



Addressing domestic violence: The Bascomb Street Surgery in transition

This case was written by **Dr Klaus Melf (MD)** and **Dr Kristin S. Scharffscher (PhD)**, Norwegian affiliate of International Physicians for the Prevention of Nuclear War (IPPNW). It was edited by Charlotte Butler, Project Consultant. The case is intended to be used as the basis for group work and class discussion rather than to illustrate either effective or ineffective handling of a Medical Peace Work situation.

© 2015, medicalpeacework.org and the authors

All rights reserved. Permission is granted for non-commercial reproduction, translation and distribution of the case study, as long as medicalpeacwork.org and the authors are given credit.

medicalpeacwork.org and the authors do not guarantee that the information in this case study is complete and correct and shall not be liable for any damages incurred as a result of its use.



Erasmus+

This case study was funded with support from the European Commission. It reflects only the authors' view. Erasmus+ and the Commission are not responsible for any use that may be made of the information it contains.

“Yet another woman killed by her husband,” said Dr John Redpath with a sigh. “According to her medical records she had been beaten for five years, been seen on several occasions by her GP and twice attended her local A&E department, once with a badly broken arm. And yet nobody had intervened. She slipped through the net of every authority that might have saved her; the doctor, the hospital, social services, the police... Why does it keep happening time and time again?” He looked up from his newspaper and realised that both of his colleagues had stopped eating their lunches and were staring at him.

“I think what you just read out is something that should concern us all deeply,” said his colleague, Dr Sonia Lindberg. Freddy Baker, the third doctor in the practice, remained silent. He was the oldest and most experienced of the three doctors who shared the busy North London practice located in Bascomb Street. John was the most recent recruit, having joined two years ago when he moved to London in 2013. The three GPs had formed the habit of eating lunch together whenever their schedules allowed. It gave them the chance to share news, discuss medical developments and benefit from each other's advice about difficult cases.

“I saw a recent study,” continued Sonia, who had a tendency to lecture, “that showed that a third of all women in the European Union have experienced physical or sexual violence at some point in their lives, and for eight percent of those women abuse happened in the last year. Just imagine how many of our own patients might have been victims, or are at risk?”¹

She looked at John and Freddy with her intent gaze, before she continued: “I think this is a major issue that's right on our doorstep. It's not just a women's issue; any of our patients, no matter if it's a woman, man, child or elderly person, can be terrorised by an abusive partner, acquaintance or care-giver,” Sonia ended firmly. “You brought up the subject, and I really think it's time to address it seriously. We do claim to run a family clinic after all. And domestic violence affects every person in a family – the perpetrator, the victim, and children who may be witnesses.”

Personal experiences

Sonia's words struck John with particular force. As a child he had been subject to regular violence by his father. His mother and siblings had been beaten, too, but he had never talked about it until just over a year ago at the surgery's Christmas get-together. John had had one drink too many and revealed his childhood experiences to his colleagues. At first he had

¹ European Union Agency for Fundamental Rights (2014) *Violence against women: an EU-wide survey - Main results*. Publications Office of the European Union, Luxembourg, 2014.
<http://fra.europa.eu/en/publication/2014/vaw-survey-main-results>

sobbed because his father had just passed away, and then he had continued to cry because he could not feel sad about it. He knew both Sonia and Freddy remembered the occasion, even though they had never since referred to it.

“Well,” began John. “I do have a patient who has come to see me several times with bruises on her face and arms. She doesn’t actually come to see me because of the bruises but for other complaints; a persistent cough, pains in her pelvis. She gave birth... last year I think it was. When I asked about the bruises, the first time she said she had fallen down the stairs in her house. Another time she said something about an accident in the garden. She blamed her poor eyesight and laughed it off, said she’s really clumsy without her glasses. And she sounded so credible, but I guess this could be a classic case...”

“You’ve never asked her?” said Sonia.

“No! I felt it would be too intrusive. That I would be accusing her of lying to me. Intrusive and insulting. Perhaps it also got too close to home. I don’t know.”

“I once asked a woman about domestic violence when she came to see me with signs of depression and anxiety. Her son was having trouble at school,” sighed Sonia. “My gut feeling turned out to be right. She admitted to having a violent husband but didn’t want to talk about it. I have never raised the subject with her again. I didn’t quite know how to help her.”

“What about you, Freddy?” asked John. “Is your record any better?”

