Guidelines for Changemakers in Domestic Violence Prevention & Response

A Multidisciplinary Guideline for Professionals in Healthcare

viprom
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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Contents

Preface

This guideline is intended for healthcare professionals who believe that change does not depend solely on major reforms, but can emerge through the steady, intentional actions of committed individuals. Such changemakers strengthen trust, open pathways to safety and support for victims of domestic violence, and build bridges between sectors within the violence protection system.

We hope this guideline empowers you to take those steps:

- to recognise opportunities for action,
- to support colleagues,
- to strengthen cooperation,
- and to contribute to a safer environment for DV victims.

Thank you for your commitment to change!

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1. Executive Summary

Changemaking begins small, but it has the power to inspire transformation far beyond the individual level.

Domestic violence (DV) is a complex public health and human rights issue that affects individuals across all demographic, cultural, and socioeconomic backgrounds (WHO 2023, FRA 2024). Professionals in healthcare may encounter its consequences daily. Yet many feel unsure how to respond effectively, influence structural frameworks, or contribute to long-term systemic change.

This guideline provides a comprehensive, practice-oriented framework for changemakers; professionals who take responsibility, inspire others, teach, collaborate, and influence systems to protect individuals being victims of domestic violence.

Drawing on VIPROM project insights, practical field experience, and academic evidence, this document describes:

- What changemaking means in practice
- The four core changemaker pathways
- Multilevel challenges and enablers
- A practical roadmap from individual to structural action
- Tools, checklists, and collaboration templates
- Guidance for group-based learning and implementation
- Recommended literature

2. Setting the Framework: Mindset, Responsibility & the Power of Small Steps

Changemaking starts small — a question, an observation, a conversation — and scales up to influence teams, institutions, and systems.

Healthcare professionals, who encounter the consequences of DV in their daily work - often lack training, resources, or systemic support needed to respond effectively.

This guideline positions DV not as an individual responsibility, but as a shared societal responsibility. It emphasises that change does not begin with policies but with everyday professional interactions: with asking questions, with court-proof documentation, with a well-placed referral, or with a moment of courageous advocacy inside one's institution.

2.1 Who Is a Changemaker?

A changemaker is a person who chooses to take intentional, constructive action within their sphere of influence. Changemakers do not wait for perfect structures; rather, they create momentum by modelling good practice, sharing knowledge, motivating colleagues, and strengthening partnerships across sectors. A changemaker is not defined by job title but by mindset and behaviour

In a nutshell, changemakers:

- notice what others overlook,
- respond when others hesitate,
- communicate with empathy and clarity,
- act despite uncertainty,
- connect people and institutions,
- advocate for DV victims and structural improvement,
- balance idealism with realism, and
- act with humility, persistence, and courage.

They contribute to safer environments, more responsive institutions, and more cohesive local networks, even in the presence of systemic gaps or constraints.

Changemakers can act in various spheres:

1. **Individual interactions** (recognition, communication, documentation of DV)
2. **Team and institutional practices** (protocols, training, organisational culture)
3. **Local cooperation networks** (DV services, police, shelters, schools):
4. **Policy-making and system-level influence** (advocacy, research, standards)

These levels are interconnected. Small actions at Level 1 can build momentum toward Level 4.

Among the four levels, the cooperation level warrants closer attention, because this is where changemakers can create the strongest impact. Multi-agency collaboration is not only essential for addressing the complexity of DV, it is also the context in which changemakers can build bridges, close gaps, and move systems forward. In practice, changemakers help institutions work together through a **coordinated, multi-agency approach** to ensure safety, early intervention, and continuous support for victims.

Collaboration in a best-case scenario includes:

- **Proactive identification and outreach**
  - Healthcare providers actively look for early warning signs, establish routines that allow for respectful communication with potential victims, offer support and initiate contact with support services if appropriate.
- **Referral pathways and information sharing**
  - Clear procedure for **referring DV victims** to the appropriate service within the support network for victims (e.g., shelters, counselling, legal support).
  - Structured information-sharing protocols allow healthcare professionals to exchange essential risk-related information while respecting confidentiality rules.
- **Case coordination**
  - Structured support coordination plans (including social workers, police DV units, shelter staff) help to avoid fragmentation and ensure continuity of care.
- **High-risk case conferences/multi-agency risk assessment conferences (MARAC)**
  - High-risk cases are first identified using a shared procedure; mainly performed by the police or social services; representatives from all relevant agencies then meet to assess danger, develop a joint risk-management plan, and assign responsibilities.
  - This approach helps close gaps between services and ensures rapid, collective responses. In the medical sector, especially psychological / psychiatric support may be needed alongside any healthcare deemed necessary to enhance the psychological stability and health of a DV victim.

