
- Had less fear for her/his safety.
- Asked patients more often about possible domestic violence.
- Offered strategies to abusers to seek help.
- Provided strategies so victims could change their situation.
- Had better access to information on managing domestic violence.
- Had methods to ask abusers about domestic violence while minimizing the risk to the victims.
It is the routine inquiry and assessment that can identify IPV/DV. Using a public health model, that has been so effective in treating other conditions and illnesses (for example, smoking cessation, drinking and driving campaigns, immunizations, etc.), it is the routine inquiry and assessment that can identify IPV/DV. Making routine inquiry and assessment of IPV/DV a routine part of healthcare history and examination, reinforces the role of healthcare providers in IPV/DV and gives the patient information about where to receive assistance if she chooses. Even if patients choose not to disclose the abuse, they know that the healthcare provider can be approached about the subject in the future.

The Guidelines recommend that all adolescent and adult patients are routinely assessed for IPV/DV. The exception, according to the Guidelines (p. 12): 

The majority of IPV perpetrators are male, so assessing all patients increases the likelihood of identifying perpetrators for victimization. We recommend routinely assessing men only if additional precautions can be taken to protect victims whose batterers claim to be abused. Training providers on perpetrator dynamics and the responses to lesbian, gay, transgender, bisexual and heterosexual victims is critical, regardless of policies to assess all patients or women only.

Patients should be asked about current and lifetime exposure to IPV victimization. Direct questions about physical, emotional and sexual abuse should be asked. Due to the long term consequences of IPV/DV on health, the Guidelines recommend integrating assessment for current and lifetime exposure into routine care. They acknowledge that in some settings lifetime exposure assessment may be limited due to time constraints, such as emergency departments or urgent care facilities.

Inquiry for past and present IPV/DV should occur:

- As part of the routine health history (e.g. social history/review of systems);
- As part of the standard health assessment (or at every encounter in urgent care);
- During every new patient encounter;
- During periodic comprehensive health visits (assess for current IPV/DV victimization only);
- During a visit for a new chief complaint (assess for current IPV/DV victimization only);
- At every new intimate relationship (assess for current IPV/DV victimization only);
- When signs and symptoms raise concerns or at other times at the provider’s discretion.

Assessment for IPV/DV should be:

- Conducted routinely, regardless of the presence or absence of indicators of abuse;
- Conducted verbally as part of a face-to-face health care encounter;
- Included in written or computer based health questionnaires;
- Direct and nonjudgmental using language that is culturally/linguistically appropriate;
- Conducted in private: no friends, relatives (except children under 3) or caregivers should be present;
- Confidential: prior to inquiry, patients should be informed of any reporting requirements or other limits to provider/patient confidentiality;
- Assisted, if needed, by interpreters who have been trained to ask about abuse and who do not know the patient or the patient’s partner, caregiver, friends or family socially.

The goals of the assessment are to:

- Create a supportive environment in which the patient can discuss the abuse;
- Enable the provider to gather information about health problems associated with the abuse; and
- Assess the immediate and long-term health and safety needs for the patient in order to develop and implement a response.
The timing of assessment is important:

- Initial assessment should occur immediately after disclosure;
- Repeat and/or expanded assessments should occur during follow-up appointments;
- At least one follow-up appointment (or referral) should be offered after disclosure of current or past abuse with health care provider, social worker or DV advocate.

**Case Study 1. Roseanne (continued)**

Today at work, Roseanne is caring for a baby in the neonatal intensive care whose mother has only come to the NICU for 2 hours in the past week. Roseanne watches the mom; she recognizes the bruises on her face, not quite covered up by makeup. She appears anxious and is tearful. Roseanne knows just how she feels—but she cannot bring herself to ask the mom about her experience. Roseanne decides to talk with her supervisor; she admits that she suspects IPV/DV in the family of the baby she is caring for. She then begins to cry and tells her supervisor that she recognizes the abuse because it looks so much like her own situation.

Roseanne requests that the supervisor intervene on behalf of the mom and screen for IPV/DV, because Roseanne is unable to do so. Roseanne's supervisor offers her support to Roseanne both for the patient and for Roseanne herself. She talks with Roseanne about safety planning, refers her to the Employee Assistance Program at work and offers emotional support as well. Roseanne recognizes that she has to make a change, but she isn't sure what to do.

For the patient who discloses current abuse, assessment should include at a minimum an **assessment of immediate safety**:

- “Are you in immediate danger?”
- “Is your partner at the health facility now?”
- “Do you want to (or have to) go home with your partner?”
- “Do you have somewhere safe to go?”
- “Have there been threats or direct abuse of the children (if s/he has children)?”
- “Are you afraid your life may be in danger?”
- “Has the violence gotten worse or is it getting scarier? Is it happening more often?”
- “Has your partner used weapons, alcohol or drugs?”
- “Has your partner ever held you or your children against your will?”
- “Does your partner ever watch you closely, follow you or stalk you?”
- “Has your partner ever threatened to kill you, him/herself or your children?”

If the patient states that there has been an escalation in the frequency and/or severity of violence, that weapons have been used, or that there has been hostage taking, stalking, homicide or suicide threats, providers should conduct a homicide/suicide assessment.

**Assess the impact of the IPV (past or present) on the patient's health.** There are common health problems associated with current or past IPV victimization. Disclosure should prompt providers to consider these healthcare risks and assess:

- How the (current or past) IPV/DV victimization affects the presenting health issue.
- “Does your partner control you access to healthcare or how you care for yourself?”
- How the (current or past) IPV/DV victimization relates to other associated health issues.
Assessment of the pattern and history of current abuse:

- “How long has the violence been going on?”
- “Have you ever been hospitalized because of the abuse?”
- “Can you tell me about your most serious event?”
- “Has your partner forced you to have sex, hurt you sexually, or forced you into sexual acts that made you uncomfortable?”
- “Have other family members, children or pets been hurt by your partner?”
- “Does your partner control your activities, money or children?”

For the patient that discloses past history of IPV/DV victimization:

- “When did the abuse occur?”
- “Do you feel you are still at risk?”
- “Are you in contact with your ex-partner?” “Do you share children or custody?”
- “How do you think the abuse has affected you emotionally and physically?”

According to the American College of Obstetricians and Gynecologists (ACOG), IPV/DV screening, which they recommend should be conducted on ALL patients, can be conducted by making the following statement and asking these three simple questions (ACOG, 2006):

"Because violence is so common in many women's lives and because there is help available for women being abused, I now ask every patient about domestic violence:

1. Within the past year -- or since you have been pregnant -- have you been hit, slapped, kicked or otherwise physically hurt by someone?
2. Are you in a relationship with a person who threatens or physically hurts you?
3. Has anyone forced you to have sexual activities that made you feel uncomfortable?"

Pregnant women should be screened throughout the pregnancy because some women do not disclose abuse the first time they are asked and abuse may begin later in pregnancy (ACOG, 2006).

Screening should occur (ACOG, 2006):

- At the first prenatal visit.
- At least once per trimester, and
- At the postpartum checkup.

ACOG also suggests that screening should occur for women who are not pregnant (ACOG, 2006):

- At routine ob-gyn visits;
- Family planning visits;
- Preconception visits.

If the patient says “no”:

- Respect the patient’s response;
- Let the patient know that you are available should the situation ever change;
- Assess again at previously recommended intervals;
If patient says “no” but you believe s/he may be at risk, discuss the specific risk factors and offer information and resources in exam and waiting rooms, or bathrooms.

Interventions will vary based on the severity of the abuse, the patient’s decisions about what s/he wants for assistance at that time and if the abuse is happening currently. It is important to let the patient know that you will help regardless of whether s/he decides to stay in or leave the abusive relationship. It is also important for the healthcare provider to NOT impose her or his own values onto the patient. Since the patient is already suffering from the abuse of control and power, the healthcare provider should support the patient to make her/his own decisions and not further exert power over the patient by making decisions for her/him.

For all patients who disclose current abuse, providers should:

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

- **Provide information:**
  - “Intimate Partner or domestic violence is common and happens in all kinds of relationships”;
  - “Violence tends to continue and often becomes more frequent and severe”; 
  - “Abuse can impact your health in many ways”; 
  - “You are not to blame, but exposure to violence in the home can emotionally and physically hurt your children or other dependent loved ones”.

- **Respond to safety issues:**
  - Offer the patient a brochure about safety planning and go over it with her/him (see Appendix D for a sample safety plan);
  - Review ideas about keeping information private and safe from the abuser;
  - Offer the patient immediate and private access to an advocate in person or via phone;
  - Offer to have a provider or advocate discuss safety then or at a later appointment;
  - If the patient wants immediate police assistance, offer to place the call;
  - Reinforce the patient’s autonomy in making decisions regarding her/his safety;
  - If there is significant risk of suicide, the patient should be kept safe in the health setting until emergency psychiatric evaluation can be obtained.

