Deliverable 6.3: VIPROM Roadmap for Victim Protection in Medicine and Domestic Violence - Informed Medical Care

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	Universität Münster	Germany
2	VICESSE	Vienna Centre for Societal Security	Austria
3	IKF	Institut für Konfliktforschung	Austria
4	GES	GESINE Intervention (Frauen helfen Frauen EN e.V.)	Germany
5	UU	Uppsala Universitet	Sweden
6	HFPA	Elliniki Psychiatrodikastiki Etaireia	Greece
7	AOU-PR	Azienda Ospedaliero-Universitaria di Parma	Italy
8	PLUS	Paris Lodron University Salzburg	Austria

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Abbreviations and acronyms

DV	Domestic Violence
TtT	Train-the-Trainer
ICC	Inter-Cultural Competence
WP	Work Package

Table of contents

1. Executive Summary

Deliverable D6.3 presents the **VIPROM Roadmap, a practical implementation manual designed to support the sustainable integration of domestic violence (DV) training into medical education and clinical practice across Europe**. Developed within the VIPROM project, the roadmap targets medical trainers, educators, clinicians, and healthcare leaders, equipping them with structured guidance, practical tools, and strategies to enhance the identification, prevention, and response to DV in healthcare settings. Healthcare professionals are often the first - and sometimes only - point of contact for victims, making targeted, evidence-based, and sustainable DV training essential. Its central aim is to further the sustainable implementation of domestic violence (DV) training in the medical sector.

The roadmap serves **as an accessible entry point to the VIPROM online training platform and associated pedagogical handbooks**, including the Train-the-Trainer (TtT) and Intercultural Competence (ICC) Handbooks, respectively. It is designed as an offline and online companion to the extensive VIPROM Training Platform, providing an **easy point of entry and quick reference guide to different sections of the platform as well as the many other project outputs**. It specifically targets healthcare professionals who are either encountering the VIPROM Training Platform for the first time, or healthcare professionals and trainers who are familiar with the Platform as a practical and teaching aid. Developed collaboratively by the VIPROM consortium over three years, the **roadmap consolidates expertise from clinical practice, research, pedagogy, and evaluation**.

Designed for usability and engagement, the roadmap **incorporates key visual and functional features**: a visually appealing layout to attract busy practitioners, color-coded chapters for intuitive navigation, QR codes and full hyperlinks linking to the online platform, clear module previews to guide learners, and practical resources such as med.doc/dent.doc cards and concise risk assessment tools. These features bridge theory and practice, facilitating immediate application in diverse healthcare settings.

2. Introduction

This deliverable (D6.3) presents the **VIPROM Roadmap for the sustainable implementation of domestic violence (DV) training in the medical sector**, developed within the EU-funded **VIPROM project** (*Victim Protection in Medicine - Exploiting practical knowledge of medical staff to enhance the multi-professional contact with victims of domestic violence*). The roadmap serves as a **practical implementation manual designed to support medical trainers, educators, clinicians, and healthcare leaders** in effectively integrating domestic violence (DV) curricula into medical education and its institutional practice across Europe.

Healthcare professionals are often the first, and sometimes the only, point of contact for individuals experiencing domestic violence. Due to their trusted role and close interaction with patients, they are uniquely positioned to identify signs of DV and initiate appropriate responses. However, indicators of DV are frequently subtle, multifaceted, and embedded in complex physical and psychological symptoms, while affected patients may be reluctant to disclose abuse due to fear, shame, or normalisation of violence. This underscores the urgent need for targeted, structured, and sustainable DV training within medical institutions.

The roadmap is conceived as an **easy entry-point** and **hands-on guide** that complements the VIPROM online training platform and several pedagogical handbooks (e.g. Train-the-Trainer Handbook, or the Handbook for Intercultural Competences) that the VIPROM consortium produced throughout the project's runtime. As an online as well as offline resource enriched with QR codes linking directly to online content, it bridges theory and practice by translating evidence-based knowledge, expert input, and project findings into easy and actionable guidance for everyday medical practice.

The VIPROM Roadmap is the result of a **joint and coordinated effort of all partners within the VIPROM consortium** over the project's three-year duration. Its development was grounded in interdisciplinary collaboration, combining clinical expertise, research insights, pedagogical know-how, and practical training experience from diverse medical and institutional contexts across Europe. Work on the roadmap was distributed among consortium partners and closely coordinated and streamlined by VICESSE through continuous exchange and editorial alignment with the external layout and production experts (Monica C. LoCascio, Ivonne Gracia Murillo), led in collaboration with the coordinating partners from University of Münster (UM). This collective approach ensured coherence across the development of this roadmap and enabled the integration of lessons learnt from curriculum development, pilot implementation, evaluation activities, and stakeholder needs assessment, **resulting in a practice-oriented and widely applicable implementation tool**.

2.1. Goals of the Roadmap

The primary goal of this roadmap is to support the sustainable implementation of domestic violence (DV) training within the medical sector by lowering the threshold for practitioners and trainers to access and utilise the VIPROM training platform and other project resources. To do so, the roadmap pursues three core objectives:

1. To **provide a structured overview** of the VIPROM online DV curricula for the medical sector
2. To **function as a practical reference guide** for trainers implementing individual training modules
3. To **share concrete recommendations**, best practices, and lessons learnt to support sustainable institutional uptake of DV training.

With regard to its content, the roadmap presents a structured synthesis of the online training platform, consolidating the following key topics:

- **Key concepts and core content** of the medical DV curricula developed in the VIPROM project
- **A quick navigation through the VIPROM training platform** and its individual modules (Module 1 – Module 10)
- **Didactical methods and pedagogical guidance** for trainers – "how to teach" the DV curricula
- **Practical insights** from pilot implementations and evaluation activities
- **Stakeholder-specific guidance** how to account for professional specificities in DV trainings
- **Intercultural competences** for how to design DV trainings that are sensitive to cultural aspects as well as intersectional categories such as age, gender, LGBTIQI+, disability, migration status, and socio-economic factors
- **Step-by-step "how-to" guidelines** for overcoming organisational and structural barriers when implementing DV training into healthcare and clinical settings
- **Strategies for long-term and sustainable implementation** beyond the project lifetime, including pathways towards national accreditation for DV programs in medical education
- And finally, an **Annex with useful resources for medical professionals** supporting them in everyday clinical practice and training design

Designed with a **strong focus on usability, the roadmap also includes practical tools such as templates, checklists, and handouts**, enabling immediate application in diverse healthcare settings. By promoting gender-sensitive and trauma-informed care, it supports both short-term improvements in clinical responses to domestic violence and long-term systemic change in how European healthcare systems address the intersection of violence, gender, and health.

Overall, this roadmap constitutes a **key sustainability instrument** of the VIPROM project, equipping medical institutions across EU Member States with the knowledge, tools, and strategies needed to embed domestic violence training as a permanent and integral component of medical education and practice.

2.2. Methodology and drafting process

The development of the VIRPROM Roadmap was led by VICESSE, which coordinated the overall process and ensured alignment with the project's strategic objectives. **As the lead, VICESSE guided the team in defining the roadmap's purpose as a practical implementation manual for domestic violence (DV) training** in the medical sector. This involved establishing a clear structure, integrating project deliverables, and prioritising usability, so that practitioners could readily access guidance, tools, and curricula developed throughout VIPROM. The lead role also included overseeing the consolidation of feedback, organising review cycles, and facilitating the presentation of the roadmap at key project milestones, including the dissemination event at the consortium meeting in Uppsala (17th and 18th September 2024).

The writing process was highly collaborative, drawing on the expertise of the entire consortium. Each partner contributed according to their individual strengths, whether in curriculum development, training design, evaluation, or intersectional competence. This consortium-wide engagement ensured that the roadmap reflected diverse perspectives and practical experiences, while maintaining coherence and consistency across its sections. Contributors worked on summarising and integrating content from the TtT Handbook, ICC Handbook, pilot evaluations, and other deliverables, thereby avoiding duplication and enhancing the value of the roadmap as a single, organised reference point for practitioners. Regular discussions addressed not only content, but also visual identity, format, and accessibility, ensuring the roadmap was suitable for both online and print dissemination.