- **Continuous follow-up and monitoring**
  - Agencies jointly monitor progress, update safety plans, and adjust support as the situation evolves.
- **Training and cross-sector understanding**
  - Regular joint training helps professionals understand each other's roles and reduce "three-planet problem" [1] misunderstandings between sectors

3. Best Practice Approaches for Changemakers

Changemakers create bridges where previously there were gaps.

3.1 Lead by Professional Example

Take responsibility and inspire others

Leading by example is at the heart of changemaking. Examples are listed in Table 1. Professionals who lead by example demonstrate DV sensitivity in their practice, model respectful communication, and influence institutional norms.

Table 1. Examples of leading by example taken from the medical sector, but can adapted to other sectors as well.

Behaviour	Impact
Asking questions about DV routinely • Use calm, validating communication • Ensure privacy and avoid companions answering for the victim • Slowing down examinations to reduce stress	Normalises DV disclosure Makes victims feel safe and respected, building patients trust.
Documenting injuries and statements accurately in a court-proof way	The documentation can be used in court if survivors decide (even later on) to pursue legal action against the perpetrator.
Referring victims to support services	Facilitates access to safety network

[1]The phrase **'three-planet problem'** is a metaphor that describes the **way in which people from different sectors or professional backgrounds can seem to come from different planets**. This can lead to misunderstandings, unrealistic expectations and communication difficulties (Hester, M. (2011))

Sharing insights with colleagues by discussing cases (anonymised) in team learning sessions and encouraging others to attend trainings	Creates institutional learning

3.2 Empower and Teach Others

*Multiply knowledge and confidence: teaching creates a **culture of shared responsibility**.*

Image by freepik

Teaching expands impact far beyond the individual. Many colleagues hesitate to support DV victims, because they fear "doing it wrong." To address these uncertainties, the VIPROM project developed **ten training modules for trainers in the medical sector** as part of the **European Training Platform on domestic violence**. These modules were translated into eleven languages and adapted to country-specific frameworks. In addition, **those modules are accompanied by a training handbook**. An **Intercultural Training Handbook** complements the modules and equips trainers with essential insights for delivering effective education in culturally diverse settings, thereby closing a significant knowledge gap in peer and student training.

Professionals who teach others help build long-term capacity and promote consistent, trauma-informed practice across institutions. Yet meaningful change also occurs beyond formal training environments: brief teaching moments, so-called micro-trainings of 5–10 minutes, and mentoring can all generate substantial impact.

Using VIPROM's training modules and the Intercultural Training Handbook, changemakers can:

- introduce and contextualise trauma-informed approaches
- model safe and appropriate screening practices
- outline referral pathways and available resources
- integrate learning in everyday team settings
- strengthen professional networks

3.3 Engage in Local Cooperation

Create connections and share responsibility

Domestic violence cannot be addressed by one sector alone. Local cooperation is the backbone of DV response and strengthens referral pathways and mutual trust. Developing a map of potential local partners can support this work by clarifying available resources, revealing gaps, and facilitating coordinated action.

Typical local partners are, for example

- women's shelters and counselling centres
- police and victim protection units
- child protection services
- migrant and integration services
- mental health and addiction services
- municipal coordinators
- schools and youth welfare offices

Table 2 serves as a generic example illustrating what a local stakeholder map may look like; it requires local adaptation by adding context-specific services, roles, and opportunities for collaboration.

Table 2. Example for mapping stakeholders locally.

Stakeholders	Role	Collaboration
Healthcare Providers	Identify DV victims	Safe screening, referral
Police	Law enforcement	Immediate safety response
Social Services	Support victims	Counselling, shelter support
Schools	Identify children at risk	Reporting, prevention
Community NGOs	Advocacy	Workshops, outreach

3.4 Influence Systems and Policies

Bring professional evidence to the policy level

Professionals carry essential knowledge about system gaps and real-world challenges.

