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Original articles and reviews

ViolHelp: results of a pilot study to identify potential warning signs and risk factors for self- and hetero-directed violence in the calls received by the Helplines of the Italian National Institute of Health

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Abstract
Background. Self- and hetero-directed violence (SHDV) is a serious public health problem and a complex phenomenon, influenced by individual and environmental factors. SHDV may occur particularly in moments of personal, economic and/or social crisis. During the COVID-19 pandemic, the ISS-Helplines operators have perceived an increase in psychological distress and self-isolation among callers. The ViolHelp project aimed at identifying potential warning signs and risk factors of SHDV emerging in the activity of the ISS-Helplines (Istituto Superiore di Sanità, ISS, Italian National Institute of Health).
Materials and methods. A dashboard collecting warning signs and risk factors of SHDV was developed to be used during the ISS-Helplines activity.
Results. In one year of data collection, 135 calls were compiled. In 106 calls, callers referred experienced violence: 72 self-directed violence (SDV), 20 hetero-directed violence (HDV), 14 both. The most frequent warning signs and risk factors for SDV were desire to die (68.6%), previous suicide attempts (31.4%) and threat of self-harm (25.6%); for HDV were depressed mood (32.4%), diagnosis of pathology and/or psychiatric disorders, desire to die, use of psychotropic drugs, and alcohol abuse (29.4%).
Conclusions. The results of this pilot project show the importance of being able to read the warning signs and to create a network that can improve information, prevention and support activities for people at risk of violence and their families.

Key words
- violence
- suicide
- prevention
- risk factors
- helpline

INTRODUCTION

The World Health Organization (WHO) defines violence as the intentional use of physical force or power, threatened or actual, against oneself, against another person or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, mal-development or deprivation [1, 2]. In 1996, the forty-ninth World Health As-

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sembly adopted resolution WHA49.25, declaring violence a major and growing public health problem across the world. In this resolution, the Assembly drew attention to the serious consequences of violence – both in the short-term and in the long-term – for individuals, families, communities and countries, and stressed the damaging effects of violence on health care services [1, 2]. To address the problem WHO produced the "World report on violence and health" (WRVH 2002), the first comprehensive review of the problem of violence on a global scale, which provides a useful framework to examining and understanding the causes and consequences of violence and for preventing violence from occurring through primary prevention programs, policy interventions and advocacy [1, 2]. The WRVH 2002 suggests also four modes in which violence may be inflicted: physical, sexual and psychological attack, and deprivation. There also are three sub-types according to the victim-perpetrator relationship: self-directed violence, which refers to violence in which the perpetrator and the victim are the same individual and is subdivided into self-abuse and suicide; interpersonal violence which refers to violence between individuals (subdivided into family and intimate partner violence and community violence); collective violence which refers to violence committed by larger groups of individuals and can be subdivided into social, political and economic violence [1, 2].

In 2019, the WHO estimates that approximately 475,000 people worldwide are victims of homicide every year (global rate of 6.2 per 100,000) and deaths by suicide turn out to be more than 700,000; moreover, for each suicide, there are more than 20 suicide attempts (https://apps.who.int/violence-info/homicide/) [3]. New provisional estimates published by the US Centers for Disease Control and Prevention in 2022 show a 4 percent increase in the national suicide rate, rising from 13.5 deaths per 100,000 population in 2020 to 14.0 deaths per 100,000 population in 2021 (https://www.cdc.gov/media/releases/2023/s0810-US-Suicide-Deaths-2022.html) [4]. On the contrary, over the past decade homicide rate in worldwide has remained relatively stable, fluctuating from 400,000 to 450,000 victims annually; in Western Europe homicide rate has fluctuated around a relatively stable longer-term trend of 1 per 100,000 population. Victims of hetero-direct violence, homicide in particularly, are more frequently man (https://apps.who.int/violence-info/homicide/) [5]. In Italy, the homicide rate has declined steadily in recent decades; however, the reduction has been more pronounced among men, who were starting from much higher levels; as a result, the gender ratio among victims has decreased. Thus, although homicides have decreased among both sexes, the percentage of women in the total number of victims has increased (https://apps.who.int/violence-info/homicide/) [6, 7].

However, homicide is just the tip of the iceberg of violence, hundreds of millions more men, women, and children suffer non-fatal forms of interpersonal violence [2]. There are many forms of violence, one is domestic violence, or intimate partner violence, violence between intimate partners, and in particular, violence acted by the man on the woman. Such violence falls within the framework of violence against women, or gender-based violence, since as the Istanbul Convention (2011) points out, gender inequality is a cause and consequence of violence against women [8].

Self- and hetero-directed violence (SHDV) is a serious public health problem and a complex phenomenon, influenced by a range of individual (genetic and psychological) and environmental (cultural, environmental, socio-demographic and economic) factors, some of them are shared between self-directed violence (SDV) and hetero-directed violence (HDV): alcohol and drug abuse, depression and exposure to a violent environment [5, 9]. Both types of violence can be read as indicators of a loss of cohesion and social malaise, and may occur particularly in moments of crisis, with a breakdown in the ability to cope with life's stresses, such as financial problems, relationship breakdowns, or chronic pain and illness [6]. Suicide and homicide thus share a common source. In Freud's psychoanalytic perspective, for example, suicide can be defined as the suicidal person's tendency to transfer hostility, usually directed at an external object, to himself through an introjection of the external object, while homicide is, conversely, the turning of aggression outwards towards another [10].

