Deliverable 2.1: Stakeholder Needs Assessment

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Victim Protection
in Medicine

Exploiting practical knowledge of medical staff to enhance
the multi-professional contact with victims of domestic violence

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About this document

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No.	Acronym	Institution	Country
1	WWU	Westfälische Wilhelms-Universität Münster	Germany
2	VICESSE	Vienna Centre for Societal Security	Austria
3	IKF	Institut für Konfliktforschung	Austria
4	GESINE	Frauen helfen Frauen e.V.	Germany
5	UU	Uppsala Universitet	Sweden
6	HFPA	Elliniki Psychiatrodikastiki Etaireia	Greece
7	AOU-PR	Azienda Ospedaliero-Universitaria di Parma	Italy

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Abbreviations and acronyms

DV	Domestic Violence
D	Deliverable
IPV	Intimate Partner Violence
ER	Emergency Room
NCK	The National Centre for Knowledge on Men's Violence against Women
CAV	Centro anti-violenza (Italy)
F2f	Face-to-face
WP	Work Package

Table of Contents

1. Executive summary

The **VIPROM project**: "*Victim protection in medicine: Exploiting practical knowledge of medical staff to enhance the multi-professional contact with victims of domestic violence*" has set ambitious goals of **developing and implementing training modules** (medical curricula) **specifically tailored to the needs of medical and healthcare professionals** in five countries to provide appropriate and responsive support to victims of domestic violence (DV). Medical and healthcare professionals play an important role in improving the health and safety of victims through early detection, adequate care and referral to specialised victim protection services. Thus, the main aims of the VIPROM project consist of developing curricula tailored to the specific needs of the medical sector, implementing these curricula, and developing train-the-trainer programmes to teach these curricula.

In order to achieve these aims, the VIPROM consortium conducted in a first step an exemplary and qualitative needs assessment in all five participating partner countries as part of Work package 2 "Needs Assessment for Sustainable Organisational Change". This **Deliverable (D2.1) presents the needs assessment** (interviews and focus groups with stakeholder groups) of the following five countries: *Sweden, Germany, Austria, Italy,* and *Greece.* The work conducted under this task (T2.2) has served the twofold purpose to assess both, the specific needs for DV training in the medical sector for various stakeholder groups (physicians; dentists; nurses; midwives and students, including: medical and dental students, nursing students and students of midwifery science), but also the commonalities between them. Although the level and availability of DV training inevitably varies between the partner countries and professionals, it became clear that there are overarching issues that need to be considered when developing and delivering DV trainings.

These **cross-cutting issues** relate to the fact that medical professionals should not only receive **theoretical** information on DV but also learn **practical skills** on how to recognise, respond to, support and document cases of DV. This includes especially the **format of the trainings**, which should be **interactive and multidisciplinary**, so that medical professionals recognise themselves and their field as important actors in the (health) prevention of DV. When developing and tailoring training modules for different medical and healthcare professionals, it is critical to consider the **specifics of each stakeholder group**.

Throughout the individual needs assessments and their comparison, it became clear that the majority of respondents placed a particular emphasis on the care of women and children when addressing issues related to DV and its treatment in medical settings. As important as it is to focus on women and children, **it is equally important that medical professionals understand the complexity of DV, its dynamics, and various forms**. The trainings must cover a broader spectrum when it comes to potential victims of DV because there is no "typical victim". It follows that DV must be viewed by medical and healthcare professionals as a complex phenomenon that is not exclusively limited to the classic and stereotypical assumptions of perpetrator/victim

categories. Rather, these forms of violence are influenced by multiple and intersecting power dynamics in which aspects such as legal status, disability, income, or age can play a decisive role.

The almost **absent issue of perpetrator programs** is in this context a remarkable insight for the project, pointing to another blind spot among medical professionals that reflects very clearly that they do not see themselves as involved in prevention. There is a need to increase the sensitivity and expertise of all healthcare professionals when it comes to prevent further victimisation of the various patients with DV experiences. Thus, they must be **trained in the sensitive treatment of various groups of victims** in the context of DV.

There is also a need for adequate **institutional support and clear procedures** as a necessary and critical prerequisite for implementing DV training into existing medical curricula (including: clear guidance, protocols, clarification of responsibilities and task areas). In addition, it has been found that the greatest challenge is to effectively use these resources (when available) and to ensure that healthcare providers actively engage with them due to time pressure and a high workload. In addition, it was stated that **supervision** should be available for medical and healthcare professionals to work through their own experiences in dealing with these difficult cases, possibly their own experiences of violence, as well as their own stereotypes in their professional context. In that vein, it became obvious that **training on secondary victimisation and retraumatisation (triggers) by medical practitioners and/or treatments and examinations** should be offered**.**

To meet all those needs, VIPROM will include these in comprehensive training materials for different medical stakeholders.

2. Introduction

The VIPROM project: "*Victim protection in medicine: Exploiting practical knowledge of medical staff to enhance the multi-professional contact with victims of domestic violence*" has set ambitious goals, namely to develop and implement training modules (medical curricula) tailored particularly to the needs of medical and healthcare professionals in five countries to support victims of domestic violence (DV) in adequate and responsive ways. Medical and healthcare professionals play an important role in improving victim's health and safety through early detection, sufficient care and referral to specialised victim protection services. Therefore, the main aims of the VIPROM project are:

- **Developing curricula** specifically tailored to the needs of the medical sector, i.e., in participatory exchange with healthcare professionals by taking into account their situated needs (e.g., organisational structures).
- **Implementing curricula** on the basis of basic as well as advanced training modules for specific demands; aiming at piloting the developed modules of the VIPROM project at the different country sites.
- Delivering **a train-the-trainer programme** to ensure an organisationally embedded knowledge transfer by taking into account the local needs encountered through the needs assessments.

In order to achieve and support these aims, the VIPROM consortium conducted in a first step an exemplary ***needs assessment (D2.1)*** in all five participating partner countries as part of work package 2 "Needs Assessment for Sustainable Organisational Change" (in short: WP2), led by VICESSE. This deliverable (D2.1) presents the needs assessment of the following five countries – the consortium partner members: *Sweden (UU), Germany (WWU & GESINE), Austria (VICESSE & IKF), Italy (AOU-PR)* and *Greece (HFPA)*. The needs assessments have focused on the following aspects:

1) general DV-sensitivity and expertise among the medical community;
2) modes of identification of DV victims in clinical settings;
3) reactions to disclosure about DV experiences by patients;
4) interventions and pathways of referral;
5) documentation and support practices in hospitals;
6) challenges and needs that healthcare professionals encounter in their daily practice when dealing with DV patients; and
7) availability and sustainability of training (needs) in each country.

In a second step, VICESSE compared and summarised these aspects of the individual country reports (needs assessments) to identify overarching key elements of professional victim protection in healthcare for developing and implementing DV trainings in a sustainable manner.

In **Chapter 3**, the report describes the *methodology*, *stakeholder groups and data* on which the individual needs assessments are based. **Chapter 4** presents the *five individual needs assessments* (country reports) along the aspects listed above in their local and situated expressions and with focus on the four medical professional stakeholder groups, namely: *physicians*, *nurses*, *medical students* and *midwives* (plus additional groups per country). **Chapter 5** then provides a *comparison* of the key aspects (challenges and needs) that should be considered when implementing training modules on DV in medical curricula and for healthcare professionals in the different countries. The chapter also attempts to integrate those aspects into what is needed across countries and among all healthcare professionals to *implement DV trainings sustainable*. **Chapter 6,** in a final step, *summarises cross-cutting issues* of the stakeholder needs assessment(s) and how those will feed into the further development of the various modules and curricula in WP3 established throughout the VIPROM project.

3. Description of methodology and data gathered

The work conducted in T2.2 "stakeholder needs assessment" has served the purpose to assess the specific needs for DV-training in the medical sector for various stakeholder groups (physicians; dentists; nurses; midwives and students, including: medical and dental students, nursing students and students of midwifery science). The availability and level of institutionalisation of DV-training inevitably varies between the partner countries. Against this backdrop, a **qualitative needs assessment** was carried out by conducting **interviews and/or focus groups** (as standard methods of qualitative social science and humanities research (SSH)) in each partner country. The aim was to evoke narrative descriptions of participants' experiences and expectations of DV-training in their medical field. In the case of the VIPROM project, the consortium partners conducted predominantly **face-to-face interviews,** in some cases **online or telephone interviews.** In some partner countries **focus groups** (interview discussion with more than 1 person, but less than 5) with **medical professionals** in **clinical settings** (i.e., professionals who primarily work at hospitals) were carried out.[1] On the basis of these qualitative interviews and/or focus group(s), the project aims to assess both, general gaps in DV-training on an international level, and the needs specific to each partner country. Moreover, specific needs for training will vary between different stakeholder groups within the medical sector. By including professionals of each of the projects different stakeholder groups (physicians, nurses, students (nursing, midwives science, medical and dental), midwives, dentists), T2.2 aims to lay the groundwork for the development of further stakeholder-specific training materials developed in WP3.

[1] However, office-based physicians and other healthcare practitioners would also represent an important medical area for early prevention/detection of DV, but were not included in the VIPROM's WP2 needs assessments.

a) Country-specific stakeholder needs assessments

Each partner country conducted a needs assessment by either interviewing a minimum of five individual professionals or by organising a focus group including five participants. The minimum requirement within the VIPROM project was that the interviews or the focus group should include at least one representative of each of the stakeholder groups. However, there was the possibility of including more professionals or students into a single focus group, or to conduct more than five interviews depending on the needs (and resources) of each partner. The data collection was conducted over a period of two months (May-June 2023).

Overview of the data set:

The needs assessments included physicians (primarily gynaecologists and emergency department physicians, and as additional groups in Germany: psychotherapists and paediatricians as best practice examples), medical students, nurses and midwives (and as additional groups in Germany: dentists, dental students, students of midwifery science, nursing students; in Austria: midwifery students, in Italy: one dentist; and in Greece: two orthopaedists) and were held partly face-to-face and partly online. More detailed information on the country-specific data samples can be found in the individual country reports below.

In total, **the VIPROM consortium conducted 88 interviews** (including focus groups in Germany and Sweden) with various healthcare professionals at different stages of their career and practice to obtain a diverse picture of training needs in different professional groups and countries. Consequently, the different approaches (small vs. large data sample; experts vs. nonexperts for DV in the medical field) support each other to make strong claims for DV training in the medical sector.

b) Cross-country qualitative comparison

Chapter 5 of this report, “Country Comparison”, provides a qualitative comparison of the key aspects that should be considered when implementing DV-trainings developed under the VIPROM project into existing medical curricula. For the comparison, the focus is on both: differences but also (and with particular emphasis on) the **commonalities** between each of the need assessments because these are expected to be most useful across all the partner countries and different disciplines and healthcare professionals. However, to account for the respondents and countries choice of topics and priorities the comparative part is structured along the same dimensions than the individual needs assessments, summarising the different parts into broader sets of conditions and practices that are deemed essential to be improved or supported when dealing with victims of DV in medical settings:

- **Expertise and awareness of violence against women** in the medical community across five EU countries

- **Procedures and practices** of identifying, engaging, supporting and referring victims of DV
- **Cross-national challenges and needs** of healthcare professionals in dealing with victims of DV
- **Sustainable implementation** of DV-trainings in medical education

These commonalities are intended to support the implementation of such DV-trainings for different healthcare professionals and medical communities in different locations. The **specificities of each partner's needs assessment** (their challenges, strategies, procedures and existing training as well as needs when dealing with patients with a DV background) are detailed in the individual country reports (see **Chapter 4**). Against this backdrop, we further summarise key findings from the individual stakeholder needs assessments on challenges, blind spots, needs and conditions that should be met and reflected when aiming at implementing such DV trainings in a sustainable manner.

4. Individual country reports

4.1 Sweden

4.1.1 Context of data collection and data set description

In Sweden, the National Centre for Knowledge on Men's Violence against Women (NCK) and Uppsala University (UU) conducted a focus group with five participants, two nurses (one specialised in cardiology, one in psychiatry), a midwife, a medical student and a gynaecologist. They all (except the student) currently work at the clinical department of NCK and can therefore be considered an expert group regarding the caretaking of women exposed to DV. There are more employees at NCK that are experts but due to the structure of the requested expert group, NCK and UU chose five professionals according to the stakeholder profile who could attend at the occasion for the interviews. All of them have, in their earlier career, worked at other working places – the cardiology nurse at the department of cardiology at Akademiska sjukhuset, Uppsala, the other nurse at the psychiatric department at Akademiska sjukhuset, Uppsala, the midwife at a maternity clinic and the physician at a gynaecological/obstetrical unit. The student did her internship at a psychiatric ward. Because of their experiences of meeting women subjected to DV at their former working places they decided to specialise in the subject and started at NCK.

All participants were middle-aged females, except for the female student who was a little bit younger than the other participants. And all participants had attended – to varying degrees – one of the courses offered by NCK on male violence against women and/or worked for NCK, e.g. at the national helpline. Both nurses completed an online course, all other participants have completed courses in men's violence against women with at least 7.5 university credit points proved by NCK.

4.1.2 General summary of the state of DV-sensitivity/expertise in the medical community

Despite the fact that all participants have completed dedicated courses on violence against women, the level of knowledge about DV varied among them due to various levels of theoretical knowledge of DV and clinical experiences, depending on how many working years' experience they had. Most of them had about 30 years, except the student who wrote an essay at the clinical department of NCK and had done internship at various medical departments during her studies. All the participants, except the medical student, had worked between two and ten years at NCK and they all had between 7,5 and 15 credit points in DV, including the student. Nevertheless, the focus group revealed mostly homogenous attitudes towards the topic of DV in medicine. All considered DV as a serious societal problem and that medical professionals play a key role in identifying and providing medical care to those being affected. All interviewees agreed that the knowledge they had gained from completing the training helped them in their work with women who had been affected by violence.

In this regard, the participants stated that they did not have sufficient knowledge about DV before completing the training, even though they were dealing with women affected by violence. Such a lack of training can manifest itself, for example, in not taking into account the whole situation of women affected by violence, but instead focusing only on their medical needs. Furthermore, the respondents pointed out that there was a general lack of knowledge about DV in their former workplaces. Respondents agreed that they themselves and their former colleagues did not understand violence as a cause of patients' symptoms. This suggests that knowledge about violence is generally low in medical departments outside the NCK clinical department. During the focus group interview, consensus among the participants became apparent that knowledge about violence is very low in psychiatric as well as in somatic care. As a result, they also have consciously chosen to work in this field (DV) on a daily basis at NCK.

In summary, the participants have acquired a considerable part of their knowledge and awareness of the topic in their training offered by NCK, whereby they were strongly motivated by personal interest and engagement. All of them had been engaged in cases of DV during their work before they started at NCK. They all reported that they had met women subjected to DV and realised that there was a lack of knowledge and possibilities to give adequate help at their former working places. They also reported realising that DV is much more common than they knew or were told about in their training.

4.1.3 Modes of identifying potential victims of DV

The DV cases reported in the Swedish focus group concerned situations that the interviewees had encountered prior to their work at NCK and their associated training. One of the cases regarded an abused woman belonging to a migrant background in addition to another that concerned a young woman with some sort of addiction. The other interviewees reported cases concerning women who

do not belong to minority groups, as they are considered white/Swedish, non-addict, and “middle-aged”.

The interviewees mentioned different indicators of violence, both non-physical and physical signs of violence. However, the main description shared by our interview partners was the patients’ changing moods when separated from their partners. For example, the two nurses described patients who felt happier or “not that sick” when their respective partner left the hospital. For example, one of the participants (the nurse from the cardiology department) mentioned that a patient’s partner got upset with her when she would not/could not let him be in the same room with his wife at the hospital. Such indicators are not always providing sufficient grounds for concluding that a person is affected by violence, but are suspicions that give rise to further action or investigation. For example, the student reported that due to such suspicions, she began asking a patient (a young female admitted to psychiatric unit) appropriate follow-up questions along this line, whereupon the patient revealed that she was in an abusive relationship.

