

Recommendations for Suicide Prevention Hotlines on Responding to Intimate Partner Violence

National Center on Domestic Violence, Trauma & Mental Health

*in Collaboration with: The National Domestic Violence Hotline,
The National Suicide Prevention Lifeline, and The University of
Rochester Laboratory of Interpersonal Violence and Victimization*

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NATIONAL
Center on
Domestic Violence, Trauma & Mental Health



The National Center on Domestic Violence, Trauma & Mental Health (NCDVTMH) is one of four Special Issue Resource Centers funded by the U.S. Department of Health and Human Services Administration on Children and Families, Family Violence Prevention and Services Program. NCDVTMH's mission is to develop and promote accessible, culturally relevant, and trauma-informed responses to domestic violence and other lifetime trauma so that survivors and their children can access the resources that are essential to their safety and well-being. Our work is survivor defined and rooted in principles of social justice.

NCDVTMH provides a comprehensive array of training, consultation and resources to support domestic violence and sexual assault advocates and their partners in the health, mental health, substance abuse, legal and child welfare fields as well as policymakers and government officials in improving agency and system responses to survivors of domestic violence and other trauma.

For more information, see WWW.NATIONALCENTERDVTRAUMAMH.ORG

Introduction

This document provides guidance for suicide prevention crisis centers on recognizing and responding to intimate partner violence (IPV) in the context of suicide prevention and other crisis calls. In addition to background information on the relationship between IPV and suicide, this document provides recommendations for suicide prevention hotlines on how to prepare their organizations to respond to IPV, and practical suggestions and tools for crisis line staff on screening, risk assessment, safety planning, and referral for callers who are experiencing IPV.

The recommendations presented in this document complement the National Suicide Prevention Lifeline's Best Practices for Helping Callers, and are designed so that they can be easily incorporated into existing suicide prevention and crisis assessment and response protocols.

Recommendations include:

- A supportive approach (good contact, collaborative problem solving, active listening);
- Assessment of risk (harm to self, harm to others, harm from an intimate partner);
- Assisting callers at imminent risk (active engagement, safety planning, active rescue); and
- Continuity of care (developing partnerships with community domestic violence (DV) programs and hotlines, linking to DV resources).

Approaches to safety, confidentiality, mandatory reporting, and active rescue differ to some extent in the context of IPV, and will be addressed specifically in this document. The term intimate partner violence or IPV is used throughout the document except when referring to domestic violence programs (DV) and services.

How this Document is Organized

This document contains two Sections:

Section One provides a basic overview of IPV, especially as it relates to suicide risk, and outlines key concepts that should be considered when developing a response to callers for whom IPV is a concern. Specifically, this section outlines:

1. The prevalence of IPV both in the general population and in specific communities, the heightened risk for suicide among survivors of IPV, the potential relationship between a caller's suicidal thoughts and abuse they may be experiencing, and the rationale for incorporating IPV assessment and response as a component of suicide prevention hotline calls;

2. Key concepts for crisis centers to consider in developing a response to IPV, with attention to the underlying dynamics of IPV and the multiple forms it can take, as well as privacy and confidentiality considerations specific to IPV;
3. Guidance for crisis center administrators on preparing their organizations to address IPV, including policies and practices that can be put in place prior to implementing these guidelines (e.g., regular staff training, work place safety policies, policies for staff who may be victims or perpetrators of IPV, and partnerships with local, state and national DV organizations and hotlines); and
4. The importance of incorporating a culturally responsive, trauma-informed approach for working with survivors of IPV and for ensuring that crisis line staff have the supports they need to do this work effectively and compassionately, while maintaining individual and organizational balance and well-being.

Section Two offers practical suggestions for engaging callers, incorporating questions about IPV-related risk, assisting with immediate safety, and providing referrals to community and other DV resources. This section also offers questions and responses to consider if a caller discloses abuse and is not in immediate danger, including recommendations for more in-depth conversations about IPV, ongoing risk, and collaborative safety planning. The suggestions offered in this section are designed to be used in conjunction with regular training on IPV and in partnership with local DV programs; state, territory and Tribal DV coalitions and hotlines; the National Domestic Violence Hotline and the Stronghearts Native Helpline; and/or national DV technical assistance providers and resource centers.

Section One – Overview: Suicide in the Context of Intimate Partner Violence

There are a number of reasons why it is important for crisis line staff to be knowledgeable about IPV; skilled in sensitive inquiry, risk assessment, and safety planning and in making linkages with local, regional and national resources. First, IPV is highly prevalent in the United States (US) and has well-documented and far-reaching health and mental health effects. Second, when people call crisis lines to reach out for help, the crisis they are experiencing and the help they are seeking may be related to IPV, making it a frequent issue in the lived experience of callers. Third, the risk for suicide among people who experience IPV is significantly higher than for people who do not. In fact, suicidality is a frequent concern for people who call domestic violence (DV) hotlines. Understanding the role IPV may be playing in a caller’s suicidal feelings or intent and attending to the additional safety issues that may be at play are critical for responding in truly helpful ways.

Incidence and Prevalence: What is known about IPV?

Recent research indicates that 35.6% of women and 28.5% of men experience abuse by an intimate partner over the course of their lives and more than 12 million women and men are victims of rape, physical violence or stalking by an intimate partner each year (Black et al., 2011). At the same time, women who are victimized by an intimate partner are significantly more likely than men to experience physical or sexual assault, coercive control, serious injury, and health and mental health consequences (Black et al., 2011; Coker et al., 2002). Rates of IPV are also significantly higher for American Indian and Alaska Native women, in part due to the ongoing effects of colonization, historical trauma, and oppression—and until recently, lack of legal jurisdiction for Tribal communities¹.

Analysis of 2010 data from the CDC’s National Intimate Partner and Sexual Violence Survey (NISVS) indicate that rates of IPV among gay men, lesbians, and people who identify as bisexual are as high (and perhaps higher) than among heterosexuals (Breiding et al., 2014). In addition, the New York Anti-Violence Project (AVP) reports that within the lesbian, gay, bisexual, transgender and queer (LGBTQ) and HIV-

¹ Under the Violence Against Women Reauthorization Act of 2013, Tribes are now able to exercise their sovereign power to investigate, prosecute, convict, and sentence both Indians and non-Indians who assault Indian spouses or dating partners or violate a protection order in Indian country. VAWA 2013 also clarifies Tribes’ sovereign power to issue and enforce civil protection orders against Indians and non-Indians. Previously, Tribes had no jurisdiction over non-Indian perpetrators of IPV. These new powers do not apply to sexual assault outside of the context of an intimate relationship or to Alaska Native villages. <http://www.justice.gov/tribal/violence-against-women-act-vawa-reauthorization-2013-0>

affected community, survivors who identify as people of color, transgender, bisexual, undocumented and who are on public assistance, report disproportionately higher rates of IPV compared to overall LGBTQ and HIV-affected IPV survivors (Waters/NCAVP, 2015).

The NISVS study also found that violence at the hands of an intimate partner often begins at a young age. Fully 23% of women and 14% of men who had ever experienced physical violence, sexual assault, or stalking by an intimate partner first experienced some form of partner violence between 11 and 17 years of age. Additional research reveals that approximately one in ten high school students reported victimization by a dating partner within the past year. The spectrum of adolescent relationship violence includes cyber abuse and harassment (predominantly via the internet/social media, and by text or chat messaging) in addition to physical and sexual violence (Black et al., 2011; Breiding et al., 2014; Kann et al., 2014; Zweig & Dank, 2013).

Why Think about IPV in the Context of a Suicide Call?

IPV and suicidality are related in complex and often reciprocal ways. As noted above, people who call suicide crisis lines may also be experiencing IPV. While there are no published data about rates of IPV among people who call suicide hotlines, research has documented high rates of IPV among women seen in mental health and substance abuse treatment settings (Chang et al., 2011; Cluss et al., 2006; Cohen et al., 2003; Dillon et al., 2013; Oram et al., 2013; Schneider et al., 2009, Engstrom et al., 2012).

Conversely, suicidality is not uncommon among people who call DV hotlines.² During the first 11 months of 2015, 3,437 callers to the National Domestic Violence Hotline (NDVH) indicated that suicidality was a concern. In addition, DV hotline callers frequently report experiencing forms of abuse specifically designed to undermine their mental health. A survey conducted in 2012 by the NDVH found that 73% of 2,733 Hotline callers reported that their abusive partner deliberately did things to make them feel like they were “going crazy” or “losing their minds” including coercing them into taking overdoses and trying to have them committed to a psychiatric unit (Warshaw et al., 2014). Understanding how these issues intersect is critical for crisis line staff and for the people who call suicide prevention hotlines.

For example, from a suicide crisis line perspective, asking if the caller is alone and then discovering that someone is there with them may come as a relief. However, from an IPV perspective, the person who

² In FY 2014 (10/1/13-9/30/14) the National Domestic Violence Hotline and LoveisRespect.org (LIR) documented 1,810 contacts with suicide listed as a victim situation. In the first 11 months of FY 2015 (10/1/14-8/27/15) the Hotline and LIR documented 3,437 contacts with suicide listed as a victim situation (note: In April 2015 NDVH/LIR changed their tracking from "suicide" to "suicide - abusive partner" and "suicide - victim/survivor").

is with them might be an abusive partner or family member who may, in fact, be contributing to the crisis and making the caller less safe. Similarly, a third-party caller may seem genuinely concerned about their partner's suicidality or mental health status, requesting advice about what to say as well as information about how to access emergency and/or inpatient psychiatric services. From a suicide crisis line perspective, this level of concern and support can be both reassuring and potentially quite helpful in marshaling a plan for safety and support. From an IPV perspective, however, the caller might be an abuser who is trying to have their partner committed as a tactic of intimidation and control and/or to undermine their partner's ability to retain custody of their children (Foley 2015). Recognizing how IPV can play out on a crisis call provides additional perspectives for listening and responding to callers who are dealing with both suicidality and IPV.

Post-disaster crisis calls may also be related to IPV. Just as the number of people experiencing mental health crises may increase in the aftermath of a disaster, rates of IPV may increase, as well. Higher levels of stress, greater isolation, and lack of reliable access to resources and supports appear to contribute to both IPV risk and mental health crises, and may lead to an upsurge in calls to crisis centers (Mechanic et al., 2001).

What Is Known about the Relationship Between Suicide and IPV?