Thus, the external environment, social structure, family, personality, culture, could determine whether aggression would be directed against oneself or others [7, 11].

For many years, therefore, WHO has been supporting to strengthen prevention strategies in each Country through a multisectoral public health approach that addresses potential risk factors at the level of the social, economic and relational context of the individual [5, 12]. Indeed, the progress made in suicide prevention at European and global level shows a reduction in the global suicide rate which nevertheless remains among the top three most frequent causes of death among people aged 15 to 29 globally and in Italy [13].

Suicide prevention is among the priority goals both at the European and global level. In 2021 WHO releases "LIVE LIFE" that is WHO's approach to suicide prevention [12, 14-21]. It details the practical aspects of implementing evidence-based interventions for preventing suicide at national level [22].

On the other hand, also interpersonal violence is a pervasive public health, human rights, and development challenge [23]. Its effects reverberate through families, communities, and nations and across generations. Homicide is simply the tip of the iceberg of much more widespread interpersonal violence. It includes different types of violence like child maltreatment, youth violence, intimate partner and sexual violence, and elder abuse. In fact, the violent act constitutes a risk factor for the mental health of the family and social network of both the victim and the perpetrator of violence, with destabilizing effects on the whole community. Attention to interpersonal violence as a global issue has expanded dramatically since the World Health Assembly identified violence as a public health priority in 1996. Reports by the United Nations (UN) have contributed greatly to increased awareness [2, 24]. These and other efforts

culminated in specific targets for eliminating interpersonal violence in the UN's post-2015 Action Agenda for Sustainable Development [24]. Worldwide, the global homicide mortality rate has slowly decreased since 2000 (https://apps.who.int/violence-info/homicide/); in Italy the decrease was more consistent than in other countries and above all for men [6, 7].

Violence prevention refers to the reduction in the frequency of new cases of violent victimization or perpetration through direct efforts to remove or reduce the underlying causes and risk factors, and by harnessing the indirect effects of other policies and programmes that may contribute to reducing exposure to underlying causes and risks [25, 26]. A prevention policy implies the existence of a harmonized articulation of measures to reduce the underlying factors of violence and crime. An important and widespread component of SHDV (including suicide) prevention strategies across different health systems are crisis helplines, which provide timely and anonymous advice to callers at current risk of violence, provide support for victims and are effective in deterring active suicidal ideations [27, 28]. Indeed, many studies confirm that crisis lines are the first point of contact with mental health services for many people [29], making them a particularly important community and public health service. These services are easily accessible, usually free of charge and anonymous. The confidential, non-directive and non-judgmental environment makes it possible to help anyone experiencing emotional difficulties or distress, or in acute crisis, and to signpost them to further support and resources if needed. Crisis hotlines are often operated by staff (often volunteers) who receive training in active listening skills, crisis intervention skills, call management, suicide and risk assessment and management, referral and follow-up. In addition, some crisis lines train staff also in specific mental health issues (e.g., substance use, mood disorders) and populations (e.g., deaf or hard of hearing, HH) [29].

Some crisis lines are focused on suicide and acceptance of callers' need to explore suicidal feelings and intentions. In these emergency situations where there are safety concerns, confidentiality is no longer maintained. In fact, they usually work closely with emergency services such as police, ambulance and hospitals [30]. The confidential services offered by crisis lines may help overcome the barrier of stigma surrounding suicide and mental health problems that could prevent a person from seeking help in other ways. Consequently, crisis lines often engage with persons who are not otherwise receiving help for their suicidal thoughts [31].

A similar situation is experienced by victims of every kind of interpersonal violence who could feel stigmatized as well and are reluctant to ask for help and this experience of isolation could exacerbate their condition and can lead to self-destructive thoughts and gestures also in this population. Therefore, helplines, being anonymous, are essential in overcoming these barriers, hooking people in distress and secondly facilitating access to specific pathways and services for self and hetero-directed violence. For these reasons, and because of an increase in the female homicide percentage [32], in 2022 the European Commission established a harmonized European helpline number for victims of violence against women and domestic violence; this number is widely advertised as a public number, free of charge and available round-the-clock. The support provided includes crisis counselling and referring to face-to-face services, such as shelters, counselling centres or the police [33].

With technological advances giving rise to modes of communication beyond phone calls, several text- and video-based crisis lines have emerged. These services may be particularly advantageous for certain groups, such as youth or deaf and HH populations. Text-based crisis lines have been rated by adolescents as convenient, acceptable, and confidential, and are associated with increased help-seeking [34]. Youths prefer to seek information and help through more modern methods and describe the web as the primary source of health information [35]. Text lines have also advantaged for staff (e.g., being able to serve multiple people at once) [30].

Compared to telephone calls, chat, and text messages, contacts tend, on average, to concern serious crises such as eating disorders, self-mutilation and sexual aggression. Contacts by Internet chat and text messages tend more frequently to concern suicide and, overall, people who make this kind of contact are at higher suicide risk than those who make contact by telephone [32].

The service delivery model of the crisis lines, in most cases, considers each call as a single session with no fixed time limit; in some cases, includes a follow-up call to check on safety and well-being; provides routine safety checks and identification of suicidal ideation and the level of suicide risk routinely on all calls, with crisis intervention techniques applied as appropriate; sometimes, offers a translation service and access for persons with hearing difficulties or other disabilities.