Their insights can inform:

- institutional protocols
- regional and global DV frameworks
- training standards
- health system guidelines
- funding priorities
- national advocacy campaigns

In addition to the local level, international collaboration expands access to best practices, enhances research dissemination, and strengthens policy advocacy. VIPROM's participation in European networks demonstrates the power of cross-border collaboration.

4. Challenges Along the Changemaker Pathway

No change without challenges.

Changemakers confront numerous challenges. Understanding these challenges helps professionals anticipate them and develop resilience strategies.

Challenges can be summarised into four clusters: individual challenges, interpersonal professional challenges, and structural challenges.

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Individual Challenges

- Feeling that DV is "not my professional role" or beyond one's authority
- Self-doubt
- Gaps in knowledge and skills
- Fear of making mistakes
- Emotional strain and feeling overwhelmed

Interpersonal Challenges

- Difficulty building trust and rapport with patients being victims of DV (medical sector specific)
- Fear of damaging the physician-patient-relationship when raising DV concerns (medical sector specific)
- Cultural barriers between individuals
- Misunderstandings between individuals from different sectors ("three-planet problem"[2])
- Stigma and victim-blaming

[2]The phrase **'three-planet problem'** is a metaphor that describes the **way in which people from different sectors or professional backgrounds can seem to come from different planets**. This can lead to misunderstandings, unrealistic expectations and communication difficulties (Hester, M. (2011).

- Power imbalances rooted in patriarchal norms
- Silencing dynamics within teams or between colleagues (e.g., discouraging involvement or minimising concerns)

Professional Challenges

- Lack of privacy in clinical settings (medical sector specific)
- Limited time for sensitive conversations in clinical encounters (medical sector specific)
- Fear of "opening a door" without resources
- Lack of training or confidence
- Emotional burden & vicarious trauma
- Confusion about reporting duties

Structural Challenges

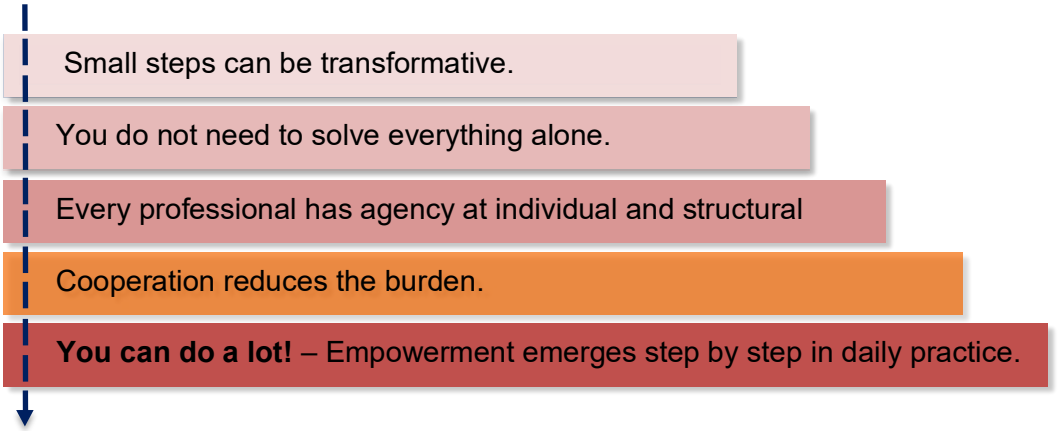
- Unclear or fragmented responsibilities within healthcare organisations (medical sector specific)
- Lack of institutional prioritisation
- Lack of resources (especially time)
- Missing standards or referral pathways
- Insufficient communication between agencies
- Weak interagency cooperation networks
- Legal complexity and uncertainty
- Underfunded support services
- Lack of institutional support for consistent DV response

Of note: challenges increase with each level of changemaking; the higher the impact, the higher the resistance and complexity.

5. You Can Do a Lot

You can do a lot — and you are not alone!

Empowerment emerges when professionals see that effective domestic violence response is possible — step by step.



Effective empowerment involves two levels: individual and structural level (please see Module 10 of the VIPROM training platform for more information). These two levels are interdependent.