Research has consistently demonstrated that victimization by an intimate partner significantly increases a person's risk for suicide (Bohn, 2003; Devries et al., 2011; Taft, 2003). Recent reviews have noted that rates of suicidal ideation and suicide attempts are three and four times higher, respectively, among women who have experienced IPV versus women who have not (Dillon et al., 2013). In community samples, 23% of women experiencing IPV reported a past suicide attempt versus just 3% without a history of IPV, and 36.8% of IPV survivors seriously considered suicide (Pico Alfonso et al., 2006; Seedat et al., 2005). More specifically, the prevalence of suicidal ideation and suicide attempts have been found to be significantly higher among women who are physically abused by their partners (Weaver et al., 2007), women who experience both physical and psychological abuse (Oquendo et al., 2005), women who are victims of marital rape and/or sexual assault (Anderson et al., 2004; Gladstone et al., 2004; Talbot et al., 2004), and women who have been sexually abused as children (Hoertel et al., 2015). Likewise, in several studies, rates of IPV have been found to be higher among women who have suicidal ideation or who have attempted suicide. A 2002 study by Thompson and colleagues reported that African American women who attempted suicide were 2.5 times more likely to have experienced physical abuse and 2.8 times more

likely to have experienced emotional abuse by an intimate partner than demographically similar women who had not been abused. In another study, over 90% of women hospitalized with suicidal ideation reported current, severe IPV (Heru et al., 2006). In sum, women who make suicide attempts experience higher rates of IPV than women who do not, and women who experience IPV have higher rates of suicide attempts and suicidal ideation than women who have not been victimized by an intimate partner.

Teen dating violence (TDV) also increases suicide risk. A key study on TDV and suicide found that suicidal ideation and suicide attempts were approximately six to nine times as common among adolescent girls who reported having been sexually or physically hurt by dating partners than those who reported no abuse (Silverman et al., 2001). Additional information on Teen Dating Violence can be found at www.loveisrespect.org and www.breakthecycle.org.

While murder/suicide is relatively infrequent (less than 1,500/year), prior domestic violence is the biggest risk factor, particularly when the person being victimized has left or is deciding to exit an abusive relationship (Auchter, 2010; Campbell et al., 2010). Analyzing 2014 data, researchers found that over 90% of murder/suicides in the US were committed by men, 81% occurred in the home and 72% involved an intimate partner. Access to a gun was also a significant factor (93% involved guns). In addition, contrary to general assumptions, 33% of the perpetrators were older adults (Langley, Violence Policy Center, 2015).

Finally, survivors of IPV³ are more likely to experience a range of mental health conditions associated with increased suicide risk, including depression, posttraumatic stress disorder (PTSD), and substance use disorders (La Flair et al., 2012; Cavanaugh et al., 2011; Devries et al., 2013; Dillon et al., 2013; Jacquier et al., 2012; McLaughlin et al., 2012; Nathanson et al., 2012; Pico-Alfonso et al., 2006; Trevillon et al., 2012; Van Dulmen et al., 2012, Thompson et al., 1999, Sareen et al., 2007). IPV survivors also experience higher rates of chronic pain and are more likely to be prescribed opioid analgesics and other psychotropic medications, which, in turn may contribute to overdose risk and suicide (Oquendo and Volkow, 2018; Wuest, J. et al., 2007; Balousek, S. et al, 2007). In addition, many survivors have experienced multiple types of adversity over the course of their lives, putting them at even greater risk for developing posttraumatic mental health conditions and potentially affecting their ability to mobilize the resources necessary to generate safety and economic stability—factors that also contribute to suicide risk (Bohn, 2003; Gradus et al., 2015; LeBouthillier et al., 2015).

While it is clear from the above literature that suicide and IPV can be related, it is important to remember that being victimized by an intimate partner is neither a psychiatric condition nor is it a sign of

³ This includes both heterosexual and LGBTQ survivors of IPV.

psychopathology. While survivors of IPV can experience a range of IPV-related mental health and substance use effects and benefit from sensitive and appropriate interventions, many are not in need of mental health or substance use treatment. For others, symptoms decrease or abate with access to safety and support; interventions, therefore, may be needed only on a temporary, time-limited basis.

Why is it Important to Ask Routinely about IPV?

Because both the experience and effects of IPV vary widely, inquiring only when abuse is suspected will miss significant numbers of people who may be at risk. Research indicates that survivors of IPV *want* to be asked, providing that they are asked confidentially and in a caring, respectful, and nonjudgmental manner (Rodriguez et al., 2001). Listening for possible “red flags”—words or phrases callers say that might indicate they are experiencing IPV—can help provide an opening for discussion (see Intimate Partner Violence Tip Sheet for examples). At a minimum, crisis line staff should ask callers about immediate safety (whether they are alone, whether it is safe for them to talk), imminent danger, and if indicated, ongoing risk both from an intimate partner and from other people in their lives. Routine inquiry is essential to assess the caller’s situation fully, understand the context of their distress, help to create safety, provide appropriate intervention, and reduce the isolation that abusers use to establish control over their partners.

At the same time, callers to a suicide hotline may also be perpetrators of IPV. Listening for and asking about perpetration also can provide opportunities to de-escalate crises and offer referrals to appropriate batterer intervention services that are evidence-based, culturally relevant, and hold survivor safety as a priority. This means referring, whenever possible, to certified Batterer Intervention Programs (BIPs) that hold those who perpetrate IPV accountable for their behavior, rather than referring to Anger Management Programs that generally do not recognize the power and control dynamics that are at the core of IPV. Services for people who abuse their partners exist in many communities. Local DV programs, state DV coalitions, the National Domestic Violence Hotline, and the Stronghearts Native Helpline can generally provide recommendations and referrals to respected programs. In addition, caution should be exercised talking with someone who is calling the crisis line about their partner, knowing that this may (or may not) be a covert attempt to garner information they can use against their partner and/or to identify who their partner is reaching out to for help.

Developing a Response to IPV: Issues to Keep in Mind

Before instituting assessment and response protocols for IPV, there are a number of IPV-specific issues that are important to keep in mind. Those most relevant for crisis line staff include understanding the coercive control dynamics of IPV, especially those related to a survivor's mental health and substance use, and understanding the unique privacy and confidentiality issues associated with IPV. These understandings are critical to establishing connections with callers while ensuring that the call itself does not further jeopardize their safety.

Understanding the Dynamics of IPV

It is important for crisis line staff to be knowledgeable about the dynamics of IPV in order to be responsive to callers who are being abused by a partner or who may be abusive themselves. By definition, IPV is an ongoing pattern of domination and control perpetrated against a current or former intimate partner through a combination of actual or threatened physical violence, sexual assault, psychological abuse, and other coercive strategies (e.g., economic abuse, or abuse targeted towards a partner's mental health or substance use). IPV can occur at any age within the context of an intimate relationship, including with a current or former spouse, sexual partner, someone a person is dating, or someone with whom they have a significant emotional connection (Warshaw and Tinnon, 2018). IPV can occur in any relationship, regardless of socioeconomic status, education level, cultural background, age, gender, race, ethnicity, sexual orientation, gender identity or religion.

Physical violence is only one of many tactics that abusers use to harm their partners, undermine their autonomy and sense of self, and keep them isolated and entrapped. Sexual violation is particularly degrading and often quite difficult to discuss. Birth control sabotage and coerced sex with other people (including coerced sexual contact for commercial gain, or trafficking) may also be taking place (Miller, et al., 2010). For some survivors, abuse may also involve other family members (i.e., adult children, biological and step-relatives, and in-laws).

Whenever there is physical or sexual abuse, psychological abuse is invariably present and can be quite severe. Psychological abuse often takes the form of verbal intimidation and threats; ridicule and humiliation; stalking and monitoring of activities; physical and social isolation from friends and family; undermining credibility; and controlling access to money, credit cards, education, healthcare, jobs and transportation. Emotional withdrawal; threats to "out" a lesbian, gay, bisexual, or transgender partner;

threats of abandonment; threats of deportation; and threats to harm or take away children are also powerful tactics of coercion and control. Psychological abuse is what survivors often describe as the most devastating aspect of their experience. Emotional abuse can occur in isolation from other forms of abuse and is important to ask about directly. Use of technology to harass, embarrass, monitor, impersonate, and stalk an intimate partner is an increasingly common form of abuse, particularly among teens and young adults.

Coercion around mental health and substance use are particularly insidious forms of abuse, especially given that the stigma associated with these issues can increase the likelihood that the perpetrator will be seen as more credible than the person they have been abusing for years. For crisis line workers, it is critical to be attuned to the ways that perpetrators of IPV actively engage in behaviors designed to undermine their partner's sanity and sobriety, including coercing them to overdose on drugs or medication and/or withdraw from substances, threatening them with involuntary psychiatric commitment and/or calling a suicide crisis line to garner support for doing so, controlling their access to treatment, sabotaging their recovery, and discrediting them with potential sources of protection and support (see <http://www.nationalcenterdvtraumamh.org/publications-products/coercion-related-to-mental-health-and-substance-use-in-the-context-of-intimate-partner-violence-a-toolkit/> and the Intimate Partner Violence Tip Sheet for additional indications of mental health and substance use coercion to ask about or listen for). Assisted outpatient treatment (outpatient commitment), psychiatric advance directives, and loosening of HIPAA protections provide additional vehicles for an abusive partner or family member to exert control. Stigma associated with substance use and mental illness reinforces the ability of abusers to use these strategies against their partners so successfully (Bennett & Bland, 2008; Warshaw et al., 2014; Warshaw et al., 2009).

It is also important to recognize that some people who report using violence against their partners may be primary victims (for example, they may be using violence in self-defense) and that some people who are, in fact, perpetrators of IPV describe *themselves* as victims. People who perpetrate IPV may do this as a way to justify their behavior or as a tactic of manipulation designed to pre-empt their partners from being able to receive victim services (including emergency shelter) or obtain legal protections (for example, protective orders or custody). Concerns about whether a caller is a victim or perpetrator can best be addressed by listening carefully to try to discern the ongoing pattern: i.e., who is being controlling or threatening and who feels afraid, isolated, and trapped. Staff at DV programs, LGBTQ-DV programs, the National Domestic Violence Hotline, and the Stronghearts Native Helpline are generally quite skilled at

teasing out these complex issues.⁴

Understanding that lethality can escalate when a survivor decides to leave is also critical. In fact, deciding whether to leave or stay with an abusive partner is a complex process that can involve multiple considerations. Survivors face many obstacles in trying to leave an abusive relationship and/or maintain their safety, credibility, and connections with others in the face of ongoing abuse. Survivors also may have many reasons for wanting to stay. Choosing to remain in an abusive relationship is often based on a strategic analysis of values, priorities, safety, and risk. Thus, safety planning in response to IPV risk takes into account not only what the person wants and values, but also whether leaving will substantively increase their level of risk, either from their abusive partner or from the circumstances they may face if they leave (e.g., loss of economic stability, homelessness, loss of health insurance, disruption of children's schooling, loss of community) (Davies & Lyon, 2014). Finding out if a caller's partner has threatened suicide or homicide is also important in IPV assessment. Threatening suicide is a frequent tactic used to manipulate and control an intimate partner to prevent them from leaving. However, these threats may result in suicide attempts which, in turn, can lead to murder-suicide (Conner et al., 2002). A person who regularly threatens suicide in order to get a partner to do something they want them to do is engaging in a form of emotional abuse. For more information on responding to these kinds of situations, see www.loveisrespect.org).