Reports from crisis lines indicate that the overall underlying motive to contact the service appears to be the need to connect safely with another person for help and support in a crisis or to meet a general emotional need. The wide range of issues reported by callers are: family and relationships problems, relationship breakdown, health and disability, self-harm, burdens associated with raising children, caring for others (such as elderly parents), work loss, other work-related issues, or a financial crisis. Mental health issues are experienced by many of those who call crisis lines [32, 36]. Some callers are or feel socially isolated.

The Istituto Superiore di Sanità, ISS (Italian National Institute of Health) is the main centre for research, control and technical-scientific advice on public health in Italy, and alongside the Ministry of Health, the Regions and the entire National Health Service, guides health policies based on scientific evidence from prevention and health promotion. The ISS offers consultancy services to citizens through the activity of national, anonymous, toll-free helplines. During the COVID-19 pandemic, which affected every country in the world and had a significant negative impact on health, economic and social aspects [26, 37-43], the ISS-Helplines dedicated to rare diseases, the fight against drugs, gambling,

tobacco and nicotine, alcohol, doping, noticed a change in the number, length and quality of calls and sometimes in the subject matter of the requests received, which made it necessary to adapt their services to deal with the emotional distress that was present in most of the calls. More than ever before, staff had to deal with psychological distress, negative emotional states, fear and anxiety expressed by callers. In this background, the project of the ISS called ViolHelp, aimed at identifying potential warning signs and risk factors of SHDV emerging in the activity of the helplines operating at the ISS itself. The project aimed to verify the need for developing a new tool to identify the state of the discomfort of the caller during ISS-Helplines calls for early detection of SHDV signs helpful to refer these callers to specific healthcare settings while respecting the specific mission of each ISS-Helpline.

MATERIALS AND METHODS

The helplines participating in the study are national, anonymous and toll-free, and don't specifically deal with violence. They provide consultancy for citizens on addiction and doping (Antismoking Helpline, Alcohol Helpline, Drug Addiction Helpline, Gambling Helpline, Anti-Doping Helpline at National Addiction and Doping Center) and rare diseases (Helpline for Rare Diseases at the National Center for Rare Diseases). These helplines can also be reached by e-mail and have a mailbox dedicated to the deaf. They are run by a staff of psychologists and experts, trained on telephone counselling methodology and public health policies, that provide caller-centered interventions to listen empathetically and without judgment to callers and facilitate them in the adoption of health choices through the activation of their own and family resources and those available in their territory.

In the first phase of the project (months 1-5), the researchers, drawing on the different expertise of the project group (psychologists, statistician, medical doctors, experts in rare diseases, experts in addictions and doping and experts in the field of SHDV), carried out a bibliographic review of the signs of SHDV identified in the scientific literature, with a particular focus on helplines dedicated to violence. The pool of ISS experts assessed the recurring signs and contextualised them in relation to the different issues dealt with by the helplines. This assessment made it possible to prepare a selection of warning signs and risk factors, which were anonymously submitted to the helpline's operators, who, based on their specific experience, focused on the warning signs that they happened to pick up during the calls to better specify them in relation to ISS-Helplines issues. This activity allowed to identify a selection of topics for the development of a dashboard to be used during calls to the ISS-Helplines in the months 7-18 of the project. Before data collection, each operator underwent a standard training programme.

The dashboard ViolHelp collected socio-demographic data, risk factors, and warning signs related to SHDV subdivided as following: birth pathway (pregnancy, abortion, adoption), psycho-behavioural risk factors (including the desire to die, self-harm thoughts, suicidal plans, depressed mood, absence of hope for future, despair, social support) substance-related disorders and addiction disorders, reported signs of self-directed violence (including previous suicide attempts, self-harm acts, access to the emergency room), signs of reported HDV (including physical, sexual, psychological, economic), social aspects and sentinel events (including bereavement, job loss, separation-divorce).

For the present analysis, two different types of outcome variables were assessed: SDV and HDV. The SDV was detected during the call by the operators through the identification of at least one of the following events or suicidal and self-harm ideas reported by the callers: previous suicide attempts, acts of self-harm, desire to die, thoughts of self-harm, suicidal plans and threats of self-harm. The HDV was detected during the call by the operators through the identification of at least one of the following types of violence: physical violence, sexual violence, psychological violence, threats, stalking, non-consensual pornography, economic violence, and bullying. All other factors were considered "non characterizing" for violence and considered as risk factors for analysis only if they were present in conjunction with one of the factors characterizing the two groups (SDV and HDV).

Descriptive analysis of socio-demographic variables and violence risk factors by SDV and HDV was performed using the commercial statistical program IBM-SPSS 27 (IBM-SPSS Corp., Armonk, NY). We used Fisher's exact test to examine the association between two dummy variables while for categorical variables we used the chi-square and Yates' corrected chi-square test. To evaluate the association between two dummy variables we use the Phi Coefficient, and we also calculate the odds ratio (OR) as a measure of association. A p-value was less than 0.05 was considered statistically significant. A p-value was less than 0.05 was considered statistically significant.

RESULTS

Data was collected between May 2022 and May 2023. In total, the data analysis refers to 135 calls received by the ISS-Helplines in which, the operators have detected indicators of /or hetero-directed reported violence and/or violence risk factors and for which the ViolHelp dashboard was opened.