The initial concept for the roadmap provided a clear framework that guided these collaborative efforts. Early drafts focused on discussing the general goals, visual design, content breakdown, and the organisation of supplementary materials such as handbooks, templates, and checklists. Contributors collectively determined the sections, including an introduction to the DV curricula, didactical guidance for trainers, lessons learned from pilot evaluations, practical implementation strategies, stakeholder-specific recommendations, and guidance for national accreditation. This interactive effort also enabled the project to leverage each partner's expertise and knowledge gained in earlier efforts in the VIPROM project:

VICESSE led the conceptualisation and coordination of the VIRPROM Roadmap. They drafted the introduction, outlining why domestic violence (DV) training for medical professionals is essential, and ensured that the roadmap remained aligned with the project's strategic objectives. Together with UU, VICESSE drew on results from the needs assessment (D2.1) and case studies (D2.2) to develop practical guidelines and tips for achieving organisational sustainability of DV training within medical institutions.

AOU-PR contributed their practical experience as medical practitioners to communicate the structure and functionality of the VIPROM training platform. They provided a clear overview of all training modules and guidance on how medical professionals can effectively use the platform to implement the curricula in their own institutions.

UM leveraged their extensive experience in DV training and their work on the Train-the-Trainer (TtT) Handbook to introduce didactical methods. Their contributions provide an entry point to the more extensive resources developed by VIRPOM, guiding trainers in applying best practices and methodologies within the medical sector.

IKF synthesised results from the evaluation of the curricula pilots they conducted (D5.1, D5.2, D5.3) to provide practical tips for implementation. Their work ensures that the roadmap is informed by empirical evidence and reflects lessons learned from real-world pilot testing.

HFA drew on their expertise regarding professional specificities to highlight the relevance of tailored training approaches. Their contribution emphasises the importance of adjusting content and methodology to the needs and contexts of different professional groups within the medical sector.

PLUS provided a low-threshold introduction to the dedicated ICC Handbook, underlining the significance of intercultural competence. Their work supports medical professionals in integrating cultural sensitivity and intersectional considerations into DV training.

VICESSE and **UU** collaborated to transform insights from the needs assessment and case studies into actionable guidelines. Their contributions help practitioners achieve sustainable implementation of DV training programs by addressing institutional and organisational challenges.

UM and **VICESSE** employed an interview format to present practical experiences, challenges, and lessons learned from the accreditation of the VIPROM curriculum in Germany. This approach provides an engaging and accessible way for medical practitioners in other countries to learn from the process and apply best practices. Moreover, it presents valuable information provided in further formats (see especially the Project **Blog on "Stepstones towards a successful accreditation of a VIPROM curriculum in medical education in Germany – a best practice example**) in a new way, avoiding redundancy and increasing the likelihood of acchieving impact among different readers.

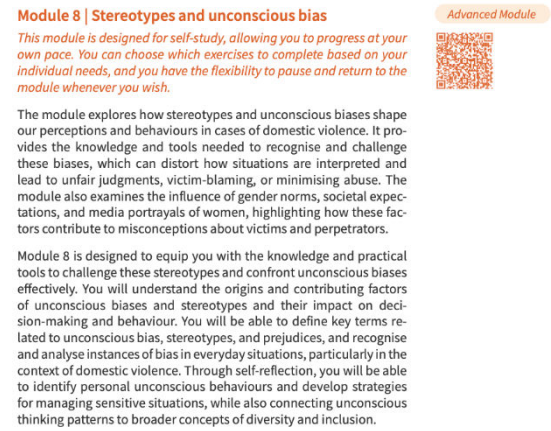
GESINE contributed their expertise in training and counseling to ensure that the roadmap is practical and usable as a working resource. Their focus was on making the roadmap immediately applicable for medical professionals in everyday practice.

By leveraging these individual contributions and through iterative review and consensus-building, the consortium ensured that the roadmap would serve as a practical, easy-to-use, and sustainable tool, providing centralized access to all VIPROM resources while facilitating adoption in medical institutions across EU member states.

2.3. Design Features

The **VIRPROM Roadmap incorporates several thoughtfully designed features to ensure it is both practical and engaging for busy medical practitioners.** Considerable effort was invested in making the roadmap visually appealing, recognising that an attractive and well-structured layout is an essential first step in encouraging practitioners to pick it up and explore its contents. To support intuitive navigation, the roadmap uses a clear color-coding system: each chapter is assigned a distinct colour that corresponds with the table of contents, allowing readers to quickly locate sections of interest and move seamlessly between topics. This design choice not only enhances usability but also provides visual cues that make the content easier to scan and remember.

Recognising the value of integrating offline and online resources, the roadmap is designed as a companion to the extensive VIPROM online platform. QR codes embedded throughout the document link directly to referenced sections of the training platform, enabling immediate access to additional materials and interactive content. For users who may prefer or require manual entry, the hyperlinks are also written out in full, ensuring accessibility even in settings where QR scanning may not be convenient. Module descriptions within the roadmap are carefully crafted to generate interest and provide learners with a clear overview of what to expect in each module, helping them to plan their learning and engage more effectively with the platform.



Module 8 | Stereotypes and unconscious bias

Advanced Module

This module is designed for self-study, allowing you to progress at your own pace. You can choose which exercises to complete based on your individual needs, and you have the flexibility to pause and return to the module whenever you wish.

The module explores how stereotypes and unconscious biases shape our perceptions and behaviours in cases of domestic violence. It provides the knowledge and tools needed to recognise and challenge these biases, which can distort how situations are interpreted and lead to unfair judgments, victim-blaming, or minimising abuse. The module also examines the influence of gender norms, societal expectations, and media portrayals of women, highlighting how these factors contribute to misconceptions about victims and perpetrators.

Module 8 is designed to equip you with the knowledge and practical tools to challenge these stereotypes and confront unconscious biases effectively. You will understand the origins and contributing factors of unconscious biases and stereotypes and their impact on decision-making and behaviour. You will be able to define key terms related to unconscious bias, stereotypes, and prejudices, and recognise and analyse instances of bias in everyday situations, particularly in the context of domestic violence. Through self-reflection, you will be able to identify personal unconscious behaviours and develop strategies for managing sensitive situations, while also connecting unconscious thinking patterns to broader concepts of diversity and inclusion.

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To further enhance practical applicability, the roadmap includes hands-on resources developed by VIPROM. These resources range from ready-to-use med.doc and dent.doc cards to concise risk assessment tools based on Campbell's danger assessment, providing practitioners with immediately actionable tools to support their work. **Together, these design features ensure that the roadmap is not only informative but also highly user-friendly,**

serving as a bridge between the comprehensive online training and day-to-day practice in medical settings. By combining visual appeal, intuitive navigation, clear module previews, direct links to online resources, and practical tools, the roadmap is crafted to facilitate both engagement and sustainable implementation of domestic violence training across the medical sector.

3. Outlook and future dissemination

The **VIPROM Roadmap provides a practical and sustainable resource to support the implementation of domestic violence (DV) training in the medical sector across Europe.** It consolidates key tools, curricula, and best practices into a single, accessible package designed for frontline medical practitioners, trainers, and institutional stakeholders. The roadmap is planned for wide dissemination through all project networks, as well as through the professional networks of individual partners and related partner projects, ensuring that it reaches both trainers and practitioners across different countries and sectors.

