Received 7 August 2015
Revised 16 November 2015
Accepted 29 December 2015

The lethality assessment program

Which survivors of intimate partner violence are most likely to participate?

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Abstract

Purpose – The purpose of this paper is to examine the differential use of the Lethality Assessment Program (LAP) – a risk-informed, collaborative police-social service intervention – across female victim-survivors of intimate partner violence (IPV) in four police jurisdictions in Oklahoma.

Design/methodology/approach – Women visited by the police during the study period participated in semi-structured telephone interviews. Logistic regression was utilized to examine what factors impacted implementation of the LAP.

Findings – There was differential use of the intervention based on the following: jurisdiction, severe violence at the incident, perpetrator's use of a weapon ever in the relationship, PTSD symptomology, and women's prior protective actions and utilization of domestic violence advocacy services.

Research limitations/implications – Future research should examine the decision-making process of survivors and police officers to better elucidate the meaning behind these statistical relationships.

Practical implications – PTSD education should be an integral part of police training on domestic violence. In addition, officers should be trained to recognize less injurious, but also damaging, forms of IPV, such as verbal abuse and coercive control.

Social implications – While police contact can provide accountability for the offender, the social service system is best equipped to provide safety options for the victim-survivor of violence.

Originality/value – Previous research has demonstrated the effectiveness of the LAP. It is important to understand how the intervention is applied in order to better understand who is most assisted by the intervention and what training or education could be beneficial for officers providing the intervention.

Keywords Gender, Domestic violence, Implementation

Paper type Research paper

Policing: An International Journal of Police Strategies & Management
Vol. 39 No. 1, 2016
pp. 64-77

1363-951X
DOI 10.1108/PIJPSM-08-2015-0094

The authors would like to thank Dave Sargent and the Maryland Network Against Domestic Violence for their development of the Lethality Assessment Program, cooperation with the evaluation, and work on behalf of victim-survivors of domestic violence.

Introduction

Intimate partner violence (IPV, also commonly called domestic violence) is a complex social issue that affects nearly 35 percent of women in their lifetimes (Black *et al.*, 2011). Police officers are often one of the first formal system contacts that abused women make, and the police response is the first step in the criminal justice system process (Messing *et al.*, 2015b; Townsend *et al.*, 2005). While police contact can provide accountability for the offender and may attend to victim-survivor safety in the short term, social services are best equipped to provide long-term safety options for the victim-survivor of violence (such as safety planning, housing assistance, mental health services), suggesting the ideal response to IPV is a coordinated criminal justice and social service response.

The Lethality Assessment Program (LAP) is one such coordinated response. The LAP uses an IPV risk assessment (called the Lethality Screen) developed for first responders to assist police officers with identifying risk for future violence and homicide at the scene of a domestic violence incident (Messing *et al.*, 2015c). For victim-survivors at high risk, police departments and local domestic violence agencies collaborate to provide immediate telephone advocacy and safety planning. The LAP has been shown to increase women's help-seeking and reduce violent victimization (Messing *et al.*, 2015d). This intervention utilizes existing community resources and, therefore, can be implemented across a wide range of jurisdictions and reach a large number of victim-survivors. However, the intervention may be utilized differentially by victim-survivors at the scene of a domestic violence incident. This research examines factors associated with victim-survivors' choice to speak to a hotline advocate at the scene of a police-involved IPV incident in four police jurisdictions in a single state.

IPV Intervention

Calling the police is a commonly employed help-seeking strategy by women in abusive relationships (Kaukinen *et al.*, 2013; Rennison and Welchans, 2000). Calls to the police increase as the severity or frequency of abuse increases (Akers and Kaukinen, 2009; Bonomi *et al.*, 2006). While accessing domestic violence services occurs less often than contacting the police, women report that contacting a domestic violence service provider and going to a shelter are helpful in the majority of cases (Hackett *et al.*, 2015; Lyon *et al.*, 2008, 2011) and shelter services were shown to be most effective in reducing severe and moderate re-assault in one prospective study (Campbell *et al.*, 2005).