Maintaining Privacy and Confidentiality

Because disclosure of abuse carries the risk of retaliatory violence, asking about IPV requires that proactive measures be taken to maintain a caller's privacy and confidentiality. This is one reason DV hotlines are completely anonymous, do not have access to identifying information, and do not keep records of their calls. By the same token, suicide crisis line information that could be subpoenaed by an abusive partner in a legal case can be potentially harmful to a survivor of IPV (i.e., using a person's efforts to seek help to discredit them). While suicide prevention and other mental health and substance use crisis lines may not have the same privacy protections that domestic violence hotlines do, there are still important steps that can be taken. For example, during a crisis call, one should only ask about abuse *after*

⁴ See <http://www.dhs.state.or.us/caf/NW%20Network%20Primary%20Aggressor%20Assessment.pdf> for a detailed assessment developed by The Northwest Network of Bisexual, Trans, Lesbian & Gay Survivors of Abuse along with a 3-part webinar series on Assessing Patterns of Coercive Control in Abusive Relationships, Part 1: A Basic Skill for LGBTQ DV Advocacy: <https://nwnetwork.adobeconnect.com/pacbusxm7qqo/>; Part 2: Practical Skills and Implementation: <https://nwnetwork.adobeconnect.com/p5r3a05j10j/>; an Part 3: Practice and Program Implementation: <https://nwnetwork.adobeconnect.com/p3a9ie8082eu/>.

determining that the caller is alone and the line is secure. For example, it is critically important to refrain from asking about IPV in the presence of another person including a partner, a personal assistant, a guardian or an unofficial interpreter, or in the presence of a person providing collateral information—even if the caller is unable to provide that information independently.⁵ Crisis line interpreter services should utilize appropriate confidentiality policies. In addition, people who perpetrate IPV often track, stalk, and monitor their partners. If a caller discloses that they are being victimized by an intimate partner, staff should talk with the caller about checking the settings on their computers and phones that can leave a call history or internet footprint that their partner might be able to identify.

Callers should also be told that the information they provide will be kept confidential to the fullest extent possible under the law. Crisis line staff should initiate an honest discussion regarding situations that might require disclosure based on applicable mandatory reporting laws (e.g., suspected child maltreatment) prior to asking for potentially actionable information from callers.

While many states do not require mandatory reporting of IPV or reporting if children witness IPV, some do.⁶ Maintaining confidentiality to the extent possible is critical to survivors' safety, keeping in mind that filing a report can increase the risk for retaliatory violence. DV programs, coalitions, and hotlines can generally provide guidance on how to work collaboratively with survivors to ensure both their and their children's safety if a report needs to be made.

Unless there is an imminent risk of suicide or homicide, IPV survivors have the right to make their own decisions about whether to involve law enforcement. Survivors are generally in the best position to judge their own and their children's safety; calling the police without the caller's permission could escalate the situation and increase their risk.

Developing a Response to IPV: Preparing Your Organization⁷

Suicide prevention crisis centers are already well-equipped to handle crisis situations, assess safety, refer callers to appropriate services, and assure necessary training and supports for staff. Crisis centers also take steps to ensure that callers have access to telephone interpretation services as needed, including services and technology for callers who have limited English proficiency, those who are deaf or

⁵ Always ask callers whom they would prefer you obtain information from and whom they trust you to talk with about their situation.

⁶ For a compendium of state mandatory reporting laws regarding IPV see: http://www.acf.hhs.gov/sites/default/files/fysb/state_compendium.pdf

⁷ For stand-alone crisis line settings, these recommendations are important in creating a safe environment for staff.

hard of hearing, and people who have disabilities. These guidelines are designed to supplement the practices that are already taking place in crisis center settings by providing recommendations for incorporating assessment for IPV into routine suicide prevention protocols, as well as additional information on asking about IPV, assessing and responding to IPV-related safety needs, and making appropriate referrals once suicide concerns have been addressed.

Before implementing practices to screen for and address IPV and its traumatic effects, it is important to ensure that staff have the knowledge, skills, and supervisory support to respond to IPV; that consultation and referral relationships with DV hotlines and local DV organizations have been established; and that IPV-related safety mechanisms are in place for staff as well as callers. Given the additional issues raised for staff in bearing witness to callers' experiences of abuse and violence, it is important to ensure that the crisis center environment supports staff in maintaining an empathic presence, provides a nonjudgmental atmosphere for staff to process and learn from challenging encounters, and attends to staff resilience and well-being. In other words, ensuring that the crisis center itself is trauma-informed as an organization is key.

Developing Training for Staff

Training for suicide prevention staff on trauma and IPV should be incorporated into staff orientation and updated regularly with periodic in-service training. Training topics should include basic dynamics of IPV; exploration of societal values, myths, and facts regarding IPV; procedures for responding to disclosures of both victimization and perpetration, including training on danger assessment and safety planning; techniques for safety planning around substance use and prescription medication in the context of IPV⁸; policies regarding confidentiality and workplace safety; and steps to promote a culturally attuned, trauma-informed approach (Elliott et al., 2005). Sample danger assessment and safety planning tools can be found in the Appendix. Training should also address policies regarding both caller confidentiality and mandatory reporting (including reporting for child abuse in the context of IPV), along with steps that can help keep both the survivor/parent and children safe. Additional training topics include strategies for understanding the dynamics of perpetration, including ways perpetrators of IPV may try to manipulate crisis line staff into believing they are “the real victim” or convince crisis line staff that their partner is

⁸ Overmedication can also be a serious safety threat to people who are experiencing IPV, making it difficult to protect themselves, make important decisions or participate in safety planning when sedated. Similarly, intoxication or withdrawal from substances can impact a survivor's ability to engage in safety planning as well.

“manic,” “psychotic,” or otherwise seriously impaired in an attempt to have their partner hospitalized as a tactic of control (Foley, 2015). For more information on these issues, see www.nationalcenterdvtraumamh.org, www.nwnetwork.org, www.thehotline.org, and/or www.nnedv.org. Additional guidance on working with survivors and perpetrators from specific communities or who are dealing with uniquely challenging types of issues can also be obtained through DV programs, domestic violence/sexual assault coalitions, the National Domestic Violence Hotline, the Stronghearts Native Helpline, and a range of national training and technical assistance centers. These local, state and national organizations offer a wealth of information and resources on a range of issues, including the IPV-related needs, concerns, resources, and legal options for specific communities and populations. Most state and Tribal DV coalitions and local programs conduct regular trainings for staff, volunteers and community partners and can serve as an excellent resource for training crisis line staff.

Developing Partnerships with Domestic Violence Programs, Coalitions and Hotlines

Ideally, suicide crisis lines will be able to establish ongoing relationships and linkage agreements with DV programs in their geographic area. Procedures should be developed for creating an appropriate referral process and for cross-consultation and training. Feedback and problem-solving mechanisms should also be put in place to ensure ongoing assessment of interagency collaboration. Establishing relationships with local, state, Tribal and national DV hotlines is also critical. DV programs often offer comprehensive safety planning, individual advocacy, support groups, legal advocacy, and 24-hour hotlines to provide information and counseling and to assist in finding shelter. There are many ways to build relationships with local DV agencies, including meeting with organizational leadership to discuss similarities, differences, and challenges in doing crisis line work, such as issues of confidentiality and mandatory reporting; inviting DV program staff to tour the crisis line call center; participating in cross-agency staff meetings to increase awareness of each agency’s services; and/or providing in-service or cross training. Suicide crisis line administrators might also consider speaking with their local DV program or state DV coalition about having selected staff participate in 40-hour training for DV advocates and volunteers. The National Domestic Violence Hotline, LoveisRespect.org, and Stronghearts Native Helpline offer resources that are relevant for suicide prevention crisis lines, both in general and on working with specific populations (i.e., teens) – see www.loveisrespect.org, www.thehotline.org, and www.strongheartshelpline.org.

Developing Workplace Safety Policies

Although uncommon, people who abuse their partners may make threatening phone calls to the crisis center or referral agencies, follow their partners to appointments, or show up at the crisis center and threaten staff, in person. While threatening calls or behavior may be retaliatory or driven by anger, they may also be deliberate attempts to intimidate staff into not providing services to their partner. At the very least, there should be a setting-wide safety plan that outlines what to do when danger is present that is included in the workplace safety manual, should a perpetrator of IPV identify the call center and decide to come to the site. Numerous online tools provide guidance regarding these issues.⁹ Examples of protections used by DV hotlines that can be put in place include: training staff to use aliases on all calls, employing an onsite security guard, escorting staff to and from their personal vehicles and to public transportation stops after hours, using key cards to get in and out of the building, ensuring that only those identified as staff are permitted to enter the building, installing panic buttons connected to police emergency dispatch, and asking police to provide frequent patrols (Amezcuca, NDVH 2015).

Crisis lines should also develop policies for responding to staff members who themselves may be victims or perpetrators of abuse. Policies should address how to: 1) recognize and respond to a staff member who is being abused by a partner; 2) ensure the safety of a staff member who may be abused, including protocols for responding to the safety needs of staff who have a protection order and how to respond should the order be violated on agency property or through the use of agency phones or computers, etc.; 3) safeguard the safety of co-workers and the office environment; 4) describe measures to address a staff person suspected of being a perpetrator without endangering the person being victimized or other staff; and 5) define agency standards for all staff regarding confidentiality and support.

Incorporating Culturally Attuned IPV and Trauma-Informed Approaches

Given the prevalence of IPV and other forms of trauma among people who experience suicidality, sensitivity to trauma and its effects are already likely to be part of suicide prevention crisis center practice (Brockie et al., 2015; Felitti et al., 1998; Sacchs-Ericsson et al., 2016). SAMHSA's *Guidance for a Trauma-Informed Approach*¹⁰ highlights the importance of realizing the widespread impact of trauma,

⁹ For examples of workplace policies on domestic violence see: <http://www.workplacesrespond.org>

¹⁰ <http://store.samhsa.gov/shin/content/SMA14-4884/SMA14-4884.pdf>

understanding potential paths for recovery; recognizing signs and symptoms of trauma among people seeking services, their families and staff; responding by integrating knowledge about trauma into policies, procedures, and practices; and taking steps to prevent retraumatization. This growing understanding has shifted the ways that trauma-related mental health symptoms are conceptualized, reframing them as survival strategies—adaptations to potentially life-threatening situations that are made when real protection is unavailable and usual coping mechanisms are overwhelmed. These ideas have also helped to reframe previously misunderstood behaviors as understandable responses to trauma and abuse. The increasing acceptance of a trauma-informed approach has also led to a greater appreciation of people’s resilience, strength, and survival skills, which in turn has helped providers to respond in more respectful, empathic, nonjudgmental, and ultimately more helpful ways (Warshaw et al., 2014).

In fact, many of the key principles of SAMHSA’s trauma-informed approach are consistent with Lifeline best practices, including striving to create physical and emotional safety; being trustworthy and transparent; fostering interactions with callers based on collaboration and mutuality; supporting callers’ empowerment, voice and choice; and working with callers to incorporate peer support strategies whenever possible. Attending to issues of cultural, historical, and gender-related trauma—many of which are ongoing—is critical to fully engaging with callers in ways that take into account the broader context of their lives. This means ensuring that responses to callers are both gender inclusive and responsive; honor the healing value of traditional cultural connections; incorporate processes that are responsive to the racial, ethnic, linguistic, and cultural needs of each individual being served; and recognize ongoing legacies of historical trauma and other forms of oppression and discrimination callers may experience (SAMHSA, 2014; Warshaw et al, 2014).