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

**Documentation**

Documentation is critical, both for the protection of the patient and of the healthcare provider. Document relevant history, including:

- Chief complaint or history of present illness.
- Record details of the abuse and its relationship to the presenting problem.
- Document any concurrent medical problems that may be related to the abuse.
- For current IPV/DV victims, document a summary of past and current abuse including:
  - Social history, including relationship to abuser and abusers name if possible;
  - Patient’s statement about what happened, not what lead up to the abuse (e.g. "boyfriend John Smith hit me in the face" not "patient arguing over money");
  - Include the date, time, and location of incidents where possible;
  - Patients appearance and demeanor (e.g. "tearful, shirt ripped" not "distraught");
  - Any objects or weapons used in an assault (e.g. knife, iron, closed or open fist);
  - Patients accounts of any threats made or other psychological abuse;
  - Names or descriptions of any witnesses to the abuse.

**Document results of physical examination:**

- Findings related to IPV/DV, neurological, gynecological, mental status exam if indicated;
- If there are injuries, (present or past) describe type, color, texture, size, and location;
- Use a body map and/or photographs to supplement written description;
- Obtain a consent form prior to photographing patient. Include a label and date.

**Document laboratory and other diagnostic procedures:**

- Record the results of any lab tests, x-rays, or other diagnostic procedures and their relationship to the current or past abuse.

**Document results of assessment, intervention and referral:**

- Record information pertaining to the patient’s health and safety assessment including your assessment of potential for serious harm, suicide and health impact of IPV/DV;
- Document referrals made and options discussed;
- Document follow-up arrangements.

If patient does not disclose IPV/DV victimization:

- Document that assessment was conducted and that the patient did not disclose abuse;
- If you suspect abuse, document your reasons for concerns: i.e. “physical findings are not congruent with history or description,” “patient presents with indications of abuse.”
Follow-up

At least one follow-up appointment (or referral) with a healthcare provider, social worker or IPV/DV advocate should be offered after disclosure of current or past abuse:

- “If you like, we can set up a follow-up appointment (or referral) to discuss this further.”
- “Is there a number or address that is safe to use to contact you?”
- “Are there days/hours when we can reach you alone?”
- “Is it safe for us to make an appointment reminder call?”

At every follow up visit with patients currently in abusive relationships:

- Review the medical record and ask about current and past episodes of IPV/DV;
- Communicate concern and assess both safety and coping or survival strategies:
  - “I am still concerned for your health and safety”
  - “Have you sought counseling, a support group or other assistance?”
  - “Has there been any escalation in the severity or frequency of the abuse?”
  - “Have you developed or used a safety plan?”
  - “Told any family or friends about the abuse?”
  - “Have you talked with your children about the abuse and what to do to stay safe?”
- Reiterate options to the patient (individual safety planning, talking with friends or family, advocacy services and support groups, transitional/temporary housing, etc.).

The Guidelines provide additional information about identifying and intervening in IPV/DV, such as:

- Setting Specific Clinical Responses: A Quick Reference Guide.
- Dilemmas Faced by Child Health Providers.
- Dilemmas When Assessing All Patients for Victimization.
- Suggested Assessment Questions and Strategies.
- Validated Abuse Assessment Tools.
  - Abuse Assessment Screen.
  - Body Map.
  - Danger Assessment Tool.
- Expanded Assessment.
- Indicators of Abuse.
- Safety Plan and Discharge Instructions * (A copy appears in the Appendix).
- Interventions with Current or Past Victims of Domestic Violence.
- State Codes on Intimate Partner Violence.
- Victimization Reporting.
- Photo Documentation and Forensic Evidence Collection.
- Confidentiality Procedures.
- Preparing Your Practice.
- Resources and Referrals.


A simple method for remembering the basics of the Guidelines is to use the RADAR method of inquiry and assessment for IPV/DV. RADAR is a mnemonic: R=Routinely screen female patients; A=Ask direct questions; D=Document your findings; A=Assess patient safety; R=Review options and referrals.
**Figure 1. RADAR Intervention Method**

**R = Routinely Screen Female Patients**

Although many women who are victims of IPV/DV will not volunteer any information, they will discuss it if asked simple, direct questions in a nonjudgmental way and in a confidential setting. *Interview the patient alone.*

**A = Ask Direct Questions**

- “Because violence is so common in many women’s lives, I’ve begun to ask about it routinely.”
- “Are you in a relationship in which you have been physically hurt or threatened?” If no, “Have you even been?”
- “Have you ever been hit, kicked or punched by your partner?”
- “Do you feel safe at home?”
- “I notice you have a number of bruises; did someone do this to you?”

- **If the patient answers “yes”:**
  
  Encourage her to talk about it: “Would you like to talk about what has happened to you?” “How do you feel about it?” “What would you like to do about this?”

  Listen nonjudgmentally. This serves both to begin the healing process for the woman and to give you an idea of what kind of referrals she may need. Often a battered woman believes her abuser’s negative messages about her. She may feel responsible, ashamed, inadequate and afraid she will be judged by you.

- **Validate her experience. Make sure she knows she is not alone.** Millions of women of every age, race, and religion face abuse, and many women find it extremely difficult to deal with the violence. Emphasize that when she wants help, it is available. Let her know that domestic violence tends to get worse and become more frequent with time and that it rarely goes away on its own. “You are not alone.” “You do not deserve to be treated this way.” “Help is available to you.”

  **Tell her the abuse is not her fault.** Explain that physical violence in a relationship is never acceptable. There’s no excuse for it – not alcohol or drugs, financial pressure, depression, jealousy or any behavior of hers. “No one has to live with violence.” “You are not to blame.” “What happened to you is a crime.”

- **If the patient answers “no”, or will not discuss the topic:**

  Be aware for any clinical signs that may indicate abuse: injury to the head, neck, torso, breasts, abdomen or genitals; bilateral or multiple injuries; delay between onset of injury and seeking treatment; explanation by the patient which is inconsistent with the type of injury; any injury during pregnancy, especially to abdomen or breasts; prior history of trauma; chronic pain symptoms for which no etiology is apparent; psychological distress such as depression, suicidal ideation, anxiety and/or sleep disorders; a partner who seems overly protective or who will not leave the woman’s side.

  If any one of these clinical signs are present, ask more specific questions. Make sure she is alone. “It looks as though someone may have hurt you. Can you tell me how it happened?” “Sometimes when people feel the way you do, it may be because they are being hurt at home. Is this happening to you?”
D = Document Your Findings

Record a description of the abuse as she has described it to you. Use statements such as “the patient states she was . . . “If she give the specific name of the assailant, sue it in your record. “She says her boyfriend John Smith struck her . . . “Record all pertinent physical findings. Use a body map to supplement the written record. Offer to photograph injuries. When serious injury or sexual abuse is detected, preserve all physical evidence. Document an opinion if the injuries were inconsistent with the patient’s explanation.

A = Assess Patient Safety

Before she leaves the medical setting, find out if she is afraid to go home. Has there been an increase in frequency or severity of violence? Have there been threats of homicide or suicide? Have there been threats to her children? Is there a gun present?

R = Review Options and Referrals

If the patient is in imminent danger, find out if there is someone with whom she can stay. Does she need immediate access to a shelter? Offer her the opportunity of a private phone to make a call. If she does not need immediate assistance, offer information about hotlines and resources in the community. (Resources for Domestic Violence in Florida can be found in the “Resource” section near the end of this course).

Remember that it may be dangerous for the woman to have these in her possession. Do not insist that she take them. Make a follow-up appointment to see her or some other method of checking in.

Other researchers and clinicians have developed additional methods for intervening in IPV/DV. Figure 2. addresses the immediate response of nurses, physicians and social workers to disclosure of IPV/DV.

Physicians, nurses, social workers immediate response at disclosure:

1. Believe patient and tell patient the behavior reported is abuse.
2. Assure patient violence is the fault of perpetrator and not the victim.
3. Assure patient that there are options and offer referral to IPV/DV Program Social Worker or other appropriate resource (see Resource section near the end of this course).
4. Give patient hotline numbers: National 1-800-799-SAFE (7233); there is also a toll-free number for the hearing impaired: 1-800-787-3224 (TDD).

Figure 2. Intimate Partner Violence (IPV) Clinical Pathway: Treatment after Disclosure (initial visit only) (Dienemann, et. al., 2003)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Clinician</th>
<th>Initial Visit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Assessment and Treatment</td>
<td>Physician and nurse</td>
<td>Presenting Complaint:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1. Assess trauma.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Document with body map/photos and description.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Refer or treat as appropriate.</td>
</tr>
</tbody>
</table>
4. Report to police if gunshot or knife wound or according to State law.

Note: In Florida, state law requires the reporting of gunshot and knife wounds.