The cornerstone of domestic violence services is safety planning. The objectives of safety planning are education and empowerment; it is a process which allows the victim-survivor to gain information, assess her situation, understand her danger, reinforce her sense of control, strategize her responses, and evaluate outcomes (McFarlane *et al.*, 1997, 2004; Campbell, 2001). Lack of awareness regarding available resources and difficulties accessing services are factors associated with remaining in an abusive relationship (Patzel, 2006). As women tend to underestimate their risk (Messing and Thaller, 2013) and safety concerns often motivate help-seeking (Pape and Arias, 2000; Short *et al.*, 2000), increasing an IPV victim-survivor's perception of risk may help encourage protective actions (Campbell *et al.*, 2005). Research suggests that low cost, clear, simple assessments and referrals, such as teaching women safety strategies over the telephone, can be effective in helping women in abusive relationships enhance their safety skills (McFarlane *et al.*, 2004).

The trend for police departments to utilize a collaborative response to IPV is growing. Specialized domestic violence units – present in 19 percent of police departments (Eitle, 2005) – have higher arrest and prosecution rates in IPV cases, resulting in higher conviction

rates (Bledsoe *et al.*, 2006; Whetstone, 2001). A coordinated response to IPV may affect the prevalence of IPV over time, indicating that collaborative efforts are helpful to victim-survivors (Post *et al.*, 2010). Departments with police and social worker teams collaborating to provide resources, crisis intervention, and advocacy do not appear to decrease incidents of IPV, but appear to encourage victim-survivors' future reporting of IPV (Davis *et al.*, 2003; Davis and Taylor, 1997; Stover *et al.*, 2010). One of the main goals of a collaborative response is victim-survivor empowerment (Davis *et al.*, 2003; Hovell *et al.*, 2006).

The LAP

The LAP, created by the Maryland Network Against Domestic Violence (MNADV) and started in Maryland, involves a police officer initiated 11-question risk assessment instrument called the Lethality Screen and an accompanying proactive response called the "Protocol Referral" that occurs at the scene of domestic violence calls. The officer has discretion over the use of the Lethality Screen, though it is suggested for use when a past or current intimate relationship is involved and there is a "manifestation of danger" by evidence of at least one of the following criteria: first, the officer believes that an assault or other violent act has occurred whether or not there was probable cause for arrest; second, the officer is concerned for the victim's safety once s/he leaves the incident scene; third, the officer is responding to a domestic violence call from a victim-survivor or a location where domestic violence had previously occurred; or finally, the officer has a "gut feeling" that the victim-survivor is in danger.

Risk assessments have been suggested for use in a variety of settings, including for use by frontline police officers, and as an educational component of empowerment-based safety planning interventions focussed on client self-determination (Campbell, 2001, 2004). Within an evidence-based practice framework, IPV risk assessment is the best evidence of risk of re-assault or homicide when considered in combination with practitioner expertise and client self-determination (Messing and Thaller, 2015). The Lethality Screen was developed by the MNADV in collaboration with researchers and practitioners. It has shown high levels of sensitivity for predicting severe IPV and near lethal IPV (approximately 93 percent) (Messing *et al.*, 2015c). Administration of the Lethality Screen usually occurs near the end of the officer's investigation. Education about risk and risk factors may assist women in recognizing the dangerousness of their situation and motivate victim-survivors of IPV to take protective actions (Pape and Arias, 2000; Short *et al.*, 2000).

The second aspect of the LAP is the "Protocol Referral" which requires a willing partnership between police departments and a local domestic violence service provider. If a victim-survivor screens in as "high risk" of homicide, the officer conveys this assessment of risk to the victim-survivor and tells her that people in similar situations have been killed. The officer then informs the victim-survivor that s/he would like to call the local 24-hour domestic violence hotline at the collaborating advocacy organization for information to help the victim-survivor and asks her to consider speaking with the hotline advocate. Regardless of the victim-survivor's decision, the officer calls the hotline and provides the advocate with basic information. If the victim-survivor has declined to speak with the advocate, the advocate provides the officer with some immediate safety planning tips for the next 24 hours to share with the victim-survivor.