More specifically, for suicide prevention crisis line staff, incorporating a trauma-informed approach means recognizing the role that trauma may be playing in a caller’s suicidal feelings and doing everything possible to ensure that the caller’s experience in reaching out for help is not retraumatizing. For crisis call centers, this means recognizing the potential impact on staff of listening to people in distress; sitting with fear and uncertainty; and facing life and death situations, often on a daily basis. This also means recognizing what staff bring to their interactions with callers and each other, including their own experiences of trauma, their personal feelings about IPV, and the ways they may be affected when they are truly open to the experiences of other people. Thus, incorporating a trauma-informed approach includes ensuring that crisis centers have both the commitment and mechanisms in place to support staff well-being, to provide regular reflective supervision, and to create safe opportunities for staff reflection

and growth (Warshaw et al., 2014; see NDVH Guiding Principles Tip Sheet).

Crisis centers may already be incorporating many of SAMHSA's ten trauma-informed implementation domains. These domains involve organizational commitment to a trauma-informed approach at the governance and leadership, policy, and financial levels; the creation of an environment that feels physically and emotionally safe to both callers and staff; processes for respectfully engaging and involving people who use the crisis line in providing meaningful feedback, including in the development of screening, assessment and crisis responses; training and workforce development on recognizing and responding to callers who have experienced various types of trauma, addressing the effects of trauma on staff, and supporting resilience, recovery and well-being for both; ongoing progress monitoring and quality assurance, including mechanisms to ensure that people who utilize crisis line services are involved in evaluating them; and cross-sector collaborations that incorporate a trauma-informed approach.

It is also important for call centers to develop working relationships with organizations that are both IPV and trauma informed to ensure safe and appropriate referrals. For more detailed information on SAMHSA's Guidance for a Trauma-Informed Approach, see <http://store.samhsa.gov/shin/content//SMA14-4884/SMA14-4884.pdf>. For information on applying this approach to a crisis hotline, see the Principles of Advocacy Tip Sheet in the Appendix.

Section Two—Practical Strategies for Responding to IPV in the Context of a Suicide Crisis Line Call

This section provides practical guidance for crisis line staff on responding to callers who may be experiencing abuse by an intimate partner. Given the multiple ways that IPV and suicide can intersect, the four parts of this section are organized to focus on the most time-sensitive concerns first (i.e., immediate safety), followed by more in-depth assessment and planning that is possible when time and safety allow.

Part I lays the groundwork for engaging with callers experiencing IPV in ways that are consistent with Lifeline best practices.

Part II outlines the steps of assessing for imminent risk from an abusive partner and responding to immediate danger. What may be new for suicide crisis center staff is the attention paid to determining whether or not the caller is alone, whether it is safe to talk, and whether the person with the caller is a potential source of support or, alternatively, someone who is likely to place the caller at greater risk.

Part III provides guidance on engaging in a more in-depth process of assessment for IPV, providing the caller is not in immediate danger and is safe to talk. Two sets of strategies are offered—one for weaving questions about IPV into a routine suicide assessment to help determine the role IPV may be playing, and another for introducing additional questions about IPV, once suicide has been addressed adequately.

Part IV provides recommendations for talking with callers about their ongoing safety and level of risk, and for engaging in a collaborative safety planning process.

These suggestions are meant to complement the formal training, workplace policies, and referral relationships that are part of an agency-wide response to IPV. Tip sheets that can help guide crisis line staff interactions with callers are also provided (see Appendix).

For an easy to follow flowchart that walks crisis line staff through the material contained in this section, see the Suicide Calls that Intersect with Intimate Partner Violence Tip Sheet found in the Appendix.

PART I— Principles for Working with Callers Experiencing IPV

Make Good Contact, Establish Rapport, and Engage in Collaborative Problem Solving

Asking about and responding to IPV can be incorporated into existing best practices for suicide prevention lifelines. Crisis line staff are already trained to make good contact with callers, establish rapport, and engage in collaborative problem solving. Principles for responding to IPV crisis calls are similar to those recommended by the National Suicide Prevention Lifeline.

Guiding principles for responding to callers experiencing IPV include:

- Building trust and developing rapport
- Listening actively and empathically
- Promoting the caller’s self-determination
- Making the caller’s safety a priority

Being knowledgeable about IPV and its potential relationship to suicidality, listening for cues (or red flags) that the caller may be experiencing IPV, and asking questions that reflect this understanding can enhance staff’s ability to resonate with callers’ experiences and to engage in more helpful and effective ways. For a person living with ongoing threats and intimidation, the experience of being treated with respect and feeling free to make choices without fear of judgment or retaliation can be therapeutic in itself. Creating an atmosphere of acceptance and validation can help to counter an abuser’s attempts to undermine a survivor’s self-perception.

There are a number of additional ways crisis line staff can communicate respect and understanding in the context of IPV, including by the way questions are asked and framed and by conveying that:

- Abuse experiences are common.
- You are willing to listen.
- You believe the caller and take the caller’s concerns seriously.
- The abuse is not the caller’s fault; no one deserves to be treated that way.
- There are resources available to help if the caller is in danger.
- The person will not be judged or stigmatized as a result of anything is disclosed during the call. (Warshaw et al., 2009)

Attending to what staff need to maintain both their empathic presence and their own balance and

well-being is also critical. Building in time to touch base with colleagues or a supervisor and ensuring opportunities to reflect on and recalibrate one's own responses can be particularly helpful (see the Guiding Principles of Advocacy Tip Sheet for more details).

MAKE GOOD CONTACT/ESTABLISH RAPPORT.

ACTIVELY LISTEN FOR CUES THAT A CALLER MAY BE EXPERIENCING IPV.

RESPOND EMPATHICALLY AND NON-JUDGMENTALLY.

PART II— Assessing and Responding to Imminent Risk and Immediate Danger

While the first priority for crisis line staff is to assess a caller's risk for suicide, initial IPV-related questions should be asked to assess whether the caller is in imminent or immediate danger from an abusive partner.

Determine whether or not a caller is alone and if it is safe to talk. Initial questions should help determine not only whether a caller is a danger themselves or others, but also whether a caller is in danger *from* another person or persons. If a caller indicates he/she is in imminent danger *from another person*, addressing immediate safety needs should take precedence (see Safety Planning section and Tip Sheets for more details). Actively engage with the caller to identify the source or sources of danger (i.e., themselves or another person) and the level of risk. If the caller indicates they are in danger from someone else, ask if the caller is alone and if it is safe to talk. Until privacy is established, ask closed-ended questions that can be answered with a “yes” or “no” in case an abusive partner is within hearing distance.

If suicide is the primary issue, proceed with the suicide assessment process. If abuse has been disclosed and the caller indicates it is not safe to talk about the abuse, ask only yes/no questions to determine immediate IPV-related safety needs and remind the caller periodically that the police can be contacted at any time if the caller uses a pre-established code phrase (see below).

If danger from an intimate partner is the primary issue, ask if it is safe to talk and if the caller feels they are in danger. If so, proceed with immediate risk assessment, including whether the caller wants to involve the police and/or whether there is a safer time or place for the person to call back (or to contact the caller if that is the individual's preference, including whether or not it is safe to leave a voice message).

If IPV is identified but the caller is not in immediate danger, ask if it is safe for the caller to talk, then ask if the caller wants to talk about the abusive situation. If so, discuss immediate safety concerns and priorities. Once suicide-related concerns have been addressed, offer referrals to a local DV program and/or local, national and Tribal DV hotlines in addition to appointments and/or referrals for mental health or substance abuse treatment, as indicated. If the caller is at risk yet does not want to pursue referral to a DV program or hotline (or is unable to do so), validate the caller's courage in making a disclosure, support the caller's efforts to engage in help-seeking and collaborate with the caller on developing strategies to increase their safety.

Screening for IPV risk early in the call increases the likelihood that IPV will be identified, that the call itself does not increase the caller's risk from IPV, and that the caller receives appropriate responses and referrals.

Be cautious about engaging the assistance of a potentially abusive partner. If a caller indicates that they are being abused by an intimate partner, involving that partner in suicide safety planning can conceivably place the caller at greater risk.

Practical Strategies

Below are some examples of ways crisis line staff can introduce the issue of safety from an abusive partner and incorporate questions about IPV into the initial suicide assessment process.

Assess for Imminent Suicide Risk

Determine if the caller is alone. If not, determine whether a potentially abusive partner or ex-partner is present, and if so, if the caller feels it is safe to speak freely. Also, determine, if the caller is in immediate danger, and if so, if they are able to escape and/or if police assistance is desired: For example:

- ✓ *Are you by yourself right now?*
- ✓ *Is there someone else there with you? Who is that person? A friend? A family member? Someone you are or have been in a relationship with?*
- ✓ *Is it safe for you to speak to me right now with that person there?*
- ✓ *Do you feel you may be in danger right now?*

If the caller is not alone and you are concerned that they might be in danger, consider providing a code word or short phrase for the caller to say if they would like the police to be called: You can say something like: *Thank you for being open with me. I'm concerned about your safety and am going to give you a short phrase to say if at any time you want me to call the police to ask them to come. The phrase is "yes, indeed" (or some alternate phrase). If at any time you say the phrase "yes, indeed" I will call for police assistance on your behalf. Please say "OK" if you understand what I have just said.*

If the caller is not alone, determine if abuse is a factor in the person's life and/or in the current call and if it is safe to continue to speak on the phone.

- ✓ *Is it safe enough for me to ask you a few more questions? Has that person ever threatened you or hurt you, or hurt someone you love, like a family member, or friend?*
- ✓ *Does this person have a weapon? Have they threatened you with this weapon or with anything else?*
- ✓ *Aside from your partner, is there anyone else there with you (e.g., children, other family members, others)? Would you be able to leave and/or take them to a safe place if you wanted to?*
- ✓ *Do you want to get help from the police right now? Would you like me to connect you to 911 or would you prefer I call for you? Remember that you can say the code phrase “yes, indeed” at any time if you would like me to get in touch with the police for you.*
- ✓ *Thank you for being open with me. Would you like to stay on the phone and talk or would you prefer to go someplace safer and call me back?*

Action Steps: Assisting Callers in Imminent Danger from a Partner or Others

If a Caller is at Imminent Risk from an Abusive Partner: If the caller is in immediate danger from an abusive partner, focus on helping them to escape and/or calling the police. As noted previously, survivors of IPV are generally best able to judge their own level of danger and to weigh the risks of police involvement in terms of potential future retaliation.

- If the caller remains on the phone, explore immediate escape routes (door, safe window, etc.).
- Connect the caller to 911 if they (or dependents or others) are in immediate danger. Call the police directly if requested or if “yes, indeed” or a different designated phrase is said.
- Provide contact information for the National Domestic Violence Hotline (1-800-799-SAFE) and/or for a local DV or rape crisis agency.
- If feasible, make arrangements to get back in contact to discuss mental health and/or substance use referral options once the caller is safe.