<table>
<thead>
<tr>
<th>Physical Assessment and Treatment</th>
<th>Physician and nurse</th>
<th>Sexual Trauma:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ask about forced or undesired sex.</td>
<td></td>
<td>1. If NO: document only.</td>
</tr>
<tr>
<td>2. If YES and not IPV/DV RAPE: examine for injuries, treat, refer, document. Discuss contraceptive options, prevent pregnancy and STDs.</td>
<td></td>
<td>If YES and IPV/DV RAPE (within last 72 hours do pelvic exam, evidence collection); examine for injuries, treat, refer, document. OFFER pregnancy test and STD/HIV test.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical Assessment and Treatment</th>
<th>Physician and nurse</th>
<th>Pain:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Assess site, type, severity, and duration.</td>
<td></td>
<td>1. If NO: document only.</td>
</tr>
<tr>
<td>2. If YES: assess pain in relation to violence history and its possible influence on sign/symptoms/illnesses, especially: Neurological, GI/Abdominal, GYN, Chronic stress, Other. Document, refer and/or treat.</td>
<td></td>
<td>If YES: assess pain in relation to violence history and its possible influence on sign/symptoms/illnesses, especially: Neurological, GI/Abdominal, GYN, Chronic stress, Other. Document, refer and/or treat.</td>
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<table>
<thead>
<tr>
<th>Psychiatric/Mental Health Assessment and Treatment</th>
<th>Physician and nurse</th>
<th>Substance Abuse:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Screen for current substance abuse problems of patient and abuser.</td>
<td></td>
<td>1. If NO: document.</td>
</tr>
<tr>
<td>2. If YES: inform of treatment options and refer if interested at this time. Document.</td>
<td></td>
<td>If YES: inform of treatment options and refer if interested at this time. Document.</td>
</tr>
<tr>
<td>3. Reinforce that this is a separate health problem from IPV/DV although it may be exacerbated by or exacerbate IPV/DV.</td>
<td></td>
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</tr>
<tr>
<td><strong>Psychiatric/Mental Health Assessment and Treatment</strong></td>
<td>Physician and nurse</td>
<td><strong>Depression:</strong></td>
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<td>------------------------------------------------------</td>
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<td>1. Assess symptoms of depression, severity and duration and relationship to IPV/DV history.</td>
</tr>
<tr>
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<td>2. Assess client's need for medication. If appropriate, prescribe psychotropic medication and/or refer for psychiatric services or counseling.</td>
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<tr>
<th><strong>Psychiatric/Mental Health Assessment and Treatment</strong></th>
<th>Physician and nurse</th>
<th><strong>PTSD/Anxiety:</strong></th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1. Assess sleep, startle, anxiety, re-experiencing of trauma (flashback), numbing.</td>
</tr>
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<td></td>
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<td>2. If YES, refer for psychiatric consult.</td>
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</tbody>
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<thead>
<tr>
<th><strong>Social Assessment and Treatment</strong></th>
<th>Social Worker or IPV/DV Advocate/Nurse</th>
<th><strong>IPV/DV Services:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1. IPV counselor meets with patient.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Assess trauma history.</td>
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</tbody>
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<thead>
<tr>
<th><strong>Social Assessment and Treatment</strong></th>
<th>Social Worker or IPV/DV Advocate/Nurse</th>
<th><strong>Additional Demographics:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1. Marital status with abuser: married, separated, divorced, widow, single.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>2. Living with abuser: yes, no, sometimes.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>3. Harassment and/or stalking by abuser?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>4. Children: number and ages. Custody?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>5. Health insurance: none, abuser's policy, personal policy.</td>
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<thead>
<tr>
<th><strong>Social Assessment and Treatment</strong></th>
<th>Social Worker or IPV/DV Advocate/Nurse</th>
<th><strong>Information on Children:</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1. During woman's treatment/hospitalization: children living with patient? Where are they</td>
</tr>
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</table>
now? How can their safety and care be assured? How support mother's custody?

2. Child trauma: ask if children demonstrating signs of trauma from observing violence (i.e., sleep problems, nightmares, aggressiveness or withdrawal, school problems). Refer if indicated.

Social Assessment and Treatment

Social Worker or IPV Advocate/Nurse

Danger:

1. Use Danger Assessment guidelines to assess IPV severity and extent of danger (A Danger Assessment can be accessed in the Appendices of the Guidelines-see Resource section of this course). Express concern for safety.

2. Explain police services. Ask if victim desires for provider to call police.


4. Explain mandatory legal reporting of child abuse. Inquire if children have been abused and refer if indicated.

Safety Planning:

Social Assessment and Treatment

Social Worker or IPV Advocate/Nurse

1. Use guidelines to assess safety behaviors and plans for future.

Safety Planning

Safety planning is an important intervention for the healthcare provider. The Safety Plan included in the Guidelines appears in Appendix D of this course.

Creating a Safety Plan

Those who are at risk of violence need to have a plan to respond to the abuse in a safe manner, often called a Safety Plan. The plan should list steps to take if a partner becomes violent or abusive. It
should also include teaching children how to call 9-1-1 for help. Women who experience dating violence or other forms of abuse also need a safety plan (SAMHSA, 2003).

Safety During a Violent Incident

You don't have control over your partner's violent actions. However, you can control how you prepare for your safety and the safety of your children (SAMHSA, 2003).

- If you think an argument may become violent, stay out of rooms that may contain possible weapons. This would include the kitchen, bathroom, and garage. Try to go to a room with an exit.
- Practice getting out safely. Which doors, windows, stairwells, and elevators will you use?
- Keep your purse and car keys close by and always keep an extra car key hidden in a safe place.
- You may need to tell a neighbor to call the police if they hear suspicious noise coming from your home. This may be difficult for you to reveal, but it is a very important step. Have a code word that will alert them to call the police. Make sure your children also know the code word and how to call 9-1-1.

Safety If You Are Planning To Leave

Some women decide that the best safety plan is to leave. Because the abuser often becomes more violent when he suspects his partner is leaving (it represents a loss of control), it is important to prepare carefully (SAMHSA, 2003).

- Leave money, an extra set of keys, an extra set of clothes, and copies of important papers (see list below) with someone you trust at least several days before you plan to leave.
- If you don't already have one, open a bank account in your name only.
- Determine who might be able to loan you money or give you a place to stay.
- Keep change for phone calls since credit cards or calling cards will show up on phone bills.

Checklist for Leaving an Abuser

The National Women's Health Information Center (USDHHS, 2005; SAMHSA, 2003) provides the following list of helpful items to get together when planning on leaving an abusive situation. Keep these items in a safe place until ready to leave, or if sudden departure is needed. If there are children in the home, take them. And take the pets too, if possible.

Figure 3. What to Bring With You When You Leave an Abuser

| 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 identification/documents |
|                                              | Immigration documents, green card, visa. |
| Important personal papers                     | • Marriage certificate.  
|                                              | • Divorce papers.       
|                                              | • Custody orders.       
|                                              | • Legal protection or restraining orders.  
|                                              | • Insurance forms and information.  
|                                              | • Health insurance papers and medical cards.  
|                                              | • Medical records for all family members including children’s immunization records.  
|                                              | • Children’s school records.  
|                                              | • Work permits.         
|                                              | • Immigration papers.   
|                                              | • Rental agreement/lease or house deed.  
|                                              | • Car title, registration, and insurance information.  |
| Funds                                         | • Cash.                
|                                              | • Credit cards.         
|                                              | • ATM card.             
|                                              | • Checkbook and bankbook (with deposit slips).  
|                                              | • Investment papers/records and account numbers.  |
| Keys                                          | • House.               
|                                              | • Car.                 
|                                              | • Safety deposit box or post office box.  |
| A way to communicate                          | • Phone calling card.  
|                                              | • Cell phone.           
|                                              | • Address book.         |
| Medications                                   | • At least 1 month’s supply for all medicines you and your children are taking, as well as a copy of the prescriptions.  |
| A way to get by                               | • Jewelry or small objects you can sell, if you run out of money or stop having access to your accounts.  |
| Things to help you cope                      | • pictures.            
|                                              | • Keepsakes.           
|                                              | • Children’s small toys or books.  
|                                              | • Clothing.            |
Safety In Your Own Residence

When you make the decision to end an abusive relationship and you plan to stay in your residence, you will need to take other precautions. You may need to obtain a protective order or peace order, both of which are court documents that provide relief to women who are experiencing abuse. Your local District Court and/or local domestic violence agency can help you with this. All protective orders order an abuser to stop threatening or committing abuse. They also require an abuser to end all contact with the victim. However, a protective order does not guarantee your safety. In addition, there are other precautions you should take (SAMHSA, 2003):

- Change the locks on all doors and windows, and install or improve security to include better outside lighting.
- Purchase rope/chain ladders to permit escape from a second story window, if it becomes necessary.
- Talk to all childcare providers and schools about who has permission to pick up the children.
- Use your community domestic violence resources for legal advice.
- Cover the mailbox with brightly colored paper to make it easier for the police to find the house if you live in a rural area where only the mailbox can be seen from the street.
- Keep the protective or peace order with you at all times.
- Tell your neighbors or landlord that your partner no longer lives with you and ask them to call the police if they see him at your home.

Safety on the Job

IPV/DV doesn’t just occur in the home. According to the National Coalition Against Domestic Violence (NCADV, n.d.b):

- For women in 2003, the 2nd leading cause of death on the job was homicide.
- Of the approximately 1 million women who are stalked each year, about one quarter admit to missing work because of the stalking, on average 11 days per year.
- 65% of respondents in a recent survey reported that a co-worker had been harassed by an intimate partner.
- One study of female domestic violence victims were left without transportation when the abuser disabled their car or took the keys.

Healthcare providers should counsel patients that safety may be increased if her/his boss and coworkers were informed about the IPV/DV situation. Employers and coworkers may be able to provide needed assistance. If there is an Employee Assistance Program available through the employer, an appointment with a mental health professional can be helpful. There may be increased safety in having more people knowledgeable about and willing to assist in the patient’s safety (SAMHSA, 2003).