4.1.4 Reactions to disclosure about DV by patients

In principle, initial reactions depend on the nature of the disclosure of the violence and the specific situation of the victim. In the focus group, two modes of reaction were mentioned: one in which professionals attempted to resolve the situation by themselves and another in which professionals referred the patient to another physician. The nurses reported that in response to the disclosure of the violence by the patient, they tried to get more information from the patients and to get more information about DV themselves. In order to get more information and knowledge on the topic of DV they contacted NCK (since realising that they could not get the information/knowledge at their own department).

In the case mentioned by the student, she had reported her suspicion to her supervisor, who is a physician, and he did not believe the story of the patient. This illustrates the obstacles/difficulties in getting professional supervision within hospitals. The case reported by the physician highlights how the two modes can merge in daily clinical practice. After the patient had been referred to the gynaecologist by a midwife from another department on suspicion of DV, the gynaecologist sought to protect the victim. To this end, the gynaecologist mobilised and practically “converted” the hospital’s resources by trying to find ways for the patient to prolong her stay in the hospital. The physician facilitated additional visits to the hospital in order to see the patient again and follow up on her situation in “private” (even though there were not necessarily medical implications in the strict sense).

4.1.5 Typical interventions and pathway of referrals

The “pathway of referrals” can be distinguished between internal and external referrals, whereby at some point medical staff will – if they believe the victim

– always contact external specialised organisations. Thus, both the nurses and the physician reported that after they had confirmed that their patients were in abusive relationships, they asked their patients if they wanted to contact NCK's helpline and/or a woman's shelter. Which pathway (internal or external) is initially chosen and how quickly the external referral is attempted, depends heavily on the knowledge about DV by the attending person and, to some extent – as the student's case shows – also on the position the person occupies in an organisation (in this case a hospital).

It should also be noted that such interventions and referrals are not always successful. In both cases, reported by the physician and the nurses, the patients refused to be referred to a specialised support organisation. In response, both nurses shared that they tried on their own to make the patient's visit to the hospital as safe as possible. Nevertheless, the nurses provided the patient with the numbers of support organisations in case the patient wanted to get support from the national helpline later. In such cases, the structural weaknesses of victim protection in the medical context become apparent, as prolonged victim support is sometimes dependent on the commitment of individuals.

4.1.6 Internal documentation and support

Regarding the internal documentation, participants of the focus group reported important changes. In particular, the nurses mentioned that in their previous positions they did not record DV in an explicit or standardised way because this was not common practice in Sweden until 2014. Nevertheless, previously, if DV cases were documented, cases were marked with the keyword "psycho-social". However, this resulted in a misleading labelling of cases and it prevented follow-up interventions and entailed the risk that continued acts of DV would go unnoticed. To improve this situation, in 2014, the national network for e-journals decided that the search term "violence exposure in close relationships" should be protected nationally. Thus, what is documented under the search term "violence exposure in close relationships" is protected/restricted from direct access to medical records logged in from home via the Internet. The nurses confirmed that the protected search term "violence exposure in close relationships" enforced in Swedish healthcare is very helpful.

Regarding support structures for victims of DV, the findings from the focus group show that **informal structures** are predominant. The student, physician, and midwife reported that it was typical for staff to first seek help from their colleagues in their own organisations. Knowledge can be passed on within the framework of such informal support structures. The midwife for example reported that practical knowledge about how to address and engage with potential victims was passed on by older colleagues. In the absence of formalised structures, however, one is confronted with a kind of "tacit knowledge" that shapes and preserves certain traditions and routines in the workplace. The hurdle in trying to provide informal support is that there are often knowledge gaps among colleagues. The student reported for example that older colleagues often lacked knowledge about DV, which could be the reason why they did not ask potential DV victims follow-up questions about violence experiences. The fact that colleagues or even supervisors do not

know **why and how to ask about DV** in healthcare was repeatedly seen as a problem by the interviewees.

4.1.7 Challenges and needs

Respondents emphasised that healthcare personnel need to know more about DV, especially in terms of knowledge about the normalisation and breakup processes was raised. The normalisation process is a process where a person subjected to DV gradually gets used to the violence, whereas the violence usually increases in the course of time. In the context of DV the term “normalisation process” generally refers to the psychological phenomenon where behaviours, beliefs, or situations that might initially be considered abnormal or unacceptable become accepted as normal over time and often lead to difficulties to leave the perpetrator. This often leads to a break-up process where it is not uncommon for the victim to leave the perpetrator several times before leaving for good, and this process is very (physically) dangerous and emotionally complicated.

Furthermore, there is a lack of expertise how the exposure to violence affects a woman’s health status and well-being, co-morbidities, and how and why DV can be part of the patient’s medical story, and how ill-health is connected to violence. Respondents also mentioned the need for clear routines and procedures at each hospital unit, the necessity of training of new employees and the availability of supervision if necessary to cope with their own experiences with these affected patients.

All respondents stated that questions about DV were not routinely asked at their previous workplaces, which was described as a challenge. Some of the respondents raised the need to receive training about both, asking questions about DV and about what to do when patients disclose experiencing abuse and violence. Training would also be needed in terms on how to document DV clearly and professionally as a necessary step to facilitate follow-up procedures and in case evidence is needed in the future (e.g., for potential court cases). The respondents also suggested training on how and why one needs to keep medical records protected and safe, especially from the possible perpetrator.

All respondents agreed that it is important to gain knowledge on risk assessments but that it should not be in depth. Because they pointed out that the healthcare personnel are not in charge of assessing risk. Hence, instead of focusing too much on risk assessments in the training, healthcare personnel should know and be trained more about the roles and responsibilities of different actors, for example, healthcare, social care, police, shelters, lawyers etc., so that it is clear who is responsible for risk assessment.

In one of the cases, an interpreter had to be involved who helped that the patient could receive information and support in her own native language. Since the patient could not speak Swedish, her way to break free from the perpetrator became more challenging which the focus group discussed further. The group expressed (particularly the

nurses and the student) high frustration of not being able to do more for the woman, or not knowing what happens after the patient leaves the hospital (as a safe space). The understanding that one can be frustrated might also be incorporated into DV training.

A slightly different perspective was voiced by the midwife, who said that there was no time to do anything about the woman's situation when it was discovered that she was being abused. She was there because she was pregnant and about to give birth and could not do anything else, such as reflect on her relationship and the violence she was subjected to. With this in mind, the focus group concluded that midwives would need practical knowledge adapted to the circumstances of the profession and to the needs of patients about to give birth, which means that women are not necessarily sick. Examples and cases that highlight how one can address a happy situation without missing to ask questions about DV would be helpful.

In addition, the findings illustrate a lack of knowledge that is implemented at an institutional or organisational level. A clear indication of this was the report of the student who described that her supervisor in the department considered her DV intervention (asking patients about possible experiences of violence) as an "additional" task, even though such questions should be compulsory, as is also enshrined in the degree programme. Therefore, systemic changes are needed that promote the anchoring of local routines on both, an individual and structural level to inform their daily working practice with their patients.

4.1.8 Availability of training and information on DV in medical curricula from the perspective of medical students

Overall, the student interviewed rated the course as good and also from our perspective, she had extensive knowledge of DV and the role of healthcare services in dealing with women who (may) be affected by violence. For further training, the student recommended more use of role-playing (actors and medical students) and early and ongoing education about DV and how to deal with it in medical settings.

4.1.9 Overview of existing trainings and training needs

Table of Existing Training

Stakeholder Group	Brief description of "Type of Training"

Multi-professional and interdisciplinary course	**Men's violence against women – multi-professional course for professionals, 15 university credits** 50%, throughout a semester - distance learning https://www.nck.uu.se/en/training-and-education/training#anchor-797138 The course aims to increase the competence of professionals in order to better detect victims of violence, provide good treatment and care for victims of violence, and work preventively against violence in close relationships. Men's violence against women is presented from an equality perspective based on international agreements and human rights.
Mixed student group and interdisciplinary course	**Men's Violence against Women, 7.5 university credits** evening, 50%, throughout a semester distance learning https://www.uu.se/en/admissions/freestanding-courses/course/?kKod=3PE122&typ=1 The course provides basic knowledge on the subject of men's violence against women from an interdisciplinary perspective. Men's violence against women is presented from an equality perspective based on international agreements and human rights. The course also gives the participants space to reflect on their own values and attitudes towards men's violence against women.
Online courses targeted to professionals and students	**An introductory course on Men's violence against women and violence in close relationships** https://webbkursomvald.se/?lang=en A web course that introduces the subject of men's violence against women and violence in close relationships.

Table of Training Needs

Stakeholder Group	Brief description of "Type of Training" desired
Mentioned by all	In addition to the points mentioned above, training tailored to the professional and practical needs of midwives, physicians and nurses was required.

4.1.10 Sustainability and implementation of trainings for medical professionals

Once or twice a year was mentioned as an ideal interval for training, however, several of the respondents voiced uncertainty when it comes to duration. In order to ensure sustainability, respondents highlighted the importance to train everyone working in healthcare settings. For the acceptance of training, it was considered important that trainers share professional background with the trainees. For example, the physician stated that it is important that the trainer teaching the physicians is also a physician. The participants also agreed that supervisors and staff members should participate in the training together in one group. Furthermore, it would be beneficial to have a mentor (professional with expert knowledge and experience about DV cases) in each department. Respondents also recommended the establishment of a DV ombudsman at the hospital to coordinate training and serve as a point of contact for cases of DV. Finally, the respondents expressed that training should be mandatory.

4.1.11 Sustainability and implementation of trainings for medical students

To ensure sustainability in medical education, the interviewed student recommended specialised courses about DV. However, one-off training and courses were considered insufficient because the knowledge acquired would be too easily lost if not used and applied regularly. In addition to lectures, the interviewees stressed role plays and simulated conversations as important elements of the training because they are more memorable than usual lectures.

To address these implementation and sustainability gaps, the Higher Education Ordinance (1993:100)[2] in Sweden was amended on July 1, 2018 to require that knowledge of men's violence against women and violence in close relationships be included in the degree curricula of a number of University education/programmes, including: physiotherapists, lawyers, physicians, psychologists, nurses, social

[2] See here: https://www.uhr.se/en/start/laws-and-regulations/Laws-and-regulations/The-Higher-Education-Ordinance/ (accessed on 4th September 2023).

workers and dentists. In 2019, also the curriculum for dental hygienists was included. Within the framework of a government assignment, NCK has developed a model course for university teachers due to this amendment. NCK also gives lectures as part of the training/educational program mentioned above.

The Swedish Higher Education Authority is an independent government agency that has evaluated the implementation of the new objectives, which has shown that all current programs in Sweden have taken the change in the law into account. In addition, the law has been interpreted in different ways, resulting in numerous quality standards for programs at different universities, colleges and institutions, which also leads in some cases to challenges.

The understanding of the concept and expressions of violence needs to be developed. There is also a need for program specific curricula as well as interprofessional collaboration in the education processes. The teachers would probably benefit from getting help to develop research-based education for their students. Because there is a lack of research in some areas of DV, many teachers do not know so much about the subject.

In Uppsala, the head of the programme for nurses has involved NCK in the education of their students about knowledge of men's violence against women and violence in close relationships. This training is a full-time course (7,5 credits) and is highly appreciated by students. Therefore, a coherent course, similar to what NCK offers to the nurses studying at UU, should be mandatory for all the programmes mentioned above. A more coherent teaching gives room for reflection and analysis and enhances tremendously the learning process of individuals.

4.2 Germany

4.2.1 Context of data collection and data set description

In Germany a total of 63 (48 females, 15 males) individuals were interviewed by WWU and GESINE. The needs assessment involved a combination of 15 focus groups and 13 individual interviews (13 in person, 11 online). The interviews and focus groups included participants from diverse background, namely 16 physicians (gynaecologist, dentists, surgeons, paediatrics, internal medicine and psychotherapy), nine midwives, six nurses, and 32 students from various fields (medical students, students of dentistry, students of midwifery science). The participants were recruited mainly through personal contacts and distribution lists of the respective students.

The majority of the interviewed individuals had not received any formal education or training on the topic of DV and thus did not feel competent to respond adequately in such situations. All the respondents unanimously expressed their desire for further training and professional development in this area.

4.2.2 General summary of the state of DV-sensitivity/expertise in the medical community

All the individuals interviewed agreed that it is their **professional duty to respond to cases of DV**. However, differences were observed in terms of knowledge and sensitivity. Physicians, especially surgeons, were found to be less informed, less able to identify nuanced indicators of DV, less knowledgeable about available support services, and less experienced in addressing and supporting patients affected by violence compared to midwives and students of midwifery. In contrast, the level of knowledge and sensitivity was found to be very high in the fields of pediatrics and psychotherapy, with reports of extensive experience in dealing with patients affected by DV.

There is a **general gap in DV-sensitivity** and **theoretical knowledge on DV in the medical sector**. In the German context, interview partners gained their expertise and sensitivity towards DV as a result of personal interest and awareness. Physicians, medical students, and students of dentistry exhibited knowledge gaps, particularly regarding communicating with affected individuals and awareness of support services, rather than in terms of prevalence or indicators of DV. In contrast, the senior gynaecologist, psychotherapist, and pediatrician demonstrated a high level of knowledge and were very sensitive to the topic. The midwives and students of midwifery also exhibited a similar level of knowledge and sensitivity. Interestingly, those also reported having more frequent contact with victims of DV compared to the other stakeholder groups.

However, it was consistently stated that sensitivity towards DV arose primarily from personal interest or direct exposure to victims and that the topic if **DV is not adequately addressed in training and education programs.**

4.2.3 Modes of identifying potential victims of DV

The most commonly reported indicators described by all stakeholder groups included **visible injuries** (e.g., fractures, bruises, swelling), **inconsistent statements, substance abuse disorders, pregnancies, and anxiety disorders**. In the field of dentistry, there was a clear difference between the theoretically known indicators for DV and the practical identification of victims of DV in everyday work, where patients are typically not identified by the presence of visible injuries, but by behavioral problems and poor dental status. This is especially true for children.

Reports about incidents of DV were obtained from both, patients who disclosed their experiences voluntarily and patients who were actively approached if DV was suspected. However, it was **more common for patients to reveal their experiences voluntarily** - **especially in the field of psychotherapy/psychiatry**. One explanation for this is that in cases of suspected DV, professional of take little action due to uncertainty how to respond, a lack of knowledge, or insufficient support from superiors. Many of the interviewees expressed hesitation in addressing their suspicions due to

concerns about potentially raising a false accusation. This uncertainty is particularly pronounced when it comes to non-physical indicators of DV.

None of the licensed dental practitioners directly addressed patients when there was a specific suspicion. In gynecology and nursing, there is also no routine questioning about experiences of DV, for example, during the medical history interview. Similarly, only a few midwives reported asking about DV during the course of their care. In contrast, in the field of paediatrics, patients are consistently and directly asked about potential experiences of DV when there is suspicion.

Not all interview partners had prior contact with victims of DV. For example, students of dentistry in the preclinical and clinical parts of their study had not encountered any cases, and surgeons also reported minimal contact with victims of DV. **Only the group of midwives, the psychotherapist, and the paediatrician reported frequent cases of DV.**

The group of midwives, gynecologists and the psychotherapist appear to be particularly sensitive to non-physical signs of violence, as they have close and ongoing contact with patients during prenatal and postnatal care, which provides them with a deeper understanding of family dynamics. This continuous involvement allows them to develop a greater insight into the presence of potential violence.

4.2.4 Reactions to disclosure about DV by patients

Midwives, the paediatrician, the psychotherapist, nursing staff, and students of midwifery science reported more direct contact with victims of violence, including in some cases within domestic (private home) settings (midwives). The described reactions demonstrated both, empathy for the existing risk of further violence and a sense of partial helplessness in terms of communication skills, motivation, or facing a lack of willingness to change on the part of victims, as well as a lack of prospects for change on the part of perpetrators.

Common among all stakeholder groups was the **uncertainty in pursuing suspicions that were not based on obvious external injuries**. It was noted that behaviour could be attributed to cultural background or language barriers. In cases of obvious injuries, there was a greater tendency to inquire about the situation, as confirmed by all professional groups.