Freddy hesitated. “I don’t think I’ve ever asked any of my patients about domestic violence,” he said slowly. “Of course, I remember some patients turning up at the surgery with contusions or lacerations, obviously due to a ‘heated tiff’.” Freddy made air quotes. “My feeling is that this is something people don’t want to talk about. It is seen as a private issue. Something embarrassing. Or perhaps I was the embarrassed one...”

After a deep breath Freddy continued: “I agree, it’s an important topic and one we haven’t faced up to properly. So perhaps, as Sonia suggests, it is time to make this a priority and see exactly what we can and need to do in our practice. But it’s too big a subject to even begin discussing during a lunch break.”

Freddy stood up, grabbed the pot from the brewer and poured coffee into three mugs already placed on the table. “We could devote some time during next Thursday’s practice meeting to look at the problem and then discuss what actions we could take. Though that needs some preparation. How on earth will we find the time for that? We’re already overloaded as it is. New demands for form filling from the Department of Health; new guidelines on what drugs we can and can’t prescribe from NICE (National Institute for Health Care and Excellence); keeping up with the infant vaccination programme; identifying ageing patients at risk in our

local population – and that's before we get to the task of actually seeing our patients. There just aren't enough hours in the day as it is, let alone room to take on a new challenge. How do you imagine a small practice like ourselves can tackle such a huge issue?"

"Well that's for us to discover, isn't it," said John. "Don't worry, old man, we'll find a way. I don't mind compiling some background material for that meeting."

The surroundings

The population served by the North London surgery was typical of many UK cities. Prosperous squares of tall houses with access to their own locked parks were occupied by the professional classes; doctors, lawyers, civil servants, bankers and businessmen. Nearby, the upwardly mobile social workers, teachers, office and local government workers were busy renovating the terraced housing – once the homes of ordinary workers but now generally beyond their means.

Just a few streets away from these two areas stood the run down blocks of council flats that housed a mixed collection of families and nationalities. White working class people, the luckier ones employed in the transport, office or council sectors, lived alongside a growing and highly diverse population of immigrants. Many of these, like an increasing number of their white neighbours, were unemployed and struggling to survive. It was a cosmopolitan society in which each population largely mixed with their own. But apart from the very well-off who had their own private health care, all of these different nationalities and ethnic groups mingled at the small surgery in Bascomb Street.

Thursday, March 5th: The surgery meeting

The following Thursday evening saw the team assembled. Apart from the three doctors, the two members of staff at the surgery were also present. Joan was the receptionist in charge of the Appointments diary. She exchanged glances with the lady sitting next to her, who wore the white overall of an auxiliary nurse. Brenda was a large, cheerful West Indian lady. She was responsible for the many routine medical jobs that didn't require a doctor's appointment, such as giving injections, renewing prescriptions, changing dressings and so on. The two knew nearly every visitor of the surgery, and everyone knew Joan and Brenda.

John held a huge folder containing numerous articles and reports with coloured charts and graphs. "Well," began Freddy. "I know you've been busy this week, John. I haven't seen you lurching. Judging by those bulging files of notes you are holding, we should be able to build a

pretty good picture of the problem. Let's not waste time but start with the information you've gathered.”

Domestic violence: The picture

“Thanks, Freddy! Well, I've looked into a lot of recent literature on domestic violence and found some depressing figures on its prevalence and health impacts. Our Office for National Statistics has calculated that one in twelve women (8.5 %) and one in twenty-two men (4.5 %) has experienced domestic violence during the last year. That's about 1.4 million women and 700,000 men in the UK alone.” John stopped for a moment and looked at his colleagues. They were all listening attentively. He continued: “Domestic violence is not only physical, but also psychological or sexual, and the offender is most commonly an intimate partner or former partner. However, this type of violence can also be committed by other family members. If we look at the total number of persons having ever experienced domestic violence since the age of sixteen, the rate is close to 30 % of all British women and 15 % of all the men.”²

“I also became aware that the percentage among the patients in our waiting rooms is likely to be higher than the national average. An enquiry into surgery waiting rooms in Hackney³ showed that 17 % of women had experienced physical violence and/or forced sex by a partner or former partner in the past year, and the lifetime prevalence there was 41 %. Three out of four women reported some form of controlling behaviour in a partner, and one in three had felt afraid of their partner at some point. Let's take a simple calculation: We see about 30 female patients on a normal day in our clinic. Using the Hackney rate, around twelve of those would have experienced physical or sexual violence at the hands of their partner at least once during their adult life; five of those women over the past year.”

“But, John, we're not in East London,” interrupted Freddy. “Hackney has a completely different demography and history. It's one of the most crime-ridden boroughs in the country – gangland!”