BRIEF RISK ASSESSMENT FOR CLINICIANS

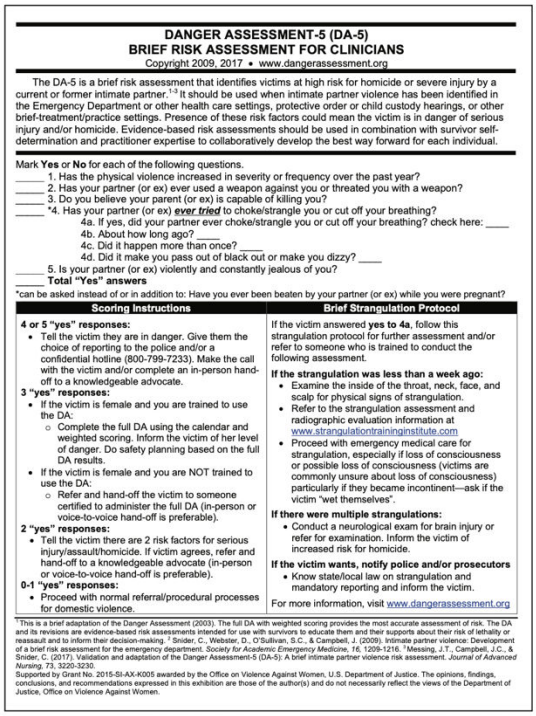
The DA-5 is a brief, evidence-based risk assessment designed to identify individuals at heightened risk of severe injury or homicide by a current or former intimate partner. It is a shortened adaptation of the validated Danger Assessment (Campbell, 2003); while the full Danger Assessment with weighted scoring provides the most precise risk estimation, the DA-5 offers a practical option for time-limited clinical and practice settings.

The DA-5 and related Danger Assessment tools are intended for use with survivors to support education about lethality and reassault risk and to inform safety-related decision-making. It is appropriate for use when intimate partner violence has been identified in emergency departments, other health care settings, protective order or child custody proceedings, and similar brief-intervention contexts. The presence of identified risk factors may indicate imminent danger of serious injury or homicide.

Please note, however, that risk assessment should be conducted in conjunction with survivor self-determination and professional clinical judgment to collaboratively determine appropriate next steps. Moreover, the use of the DA-5 requires specific training and expertise. If you are interested in aquiring such expertise, the Johns Hopkins School of Nursing offers online training on the use of the danger assessment, which you can find by following the QR-code in the margin.

Additional information on the validation and adaptation of the DA-5 is available in published literature, such as the study linked here: *https://pubmed.ncbi.nlm.nih.gov/28921610/*

→ *https://www.dangerassessment.org/TrainingOptions.aspx*



DANGER ASSESSMENT-5 (DA-5)
BRIEF RISK ASSESSMENT FOR CLINICIANS
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The DA-5 is a brief risk assessment that identifies victims at high risk for homicide or severe injury by a current or former intimate partner.[1-3] It should be used when intimate partner violence has been identified in the Emergency Department or other health care settings, protective order or child custody hearings, or other brief-treatment/practice settings. Presence of these risk factors could mean the victim is in danger of serious injury and/or homicide. Evidence-based risk assessments should be used in combination with survivor self-determination and practitioner expertise to collaboratively develop the best way forward for each individual.

Mark **Yes** or **No** for each of the following questions.
____ 1. Has the physical violence increased in severity or frequency over the past year?
____ 2. Has your partner (or ex) ever used a weapon against you or threated you with a weapon?
____ 3. Do you believe your parent (or ex) is capable of killing you?
____ *4. Has your partner (or ex) ***ever tried*** to choke/strangle you or cut off your breathing?
4a. If yes, did your partner ever choke/strangle you or cut off your breathing? check here: ____
4b. About how long ago? ____
4c. Did it happen more than once? ____
4d. Did it make you pass out of black out or make you dizzy? ____
____ 5. Is your partner (or ex) violently and constantly jealous of you?
____ **Total "Yes" answers**
*can be asked instead of or in addition to: Have you ever been beaten by your partner (or ex) while you were pregnant?

Scoring Instructions	Brief Strangulation Protocol
4 or 5 "yes" responses: • Tell the victim they are in danger. Give them the choice of reporting to the police and/or a confidential hotline (800-799-7233). Make the call with the victim and/or complete an in-person hand-off to a knowledgeable advocate. **3 "yes" responses:** • If the victim is female and you are trained to use the DA: ○ Complete the full DA using the calendar and weighted scoring. Inform the victim of her level of danger. Do safety planning based on the full DA results. • If the victim is female and you are NOT trained to use the DA: ○ Refer and hand-off the victim to someone certified to administer the full DA (in-person or voice-to-voice hand-off is preferable). **2 "yes" responses:** • Tell the victim there are 2 risk factors for serious injury/assault/homicide. If victim agrees, refer and hand-off to a knowledgeable advocate (in-person or voice-to-voice hand-off is preferable). **0-1 "yes" responses:** • Proceed with normal referral/procedural processes for domestic violence.	If the victim answered **yes to 4a**, follow this strangulation protocol for further assessment and/or refer to someone who is trained to conduct the following assessment. **If the strangulation was less than a week ago:** • Examine the inside of the throat, neck, face, and scalp for physical signs of strangulation. • Refer to the strangulation assessment and radiographic evaluation information at www.strangulationtraininginstitute.com • Proceed with emergency medical care for strangulation, especially if loss of consciousness or possible loss of consciousness (victims are commonly unsure about loss of consciousness) particularly if they became incontinent—ask if the victim "wet themselves". **If there were multiple strangulations:** • Conduct a neurological exam for brain injury or refer for examination. Inform the victim of increased risk for homicide. **If the victim wants, notify police and/or prosecutors** • Know state/local law on strangulation and mandatory reporting and inform the victim. For more information, visit www.dangerassessment.org

[1] This is a brief adaptation of the Danger Assessment (2003). The full DA with weighted scoring provides the most accurate assessment of risk. The DA and its revisions are evidence-based risk assessments intended for use with survivors to educate them and their supports about their risk of lethality or reassault and to inform their decision-making. [2] Snider, C., Webster, D., O'Sullivan, S.C., & Campbell, J. (2009). Intimate partner violence: Development of a brief risk assessment for the emergency department. *Society for Academic Emergency Medicine, 16*, 1208-1216. [3] Messing, J.T., Campbell, J.C., & Snider, C. (2017). Validation and adaptation of the Danger Assessment-5 (DA-5): A brief intimate partner violence risk assessment. *Journal of Advanced Nursing, 73*, 3220-3230.
Supported by Grant No. 2015-SI-AX-K005 awarded by the Office on Violence Against Women, U.S. Department of Justice. The opinions, findings, conclusions, and recommendations expressed in this exhibition are those of the author(s) and do not necessarily reflect the views of the Department of Justice, Office on Violence Against Women.

To further extend its accessibility, there are plans to **translate the roadmap into additional languages in the future.** Discussions are already underway with stakeholders in Austria regarding financing a German translation tailored to the Austrian context. This initiative would also include the production of the first run of physical copies, complementing the digital version and increasing availability for institutions and practitioners who prefer printed materials.

By combining structured guidance, practical tools, and illustrative examples, the roadmap aims to strengthen institutional capacity and support sustainable implementation of DV training in medical settings. Through its broad dissemination and planned multilingual availability, it contributes to closing training gaps, promoting professional

competence, and fostering a coordinated, effective response to domestic violence across Europe.

4. Annex

In the Annex you will find the complete **VIPROM Roadmap for Victim Protection in Medicine and Domestic Violence - Informed Medical Care** (see following pages). The linke to the print-version and online version can be also found on the project webpage and in the training repository.

viprom

Roadmap

Victim Protection
in Medicine

for Victim Protection *in* Medicine
and Domestic Violence - Informed Medical Care

Paul Herbinger, Michaela Scheriau (Ed.)

viprom
Victim Protection
in Medicine

Roadmap

for **Victim Protection** *in* **Medicine**
and **Domestic Violence - Informed Medical Care**

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Co-funded by
the European Union

Roadmap for Victim Protection in Medicine and DV-informed Medical Care

Paul Luca Herbinger, Michaela Scheriau (Ed.)

Date 2026

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VIPROM Consortium

The VIPROM consortium consists of nine partners from five European countries (Austria, Germany, Greece, Italy, Sweden).