During the period under consideration, more than three out of four of the 135 calls (74.5%) referred to the operators to have experienced self-and/or hetero directed violence. For only 29 callers (21.5%) the operators of the ISS-Helplines identified risk factors for violence that were not those that characterized the two categories (SDV or HDV); for these callers, the ISS-Helplines operators opened the dashboard and nevertheless collected risk factors for SHDV. The following analysis refers to the 106 subjects who referred to the operators to have experienced violence.

The number of calls involved in the study differed by each helpline during this period. Considering the number of calls for which the ViolHelp dashboard has been filled out compared to the number of calls received by each service, the Alcohol Helpline and the Drug Addic-

tion Helpline were found the services with the highest percentage of ViolHelp dashboards of calls respectively received by these two helplines (respectively 4.8% and 4.3%) followed by the Gambling Helpline (0.7%), the Helpline for Rare Diseases (0.3%) and the Antismoking Helpline (0.2%) (*Figure 1*).

The services that received the most calls (35) considered by the operators to be at risk for SHDV were the Gambling Helpline and the Alcohol Helpline followed by the Antismoking Helpline (17); 12 calls were received by the Drug Addiction Helpline and 7 by the Helpline for Rare Diseases. No ViolHelp dashboards was opened for the Anti-Doping Helpline.

Of the 106 calls analysed, 53.3% of callers were male, 44.8% female, and 2 people indicated another gender; in 1 caller, data was missing (*Table 1*).

Analysis by gender and age group showed that among men the highest percentage of calls (58.2%) came from people under 44 years old followed by age group 45-64 years old (29.1%) and lastly by people 65 years and older (12.7%). Among females the most prevalent age group was 45-64 years old (50.0%); the percentage of callers in the youngest age group (<44 years) dropped to 27.3% and the percentage of women aged 65 years and older was 22.7% (*Table 1*).

One out of two men are engaged and 22.9% are looking for a job; the percentage among women are lower because only 30.0% are engaged and 10.0% are waiting for a job. The percentage of retired is higher among women than men (*Table 1*).

Considering the educational level of callers, more than half of the callers indicated a secondary school degree followed by those who had a middle school diploma (30.3%); 7.6% had an elementary school qualification or no education all and only 3.0% had at least a bachelor's degree (*Table 1*).

Although the percentage of callers living alone was similar among males (30.8%) and females (31.0%) (p=0.580), there was a gender difference related to the cohabitation status: the percentage of men living with other person different by relatives was 34.6% while the percentage among women was 14.3%, (p=0.021), finally there were not callers among men that live alone with sons while the percentage among women was 19.1% (*Table 1*).

The operators of the ISS-Helplines have collected information considering whether the callers had called for him/herself or other persons like parents, sons, other relatives, or friends. We observed a significant gender difference among subjects who have called the ISS-Helplines for themselves (31.1%): males were almost twice as females (*Table 1*).

The operators of the ISS-Helplines have collected information considering if the information on violence was referred to the callers themselves or other persons like parents, sons, other relatives, or friends. Almost one out of two of the callers reported information on violence referred to themselves without gender difference (p=0.567) (*Table 1*).

Regarding violence experienced and the highlighted violence risk factors, in 85.8% of the cases, the information was related to the same person for whom the helplines had been contacted. When subjects called the helplines for their spouse or partner (9.4%) in 40.0% of cases, the information on violence was referred to themselves and not to the person they had called for. For those who called for themselves (31.1%), in all the cases they reported information of violence referred to themselves (data not showed).

Looking in detail at the 106 subjects that contacted the ISS-Helplines, overall, 82.1% of them had called the specific Helplines for gambling, alcohol, and