If the Caller is at Imminent Risk for Suicide: In addition to conducting an assessment and initiating intervention as dictated by the crisis line protocol (e.g., National Suicide Prevention Lifeline assessment and safety planning procedures), **take steps to ensure that the intervention and referral process does not increase danger from a potentially abusive partner.**

- Ask about and advise police about the presence of weapons in the home.

- Advise responders not to discuss IPV with a potentially abusive partner present.
- Advise responders not to ask the abusive partner to provide collateral information.
- Advise responders to consider information volunteered by others in context, as accounts provided by an abuser may be distorted or untrue.
- If a caller is going to an emergency room or is being hospitalized, with the caller's permission, advise intake personnel that IPV assessment, safety planning, and linkage with DV or rape crisis services should be addressed prior to discharge.

DISCUSS ESCAPE ROUTES.

CALL THE POLICE IF INDICATED.

***TAKE PRECAUTIONS RE: POTENTIAL DANGER FROM ABUSIVE PARTNER WHEN
RESPONDING TO IMMINENT SUICIDE RISK.***

PART III— Asking about IPV When the Caller is Not in Immediate Danger and it is Safe to Talk

Once immediate safety has been established, opportunities for more in-depth discussions with callers about what they may be experiencing in relation to IPV or other trauma, including ongoing safety, how it is affecting them, what their priorities and concerns are, and what they would like to do, become possible. Questions about IPV can be woven into the suicide assessment process itself or introduced after suicide has been addressed.

Incorporating Questions about IPV into the Suicide Assessment Process

If the caller is not in immediate danger and it is safe to talk, questions about IPV can be easily woven into a more in-depth suicide assessment. As part of the assessment process, it is important to consider the role that IPV may be playing in the caller's suicidal feelings, and how that might affect immediate safety planning and/or intervention for suicide risk. Provided below are a few ways questions about IPV can be incorporated into the suicide assessment process:

- **Desire:** *“Are you thinking about suicide? Let’s talk more about what’s causing you to feel that way. Sometimes when people are thinking about hurting themselves or when people are feeling the way you do, they are having problems with their relationship. Is that something you are experiencing?” Or, “Sometimes when people feel suicidal it’s because of trouble they are having with a relationship. May I ask you a few questions about that?”*
- **Capability and Intent:** If a person reveals they have the means to carry out a plan and/or has an intention to die, you could say: *“Tell me more about what has brought you to this place. Does your partner know about your plan? How have they responded? Has your partner contributed toward your feeling of wanting to end your life? Are you using alcohol or drugs to cope with the pain? Does your partner encourage you to drink or use other drugs?”*
- **Buffers:** Consider IPV when asking whether the caller is close to any family or friends. *“Can you tell me more about your support system? Many people with controlling partners tell me they have been kept isolated from family and friends. Has that been your experience? Can you tell me more about that?”*

Additional considerations to keep in mind about the possible relationship between IPV and suicidality include whether or not mental health or substance use coercion is part of the picture. For example:

- Have any behaviors or actions on the part of the abuser preceded the caller's suicidal ideation or precipitated the caller's desire to self-harm or overdose?

- Is an abusive partner deliberately doing things to exacerbate a caller’s mental health or substance use condition, including telling him/her that their life is worthless or the caller should commit suicide?
- Has an abusive partner coerced the caller into taking an overdose and then had them call the crisis line? Or, is the abusive individual the one placing the call to the crisis line?
- Is an abusive partner preventing the caller from following through with mental health or addiction services, thus leading to greater despair or a sense of unending entrapment?
- Has the situation made the caller ever feel so desperate that they thought about killing the abusive partner?
- Is the caller feeling trapped and isolated because the abusive partner has made efforts to convince others that they are “crazy” or an “addict”? Has the partner tried to persuade the caller that no one will believe them or take them seriously and they will lose (custody of) their children?
- Does the caller feel trapped in the relationship and not see any other way out besides suicide?
- Is this a third party caller trying to find out how to have their partner involuntarily committed to a psychiatric unit or to outpatient treatment? Does the third party caller sound genuinely concerned or worried about their partner? Do they sound afraid? Or, do they sound angry or controlling? Does what the caller is saying about their partner match what they are asking for?

Once IPV (or any other type of abuse) has been disclosed and suicide has been addressed, offer referrals to the National Domestic Violence Hotline [1-800-799-7233 (SAFE)] and/or to local DV or Rape Crisis hotlines or programs, as appropriate.

- **Keep in mind** that not everyone who experiences IPV will want or be able to call a DV hotline, especially at the time of their call to the suicide crisis line. Therefore, it is important for crisis line workers to be prepared to work in partnership with callers to assess ongoing safety and to develop safety planning strategies. Offer referrals to NDVH or the Stronghearts Native Helpline and local or Tribal DV programs and hotlines should the caller wish to pursue this at a later time.

ASK ABOUT THE ROLE OF IPV IN CURRENT SUICIDAL FEELINGS.

ASK ABOUT SUICIDE-RELATED COERCION.

BE ATTENTIVE TO THIRD PARTY CALLERS WHO MAY BE PERPETRATORS OF IPV.

Asking about IPV Once a Suicide Assessment Has Been Made

Crisis line staff can also introduce questions about IPV and ongoing safety into crisis call(s) once a suicide assessment has been made. Initially, crisis staff may feel uncomfortable asking about IPV as they transition from suicide screening, assessment, and referral to IPV screening, assessment, and referral. What is most important in talking with callers about IPV is making a good connection and fostering a sense of emotional safety that makes it possible for callers to feel comfortable talking about the abuse they may be experiencing. Begin with framing questions that either tie inquiry to what the caller has already disclosed, or alternatively, let the caller know that IPV is something that many people experience and that they are not alone. Again, being open, empathic, and nonjudgmental are essential to creating emotional safety.

- ✓ ***From what you have told me, it sounds like...***
 - *You have some concerns about your safety,*
 - *You are concerned about the way your partner is treating you,*
 - *You are feeling overwhelmed and scared,*
 - *You're not sure who you can trust.*
- ✓ ***Can you tell me more about your support system?***
- ✓ ***I don't know if this is true for you but a lot of times when people are feeling the way you are, it turns out (or, they tell me) they're experiencing some difficulties in their relationship. Is that something that you've been going through? I wonder if some of what you are experiencing may be related to how you are being treated at home.***
- ✓ ***Would it be okay if I ask you some questions about your relationship?***
- ✓ ***Do you feel safe in your current relationship? Is there anyone in your life who makes you feel afraid? Has anyone hurt or threatened to hurt you or anyone you love or care about (friends, family, co-workers)? Is there someone you've been involved with previously who is making you feel unsafe now?***

Gaining familiarity with the range of abusive behaviors to which survivors can be subjected allows crisis line staff to look for openings, respond to cues, and gently inquire about the kinds of things callers may have experienced. Many abuse “screens” ask about specific behaviors rather than about “abuse” in general, since many survivors may not self-identify as “abused.” Therefore, rather than asking, “Are you a victim of abuse?” crisis line staff should weave questions, such as those below, into their conversation with the caller.

- ✓ *Has your partner ever physically hurt you (for example, hit you, slapped you, kicked you, choked or strangled you, sexually assaulted you), or threatened to hurt you or people you love?*
- ✓ *Does your partner ever try to control what you do, who you talk to, where you go, or what you say?*
- ✓ *Has your partner ever pressured you or forced you into engaging in sexual activity when you didn't want to or that made you uncomfortable?*
- ✓ *Does your partner do things to demean you or put you down in front of other people?*
- ✓ *Has your partner ever taken or destroyed your belongings, or tried to harm or control you in any other way?*
- ✓ *Does your partner ever deliberately do or say things to make doubt your sanity?*
- ✓ *Does your partner ever try to prevent you from accessing treatment or taking medications you've been prescribed?*
- ✓ *Does your partner ever pressure or force you to use alcohol or other drugs or use more than you want to?*
- ✓ *Do you feel safe and comfortable continuing to discuss your situation right now? If not, is there is a place and time when it might feel safe enough to talk, either on the phone or in person?*

While a caller might not be in immediate danger from their partner, it still may not be safe to talk about the abuse if their partner or anyone else can hear their conversation. The caller may need to find a private location and a phone that isn't being monitored by their partner in order to safely discuss their situation. For a full list of common abusive behaviors see the Intimate Partner Violence Tip Sheet. The more familiar staff are with the dynamics of abuse and the range of questions that can be asked, the more likely they will pick up on cues and resonate empathically with callers' experiences.

Pay attention to:

- Cues that indicate possible physical, sexual, emotional, economic, or electronic/internet-based abuse;
- Cues that the caller is being isolated and controlled by a partner;
- Cues that the abuser may be using or manipulating the children to control their partner;
- Cues that the abuser is deliberately taking steps to jeopardize the caller's mental health or sobriety and/or coercing the caller to engage in behaviors that are harmful, risky, or unsafe.

ASK INITIAL FRAMING QUESTIONS.

BECOME COMFORTABLE ASKING BASIC IPV SCREENING QUESTIONS.

***BECOME FAMILIAR WITH THE RANGE OF COMMON ABUSIVE BEHAVIORS AND
ATTEND TO CUES.***

PART IV— Evaluating Risk and Planning for Safety: Assessing Safety, Identifying Risk Factors for Lethality, and Engaging in a Collaborative Safety Planning Process

Safety planning is an individualized, practical, and often iterative process that provides an organized and easily understood course of action with the goal of increasing the safety of IPV survivors and their children. Safety planning involves helping a caller build a blueprint for a safer life. It is a personalized, practical plan that includes ways for a caller to remain safe while in an abusive relationship, during the process of leaving, or after they have left. A well-developed safety plan will have all the vital information the caller needs to address their concerns and priorities and will be tailored to their unique situation. Effective safety planning does NOT include telling a caller what to do and never blames a person for the situation they are in. Safety plans are never static and are meant to be adaptable as the caller's needs, wishes and circumstances change (see Intimate Partner Violence Safety Planning Tip Sheet).

Effective safety planning incorporates **safety assessment** to lay the groundwork, **lethality assessment** to better understand the level of potential risk, and **developing an individualized plan** that focuses on ongoing physical and emotional safety for the caller (Feltus, 2014 NDVH).

Assessing Safety

Even if the caller is not in immediate danger from IPV, it is important to take steps to assess the potential for escalation and future danger, including during the call itself, and to explore additional steps that can be taken to facilitate the caller's safety and security. Accordingly, while the call is in process, check back in periodically to assess for escalating danger. For example, has their partner returned during the call and started making threats?

In addition to the questions below, please refer to the Intimate Partner Violence Tip Sheet in the Appendix.