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https://www.uni-muenster.de/en/

Universität Münster

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Vienna Centre for Societal Security Research GmbH (VICESSE) - Austria
https://www.victesse.eu/

VICE

SSE

The Institute of Conflict Research (IKF) - Austria
https://ikf.ac.at/

IKF Institut für Konflikt Forschung

GESINE Intervention (GES) - Germany-
https://www.gesine-intervention.de/

gesine intervention

Uppsala University (Nationellt centrum för kvinnofrid – NCK & Uppsala universitet) (UU) - Sweden
https://www.uu.se/centrum/nck/

UPPSALA UNIVERSITET

NCK
THE NATIONAL CENTRE FOR KNOWLEDGE ON MEN'S VIOLENCE AGAINST WOMEN

Hellenic Forensic Psychiatric Association (HFPA) – Greece
https://www.psychiatrodikastiki.gr/index.php/el/

ΕΛΛΗΝΙΚΗ ΨΥΧΙΑΤΡΟΔΙΚΑΣΤΙΚΗ ΕΤΑΙΡΕΙΑ
ΕΨΔΕ
2011
HELLENIC FORENSIC PSYCHIATRIC ASSOCIATION

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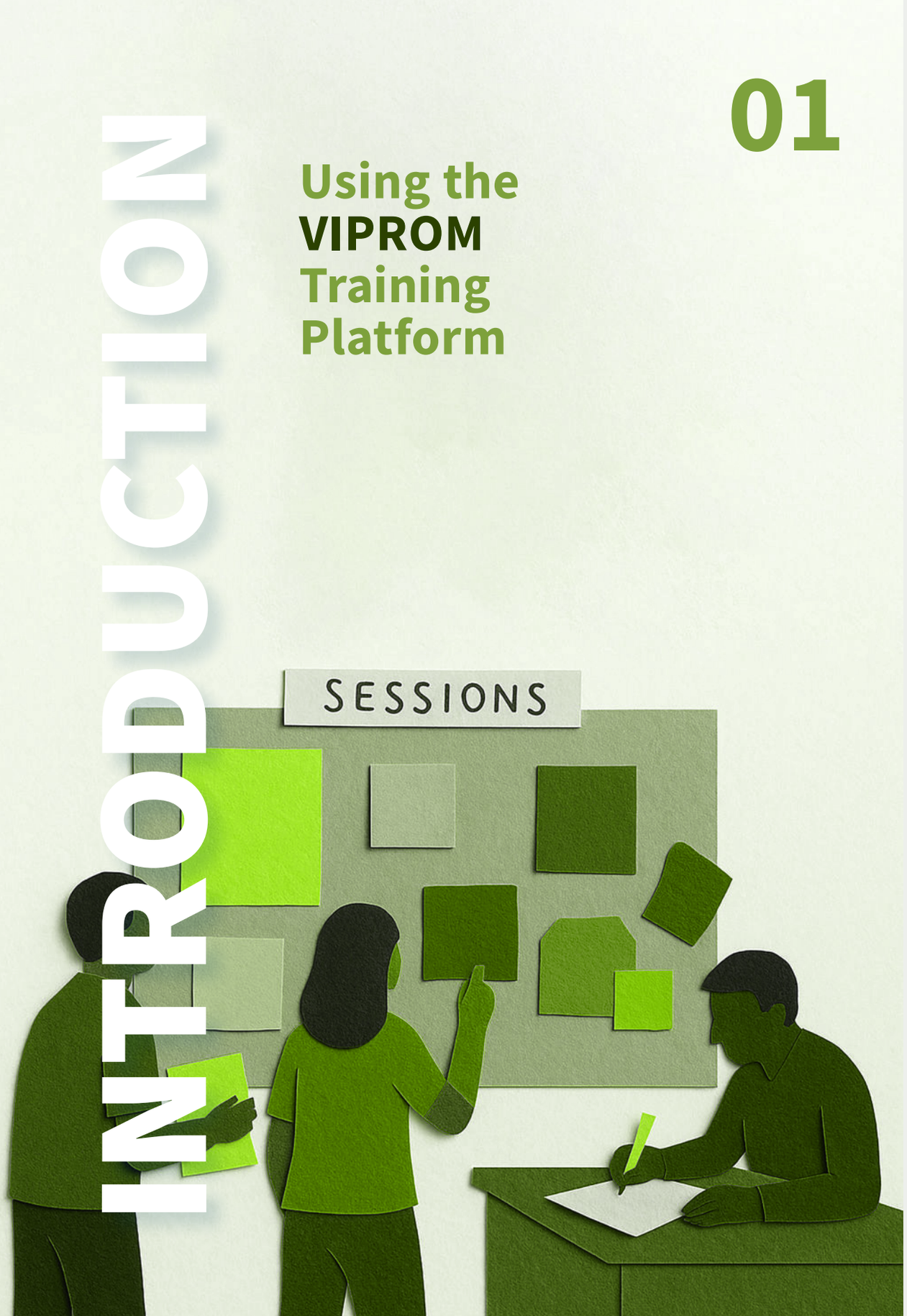
01 Using the VIPROM Training Platform



This booklet is your hands-on guide – a roadmap – to putting domestic violence training into practice in your medical institution. Designed with healthcare professionals in mind, it is intended as a practical companion to the extensive, freely available ***VIPROM online training platform***, developed to assist medical professionals in teaching domestic violence courses. The training platform supports by offering tailored training materials, sharing suitable teaching methods, and clear guidelines for integrating domestic violence curricula into medical institutions in a sustainable way.

→ *https://training.viprom-cerv.eu/en/*

Developed as part of the ***VIPROM project*** (*Victim Protection in Medicine – Exploiting practical knowledge of medical staff to enhance the multi-professional contact with victims of domestic violence*), funded by the European Union, this roadmap was designed specifically as an easy entry-point for trainers, who want to improve the response to domestic violence among their colleagues and in their medical institutions as a whole.

→ *https://viprom-cerv.eu/*

The roadmap has three main goals:

- to introduce and provide an overview of the VIPROM online curricula
- to serve as a practical reference guide for the different modules of the training platform
- and to share tips and real-life experiences to help you implement domestic violence training in your medical institution.

As an offline resource, this roadmap compliments the European online training platform and ***pedagogic training handbook*** by including QR codes throughout the different sections, directly linking readers to corresponding online content.

→ *https://viprom-cerv.eu/*

What's more, this roadmap is more than just a guide. It offers clear, step-by-step recommendations for incorporating gender-sensitive and trauma-informed care into daily medical practice. Drawing on research findings, expert input, and real-world examples collected throughout the VIPROM project, it provides practical advice on how healthcare professionals can identify signs of domestic violence, respond appropriately across medical specialties, and help create lasting institutional change. Aimed at clinicians, medical educators, and healthcare leaders, it offers a structured framework to support both immediate action and long-term transformation in how healthcare systems address the complex intersection of gender, violence, and health.

Why domestic violence training of medical professionals is important:

Healthcare practitioners are often the first (and sometimes the only) professionals to come into contact with individuals experiencing domestic violence, placing them in a key position to recognize signs of such abuse. Their close, personal contact with victims of violence as medical patients, combined with their trusted role, makes them essential in identifying abuse early and offering support. This is why **Healthcare professionals have a crucial role in recognising and responding to domestic violence**.

At the same time, it is not always clear whether patients are victims of domestic violence (DV), as many indicators are subtle and not easy to recognise. For example, patients may show symptoms like depression, anxiety, post-traumatic stress disorder (PTSD), eating disorders, or even schizophrenia, which might be associated with past experiences of domestic or interpersonal violence.

Patients may not talk about abuse because they feel ashamed, afraid, or believe that it's normal.

This is why it is crucial for healthcare providers to receive training on how to identify potential victims of domestic violence, recognise these challenges and approach each case with attention, respect and understanding.

02

WHAT IS the VIPROM Training Platform and how can you use it?

The *VIPROM training platform* is a free, web-based resource offering educational materials and pedagogical tools tailored to healthcare professionals. It is part of a wider *European Training Platform* on Domestic Violence that we have been progressively developing across three research projects (IMPRODOVA, IMPROVE, and VIPROM), funded by the European Commission since 2018. While the European Training Platform also includes training resources tailored to important stakeholders such as police, social-, and legal sectors, the **VIPROM platform is entirely dedicated to medical practitioners**.

→ *https://training.improdova.eu/en/training-modules-for-the-health-sector/*

→ *You can find additional training materials for other professions (Police, Social Sector, Legal Sector) here: https://training.improdova.eu/en/*

The goal of this platform is to strengthen the ability medical professionals to identify signs of abuse and confidently integrate victim protection into your daily clinical practice.