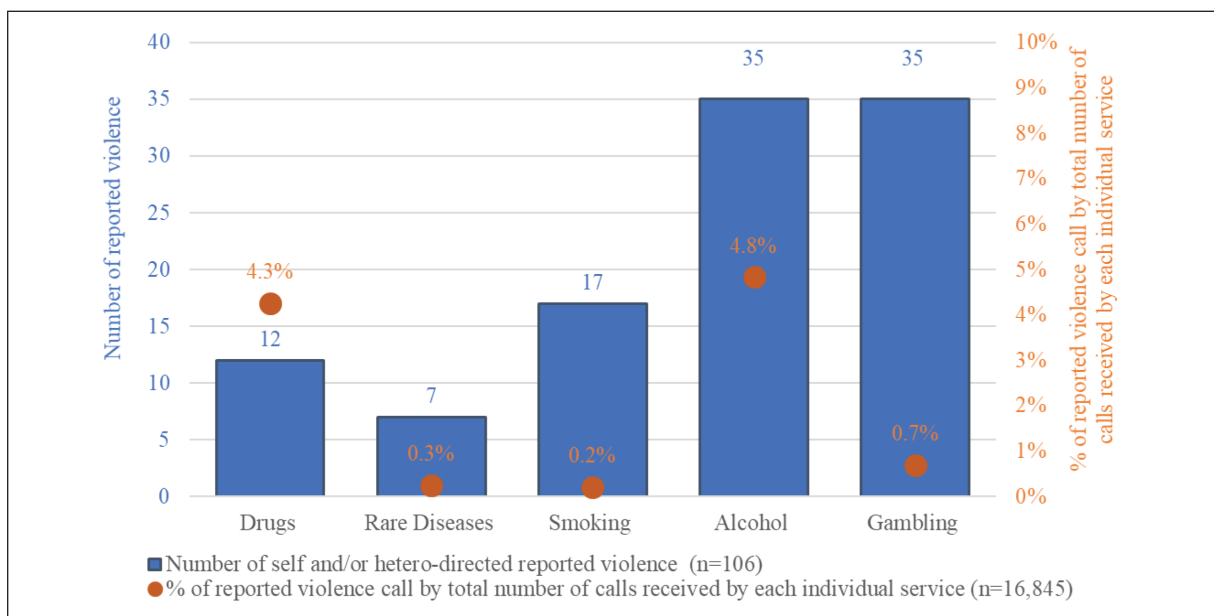

Figure 1
Number of calls by each ISS-Helpline and percentage of reported violence calls by total number of calls received by each service. ISS: Istituto Superiore di Sanità, Rome, Italy.

Table 1
Socio-demographic characteristics of subjects who have called the ISS-Helplines

		Men		Women		Total*	
		n	%	n	%	n	%
Gender		56	53.3	47	44.8	105	-
Helpline services	Antismoking	10	17.9	7	14.9	17	16.0
	Alcohol	15	26.8	19	40.4	35	33.0
	Drug	8	14.3	3	6.4	12	11.3
	Gambling	21	37.5	14	29.8	35	33.0
	Rare diseases	2	3.6	4	8.5	7	6.6
Total		56	100.0	47	100.0	106	100.0
Age groups**	≤44 years	32	58.2	12	27.3	46	45.1
	45-64 years	16	29.1	22	50.0	39	38.2
	65+ years	7	12.7	10	22.7	17	16.7
Total		55	100.0	44	100.0	102	100.0
Labour status**	Employed	23	47.9	9	30.0	32	40.0
	Searching for employment	11	22.9	3	10.0	15	18.8
	Retired	5	10.4	5	16.7	11	13.8
	Other condition	9	18.8	13	43.3	22	27.5
Total		48	100.0	30	100.0	80	100.0
School qualification	Primary education/no education	2	5.1	2	8.0	5	7.6
	Diploma of lower/upper secondary education/technical specialisation	12	30.8	7	28.0	20	30.3
		24	61.5	15	60.0	39	59.1
	University education	1	2.6	1	4.0	2	3.0
Total		39	100.0	25	100.0	66	100.0
Cohabitation status**	Living alone	16	30.8	13	31.0	29	30.2
	Living with partner without sons	5	9.6	6	14.3	11	11.5
	Living with partner with son	13	25.0	9	21.4	22	22.9
	Living alone with sons	0	0.0	8	19.1	8	8.3
	Living with others	18	34.6	6	14.3	26	27.1
Total		52	100.0	42	100.0	96	100.0
Do you call for:	Me myself**	23	41.1	10	21.3	33	31.1
	Parents	3	5.4	8	17.0	11	10.4
	Partners	3	5.4	6	12.8	10	9.4
	Brother/sister	7	12.5	9	19.2	16	15.1
	Sons	10	17.9	7	14.9	17	16.0
	Other relatives	6	10.7	6	12.8	13	12.3
	A friend	4	7.1	1	2.1	6	5.7
Total		56	100.0	47	100.0	106	100.0
The collected information refers to:	Me myself**	24	42.9	20	42.6	44	41.5
	Parents	3	5.4	10	21.3	13	12.3
	Partners	3	5.4	0	0.0	4	3.8
	Brothers and sisters	7	12.5	8	17.0	15	14.2
	Sons	9	16.1	2	4.3	11	10.4
	Other relatives	6	10.7	6	12.8	13	12.3
	A friend	4	7.1	1	2.1	6	5.7
Total		56	100.0	47	100.0	106	100.0

*Data on "other gender" was included; **there's a difference by gender ($p<0.05$); ISS: Istituto Superiore di Sanità, Rome, Italy.

tobacco and nicotine issues. Over half of the people who called the Antismoking Helpline were calling for themselves and the information about violence was referred to themselves; in 41.2% of cases, however, they were calling for other people (relatives and friends) and the information about violence concerned the person they had called for. In the case of the Gambling Helpline, 45.7% of the callers contacted the service for other persons, and the information about violence was referred to them; 37.1% of subjects have called for themselves and reported information on violence about themselves. In the Alcohol Helpline, in two out of three cases, subjects called for other people and the violence was not referred to the callers, in comparison the percentage of those who called for themselves and gave information on violence related to themselves fell to 14.3% (*Figure 2*).

In 106 calls callers referred to the ISS-Helplines operators to have experienced violence. Among those, 72 callers referred to experiencing SDV, 20 referred to having experienced HDV, and 14 referred to having experienced both.

Among the 86 callers from subjects who experienced SDV, 73 callers referred to experiencing only SDV, and 14 referred to having experienced both SDV and HDV.

The most frequent types of SDV highlighted by the ISS-Helplines operators were the desire to die for more than two thirds, followed by previous suicide attempts for almost one third, the threat of self-harm (25.6%), suicidal plans (18.6%), self-harm thoughts (15.1%) and self-harm acts (8.1%) (*Figure 1S available online as Supplementary Material*).

The most frequent risk factors identified by the ISS-Helplines operators were for half of the call depressed mood and for more than one third alcohol abuse, pharmacological therapy, absence of hope for the future, use of psychotropic drugs, and having received a diagnosis of pathology and/or psychiatric disorders. More than one out of five callers also reported tobacco and/or nicotine dependence, lack of social support, having had access to the PS, and gambling habits.