Frequent reports highlighted that individuals felt that they were not in the "appropriate position" to investigate or raise suspicions. This was often attributed due to the hierarchical structures within the hospital setting, time constraints, and a lack of support from superiors, which prevented to act effectively.

An exception to this is observed in the field of paediatrics, where suspicions of DV **are always directly addressed**. Furthermore, experts (senior physicians)

within the same hospital, who possess extensive experience in this area, are informed. If necessary, consultation with the ethics committee is sought. A collective assessment is made, and the situation is addressed with the parents.

In the field of dentistry, there was a notable absence of direct discussions regarding suspicions of DV with patients. Instead, the focus was primarily on maintaining a positive and comfortable environment for the patients. Additionally, there was a specific instance where a suspected case involving a child was not pursued further due to concerns about the potential reaction from the parents.

4.2.5 Typical interventions and pathway of referrals

Occasional referrals by interviewees to women's counselling centres or similar support services were reported, with personal contact playing a more significant role than mere theoretical awareness of these resources. Differences within the stakeholder groups were found in terms of knowledge about specialised victim support services and referrals to such services. **Most physicians, nurses, medical students, dentists and students of dentistry demonstrated a significant lack of awareness regarding specialised victim support services with substantial knowledge gaps in interventions and referrals.**

In most cases (with exception of the trained leading gynaecologist) physicians made no referral to a victim support service in cases of DV. The field of paediatrics and psychosomatic/psychotherapy stands out as an exception, demonstrating a clear and well-defined approach involving:

- The process of hospital admission.
- The documentation procedure, which adheres to standards for legal proceedings.
- In terms of engagement with child and family services.
- The collaboration with the police.

Our interviews also revealed that factors such as high staff turnover, limited time and resources, and the organisational culture and leadership approach play a significant role in shaping the quality, sustainability, implementation, and effectiveness of violence intervention strategies in clinical settings. Consequently, these factors have a direct impact on interventions. In the face of limited resources, the topic of DV tends to fade into the background unless it is consistently brought to attention by e.g. training. Moreover, the availability of training themselves are influenced by the availability, or lack thereof, of resources.

In contrast, midwives and students of midwifery science exhibited a stronger sensitivity and knowledge on the topic. Nevertheless, also the majority of respondents form this group highlighted a notable sense of professional frustration. In this context, persistent hierarchical structures, time constraints, lack of interest from superiors, absence of clear guidelines and protocols, limited access to relevant information, shortcomings in healthcare policy and poor-quality development were

identified as significant obstacles to the development and effective implementation of appropriate intervention strategies

In sum, the lack of established intervention routines leads healthcare professionals to seek individual solutions when faced with such situations. This highlights the **need for standardised guidelines and protocols** to ensure consistent and effective responses to violence within healthcare settings, as well **as mandatory training.**

4.2.6 Internal documentation and support

Most respondents indicated that there were no established documentation procedures specifically for cases of DV. However, gynaecologists in clinical settings mentioned the use of a dedicated program called *iGOPSIS* for documentation purposes. In the field of paediatrics, there is a well-defined protocol for documenting cases of DV in a comprehensive and legally valid manner within the patient's medical records. Regular training sessions are conducted to ensure healthcare professionals are well-versed in this process, and an expert committee is available to provide guidance and evaluation. The documentation is clearly outlined in the corresponding guidelines.

We found that there is no specific documentation guideline in place for the group of surgeons, dentists, and psychotherapists. Dentists, in particular, reported feeling uncertain about documenting such cases.

Among all the stakeholder-groups, there was a shared agreement **calling for stronger support, both institutionally and from supervisors, along with a desire to reduce time pressure**. The potential for support through supervision, psychologist-led employee discussions, peer exchanges, and, in some cases, conversations with superiors was recognised. Additionally, the availability of GESINE (case clarification) was mentioned as a valuable resource.

Concordantly, all interviewees stated that the **informal exchange of experiences and insights among colleagues as the most valuable resource.** Additionally, there was a strong desire for interdisciplinary case conferences, where instances of DV or other distressing situations could be discussed and addressed collaboratively. Such forums would provide a supportive environment for sharing knowledge, strategies, and best practices, ultimately enhancing the overall response to these complex issues.

4.2.7 Challenges and needs

There was consensus among all stakeholder groups regarding the **interest and necessity for further training and education**.

Across the majority of the surveyed stakeholder groups (with the exception of paediatrics and psychosomatics/psychotherapy), there is a prevailing uncertainty regarding the management of DV victims. Consequently, there was a strong call for **mandatory education and training** on this topic during academic studies or professional training. Moreover, there was a consensus on the importance of regular and obligatory continuing education programs to enhance knowledge and competence in addressing DV.

Specific needs were mentioned in some stakeholder groups. In surgery, there was a collective call for greater awareness, the establishment of guidelines, and enhanced knowledge regarding available support services. On a personal level, there was a strong desire for supervision, individual guidance, and support from the hospital and superiors. The group of dentists emphasised the importance of having a communication guide with exemplary cases. Key challenges for dentists in particular are concerns about potential false accusations when there is suspicion, and not being perceived as the appropriate point of contact by patients. In cases of suspected DV, dentists did not dare to address it, but tried to create at least a pleasant atmosphere for patients during treatment.

In contrast, in paediatrics, there is a well-established framework for addressing cases of DV. Accessible information and ample support are in place to assist healthcare professionals. However, **the main challenge** lies in effectively utilising the available resources and ensuring that healthcare providers actively engage with them. Therefore bi-annual training sessions in the paediatric outpatient clinic and 5-6 sessions in the delivery room on the topic DV are being held in the university hospital Münster.

Furthermore, it became evident that even though each stakeholder group faces its own unique challenges, **all are constrained by limited time resources** as mentioned before**.** The importance of **multidisciplinary teams and effective collaboration was highlighted as essential for providing high-quality medical care in general, and specifically for addressing the needs of victims of violence.** However, in addition to offering such training programs, there is a fundamental need to establish institutional support. This includes recognising the importance of these trainings by considering them as part of the employees' working hours or providing them with time off from their duties. Moreover, on an organisational level, it is crucial to ensure the availability of training opportunities delivered by qualified professionals, which are also recognised for continuing education credits.

Specific needs related to training were mentioned by dentists and midwives. **A format combining theory and practice, including interactive training with simulated patient-practitioner interaction, was considered beneficial.** It was also suggested that dental assistants should participate in these trainings as they can contribute to identifying victims of DV. Both groups identified the development of an app as a valuable tool, providing information on action suggestions, location-specific contacts, assistance, and resources for both professionals and patients.

4.2.8 Availability of training and information on DV in medical curricula from the perspective of medical students

The general knowledge level regarding DV is unsatisfactory, with few exceptions. The students of dentistry, in particular, demonstrated significant gaps in their understanding of indicators, referral processes, legal aspects, and interactions with victims. Across all participants, there was a unanimous desire to acquire the necessary competencies to identify and provide appropriate and compassionate care for victims of DV. None of the respondents reported feeling adequately prepared or competent in addressing DV within their current educational framework. One medical student mentioned a single mandatory session that briefly covered DV for a few hours, while two midwifery students mentioned attending a voluntary course consisting of two three-hour sessions. Notably, the topic of DV is absent from dental education curricula.

The expressed desire mainly focused on the need for lectures or seminars that would **address the topic both theoretically** (covering indicators, legal aspects, referrals, communication skills, etc.) **combined with practical interactive trainings** with simulated patients to practice communication and interaction. Additionally, it was suggested that the topic should not be superficially addressed, but rather be offered as a lecture series, allowing for comprehensive understanding. A comprehensive education would help destigmatise the topic and reduce personal barriers in routinely asking patients about their experiences.

4.2.9 Overview of existing trainings and training needs

Table of Existing Trainings

Stakeholder Group	Brief description of "Type of Training"
Physicians	VIPROM materials
Physicians & Nursing Staff	"Procedure for Suspected Child Endangerment" Instructions for structured procedure in case of suspicion of child endangerment: Scope Children's and Adolescent Medicine Department - General Pediatrics of the University Hospital Münster. The document is revised every two years.
Leading gynaecologist (GESINE)	Foundation Training, 6 hours Basic knowledge: none, Modules: Relevance, Recognition, Documentation, Referral, Specificity: Physicians, Participation is mandatory within the scope of a scientific project, Offline, Providers: Combined Violence Protection Expert GESINE + Forensic Medical Examiner.
Gynecology department staff (GESINE)	Summary of Basic Training: Participants: Entire department Duration: 3 hours Specificity: Gynaecology and Obstetrics In-house training Modules: Health implications of intimate partner violence, how to address the issue, referral.
Gynecologists (WWU)	Training for the iGOPSIS program Physicians participated once online and once in person in Düsseldorf, led by forensic medical examiners. The training is recommended but voluntary, with a focus on handling the documentation system and court-admissible evidence collection.
Midwives (GESINE)	Participants: Entire department (Obstetrics)

	Duration: 6 hours Basic + 3 hours Forensic Evidence Collection Specificity: Antenatal care, delivery, and postpartum care In-house training.
Midwives (WWU)	Training by the Midwives Network, with a guest from the City of Münster (employee from the Youth Welfare Office). Individual session in person, where a traffic light system was presented to assess a situation and determine appropriate actions. The training is optional and is not free of cost.
One medical student	A few hours lecture on the topic.
Students of midwifery science	Lecture by guest lecturer Martina Kruse, a midwife and trauma therapist, as part of a non-mandatory curriculum, consisting of two afternoons, each lasting 3 hours.
One dentist (WWU)	Training before going to university when working as a youth leader: Child endangerment: One-day on-site training Not mandatory

Table of Trainings Needs

Stakeholder Group	Brief description of "Type of Training" desired
Overlapping across all stakeholder groups	- Theoretical and a practical interactive part - Longer in-person sessions with shorter webinar components - Non-medical trainers with direct contact with victims of violence
Physicians	<u>Guidelines</u> Development of guidelines throughout the VIPROM project. Collaborative guideline developed in cooperation with other professions. <u>Training formats</u> - One individual prefers shorter inputs (2 hours) followed by team discussions. - One medical professional prefers webinars combined with short in-person sessions, such as those focused on communication skills. - A one-day training is favored <u>Training content</u> - One medical professional desires a forensic component provided by a forensic medical examiner.

	- One medical professional wishes to receive examination kits for documenting findings in the context of anonymous evidence collection. - Simulation scenarios
Dentist	<u>Training formats</u> - Mandatory training - Offline - Half-day duration -Training for all employees in dental hygiene <u>Trainers</u> - Conducted by psychologists, social workers, or police officers <u>Training content</u> - Conversation guide and interaction (providing informational flyers for patients and information sheets for contact points and contact persons). - Content includes how to address violence properly? What to do when suspicions are confirmed? How to refer appropriately? General information about the support system and legal options.
Gynaecologists	<u>Guidelines</u> -Inclusion of the topic in existing concepts <u>Training formats</u> - Expansion of the *iGOPSIS* training (mandatory) - Incorporation of the topic in the training for psychosomatic primary care (mandatory) - Preference for in-person seminars, with a supplementary theoretical component as a webinar or webinars combined with short in-person sessions, such as those focused on communication skills - Favoring one-day training sessions, with one individual desiring shorter inputs (2 hours) followed by team discussions.

	Training content - Training with simulated patients at the study hospital (mandatory)
Nursing professionals	- As part of the training, offline and mandatory. - As part of continuing education, led by psychologists.
Midwives	Training formats - As part of the apprenticeship - Particularly within the scope of continuing education, preferably recognised as "emergency training," regardless of who would lead such training, but the person should be an expert in the field of DV. Training content - Testimonial from a victim of DV with an opportunity for participants to ask questions.
Students of midwifery science, medical students and students of dentistry	Training formats - Mandatory one-time seminar lasting 3-4 hours - Possibly a lecture series as well - Offline format Training content - Communication skills and interaction - practiced through role plays with actors (simulated patients), and subsequently being evaluated. - Workshop with a survivor of DV and a psychologist. - Identification based on indicators using photos and case studies, communication skills, referral, legal framework, documentation, personal experiences).

4.2.10 Sustainability and implementation of trainings for medical professionals

The majority of interviewees finds online training sessions convenient but still desire an in-person component, as they feel that regular interaction is often lacking. Ideally, a training program should span at least one day and preferably be offered on a recurring basis to ensure continuous learning and engagement.

Practical relevance was a key consideration for all participants in the training. Respondents emphasised the importance of gaining theoretical foundations related to identifying potential victims, effective communication techniques, legal aspects, referrals, and documentation. The physicians formulated a specific request for examination kits to aid in the documentation of findings during anonymous evidence collection. Additionally, there was a consensus on the need to focus on the psychosocial and psychological aspects of supporting victims of DV.

Cross-disciplinary courses involving other stakeholders were unanimously mentioned as beneficial. Surgeons expressed a desire for a collaborative guideline developed in cooperation with other professions.

Differences were primarily observed in the specific content of the training. The group of dentists expressed a desire for a practical component involving role-playing exercises, potentially with the involvement of external actors, to apply their learning in a realistic setting. The group of midwives highlighted the value of supervised case discussions, such as through supervision, as a valuable learning opportunity. The group of surgeons expressed a preference for a "simulation" teaching format and emphasised the importance of interprofessional collaboration and consistent access to knowledgeable contacts. The group of gynaecologists highlighted the importance of integrating the topic of DV into existing structures. They suggested incorporating it into training programs at the university hospital during the study period, making it a mandatory component of psychosomatic basic care training during specialist medical training, and including it in the *iGOBSIS* training. The group of nursing professionals expressed the desire for the integration of the topic of DV into their education. The group of midwives also found it very important to include training about DV in their mandatory training sessions. They emphasised the importance of keeping the costs associated with the training as low as possible or even free of costs.

All stakeholders agreed that the trainers should be competent in the subject matter. However, there were differences in the preferred professions of the trainers. The majority favored non-medical trainers who have direct contact with victims of DV, while some specifically wished for psychologists, social workers, forensic experts, or police officers to teach. This highlights that the importance of multidisciplinary perspectives in addressing the complexities of DV and ensuring comprehensive training for all professionals involved in supporting and caring for victims.

4.2.11 Sustainability and implementation of trainings for medical students

All the surveyed students agreed that the topic of **DV should be present and taught as a mandatory subject during their studies or training**. There were overlaps in the desired formats, with both theoretical and practical components being mentioned interactive training on-site. Also, the interviewed students suggested conducting role-plays with simulated actor-patients interaction to gain more confidence in communication and

apply the theoretical knowledge in a simulated setting. This could be incorporated into existing trainings or thematic weeks in the medical curriculum. Furthermore, specific attention to DV could be given in the forensic medicine course, as well as in psychiatry and psychosomatics. The students of midwifery found it valuable to have a format that includes the presence of victims/survivors and a psychologist. The dental students expressed a desire for interdisciplinary courses with medical students in order to learn about medical implications and indicators that go beyond the specialised head and neck area that dentists focus on.

Generally, it was considered important to provide post-training debriefing sessions to address any potential retraumatisation among individuals who have personal experiences with DV.

4.3 Austria

4.3.1 Context of data collection and data set description

In Austria, a total of six interviews were conducted. The sample includes all relevant stakeholder groups the project focuses on, including: one physician, one midwife, one nurse, one medical student and one group interview with two students of midwifery science. All interviewees have been female. The interviewees were selected on the basis of previous project contacts (in the context of DV projects – partly EU-funded –, especially from the preceding project IMPRODOVA) by considering the diversity of stakeholders as well as different knowledge bases in the medical sector. Given the rather small interview sample, the aim was to conduct in-depth interviews with healthcare professionals who are knowledgeable about the issue of DV against women and familiar with common practice in dealing with victims of DV in the medical field in Austria. In this way, it should be ensured that, despite the small sample, detailed and in-depth information is collected on the training and education needs of medical professionals and students in relation to DV.