The content on the platform follows a modular structure consisting of ten interconnected modules (see chapter 3 for an overview). To help trainers, we have also included a dedicated section stratified by teaching tools such as case studies and videos. On the platform you will find downloadable, tailored factsheets summarising the key content of most modules, along with knowledge assessments to gauge user understanding. We have also included numerous reflective tasks suitable for classroom use, homework, or group activities. Interactive components such as case scenarios and practical exercises give learners hands-on experience and help them apply concepts in real-world contexts. Additionally, comprehensive training materials are provided, including training videos, supplementary readings, and other resources designed to support trainers. This ensures trainers have everything they need to deliver effective and engaging sessions.

The platform is a living resource and will be updated regularly. All materials are evidence-based, referenced, and reviewed by domestic violence experts from the VIPROM partnership. A strong emphasis is placed on stakeholder-specific content tailored to Gynaecology/Obstetrics, Surgery/Emergency Care, Paediatrics, and Dentistry.

FOR WHOM IS IT INTENDED?

If you are a trainer and plan to conduct courses on DV in the health care sector, **this roadmap and the VIPROM training platform were developed for you**! It has been specifically designed as a resource for **trainers** who want to conduct trainings on domestic violence in their medical institutions. It offers comprehensive materials and content on domestic violence, providing the knowledge and skills needed to teach a range of stakeholder groups, including nurses, midwives, medical doctors, dentists, and medical and dental students.

Links to some of the other languages available here:

→ **English – tailored to the International context:** *https://training.improdova.eu/en/training-modules-for-the-health-sector/*

→ **Portugese:** *https://training.improdova.eu/pt/training-modules-for-the-health-sector-pt/*

→ **Hungarian:** *https://training.improdova.eu/hu/training-modules-for-the-health-sector-hu/*

→ **Finnish:** *https://training.improdova.eu/fi/training-modules-for-the-health-sector-fi/*

→ **Spanish:** *https://training.improdova.eu/es/training-modules-for-the-health-sector-es/*

→ **French:** *https://training.improdova.eu/fr/training-modules-for-the-health-sector-fr/*

→ **Greek:** *https://training.improdova.eu/el/training-modules-for-the-health-sector-el/*

→ **Swedish:** *https://training.improdova.eu/sv/training-modules-for-the-health-sector-sv/*

→ **German – tailored to the Austrian context:** *https://training.improdova.eu/de-at/trainingsmodule-fur-den-gesundheitssektor-at/*

→ **Italian:** *https://training.improdova.eu/it/training-modules-for-the-health-sector-it/*

→ **German – tailored to the German context:** *https://training.improdova.eu/de/trainingsmodule-fur-den-gesundheitssektor/*

The roadmap provides an overview of all resources and tips that we have developed to help trainers plan and deliver courses on DV in the medical sector, including:

- complete curricula of teaching material on a huge array of aspects relevant to responding to DV in healthcare *(chapter 3)*
- strategic considerations when trying to establish DV-trainings in your institution *(chapter 8)*
- links to our dedicated handbook on becoming a DV-trainer *(chapter 4)*
- as well as to our handbook on intercultural competences *(chapter 7)*

Our materials are also designed to be useful for both, mixed groups of health personnel or single homogeneous groups, such as medical doctors and nurses in the emergency room or gynaecology, midwives, radiologists, dentists, general practitioners, or line managers. Psychologists are also included among health care personnel.

The platform related to the medical sector is available in 11 different languages (Portuguese Spanish, Finnish, French, Hungarian, *Italian*, *Greek*, *Swedish*, *German-tailored to the Austrian context*, German and *English*, and is structured in ten modules, each focused on a different aspect of responding to a case of DV.

MODULES

VIPROM

03

A quick reference guide and link to all topics covered

(and why they are important)

The VIPROM Training Platform is divided into 10 modules, each focusing on a core topic in relation to domestic violence as a healthcare professional.

Modules 1 through 4 provide **foundational information** and can be considered the core of a VIPROM training curricula. **Module 1** introduces medical professionals to the forms and dynamics of domestic violence, while **Modules 2 and 3,** respectively, cover indicators for domestic violence and how to communicate around cases involving victims of DV. Finally, **Module 4** presents the crucial topic of medical evaluation and securing of evidence. These four modules should be seen as a mandatory part of an ideal VIPROM training course.

Modules 5 through 7 can be considered as **more advanced content**, providing specialised content building on the foundational modules. These include **Module 5** dealing with risk assessment and safety planning, **Module 6** presenting international standards and legal frameworks in Europe, and **Module 7** sharing the principles of inter-organizational cooperation in cases of domestic violence.

The platform also includes three modules that are designed for self-study: **Module 8** focuses on stereotypes and unconscious bias in DV, while **Module 9** deals with the self-care for health sector practitioners dealing with DV and **Module 10** is a self-study module for line-managers handling cases of domestic violence.

On the next pages, we have included brief descriptions of the topics covered by each module, why each module is important for practitioners, and what you will have learned after completing each one.

Module 1
Dynamics and forms of domestic violence

Module 2
Indicators of domestic violence

Module 3
Communication in cases of domestic violence

Module 4
Medical evaluation and securing of evidence

Module 5
Risk assessment and safety planning

Module 6
International standards and legal frameworks in Europe

Module 7
Principles of inter-organisational cooperation in cases of domestic violence

Module 8
Stereotypes and unconscious bias

Module 9
Self Care

Module 10
Line managers in cases of domestic violence

Mandatory Module

Module 1 | Dynamics and forms of domestic violence

This foundational module offers a broad overview of the different forms domestic violence can take, while also providing the theoretical framework needed to understand its complexity. It explores how DV affects various vulnerable groups such as people with disabilities, older adults, and LGBTQI+ (Lesbian, Gay, Bisexual, Transgender, Intersex, Queer, as well as other identities not specifically named in the acronym) individuals, highlighting the unique challenges and risks these populations may face.

Module 1 sets the stage for the rest of the training by helping you develop a deeper, more nuanced understanding of domestic violence. Through this lens, you'll begin to build the skills necessary to recognise victims, respond appropriately, and tailor your support to each individual's circumstances.

By the end of this module, trainers will have the tools to provide trainees with a clearer understanding of the dynamics of DV and the various forms of violence you may encounter.

Mandatory Module

Module 2 | Indicators of domestic violence

This module takes an in-depth look at how to identify victims of DV within the healthcare system, the challenges involved, and the effects DV has on those affected. It describes both the physical and psychological consequences of DV, including its impact on children. The module also addresses marginalised victim as well as frequently overlooked groups, such as men or the elderly as victims of DV.

Module 2 plays a crucial role in equipping practitioners with practical tools to identify and support victims. Healthcare professionals are provided with specialised indicators to help recognise and support victims, including dedicated guidance for medical fields where signs of physical domestic violence can be seen most frequently such as *gynaecology/obstetrics*, emergency and surgical care, paediatrics, *and dentistry*.

By the end of this module, trainers will have all the necessary training materials to teach healthcare professionals how to recognise behavioural, physical and emotional cues, understand the effects of witnessing violence (including its effects on children) and identify domestic violence indicators across various medical fields.

→ *https://training.improdova.eu/en/training-modules-for-the-health-sector/module-2-indicators-for-domestic-violence/#Medicine:-Indicators-for-gynaecology/obstetrics,-surgery-&-paediatrics-*

→ *https://training.improdova.eu/en/training-modules-for-the-health-sector/module-2-indicators-for-domestic-violence/#Dentistry:-Further-information-*

Mandatory Module

Module 3 | Communication in cases of domestic violence

This module explores the vital topic of communication in situations where domestic violence is suspected, providing medical professionals with guidance on how to talk with victims. After outlining common barriers to disclosure, the module introduces key communication principles such as open-ended questioning, normalising language, direct questions, trauma-informed and patient-centred care, and gender-sensitive communication.