If the victim-survivor chooses to speak with the hotline advocate, the conversation is brief (approximately ten minutes) and focussed, both because the officer must return to service and the victim-survivor may not be in a position to attend to a great deal of information. The hotline advocates are specially trained to communicate with and

engage victim-survivors in this unique situation where time is limited and where they have just been informed by an officer that they are at high risk. Guidelines for hotline advocates convey four main points: first, gaining the victim-survivor's trust; second, reinforcing the information provided by the officer about the danger the victim-survivor is in (and thus reinforcing the partnership with police); third, educating the victim-survivor and doing immediate safety planning; and finally, actively encouraging the victim-survivor to come in for services.

Through years of experience implementing the LAP, advocates have learned that most victim-survivors encountered in calls from the scene of a domestic violence incident are different from victim-survivors who initiate calls to the hotline for help. Victim-survivors at the scene of an incident may not be ready to accept help from social services or may have not yet even recognized that they are victim-survivors of abuse. The advocate, therefore, may need to provide more education about domestic violence and related services and give more encouragement to access services than they would a victim-survivor who initiated services on their own. Self-determination and empowerment are the cornerstones of the LAP, an intervention intended to guide victim-survivors toward decisions of self-care.

In Maryland, 100 percent of police departments that respond to domestic violence calls are LAP participants, including the Maryland State Police, as are all 20 domestic violence programs in all 24 state jurisdictions (D. Sargent, personal communication, May 12, 2014). In 2012, 100 agencies in Maryland completed 12,108 Lethality Screens. Of those, 6,224 (51 percent) victim-survivors screened in as high risk for homicide. Of the victim-survivors at high risk, 3,277 (53 percent) spoke on the phone to a hotline advocate and of those, 925 (28 percent) utilized services (Maryland Network Against Domestic Violence (MNADV), 2013), indicating they took concrete action of either going into shelter or to the domestic violence program for counseling, legal, or other direct services. This is a remarkable number of victim-survivors who spoke to the hotline advocate and went in for services; credit for this lies directly with officers and advocates.

Evaluation of the LAP

In 2008, the National Institute of Justice funded a quasi-experimental field evaluation of the LAP in Oklahoma (see Messing *et al.*, 2015a, c, d). This evaluation found that women who screened in as high risk and spoke to the hotline advocate were more likely to seek domestic violence services and remove or hide their partner's weapons immediately after the intervention. They were also more likely to have applied for and received a protection order, obtained something to protect themselves, sought medical attention due to violence, and hidden from their partner approximately seven months later. The partners of women who engaged in the LAP were more likely to go somewhere that they could not find or see the victim-survivor, such as jail. Many of these protective strategies were associated with decreased frequency and severity of violence. Indeed, in the seven months post-intervention, the frequency and severity of abuse was significantly less among those women who had participated in the LAP intervention (Messing *et al.*, 2015d). Descriptive data has been gathered in other communities (e.g. Klein, 2012) but, despite rapid expansion of the LAP, there has been limited evaluation research conducted.

Expanding the LAP

Early on, the MNADV did not have the resources to assist the many agencies that wanted to participate. In 2008, the MNADV was awarded a Federal Byrne grant, and

used this funding to train 29 jurisdictions across six states. Each of these 29 jurisdictions has implemented the LAP, five of these have offered to provide training to other jurisdictions in their state, and three jurisdictions have actually provided training in their respective states. New Hampshire, for example, under the guidance of the state attorney general's office and a coordinator who is a retired chief of police, has now trained all ten counties in the state. The LAP has continued to expand with hundreds of police departments and their partnering domestic violence programs trained and the LAP implemented in jurisdictions of 31 states besides Maryland. In some states (e.g. Pennsylvania, Connecticut), the state Coalition Against Domestic Violence has taken the lead and has implemented the LAP statewide.