4.3.2 General summary of the state of DV-sensitivity/expertise in the medical community

All interviewed professionals, including the medical as well as the midwifery students showed a high level of sensitivity and awareness of the important role medical professionals play in detecting and addressing DV/IPV in medical settings (as early detection and support). This awareness was particularly high with regard to the responsibility of medical staff in supporting victims, which included providing victims with adequate and helpful information about support services and structures such as violence protection centres, women's shelters, etc. It became also clear that personal interest and awareness are the main factors to engage with the topic of DV more broadly in medical settings.

The students also showed a high sensitivity towards the topic, but lacked knowledge on how to act in a concrete situation with affected patients. The importance of training was also evident among midwifery students, whose knowledge of DV was

limited. In contrast, they had a good level of knowledge about female genital mutilation (FGM), which is part of their training. The medical student had a high level of sensitivity regarding questions of violence in relation to the psychological and medical treatment of children and adolescents in psychiatric context, but not so much about DV in general. According to the student, her sensitivity and knowledge is based on practical experience and not so much on theoretical knowledge and courses. University courses that are tackling the issues of DV in medical curricula exist, but are limited. According to the student, the topic is predominantly taught in the context of certain medical specialisations, e.g. gynaecology, child and adolescent psychiatry.

The interviewed midwife and nurse are both working in a leading position. The nurse has been also part of the victim protection group in her hospital.[3] Both showed very high levels of sensitivity, practical as well as theoretical knowledge and experience, which they both stated to have acquired due to their high level of personal engagement with the topic.

In sum, in Austria there are clear tendencies that DV becomes more and more visibly embedded in medical curricula (such as in the case of the education of midwives, e.g. at the Health University of Applied Sciences Tyrol).

4.3.3 Modes of identifying potential victims of DV

The most obvious signs that were mentioned by all interviewed professionals, include physical signs, such as: scars, bruises and fractures. In particular, in the case of the physician these signs were emphasised as they are typical for her work at the department of trauma surgery (patients with bruises, broken bones, sometimes stab wounds and others). Aetiology as part of the common medical professional's responsibility does not necessarily include the follow-up on vague feelings or suspicions. This depends always on the treating physician whether to follow "gut feelings" and how-to follow-up on them (indications of this sort would be, for example, when a patient's story or behaviour changes regularly, or nervousness etc.). Particularly, in the case of trauma surgery department, the physician mentioned that the first step is to document the history of the injuries.

Further indications that were mentioned are being repeatedly ill and suffering from mental illness. Yet, in the interviews, the focus was clearly on physical indicators and less on psychological indicators of DV. This stems from the way how medical records are handled in a clinical setting. For a

[3] In Austria, hospitals are required to install a so-called victim protection group (as well as child protection group), which are responsible for implementing standards for the care of patients with a DV-background in medical settings/hospitals (how to identify, how to address, how to document etc.), see here: https://toolbox-opferschutz.at/Opferschutzgruppen (accessed on 1st July 2023).

comprehensive identification this poses a problem, as medical professionals face the challenge of how to treat and follow-up on more subtle or other (psychological) forms of DV.

In the context of midwifery, restlessness, nervousness, anxiety, pain (in general or specifically related to vaginal examination) were mainly mentioned as possible indicators. Here, it is particularly important to recognise and perceive such sometimes subtle signals. However, not all women who express such symptoms are victims of DV, which is also important to bear in mind. The vaginal examination as the reproductive area is very vulnerable/susceptible to triggers. Therefore, it is important for midwives to understand what a trigger is and what reactions can follow. For example, even foetal movement can be a trigger and cause pain in a pregnant woman who has experienced strong forms of violence.

Identifying and perceiving such signs or indicators depends on both (practical) experience, empathy, but also theoretical knowledge, which was specifically emphasised by the midwife. While it is challenging to deal with these issues and vulnerable patients, it is a necessity and needs to be visibly embedded in curricula, so that younger colleagues and future midwives and nurses are able to deal and cope with affected patients.

Stories about practical experience by medical professionals:

a) The medical student told a story about an encounter with a child in the paediatrics department. The child came with a very big bump at the head that turned out to be a tumour. In this case, the treating physicians (and medical student) had quickly the suspicion that the parents are not caring well for the child (case of child neglect) because the bump was quite big and medical professionals wondered how it is possible to wait and ignore that for such a long time. In this case, they informed the internal social workers of the hospital (internal referral procedure) and the social workers proceeded with the case, including the whole bureaucracy (e.g. informing the youth welfare office etc.).

b) One of the interviewed midwifery students got suspicious during her first practical training when a patient, a very young mother, was called by her partner incessantly and in a very brisk tone even during care work. The interviewee recalls her “strange gut feeling”, but did not feel competent and secure enough to follow-up on that feeling.

c) The other interviewed midwife student recalled some suspicious situations, e.g. when women depicted strange scars (e.g. cigarette burns on their legs), or experienced pain during (vaginal) examinations. Even though there could be many reasons for this, the interviewee said that such cases would always merit suspicion. She stressed the “helplessness” not only of the students, but of the medical personnel more broadly in such cases (how to follow-up on such

suspicious moments without knowing exactly or being equipped well to address such feelings).

Each of these stories illustrate that for medical professionals it is important to be able to identify a potential case of DV. Especially obvious cases, like the first example of potential child neglect, need to be identified reliably, because only obvious indications can enter a medical record, according to our interviewees (see Chapter 4.3.6 “internal documentation and support”). This has to do with the character of the medical record in a clinical setting, which is guiding for medical professions. This could cause problems because medical professionals tend not to follow-up on more subtle signs, signals and symptoms of DV such as psychological forms of DV, which could be indeed a cause for many symptoms.

The medical sector is thus a relevant area for the identification of potential victims of DV, which indicates the importance of improving the possibilities and methods of identification in a medical setting. For example, in the absence of a physical examination, psychiatric counselling may not be able to identify physical injuries, but in comparison to outpatient treatment it is the more appropriate setting to ask questions about suicidality, experiences of violence or “voices in the head”.

4.3.4 Reactions to disclosure about DV by patients

Students mentioned an **experienced medical professional** as a relevant person in responding and dealing with affected patients. As many medical students are quite young (in their mid-20’s), they often lack relevant life and professional **experience** at the beginning of their careers**,** which are important factors in dealing and addressing sensitively a suspicion of the presence of DV. Such a lack of experience could also cause problems in addressing DV, for example because large age differences between young medical staff and significantly older patients are governed by societal age-based norms of expectation and interaction.

The senior midwife stressed the importance of **asking about a patient’s experience of violence** in a direct but sensitive way. Ideally, such questions should be included in the standard medical questionnaires, similar to questions on blood pressure, diabetes, etc. This would also challenge the social taboo around experiences of violence.

The physician mentioned the high levels of **time pressure** at her ward at the trauma surgery. During her 8-hour shift, she is confronted with a high turnover of patients, which is why she can only spend very little time to each individual patient. This time pressure does not allow medical professionals to have in-depth conversations with their patients, which would be necessary to adequately address issues of DV. Furthermore, the treatment site of trauma surgery does not provide much private space to talk openly about issues of DV.

There were differences recognisable among the interviewed professionals and students whether questions about violence experience should be asked in a general manner. Midwifery students as well as the midwife and nurse argued for integrating such a question into the medical record, whereas the medical student and physician did not see this as an absolute necessity.

4.3.5 Typical interventions and pathway of referrals

In Austria, respondents reported several forms of intervention and referral. In clinics and hospitals, for example, there are often social workers who act as contact persons. Here, the medical student stated that an internal referral of victims would be made to the hospital social workers, who handle and process the case in a standardised manner. In the case of the trauma surgery department, they file a complaint in all cases unless the accident was clearly caused by the victim her/himself. There is no differentiation between severe and minor cases. In contrast, the nurse mentioned that beside the provision of information or the referral to specialised victim protection services, victims are asked whether the police is or should be informed. Specialised service is provided by the so-called victim protection groups („Opferschutzgruppen“, OSG), which have been mandatory internal support structures in hospitals since 2009 to ensure early identification of victims of violence and high-quality support (i.e. high-quality response by medical staff). Of note, the main role of the OSG is to develop and implement standards and training for medical staff, not to support them in direct contact with victims of violence.

Further formalised/standardised interventions that were mentioned by participants, include:

- An **emergency call** called “**Dr. Viola”** for victims of violence, which is operational at the Innsbruck Regional Hospital's violence protection services; they have made it their mission to make the hospital known to the public as a safe place. Everyone – regardless of their sex – who feels acutely threatened and seeks protection will find help by using the phrase “I need to see Dr. Viola”. All employees on the premises of the Innsbruck hospital are informed about the emergency call and will take all necessary steps to help the person concerned and care for their safety.
- **The psychiatry as council** for victims of DV. For instance, in the department of psychiatry for children and adolescents there are established procedures for handling cases of violence. Yet, this is not the case in every department.
- In cases of **severe violence** and/or rape, the hospital has to **take legal action and file a complaint**. The complaint is filed by the medical director (not by a physician or a department).

Injuries are documented by using the "MedPol-Bogen" (medicine-police-sheet)[4] that has been developed for judicial documentation.

- **The so called "rape kit" as a further formalised intervention tool** has to be used by a specialised team (also in the context of potential future judicial documentation) and was also mentioned by most of our interviewees. The rape kit is a "tool kit" that includes a checklist, materials, and instructions, along with envelopes and containers to package any specimens collected during the examination (this, however, is not used by physicians themselves, but by a gynaecologist). The students did not know the exact functioning of the rape kit, but only knew that it has to be used for patients that have become victims of rape.
- **Need for (professional) interpreters** in case of language barriers when treating and supporting victims of DV.
- In the case of DV, a patient is asked if a **police intervention** took already place, i.e. if a barring order was issued (especially in the context of the trauma surgery and an injury). If this is not the case, protection is regarded a necessary step. If the victim cannot stay overnight at a safe place, women's shelters are contacted. If specialised services lack space, one option is the hospital admission of the patient for her protection. However, for such cases only the beds in the trauma surgery department are available, and the attending physician decides whether to keep the victim at the hospital.
- **The pastoral care can also function** as support structure for victims as well as professionals in case of violent experiences and traumatisation.

In sum, in Austria there exists a broad range of potential interventions that most of the healthcare professionals we interviewed are aware of. Sufficient knowledge about these interventions is necessary as healthcare professionals carry a special responsibility to identify and address DV in the context of victims' health prevention and health maintenance. Therefore, it is indispensable that medical professionals also know about the possibilities of the referral of victims to violence protection centers and women's shelters. However, the strong commitment towards patients' and women's autonomy was also mentioned by our interviewees, which in consequence means that they cannot be forced to adhere to these offers provided by medical professionals. However, healthcare professionals are experts in terms of health and disease and its treatment, but not necessarily in terms of questions of violence (for which own experts exist, such as violence protection centers). Therefore, the importance of cooperation with other experts from different sectors was stressed, but also the importance of developing and implementing stronger measures for the identification of DV and improving initial reaction, referral and documentation within medical practice and education.

[4] https://toolbox-opferschutz.at/sites/toolbox-opferschutz.at/files/inline-files/Anhang%2016_MedPol.pdf (accessed on 10th of July 2023).

Generally, some of our interviewees raised the question at which point professionals are required to officially register, refer and report DV cases, e.g., to the police. The unanimous opinion was that special care must be taken when endangering oneself and others. Professional confidentiality was also an important issue and constitutes a gray area in some respect, which makes it sometimes unclear under which conditions medical professionals have a duty to report. The only exception was mentioned with regard to a child's welfare and if children are seriously threatened or abused (rape and grievous bodily harm). Overall, respondents oscillated between a commitment to respect high levels of patient autonomy in the context of women's empowerment and their professional responsibilities in the context of early detection and healthcare prevention.

Among the students interviewed, there were different levels of knowledge regarding interventions. The medical student lacked knowledge about different types of intervention(s) and referral(s), including, for example, notification requirements, except of an obvious case of child neglect. Furthermore, she was also not aware of any information material that is readily available for victims of violence at different areas at the hospital (e.g. bathroom, waiting area). **Hence, the medical student mentioned explicitly that it would be very helpful to have an easily accessible list or collection with relevant information on support services and referral procedures** as there is not so much time during routine medical work to search on the internet for help services and other information that could be relevant in a particular case. Ideally, this information would be directly accessible on the PC-desktop of medical professionals, instead of having to search for it on the intranet.

In contrast, the midwifery students knew about a number of important specialised services (violence protection centres, women's shelters, 24-hour women's emergency hotline) but had no immediate experience or personal contacts. They remarked critically upon this fact as they felt more confident referring patients to specialised services if they were personally convinced that patients were "in good hands" there.

4.3.6 Internal documentation and support

Respondents did not report any specific or standardised internal documentation of DV cases and the students had no specific knowledge about internal documentation procedures. The physician mentioned current and ongoing internal discussions at her department about making such files "visible" by marking them. One challenge is how to incorporate such documentation methods specific to DV into existing medical documentation. In the case of **forensic documentation** undertaken at the trauma surgery, only physical injuries are recorded as these have to be described precisely. Thus, emotional or psychological indicators of DV are difficult to document. The more general **medical record** (documentation of a patient's medical history) is a **legal document** and as such cannot be modified freely. Hence, it is not possible to document every suspicion, because medical professionals are also contestable on this basis. In order to enter the medical record a suspicion has to be verifiable, such as an obvious wound or hematoma. In

contrast, suspicions based on “gut feelings” cannot be entered. These feelings are rather discussed in an informal setting with colleagues.

The physician stressed the importance of correct wording with regard to the court when documenting DV cases. Consequently, for rather vague “feelings” or “suspicions”, i.e. those which are not obvious (i.e. as a visible symptom on the body), there would be a need to create space to express and document them in an adequate way. The students emphasised that medical professionals already spend a lot of time in front of their computers and with documentation, almost more than with their patients. Hence, caution is required if and how to formalise and integrate additional steps into their working practices, as it would be more important that professionals have sufficient time with and for their patients, especially in case of sensitive areas and issues such as DV.

Although the respondents mentioned the existence of internal supporting structures, such as supervision, these are rarely used by medical professionals. The interviewed physician mentioned that the use of supervision could be interpreted as an indication for weakness by other colleagues, at least in the trauma surgery, which is male-dominated. There is also no established practice or support system for colleagues and employees who are overloaded by DV (or other demanding) cases. In terms of support structures, the medical student mentioned a physician at the department for psychiatry of children and adolescents, who offers a support group for medical students that is in high demand. At the same time, she stressed that she did not have the opportunity to participate in such support groups due to high curriculum pressure and resulting lack of time.

4.3.7 Challenges and needs

Challenges that were mentioned in the context of dealing with DV cases in medical settings:

- A major challenge at an *organisational (implementation) level* is the recognition of the political importance of the issue and the extent of DV in society, as well as the problem of hospital management in realising the significance of the medical sector in counteracting DV and its role in the context of healthcare prevention. All of our interviewees (students as well as professionals) mentioned that it depends on the head of a ward/department if DV/IPV is regarded an important issue (and if trainings are conducted respectively).

- Further main obstacles in the medical sector are quite in general: lack of resources, lack of time to care for the patients in a sensitive and emphatic way and lack of trainings respectively. This notorious lack of time and money permeates education and hospital practices more broadly, which complicates processes of long-term implementation of victim protection in medical settings (which quite often depends on the personal engagement of individual professionals).

- Building relationships of trust between healthcare professionals and patients: It is essential to build a trusting relationship between patient/victim and healthcare professional (this was particularly stressed by the midwife who is also psychotherapist).

Midwives are important healthcare professionals in the healthcare sector to recognise and address the issue of DV, but they are not inevitably the experts to further process the DV cases (such as psychotherapy, violence protection centres etc.) in terms of breaking through the violence dynamics in the relationship (to stop it), to work through the problem, to support the victim in ways that fits her interests and respects her autonomy. This is usually a laborious and long path that is individual in each case and often takes years (the interviewee compared it to a behaviour change).