At its core, the module provides practical examples of screening questions, recommended and less recommended phrases, and effective responses to disclosures. It also highlights guidelines from the Irish College of General Practitioners which emphasises the importance of making referrals to specialised services, even when patients may not perceive an immediate need. Special attention is given to communication within specific clinical contexts such as gynaecology/obstetrics, surgical emergency room, paediatrics and dentistry where professionals may encounter unique challenges when working with patients affected by DV.

By the end of this module, trainers will have the tools they need in trainings to help trainees feel more confident about asking questions about domestic violence and navigating difficult conversations. The aim is to ensure that victims receive the appropriate care and referrals. Trainees will recognise common barriers to disclosure, develop patient-centred communication techniques that support the identification of domestic violence, and understand how to apply trauma-informed approaches after a disclosure.

Mandatory Module

Module 4 | Medical evaluation and securing of evidence

This module provides detailed guidance on how to properly document cases of confirmed or suspected domestic violence in medical records. It covers how to conduct clinical examinations with care and respect for the patient's dignity, ensuring that both medical and emotional needs are addressed.

A key focus of the module is on ethical considerations, helping practitioners understand their responsibilities while maintaining a patient-centred approach. Importantly, the module also explains methods for preserving medical and forensic evidence in a way that ensures it can be used reliably in any future legal proceedings. This includes practical steps for documentation, handling physical findings, and securing materials so they remain admissible in court if needed.

The goal is to equip trainers with the resources to provide healthcare professionals in trainings with the knowledge on how to document DV injuries in a way that is suitable for legal proceedings (including relevant legal considerations) and provide pointers on the sensitivity required in this work.

Advanced Module

Module 5 | Risk assessment and Safety Planning

Module 5 provides an overview of general and high-risk factors for domestic violence (DV), helping healthcare professionals recognise and prevent DV among patients. It highlights key sex and gender considerations relevant to risk assessment and safety planning, and includes specific guidance for those working in gynaecology/obstetrics, emergency care, paediatrics, and dentistry.

While healthcare professionals are not responsible for conducting full risk assessments or safety plans, they should understand the process to offer accurate information and support. The module covers risk assessment, safety planning, DV risk factors, sex and gender aspects, and effective communication of safety measures. This module equips trainers with the tools and insights needed to teach on how to conduct sensitive, accurate risk assessments and to collaborate effectively with victims in creating strategies that prioritize their safety and well-being.

This module will enable trainers to teach trainees how to conduct comprehensive risk assessments and recognise the role of sex and gender dynamics in risk evaluation., and develop effective safety-planning strategies to support victims. Materials are designed to create awareness of the different types and levels of risk encountered when working with patients exposed to violence.

Advanced Module

Module 6 | International standards and legal frameworks in Europe

This Module provides an in-depth exploration of international standards for combating combat domestic violence, with a special emphasis on important Frameworks like the Istanbul Convention. It carefully explains how these global standards guide national policies and protections.

The module also offers an overview of domestic legal frameworks for the countries currently included on the European training platform, highlighting how each incorporates international commitments into their own laws. Through this, users gain a clear understanding of the broader legal landscape surrounding domestic violence.

Ultimately, the aim is to equip professionals after training with a thorough grasp of both international and national legal tools, enabling them to navigate and apply these frameworks effectively in their work to protect and support survivors.

Advanced Module

Module 7 | Principles of inter-organisational cooperation in cases of domestic violence

Module 7 explains how key stakeholders including police, legal authorities, social services, and the medical sector, collaborate in domestic violence cases, outlining both the challenges and the benefits of effective cooperation. It highlights the specific role of the health sector and provides an overview of the essential steps involved in criminal procedures related to domestic violence.

Because these procedures differ across countries, the module includes examples from Austria, Germany, Greece, Hungary, Italy, Finland, France, Portugal, Spain, and Sweden. It addresses inter-agency cooperation, the health sector's responsibilities, criminal procedures in DV cases, and national variations in these procedures.

Learners will understand after being trained in the content of Module 7 how frontline responders collaborate, with particular attention to the medical sector. They will recognise why cooperation within multi-professional teams is essential for effectively addressing domestic violence and managing related challenges. They will also acquire knowledge of inter-agency processes and criminal procedures relevant to domestic violence cases.

Advanced Module

Module 8 | Stereotypes and unconscious bias

This module is designed for self-study, allowing you to progress at your own pace. You can choose which exercises to complete based on your individual needs, and you have the flexibility to pause and return to the module whenever you wish.

The module explores how stereotypes and unconscious biases shape our perceptions and behaviours in cases of domestic violence. It provides the knowledge and tools needed to recognise and challenge these biases, which can distort how situations are interpreted and lead to unfair judgments, victim-blaming, or minimising abuse. The module also examines the influence of gender norms, societal expectations, and media portrayals of women, highlighting how these factors contribute to misconceptions about victims and perpetrators.

Module 8 is designed to equip you with the knowledge and practical tools to challenge these stereotypes and confront unconscious biases effectively. You will understand the origins and contributing factors of unconscious biases and stereotypes and their impact on decision-making and behaviour. You will be able to define key terms related to unconscious bias, stereotypes, and prejudices, and recognise and analyse instances of bias in everyday situations, particularly in the context of domestic violence. Through self-reflection, you will be able to identify personal unconscious behaviours and develop strategies for managing sensitive situations, while also connecting unconscious thinking patterns to broader concepts of diversity and inclusion.

Advanced Module

Module 9 | Self Care

Like with module 8, you can work through this module at your own pace, choosing the exercises that best fit your needs, and you can pause and resume the module whenever you like.

Module 9 introduces the importance of self-care for professionals working with victims of domestic violence. It highlights the mental and emotional demands of this work, including the risks of stress, burnout, and secondary traumatisation, and equips practitioners with strategies to protect their wellbeing. The module covers understanding stress, recognising early warning signs, developing effective self-care practices, maintaining interpersonal and organisational boundaries, and building resilience in challenging situations. Importantly, the module also integrates key aspects of self-care in other relevant modules.

Through this module, you will understand the importance of self-care and develop practical skills to implement effective self-care routines and strategies. You will recognise why frontline responders working with domestic violence victims are at high risk of burnout and vicarious trauma, become familiar with relevant risk factors, and learn to identify the signs and symptoms of stress, burnout, and secondary traumatisation.

Advanced Module

Module 10 | Line managers in cases of domestic violence

This module is for self-study and is explicitly designed for line managers, who oversee professionals involved in domestic violence cases.

Module 10 introduces line managers handling domestic violence cases to the principles of multi-agency cooperation and risk assessment. It emphasises how institutions collaborate, share information, and coordinate interventions to enhance victim safety. The module provides an overview of risk assessment methods, including the Risk Assessment Integration Module (RAIMO), and explores practical tools and organisational challenges in inter-agency settings. An excursus on domestic violence during disasters highlights how crises can increase risks and disrupt support structures.

Through European good practice examples, the module supports line managers in promoting structured, safety-oriented, and gender-sensitive cooperation. Designed for self-study, it equips managers with the knowledge needed to guide teams effectively and strengthen cross-institutional responses. The goals of this module are to help you understand the foundations and challenges of interagency cooperation, especially the unique difficulties that emerge during crises, as well as to deepen your knowledge of the factors involved in effective risk assessment.

By completing this module you will understand the principles and challenges of inter-agency collaboration, particularly during crises, and recognise key factors in assessing domestic violence risk and victim vulnerability. You will be able to promote victim safety through informed consent, confidentiality, and timely information sharing, while appreciating the role of coordinated multi-agency efforts in managing risk and supporting survivors.

04 the VIPROM Training Platform: Didactics

The **VIPROM Training Platform** is a specialised educational tool designed to enable trainers to provide healthcare professionals with the skills necessary to recognise, respond to, and support victims of domestic violence.

So, what do you need to take into consideration if you're thinking about teaching the VIPROM curriculum?

A key element of the platform is that it is coupled with a **Train-the-Trainer (TtT)** programme. The goal is to support you as trainer providing domestic violence trainings using tools and materials from the European training platform. You as trainer will, in turn, train others within the healthcare system. The **TtT Handbook** serves as the principal resource and offers guidance, strategies, and practical tools for effective teaching.