Differential application of interventions

Research has demonstrated that police officers differentially enact policies across the victim-offender pairs that they come into contact with, and victim-survivors of violence differentially use services available to them. When examining arrest, for example, there are various factors associated with characteristics of the victim-survivor, offender or relationship that increase the likelihood of arrest in IPV cases. These include being married or co-habiting (Dichter *et al.*, 2011), substance use at the time of the incident by the offender (Dichter *et al.*, 2011; Eitle, 2005), and prior criminal history (Hirschel, 2008; Maxwell *et al.*, 2002). Characteristics of the incident are associated with arrest, including visible injury (Dichter *et al.*, 2011; Hirschel, 2008; McLaughry *et al.*, 2013; Tatum and Pence, 2015) and use of a weapon (Dichter *et al.*, 2011; Lee *et al.*, 2013). Additionally, officers have discretion when determining probable cause (Zeoli *et al.*, 2011) and when determining if a call for service is in fact a domestic violence call (Myhill and Johnson, 2015).

When responding to IPV calls, police interaction with victim-survivors impacts their engagement with the criminal justice system. Victim-survivors who feel respected and heard by police at the scene of an IPV call are more likely to engage criminal justice services in the future (Fleury-Steiner *et al.*, 2006). Furthermore, police interventions that include collaboration with social services have been shown to increase trust between victim-survivors and police and, therefore, increase the likelihood that the victim-survivor will cooperate with the criminal justice process (Stover *et al.*, 2010). Because officer actions and attitudes affect women's engagement in the criminal justice process, it is reasonable to expect that officers' actions and attitudes affect women's decisions when faced, through the LAP intervention, with the choice to speak to a social service provider at the scene of a police-involved IPV incident. Therefore, this study examines the association between demographic characteristics, relationship characteristics, history of violent victimization, violence at the incident where the LAP was implemented, prior protective actions, victim-survivor mental health status, and jurisdiction on victim-survivors' choice to speak to the hotline counselor across four jurisdictions implementing the LAP.

Methods

The LAP was implemented in seven jurisdictions in Oklahoma, four of which participated in this research examining the implementation fidelity of the intervention. This research was funded by the National Institute of Justice (2008-WG-BX-0002) and approved by the institutional review boards of the University of Oklahoma Health Sciences Center, Oklahoma State Department of Health, Arizona State University, Johns Hopkins University, Cherokee Nation, and the National Institute of Justice.

Participant recruitment

When police officers responded to a domestic violence incident and there was a past or current intimate relationship, the officer initiated the LAP protocol. Once the intervention was complete, the officer asked the victim-survivor if a researcher could contact her regardless of whether she answered the 11-questions, screened in as high risk, or spoke on the phone to the hotline advocate. If the victim-survivor agreed, the officer documented one to two safe telephone numbers and a safe time to call the victim-survivor. This information was faxed or e-mailed to researchers, typically within one to five days.

Recruitment occurred from October 2010 through February 2013, during which time 2,022 women were referred to the study. The telephone numbers given to the research team through the referral process were disconnected, never answered, or incorrect for 1,041 (51.48 percent) victim-survivors. An additional 43 (2.1 percent) women were not eligible to participate in the study (e.g. under 18 or not a victim of IPV). A total of 938 eligible referred victim-survivors were contacted by researchers. Of these 938 women, 657 (70.04 percent) participated in a 45-minute structured telephone interview. Nine duplicate participants were removed from the data set, resulting in a total of 648 women in the sample. Of these, 563 (86.88 percent) women were classified as high risk based on their Lethality Screen responses ($n = 538$) or based on officer belief ($n = 25$), and 347 (61.6 percent) of those women spoke with a hotline advocate. The main analysis presented here compares women who screened in as high risk and did not speak to a hotline advocate ($n = 216$) to women who screened in as high risk and spoke to a hotline advocate ($n = 347$).

Measurement

Demographic and relationship characteristics. Participants were asked to report their educational achievement, employment status, race/ethnicity, and age. Participants were able to self-report as many racial/ethnic identities as appropriate. These responses were collapsed into five mutually exclusive categories: white, African American, Latina, Native American, multiracial, and other.

Participants were asked to report their legal marital status as single, married, separated, or divorced. Participants were also asked to report whether they were currently living with their abusive intimate partner, whether they had children living in their household, whether they had children with their abusive partner, and whether they were pregnant at the time of the interview.