- Make sure that the victim’s workplace is listed on the protective order. Make sure that the employer and the security people at the workplace have copies. Providing a photo of the abuser may also be helpful.
- Review the safety of the parking lot or garage. Arrange for someone to walk with the victim to and from the parking lot and the office.
- Whenever possible, attempt to move to another, less visible space if the victim’s workplace: office or desk can be seen from the street or parking lot.
- Rearrange the work schedule of the victim, so that arrival and departure times vary.
- Add caller ID to the victim’s phone service and save all faxes and/or e-mails that may give legal proof that the abuser is disobeying the no-contact rule of the protection order.
• Review the safety of the childcare plan. Make sure the protective order includes all important addresses. This would also include the address of the schools and/or day care facilities attended by any children.

**Case Study #4. Rita (Continued)**

Since Rita and Toby moved in with her sister, Cliff has been calling her repeatedly on her cell phone and threatening her. He’s been to the house several times, pounding on the doors, trying to get into the house. She went to the police department to file an Order of Protection against Cliff, including limiting his ability to contact her by phone, mail or come anywhere near her and her son at her sister’s house, at work or at Toby’s school. She talked with her boss at work and provided a photo of Cliff, so that the receptionist will call the police if Cliff comes into the building. None of this has stopped Cliff. Yesterday when she went to the grocery store, Cliff was in the parking lot, he grabbed her arm and tried to make her get into his car. She screamed and tried to get away from him. Cliff only let go and left in his car when 2 men came over (they happened to be off duty police officers) and asked if she was ok. Today, Rita’s boss called her to let her know that Cliff had been seen walking outside the building and that the police had been called; Cliff left before they arrived. Her coworkers have answered several calls from Cliff, telling him that Rita is unable to come to the phone. Rita is shaken and scared, wondering when this was going to end.

**Guidelines for Intervening in Elder Abuse**

Currently there are no national best practice guidelines for intervening in elder abuse. Many of the interventions addressed in the best practice guidelines for IPV/DV have application to the issue of elder abuse, because of the vulnerability of the elder, additional human service and advocacy agencies may become involved.

Healthcare visits may be the only times victims leave their homes or are allowed out by the abuser. Because older adults do not usually self-report instances of elder abuse, the responsibility for identification, reporting, and intervention rests largely with healthcare professionals, social service agencies, and police departments (Sellas & Krause, 2006). Sellas & Krause (2006) have identified guidelines for intervening in elder abuse. They report that the American Medical Association recommends that physicians ask about abuse during routine healthcare visits with their elderly patients. These authors also report that there has been limited research in the area of elder abuse, limiting the research-supported recommendations for intervention.

Despite the limited research on interventions, the laws in Kentucky and in most other states are quite clear. Whenever elder abuse is suspected, it should be reported to the Department of Community Based Services and Adult Protective Services should investigate. Services can be offered to mitigate the situation or to remove the abused for the abusive environment.

**The Military and IPV/DV**

According to the National Coalition Against Domestic violence (NCADV) (n.d. c), in 2001:

• There were more then 18,000 incidents of spousal abuse reported to the Department of Defense’s Family Advocacy Program.
• 84% of these incidents involved physical abuse.
• 62% of the abusers were on active duty military.
• 66% of victims were identified as women, the civilian spouses of active duty personnel.
• Among active duty women, 30% reported an adult life-time prevalence of IPV/DV and 22% reported IPV/DV during active military duty.
Among Navy recruits, 54% of men and 40% of women have witness parental IPV/DV prior to their enlistment.

Legal Remedies for Protection from IPV/DV and Elder Abuse

Some states mandate the reporting of IPV/DV some authority such as the police. Only Kentucky requires reporting to the state Department for Community Based Services (DCBS), a statewide, county-based victim service agency. What this means is that in Kentucky mandatory reporting is actually the mandatory connecting of victims of IPV/DV with trained community ‘specialists’ who offer protection, information and advocacy in a safe, confidential manner.

State statutes also require all courts to provide 24-hour access to emergency protection orders. Violation of a protection order is a Class A misdemeanor. No contact orders are issued as a condition of release. Each court is also mandated to establish local protocols in domestic violence matters. The protocols must be submitted to the Kentucky Supreme Court for review.

Reporting of spouse and partner abuse from victims themselves, by the general public and by professionals has continued to increase over the years. The DCBS data identifies a concurrent increase in the reporting of domestic violence by professionals: law enforcement officers, physicians and other healthcare providers (Fritsch, 2002).

In a recent survey by the Domestic Violence Subcommittee of the Kentucky Medical Association (KMA) (Fritsch, 2002):

- 59% of physicians responding indicated that mandatory reporting needs to be in place, and
- 47% of physicians indicated they had reported spouse abuse.

Who Must Report (KRS 209.030)

Any person, including, but not limited to, physician, law enforcement officer, nurse, social worker, department personnel, coroner, medical examiner, alternate care facility employee, or caretaker, having reasonable cause to suspect that an adult has suffered abuse, neglect, or exploitation, shall report or cause reports to be made in accordance with the provisions of this chapter. Death of the adult does not relieve one of the responsibility for reporting the circumstances surrounding the death.

Investigation Process (KRS 209.030)

Upon receipt of a report, the Department for Social Services is required to notify the appropriate law enforcement agency, conduct an investigation of the allegation and offer protective services to the victim. Adult protective services differ from child protective services in that they are voluntary and may be refused by the adult victim. Department personnel may enter any health facility or health services licensed by the cabinet at any reasonable time to carry out the investigation, and may enter private premises with the permission of the adult or the caretaker.

Immunity (KRS 209.050060)

Anyone acting upon reasonable cause in the making of a report in good faith shall have immunity from any civil or criminal liability. Neither the husband-wife nor the psychiatrist-patient privilege shall be a ground for refusing to report known or suspected adult abuse.
Confidentiality (KRS 209.140)

All information obtained by the Department for Social Services in the course of an investigation under this chapter shall not be divulged to anyone except:

- Persons suspected of abuse, neglect or exploitation, provided that in such cases names of informants shall be withheld unless otherwise ordered by the court;
- Persons within the cabinet with a legitimate interest or responsibility related to the case;
- Other medical, psychological, or social service agency, or law enforcement agency with a legitimate interest in the case;
- Those persons so authorized by court order; and
- The alleged abused or neglected person.

Inappropriate disclosure of health information may violate patient/provider confidentiality, including the federal Healthcare Insurance Portability Act (HIPAA). As important, the inappropriate disclosure of suspected IPV/DV and elder abuse can threaten patient safety. Perpetrators who discover that a victim has sought care may retaliate with further violence. Employers, insurers, law enforcement agencies, and community members who discover abuse may discriminate against a victim or alert the perpetrator. It is imperative that policy, protocol, and practice surrounding the use and disclosure of health information regarding victims of IPV/DV and elder abuse should respect patient confidentiality and autonomy and serve to improve the safety and health status of victims of IPV/DV.

Emergency Protective Services (KRS 209.100)

A court may order protective services on an emergency basis if the court finds that the adult:

- Is in a state of abuse or neglect and an emergency exists;
- Is in need of protective services;
- Lacks the capacity to consent or refuse to consent to such services; and
- No person authorized by law or court order to give consent for the adult is available to consent to emergency protective services or such person refuses to give consent.

Penalty (KRS 209.990)

- Anyone knowingly or wantonly violating the provisions of KRS 209.030(2) shall be guilty of a Class B misdemeanor as designated in KRS 532.090. Each violation shall constitute a separate offense.
- Any caretaker who knowingly abuses or neglects an adult is guilty of a Class C felony.
- Any caretaker who wantonly abuses or neglects an adult is guilty of a Class D felony.
- Any caretaker who recklessly abuses or neglects an adult is guilty of a Class A misdemeanor.
- Any caretaker who knowingly exploits an adult, resulting in a total loss to the adult of more than three hundred dollars ($300) in financial or other resources, or both, is guilty of a Class C felony.
- Any caretaker who wantonly or recklessly exploits an adult, resulting in a total loss to the adult of more than three hundred dollars ($300) in financial or other resources, or both, is guilty of a Class D felony.
- Any caretaker who knowingly, wantonly, or recklessly exploits an adult, resulting in a total loss to the adult of three hundred dollars ($300) or less in financial or other resources, or both, is guilty of a Class A misdemeanor.
In Kentucky, a comprehensive response is aimed at elder abuse. It includes not only APS, but myriad partnering agencies including law enforcement, advocates, mental and physical health providers and courts. Local Coordinating Councils on Elder Abuse have expanded throughout the Commonwealth and the Cabinet for Health and Family Services has significantly expanded its staff dedicated to adult issues. Local Coordinating Councils are in all but nine (9) of the 120 counties.

In the Commonwealth of Kentucky, the Department for Community Based Services (DCBS) accepts all reports that allege physical abuse, sexual abuse, neglect, exploitation or mental injury of individuals of adults.

Reports not meeting the definition of adult may be reviewed to determine if the information or allegation meets acceptance criteria for General Adult Services or is appropriate for referral to other community partners for assistance.