WHAT DO I NEED TO KNOW TO TEACH THE VIPROM CURRICULA SUCCESSFULLY?

Before teaching the VIPROM curricula, trainers should familiarise themselves with the following key components:

Aims of their VIPROM Training

The primary aim of the VIPROM curricula is to support you a trainer to provide healthcare professionals with the knowledge and practical skills required to identify and support victims of domestic violence.

Key learning objectives may include (depending on the chosen target group):

- Identifying signs of domestic violence in patients
- Communicating with patients with empathy, trauma-sensitivity and professionalism
- Documenting injuries being suitable for legal proceedings
- Understanding the importance of maintaining confidentiality and trust
- Encouraging interdisciplinary collaboration to provide holistic care
- Supporting healthcare professionals to make appropriate referrals to legal and social services

Methods Used in VIPROM Training

The VIPROM curricula employ a combination of **theoretical and practical teaching methods**, ensuring that the training is both informative and applicable. As trainer you should have knowledge in:

- **Interactive Teaching**: Engaging your trainees through group discussions, role plays, case studies, and reflective exercises
- **Competency-Based Learning**: Focusing not just on knowledge acquisition but on the ability to demonstrate the necessary competencies in real-world situations
- **Multidisciplinary Approach**: Highlighting the importance of collaboration between healthcare providers and other professionals, such as social workers, police, and counsellors

Core Concepts in the VIPROM Training

The VIPROM curricula are grounded in several core concepts, including:

- **Victim-Centred Care**: Treating victims with dignity and compassion, and empowering them to make informed decisions
- **Confidentiality**: Handling personal and sensitive information securely and respectfully
- **Legal and Ethical Standards**: Understanding the legal responsibilities of healthcare providers when addressing domestic violence
- **Psychosocial Impact of Violence**: Recognising the emotional, psychological, and social effects of violence on individuals and families

INTRODUCING THE TTT HANDBOOK AND ITS TARGET GROUP

→ *https://viprom-cerv.eu/training/training-courses/*

The *TtT Handbook* is available through the VIPROM webpage in 5 different languages. The handbook provides you with a more in-depth look at the process of teaching the VIPROM curricula, offering insights into the **core didactic methods**, practical tips for successful delivery, and guidance on how to use the **TtT Handbook** to achieve the best possible outcomes. **The focus is less on what to teach, but rather on how to teach!**

Download the *VIPROM Training Handbooks*

→ *https://viprom-cerv.eu/training/training-materials/*

The handbook includes:

Step-by-Step Teaching Guidelines

- Instructions on structuring and delivering trainings with high quality
- Tips on managing group dynamics and encouraging active participation
- Strategies for creating a safe, inclusive learning environment—particularly important when exploring sensitive subjects such as domestic violence

Trainer Competencies

- The handbook outlines the key competencies required for you as trainer, including facilitation skills, empathy, adaptability, and reflective practice
- You as trainer should also reflect on how your own experiences and biases that might influence your approach, as this will help you to develop a more objective view of the situation.

Practical Tools

- Templates, checklists, and evaluation tools to help trainers assess learning progress and training effectiveness
- Quizzes, feedback forms, and other instruments to monitor knowledge retention and identify areas for further development

CORE DIDACTIC METHODS FOR TEACHING THE VIPROM CURRICULA

To deliver the VIPROM curricula effectively, you as trainer should employ a variety of didactic approaches that suit adult learners in healthcare settings. Key methods include:

Interactive Learning

- Adult learners benefit from active engagement. Trainers should include **role plays**, **case studies**, and **group discussions** that reflect real-life situations.
- For example, simulate a consultation with a victim of domestic violence to help learners practise empathetic communication and referral skills.

Competency-Based Training

- The training emphasises the application of knowledge. You should support medical stakeholders in acquiring and demonstrating practical skills, such as conducting screenings or navigating legal procedures.
- Feedback should be clear, constructive, and focused on professional development.

Blended Learning (Face-to-Face and Online)

- The VIPROM platform enables blended learning, combining in-person sessions with digital resources like videos, quizzes, and reading materials.
- You, as trainer, should integrate online content with interactive sessions for a comprehensive learning experience. For instance, your trainees might complete an online module on the psychological effects of violence as part of a home assignment before attending a face-to-face workshop *(e.g. Module 9)*.

→ *https://training.improdova.eu/en/training-modules-for-the-health-sector/module-9-self-care/*

Reflective Practice

- Encouraging your trainees to reflect on their beliefs, assumptions, and responses is crucial for growth and professional awareness.
- You should embed reflection exercises, such as journaling or guided group reflections, throughout the training.

Continuous Assessment and Feedback

- Regular assessment could be used to provide you as trainer with the opportunity to monitor progress and identify learning needs. Methods may include formative quizzes, peer review, and group work.
- Feedback should aim to build trainees' confidence while highlighting specific areas for improvement.

KEY POINTS TO TAKE AWAY

By applying the methods outlined in the **TtT Handbook**, you as trainer can effectively deliver the VIPROM curricula to empower healthcare professionals to provide sensitive, competent, and comprehensive support to victims of domestic violence. The training is more than sharing information—it is about building empathy, confidence, and the ability to act. Through reflective practice and ongoing assessment, trainers can nurture a healthcare workforce ready to respond with compassion and professionalism.

FURTHER READING AND RESOURCES

If you are interested to deepen your understanding of the VIPROM Training Platform and enhance your teaching practice in addition to the TtT handbook, the following resources are highly *recommended, which can also be found under the repository of* ***trainings.***

→ *https://training.improdova.eu/en/training-modules-for-the-health-sector/training-materials-for-the-health-sector/repository-of-trainings-on-domestic-violence/*

VIPROM Deliverable 3.2: EU and National TtT Curricula Design:

This key document outlines the development and structure of the Train-the-Trainer curricula, tailored to various frontline responders. It offers valuable insights into how the training has been adapted across different national contexts and professional groups:

→ *http://viprom-cerv.eu/wp-content/uploads/2024/12/VIPROM_Deliverable_D3.2_WebsiteVersion.pdf*

VIPROM Med.DocCard and Dent.DocCard Cards

By following the QR code you can access our ***Med.Doc and Dent.Doc cards***. These cards were designed to be downloaded, printed out and laminated before use (Note: be sure to print at a size of 99 x 204 mm, so that 1 cm on the card corresponds to 1 cm in the actual size.). The Med.DocCard and Dent.DocCard cards respectively present the most important aspects of medical and dental intervention in cases of domestic violence and summarise the court-proof documentation of injuries. They were designed as a quick reference for medical practitioners who have already gone through DV training, as reminder of the most important steps to perform and also to support documenting the size of injuries (e.g. by using the scale on this card). You can also find both of these cards printed to correct scale in the annex of useful resources in this roadmap.

→ *https://viprom-cerv.eu/training/training-materials/*

Med.DocCard *Dent.DocCard*

→ *https://training.improdova.eu/wp-content/uploads/2025/08/IMPROVE_pedagogic_handbook_Domestic_Violence_trainers_EN.pdf*

The IMPROVE 'Pedagogical Handbook for Domestic Violence Trainers'

This ***handbook*** from the EU Project IMPROVE explains across seven chapters how the information, training materials and tools provided by the IMPROVE training platform on domestic violence can be used by trainers. Its focus is on intersectoral training of first-Line professionals in the police, justice, medical and social sectors.

→ *https://training.improdova.eu/en/training-modules-for-the-health-sector/training-materials-for-the-health-sector/repository-of-trainings-on-domestic-violence/*

Repository of trainings on domestic violence

Additional training material such as collection of training concepts, slides and additional material for trainers can be found ***here*** with some general suggestions for different training formats when you use the European training platform on domestic violence as a source when preparing your trainings.