The ISS-Helplines answered 34 calls from people who reported having experienced HDV, 20 callers referred to experiencing only HDV, and 14 referred to having experienced both SDV and HDV. The most frequent types of HDV highlighted by the ISS-Helplines operators were physical violence for more than two thirds, threats for almost half and psychological violence for more than one third; only 4 callers referred economic violence, and bullying while sexual violence, stalking and non-consensual pornography were reported only by one subject (*Figure 1S available online as Supplementary Material*).

The most frequent risk factors for HDV identified by the ISS-Helplines operators were depressed mood for almost a third, followed by having received a diagnosis of pathology and/or psychiatric disorders, desire to die, use of psychotropic drugs, and alcohol abuse (29.4%). More than one out of four have tobacco and/or nicotine dependence while 23.5% of callers reported access to emergency room and lack of social support. The absence of hope for the future, pharmacological therapy, and financial difficulties were also reported by 20.6% of subjects (*Table 2*).

The analysis of the two different typologies of violence showed that depressed mood was the prevalent risk factor for both. Looking at the first ten risk factors highlighted by ISS-Helplines operators, nine out of ten are highlighted in the case of both HDV and SDV, even in a different order (*Table 2*).

The risk factors related to addictions have been highlighted by the operators of the ISS-Helplines (in four out of five cases specific for addictions) both in the case of HDV and in the case of SDV even if with a different priority; for gaming the percentage is higher among subjects who reported SDV than in subjects who reported HDV (SDV 27.9% *vs* HDV 5.9% p=0.026) (*Table 2*).

DISCUSSION

The aim of the project was to assess the need to create a useful tool for non-violence-specific ISS-Helplines operators to intercept and redirect people with signs of SDV and HDV to specific resources and healthcare settings. The ISS-Helplines operators conducted every call

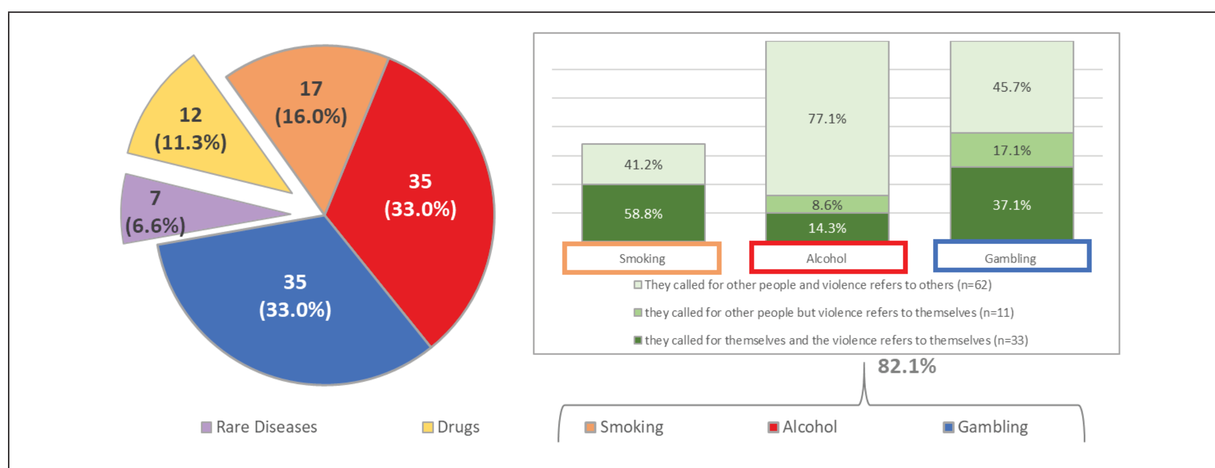

Figure 2
Distribution (%) of calls by ISS-Helplines. ISS: Istituto Superiore di Sanità, Rome, Italy.