Each report is considered for investigation or preventive services and when a report is accepted, the adult is offered services. Each level of intervention provides important services and preventive or protective services should be offered to each adult. If elder abuse is not substantiated, most APS agencies will work as necessary with other community agencies to obtain any social and health services that the older person needs (AOA, 2006). The older person has the right to refuse services offered by APS. The APS agency provides service only if the senior agrees or has been declared incapacitated by the court and a guardian has been appointed. The APS agency only takes such action as a last resort (AOA, 2006).

The Department also accepts reports alleging that an adult died as a result of abuse or neglect, including spousal homicide or homicide/suicide. These may include but are not limited to reports by law enforcement, a coroner or other sources; discovery of the death during an adult or child protective services investigation; or, reasonable cause to believe that a previous death was the result of abuse or neglect.

The APS agency screens calls for potential seriousness, and it keeps the information it receives confidential. If the agency decides the situation possibly violates state elder abuse laws, it assigns a caseworker to conduct an investigation (in cases of an emergency, usually within 24 hours). If the victim needs crisis intervention, services are available.

**Treatment for IPV/DV and Elder Abuse**

Treatment models exist for perpetrators of violence and for the victims of violence. A highly regarded model, the Duluth Domestic Violence Prevention Program (www.duluth-model.org), proposes a community-based intervention wherein safety for the victim is central. It aims to coordinate the efforts of the various agencies' involved in this complex issue to also make the victim's safety the main focus by facilitating each agencies own organizational and institutional procedures to promote the same goal.

Treatment occurs on the individual, family, community and societal levels. A coordinated effort must be achieved between law enforcement, the courts, probation, mental health and physical health care providers. Domestic Abuse Intervention Project in Duluth includes a 28-week education program of offenders. The program uses the curriculum *Creating a Process of Change for Men Who Batter* which they developed.

**Wheel of Equality**

The wheel below, also developed by the Duluth Domestic Violence Prevention Program, aims to change the unequal and violent dynamics to one in which both partners share equality and safety.
Violence against women does not just involve the victim and the perpetrator. These individuals live in a context that includes the community and the institutions that communities rely on. It is only through the coordinated efforts of the various community agencies that the issue of this violence will be addressed. Such institutions include: law enforcement, the courts, legislative action, adult protective services, advocacy groups, educational systems, healthcare systems, the media, religious institutions and employers. The National Center for Domestic and Sexual Violence (2005) has identified the ideal community response to IPV/DV. It includes multiple goals for many sub-groups in the community:

Interventions for men:

- Acknowledge that all men benefit from men’s violence.
- Actively oppose men’s violence.
- Use peer pressure to stop violence against women and children.
- Make peace, justice, and equality masculine virtues.
- Vigorously confront men who indulge in misogynistic behavior.
• Seek out and accept the leadership of women.

Interventions for the media:

• Educate the community about the epidemic of violence against women.
• Prioritize safety, equal opportunity, and justice for women and children over profit, popularity, and advantage.
• Expose and condemn patriarchal privilege, abuse, secrecy, and chauvinism.
• Cease the glorification of violence against women and children.

Interventions for the clergy:

• Conduct outreach within the congregation regarding domestic violence and provide a safe environment for women to discuss their experiences.
• Develop internal policies for responding to domestic violence.
• Speak out against domestic violence from the pulpit.
• Organize multi-faith coalitions to educate the religious community.
• Interact with the existing domestic violence intervention community.

Interventions for the educational system:

• Dialogue with students about violence in their homes, the dynamics of domestic violence, and how it’s founded on the oppression of women and the worship of men.
• Provide a leadership role in research and theoretical development that prioritizes gender justice, equal opportunity, and peace.
• Intervene in harassment, abuse, violence, and intimidation of girls and women in the educational system.

Interventions for the justice system:

• Adopt mandatory arrest policy for men who batter.
• Refer batterers exclusively to intervention programs that meet state or federal standards.
• Never offer delayed or deferred sentence options to batterers.
• Provide easily accessible protection orders and back them up.
• Incarcerate batterers for noncompliance with any aspect of their adjudication.

Interventions for employers:

• Condition batterers’ continuing employment on remaining nonviolent.
• Actively intervene against men’s stalking in the workplace.
• Support, financially and otherwise, advocacy and services for battered women and children.
• Continually educate and dialogue about domestic violence issues through personnel services.

Interventions for the government:

• Pass laws that: define battering by men as criminal behavior without exception; vigorously and progressively sanction men’s battering behavior; create standards for accountable batterer-intervention programs; and require coordinated systems of intervention in domestic violence.
• Provide ample funding to accomplish the goal of eradicating domestic violence.

Interventions for social service providers:
• Become social change advocates for battered women.
• Refer batterers to accountable intervention programs.
• Stop blaming batterers' behavior on myths such as drugs and alcohol, family history, anger, provocation, "loss of control," etc.
• Design and deliver services that are sensitive to women and children's safety needs.
• Minimize how batterers use them to continue battering their families.

Conclusion

Domestic violence, intimate partner violence, elder abuse, wife abuse, battering, spousal abuse...whatever you call it, it's a crime and it is a serious public health issue for individuals, families and societies. Because our patriarchal society continues to view women as "less than", the value of women in our society, while having made great gains over the last 50 years, continues to promote that men have more worth than do women. For example, according to the US Bureau of Labor Statistics, in 2004, women's median weekly earnings were 80 percent of men's (USDOL-BLS, 2005). While this is an improvement, much still needs to be done to combat the premise that one person has more value than another, that one person has power and control over another.

The abuse discussed in this course has focused on IPV/DV and elder abuse, both of which most frequently occur with women as the victims and men as the perpetrators. There are many interrelated factors that contribute to this significant problem. Again, the learner is cautioned to remember that although statistically this is the most common way that abuse occurs, it is important to note that women can also be the perpetrators and men can be the victims; abuse and neglect occurs in same-sex relationships at approximately the same frequency.

Healthcare providers can help alleviate the immediate suffering and significant long-term impact of IPV/DV and elder abuse by increasing their knowledge and skill regarding these issues by engaging in training such as this course, screening for IPV/DV and elder abuse, identifying IPV/DV and elder abuse when it occurs and providing sound, best-practice interventions. The safety and welfare of the victim is critical.
Appendix A. Important Phone Numbers

If you are in immediate danger, call 911

Kentucky Adult and Child Abuse Reporting Hotline
1-800-752-6200

Kentucky Spouse Abuse Hotline
1-800-544-2022

Kentucky Elder Abuse Hotline
1-800-752-6200

Kentucky Council on Child Abuse Parent Helpline
1-800-432-9251

Kentucky Long Term Care Ombudsman
1-800-372-2991
TTY (for hearing impaired)
1-800-627-4702

Kentucky Attorney General's Patient Abuse Tip Line
1-877-ABUSE TIP (1-877-228-7384)

National Domestic Violence Hotline
1-800-799-SAFE (7233)

National Sexual Assault Hotline
1-800-656-4673
Appendix B. If You Think You are Being Stalked

Take these steps:

- If you are in immediate danger, find a safe place to go, like a police station, friend’s house, domestic violence shelter, or a public area. If you can’t get out of danger, but can get to a phone, call 911.

- If you think you could be in danger, get a restraining order. A restraining order requires the stalker to stay away from you and not contact you. Talk to a victim advocate or attorney in your area to see how to get a restraining order and if an arrest can be made if the stalker violates the order.

- File a complaint with the police. Tell them about all threats.

- Write down every incident that happens. Include the time, date, and other important information.

- Keep videotapes, audiotapes, answering machine/voicemail messages, photos of property damage, and letters.

- Contact support systems to help you, including domestic violence and rape crisis hotlines, domestic violence shelters, the district attorney’s office, police, counseling services, and support groups. Make sure to also keep these numbers handy, just in case you need them.

- Tell important people about the stalking problem, including the police, your employer, and family, friends, and neighbors (USDHHS, 2005c).
Appendix C. Protecting Yourself from Date Rape Drugs

Protection from Date Rape Drugs

Protect yourself from being a victim (USDHHS, 2004):

- Don't accept drinks from other people.
- Open containers yourself.
- Keep your drink with you at all times, even when you go to the bathroom.
- Don't share drinks.
- Don't drink from punch bowls or other large, common, open containers. They may already have drugs in them.
- Don't drink anything that tastes or smells strange. Sometimes, GHB tastes salty.
- Have a non-drinking friend with you to make sure nothing happens.

If you think that you have been drugged and raped:

- Go to the police station or hospital right away.
- Get a urine (pee) test as soon as possible. The drugs leave your system quickly. Rohypnol stays in the body for several hours, and can be detected in the urine up to 72 hours after taking it. GHB leaves the body in 12 hours.
- Don't urinate before getting help.
- Don't douche, bathe, or change clothes before getting help. These things may give evidence of the rape.
- You also can call a crisis center or a hotline to talk with a counselor. One national hotline is the National Domestic Violence Hotline at 800-799SAFE or 800-787-3224 (TDD). Feelings of shame, guilt, fear and shock are normal. It is important to get counseling from a trusted professional.
## Appendix D. Safety Plan

### Safety during a violent incident

I can use some or all of the following strategies:

A. If I have/decide to leave my home, I will go to _________________________________.

B. I can tell __________________ about the violence and request they call the police if they hear suspicious noises coming from my house.