Safety assessment can include questions such as:

- ✓ *Do you feel safe and comfortable discussing your situation right now? If not, is there a place and time when it might feel safe enough to talk?*
- ✓ *Can you tell me something about the person you are afraid of? Is it your partner?*
- ✓ *You said there is someone who makes you afraid or who hurts or threatens to hurt you. Can you tell me about what's been going on and what you are most concerned about?*

- ✓ *Has this ever happened before? What did you do then? Do you think it would work again?*
- ✓ *Has your partner made any specific threats to harm you or anyone else? What kinds of threats were made? Has your partner made specific threats about what would happen if you were to leave? Do you think they would try to carry out those threats?*
- ✓ *Do you think your partner is suicidal? Has your partner threatened to commit suicide if you leave?*
- ✓ *Is the abuse escalating, becoming more frequent, more severe or increasingly frightening?*
- ✓ *Have you ever tried to leave before? What happened? Is leaving something you are considering now?*
- ✓ *If you make the decision to leave, do you think you would be able to leave safely? Would you be able to take your children with you? What supports would you need to be able to leave safely?*
- ✓ *If you decide to leave, is there a place you can go where you would be safe? Do you need emergency shelter?* Keep in mind that many survivors do not want to leave their partners permanently but may feel the need to do so during times of crisis or in the face of immediate or escalating danger. It is important not to start from the assumption that what the person needs to do is to leave.
- ✓ *Have you called the police before? What happened? Is there any reason you might not want to call the police? In what circumstances would you call the police?*
- ✓ *Do you have a protective order? Has your partner obeyed it? Violated it?*
- ✓ *Do you know the number of a local domestic violence or rape crisis program, or the National Domestic Violence Hotline number (1-800-799-SAFE), or the Stronghearts Native Helpline number? (1-844-762-8483/1-844-7NATIVE).*
- ✓ *Is it safe for you to write this number down?*
- ✓ *Is there another time I can call you when it would be safe to talk or another number you'd prefer I call where it would be safe to leave a message?*
- ✓ *Thank you for being open with me. I'm worried about your safety. Would it be okay to brainstorm together about additional ways to keep you (and your children) safe?*

Assessing Risk for Lethality

If the caller indicates that the abuse is escalating or that serious threats have been made, crisis line staff should proceed with a Lethality Assessment. A Lethality Assessment is a subset of safety planning that looks at behaviors and situations that are statistically correlated with homicide attempts. These factors indicate a higher risk that an abusive individual will attempt to kill their partner, either for revenge or as a way to “enforce” ultimate control.

Indicators of potentially lethal risk include leaving or planning to leave the relationship, the presence of firearms in the home, a history or current or recent stalking behavior, and if the caller is pregnant (Feltes, 2014 NDVH). While DV hotline and program staff are trained to conduct detailed lethality assessments (also known as “danger assessments”), it is useful for crisis line staff to become familiar with the factors known to be associated with higher lethality risk. Basic familiarity with lethality assessment allows crisis line staff to listen for cues and to be prepared to ask follow-up questions, as indicated.

Lethality Risk Factors include:

- The caller’s level of fear and perceived danger
- Escalation in the frequency and severity of threats, abuse, level of control, or stalking
- A partner’s access to or use of weapons
- An abuser’s increasing mental instability, depression, suicidality, or drug use
- Violence outside the home, cruelty to animals or pets, criminal record, or violence toward children
- Pathological jealousy
- A history of coerced sex
- A history of attempted choking or strangulation
- The abuser’s ability to use their professional status as a tactic of coercion or manipulation (i.e., police, lawyer, mental health professional, physician)
- The partner’s awareness of the caller’s plans to leave
- For additional information about conducting a lethality assessment, please refer to the sample questions in the text box below, which have been adapted from the Danger Assessment Tool developed by Campbell et al., 2007.

<http://www.dangerassessment.org/uploads/pdf/DAEnglish2010.pdf>.

ASK ABOUT CURRENT AND ONGOING SAFETY.

BECOME FAMILIAR WITH DANGER ASSESSMENT QUESTIONS TO LISTEN FOR CUES.

DISCUSS SAFETY-RELATED NEEDS.

TALKING WITH CALLERS ABOUT ONGOING DANGER: QUESTIONS TO KEEP IN MIND

- ✓ *Are you afraid of your partner or afraid your life may be in danger? Are the threats or physical violence becoming more frequent, severe, or frightening?*
- ✓ *Has your partner become more controlling, making it harder for you to make phone calls or get away? Does your partner control most of your daily activities? Have they been stalking you?*
- ✓ *Has your partner threatened to kill you and/or do you think they are capable of killing you? Does your partner have access to any weapons? Is there a gun in the house? Have they used them against you or threatened you with them?*
- ✓ *Are you planning to leave your partner? Does your partner know about your plans? Do violence and threats increase around impending separation?*
- ✓ *Has your partner shown any evidence of severe depression, alcohol or drug binges (uppers), or increasing mental instability (erratic changes in mood or behavior)? Have they threatened suicide or homicide?*
- ✓ *Does your partner have a criminal record? Are they currently engaged in any criminal activity? Do you know if they were abusive with previous romantic partners? Have they been violent outside the home? Has your partner injured any animals or pets? Are they violent toward the children? Has this been recent?*
- ✓ *What is your partner's profession? Could they use it against you (i.e., police officer, lawyer, mental health professional, etc.)*
- ✓ *Does your partner feel like they own you ("If I can't have you, no one will")? Are they violently jealous and always accusing you of infidelity?*
- ✓ *Has your partner forced you to have sex with them recently? Have they physically abused you while you were pregnant? Have they ever tried to grab your neck or attempt to strangle you? Have they ever injured you so badly you needed medical care?*

PART V—Engaging in a Collaborative Safety Planning Process

Ideally, detailed safety planning (including arranging for follow up) should be done in concert with an advocate from a local DV program or hotline or with the National Domestic Violence Hotline (1-800-799-SAFE). If a caller is at risk and is unable or does not want to contact a DV hotline or local DV program, the crisis worker should work with the caller to develop initial safety planning strategies while still on the phone. IPV safety planning utilizes the same engagement and collaborative problem-solving approaches employed by suicide prevention hotlines.

The details of each safety plan will vary depending on the individual circumstance of the caller, the extent to which the focus is on how to remain safe while in the relationship, how to safely leave the relationship, or how to be safe after leaving (when danger is likely to increase). Again, DV programs and hotlines are highly skilled in this type of safety planning. Developing strong partnerships can help enhance crisis workers' effectiveness in this area.

It is also important to remember that IPV involves an ongoing pattern of coercive and controlling behavior that the caller is likely to have been living with and managing over time. Therefore, rather than offering solutions, it is far more helpful and empowering to ask the caller what they have done in the past to stay physically and emotionally safe. Find out if the caller thinks strategies that have been used successfully in the past will work now. If not, what do they think might be most helpful? Then discuss additional options the caller may not have previously considered, such as:

1. *Some people have told me.... Do you think that might work in your situation?*

Examples might include:

- Calling a friend, so the partner knows someone is listening
- Making sure guns and knives are hidden, locked, and unloaded or at least out of sight and easy reach
- Sending the children to someone else's home when there is increased danger
- Keeping keys, money, and medication in a secure, rapidly accessible "grab and go" location outside of the house
- Storing important papers and records (or copies) in a safe location not accessible to the abusive partner (e.g., at work, in a safe deposit box, at a friend or relative's house, etc.)
- Leaving the house overnight, although in some situations, danger may increase upon returning

2. *Let's talk about basic steps you can take to increase your own and your children's safety:*

Examples might include:

- Planning ahead for a safe place to go if the caller has to escape quickly
- Determining if an episode of severe abuse can be anticipated and leaving before it occurs
- Letting trusted neighbors know to call 911 if they hear the caller being mistreated
- Teaching children how to escape, get help, or call 911
- Getting out of rooms where abuse, including sexual violence, is more likely to occur or rooms from which it is difficult to get help or escape, such as kitchens, bathrooms, and bedrooms
- Making sure a phone is charged up and accessible at all times and knowing what numbers to call for help. A prepaid wireless phone that can be kept hidden from the abuser can be a vital asset. If necessary, a cell phone for emergency use can be obtained through a DV program or the Verizon Wireless Hope Line (<http://www.verizonwireless.com/aboutus/hopeline/index.html>)
- Limiting or abstaining from using alcohol or other mind-altering or sedating drugs while in escalating or imminent danger
- Obtaining an Order of Protection, leaving a copy at work and with the children's school(s), and keeping it on one's person at all times
- Accessing legal resources, including links to legal services for immigrant, refugee, and undocumented individuals; survivors who have disabilities; LGBTQ survivors; and others.

Safety planning for IPV also involves attending to emotional safety as well as developing strategies for talking with family and friends - skills that are already familiar to crisis line workers. Emotional safety planning in the context of IPV also includes talking with callers about identifying supportive family, friends, coworkers, and neighbors who can validate their perceptions if an abusive partner is trying to undermine their sense of self, their mental health and/or their recovery, and who can be available in case of emergency. For more details on safety planning around mental health and substance use coercion, see <http://www.nationalcenterdvtraumamh.org/publications-products/coercion-related-to-mental-health-and-substance-use-in-the-context-of-intimate-partner-violence-a-toolkit/>. For more detailed safety

planning guidance, please refer to the Intimate Partner Violence Safety Planning Tip Sheet in the Appendix.

In closing, let the caller know how glad you are that they reached out, acknowledge the caller's courage and strengths, discuss what the caller plans to do after the call is over and talk about any additional follow-up plans.

***DISCUSS WHAT THE CALLER WANTS AND WHAT HAS AND HASN'T WORKED.
COLLABORATIVELY DEVELOP STRATEGIES THAT SUPPORT THE CALLER'S PHYSICAL
AND EMOTIONAL SAFETY.***

Appendix I

IPV SAFETY PLANNING PROCESS

Safety planning is anything you do that enhances a victim/survivor's emotional, physical, or mental safety before, during, and after the abusive relationship.

Safety planning is a multi-layered process developed with the intention of providing an organized and easily understood course of action to increase the safety of survivors and their children. It is the course of action you can help the caller decide upon based on all the information you have gleaned through your assessment. It incorporates safety assessment to lay the groundwork, lethality assessment to understand the scope of necessary planning, emotional safety to support a caller's resiliency, and sustainable safety planning that focuses on every aspect of safety for the caller.

Lethality Assessment is a subset of safety planning that looks at behaviors and situations that are statistically correlated to homicide attempts. These factors indicate a higher risk that an abusive individual will attempt to kill his/her partner, either for revenge or to "enforce" ultimate control. Indicators of potentially lethal risk include leaving or planning to leave the relationship, the presence of firearms in the home, a history or current or recent stalking behavior, and if the caller is pregnant. For additional information about conducting a lethality assessment, see the Danger Assessment Tool (Campbell et al., 2007)

<http://www.dangerassessment.org/uploads/pdf/DAEnglish2010.pdf>.