- A main challenge for midwives is the gap between theory and practice: the issue is present in education, but it is difficult to deal with it in the daily practice (how to handle, how to react, how to talk, how to address etc.); a related question in this context is: what could strengthen midwives in their daily handling with women who experience DV.

- Own experiences of violence and violence at the workplace could be additional challenges for healthcare professionals in dealing adequately with DV cases in medical settings. There is a need for creating safe spaces and time for reflecting such experiences or feelings of anxiety among professionals. Supervision as it is practiced in case of psychotherapy could be a role model for creating such spaces.

- Lack of institutionalisation of midwives as long-term counsellors during pregnancy (the costs for a personal midwife who accompany the woman or couple during pregnancy has to be covered privately).

- Regarding the counselling situation with women, the students stressed the fact that in reality most women (i.e. those not opting for a home birth or a private midwife) have just one counselling session with a midwife during their pregnancy, which is optional, so not all pregnant women attend it. The midwifery students expressed different opinions that there is no clear guidance on whether partners are invited to take part in these talks or not.

Needs that were mentioned in the context of dealing with DV cases in medical settings

- Time and resources to establish a trusting relationship with the patient

- Integrating questions about experiences of violence into the anamnesis: Potential question that can be asked: Do you have experience with violence? Do I have to watch out for something specific during examination? Do you

ever meet violence? Such questions should become part of the usual anamnesis and should be recorded directly during the medical examination.

- Increasing patient autonomy when it comes to the medical examination (being sensitive, asking if the examination and its methods is fine with the patient and her feelings).

- Pregnancy, childbirth and related medical examinations are special life circumstances and areas vulnerable to re-traumatisation, if there have been previous experiences of intimate partner/family violence. Thus, midwives have to pay special attention to these issues and to the issue/role of trauma (triggers) and the potential of re-traumatisation during childbirth and examinations. However, it was also stressed that not every woman who is anxious and/or nervous in the context of pregnancy, medical examinations and/or traumatisation during childbirth has violent experiences. It is always important to investigate the individual reasons why a woman experiences a trauma during pregnancy and childbirth.

- Eye contact can be an expression of sensitivity and awareness during examinations. Thus, special awareness in each case for every woman is important.

- Information material on violence protection services should be available and easily accessible at all hospitals for both: medical professionals as well as patients (e.g. in bathrooms, waiting areas, entrance areas etc.)

- Checklists how to proceed in cases of DV (physician at trauma surgery)

- Institutionalisation of supervisions for healthcare professionals to cope with burdensome feelings, uncertainties or even traumata (potentially own experiences of violence, which could also refer to experiences of violence that professionals have made at their working places).

- Family midwives were mentioned as good examples for good case management (Germany and Switzerland) for ‘stressed’ families. They are specially trained and are an additional service for parents with increased care needs in the first year of their child’s life.

- The most important aspect, however, would be to develop an adequate vocabulary for addressing the topic of DV during medical treatments and examinations.

4.3.8 Availability of training and information on DV in medical curricula from the perspective of medical students

Sensitivity among the students was high, but due to the self-selection of participants this might not be representative of students in general. The interviewees recalled the training they received on

DV/IPV in great detail and criticised that the topic gained too little attention in their studies.

According to the two midwifery students, DV/IPV was explicitly addressed in two courses, one of them in form of a lecture by an expert from a victim support organisation (AÖF, the association of autonomous women's shelters in Austria), covering which kind of wounds or scars were indicators for cases of DV/IPV, as well as introducing protection against violence centres that women could be referred to. Both interviewees rated this lecture as very informative and helpful. The second course had been on prenatal care held by a midwife earlier in their studies and covered broadly similar topics, e.g. stressing that bruises that had been inflicted at different times could be an indication. Students were also told to do a general screening for DV/IPV in the course of the (optional) consultation with a midwife for pregnant women included in the Austrian system for prenatal care (mother-child-pass) by directly asking the women if they had any experiences with violence. Both of these courses were mandatory. However, both interviewees criticised that the courses did not include many practical elements. They also argued that students were not reminded of the importance of the topic again towards the end of their studies, as they felt that attention was also lacking in midwives' daily work.

In relation to the above-mentioned problem of missing questions about DV/IPV in the medical record and lack of time that healthcare professionals face in their daily work, the medical student highlighted some problems she spots in the implementation of more courses on DV/IPV in existing medical curricula. On the one hand, it is difficult to standardise the handling of such sensitive issues because it simply requires a lot of interpersonal sensitivity, empathy and experience. On the other hand, the curricula are already very packed with courses. The medical student sees the topic rather in the advanced stage of trainings for medical professionals, where it could be implemented as an obligatory course. Making advanced training obligatory for professionals could be a tool to regulate and anchor the issue of DV/IPV as an integral part of medical education. According to this student, DV is, however, a topic that requires some sort of experience and personal strength to be able to address and cope with appropriately (within a concrete situation and at an interpersonal level) and thus, it should rather be an advanced module of training.

The student further stressed that DV/IPV is a topic with which society has to come to terms with more broadly in terms of politicising the societal dimension of the problem of DV, including removal of taboos and de-stigmatisation in terms of prevention and education.

4.3.9 Overview of existing trainings and training needs

Table of Existing Trainings

Stakeholder Group	Brief description of "Type of Training"
Physicians & Nursing Staff	-Training event "victim protection" organised by the victim protection group in the General Hospital Vienna (AKH) (there are several of this kind because it is one of the OSG's tasks to organise such trainings for medical staff in the hospital): Whole day, voluntary, online & offline seminar on victim's protection in the medical field consisting of lectures by DV-experts from the medical field, external DV experts and law enforcement. The scope entailed high-level specialised information on the Medical-DV-support network in Vienna and on the national level in Austria, prejudice relating to DV in the medical field, national-level documentation of DV in the medical sector, as well as lectures by law-enforcement, victim's protection groups, and men's counselling to facilitate multi-stakeholder cooperation. Such continuing training & networking for physicians and nursing staff is provided several times per year by the victim's protection groups in hospitals (though such training activity varies between different hospitals). - Nurses are obliged to participate in regular team meetings (ten times per year, at least in the hospital of the nurse we interviewed); these meetings last about two hours; they are not patient-centred, instead they talk and learn about topics and 'general' information, for example on dynamics, indications of DV/IPV. - New colleagues (nurses) at the department of the interviewed nurse are introduced to all important topics in individual interviews.
Midwives	- Since 2020 DV/IPV is visibly anchored in the midwives' curricula at the Health University of Applied Sciences Tyrol. - Courses on resilience development for midwives, raising awareness of which women experience birth as traumatic. Guidelines that are used and might be used in courses: ‚Let's talk – A handout for midwives on talking about violence' (Original title: „Lass uns reden – Eine Handreichung für Hebammen zu Gesprächen über Gewalt"; see: https://www.fhg-tirol.ac.at/data.cfm?vpath=dokumente-forschung/projekte/lass-uns-reden_eine-handreichung-zu-gespraechen-ueber-gewalt). - There are several guidelines for midwives, for instance: ‚Domestic violence – perceive – intervene' (Original title: „Häusliche Gewalt – wahrnehmen – intervenieren") in the women's clinic "Maternité, Stadtspital Triemli Zürich" (Lit.: Bass B. et al.; In: Häusliche Gewalt erkennen und richtig reagieren: Fachstelle für Gleichstellung Stadt Zürich et al. (Hrsg).2006, 2. Auflage 2010. Handbuch, Verlag Hans Huber Bern).
Nursing students	-Nursing students have two lectures on DV in their curriculum

Table of Training Needs

Stakeholder Group	Brief description of "Type of Training" desired
Physicians	- Conversation guidance (how to raise the topic of DV with patients) - In-person training with practical examples and mock-conversations - Workshop setting - 1-2 hours - Provided by medical or external DV experts
Midwives	- Developing a vocabulary for addressing the issue of DV sensitively, especially in the context of reproductive treatments and examinations. - The professional midwife explicitly would recommend obligatory supervision for midwives and medical professionals as a whole, as in the case of psychotherapists. Violence and DV in particular are difficult topics that entail complex care-situations in medical settings, which are quite often difficult to bear for individual professionals on their own → development of adequate support structures for healthcare professionals where difficult cases can be discussed and processed. - Learning and paying attention to the topic of triggers and re-traumatisation through medical treatments (physiotherapy, massages, speech therapy …).
Midwifery students	- Hands-on training (role-play, workshops) - Experts from violence protections organisations as well as experienced midwives as trainers - Concrete examples/case studies ("Fallbeispiele") - Working on "plans for action" (i.e. how to react in cases of DV/IPV) - General information on the system of victim protection and on potential roles for midwives (including e.g. OSGs) - Inclusion into practical training (e.g. defining learning outcomes related to DV/IPV, thereby making it a necessity for trainers to teach about their experiences) - Interdisciplinary trainings (medical professions, potentially even broader)

4.3.10 Sustainability and implementation of trainings for medical professionals and students

The medical sector plays an important role in combating DV as a major societal challenge, as it is often the first point of contact for victims of violence. In the following, some essential aspects are presented that are important for a sustainable implementation and organisational anchoring of the topic of DV in the medical field and its education and training. We summarise the points that were mentioned by both students and medical professionals.

Language sensitivity and the development of an **adequate vocabulary to address experiences of DV** with patients is a relevant issue raised by both students and the midwife. This includes: phrasing and questions that healthcare professionals can use to address such delicate topics and experiences with their patients.

Interdisciplinarity and **cross-disciplinarity** were also mentioned as supportive aspects of medical and/or healthcare education and training. The role of trainers and their professional background was addressed by our interviewees. Ideally, trainings should be conducted by interdisciplinary teams so that healthcare professionals recognise their central role in protecting victims when DV occurs. Medical professionals should hold joint courses with experts from violence protection organisations, forensic psychiatrists, and/or the police. So, the ideal case would be that trainings are offered by mixed and interdisciplinary experts to also improve cooperation among professionals. However, it was stressed that it is highly important that medical professionals, who have both medical expertise and knowledge of internal hospital procedures and medical curricula, should be at the centre of these trainings as trainers. This cooperation was considered important by our interviewees, especially in terms of sustainable implementation and acceptance of such trainings. Both medical expertise as well as expert knowledge of violence and its dynamics are required and should be strengthened among the medical community.

As relevant **format and duration of such trainings** (raising awareness and sensitivity of the medical sector), respondents stressed the importance of having **regular basic as well as advanced trainings**. The more experienced professionals, such as the physician, the nurse and midwife, also underlined the importance of integrating DV/IPV already into the early stages of medical education, because these are difficult topics that need sensitive ways of intervention and response skills. Therefore, it is much more efficient if students (and young physicians and other healthcare professionals) are prepared and equipped with helpful tools early on.

Role play and simulation training with actors were mentioned as further supportive formats of training, especially by students with regard to their lack of practical experience and knowledge. This would be quite helpful for them to acquire practical skills in dealing with potential victims of DV. Also, courses on legal aspects of medical practice and how to document properly were mentioned in this regard.

Moreover, **supervision for medical and healthcare professionals** was stressed as a very relevant but missing part of dealing with patients with a DV background. This was particularly highlighted by the midwife in the context of strengthening midwives' resilience in dealing with victims of DV. Supervision could be also an important space to address and reflect their own experiences of violence. In this context, another important topic was addressed in and for training courses on the topic of DV in the medical field, namely the reflection of personal experiences of violence. This was mentioned in particular with regard to the work context, a topic that

has become even more important during Covid-19 pandemic, in which hospitals were under massive pressure.

4.4 Italy

4.4.1 Context of data collection and data set description

In Italy, a total of six individual telephone interviews were conducted by the AOU-PR. Participants were recruited through personal relations and among work colleagues, and included one representative per stakeholder group, that is one emergency room physician (female), one emergency department nurse (female), one medical student (male), one midwife (female), a gynaecologist (female), and a dentist (female).

4.4.2 General summary of the state of DV-sensitivity/expertise in the medical community

Despite the professional and experiential heterogeneity of the participants, commonalities in attitudes and views on the topic of DV and related specialised training could be identified. All participants showed a high degree of sensitivity towards the topic of DV. This sensitivity results from personal interest and/or specific personal (e.g. voluntary) and professional experience. Unanimous feedback among all professionals was about the lack of in-depth knowledge about DV in the work context, which could be remedied by specific DV training.

4.4.3 Modes of identifying potential victims of DV

According to the respondents, the main indicators of suspected violence are signs and symptoms on the victim's body, such as bruises and injuries. This view was shared across all respondents irrespective of their professional background. (e.g. midwife, dentist, nurse). Other typical indicators would be combined injuries, such as injuries from blows to the face and neck that cannot be attributed to an accidental fall, along with other signs, such as injuries to the arms and hands. In gynaecology, injuries to the legs of women are considered to be signs that a woman who has been a victim of violence may also have been a victim of rape. Another indicator would be the partner's behaviour during the medical visit (e.g. nervous, bad-tempered, aggressive, impetuous, arrogant, pushy).

Respondents reported that victims rarely report the incident and do not voluntarily disclose their victimisation, especially when the aggressor (e.g. partner) is present. When interviewed alone, they sometimes described the violence they suffered. Another important indicator for suspecting violence is if victims behave insecure in telling the incident and lack clarity and coherency in their story. Victims would often not dare to talk about their experiences and defend themselves. If they do entrust themselves to the medical staff and talk about the events, they are often frightened, and trivialise the violence or consider it to be something "normal".

Different ways of blandishing and or whitewashing of reality are a typical sign among victims of DV. According to our interviewees, such behaviour is more typical of the migrant population living in Italy. Some participants stated that there are cultures where the respect and value of women are differently perceived from those in Italy, and that these cultural differences also lead to difficulties in handling DV cases.

Another sign of violence are the repeated accesses to the emergency room (ER) which seem poorly justified (e.g., falling-down stairs, banging on the door, on the edge of furniture). Women often spontaneously access the health services in order to seek protection. Yet, it is difficult for health personnel to identify the reason for this help-seeking behaviour, as victims are often embarrassed to disclose that they have been raped, especially in DV cases (because it involves their own partner).

The dentist reported about economic violence. For example, husbands in charge of the money of the family would often decide whether dental care was needed or not and the accompanying partner being intrusive and controlling. Once in the dental office women do not typically speak for themselves, if their partner is present.

No differences were found across professionals among the methods of identifying DV: participants were familiar with those in theory. However, theoretical knowledge is often insufficient with a lack in clear operational instructions about how to proceed after disclosure of DV. Therefore, experience makes the difference. In summary, there are more differences in practical (experiential) knowledge across participants than in theoretical (training) knowledge.

4.4.4 Reactions to disclosure about DV by patients

Respondents described difficulties in reacting appropriately to a situation of suspected DV. Situations of dismay, feelings of helplessness and unpreparedness were described. Participants reported being shocked, stunned and embittered about the situations they encountered. In addition, participants recounted feelings of anger and bitterness, as it is often difficult for women who have been victims of violence to leave violent relationships, especially if they do not press charges.

In terms of reactions, participants stated that due to the high number of admissions especially for the staff of the PS, there is often no time to adequately engage with victims. The nurse and the midwife described that in cases of violence, there is a protocol and procedure which ensures privacy. In addition, it is possible to support people affected by violence through the mobilisation of a network of protective actors. For example, if a woman who has been a victim of DV is admitted to the hospital, such a procedure can be initiated which also involves the police. However, one of the challenges of such procedures, as the interviewees unanimously stated, is that women often do not want to press charges and/or are forced by social pressure to keep quiet (omerta). As such procedures cannot be effectively carried out without the consent and will of the

women, medical personnel are faced with the challenge of implementing measures that meet the needs of the women while protecting them as much as possible. In serious cases of violence, participants stated that they are obliged to report the crime. If, in contrast, the injuries are minor, they can only try to explain the extent of the injuries to the woman, but it is up to the woman to decide what she wants to do since they are autonomous and adult persons.