C. I can teach my children how to use the telephone to contact the police.

D. I will use __________________ as my code word so someone can call for help.

E. I can keep my purse/car keys ready at __________________________ in order to leave quickly.

F. I will use my judgment and intuition. If the situation is very serious, I can give my partner what he/she wants to calm him/her down. I have to protect myself until I/we are out of danger.

### Safety when preparing to leave

I can use some or all of the following safety strategies:

A. I will keep copies of important documents, keys, clothes and money at ___________________________.

B. I will open a savings account by __________________________ to increase my independence.

C. Other things that increase my independence include:

D. I can keep change for my phone calls on me at all times. I understand that if I use my telephone credit card, the telephone bill will show my partner those numbers that I called after I left.

E. I will check with ____________________________ and my advocate ____________________________ to see who would be able to let me stay with them or lend me some money.

F. If I plan to leave, I won’t tell my abuser in advance face to face, but I will call or leave a note from a safe place.

### Safety in my own residence

Safety measures I can use include:

A. I can change the locks on my doors and windows as soon as possible.

B. I can replace wooden doors with steel/metal doors.

C. I can install additional locks, window bars, poles to wedge against doors, and electronic systems, etc.

D. I can install motion lights outside.

E. I will teach my children how to make a collect call to ____________________________ if my partner takes the children.

F. I will tell people who take care of my children that my partner is not permitted to pick up my children.

G. I can inform ____________________________ that my partner no longer resides with me and they should call the police if he is observed near my residence.

### Safety with a protection order

The following are steps that help the enforcement of my protection order:

A. Always carry a certified copy with me and keep a photocopy.

B. I will give my protection order to police departments in the community where I work and live.

C. I can get my protection order to specify and describe all guns my partner may own and authorize a search for removal.
Appendix E. DISCHARGE INSTRUCTIONS

If you are currently being abused...

Are you here as a result of someone hitting or threatening you—a spouse, boyfriend, lover, relative or someone you know? Have you been sexually abused by someone you know? As you read this, you may be feeling confused, frightened, sad, angry or ashamed. You are not alone! Unfortunately, what happened to you is very common. Domestic violence does not go away on its own. It tends to get worse and more frequent with time. There are people who can help you. If you want to begin talking about the problem, need a safe place to stay or want legal advice—call one of the agencies listed on the back of this instruction sheet today.

While still at the clinic...

- Think about whether it is safe to return home. If not, call one of the resources listed on the back of this instruction sheet or stay with a friend or relative.
- You have received instructions on caring for your injuries and taking medications prescribed. Remember, if you have received tranquilizers they may help you rest but they won’t solve the problem of battering.
- Battering is a crime and you have the right to legal intervention. You should consider calling the police for assistance (see information on back of this sheet). You may also obtain a court order prohibiting your partner from contacting you in any way (including in person or by phone). Contact a local DV program or an attorney for more information.
- Ask the doctor or nurse to take photos of your injuries to become part of your medical record.

When you get home...

- Develop an “exit plan” in advance for you and your children. Know exactly where you could go even in the middle of the night—and how to get there.
- Pack an “overnight bag” in case you have to leave home in a hurry. Either hide it yourself or give it to a friend to keep for you.
- Pack toilet articles, medications, an extra set of keys to the house and car, an extra set of clothing for you and your children, and a toy for each child.
- Have extra cash, loose change for phone calls, checkbook, or savings account book hidden or with a friend.
- Pack important papers and financial records (the originals or copies), such as social security cards, birth certificates, green cards, passports, work authorization and any other immigration documents, voter registration cards, medical cards and records, drivers license, rent receipts, title to the car and proof of insurance, etc.
- Notify your neighbors if you think it is safe.
Resources

The Kentucky domestic violence programs began as safe shelters for victims of domestic violence, but as understanding of the complex issues facing victims of domestic violence continues to grow, domestic violence programs are increasingly committed to providing strong client support services. In addition to providing a safe, secure environment for victims/survivors and their children, programs now also offer a variety of support services to residents and non-residents including:

- Legal/Court advocacy.
- Case management.
- Safety planning.
- Support groups.
- Individual counseling.
- Housing assistance.
- Job search.
- Children's groups.

Programs are also working with clients on resume writing, improving basic job skills, parenting, budgeting, and drug and alcohol issues.

The programs are also committed to preventing future domestic violence through public awareness and community education efforts. Domestic violence programs are working with schools, local professionals, and community groups to increase understanding of domestic violence issues.

(1) **Purchase Area Development District**

Includes the Western Kentucky counties of Ballard, Calloway, Carlisle, Fulton, McCracken, Graves, Marshall and Hickman; including the communities of Paducah, Murray, Mayfield and Benton.

**Merryman House**
Crisis Line: (800) 585-2686
Business Line: (270) 443-6282

(2) **Pennyrile Area Development District**

Includes the Western Kentucky counties of Livingston, Crittendon, Lyon, Caldwell, Trigg, Hopkins, Christian, Muhlenberg and Todd; including the communities of Hopkinsville, Madisonville, Cadiz and Greenville.

**Sanctuary, Inc.**
Crisis Line: (800) 766-0000
Business Line: (270) 885-4572

(3) **Green River Area Development District**

Includes the Western Kentucky counties of Union, Webster, Henderson, Daviess, McLean, Ohio and Hancock; including the communities of Henderson, Owensboro, Beaver Dam and Providence.
OASIS
Crisis Line: (800) 882-2873
Business Line: (270) 685-0260

(4) Barren River Area Development District

Includes the South Central Kentucky counties of Logan, Butler, Warren, Simpson, Allen, Monroe, Barren, Metcalfe, Hart and Edmonson; including the communities of Bowling Green, Glasgow, Horse Cave and Russellville.

BRASS
Crisis Line: (800) 928-1183
Business Line: (270) 781-9334

(5) Lincoln Trail Area Development District

Includes the West Central Kentucky counties of Breckenridge, Grayson, Hardin, Meade, Larue, Nelson, Washington and Marion counties; including the communities of Springfield, Lebanon, Bardstown and Elizabethtown.

Springhaven Inc.
Crisis Line: (800) 767-5838
Business Line: (270) 765-4057

(6) KIPDA Area Development District

Includes the Louisville Metro Area counties of Trimble, Oldham, Shelby, Jefferson, Bullitt and Spencer; including the communities of Louisville, Shelbyville, Taylorsville and LaGrange.

The Center for Women and Families
Crisis Line: (877) 803-7577
Business Line: (502) 581-7200

(7) Northern Kentucky Area Development District

Includes the Northern Kentucky counties of Carroll, Gallatin, Owen, Grant, Pendleton, Boone, Kenton and Campbell counties; including the communities of Carrollton, Warsaw, Owenton, Dry Ridge, Falmouth, Covington and Florence.

Women's Crisis Center
Crisis Line: (800) 928-3335 or (859) 491-3335
Business Line: (859) 655-2650

(8) Bluegrass Area Development District

Includes the Central Kentucky counties of Franklin, Anderson, Mercer, Boyle, Lincoln, Garrard, Jessamine, Woodford, Scott, Fayette, Madison, Estill, Powell, Clark, Bourbon, Nicholas and Harrison counties; including the communities of Frankfort, Harrodsburg, Danville, Richmond, Lexington, Cynthiana, Paris and Winchester.
Bluegrass Domestic Violence Program
Crisis Line: (800) 544-2022
Business Line: (859) 233-0657

(9) Lake Cumberland Area Development District
Includes the South Central Kentucky counties of Green, Taylor, Adair, Cumberland, Clinton, Russell, Casey, Pulaski, Wayne and McCreary; including the communities of Campbellsville, Columbia, Jamestown, Liberty and Somerset.

Bethany House Abuse Shelter, Inc.
Crisis Line: (800) 755-2017
Business Line: (606) 679-1553

(10) Cumberland Valley Area Development District
Includes the South Eastern Kentucky counties of Rockcastle, Jackson, Laurel, Clay, Knox, Whitley, Bell and Harlan; including the communities of Mt. Vernon, McKee, London, Manchester, Williamsburg and Middlesboro.

Family Life Abuse Center
Crisis Line: (800) 755-5348
Business Line: (606) 256-9511 or (606) 256-2724

(11) Kentucky River Area Development District
Includes the South Eastern Kentucky counties of Wolfe, Lee, Owsley, Breathitt, Knott, Letcher, Perry and Leslie; including the communities of Campton, Booneville, Jackson, Hyden, Hazard and Whitesburg.

LKLP Safe House
Crisis Line: (800) 928-3131
Business Line: (606) 439-1552

(12) Big Sandy Area Development District
Includes the Eastern Kentucky counties of Magoffin, Johnson, Floyd, Martin and Pike; including the communities of Salyersburg, Prestonsburg, Paintsville and Pikeville.

Big Sandy Family Abuse Center
Crisis Line: (800) 649-6605
Business Line: (606) 285-9079

(13) Gateway Area Development District
Includes the Eastern Kentucky counties of Montgomery, Bath, Menifee, Rowan and Morgan; including the communities of Mt. Sterling, Owingsville, Frenchburg, Morehead and West Liberty.