IPV and abuse. Experiences of IPV and abuse in the relationship ("ever") were assessed using an adapted version of the revised Conflict Tactics Scale (Straus *et al.*, 1996). Violence at the incident to which police responded ("the index event") was measured with a checklist of violent acts. Women were able to indicate which violent acts their partner committed during the index event including: punching, slamming them down/against an object, grabbing, throwing objects, vandalism, biting, strangulation, pushing, forcing entry into their home, ripping their clothing, hitting them with an object, slapping, holding down, burning, brandishing a gun, brandishing a knife, using a gun, cutting/stabbing, kicking/stomping, or some other act of violence.

Protective actions. Emergency safety planning actions in the past six months were assessed using an adapted version of McFarlane *et al.* (2004) safety promoting behavior checklist. Items on this scale included whether the participant had: hidden money, an extra set of house keys, car keys, or another belonging or object that may help her to

flee her relationship, established a code with family or friends (to let them know when she is in trouble), asked neighbors to call the police if violence begins, removed or hidden her partner's weapons, made available paperwork such as social security numbers, birth certificates, bank account numbers, driver's license or identification, insurance policies or numbers, hidden valuable jewelry, hidden extra money, and made available a hidden bag with extra clothing. These items were summed to examine the number of emergency safety strategies that women took prior to the police visit. Additional questions were asked to examine the formal help-seeking strategies that women had engaged in, such as seeking domestic violence services, applying for a protection order, and seeking medical treatment due to violence.

Posttraumatic stress disorder (PTSD) symptoms. PTSD symptoms were measured with the Primary Care Post-Traumatic Stress Disorder Screen (PC-PTSD; Prins *et al.*, 2003). The PC-PTSD is a recommended screen (Davis *et al.*, 2009) that has been used to examine the association of PTSD to childhood and adult victimization including IPV (Kimerling *et al.*, 2009; Messing *et al.*, 2012; Wilson *et al.*, 2011). Participants in this study were asked to respond "yes" (= 1) or "no" (= 0) to four items, each of which examines a different symptom of PTSD (avoidance, numbing, re-experiencing, hyperarousal) tied directly to the participant's experience of IPV. The measured PTSD symptoms were examined as a linear variable (0-4) indicating the number of PTSD symptoms reported by the participant.

Data analysis

We utilized descriptive statistics to examine characteristics of the sample and police officer's use of the Lethality Screen. Logistic regression was utilized to determine whether the intervention was applied consistently across women screened in as high risk. This allowed us to examine whether demographic and relationship characteristics, experiences of violence in the relationship and at the index incident, prior protective actions, mental health status, and jurisdiction had an effect on who spoke to the hotline advocate. Each potential independent variable was entered into the logistic regression model with the dependent variable alone, and independent variables associated with speaking to the hotline advocate at the $p < 0.10$ level were considered for inclusion in the final model.

Results

Figure 1 describes police officer's use of the Lethality Screen. Officers did not complete the Lethality Screen for 21 (3.2 percent) of 648 women who were referred to the study and who completed an interview. Overall, officers misclassified victim-survivors risk level in 3.1 percent ($n = 20$) of cases. These misclassifications were more likely to screen lower risk victims in as high risk than to screen high-risk victims out as lower risk. In 25 cases, officers reported that the victim-survivor did not screen in according to the protocol, but the officer believed the victim-survivor to be at high risk. In 2 of these cases, when researchers calculated the Lethality Screen score, the victim-survivor screened in according to the protocol.