Regarding the difficulties encountered in the management and care of women who became victims of DV, the differences between the interview partners are noteworthy. As emphasised above, the staff of the ER and the gynaecology and obstetrics department have a more structured protocol, which gives much more personal security, on a procedural level but not necessarily on a psychological level. In case of a suspicion, the staff seeks a situation of privacy in which the medical physician can talk to the victim alone and in a safe atmosphere.

Despite such procedures, all professionals state that they do not feel competent or confident enough in dealing with these cases. The interviewees expressed a desire to be supported by specialised personnel because certain cases have a strong psychological impact to deal with, i.e. also on their own well-being, coping capacity. Participants also report a feeling of loneliness as a result of being confronted with cases of DV. There is internal support in the form of exchange within the team dealing with the case. In addition, a psychologist would be available as another contact person for the victims and the staff.

4.4.5 Typical interventions and pathway of referrals

According to the respondents, medical staff would refer victims to specialised victim support services, but not all victims can be referred to them. With regard to non-medical specialised institutions, respondents stated that staff would know about counselling centres at the local/regional level, but many victims of DV do not turn to these services because they are either not aware of them or because they are afraid. Medical staff usually asks victims directly about the incident, but there are gaps/problems in relation to interventions and referrals, especially in cases of silence/non-disclosure of the victim and in the presence of the abusive partner.

As already discussed, the various interviewees complained about a lack of structured training on the topic of DV, which would also help the implementation of procedures (e.g. victim intake, psychological support, referral to community services, reporting to the police). There were differences among stakeholder groups in the availability of practical experience and knowledge, as well as structured protocols. For example, there is a gynaecological emergency room, which is in contact with the ER and vice versa. Discussion with colleagues also appears to be crucial. All interviewees reiterated that female victims of DV need not only clinical interventions, but also psychological support. For single, homeless women, maybe with children, the involvement (notification) of the out of hospital local network is mandatory. The social worker is often

contacted, who acts as a bridge between the hospital and the territory. Sometimes a referral is also made to violence protection services (counselling and especially CAV) and, if there is a complaint by the victim, also to the police.

4.4.6 Internal documentation and support

The ER staff has a protocol for cases of DV (forms and internal documentation tools), with a dedicated team to manage cases of gender-based violence or DV. Efforts are made to provide victims with a dedicated room, but time is often lacking. The ER therefore has a well-defined procedure managed by a small group.

Obstetrics and gynaecology staff also follow a structured pathway with an internal protocol. However, the respondents stated that in comparison to the ER there were deficits with regard to legal and psychosocial aspects. Thus, medical staff would frequently require more information on how to approach the woman (e.g. how to formulate a report and see what to write) and how best to carry out their responsibilities in these cases. Nevertheless, the obstetrical-gynaecological ER is a privileged place as compared to the general ER because they have to deal with a lower number of overall cases. Therefore, there is more time to devote to the woman who may have been victims of DV, compared to the PS. In turn the cases admitted to the obstetrical-gynaecological ER are described as more difficult to manage. Participants state that they have to improvise as psychologists and need training in this regard. If the DV problem is not solved, the training nevertheless prepares the staff better to handle the cases.

4.4.7 Challenges and needs

Organisational challenges

1) At the procedural level in some departments (e.g., ER and gynaecology and obstetrics), the actions envisaged are clear, but at the psychological level they are difficult to manage. Both groups of medical professionals, those who have little experience and those who have more, generally feel unprepared, especially because of their high sense of professional responsibility towards victims of DV.

2) One of the main challenges that medical professionals report is the lack of proper training after the setup of procedures.

3) Another major challenge is to protect the woman, and if necessary, also their children. To minimise the risk of victims, hospital discharge does not take place unless a support network is in place, including educators, social workers and the staff responsible for bringing the woman home, even if it is temporary. Care is taken that the partner does not come to the ward, to protect the woman. An anonymity procedure is also activated to protect the woman on the ward.

4) Another challenge constitutes that wards are still predominantly occupied by male physicians, although there is clear evidence that female victims of violence are more likely to open up in the presence of female staff. A similar problem arises with interventions by medical personnel where the police are involved. Here, male officers, who can be perceived as scary, usually accompany the medical staff.

5) Finally, respondents sometimes do not know whether to proceed ex officio and how far they can go, and if it is their responsibility.

The interviewees emphasised that only forensic and legal aspects are covered in training, but there are no clear guidelines for the practical aspects of dealing with potential victims. The analysis suggests that the respondents did not acquire their competence/sensitivity through formal training, but because of their personal interest in the topic and their professional and/or private experiences. This leaves health professionals with a feeling of acting according to “common sense”, which is often accompanied by a sense of powerlessness and doubts about their actions. Participants stated that they need training provided by experts and professionals in the field, especially psychologists, but also experts in law, law enforcement and related services, as well as forensic specialists. This would greatly improve the quality of care, professionalism and accountability.

Individual challenges

1) One individual challenge is to approach the patient in the best possible way, in offering gentleness, comfort and tranquillity, that is to establish a safe space for trust and confidence.

The respondents stated that medical staff would lack related skills and knowledge to achieve this because of the lack of psychological training. If medical education/training would also include the mediation of psychological competence, then, especially in times were hospital admission are high and the time that can be devoted to women is reduced, this could highly benefit the engagement with potential victims.

The need for training is voiced across all stakeholder groups, as currently it is the individual level of experience which determines the quality of support: Female professionals (physicians and nurses) in the ER have a particularly frequent case history and therefore are the most experienced in the field. Next are the midwives and gynaecologists, the dentist and lastly the student. All the professionals advocate for a dedicated and professionally trained team to engage with victims of DV, if possible, with the opportunity of a separate private pathway in the ER.

2) Another important challenge voiced by our respondents is the prevention of secondary victimisation, i.e., the distortions that occur in the Italian justice system that lead women who have suffered violence to be penalised a second time by the institutions themselves.

4.4.8 Availability of training and information on DV in medical curricula from the perspective of medical students

The interviewed student showed a high awareness of the issue of DV, even though he has not completed any specific training. However, he also voiced insecurity about how to act in the concrete engagement with victims, fearing that one might do more harm than good. There is also the fear that the clinical examination can re-traumatise female victims. Hence, psychological support would be required, which would have a positive impact on the engagement with (potential) victims. In terms of actual knowledge, our analysis suggests that little knowledge about DV exists among medical students, except for the medico-legal aspects. Therefore, students would need training provided by a multidisciplinary team, consisting of psychologists, forensic physicians, and third sector persons involved in the handling of these cases. The student reported that from his point of view there is also a need for psychological support for health professionals, who may feel lost when faced with a case of DV.

4.4.9 Overview of existing trainings and training needs

Table of Existing Trainings

Stakeholder Group	Brief description of "Type of Training"
Physicians & Nurses	Training for physicians and nurses in order to increase their capacity to diagnose, manage and treat gender-based violence, strengthen or establish multidisciplinary territorial anti-violence networks
All stakeholders	-Information on: Diagnose and treat cases of gender-based violence; Activate/strengthen multidisciplinary territorial anti-violence networks; Identify and assess the risk of re-victimisation. -Identification, admission, taking charge and support of cases of violence against women, in a relational context, or against children. -Increase the capacity to identify, diagnose, manage and treat gender-based violence, prevent cases of re-victimisation, foster the establishment of networks between ED and the social-health and voluntary structures in the area -The purpose of the FAD course is to promote the skills of health and social workers in identifying cases of violence against women and witnessing violence, using appropriate communication-relational strategies, and recognising the role of territorial networks.

Table of Training Needs

Stakeholder Group	Brief description of "Type of Training" desired
All stakeholders	Training should be mandatory for all professions. The course should be managed by physicians, nursing staff, lawyers, psychologists. No other specificities were mentioned by respondents.

4.4.10 Sustainability and implementation of trainings for medical professionals

There are no specific reports on formats for delivering training (e.g. online/offline). There is also no preferred mode on the setting and duration of such trainings. Rather, respondents emphasised that the training should be mandatory and cover all medical staff. The training should cover both, basic and specialised knowledge. Preferred trainers include experts from fields such as psychology, medicine, social work law or members from associations, for example the centre for care of victims of violence (CAV: centro anti-violenza in Italy).

4.4.11 Sustainability and implementation of trainings for medical students

In terms of an adequate implementation of the issue of DV in medical training, the training should be led by a multidisciplinary team consisting of a psychologist, a forensic physician and people from the third sector involved in the treatment of these cases, for example the centre for care of victims of violence (CAV: centro anti-violenza) in Italy.

Thus, there is a need for training that covers all aspects of such a complex situation. Furthermore, it would be desirable to have a psychologist available to support students in engaging and communicating with victims of DV.

4.5 Greece

4.5.1 Context of data collection and data set description

In Greece, the HFPA conducted eight interviews. The sample comprised of six female and two male respondents with different medical-professional background, including two orthopaedics, two nurses,

one gynaecologist, one midwife and two medical students. The sample was recruited from Attikon University General Hospital, in Athens, Greece. The decisive factor for recruiting participants from Attikon University General Hospital was, on the one hand, that Attikon, as a large general hospital, has one of the highest outpatient volumes in the region and is considered to be one of the best university hospitals in Greece. On the other hand, since many of the researchers are employed there themselves, participants could be recruited more efficiently.

In general, **the participants had low levels of knowledge and awareness of DV related training**. Interest and engagement in addressing and dealing with DV as an issue in the medical field was heterogeneous and **varied between the male (physicians) and female participants (nurses, midwives and students)**. While the latter were comparatively enthusiastic about taking part in the study because they believe that it is their professional duty to recognise and act against DV, the male physicians seemed less concerned about the issue.

4.5.2 General summary of the state of DV-sensitivity/expertise in the medical community

The majority of the respondents stated that their awareness of DV had been raised mainly through media coverage and incidents of DV in their own family environment. **None of the participants had received any formal training on the topic of DV in general or violence against women during their studies**. However, the students reported that they had attended a course on DV against children as part of their paediatrics studies. This training included lectures on the theoretical background of domestic child abuse and the relevant legal framework, role-playing with actors, presentation of case studies, hypothetical scenarios, and familiarisation with a formal protocol used in cases of suspected and/or admitted child abuse.

The female respondents (midwives, nurses, students) seemed to be more aware of the problem and considered dealing with DV to be a “women's issue”. While the male physicians also stated that it was important to address DV, they seemed to do so out of political correctness rather than being truly concerned with the consequences that DV brings to the individual and to society in general.

With the exception of students, respondents had extensive practical experience with abused patients, but indicated that this experience was not accompanied by a theoretical framework for recognising DV and implementing appropriate and victim-friendly protocols.

4.5.3 Modes of identifying potential victims of DV

Respondents indicated that identification of DV cases is **based mainly on clinical examination** and the extent or localisation of an injury in relation to the expected injury, according to the patient’s narrative of the incident. In such cases, all respondents seem to note a discrepancy between the victim’s physical signs of trauma and the patient’s rationale for

the cause of the injury. In addition, respondents reported suspecting DV when the partner and potential perpetrator insists on being present during the examination and when other signs are present, including but not limited to shame, guilt, distress and fear. Overall, **female professionals appear to be more sensitive to non-verbal communication** and therefore more able to recognise a potential victim of DV.

In sum, the interviewees noted that in almost all suspected cases, identification is strongly based on physical injuries rather than psychological signs, which are underrepresented or usually not recognised. Significant attention is also given to the behaviour of the partner and potential perpetrator (e.g., moving close to the victim to avoid detection), which is usually considered as a warning sign of DV by medical staff.

4.5.4 Reactions to disclosure about DV by patients

After the patient's report and given sufficient circumstantial evidence of DV, interviewees reported that they would openly ask patients if they had been abused to confirm their initial suspicions. However, in most of the cases, respondents would receive a negative answer, especially if a relative or the perpetrator is present. The midwife explicitly stated that if there is a suspicion of DV, she isolates the victim in the examination room, under the pretence of conducting further tests, and asks if the patient would like to request (specialised) help. In cases of severe or extensive injuries, the physicians and medical students try to admit the patients to the clinic to have more time and opportunity for further action. **When recording cases, either based on the victim's information or on suspicion, the respondents would mark this case in the Outpatient Records Book as a "possible case of DV".**

4.5.5 Typical interventions and pathway of referrals

All respondents stated that there is **no formal protocol or procedure they can follow in such an event**. In the event of suspicion, the medical staff responsible for the patient's care takes actions at their own discretion and/or in collaboration with the rest of the team. The only formal action is to record the incident in the respective section, stating "suspicion of DV or DV report by patient". At most, respondents reported that they would notify the hospital's social service, provided the victim consented to such action. The social service, in turn, would notify the Liaison psychiatric team for psychiatric and psychological support for the victim.

Overall, all interviewees reported a lack of knowledge regarding appropriate referral procedures, legal actions, or specialised organisations that could adequately support victims of DV.

4.5.6 Internal documentation and support

None of the respondents was aware of an internal documentation protocol, implemented in a case of suspected or reported violence. The only formal action is to record the incident in the respective section, stating "suspicion of DV or DV report by patient". In terms of their personal support of such an incident, only students expressed the need to receive psychological support in order to be better equipped to help the victim, as well as to protect their own mental health, and strengthen their resilience.

4.5.7 Challenges and needs

Participants reported numerous challenges, especially in identifying and reporting DV cases. Other main challenges concerned the lack of time, especially in the emergency room, as well as the constant presence of the perpetrator during examination and the victims' fear or reluctance to cooperate with medical staff. Another major problem is their reported lack of knowledge of the current legal framework governing DV, and specifically whether medical professionals would have the possibility and legal capabilities to take the initiative for initiating legal intervention and what the consequences of such action might be for themselves (fear of legal liabilities).

Moreover, participants highlighted the absence of a forensic pathologist in hospitals, the need for the victim to personally seek for a forensic evaluation, as well as the total lack of formal response protocols. They also expressed the need to be formally trained in victim identification and the legal framework which governs DV. Midwives and nurses, apart from victim identification, would like to be in a better position to intervene effectively, under the precondition of more intense training, the existence of appropriate facilities where they could accommodate the patient, with more and specialised personal in DV and better cooperation with physicians when dealing with such cases.

Finally, interviewees expressed the need for having available brochures, leaflets and victim identification sheets, designed by experts in the field, as well as an organisationally established unanimous procedure when dealing with cases of DV.

4.5.8 Availability of training and information on DV in medical curricula from the perspective of medical students

The interviewed students expressed a sense of responsibility, along with higher levels of anxiety and stress when coming across with a possible victim of DV. Considering that the medical students had only received specialised training on DV against children, they expressed the need for a similar course for adult victims of DV.

4.5.9 Overview of existing trainings and training needs

Table of Existing Trainings

Stakeholder Group	Brief description of "Type of Training"
Medical Students	Formal training regarding DV against children
	Within the framework of the Pediatrics course
	Mandatory
	Included modules on theoretical background of DV, role-plays with actors, hypothetical scenarios and case studies

4.5.10 Sustainability and implementation of trainings for medical professionals

The majority of respondents, view DV as a matter of emergency and crisis that should be treated accordingly. They unanimously agreed that training on this subject should be mandatory as part of their basic university education and should be conducted regularly (e.g., annually or biannually) by mental health professionals in an organised and formal manner. In the same context, protocols should exist, similar to other specific medical procedures that are currently in place for emergency cases (i.e. blue-line in cardiac arrest).

4.5.11 Sustainability and implementation of trainings for medical students

All students consider DV an important issue and expressed the need for training as part of their education at the university. They unanimously agreed that training on this subject should be mandatory and conducted on a regular basis (e.g. annually or biannually) by mental health professionals in an organised and formal manner.

5. Country comparison

After having detailed the individual needs assessments of the partner countries, we now compare the key aspects (commonalities) with the aim to highlight the commonalities (by juxtaposing them with some of the specificities of the partner countries) between the individual needs assessments in order to pinpoint those key aspects that should be further considered when implementing DV training.