“That's maybe right,” John replied calmly. “We don't know the figures for this area. But my point is that women, and certainly men and children too, who have been beaten or otherwise abused at home, more often get health problems. They are therefore more likely to turn up in

² Office for National Statistics (2015) *Focus on Violent Crime and Sexual Offences, 2013/14*. London, UK. February 2015. <http://www.ons.gov.uk/ons/rel/crime-stats/crime-statistics/focus-on-violent-crime-and-sexual-offences--2013-14/index.html>

³ Richardson J et al. (2002) “Identifying domestic violence: cross sectional study in primary care”. *BMJ* 2002; 324: 1-6.

the surgeries. Look at this world map,” he continued, passing round a report from the World Health Organization (WHO) which was folded open. “It shows the rate of physical and sexual violence against women in different regions. Africa, the Eastern Mediterranean Region and South-East-Asia have the highest rates here. We should probably have this in mind, when seeing newly arrived immigrants” (Exhibit 1).

Health consequences

John continued to talk as the report was passed around the table. “Even more important is that very few victims of domestic violence come to see the doctor because of their physical injuries. Many more attend our surgery with chronic diseases and psycho-social problems. There is another interesting figure in this report,” John added as he pointed to the publication now in Brend’s hands. “It is a flow diagram showing how partner violence harms the victim not only because of the physical trauma, but also because of the psychological stress and the control and fear mechanisms associated with it” (Exhibit 2).

“According to an American study on diagnoses of women who have experienced partner violence over the past year, their medical records showed a six-fold increased risk of clinically identified substance abuse, a three-fold increased risk of depression, and a more than a doubled risk of anxiety/neuroses and tobacco use. Significantly more of those women, compared with women without partner violence, had also musculo-skeletal diagnoses, menstrual disorders, headaches, chest pain, abdominal pain, reflux disease, and so on.”⁴

“Okay. I think we've all got your point,” commented Freddy. “It’s true that we often see patients with inexplicable ailments and diseases. These could be the symptoms or consequences of violence. Maybe we should learn to ask the right questions?” Everyone around the table nodded in agreement.

Role in violence prevention

“What I find particularly disturbing about these figures,” said Sonia, “is that every day we also see patients in our surgery, who are likely to experience domestic violence in the near future. So my question is – can we do anything to prevent violence from happening in the first place?”

“But, Sonia, primary prevention is not our job,” protested John. “That’s something we should leave to teachers and public health services to deal with.”

⁴ Bonomi AE, Anderson MP, Reid RF, et al. (2009) “Medical and psychosocial diagnoses in women with a history of intimate partner violence”. *Arch Intern Med* 2009; 169: 1692-1697.

Freddy leaned back in his chair. "Primary prevention would require us knowing about the risk factors for domestic violence as well as protective factors. And we would need to educate ourselves about possible effective interventions."

"Well, you are right!" replied John. "The greatest risk factor for experiencing domestic violence is having experienced violence before. It therefore makes sense to check whether there has been violence in the life of a patient, and not wait until we see acute signs and symptoms of it."

"But, why is it so difficult for our patients to tell us these things voluntarily?" asked Sonia.

"There might be certain barriers for disclosing a history of violence, such as a feeling of guilt for what has happened, fear for retaliation, or confusion and ambiguity when the perpetrator is a beloved one. And," continued Freddy, "there are barriers on our side, too. For instance, not feeling comfortable or skilled to inquire about such issues."

"We should have clinical protocols and care pathways on domestic violence," intervened Joan. "This could make it easier for Brenda and me, too. We often see and hear things which are suspicious, and it would be good to know what we are then supposed to do. You have very packed schedules. You cannot expect patients to talk about difficult things under time pressure. We will need to give them more time. I suggest that patients where we think that violence could be an issue, are scheduled in the afternoon, when the surgery is a bit quieter."

Brenda nodded in agreement. "Not to forget the language and cultural differences. Those things can also make it difficult for some women to talk about it, or to trust you white doctors. And when a woman is accompanied by her husband or another relative who is helping with translation, that's hardly a great starting point when you want to disclose an abusive relationship at home, is it? There's another issue, too." Brenda pointed in the direction of the reception and waiting room. "I don't know if you've noticed, but we've got pamphlets and posters on diet, on cholesterol, on how to stop smoking and various other health issues, but nothing at all about domestic violence. No helpline number. No web-links. No invitation to talk to us about it. Nothing! Not even in the Ladies Room. How on earth would our patients know that we care about the troubles they face at home?"