Table 2
Self- and hetero-directed violence by risk factors

	SDV (n=86)		HDV (n=34)		Fisher's exact test	Phi test	Odd ratio (SDV/HDV)
Violence risk factors	n	%	n	%	p	value	value
Previous suicide attempts	-	-	4	11.8	-	-	-
Family suicide (o suicide attempts)	6	7.0	3	8.8	0.712	-0.032	0.775
Friend suicide (o suicide attempts)	3	3.5	1	2.9	1.000	0.014	1.193
Diagnosis of pathology and/or psychiatric disorders	29	33.7	10	29.4	0.829	0.041	1.221
Family diagnosis of pathology and/or psychiatric disorders	7	8.1	5	14.7	0.317	-0.099	0.514
Physical illness	17	19.8	4	11.8	0.425	0.095	1.848
Family physical illness	7	8.1	1	2.9	0.438	0.094	2.924
Self-harm acts	-	-	4	11.8	-	-	-
Hospitalization risk factors	n	%	n	%	p		value
Emergency room access	25	29.1	8	23.5	0.652	0.056	1.332
Hospital access	22	25.6	5	14.7	0.233	0.117	1.994
Mandatory medical treatment	10	11.6	5	14.7	0.760	-0.042	0.763
HDV risk factors	n	%	n	%	p		value
Physical violence	12	14.0	-	-	-	-	-
Sexual violence	1	1.2	-	-	-	-	-
Psychological violence	3	3.5	-	-	-	-	-
Threats	5	5.8	-	-	-	-	-
Stalking	1	1.2	-	-	-	-	-
Non-consensual pornography	1	1.2	-	-	-	-	-
Economic violence	1	1.2	-	-	-	-	-
Bullying	3	3.5	-	-	-	-	-
Psycho-behavioral risk factors	n	%	n	%	p		value
Desire to die	-	-	10	29.4	-	-	-
Self-harm thoughts	-	-	4	11.8	-	-	-
Suicidal plans	-	-	2	5.9	-	-	-
Threat of self-harm	-	-	5	14.7	-	-	-
Guilt	12	14.0	0	0.0	0.019	0.210*	-
Impulsiveness	7	8.1	2	5.9	1.000	0.039	1.418
Hostile and/or aggressive personality	14	16.3	4	11.8	0.777	0.057	1.458
Anxiety	10	11.6	4	11.8	1.000	-0.002	0.987
Depressed mood	43	50.0	11	32.4	0.104	0.160	2.091
Fear	1	1.2	2	5.9	0.193	-1.360	0.188
Mutism-long silence	4	4.7	2	5.9	1.000	-0.025	0.780
Easy crying	11	12.8	3	8.8	0.755	0.056	1.516
Agitation	9	10.5	5	14.7	0.536	-0.060	0.678
Low self-esteem	8	9.3	2	5.9	0.723	0.056	1.641
Confusional state	8	9.3	2	5.9	0.723	0.056	1.641
Reported sudden mood changes/fluctuating mood	9	10.5	3	8.8	1.000	0.025	1.208
Reported insomnia and sleep disorders	14	16.3	3	8.8	0.390	0.096	2.009
Reported desire not to leave the house	8	9.3	0	0.0	0.103	0.168	-
Reported having no contacts	2	2.3	1	2.9	1.000	-0.018	0.786
Dispaire	20	23.3	3	8.8	0.078	0.165	3.131
Absence of hope for the future	30	34.9	7	20.6	0.187	0.139	2.066

Continues

Table 2
Continued

Addictions risk factors	**n**	**%**	**n**	**%**	**p**		**value**
Use of psychiatric drugs	29	33.7	10	29.4	0.829	0.041	1.221
Food disorders	5	5.8	1	2.9	0.674	0.059	2.037
Alcohol use	34	39.5	10	29.4	0.401	0.095	1.569
Cannabis	8	9.3	3	8.8	1.000	0.007	1.060
Opiates	4	4.7	0	0.0	0.576	0.117	-
Amphetamine	6	7.0	0	0.0	0.182	0.144	-
Gamble	24	27.9	2	5.9	0.007	0.241*	6.194**
Tobacco and nicotine	28	32.6	9	26.5	0.662	0.059	1.341
Social and economic aspects	**n**	**%**	**n**	**%**	**p**		**value**
Lack of social support	27	31.4	8	23.5	0.505	0.078	1.487
Psychotherapeutic pathways	16	18.6	5	14.7	0.791	0.046	1.326
Pharmacological therapy	33	38.4	7	20.6	0.085	0.170	2.402
Sentinel events	**n**	**%**	**n**	**%**	**p**		**value**
Deaths in the family or loved ones	16	18.6	5	14.7	0.791	0.046	1.326
Loss of job	13	15.1	5	14.7	1.000	0.005	1.033
Separation, divorce	9	10.5	2	5.9	0.726	0.072	1.870
Problem with the law	3	3.5	2	5.9	0.621	-0.054	0.578
Financial problems	21	24.4	7	20.6	0.812	0.041	1.246
School problem	2	2.3	2	5.9	0.318	-0.089	0.381
Conflicts with spouse/partner	9	10.5	4	11.8	1.000	-0.019	0.877
Family conflicts	14	16.3	6	17.7	1.000	-0.017	0.907

*p<0.05; **95% CI (confidence interval) do not include 1; SDV: self-directed violence; HDV: hetero-directed violence.

following the standardised methodological model, provided for telephone counselling interventions, regarding the particular topic dealt with each ISS-Helplines and detected risk factors and warning signs of violence that spontaneously emerged during the call. In order to avoid the induction of thoughts of SDV and/or HDV, the operator was not allowed to further investigate and ask personal questions concerning the topics of interest of the project.

To facilitate this process, a dashboard was created and tested to standardise the collection of risk factors and warning signs associated with violence that could have emerged during the phone calls.

The activity, which was carried out for 12 months, intercepted 106 callers, who were affected by violence, demonstrating how this type of service can contribute to prevent and intercept this phenomenon, as well as to create and strengthen cooperation networks in the field of violence.

The experimental nature of the pilot study precludes comparisons with other studies as, to our knowledge, the literature only includes studies of helplines specific for violence. However, the results of the project show how the issue of violence can be subtly present, latent even in health promotion and disease prevention services that do not directly address it, especially when dealing with risk factors for violence, such as addiction. A tool tailored to and embedded in the specific issues of the telephone services in which it is applied, accompanied by adequate training in its use and in the phenomenon of violence, can help to identify risk factors for violence. Such a tool can firstly raise awareness of the issue of violence and secondly enable a broader and less sectorial approach to health and mental health, while simultaneously facilitating targeted referrals to local services.