D.O.V.E.S.
Crisis Line: (800) 221-4361
Business Line: (606) 784-6880
(14) **Buffalo Trace Area Development District**

Includes the North Eastern Kentucky counties of Bracken, Robertson, Mason, Fleming and Lewis; including the communities of Augusta, Maysville, Flemingsburg and Vanceburg.

**Women's Crisis Center**
Crisis Line: (800) 928-6708 or (606) 564-6708
Business Line: (859) 655-2650

(15) **FIVCO Area Development District**

Includes the North Eastern Kentucky counties of Greenup, Boyd, Carter, Elliott and Lawrence; including the communities of Ashland, Catlettsburg and Grayson.

**Safe Harbor, Inc.**
Crisis Line: (800) 926-2150
Business Line: (606) 329-9304

**Additional Shelter Programs in Kentucky**

**Resurrection Home**, serving Lee and Owsley counties
Crisis Line: (606) 464-8481
Crisis Line: (800) 928-4638 in Owlsley County

**The Caring Place, Inc.**, serving Washington, Marion and Nelson counties
Crisis Line: (800) 692-9394
Business Phone: (270) 692-9300

**Safe Place**, serving Pike County
Crisis Line: (800) 292-7840
Business Phone: (606) 437-9587

**Domestic Violence Organizations**

**Family Violence Prevention Fund (FVPF)** is a national non-profit organization that focuses on domestic violence education, prevention and public policy reform. 383 Rhode Island St., Suite 304, San Francisco, CA 94103-5133 phone: (415) 252-8900 TTY: (800) 595-4889 fax: (415) 252-8991 e-mail: fund@endabuse.org website: www.endabuse.org

**National Coalition Against Domestic Violence (NCADV)** is dedicated to the empowerment of battered women and their children and is committed to the elimination of personal and societal violence in the lives of battered women and their children. PO Box 18749, Denver, CO 80218 phone: (303) 839-1852 fax: (303) 831-9251 website: www.ncadv.org

**Pennsylvania Coalition Against Domestic Violence and National Resource Center (PCADV)** is a private, nonprofit membership organization and is dedicated to ending domestic violence and helping battered women and their children reestablish physical, social, and economic dignity. 6400 Flank Drive, Suite 1300, Harrisburg, PA 17112 phone: (800) 932-4632 fax: (717) 671-8149 website: www.pcadv.org
The National Network to End Domestic Violence (NNEDV) is a membership and advocacy organization of state domestic violence coalitions, allied organizations and supportive individuals and is a leading voice among domestic violence advocates in public policy. 660 Pennsylvania Ave., SE, Suite 303, Washington D.C. phone: (202) 543-5566 email: nnedv@bellatlantic.net website: www.nnedv.org

Sacred Circle: The National Resource Center to End Violence Against Native Women is dedicated to the actions that promote the sovereignty and safety of native women. 722 St. Joseph St., Rapid City, SD 57701 phone: (605) 341-2050 (877) RED ROAD (733-7623).

Asian & Pacific Islander Institute on Domestic Violence strives to eliminate domestic violence in Asian and Pacific Islander communities by increasing awareness about the extent and depth of the problem making culturally specific issues visible; strengthening community models of prevention and intervention; identifying and expanding resources; informing and promoting research and policy; and deepening understanding and analysis of the issues surrounding violence against women. 942 Market Street, Suite 200, San Francisco, CA 94102 phone: (415) 954-9964 fax: (415) 954-9999 website: www.apiahf.org

Institute on Domestic Violence in the African American Community provides an interdisciplinary vehicle and forum by which scholars, practitioners, and observers of family violence within the African American community will have the continual opportunity to articulate their perspectives on family violence through research findings, the examination of service delivery and intervention mechanisms, and the identification of appropriate and effective responses to prevent/reduce family violence in the African American community. 290 Peters Hall 1404 Gortner Avenue, St. Paul, MN 55108-6142 phone: (877) NIDVAAC (643-8222) fax: (612) 624-9201 website: www.dvinstitute.org

National Latino Alliance for the Elimination of Domestic Violence is a network of nationally recognized Latina and Latino advocates, community activists, practitioners, researchers, and survivors of domestic violence working together to promote understand, sustain dialogue, and generate solutions to move toward the elimination of domestic violence in Latino communities, with an understanding of the sacredness of all relations and communities. P.O. Box 322086, Fort Washington, New York, NY 10032 phone: (800) 342-9903 fax: (800) 216-2404 website: www.dvalianza.org

Clinical Materials for the Healthcare Setting

The National Health Resource Center on Domestic Violence a project of the FVPF, provides support to thousands of health care professionals, policy makers and domestic violence advocates through its four main program areas: model training strategies, practical tools, technical assistance, and public policy. 383 Rhode Island St., Suite 304, San Francisco, CA 94103-5133 phone: (888) Rx-ABUSE TTY: (800) 595-4889 fax: (415) 252-8991 e-mail: health@endabuse.org website: www.endabuse.org/health

Physicians for a Violence-free Society (PVS) is a national non-profit organization that helps physicians and other health professionals improve their response to victims of violence, particularly IPV through educational programs, written materials and web-based resources. 160 14th Street, San Francisco, CA 94103 phone: (415) 621-3584 fax: (415) 621-3438 e-mail: pvs@pvs.org website: www.pvs.org

Alaska Family Violence Prevention Project specializes in training for health care and service providers, provides articles and curricula in PowerPoint that can be
downloaded, acts as a clearinghouse of education materials
website: http://www.hss.state.ak.us/dph/chems/injury_prevention/akfvpp/

**California Medical Training Center** trains medical professionals to effectively identify, evaluate and treat victims of child abuse and neglect, sexual assault, domestic violence, and elder and dependent adult abuse and offers comprehensive domestic violence curriculum targeted for a continuum of learners. 3300 Stockton Boulevard, Sacramento, CA 95820 e-mail: mtc@ucdmc.ucdavis.edu website: www.calmtc.org

**Websites of Interest for Adolescents**

**The Empower Program** works with youth to end the culture of violence. 1312 8th Street, Washington, DC 20001 phone: (202) 882-2800 fax: (202) 234-1901 e-mail: empower@empowered.org website: www.empowered.org

**Girls Incorporated National Resource Center** is a national youth organization dedicated to inspiring all girls to be strong, smart and bold. 441 West Michigan Street, Indianapolis, IN 46202 phone: (317) 634-7546 fax: (317) 634-3024 e-mail: girlsinc@girls-inc.org website: www.girlsinc.org

**Liz Claiborne Inc.** produces “A Teen’s Handbook” and web pages to help teens learn about dating violence by providing facts, guidance and resources. To order a free handbook, phone: (800) 449-STOP (7867) website: www.lizclaiborne.com/lizinc/lizworks/women/handbook.asp#teen

**Youth Resource** website created for GLBTQ youth to promote sexual health website: www.youthresource.com

**Lesbian, Gay, Transgendered, Bisexual, Queer (LGBTQ)**

**Community United Against Violence (CUAV)** is a 20-year old multicultural organization working to end violence against and within lesbian, gay, bisexual, transgender and queer/questioning (LGBTQ) communities. The Love & Justice Project aims to lead the discussion on positive communication skills, consensual sexuality, partnership decision making and naming abusive behavior in LGBTQ youth relationships by building bridges and community resources between LGBTQ youth and elders. 973 Market St., #500, San Francisco, CA 94103 phone: (415) 777-5500 fax: (415) 777-5565 24 Hr. Support Line: (415) 333-HELP (4357) e-mail: cuav@aol.com website: www.cuav.org

**Parents, Families, and Friends of Lesbians and Gays (PFLAG)** is a national organization that promotes the health and well-being of gay, lesbian, bisexual and transgendered persons, their families and friends. Their web site provides users with information on local chapters, advocacy and support information and other resources that support the family and friends of gays and lesbians. 1726 M Street, NW, Suite 400, Washington, DC 20036 phone: (202) 467-8180 fax: (202) 467-8194 e-mail: info@pflag.org website: www.pflag.org

**Gay Men’s Domestic Violence Project** is a grassroots, non-profit organization in Boston providing community education and direct services for clients. GMDVP offers shelter, guidance, and resources to allow gay, bisexual, and transgender men in crisis to remove themselves from violent situations and relationships GMDVP, PMB 131, 955 Mass Ave. Cambridge, MA 02139 fax: (617) 354-6072 phone: (617) 354-6056 crisis: (800) 832-1901 toll-free: (800) 832-1901 website: www.gmdvp.org

**Network for Battered Lesbians and Bisexual Women** was formed to address
battering in lesbian, bisexual women’s, and transgender communities. POB 6011 Boston, MA 02114 phone/TTY: (617) 695-0877 hotline/TTY: (617) 423-7233 website: www.thenetworklared.org

The Northwest Network provides support and advocacy for bisexual, transgender, lesbian and gay survivors of abuse and dating violence. P.O. Box 20398, Seattle, Washington 98102 phone: (206) 568-7777 TTY: (206) 517-9670 website: www.nwnetwork.org

The Survivor Project expanding access to sex/gender variant survivors of domestic violence. P.O. Box 40664, Portland, Oregon 97240 phone: (503) 288-3191 email: info@survivorproject.org website: www.survivorproject.org