The three doctors looked at each other and smiled. "As usual," said Freddy, "the most practical suggestions come from you two. Thank you. We obviously have to work in our own back yard."

"There is a lot we can do to prevent violence from being repeated," said Sonia. "Last but not least we could educate ourselves on how to identify early signs and symptoms of domestic violence, how to communicate with our patients without being intrusive, and how to care for and support those who have already experienced violence. Plus, we should keep in mind that there might be children suffering, too. This might be our biggest contribution to protecting our patients' health and breaking cycles of violence." Sonia stopped for a moment and then

continued. “Why don't we organise a workshop where we can try to put these different strategies into practice, perhaps do role plays about difficult questions and elaborate our protocols on domestic violence?”

Everyone at the meeting agreed on a time for such a workshop two weeks later. Sonia volunteered to find some patient cases that could be anonymised and used for simulations and role plays. John offered to check with his professional network to find out how other surgeries were dealing with the problem, and Freddy decided he would be best suited to check the political and legal aspects of domestic violence.

“Would you have the time to look into coordination efforts?” Freddy asked Joan. “By that I mean how to work with the many different stakeholders involved, such as the police, social workers, specialist agencies, and so on. And if you have time, Brenda,” he continued, “do you think you could find out who in our neighbourhood is currently offering help with this problem? Perhaps there is a Women's Group in the area? We should know about local support and resources, where we can direct victims for practical help or assistance if they want to leave an abusive partner.”

Monday March 16th: Email from Freddy

Dear team,

As agreed, we will hold a workshop on domestic violence this coming Friday, March 20th. I hope we can begin promptly at 3pm, as that will give us two and a half hours to cover as much as we can. It's an ambitious programme! We need to finish by 5.30 pm so that we have time to prepare for evening surgery at 6pm.

I have come across two particularly useful reports published by WHO. One of these is a collection of evidence about violence prevention.⁵ Just to follow up on our discussion on preventing violence in the first place, please have a look on the page about treating problem drinkers (Exhibit 3). There might also be other risk factors that we could try to modify, for instance unwanted pregnancies or mental disorders.

The other publication is a set of guidelines on how to respond to violence against women.⁶ They cover many of the issues we discussed at our surgery meeting. It would

⁵) WHO (2010). *Violence prevention: the evidence*. WHO, Geneva.

http://www.who.int/violence_injury_prevention/violence/4th_milestones_meeting/publications/en/

⁶) WHO (2013). *Responding to intimate partner violence and sexual violence against women – WHO clinical and policy guidelines*. WHO, Geneva.

<http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/>

be useful if you could find time at least to look at the figure on the care pathway (Exhibit 4).

Also attached is a danger assessment form and a safety plan which might be useful for our own protocols (Exhibits 5 and 6).

Provisionally, I think that the main objectives of our workshop should be to:

1. Identify our personal, structural and cultural barriers to addressing DV
2. Try to create the best strategies/tools to overcome these barriers
3. Prepare an implementation plan for the best strategies/tools

I look forward to discussing this with you all, and to hear your comments and ideas!