Sustainable Safety Planning: The goal of sustainable safety planning is to promote safety and autonomy in every aspect of the caller's daily life. Sustainable safety planning includes attending to: basic necessities of daily living such as adequate food, clothing and safe shelter; assuring that health and mental health needs are met; working toward freedom from violence at the hands of one's current or former partner; relapse prevention strategies for those who are dealing with substance abuse; financial security; mobility; and planning for self-protection and independent, violence-free living. When sustainable safety planning is kept in the forefront, survivors will be better able to meet their own basic needs while accessing supports for mental health, trauma, and substance abuse-related recovery and healing. Effective safety planning is comprehensive, holistic and includes the survivor's perspectives and priorities, while remaining mindful of the safety and security needs of dependent children, other family members, pets, neighbors, friends, and the community at-large.

IPV SAFETY PLANNING PROCESS, CONTINUED**Topics to Explore with the Caller Include:**

- How to remain safe while in the relationship
- How to file a police report and get an Order of Protection
- How to leave safely
- How to cope with emotions
- How to tell family and friends

Strategies to Protect Against Harm

- Have an escape route
- Find a room with a lock and working phone
- How to stay safe in the home

Appendix II

CUES TO LISTEN FOR AND POSSIBLE FOLLOW-UP QUESTIONS

Talking with callers about their experiences creates a way for both crisis line staff and callers, themselves, to identify ongoing patterns and recognize escalating danger more clearly. The questions below are not intended as a questionnaire or checklist. Rather, knowing about the kinds of experiences callers may have can help staff engage in a more empathic and culturally responsive manner. Gaining familiarity and comfort with asking about IPV, drawing from the range of questions below, can help staff become attuned to the kinds of cues to listen for, and additional experiences they might ask about during calls.

IPV Assessment Follow-up Questions

- ✓ What kinds of things has your partner done to hurt you?

Physical Abuse

- ✓ Has your partner ever...
 - Pushed you?
 - Hit, kicked, punched or burned you?
 - Deprived you of sleep, food, medication or basic necessities?
 - Beaten you up?
 - Hurt you while you were pregnant?
 - Grabbed you by the neck or tried to choke or strangle you (blocked your airway, smothered you, or placed his/her hands, a belt or another object around your neck)?
 - Injured you so badly that you needed medical care?
 - Threatened you with a gun or knife? Used a gun or knife on you?
 - Harmed or threatened to harm you, your children, or themselves?
 - Harmed or threatened to harm someone else you care about?
 - Forced you to use alcohol or other drugs more than you wanted to?
 - Injured or killed animals or pets?

Psychological Abuse

- ✓ Has your partner ever...
 - Called you names or told you that you are ugly or worthless?
 - Humiliated you, controlled you, or tried to keep you from doing things you wanted to do?
 - Destroyed something meaningful to you?
 - Accused you of having an affair?
 - Monitored your whereabouts? Followed or stalked you?
 - Texted you repeatedly and demanded that you answer?
 - Threatened homicide or suicide or described detailed fantasies of doing so? (“I’m going to get you,” “You’ll pay for this,” “I’ll kill myself if you leave.”)?
 - Threatened to “out” you or threatened your immigration status?
 - Tried to undermine your spiritual beliefs or keep you from practicing your religion?
 - Told you that you are “crazy” and that no one will believe you or take you seriously?
 - Called you a lush, drunk, junkie, coke-whore, or other degrading name and said no one would believe you or you would be arrested if you reported abuse?
 - When you are with or around your partner, do you feel like you are walking on eggshells?

Sexual Abuse and Reproductive Coercion

- ✓ Has your partner ever...
 - Made you look at sexually explicit material that you didn’t want to see?
 - Called you sexually demeaning names?
 - Forced or pressured you into engaging in sexual activities that you didn’t want to do?
 - Forced you to participate in degrading or frightening rituals?
 - Made you feel afraid to say no if you don't want to have sex?
 - Used alcohol or other drugs to gain compliance for unwanted sexual behavior?
 - Forced or pressured you to have sex with other people?
 - Messed with your birth control?

- Forced you to become pregnant?
- Forced you to have an abortion?

Other Types of Abuse

- ✓ Has your partner ever...
 - Prevented you from seeing friends and family?
 - Attempted or threatened to remove your children from your care or to use your mental health condition against you?
 - Interfered with your ability to go to school or do your job, or did things that got you in trouble at work or risked your getting you fired?
 - Controlled the household finances?
 - Used household money to support an alcohol or other drug habit?
 - Forced you to do things you don't want to in exchange for alcohol or other drugs?
 - Taken so much money that you can't meet your needs?
 - Tried to control your medication or your treatment or had you hospitalized against your will?
 - When, where, how, how often, etc. did/has this occurred? (Please tell me more)
 - Is your situation getting worse? Are you feeling more isolated or afraid?
 - If the abuser is an ex-partner, do you feel you are still at risk? Do you share custody of your children? Are you still in contact?

Digital Harassment, Impersonation and Stalking

- ✓ Has your partner ever...
 - Told you who you can or can't be friends with on social media?
 - Sent you negative, insulting or even threatening emails, Facebook messages, tweets, DMs or other messages online?
 - Stolen or insisted on being given your passwords?
 - Pressured you to send explicit photos or videos?
 - Threatened to post/share explicit images of you?

- Used sites like foursquare and others to keep constant tabs on you?
- Constantly texted you and made you feel like you can't be separated from your phone for fear that you will be punished?
- Looked through your phone frequently? Checked up on your pictures, texts, and outgoing calls?

Mental Health Coercion

- ✓ Has your partner ever...
 - Intentionally done things to make you feel "crazy" or like you are "losing your mind"?
 - Told you that you are lazy, stupid, "crazy," or a bad parent because of a mental health condition?
 - Kept you up all night or try to prevent you from sleeping?
 - Blamed you for the abuse by saying you're the one who is "crazy"?
 - Told you no one will believe what you say because of your mental health condition?
 - Used your mental health condition to undermine or humiliate you with other people?
 - Threatened you will lose custody of your children because of your mental health status?
 - Done things to cause your mental health symptoms to get worse?
 - Tried to prevent or discourage you from accessing mental health treatment or taking your prescription medication?
 - Restricted or interfered with your ability to speak for yourself with doctors or mental health professionals?
 - Tried to control your prescription medication (such as by forcing you to take an overdose, giving you too much or too little medication, or preventing you from taking it at all)?
 - Threatened or tried to have you committed to an inpatient psychiatric unit?
- ✓ Are there other things your partner has done that you'd like to talk with me about?
- ✓ What have you noticed about how this is affecting you?

Substance Use Coercion

- Do you ever use alcohol or other drugs to try and numb the effects of abuse?
- Has your partner ever made you use alcohol or other drugs, made you use more than you wanted, or threatened to harm you or leave you if you didn't?
- Does your partner control your access to alcohol or other drugs, and then use that control to manipulate you or make you do things that you don't want to do?
- Does your partner justify name-calling, criticizing, belittling, and undermining you because of your alcohol or drug use?
- Has your partner told you that you are to blame when they treat you badly, abuse you, or sexually assault you—saying it's your fault or your deserved it because you drink alcohol or use other drugs?
- Has your partner ever forced or coerced you into doing something illegal (e.g., dealing, stealing, trading sex for drugs) or other things you felt uncomfortable with in order to obtain alcohol or other drugs?
- Have you ever been afraid to call the police for help because your partner said you would be arrested for being high or your children would be taken away?
- Has your partner ever threatened you would lose custody of your children because of your alcohol or drug use?
- Has your partner ever tried to manipulate you by making you go into withdrawal?
- Has your partner ever stopped you from cutting down or quitting alcohol or other drugs when you wanted to, or made it harder for you to do so?
- Has your partner ever prevented you from attending a recovery meeting, interfered with your treatment, or sabotaged your recovery in other ways?
- Has your partner ever used alcohol or other drugs as a way to get you to engage in in sexual activities you were uncomfortable with or did not agree to?
- What have you noticed about how what your partner is doing is affecting you?
- Are there other things your partner has done that you'd like to discuss?

Appendix III

NATIONAL DOMESTIC VIOLENCE HOTLINE TIP SHEETS

Tip Sheet Index:

- The Guiding Principles of Advocacy Tip Sheet**
- Intimate Partner Violence Tip Sheet**
- Suicide Calls That Intersect with Intimate Partner Violence Tip Sheet**
- Intimate Partner Violence Safety Planning Tip Sheet**

Appendix IV

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The Guiding Principles of Advocacy

The **Guiding Principles** are the nuts and bolts that get the job done.

Build Trust / Develop Rapport

- Welcome the contact with a helpful, warm and friendly tone.
- Reassure the contact the conversation is confidential and anonymous.
- Treat the contact with dignity and respect.
- Offer the contact space to share their experiences and needs by asking open-ended questions and validating the contact's feelings.

Listen Actively and Empathetically

- Minimize distractions and increase your ability to be completely present for the contact.
- Give the contact the time that they need to talk, indicate that you're listening by asking clarifying questions, offering validation, and using minimal encouragers.
- Reflect what you're hearing the contact express as their primary needs, feelings, and experiences.

Promote Caller's Self Determination

- Be patient and non-judgmental as the contact identifies needs and options.
- Support the contact's decisions and help identify potential outcomes.
- Understand where the contact may be in their process of change and what types of next steps they might be ready to take.
- Validate contact's strengths and progress made.
- Understand how contact's cultural background and experiences may inform their choices and options.

Make the Caller's Safety a Priority

- Listen for and acknowledge red flags of potentially dangerous and/or lethal behaviors or threats in your contact's situation.
- Develop a safety plan with your contact tailored to your contact's individualized needs to minimize risks in their specific situation.
- Strategize around ways to increase emotional/psychological well-being, as well as physical and sexual safety.
- Explore risks and benefits of options available to the contact and, as appropriate, help the contact access local service systems, advocating on their behalf when necessary.

Balance Your Needs With Those of the Caller

- Take the time to process difficult conversations.
- Use your fellow advocates for support.
- Regularly assess your emotional state and problem solve with your supervisor.
- Take breaks regularly.
- Develop and maintain a plan for your personal wellness.

Intimate Partner Violence Tip Sheet

What is Intimate Partner Violence (IPV)/Domestic Violence (DV)?

IPV/DV is a pattern of abusive behavior in any relationship that is used by one partner to gain or maintain power and control over another intimate partner. DV can be emotional, physical, economic, digital, or sexual, including actions or threats of actions that influence another person.