A total of 563 (86.9 percent) women screened in as high risk based on the Lethality Screen or officer's belief that they were at risk. These women ranged in age from 18-79 years with a mean age of 32.38 (SD = 10.12) years. The largest racial/ethnic group was white (44.5 percent), followed by African American (28.1 percent), Native American (9.0 percent), Latina (8.3 percent), multiracial (6.6 percent), and other (3.5 percent). Regarding

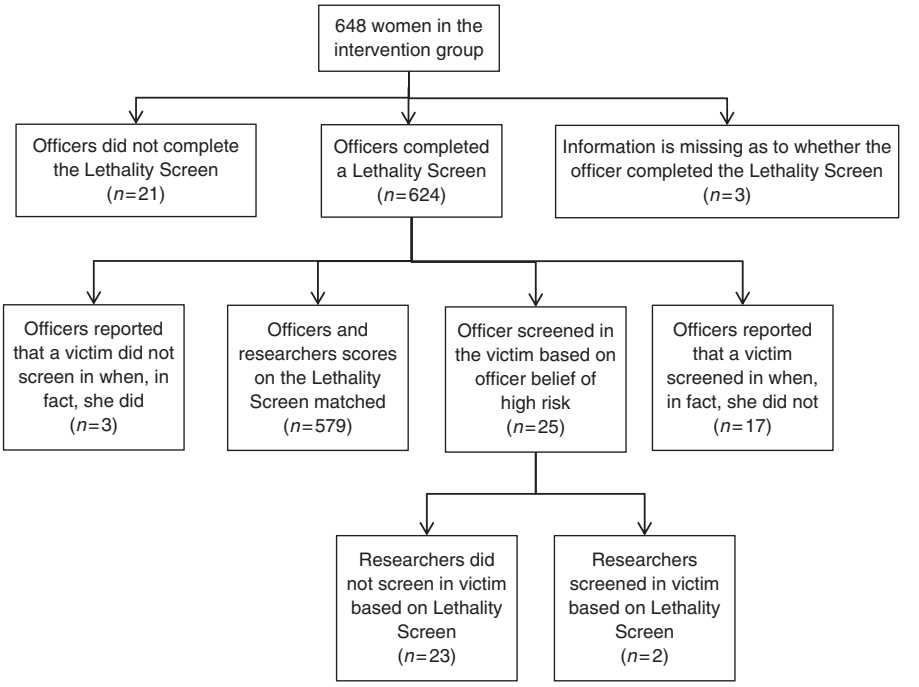

Figure 1. Implementation fidelity of the Lethality Screen

children, 65.2 percent of participants had children living in their household, 51.9 percent had a child in common with their abusive partner, and 6.9 percent of participants reported they were currently pregnant. Approximately one-quarter (25.2 percent) of participants reported that they completed high school or have a GED, 23.2 percent reported having less than a high school education, and the remaining 51.6 percent reported some college education or higher. Less than half of participants were employed part- or full-time (39.3 percent). In regard to marital status, 62.5 percent of participants reported they were single, 24.5 percent reported they were married, 5.6 percent reported they were separated, and 7.4 percent reported they were divorced. Less than one-fifth (18.1 percent) of women said they were living with their partner at the time of the interview.

Of the women who screened in as high risk, 347 (61.6 percent) spoke to a hotline advocate. As shown in Table I, Jurisdictions 1 and 2 had significantly more women speak to the advocate than in the other participating jurisdictions combined (64.5 percent in Jurisdiction 1, 77.8 percent in Jurisdiction 2, 52.8 percent in Jurisdiction 3, and 42.1 percent in Jurisdiction 4). No demographic or relationship characteristics were associated with speaking to the advocate. However, experiences of violence both at the index incident and ever in the relationship were associated with speaking to the advocate. The victim-survivor's partner punching her or hitting her with an object at the index incident led to a significant increase in the likelihood that she spoke to the advocate. Similarly, the participant's partner ever having used a knife or gun on her increased the likelihood that she would speak to the advocate.

Women's emergency safety planning strategies and utilization of services due to domestic violence in their relationship also had an impact on whether or not they spoke to the advocate. For each additional emergency or safety planning strategy on the modified