Freddy

Friday March 20th: The workshop

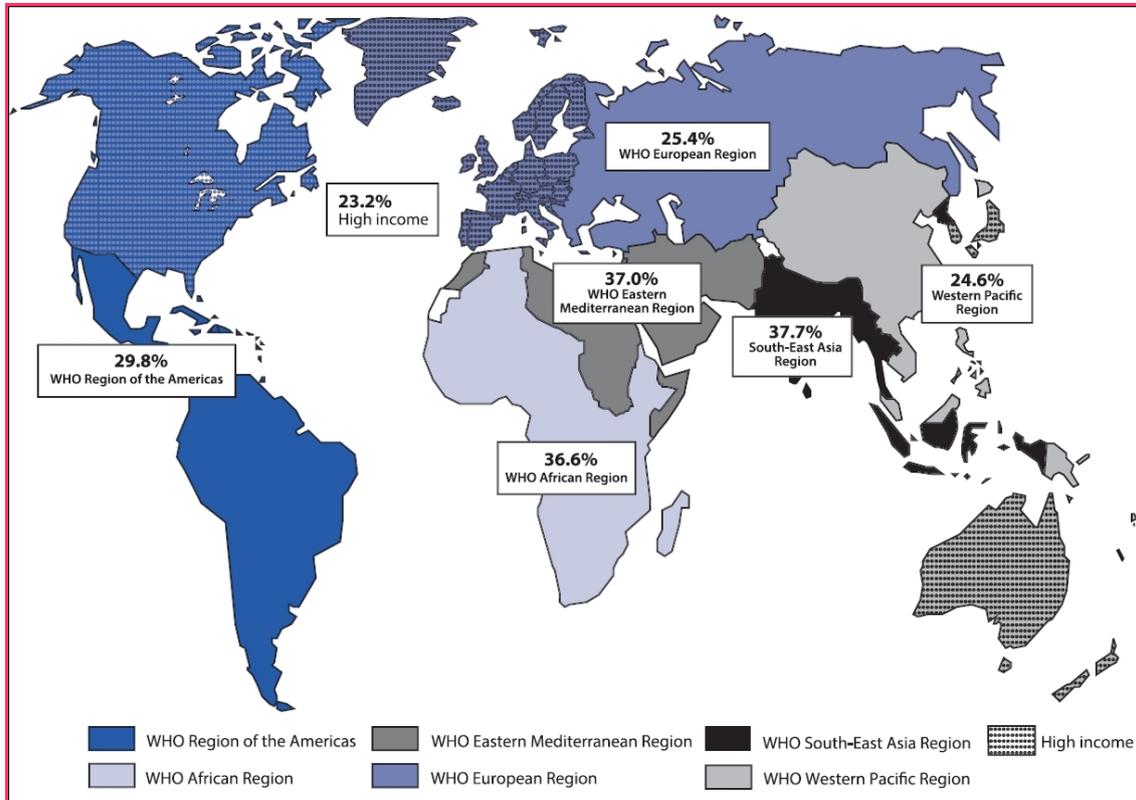
At 2:50pm, Freddy entered the meeting room holding a plate with a large fruit cake on it. John followed right behind him with another plate of biscuits while Sonia carried five pads of paper and several pens, which she proceeded to set out round the table. Joan and Brenda were already there and the room smelled of freshly brewed coffee.

Freddy and John then started to battle with a rickety flip chart that seemed too big for the small meeting room. Eventually it was stable and Freddy sellotaped a large printout of the workshop objectives onto the front sheet.

“Right!” said Freddy. “Let’s all sit down! Everyone’s got a pen, something to write on and the right glasses so they can see the flip chart? Good. Well, let's make a start. Today, we are going to try and work out how to incorporate best practice regarding the prevention, identification and treatment of domestic violence at our surgery,” he began. “By the end of the afternoon, I hope we will have been able to map out a strategy in which we can all play our part, so that patients are no longer afraid or feel they have to hide their sufferings from us. I want us to make them feel that in Bascomb Street Surgery they can find a sympathetic ear and expert help; that we won't just treat their bruises but help them to change their own life and that of their family. It's a big task, I know, but I believe this team has the will and energy to do this. We just have to find the best way forward. I don't want any of our patients to end up in the headline of a newspaper.”