Anti-Violence Project serves LGTB & HIV-positive and others affected by violence. 240 West 35th St., Suite 200, New York, NY 10001 24-hour bi-lingual Hotline: (212) 714-1141 TTY: (212) 714-1134 website: www.avp.org

Websites of Interest for Male Victims of Domestic and Sexual Violence

Menweb information for battered men on how to cope and the steps they should take, as well as other resources. website: http://www.batteredmen.com/

National Organization on Male Sexual Victimization committed to prevention, treatment & elimination of all forms of sexual victimization of boys and men website: www.nomsu.org

Teen Pregnancy

American College of Obstetricians and Gynecologists (ACOG) has a membership of 40,000 physicians and is the nation's leading group of professionals providing health care for women. ACOG’s website provides adolescent sexual assault assessment tools as well as other teen pregnancy materials. To request free copies of their educational bulletins, call: (202) 638-5577 or e-mail: violence@acog.org ACOG, 409 12th Street, SW, PO Box 96920 Washington, DC 20024 phone: (202) 863-2487 fax: (202) 484-3917 e-mail: adolphth@acog.org website: www.acog.org

Sexual Assault

Center for the Prevention of Sexual and Domestic Violence is an interreligious educational resource addressing issues of sexual and domestic violence whose goal is to engage religious leaders in the task of ending abuse, and to serve as a bridge between religious and secular communities. 936 North 34th St., Suite 200, Seattle, WA 98103 phone: (206) 634-1903 fax: (206) 634-0115 e-mail: cpsdv@cpsdv.org website: www.cpsdv.org

Rape Abuse & Incest National Network (RAINN) (see “Hotlines”)

Sexual Assault Resource Service (SARS) is designed for nursing professionals involved in providing evaluations of sexually abused victims. SARS’ website provides information and technical assistance to individuals and institutions interested in developing new SANE-SART programs or improving existing ones. website: www.sane-sart.com

Elder Abuse
NCEA is a resource for public and private agencies, professionals, service providers, and individuals interested in elder abuse prevention information, training, technical assistance, and research.

Eldercare Locator is sponsored by the Administration on Aging (AoA). If you know the address and ZIP code of the older person being abused, Eldercare Locator can refer you to the appropriate agency in the area to report the suspected abuse. 1-800-677-1116.

Animal Cruelty and Family Violence

The Humane Society of the United States, through its First Strike campaign, is dedicated to raising public and professional awareness about the connection between animal cruelty and family violence. 2100 L Street, NW, Washington, DC 20037 phone: (301) 258-3076; toll-free (888) 213-0956 fax (301) 258-3074 e-mail: firststrike@hsus.org website: www.hsus.org/firststrike

Other Websites of Interest

American Academy of Pediatrics: www.aap.org

American College of Emergency Physicians: www.acep.org

American College of Nurse Midwives: www.acnm.org

American College of Obstetricians and Gynecologists: www.acog.org

American Medical Association: www.ama-assn.org

American Medical Women's Association: www.amwa-doc.org

American Psychological Association: www.apa.org

Association of Traumatic Stress Specialists: http://www.atss-hq.com

Battered Women and Their Children: http://hosting.uaa.alaska.edu/afhrm1/wacan

Child Witness to Violence Project at Boston Medical Center: www.childwitnessstoviolence.org

International Association of Forensic Nurses: www.forensicnurse.org

Johns Hopkins University School of Nursing: www.son.jhmi.edu

Massachusetts Medical Society: www.massmed.org

Men Stopping Violence: www.menstoppingviolence.org
National Sexual Violence Resource Center: www.nsvor.org

Society of Academic Emergency Medicine: www.saem.org

Trafficking Information and Referral Hotline at 1.888.3737.888.

This hotline will help you determine if you have encountered victims of human trafficking, will identify local resources available in your community to help victims, and will help you coordinate with local social service organizations to help protect and serve victims so they can begin the process of restoring their lives. For more information on human trafficking visit www.acf.hhs.gov/trafficking.

National Guideline Clearinghouse

The National Guideline Clearinghouse (NGC) is a comprehensive database of evidence-based clinical practice guidelines and related documents. NGC is an initiative of the Agency for Healthcare Research and Quality (AHRQ), U.S. Department of Health and Human Services. NGC was originally created by AHRQ in partnership with the American Medical Association and the American Association of Health Plans (now America's Health Insurance Plans [AHIP]).

The NGC mission is to provide physicians, nurses, and other health professionals, health care providers, health plans, integrated delivery systems, purchasers and others an accessible mechanism for obtaining objective, detailed information on clinical practice guidelines and to further their dissemination, implementation and use. Website: www.guidelines.gov.

References


Kentucky State Mandated Domestic Violence/Intimate Partner Violence and Elder Abuse: Applying Best Practice Guidelines

Test

1. Intimate partner violence/domestic violence (IPV/DV) is best conceptualized as:
   A. A public health problem, impacting large numbers of the population.
   B. A family problem, best dealt with within the family.
   C. A reportable crime in Kentucky regardless of whether or not a weapon was used in the abuse.
   D. All of the above.

2. The 4 main types of IPV/DV, according to Saltzman and colleagues, are:
   A. Stalking, psychological violence; neglect and physical violence.
   B. Physical violence, sexual violence; stalking; and emotional violence.
   C. Physical violence; sexual violence; threats of physical and sexual violence; emotional and psychological violence.
   D. None of the above.

3. The state of Kentucky defines domestic violence and abuse as:
   A. Physical injury, serious physical injury, sexual abuse, assault, or the infliction of fear of imminent physical injury, serious physical injury, sexual abuse, or assault between family members or members of an unmarried couple.
   B. Family member means a spouse, previous spouse, a parent, a child, a stepchild, or any other person related by consanguinity in the second degree. “Member of an unmarried couple” means each member of an unmarried couple which allegedly has a child in common, any children of that couple, or member of an unmarried couple who are living together or have previously lived together.
   C. The state definition of domestic violence only includes persons who are currently living together or who lived together in the past unless they share a common child, regardless of sex.
   D. All of the above.

4. IPV/DV tends to be a chronic problem, particularly in Kentucky. While the national lifetime prevalence rate of IPV/DV among women was 25.5%, or 1 in 4 women, the lifetime prevalence for IPV/DV among women in Kentucky is 36.6%, or 1 in 3 women.
   A. True.
   B. False.

5. According to the Centers for Disease Control and Prevention (CDC), IPV/DV results in nearly 2 million injuries and 1,300 deaths nationwide every year.
   A. True.
   B. False.
6. IPV/DV results in multiple consequences for victims, families and societies. Acute and chronic consequences for the victim include:
   A. Physical injuries and conditions.
   B. Emotional and psychological sequelae, which may lead to high-risk behavior.
   C. Social and economic consequences.
   D. All of the above.

7. Risk factors for IPV/DV victimization include all the following EXCEPT:
   A. Witnessing or experiencing violence as a child.
   B. Economic security.
   C. Weak community sanctions against IPV/DV such as police being unwilling to intervene.
   D. Dominance and control by one partner in the relationship.

8. According to the best-practice guidelines discussed in this course, it is assessment for IPV/DV should occur:
   A. Only with pregnant women at their first prenatal visit.
   B. Routinely regardless of the presence or absence of indicators of abuse.
   C. Whenever the patient discloses the violence.
   D. Only in the company of the alleged abuser.

9. In the RADAR method discussed in this course, healthcare providers can initiate the subject of IPV/DV by asking any of the following EXCEPT:
   A. "Because violence is so common in many women's lives, I've begun to ask about it routinely."
   B. "You're not the victim of violence at home, are you?"
   C. "Are you in a relationship in which you have been physically hurt or threatened?"
   D. "Have you ever been hit, kicked or punched by your partner?"

10. In the guidelines discussed in this course, choose the best interventions to be used in situations of IPV/DV:
    A. Provide information, the means to achieve safety for the victim.
    B. Encourage the victim to leave the abuser immediately.
    C. Provide validation; provide information; respond to safety issues; and make referrals for further intervention or follow-up.
    D. Remind the victim that she/he plays a part in perpetuating the abuse going.

11. In Kentucky, the legal definition of an adult, discussed in this course, is a person 18 years or older who, due to mental or physical dysfunction, may be in need of protective services, as well as any person without regard to age who is the victim of abuse or neglect inflicted by a spouse.
    A. True.
    B. False.

12. In Kentucky, the forms of elder abuse are: Abuse, mental injury, neglect, and exploitation.
    A. True.
    B. False.
13. Neglect can take a number of forms. According to Kentucky law discussed in this course, each of the following is considered neglect EXCEPT:

A. Spouse/partner neglect.
B. Caretaker neglect.
C. Social neglect.
D. Self-neglect.

14. Any caretaker who knowingly abuses or neglects an adult is guilty of a Class C felony, as per KRS 209.990.

A. True.
B. False.

15. It is a requirement in Kentucky that physicians, law enforcement officers, nurses, social workers, coroner, medical examiner, employees of alternate care facilities, or caretakers, as well as Department of Social Services personnel must report any suspicion that an adult has suffered abuse, neglect or exploitation.

A. True.
B. False.