5.1 Expertise and awareness of violence against women in the medical community across five EU countries

The comparison of interview findings between the countries shows similar attitudes and assessments regarding the level of knowledge and awareness of respondents about DV. In particular, the view that the healthcare and medical sector has a central role and responsibility in identifying DV and in providing initial care and referral of victims was shared by almost all respondents. This commitment is also reflected in the working practices and mentalities of many interviewees, who are often important actors within their organisations (hospitals) in both: treating victims and raising awareness of the problem of DV among their colleagues. Typically, the decisive factor for this commitment, the associated acquisition of knowledge and related efforts to improve the practices in one's organisation is usually based on their personal engagement and interest in the issue of DV.

Such personal engagement among medical staff is certainly desirable but it should not and cannot be seen as a substitute for standardised training and intervention practice in the care of victims of DV in the medical field. There are several reasons for this: First, adequate care and support of potential victims of DV cannot and must not depend on whether or not there is enough engaged staff. Second, the lack of a structural framework for victim protection and support in clinics increases the pressure on committed staff, because they are then seen and treated as the responsible experts. As a consequence, dedicated staff may assume or are assigned in practice an informal role in addition to their formal responsibilities. This is likely to increase their overall stress and workload putting additional pressure on them. This in turn is likely to have a (negative) impact on their capacity to properly support victims of DV. And third, while acknowledging this personal commitment and interest, it is always desirable that in addition to the knowledge acquired in practice, the "state of the art" knowledge, which is the result of targeted psycho-social research for the best possible identification and support of victims, is made available to all practitioners. In the interviews conducted, this is reflected in the fact that participants from all countries stated that although they have gained a lot of practical know-how through their contact with victims, they often lack theoretical knowledge. This in turn can lead to the situation that medical professionals may be well aware of physical or emotional signs of violence and know how to meet the medical needs of victims. Yet they may not be well prepared to offer comprehensive support. For example, medical staff may lack the knowledge and confidence to talk with victims about

their experiences, about available support services, or about the consequences of an intervention such as reporting.

The value of such theoretical knowledge is clearly shown in the results from Sweden where some participants stated that they had acquired practical knowledge due to their personal interest in the topic and their contact with victims. However, their knowledge and their ability to adequately support victims have only been improved through formalised and professionalised training offered by NCK. Against this background, it is not surprising that respondents in all countries recognised and supported the need for mandatory training and awareness-raising measures on DV among medical professionals and students.

Another cross-country finding was that experience with and knowledge about DV varied by professional specialisation/background. Although, there is no consistent cross-country feature identifiable as to which professionals are particularly sensitive to the issue of DV, in most countries the participants seem to have at least slightly different levels of knowledge depending on their medical specialisation. In Italy, for example, DV against children is taught as part of the training in paediatrics. In Germany, there seems to be a better knowledge base in the field of midwifery, gynaecology, psychotherapy, and paediatrics compared to surgery and dentistry. One possible reason for these differences could be that knowledge about and awareness of DV seems to be higher when medical staff come into contact with victims of DV on a more regular basis. However, it must be acknowledged that the direction of such a relationship is mutually dependent: knowledge and awareness increase with more frequent contact, and that increased knowledge and awareness leads to more cases being „discovered“.

5.2 Procedures and practices of identifying, engaging, supporting and referring victims of DV

Identification

Across all countries, the medical professionals interviewed for this project reported that standardised protocols, which include questions about DV and are applied to all (female) patients, are hardly available outside specialised departments (e.g., gynaecology) and hence there is no generalised standardised practice of asking patients if they have been abused or if their health constitution is linked to experiences of DV.

As **indicators** for possible exposure to violence, physical injuries (scars, bruises and fractures) are seen as the primary indicators. This is especially true when injuries are combined (e.g. to the face, neck and arms) or the type of injury seems medically unlikely when compared to the patient-reported history of the injury. Other indications include repeated and/or chronic illnesses, which may be indicative of trauma; or an increased number of visits to outpatient

clinics, without any apparent medical reason. Sometimes, also untreated illnesses or injuries that cannot be directly attributed to an act of violence can indicate neglect/abuse, for example, when parents do not consult a physician timely in case of a persistent physical symptomatic that can easily be identified by laypersons (e.g., bumps that do not heal or lymph nodes that do not decongest). In addition to physical symptoms, respondents from all countries also see psychological symptoms or addictions as potential indicators of DV, even if these are seen as less meaningful, which may be attributed to a lack of sensitivity and comprehensive knowledge about DV among healthcare professionals. For example, anxiety disorders, a high degree of nervousness, insecurity in communication (e.g. repeated contradictory statements about the course of the injury, reluctance in describing the course of the injury) or restlessness, especially in combination with physical injuries, can all be indicators of DV experiences.

Differences in identification can also be found with regard to different medical fields and/or different healthcare professionals. In the context of midwifery, symptoms such as restlessness, nervousness, fear and pain (specifically in connection with vaginal examination) were mentioned as typical symptoms of victims of violence. In gynaecology, injuries to the legs and the intimate/vaginal area are considered signs that a woman, who has been a victim of violence may also have been a victim of rape. Differences between the countries can be seen in relation to the expert's assessment of the extent to which patients themselves are perceived as confident and willing to disclose the violence they experienced.

Initial reactions and follow-up referrals and interventions

Typically, the **first reaction** reported by participants across all countries to signs of DV is a compassionate enquiry, i.e. an attempt to create a trusting communicative and treatment environment, so that victims, if they have actually experienced violence, can feel safe during examination and freely talk about their experiences. In some cases, there are even standardised procedures. In Italy or Greece, for example, certain departments/professionals from different backgrounds like midwifery have implemented standardised measures in cases of suspicion of DV, such as separating victims from the partner if they are present. Depending on the circumstance, in a second step this initial response can be followed up with specialised interventions, like psychological or police support (see further below). Interviewees from Greece stated that in the case of a suspicion of DV, a corresponding note is inserted in the Outpatient Records Book (i.e., general records of hospital admissions and discharges). Across all countries, however, decisions about whether to follow up on a suspicion and how to do so seem to depend heavily on the individual professional. The concrete measures taken by dedicated individuals in turn depend on the organisational circumstances and on the individual expertise. Across all countries, respondents' answers show different attitudes towards dealing with suspected cases of violence, which are influenced by two factors. **Organisational factors** include the high work load and related time pressure that medical staff in general face in their work, which often leaves little time for in-depth

conversations with patients. In contrast, in departments with lower patient frequency more time can be dedicated to patients who have become potential victims of DV. Furthermore, respondents from Germany stated that they did not feel to be in the “right position” to conduct investigations or report suspected cases. This was mainly attributed to the hierarchical structures within the medical sectors, especially within hospitals, or the lack of support or interest from supervisors. **Individual factors that** hindered prompt and effective reactions, including a lack of expertise and professional knowledge in interacting with victims of DV, led to feelings of insecurity, e.g. about how to communicate appropriately, as well as to feelings of dismay or perceived helplessness. In practice, as participants reported, this lack of proper training can also result in uncertainty when pursuing suspicions, especially if they are not based on obvious, physical (i.e., predominantly visible) injuries on the body.

When it comes to effective **interventions**, a distinction can be drawn between “internal” and “external” interventions of victims of DV. The former refers to interventions within the hospital or clinic, where victims of DV are referred to specialised colleagues or departments within the organisation who have specific expertise. For example, in Austria there are specific organisational units within hospitals, called "victim protection groups", or internal social workers. Typically, internal referral interventions precede and prepare the provision of external referrals of victims to specialised external support and intervention services, provided by non-medical organisations, such as violence protection centres.

In all countries, participants reported the availability of some form of **internal intervention** system in the event of suspected abuse. These interventions range from dedicated victim protection groups/teams within hospitals, to hospitals own social services as in Greece and Austria, to specialised individual internal experts as in Sweden and some medical departments in Germany. In addition to such established and formalised measures, the respondents also described informal internal referrals of possible victims to colleagues, who have specific expertise. However, the internal referral to colleagues or supervisors can also pose a risk, as some examples in the country reports show that such reports can be met with reluctance or even rejection to act (see e.g. p. 22 in this report). Where professional internal referral pathways or formalised procedures are lacking, it is often up to the commitment and knowledge of the individual staff members and their supervisors whether an intervention is undertaken. Ultimately, the lack of knowledge, guidelines and protocols puts additional pressure on healthcare professionals to seek individual solutions, such as admitting victims of violence to hospital without an adequate medical reason.

In contrast to these **internal interventions**, **external interventions** are carried out with the support of non-medical organisations such as victim protection services or the police. However, none of the respondents, in any of the countries surveyed reported the existence of structured and formalised procedures that offer guidance under which conditions which support organisation should/must be contacted to support victims. Rather, most country reports indicate a lack of knowledge about the availability and appropriateness of external support.

Consequently, a lack of theoretical knowledge about victim protection resources is evident. In some cases, however, the participants stated that this lack of knowledge about victim protection services or women's shelters and the missing of standardised cooperation was compensated by personal contacts of the medical staff to corresponding facilities. However, this was not a sustainable intervention measure.

Finally, two aspects deserve further attention. First, even in the case of formalised and established interventions and referrals, these are not always successful because patients could reject them due to different reasons. Healthcare professionals from all countries emphasised the high priority of patient's autonomy and that interventions cannot be successfully initiated against the will of the victims. Second, it is important to note that healthcare professionals are experts on healthcare and treatment of illnesses, but not necessarily on issues of violence (for which there are separate experts exist, such as those from violence protection centres). This means that medical personnel are required and responsible for the identification and initial intervention in cases of DV and need appropriate expertise to do so adequately. As far as the interventions of medical personnel are concerned, however, they must not be overburdened. In particular, the long-term care of victims of DV or the handling of possible perpetrators must be taken over by specialised actors such as violence protections centres, psychotherapy and/or women's shelters.

Internal documentation

As far as the **documentation of cases** of DV is concerned, there are very different procedures depending on the country. In general, standardised documentation of cases of violence that is applicable across different medical fields and departments, or corresponding guidelines, do not exist, except in Sweden. Here, such an overarching documentation system has been implemented in 2014, enabling the entry of "violence exposure in close relationship" in the National E-Journal (that is a national patient-accessible electronic health record). This can then be queried by medical staff. The documentation reported by the Italian participants is not quite as comprehensive, but different departments have different standardised protocols. For example, there are specific procedures for documenting DV for staff in the emergency department as well as in obstetrics and gynaecology. Such department-specific documentation procedures were also reported by the participants from Germany. Thus, although there is also no general established documentation method, specific wards such as gynaecology or paediatrics have their own programmes and procedures for documenting DV. In Austria, a standardised documentation method for DV exists only for cases of rape and severe forms of violence. The so-called "rape kit" is used to document evidence of rape in a way that can be used in court. In those cases where the hospital is legally required to file a criminal report, the MEDPOL-Bogen (medicine-police-sheet) is used to record severe case to violence. Otherwise, according to the interviewees in Austria, the problem of documenting DV is that established documentation procedures, such as the forensic documentation of injuries or the patient record, are specialised documents whose content is thematically

predetermined and which cannot be modified as desired. Thus, for various forms of documentation, such as the patient file, there are legal requirements as to what should and should not be included and recorded in it. In Greece there are also no dedicated protocols or guidelines for documentation, according to the interviewed professionals. However, there is the possibility to enter the suspicion or report of DV in the corresponding patient record.

Support structures

As far as **support structures** for medical staff and students confronted with DV cases are concerned, there are voices across all countries requesting improvements, especially through psychological support. Such support is needed both for dealing with issues related to the confrontation with cases of DV and to be able to better deal with possible victims from a psychological point of view. It is emphasised, for example by respondents in Sweden or Germany, that informal support structures currently dominate. Although these are described as an essential and indispensable means of exchange and knowledge transfer, they are not sufficient. Furthermore, as emphasised in the German sample, this informal exchange seems to be mainly horizontal in character, while vertical support structures, which would include supervisors or be embedded in organisational policies, are underdeveloped. Hence, ideally, semi-formal support should be organised, i.e. non-compulsory, low-threshold supervision formats (i.e. without registration and as part of working time) that can be attended by several people at the same time and are aimed at both staff and supervisors. Finally, it should be noted that such support services (e.g. supervision) need to be promoted and normalised in the organisational culture (maybe it should even be made mandatory as it is the case in psychotherapy). Because as the report from Austria shows, such offers are not attended by healthcare professionals if prejudices (e.g. to be considered weak by colleagues) are not reduced.

5.3 Cross-national challenges and needs of healthcare professionals in dealing with victims of DV

Lack of time and resources among healthcare professionals

Main challenges that were raised unanimously across all countries, included: proper identification and documentation procedures of DV cases in medical settings. In relation with this, all interviewed healthcare professionals emphasised the **notorious lack of time and resources** that can be devoted to patients who were victims of DV. This was particularly evident in high-pressure wards like the emergency room, i.e. especially in terms of scarce time and a high fluctuation of patients in relation with a limited number of beds that could be offered to victims of DV in case of potentially acute hazardous situations. Also, the presence of perpetrators was mentioned as an aggravating circumstance when dealing with women who were victims of DV in medical settings. A lack of resources and a lack of time more generally contribute to the **difficulty of creating adequate**

relationships of care and trust between patients and physicians, or other healthcare professionals. However, this notorious lack of time and money permeates education and hospital practice more broadly, making it difficult to implement sustainable victim protection in medical settings (which so far often depends on the personal commitment of individual professionals in these medical settings).

Lack of knowledge and expertise on DV & the role of healthcare professionals in early detection

Most of the professionals interviewed stressed a **lack of expertise and knowledge about DV and intimate partner violence**. Among their colleagues, respondents recognised a lack of awareness of the importance of the medical sector in early detection and support measures for victims of DV. Respondents in Greece specifically pointed out their ignorance of the current legal framework on DV, in particular whether medical professionals would have the ability and legal means to take the initiative to intervene legally, and what the consequences of such action might be for themselves (fear of legal liability). These uncertainties indicate a **problem for professional responsibilities and a need for clarification of jurisdictional task areas** of medical professionals when it comes to the handling of patients who were victims of DV. Similarly in Sweden, the respondents stressed a lack of expertise among healthcare professionals about how the experience of violence might affect woman's health, well-being and comorbidities. Furthermore, they need more information on how and why DV may be part of a patient's medical history and how illness and violence are related.

Lack of clear procedures, guidance and fact sheets for handling DV cases in medical settings

Related to the above-mentioned lack of time and expertise, respondents also criticised the **absence of clear guidance, checklists and procedures** on how to deal properly with victims of DV in medical settings. In Sweden, the interviewed professionals mentioned in particular the need for clear routines and procedures in each hospital unit, the need to train new staff, and the availability of supervision, if needed, to manage and cope with their own experiences with these troubled patients. Healthcare professionals in Greece also highlighted the absence of a forensic pathologist in hospitals, the need for the victim to personally seek for a forensic evaluation, as well as the total lack of formal response protocols. In this respect, the Greek respondents in particular expressed the need for brochures, fact sheets, and victim identification forms designed by experts in the field, as well as an organisationally defined, unanimous process for handling DV cases.

In Germany and Austria, stakeholder specific needs were expressed, too. For example, German surgeons argued for specific guidelines for the surgery department as well as for a clear code of conduct in cases of DV management in medical settings. In surgery, there was a collective call for greater awareness, the establishment of guidelines, and enhanced knowledge regarding available support services. On a personal level, there was a strong desire for supervision, individual guidance, and support from the hospital management and their supervisors. Whereas the group of dentists, interviewed by the German partners of the VIPROM project, articulated the need for a clear

communication guide with case examples, because the biggest challenge for them was to act on false accusations. Furthermore, they expressed uncertainty whether they were even perceived as a suitable point of contact for victims of DV.

In the German group of paediatricians interviewed, there is a well-established framework for dealing with cases of DV. They seem to be the most knowledgeable group when it comes to victims of DV and how to approach them, most likely depending on their specific field of expertise comparable to gynecologists. There is accessible information and ample support for healthcare professionals in this group of physicians. However, the main challenge that the paediatricians reported is to use these available resources effectively and to ensure that healthcare professionals actively engage with them. Therefore bi-annual training sessions and regular exchange meetings are organised.