Exhibit 1

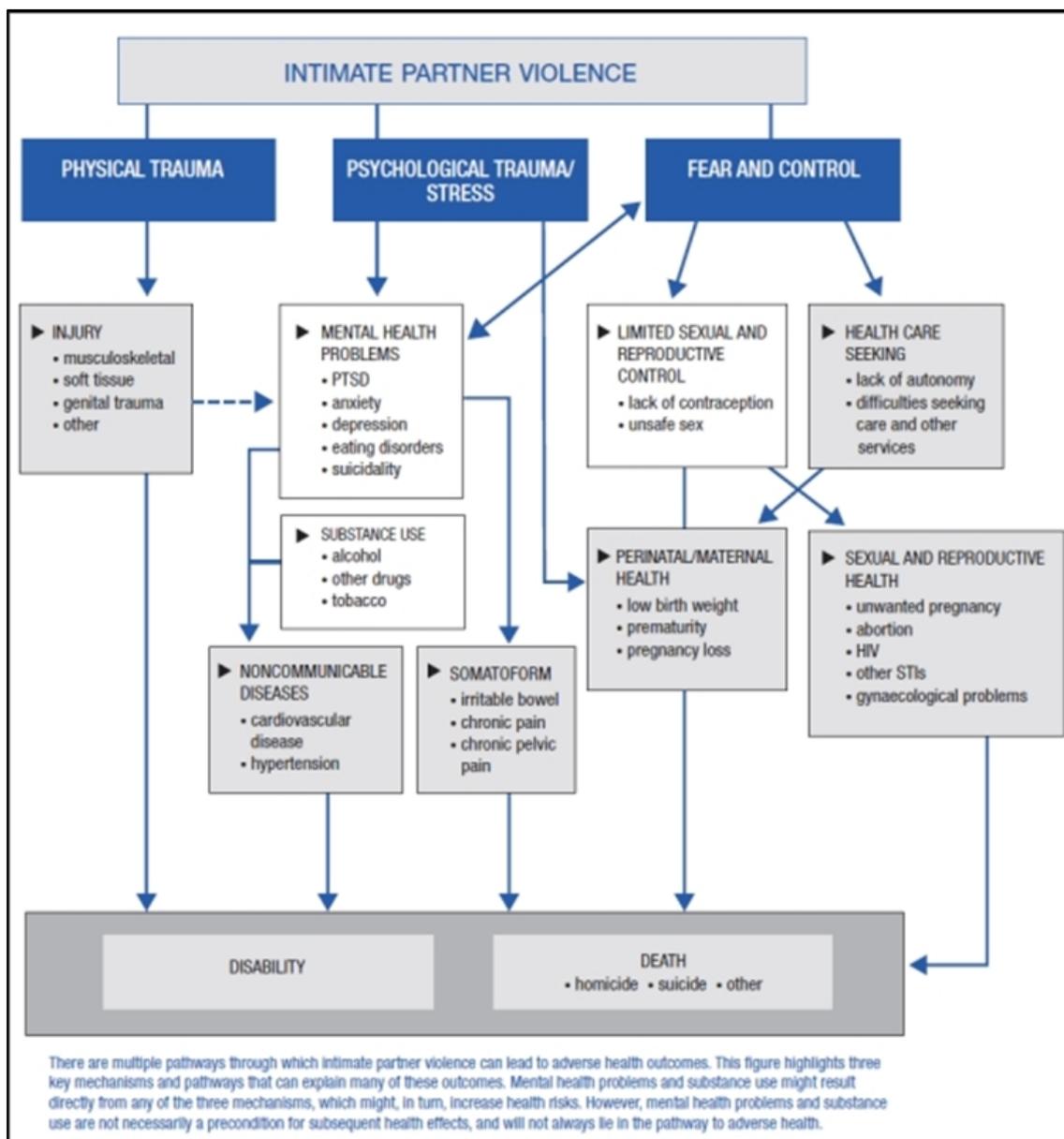
World map of regional rates of violence against women



Source: Garcia-Moreno C, Pallitto C, Devries K, Stöckl H, Watts C, Abrahams N (2013) *Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence*. Geneva: WHO. Page 18.
<http://www.who.int/reproductivehealth/publications/violence/9789241564625/en/>

Exhibit 2

Pathways and health effects of intimate partner violence



Source: Garcia-Moreno C, Pallitto C, Devries K, Stöckl H, Watts C, Abrahams N (2013) *Global and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violence*. Geneva: WHO. Page 8.
<http://www.who.int/reproductivehealth/publications/violence/9789241564625/en/>

Exhibit 3

Violence prevention: Reducing alcohol use in problem drinkers

A systematic review of randomized controlled trials concluded that the following measures to address alcohol use in problem drinkers can reduce violence (59):

- In the United States, screening and brief intervention³ with problem drinkers, including two 15 minute sessions with physicians and two follow up phone calls by nurses, was associated with fewer arrests for assault, battery and/or child abuse among participants than in those receiving standard care (8% versus 11%). Sustained reductions in binge drinking were also reported (60,61).
- In Australia, problem drinkers receiving cognitive behavioural therapy (e.g. goal setting, self-monitoring, problem solving) showed reduced risks of committing assault in the six months after treatment (0%) compared with those receiving cue exposure therapy (e.g. understanding drinking triggers, resisting alcohol after moderate consumption) (5%) (62).
- In Australia, partners of problem drinkers taking part in the Pressures to Change programme, which teaches participants strategies to promote positive changes in their partners' drinking behaviours, reported reduced intimate partner violence after the intervention (4 out of 16 participants in the programme versus 3 out of 7 controls) (63).
- In the United States, telephone aftercare for dependent drinkers discharged from hospital-based alcohol treatment services, providing

a biweekly source of support to patients for a year following treatment, reduced suicide attempts in participants (4 out of 125 receiving the interventions versus 11 out of 167 controls) (64).

The review also found evidence that interventions with problem drinkers reduced other alcohol-related injury types (e.g. road traffic injuries).