Variable	Indicator	Coefficient (SE)	Conditional OR (95% CI)	*p*-value
Jurisdiction	3 and 4	Referent	–	–
	1	0.45 (0.21)	1.57 (1.05-2.35)	$p = 0.029$
	2	1.40 (0.61)	4.05 (1.23-13.34)	$p = 0.022$
At the index offense, the participant's partner hit her with an object	Yes	0.77 (0.34)	2.15 (1.10-4.21)	$p = 0.025$
At the index offense, the participant's partner punched her	Yes	0.51 (0.19)	1.66 (1.15-2.40)	$p = 0.006$
The participant's partner had used a knife or a gun against her (ever)	Yes	0.55 (0.24)	1.73 (1.08-2.78)	$p = 0.024$
PC-PTSD score	Linear (0-4)	−0.15 (0.06)	0.86 (0.77-0.96)	$p = 0.007$
Number of emergency safety planning strategies used in the past 6 months	Linear (0-8)	0.12 (0.06)	1.13 (1.02-1.26)	$p = 0.024$
Participant has received domestic violence services in her relationship	Yes	−0.69 (0.27)	0.50 (0.30-0.85)	$p = 0.010$

Notes: Model Fit Statistics: log likelihood = −349.73, $\chi^2(8) = 43.49$. $p < 0.001$, pseudo $R^2 = 0.0585$

Table I.
Did the victim-survivor speak to the hotline advocate?

version of McFarlane's Safety Behavior checklist (e.g. asked neighbors to call police if violence begins, removed/hid weapons, packed a bag with extra clothing) that the participant had engaged in during the six months prior to the index offense, the participant was 13 percent more likely to speak with the advocate. However, if the victim-survivor had ever received formal domestic violence services in her relationship, she was 50 percent less likely to speak to the advocate. Finally, for each additional PTSD symptom that women reported (0-4), they were 15 percent less likely to speak to the hotline advocate.

Discussion

Nearly 90 percent of the women who participated in the study screened in as high risk. This is a higher proportion than those who screened in across Maryland in 2012 (51 percent; MNADV, 2013). This may be because we interviewed women at higher risk. Or, this may indicate that women in Oklahoma who called the police were at higher risk than women in Maryland, suggesting regional differences in women's utilization of the police and their risk when accessing the police as a resource. The Lethality Screen was designed to have high sensitivity, but specificity was low in all analyses of predictive validity (Messing *et al.*, 2015c). Thus the Lethality Screen is likely to screen in women who will not be re-assaulted in the following seven months. While this may create additional burden for police departments, it is more appropriate to provide the intervention when someone is at low risk of future severe or lethal violence than to fail to provide the intervention to someone at risk.

The majority (61.6 percent) of women who screened in as high risk spoke to the domestic violence advocate on the phone at the scene of the incident. This finding demonstrates the utility of the LAP as officers are able to place a majority of high-risk victims of IPV in contact with an advocate at the scene of an IPV incident. Whether or not victim-survivors choose to seek additional services, placing them in contact with an advocate at the scene educates and familiarizes them with available services and may answer questions or assist with immediate safety planning. The proportion of high risk women who spoke to an advocate in this study is slightly higher than the 53 percent of

women who spoke to an advocate in Maryland in 2012 (MNADV, 2013). It is, however, important to note that the proportion of women who spoke to the advocate on the phone varied from 41.2-77.8 percent by police jurisdiction. Data collected by MNADV (2013) demonstrates that, in the highest performing police departments, 70-95 percent of women speak on the phone to an advocate. Given the impact that police officer attitudes and actions have on women's behavior in other areas of the criminal justice system (Fleury-Steiner *et al.*, 2006; Stover *et al.*, 2010), it is likely that these differences across jurisdictions indicate differences in the ways that police officers approach victim-survivors and implementation of the LAP. Perhaps some departments maintain a stricter adherence to the protocol and consistently ask women if they would like to speak with the hotline advocate (see also Messing *et al.*, 2011). It may also be that departments with more positive officer attitudes about the intervention or about domestic violence in general facilitate women's decision to speak with the hotline advocate (Sinden and Stephens, 1999). Future research should examine police officer roles in this context through observation and qualitative interviews.