In addition, most respondents in all five countries expressed a need for **supervision** to help themselves processing their own experiences in dealing with these challenging cases, and possibly their own experiences of violence, either from a professional or private context.

Need of interagency cooperation and knowledge transfer among different professionals

Further uncertainties were expressed regarding **professional responsibilities and accountabilities**. This primarily concerns **cooperation between different actors and institutions** and that clear areas of responsibility and roles should be defined. As mentioned earlier, healthcare professionals across all five countries face the common challenge of limited time resources available to them to engage with issues in addition to and besides their daily work. In this respect, the importance of **multidisciplinary teams and effective collaboration** was emphasised as essential for providing high-quality medical care in general and specifically for addressing the needs of victims of DV. Therefore, training programs addressing medical professionals from different disciplines and fostering these collaborations are a necessity. However, in addition to **offering such training programs**, it is essential to establish **institutional support**. This includes recognising the importance of these trainings by considering them as part of the employees' working hours or granting them with time off from their daily duties or rather to perceive it as integral to their professional responsibility. Therefore, it must be integrated into their daily working practices and perceived as integral part of it when it comes to early detection of DV cases. In this context, respondents in Austria also pointed out that the hospital management does not recognise the importance of the medical sector in combating DV and its role in terms of (women's) health prevention. There is an urgent need to increase awareness of the political importance of the issue and the extent of DV in society at an organisational and institutional and implementation level in the healthcare sector. In addition, it is essential to institutionalise the importance of the medical sector in early detection, referral and documentation of DV. Moreover, the gender gap was specifically addressed by Italian respondents, namely the dominance of male physicians and police officers in external referral procedures; however, female victims of DV are more likely to open up in the presence of female medical staff.

Need of tailored trainings for the medical sector and healthcare professionals

There is a prevailing uncertainty regarding the management of DV victims in medical settings among healthcare professionals across all five countries. Consequently, there was a strong call for **mandatory education and training** on this topic during academic studies and/or professional training.

Swedish respondents also emphasised acquiring knowledge about risk assessments, but it should not be in-depth. This is because they pointed out that healthcare personnel are not responsible for risk assessment in a strict sense. Instead of focusing too much on risk assessments in training, **healthcare personnel should know and be trained more about the roles and responsibilities of different actors**, for example, healthcare, social work, police, shelters, lawyers, etc., so that it is clear who is responsible for risk assessment and/or other support measures.

Further, there is a **need for trainings about how to address and deal with victims of DV**, especially in the context of evidence collection for potential future court cases. Some of the respondents raised the need to receive training about both, asking questions about DV and about what to do when patients disclose experiencing abuse and violence. Training would also be needed in terms of how to document DV clearly and professionally as a necessary step to facilitate follow-up procedures and in case evidence is needed.

In Germany, Austria and Sweden, a particular need for tailored trainings for specific stakeholder groups was also expressed. Midwives, for example, are confronted with special care situations (a pregnant woman who wants to give birth) that are not necessarily characterised by the care for a sick person, but for a pregnant woman. This implicates that the profession of midwifery would need examples and cases that show how to address questions about DV in a normally beautiful situation.

These aspects regarding the need for training and to some extent its absence in current medical curricula also signal the importance of interagency cooperation between different actors in dealing with victims of DV and the clarification of responsibilities among them. In Italy, the interviewees particularly emphasised that their training only covered **forensic and legal aspects**, but that there were no clear guidelines for the **practical aspects of dealing with potential victims**. This suggests that the respondents did not acquire their competence/sensitivity through formal training, but because of their personal interest and engagement in the topic and their professional and/or private experiences. This leaves healthcare professionals feeling like they are acting on “common sense”, which is often accompanied by feelings of powerlessness and doubt about their actions. Participants indicated a need for training by experts and professionals in the field, particularly psychologists, but also experts in law, law enforcement and related services, as well as forensic specialists. This would greatly **improve the quality of care, professionalism and accountability.**

Another need that was mentioned by most of the respondents is the need for **supervision and/or psychological training for healthcare professionals**. The need for psychological training was particularly emphasised by Italian respondents. Frequently, the biggest difficulty is not necessarily how to deal with victims of DV at an professional level, but primarily how to deal with such encounters at the psychological level. Therefore, many of our respondents suggested **supervision as a safe space** where one's own experiences of violence (including possible violence at the workplace) and the challenge of dealing with DV cases can be discussed and processed. There is a need to create more of such safe spaces and time for reflection on such experiences or feelings of fear among professionals. Supervision, as practiced in psychotherapy, could be a model for creating such spaces. In addition, there is a **need for further training** in gaining knowledge **on secondary victimisation and re-traumatisation** through medical personnel and/or treatments and examinations.

Other specific needs related to training were mentioned by dentists and midwives in Germany. **A format that combines theory and practice**, including **interactive training with simulated patient-practitioner interaction**, was considered beneficial. The gap between theory and practice was particularly communicated by midwives (specifically by the German and Austrian interviewees): although the issue of DV is present in their education, it is very often difficult for them to deal with it in their daily practice, including: how to properly handle, how to react, how to talk, how to address these patients who were victims of DV. A related question in this context constitutes: what could strengthen the resilience of midwives in their daily handling with women who experience DV.

Moreover, a further challenge (mentioned particularly in Austria, Germany and Italy) is that the intervention and management of violence against women is very often seen as a kind of additional task, not necessarily considered as part of the medical staff's responsibility. However, at the same time, this shows that a broader, systemic change is needed to anchor the issue of DV and appropriate intervention measures sustainably in the medical field and its training among different professional healthcare groups.

5.4 Sustainable implementation of DV trainings in medical education

In the following, key aspects are listed that were considered essential for a sustainable uptake and inclusion of DV-related topics into current medical education and healthcare trainings across all countries and healthcare professionals. These aspects are directly related to the above-mentioned challenges and needs that our interviewees encounter in their daily practices in terms of identification, adequate reactions, internal support and cooperation with other actors and institutions, referral procedures and documentation practices in medical institutions. This chapter summarises cross-cutting elements for all stakeholder groups in this needs assessment, which has included: physicians (primarily gynaecologists and emergency department physicians), medical students, nurses and midwives (and as additional groups in Germany: dentists; in Austria: midwifery students, in Italy: also, one dentist; and in Greece: two orthopaedist).

The list below addresses four main areas that were considered essential for a sustainable integration of DV issues into educational programs by the healthcare professionals of this needs assessment: 1) the regularity/duration of trainings, 2) the format of trainings and background of trainers, 3) the content of training (including stakeholder specifics), and 4) practical (organisational & administrative) elements, all of which need to be considered when delivering DV training to different healthcare professionals.

Regularity and duration of DV-trainings

Almost all healthcare professionals who participated in the individual needs assessments have agreed on the **need for regular training**: In Sweden, for example, respondents suggested to have a training interval of twice a year to be able to provide regular training to all, including new staff. If the aim is to reach everyone with these trainings, they must be organised in a more or less **mandatory way**, as it is also the case with other medical trainings.

Regarding the format of these trainings, the respondents were in favour of **mixed formats**, i.e., online courses as well as face-to-face seminars, but continuity was mentioned as one of the most important elements to sustainably anchor the issue of DV in medical education. The **early integration of the topic of DV** into existing medical curricula is important, because it is a quite difficult topic that requires sensitive ways of intervention and response skills. Therefore, it is better if students and young physicians and other healthcare professionals, such as midwives, are prepared and equipped with helpful tools early on in their education. It also sensitises young professionals to recognise early on their important role as frontline responders in terms of health prevention and the provision of sufficient care in such cases of DV, and the importance to refer victims of DV to further specialised support services. In addition to basic courses, the role of continuous learning also includes specialised (stakeholder-specific and/or content-specific) training on specific issues related to this topic.

Medical and midwifery students also considered DV an important issue and expressed the need for training as part of their studies. They unanimously agreed that training on this subject should be mandatory and conducted on a regular basis (e.g., annually or biannually) by mental health professionals (this was particularly mentioned by students in Greece) in an organised manner.

Format of trainings and background of trainers

In Greece, respondents collectively agreed that training on violence against women and children should be mandatory as part of basic university training, as DV represents an emergency and crisis in which it is necessary to act in an organised and careful manner. In this context, **protocols** were mentioned as important **guidance tools** for such cases, similar to other specific medical procedures currently in place for emergency cases. Interviewees from Sweden stressed that various **interactive formats**, such as *role-playing*, *simulated conversations*, and *mock sessions*, are important elements of

sustainable training. Regular (especially face-to-face) interaction is likewise important for the teaching experience and to foster a sustainable learning process among students and healthcare professionals.

The importance of **interdisciplinary** and **multidisciplinary courses** was also consistently mentioned, especially to recognise the health sector's crucial role in interacting with other actors and institutions to address DV and support affected people. Surgeons in Germany also mentioned simulation trainings as valuable formats and stressed the importance of interprofessional collaboration and consistent access to relevant and knowledgeable contacts.

Furthermore, respondents expressed the wish to be trained by competent **trainers with diverse backgrounds**, including those who are experts on intimate partner violence, as well as medical professionals who are knowledgeable on health and disease and are well versed in the internal workings of their organisations such as clinics and hospitals. Further experts might include social workers, forensic experts or others with specific and useful knowledge and experiences for medical and healthcare professionals. **Supervision** or **trainings offered by psychologists** to deal with sensitive experiences with DV cases and victims and/or professionals' own experiences of violence were frequently mentioned by the midwives interviewed in Austria, but also in Germany and Greece. This could strengthen their resilience.

In sum, a multidisciplinary issue deserves multidisciplinary attention of all these different professionals and their cooperation.

Content of DV-training and stakeholder-specifics

Such trainings should cover all relevant aspects of such complex situations, providing space for reflection and analysis and enhancing through that the learning process of individuals. The **practical relevance** – or the practice-theory nexus – of such trainings was emphasised by all of the interviewees and focus groups. This means, that trainings should not only focus on knowledge transfer, but in particular on the role and meaning of and for the professionals' daily working practices and how to deal in these concrete situations with DV. This includes the subjects we have assessed in this report: identification of potential victims of DV during treatments, communication techniques, legal aspects and duties (referral, duty of disclosure), and documentation of DV. In addition, the professionals articulated a pressing need to focus on psychological and psychosocial aspects of supporting victims of DV; in particular, the topics of re-victimisation and re-traumatisation were stressed. Moreover, case discussions were also mentioned as a practice-relevant mode of teaching as well as the aforementioned supervisions (especially by midwives) and post-training debriefings to address possible re-traumatisation in individuals/students with personal experiences of violent acts.

Among Austrian respondents, some additional aspects were mentioned that should be particularly captured by trainings on the issue of DV. For example, **language sensitivity** and the development of

adequate **vocabulary** to address experiences of DV with patients, including: phrasing and questions that healthcare professionals can use to address such delicate topics and experiences with their patients. Furthermore, the focus should be on the care for women and children in terms of health prevention.

Practical elements for a sustainable implementation of trainings

The **organisation and coordination** of these trainings should be highlighted here as a final important aspect for a sustainable integration in existing curricula. In this regard, the establishment of an **ombudsman for DV** in hospitals was considered as a relevant or helpful institution, especially by the interviewees in Sweden. The ombudsman could have a similar function and role as, for example, the **victim protection groups** in Austrian hospitals: setting standards and coordinating trainings (following the needs of professionals), and further serving as a contact point for cases of DV. In Germany, another relevant aspect was that the **costs** of such trainings should be kept as low as possible to enable high participation and not create further restrictions through high fees.

6. Conclusions

Against this backdrop, the report highlights in a final step the blind spots, needs and conditions that should be taken into account when implementing DV trainings sustainably. When comparing the individual needs assessments, it became clear that there are some overarching issues that should be further considered in the development of the VIPROM DV curricula. These insights should ideally be incorporated into the further development of the various modules that will be created in WP3 of the VIPROM project.

First, a majority of respondents have put a special focus on the care of women and children when it comes to questions of DV and its handling in the medical field. While it is clear that education and training should ideally reach all healthcare professions, it was very often mentioned that a particular focus should be laid on professions that deal primarily with women's health and female patients, such as: gynaecology, midwifery, child and adolescent psychiatry. On the one hand, this is partly because the VIPROM partners put a strong focus on midwives (and to some extent also on gynaecologists) in their needs assessment, two professions that by their nature deal exclusively with female patients. On the other hand, VIPROM has also included other professionals and students from different specialities who sometimes point in the same direction, and this could be interpreted as a sign that even sensitised professionals have a blind spot when it comes to male victims. However, it is important to emphasise that **DV trainings must cover a broader spectrum when it comes to potential victims of DV, because even though the majority of victims are women, there is no "typical victim"**. It follows that DV must be viewed by medical professionals as a complex phenomenon that is not exclusively limited to the classic and stereotypical assumptions of perpetrator/victim categories. Rather, these forms of violence are influenced by multiple and

intersecting power dynamics in which aspects such as legal status, disability, income, or age can play a decisive role. In terms of healthcare prevention, it is of utmost importance that all healthcare and medical professionals are trained in the sensitive treatment of various groups of DV victims.[5]

Second, when developing and tailoring training modules to different medical professionals, it is crucial to account for **stakeholder specificity**. As we have seen, there are professional groups that are quite knowledgeable when it comes to the treatment and support of victims of DV and how to approach them in sensitive ways depending on their areas of expertise (as the group of paediatricians in the German sample, or the midwives interviewed e.g. in Austria or Sweden). Among the first group, there is ample support and information readily available, which could function as a best practice for other stakeholder groups. However, there are professional groups that are less well informed and have less training materials available to them. Therefore, it is necessary to increase the sensitivity and expertise of all medical professionals when it comes to patients with DV experiences, which is the aim of the VIPROM project by developing comprehensive training material for different stakeholders.

This leads to the **third** point, **institutional support and clear procedures** as a necessary and critical prerequisite for implementing DV training in medical curricula (including: guidance, protocols and clarification of responsibilities, task areas and cooperation between medical professionals and other, external professions). There was also a clear consensus among the sensitised and knowledgeable professional groups that the biggest challenge is to effectively use these resources (if available) and to ensure that medical professionals actively engage with them. In this regard, **supervision** should again be highlighted as a very helpful format for medical professionals to work through their own experiences in dealing with these difficult cases, possibly their own experiences of violence, as well as their own stereotypes in their professional context. This is because the greatest difficulty is often not only how to deal with victims of DV at a professional level, but more importantly how to deal with such encounters at the psychological level. Therefore, many of the respondents suggested **supervision as a safe space** where one's own experiences of violence (including possible violence at the workplace) and the challenge of dealing with DV cases can be discussed and processed. There is a need to create more of such safe spaces and time for reflection on such experiences or feelings of fear among professionals. Supervision, as practiced in psychotherapy, could be a model for creating such spaces. In addition, there is a **need for training** to acquire knowledge **about secondary victimisation and re-traumatisation (triggers)** by medical personnel and/or treatments and examinations.

These are **important cross-cutting issues** that need to be considered in the further development of DV training. Medical professionals should not only receive theoretical information on DV but also learn

[5] See here: the European training platform on DV (developed under IMPRODOVA, and specified and pursued further with VIPROM and IMPROVE: https://training.improdova.eu/en/training-modules-for-the-health-sector/module-1-forms-and-dynamics-of-domestic-violence/2/#Victims (accessed on 6th of September 2023).

practical skills on how to recognise, respond to, support and document cases of DV. Medical professionals must recognise themselves and their field as important actors in (health) prevention related to DV, e.g. also in terms of removing taboos by asking questions about violence. In this context, the almost absent topic of perpetrator programs in the interviews is a notable insight for the project, signalling another blind spot among medical professionals. This reflects very clearly that medical professionals do not see themselves as involved in prevention. There is a need to increase the sensitivity and expertise of all healthcare professionals when it comes to prevent further victimisation of the various patients with DV experiences. Thus, they must be **trained in the sensitive treatment of various groups of victims** in the context of DV. These issues need to be addressed and brought to the attention of medical professionals through continuous, early, multidisciplinary and targeted training to increase their awareness of violence prevention.