Other studies have shown that structured treatment for alcohol dependence can reduce violence. For example, a before and after study in the United States followed 301 alcohol dependent males through an outpatient treatment programme that included eight individual and 16 group therapy sessions over a 12-week period (65). In the year prior to treatment, 56% of participants reported having been violent towards their female partner compared to 14% in a non-alcohol dependent control group. A year after the programme, violence had decreased to 25% in the alcohol dependent group. However, over half of the sample had relapsed into alcohol use; among remitted alcoholics, violence had decreased to 15%. There were also reductions in female-to-male aggression in remitted alcoholics within the programme. Similar beneficial effects on both male-to-female and female-to-male violence have been achieved, also in the United States, through an abstinence-oriented programme for male alcoholics combined with cognitive behavioural treatment for depression or relaxation therapy (66), and through behavioural marital therapy⁴ for newly-abstinent male alcoholics and their partners (67,68).

³ Brief interventions aim to identify a real or potential alcohol problem and motivate the individual to do something about it. Conducted in a variety of settings, particularly primary care and other health services, they typically comprise short one-on-one sessions providing at-risk drinkers with information on the adverse consequences of alcohol and techniques to help moderate their consumption.

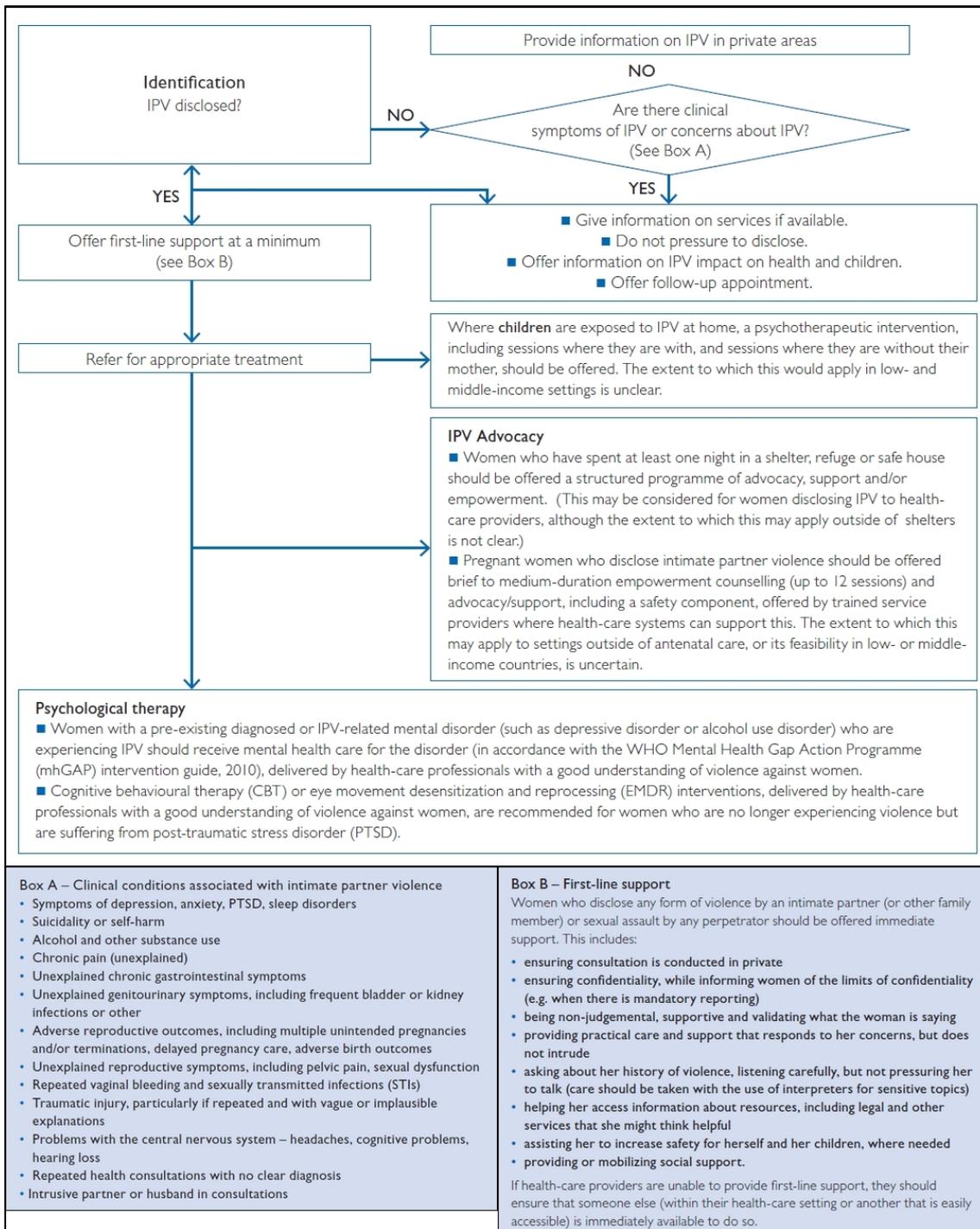
⁴ This seeks to promote relationship factors that are conducive to abstinence, including developing relationships with better communication and involving partners in abstinence promoting activities.