This study found that women's experiences of violence at the index incident and in the relationship increased the likelihood of speaking to the hotline advocate. This may be because women are more likely to reach out for assistance when they have experienced greater levels of violence and injury during the course of their relationship or at the index incident. Alternatively, officers may be more likely to offer the advocacy intervention to women who have experienced higher levels of violence. Both officers and victim-survivors may perceive that higher levels of violence indicate more immediate danger, particularly when a victim-survivor experienced severe violence at the index incident. Punching and hitting with an object – the two violent acts that led to increased likelihood of speaking to an advocate – are also likely to injure the victim-survivor. Perhaps officers are more sensitive to the needs of a victim-survivor, and more likely to encourage engagement with the intervention, when she has visible injuries. This would be consistent with the literature on differential application of arrest when visible injuries are present (Dichter *et al.*, 2011; Hirschel, 2008; McLaughry *et al.*, 2013; Tatum and Pence, 2015). Future research should examine the association between risk, violence and injury at the scene of a domestic violence incident, and variables specific to officers' implementation of the intervention.

Women's prior use of emergency safety planning strategies increased the likelihood of speaking to a hotline advocate. Perhaps women who had been using emergency safety planning strategies were more ready to reach out for assistance from an advocate. It may also be that officers who ascertain that a woman is using protective strategies see additional utility in utilizing the advocate. On the other hand, women's prior use of formal domestic violence services decreases the likelihood that they will speak to an advocate on the telephone. Women who had received prior services may have felt they did not need to speak to the hotline advocate. Officers may have similarly felt it was not necessary for the victim-survivor to speak to a hotline advocate if they were familiar with or had received services in the past. The LAP is intended to provide women with an immediate opportunity to engage in additional help-seeking should they choose to do so. That not all women choose to speak to the advocate (and that not all women choose to follow-up by seeking additional services) demonstrates that women are able to exercise their autonomy during the intervention and make the decisions they perceive to be most beneficial for their situation. Future research should examine the decision making process of victim-survivors to better elucidate the meaning behind these statistical relationships.

An increase in PTSD symptoms (hyperarousal, numbing, re-experiencing, avoidance) was negatively related to speaking with the advocate in this sample. Given the high proportion of women in this sample experiencing PTSD symptomology (see Wilson *et al.*, 2011) as well as the high proportion of IPV survivors who suffer from PTSD (e.g. Campbell, 2001), this finding has important implications for practice. Women who are experiencing PTSD symptoms may be less willing to utilize services. PTSD symptoms may make women more distrustful of police and/or helping professionals, and experiencing these symptoms (such as numbing or avoidance) may make them less able to respond. Police officers also may be less willing to offer the intervention when women are suffering from these symptoms. For example, PTSD hyperarousal is associated with anger and verbal and physical aggression which may make women appear less "victim-like" or in need of assistance. Increased training for police on PTSD symptoms and the mental health effects of IPV is warranted. Police officers who are aware of the effects of PTSD on a victim-survivor's presentation, affect, and behavior during a police interview may intervene more effectively.

Victim-survivor demographic and relationship characteristics were not associated with implementation of the LAP. Women's relationship status, whether they were living with their abusive partner or had children with him, also were not associated with engagement in the intervention. This is not consistent with the literature on differential application of arrest (Dichter *et al.*, 2011) and should be explored in future research. There were no significant effects of race/ethnicity on engagement in the intervention. This is particularly noteworthy given that a high proportion of this sample was Native American, a group at high risk for IPV and intimate partner homicide (Black *et al.*, 2011). Given the mixed evidence about the impact of race/ethnicity on arrest (Dichter *et al.*, 2011; Hirschel, 2008; Maxwell *et al.*, 2002), this should be further explored in future research.

In conclusion, this research is the first examination of the application of the LAP intervention at the scene of domestic violence incidents. It is important to understand how the intervention is applied in order to better understand who is most assisted by the intervention and what training or education could be beneficial for officers providing the intervention. Based on this examination, it appears that training in PTSD should be an integral part of training on domestic violence. In addition, officers should be trained to recognize the less injurious, but also damaging, forms of IPV, such as verbal abuse and coercive control (Stark, 2007). Police may also be educated about women's use of services and the necessity of engaging in multiple and ongoing services that respect women's autonomy and encourage safety both for victim-survivors who choose to stay with their partner and those who choose to terminate their relationship. Interventions that bring together the social service and criminal justice response to IPV have the potential to enhance police response to domestic violence.

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