Emotional	Physical	Financial	Digital	Sexual	Mental Health	Substance Abuse
Calling you names, insulting you or continually criticizing you	Pulling your hair, punching, slapping, kicking, biting or choking you	Preventing you from viewing or having access to bank accounts	Telling you who you can or can't be friends with on social media	Forcing/manipulating you into to having sex/performing sexual acts	Intentionally doing things to make you feel "crazy" or like you are losing your mind	Forcing you to use drugs or alcohol (especially if you've had a substance abuse issue in the past)
Humiliating you in any way	Preventing you from calling the police or seeking medical attention	Living in your home but refusing to work or contribute to the household	Sending you negative, insulting or even threatening emails, Facebook messages, tweets, DMs or other messages online	Forcing you to watch pornography	Telling you that you are lazy, stupid, crazy, or a bad parent because of a mental health condition	Being told you that you are to blame for abuse or sexual assault because of your use of alcohol or other drugs
Punishing you by withholding affection	Using weapons to threaten to hurt you, or actually hurting you with weapons	Giving an allowance and closely watching how you spend it or demanding receipts for purchases	Stealing or insisting to be given your passwords	Hurting you with weapons or objects during sex	Blaming you for the abuse by saying you're the one who is "crazy"	Being prevented from attending a recovery meeting or interference with your substance abuse treatment
Monitoring where you go, who you call and who you spend time with	Trapping you in your home or keeping you from leaving	Forbidding you to work or limiting the hours that you can work	Pressuring you to send explicit video/pictures	Forcing you to dress in a sexual way	Telling you no one will believe what you say because of your mental health condition	Being forced/coerced into engaging in illegal activities (e.g., dealing, stealing, trading sex for drugs) or other activities that you feel uncomfortable with in order to obtain alcohol/ other drugs
Blaming you for the abuse	Harming your children	Placing your paycheck in their bank account and denying you access to it	Threatening to post/ share explicit images of you	Continuing to pressure you after you say no	Using your mental health condition to undermine or humiliate you with other people	
Telling you that you will never find anyone better, or that you are lucky to be with them	Controlling your eating and sleeping habits	Refusing to give you money to pay for necessities like food, clothing, transportation, or medical care	Using GPS tracking capabilities to keep constant tabs on you	Ignoring your feelings regarding sex	Threatening you will lose custody of your children because of your mental health status	
Trying to isolate you from family or friends	Abandoning you in unfamiliar or unsafe places		Constantly texting you and making you feel like you can't be separated from your phone for fear that you will be punished	Playing on the fact that you're in a relationship, saying things such as: "Sex is the way to prove your love for me"		
Accusing you of cheating & often being jealous of your outside relationships	Erratic or dangerous driving intended to threaten or intimidate		Looking through your phone frequently, checks up on your pictures, texts and outgoing calls	Demanding sex when you're sick, tired or after hurting you		
Threatening to hurt you, the children, your family or your pets				Reproductive Coercion		
Demanding to know where you are every minute				Forcing you to not use any birth control (ex. the pill, condom, shot, ring, etc.)	Trying to prevent or discourage you from accessing mental health treatment or taking your prescription medication	
Refusing to trust you and acting jealous or possessive				Continually keeping you pregnant	Threatening to have you committed to an inpatient psychiatric unit	
Damaging your property when they're angry (throwing objects, punching walls, kicking doors, etc.)				Sabotaging birth control methods		
				Forcing you to get an abortion, or preventing you from getting one		

Who Can Be In an Abusive Relationship?

Anyone can be abusive and anyone can be the victim of abuse. It happens regardless of gender, age, sexual orientation, race or economic background. While an abusive person often blames their partner to justify their behavior, abuse has nothing to do with the person it's directed at, and it's never a result of anything to do with the relationship or a particular situation. Abuse is a personal choice and a strategic behavior used to create the abusive person's desired power dynamic. Regardless of the circumstances of the relationship or the pasts of either partner, no one ever deserves to be abused.

IPV Assessment Follow-Up Questions: Below are some additional questions the Advocate can ask the caller to further identify DV.

- What kinds of things has your partner done to hurt you?
 - Has your partner ever hit, kicked, punched or burned you? Has your partner ever injured you so badly that you needed medical care? Has your partner ever threatened you with a gun or knife?
 - How did you and your partner decide to have children? How did your partner act while you were pregnant?"
 - Has your partner ever called you names or told you that you are ugly or worthless? Has your partner ever destroyed something meaningful to you?
 - What would happen if you told your partner you did not want to have sex?
 - Has your partner ever called you sexually demeaning names? Do you feel you can say "no" if you don't want to have sex?
 - When you are with your partner, do you feel like you are walking on eggshells?
 - Are you afraid for your life?
 - Is the abuse part of the reason you reached out to us today? Is the abuse part of the reason you are feeling like hurting yourself?
 - When, where, how and how often does the abuse occur?
-

What you can say to a survivor/victim in an abusive situation:

- I know it took a lot of courage to call us today and talk about everything that's been happening to you.
- You are very strong and brave to share this with me.
- You do not deserve to be treated like this. No one deserves to be hurt and abused.
- It's ok to feel the way you do. Anybody would and I am very glad you felt safe to share this with me.
- I can share some information that might be able to help you.

Suicide Crisis Calls That Intersect With Intimate Partner Violence (IPV)

**Call Comes into the
Lifeline Crisis Line**

Proceed with Lifeline's Suicide Assessment and Listen for IPV "Red Flags"

- The person is afraid all the time
- The person has been isolated from family/friends
- The person "can't do anything right"
- The person is yelled at, criticized, humiliated by their intimate partner
- The person is to blame for their intimate partner's behavior

YES (For more see *IPV Tip Sheet*)

Proceed with Suicide Intervention to include IPV Safety Planning

- How to remain safe in the relationship
- How to file police report and restraining order
- How to leave safely/have an escape route
- How to safety plan with children
- How to cope with emotions
- How to stay safe in the home

(For more see *Safety Planning Tip Sheet*)

Referrals

Provide referrals
to The Hotline:

**1-800-799-SAFE (7233)
or thehotline.org**

and/or other local
DV agencies

Determine Level of Suicide Risk: Safety Risk Assessment

**Are you alone now?
Is it safe to talk on
the phone now?**

Determine Safety Priorities

- Would you like to stay on the phone and talk, or would you prefer to go someplace safer and call me back?
- Do you want to get help from the police right now?
- Have you been having thoughts of harming or killing yourself (or someone else)? Have you ever tried to harm yourself or end your life?
- Has the person you're currently with ever threatened you or hurt you or someone you love?
- Create safety code word with caller

NO

Suicide is Primary Concern

- Proceed with suicide assessment and intervention, including considerations for IPV-specific risks
 - Advise responders not to discuss IPV with potentially abusive partner
 - Advise police of abuse/presence of weapons in the home
 - Advise hospital intake personnel to perform IPV assessment, safety planning and/or linkage with DV/rape crisis services

Imminent Danger from Abusive Partner is Primary Concern

- If the caller chooses to remain on the phone, discuss immediate escape routes
- Connect the caller with 911 if they or their children are in immediate danger
- Make arrangements to get back in contact to discuss mental health and/or substance abuse referral options once caller is safe. Share contact information for The Hotline

(For more see *Recommendations for Suicide Prevention Hotlines on Responding to Intimate Partner Violence*)



Intimate Partner Violence Safety Planning Tip Sheet

What is Safety Planning?

Safety planning is helping a caller build a blueprint for a safer life. It is a personalized, practical plan that includes ways to remain safe while in a relationship, planning to leave or after leaving. A good safety plan will have all of the vital information a caller needs and be tailored to their unique situation.

NOTE: Safety planning is NOT telling the caller what to do or blaming the caller.

Assessing Immediate Danger

In order to determine what type of safety plan should be developed in conjunction with the caller, it is first important to identify if the caller might be in immediate danger. Below are some questions you can ask to determine if the caller is in immediate danger.

- Is that person there right now?
- Is it safe enough for me to ask you a few questions?
- Do you feel you are in immediate danger?
- Does this person have a weapon? Are they threatening to use it?
- Who else is there (e.g. children)? Can you leave to a safe place?

If caller is in immediate danger from a partner or others:

- Suggest that caller contact police or offer to call police on their behalf
- Give contact information for National Domestic Violence Hotline (1-800-799-SAFE) and/or local DV agency
- Make arrangements to get back in contact to explore mental health referral options once the caller is safe

How to Assess Safety Further IF THERE IS NO Immediate Danger Threat

Ask callers what they have done thus far to protect themselves and their children. Ask if they think this will work again and if not, what they think might work. You could say, "Some people tell me...Do you think that would work?" Examples can include:

- Calling a friend, so the partner knows someone is listening
- Removing guns from the home if possible or hiding guns, knives or other weapons
- Sending the children to someone else's home when there is increased danger
- Keeping keys and money available outside of the house, and keeping a full tank of gas
- Storing important papers and records (or copies) in a safe location
- Leaving the house overnight



Safety Strategies

For callers that do not feel safe to call law enforcement or cannot, below are other safety strategies that can be shared with them.

Safety Planning to Prevent Injury

- Identify safe areas of the house where there are no weapons and there are ways to escape. If arguments occur, try move to those areas.
- Make yourself a small target. Dive into a corner & tuck into a ball with your face protected, arms around each side of your head, fingers entwined.
- If possible, have a phone accessible at all times and know what numbers to call for help. Keep cell phones charged.
- Keep weapons like guns and knives locked away and as inaccessible as possible.
- Create several plausible reasons for leaving the house at different times of the day/night.
- Purchase a TracFone (prepaid wireless phone) and hide it from abusive partner so it can be used in an emergency.

Safety Planning With Children

- Teach children when and how to call 911.
- Children should also know the escape route (perhaps call it a “fire drill”) so as not to tell the abuser of the plan.
- Create a code word that you can say when they need to leave the home in case of an emergency (teach them not to share this word with anyone).
- In the house: identify a room they can go to when they’re afraid & something they can think about or hold (e.g. stuffed animal) when they’re scared.
- Teach them that although they want to protect their parent, they should never intervene.
- Help them make a list of people they are comfortable talking with and expressing themselves to about the violence, and let them know the abuse is not their fault.

Safety Planning When Leaving

- Keep any evidence of physical abuse, such as picture of injuries, and/or of digital abuse, such as screenshots of threatening texts. Keep a journal of all violent incidences, noting dates, event and threats made. Keep journal in safe place.
- Find out how to obtain a Protective Order for you and, if applicable, your children.
- Know where you can go got get help. Tell someone what is happening to you.
- If you are injured, go to a medical facility and seek treatment. If you feel comfortable, disclose the abuse and ask them to document the visit.
- Contact your local shelter and find out about laws and other resources available to you before you have to use them in a crisis. WomensLaw.org has state by state legal information.
- Try to set money aside or ask friends/family to hold money for you as well as any important documents (e.g. birth certificates, SSN, etc.).

Not all callers are in a place to leave the relationship. Below are some suggested emotional safety planning tips you can share with callers as they navigate if and when they will leave an abusive relationship.

Emotional Safety Planning

- Seek out supportive people. A trusted friend/family member can help create a calm atmosphere to think through the situation and options.
- Identify and work towards achievable goals (e.g. calling a local resource and seeing what is available in your area or calling The Hotline).
- Create a peaceful space for yourself. Find a physical space where your mind can relax and feel safe such as a room in your house, space under a tree, comfy chair.
- Be kind to yourself. Speak kindly of yourself and give yourself breaks throughout the day to cope with your situation. Take a bath or walk to clear your mind. Try and eat healthy and get sleep. Take deep breaths to re-energize your brain and thoughts.
- Remind yourself of your great value. Reminding yourself that you matter and are special is very crucial to your emotional health.