Source: WHO (2010) *Violence prevention: the evidence*. WHO, Geneva. Page 54.

http://www.who.int/violence_injury_prevention/violence/4th_milestones_meeting/publications/en/

Exhibit 4

Care pathway for intimate partner violence



Source: WHO (2013) *Responding to intimate partner violence and sexual violence against women – WHO clinical and policy guidelines*. WHO. Geneva. Page 24.

<http://www.who.int/reproductivehealth/publications/violence/9789241548595/en/>

Exhibit 5

Short danger assessment scheme

DANGER ASSESSMENT-5

Jacquelyn C. Campbell, Ph.D., R.N.
Copyright, 2015; www.dangerassessment.com

This brief risk assessment identifies women who are at high risk for homicide or severe injury by an intimate partner.^{1, 2}

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

- 1. Has the physical violence increased in frequency or over the past year?
- 2. Has he ever used a weapon against you or threatened you with a weapon?
- 3. Do you believe he is capable of killing you?
- 4. Does he ever try to choke you?
- 5. Is he violently and constantly jealous of you?

Protocol suggestions for use of **DANGER ASSESSMENT-5**

- Use 5-item version in ED, protective order hearings, child custody etc.
- If 4 or 5 yes responses, policy is to report to police &/or to domestic violence advocacy program or national hotline (800-799-7233) – her choice – do it with her.
- If 3 of 5, do full Danger Assessment or refer to someone certified in administering DA and proceed based on results.
- If 2 of 5, tell her that she has 2 of 5 highly predictive risk factors for serious assault/homicide – highly recommend further immediate advocacy – call with her.
- If 0-1 of 5, proceed with normal referral/procedural processes for DV.

Source: Campbell JC, (2004) *Danger Assessment*. Retrieved March 23, 2015, from <http://www.dangerassessment.org>

Exhibit 6

Safety Planning

SAFETY PLANNING



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

Safety Packing List

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

Identification for yourself and your children

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

Important papers

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

Money and other ways to get by

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

Keys

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

Ways to communicate

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

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

Medications

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

Things to help you cope

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

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

page 1

15



<http://www.womenshealth.gov>

800-994-9662

TDD: 888-220-5446

Help Hotlines

Call the hotlines below for help if you have been hurt by someone you know or have been attacked by a stranger. You will not have to pay for the call, and you can ask to have your information kept confidential.

The National Domestic Violence Hotline

- Call 800-799-SAFE (7233) or 800-787-3224 (TTY).
- Staff are available 24 hours a day, 7 days a week.
- More than 170 languages are available.
- You will hear a recording and may have to wait for a short time.
- Hotline staff offer safety planning and crisis help. They can connect you to shelters and services in your area.
- Staff can send out written information on topics such as domestic violence, sexual assault, and the legal system.
- You can get help through e-mail on the hotline's contact page.

The National Teen Dating Abuse Helpline

- Call 866-331-9474 or 866-331-8453 (TTY).
- Staff are available 24 hours a day, 7 days a week.

- You will hear a recording and may have to wait for a short time.
- You can get help through a live online chat from 5:00 p.m. to 3:00 a.m. (Eastern Standard Time). Click here to learn more about the National Teen Dating Abuse Helpline Live Chat.
- You can ask questions through e-mail at the helpline's contact page.

The National Sexual Assault Hotline

- Call 800-656-4673.
- Staff are available 24 hours a day, 7 days a week.
- You will hear a recording that asks whether you prefer English or Spanish and if you want to talk to a hotline staff member.
- You can get live online help through the National Sexual Assault Online Hotline 24 hours a day, 7 days a week.

All material contained in this FAQ is free of copyright restrictions, and may be copied, reproduced, or duplicated without permission of the Office on Women's Health in the Department of Health and Human Services. Citation of the source is appreciated.

Content last updated March 7, 2011

page 2

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

Source: U.S. Department of Health and Human Services, Office on Women's Health (2011) *Safety Planning*. Retrieved March 23, 2015, from <http://womenshealth.gov/violence-against-women/get-help-for-violence/safety-planning-for-abusive-situations.html>