Examples for individual levels are:

- ✓ Recognising signs of DV
- ✓ Safe conversation skills
- ✓ Documentation
- ✓ Referrals
- ✓ Peer influence
- ✓ Connecting with local services
- ✓ Embedding DV topics in routine education moments
- ✓ Maintaining self-care

Example for structural levels are

- ✓ Protected time and resources
- ✓ Standardised documentation
- ✓ Clear protocols and referral pathways
- ✓ Internal communication systems
- ✓ Training programs
- ✓ Leadership culture
- ✓ Innovation in practice
- ✓ Practice-research connections
- ✓ Policy advocacy

It is important for organisations to prioritise safety, support, and reflective practice, with leadership playing a vital role in institutionalising DV programmes. Effective DV responses require strong internal structures alongside coordinated multi-agency cooperation (see Module 10, Module 7). This cooperation depends on developing a shared vocabulary, establishing mutual trust, and fostering respect for different professional logics. These foundations can be supported by clear data-protection and confidentiality agreements, well-defined referral pathways, and rapid information-sharing protocols. Joint case reviews are ideal to support continuous learning, quality improvement, and effective collaborative practice.

6. Changemaker Roadmap

- 1. Explore Your Landscape
- 2. Start Small with Realistic Interventions
- 3. Build Internal and External Partnerships
- 4. Create Visibility and Awareness
- 5. Advocate for Structural Support
- 6. Reflect, Evaluate, and Adapt

7. Conclusions

Changemaking is a long-term process. It begins with every professional who chooses to act and expands when teams, institutions, and systems evolve together. Your actions matter. Your role model and leadership matter.

8. Further reading

(1) WHO (2023). *Violence against women prevalence estimates, 2023* **ISBN:** 978-92-4-011696-2. *https://www.who.int/health-topics/violence-against-women*

(2) Hester, M. (2011). HeszerThe Three Planet Model: Towards an Understanding of Contradictions in Approaches to Women and Children's Safety in Contexts of Domestic Violence. https://academic.oup.com/bjsw/article/41/5/837/1640422?login=true

(3) FRA (2014). *EU-wide Survey on Violence Against Women.* https://rm.coe.int/1680591fd9

(4) García-Moreno, Claudia et al. (2015) *The health-systems response to violence against women.* The Lancet, Volume 385, 1567 – 1579, https://www.thelancet.com/action/showPdf?pii=S0140-6736%2814%2961837-7

9. Appendices: Tools, Resources, and an Example for a Workshop

Key resources include VIPROM training modules, EU webinars, referral templates, risk assessment tools, and cultural competence frameworks.

Appendix 9.1 Group Exercise: From Ideas to Action

This example can be adapted for use in workshops or training sessions.

Objective

Participants **learn how to map their own professional environment** to be able to **identify and to develop their own changemaker identity:**

- What already exists in the local DV response
- What is missing in this local landscape
- What they can realistically begin to change
- What support they require

Steps I-III to be taken (min. 25 minutes) in small groups (max. 4 participants)

Step I – Orientation (8 min)

Discuss:

- What already exists in your organisation or country?
- Where are the gaps?
- How do experiences differ between disciplines or regions?

Step II – Focusing (8 min)

Discuss:

- What small changes are both effective and realistic?
- What is a practical first step?
- What support/resources would help?

Step III – Sharing (3 min)

Prepare one example for the plenary:

- Indicate the level: individual or structural
- Explain why it is important
- Describe realistic first steps

The duration of sharing the group examples depends on the number of groups.

Possible step IV: Plenary discussion (duration depends on the amount of examples, the challenges/complexity of the steps to be taken, thus, the expressed need for further discussion)

Appendix 9.2 Practical Tools for Changemakers

Tool 1 – Safe Conversation

- Medical specific: “I ask all my patients this because safety is important…”
- “Is there anything happening that makes you feel afraid at home?”
- “Your information is confidential and your safety matters.”

Tool 2 – Mini Risk Assessment

- Immediate danger?
- Children affected?
- Access to escape routes?
- Weapons in the home?
- Escalation in recent weeks?

Tool 3 – Referral Template

Includes:

- Situation summary
- Risk indicators
- Consent and confidentiality notes
- Follow-up agreement

Tool 4 – Documentation Standards (medical sector specific)

- Neutral, factual wording
- Injuries described with size, position, colour (see VIPROM Med.DocCard© and Dent.DocCard©, respectively)
- Exact quotes using quotation marks
- Photos according to local policy