In our experience, the services that received the highest number of calls (35) considered to be at risk for SHDV, were the Gambling Helpline and the Alcohol Helpline. Almost half of the callers reported information on violence referring to themselves, with no gender difference. More than half of the callers reported information on violence referring to someone they care for, indicating how this large percentage of family members and friends can act as sentinels to the phenomenon of violence, often recognizing signs that they do not know how to interpret. In both cases, finding a welcoming, confidential, and competent listening space, in which the operator is capable of intercepting, warning signs of violence, can facilitate the willingness to seek help and, for relatives, help family members to make sense of signals they did not know how to interpret.

There were more calls regarding SDV compared to HDV: 72 for SDV, 20 for HDV, 14 for both. In line with what has been reported in the literature, our study confirms the commonality of several risk factors between SDV and HDV, although in a different rank order in each group. It is worth noticing that depressed mood is

the most important factor for both SDV and HDV. The Gambling Helpline was found to be more involved in self-directed violence.

The dashboard created for the Violhelp project was the starting point for this study and its experimentation highlighted both its potential and the critical issues to be worked on in order to refine the tool and the data collection methodology.

During the course of the project, some critical issues were encountered. In the data collection phase, for the ISS-Helplines operators, it proved complex to retrieve some of the information present in the dashboard, such as the time span of the detected events, also due to the project's request not to solicit the caller's report of violence. The analysis showed that some items entered in the dashboard were never detected by the operators during the calls. Furthermore, in 29 cases, the difficulty to associate some risk factors to the two types of violence became apparent, since the callers had not declared any of the risk factors characterising the two categories (SDV and HDV).

Strengths and limitations

The helplines involved in the study do not deal specifically with violence, and indeed the aim of the project was precisely to test whether the operators of these helplines, appropriately trained, could intercept situations of SHDV with the help of a specific tool. For this reason, the number of calls analysed in this study represents only a small percentage of the calls received by the helplines involved (from 0.2% to 4.8% of the total calls received by each helpline). This limitation also proved to be the strength of testing a tool for use by non-violence helpline operators.

The anonymity of the helpline is a second limitation, but also a strength. While anonymity guarantees confidentiality, freedom of expression and a non-judgmental relationship of trust, it also allows only minimal information to be recorded about each contact (duration, sex of the caller, sometimes age, etc.), and there is no way of verifying the personal details that may have been revealed during the call or no way of creating an accurate profile of the caller. Then, the study findings are based on users' self-reported information, attitudes and behaviours. All data are anonymous, self-reported and limited to the single point in time of the call.

The smallness of the sample did not make possible to explore the association between risk factors and socio-demographic characteristics of the 106 persons affected by SDV and/or HDV, as well as to have an in-depth, gender-specific analysis.

Both in HDV and SDV, the risk factors related to addictions (alcohol, gambling, tobacco and nicotine, and drugs) have been frequently highlighted by the operators of the ISS-Helplines. This can be also attributable to the typology of the ISS-Helplines involved in the project that, in four out of five cases referred to addictions. The last limitation in this pilot study is the use of the telephone helpline, which is often not used by young people and children who prefer short written communication to verbal communication, being more comfortable with SMS, chat or emails [44-48].

CONCLUSIONS

Although there are many definitions of violence, it should be noted that it is a cross-cutting phenomenon, for this reason it is very important that public health practitioners understand the broad scope of violence and are able to identify modes for successful intervention to prevent violence and its health and social impacts.

The health emergency, caused by the COVID-19 pandemic, which resulted in social containment and distancing measures, have had repercussions on SHDV. In the face of a general contraction of support services, the effort and commitment of helplines has been considerable. The scientific literature points to the strengthening and networking of health services as the most effective tools to counter the phenomenon of violence through the development of protocols and skills of service workers and the creation of networks for recognition of violence events. The role of the health care system is central in estimating the size of the phenomenon, its causes and consequences on health status; recognizing violence and providing appropriate interventions at all levels; and developing and evaluating violence prevention programs. Among health care services, helplines represent an important point for intercepting violence. This pilot study has shown that helplines are an important first point of contact in the prevention and care of people with health problems, psychosocial concerns and those at risk of SHDV. Helplines can provide confidential information and emotional support and intervene with people in crisis, even if they are not specialised in a specific area. The trained ISS-Helplines operators involved in the study have detected the discomfort and fragility of a small part of the population with a suspicion of violence also thanks to the active and attentive listening features of the telephone counselling methodology.

The results of this pilot project show how important is to know how to read the signs of SHDV and the need to have a network capable of improving information, prevention and support activities for people at risk of violence and their families.

In the future, the possibility of extending the helplines services to other communication tools like SMS, chat or emails, preferred by young people could be explored. Text-based counselling also helps to rebalance the power between the child/young adult and the counsellor and gives the user more control over their self-presentation.

It is therefore useful that the ViolHelp experience can be replicated and implemented by other helplines, with whom the ISS-Helplines can share experience, training and tools (e.g., an expanded and improved dashboard).

Authors' contributions

RD, SG, MD, AS, CM, MV, EL and LM conceptualized the study, SG and MV analysed the data and RD, SG, MD, AS and LM wrote the first draft of the manuscript. AS, CM, MV and EL provided important contributions for the interpretation of findings. MO, AFo and AFa carefully revised the final draft of the manuscript. All Authors have read and approved the last version of the manuscript.

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Conflict of interest statement

The Authors declare no conflict of interest.

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