→ *See our Intercultural Competence Handbook: https://eplus.uni-salzburg.at/obvusboa/download/pdf/11689053*

General Didactic Tips for Implementation of DV-Trainings:

1. Understand cultural and linguistic diversity: training should be culturally sensitive and linguistically accessible, considering the diverse backgrounds of patients and providers.
2. Recognise power dynamics: DV often involves power imbalances, and training should address how these dynamics impact healthcare interactions.
3. Address systemic barriers: training should address barriers within healthcare systems, such as lack of privacy or fear of involving law enforcement.
4. Emphasise empowerment: focus on empowering victims and providing them with resources and support.
5. Cross training: encourage collaboration and cross-training among different disciplines to improve coordination and communication.
6. Address mental health: recognise the link between DV and mental health and provide training on how to address the mental health needs of affected patients.
7. Map your local resources: create a comprehensive resource directory for DV victims, including information on support services and legal options.
8. Promote confidentiality: educate healthcare providers about the importance of confidentiality and the potential impact of breaches on victims.
9. Utilise diverse training methods: employ a variety of training methods, such as case studies, simulations, and interactive workshops, to cater for different learning styles.

Want to understand the realities on the ground? On the VIPROM website, you'll get a closer look at the stakeholder specificities. These insights offer a valuable lens on stakeholder needs, and ***the link to the full needs assessment will take you even deeper into these details***.

→ *https://viprom-cerv.eu/wp-content/uploads/2024/05/VIPROM_D2.1_WebsiteVersion_V2_upload.pdf*

PRACTICAL TIPS

05 VIPROM Curricula: Practical Tips

→ *https://training.viprom-cerv.eu/en/*

Now, after you've familiarised yourself with the *VIPROM training platform*, set the main content of your training, designed a didactic approach you feel comfortable with and picked the *training material* – **what could possibly go wrong?**

The very short (and reassuring) answer: Actually, **not that much**!

The longer answer: The *evaluation of the pilot-trainings* held in the VIPROM-project shows them to be highly successful among participants and effective in communicating the desired content and in training important skills. This **positive assessment** holds irrespective of location, professional background of the target group and organisational differences between trainings.

Nevertheless, there are a few aspects that can bring **challenges** to your training and that should be considered beforehand. Unsurprisingly many of them are related to organisational aspects. Let's have a look at some of them!

→ *See also our Train-the-Trainer Handbook: https://viprom-cerv.eu/wp-content/uploads/2024/07/VIPROM_TTT-Handbook-English.pdf*

→ *https://viprom-cerv.eu/wp-content/uploads/2025/11/VIPROM_Deliverable_5.3_WebsiteVersion.pdf*

ORGANISING YOUR TRAININGS

Recruiting participants

Even though there is interest in the topic it might in some cases be difficult to find enough participants for a planned training. The main reasons for this are severe time-constraints among medical professionals. These constraints might also lead to situations where you "preach to the converted", i.e. highly interested and motivated participants, who are willing to sacrifice a free weekend or several evenings. While there is no silver bullet to rectify systemic difficulties, a number of strategies might be helpful, depending on circumstances.

Use established organisational structures

If possible, use **established structures** to organise and communicate trainings to reduce the burden of organisational work. In different locations opportunities can vary broadly – it could e.g. be a framework for regular trainings at your clinic, an organisational unit dealing with gender, equality and diversity, a professional association in your field or a specialised network, among many others. This does not only save you some time and effort, it also guarantees that the trainings are formally accepted as part of professional development.

CONDUCTING YOUR TRAININGS

Focus on what matters most

While the VIPROM-training curricula is tailored to longer (e.g. 1.5 days) trainings, you can always design shorter trainings using only part of the materials. Feel free to pick and choose! It is not feasibly for one training to cover all possible aspects.[1] Sometimes specific questions (e.g. documentation) are especially pressing in a certain context. Don´t hesitate to devote more time to those and to go beyond the VIPROM-material whenever necessary.

Self-Study

→ *VIPROM Webinar Series: https://viprom-cerv.eu/european-webinar-series/*

It might be possible to cover some topics through **self-study** or in the form of a pre-recorded lecture rather than during face-to-face training. This might have the benefit of freeing up time for the interactive, hands-on parts of the VIPROM-training, which were deemed most helpful by participants. As a useful resource along these lines, the VIPROM project conducted a series of online Webinars centred on our Modules which are readily available on the European YouTube Platform on DV (follow the *QR code* to see the VIPROM Webinar Series). But keep in mind how valuable medical professionals' time is. Don't let the self-study part become overwhelming and clearly frame it as part of the training (for more tips see the QR codes for "**Flipped Classroom**") rather than 'only' preparatory work.

Flipped Classroom Links:

→ *https://epale.ec.europa.eu/en/blog/flipped-learning-model-adult-education*

→ *https://www.tandfonline.com/doi/full/10.3109/0142159X.2014.923821*

Timing

Timing is essential, but tricky. There is no "right" way when it comes to deciding whether to have one or even two long training day(s) (possibly on the weekend) or several short ones (e.g. one evening a week for four weeks). If possible, try both.

Setting the Stage

Pay attention to the training location and setting. How participants are seated, whether communication between them flows freely and what the area for breaks looks like, might preconfigure the training atmosphere to quite a large extent. Of course, you will not always be able to choose a perfect room, but often taking the time to move a few tables and chairs in the beginning will be worth the effort later on.

1 Be prepared for participants *always* complaining about topics that were 'missing' or did not get enough attention. Don't take this as criticism, but as a sign of high interest and engagement.

Overcoming stereotypes

One well-known challenge concerns the **recruitment of men** as participants based on the incorrect framing of DV as a "women's issue". While you will not be able to single-handedly reverse deeply ingrained stereotypes, it might be helpful to frame your training differently, e.g. using non-stereotypical language and counter-intuitive imagery in your announcement.

How to keep things engaging

Once your training has started, your participants are eager to learn and you involved them from the very beginning in your efforts to create a safe space, there is – seriously! – not much that can go wrong.

The VIPROM-evaluation showed repeatedly that there are two elements of the VIPROM-trainings that play a huge part in making them a success:

10. The **hands-on exercises**, role plays and scenario work. Though such exercises are great with any group of learners, we especially recommend them for work with students.

11. Sharing of experiences, ideas and strategies among participants. Especially experienced medical professionals find it easy to learn from discussing real-world cases they have encountered and from reflecting on their own and other possible actions.

While as a trainer transferring knowledge of course remains an important part of your job, acting as a role model in establishing an **atmosphere of trust and equality** is no less important. Small gestures, like sharing your **motivation** for dealing intensely with DV or simply being open about **not (yet) knowing the answer** to a specific question, go a long way in establishing that atmosphere. If it works you might get back something beautiful like this appraisal of the VIPROM-training by a participant:

"Leaving this training, I don't feel completely ready to communicate with a suspected victim of abuse, but I feel much less uncomfortable doing so."

AFTER YOUR FIRST TRAINING...

After a successful training you might reach similar conclusions as did the VIPROM-team:

1. Trainings on DV in the medical sector are extremely important. They are intense work but are also very rewarding, especially when you see interest and engagement growing among your colleagues.

2. While you are likely to be enthusiastic about keeping up this important work, the question might be how to keep the ball rolling.

Therefore, chapter 7 will provide you with valuable practical, field-tested tips for ensuring continuous and comprehensive DV trainings for all professionals in your institutions tips based on three case studies the VIPROM-team conducted.

06 Tailoring Training to Professional Specificities

Why DV-Training should be tailored

It's essential to shape domestic violence (DV) training and responses tailored to the specific roles of medical professionals and students. Doing so not only makes interventions more effective, but also helps improve the quality of patient care. Different healthcare professionals engage with patients in different ways, and this shapes how they encounter and respond to DV situations. A one-size-fits-all approach does not do the complex work of health care justice.

Different medical specialties - like emergency medicine, Gynaecology/ Obstetrics, dentistry and paediatrics - each bring their own set of challenges and opportunities when it comes to addressing domestic violence. That's why it makes sense to tailor training to fit the specific needs of different areas. The environment professionals work in, along with the resources they have access to, really shapes how DV is recognised and handled.

For instance, those in emergency medicine often need to act quickly—spotting signs of DV in trauma cases, offering immediate support, and making fast, appropriate treat decisions. OB/GYN providers might take a different approach, focusing more on screening during pregnancy, helping develop safety plans for pregnant patients, and connecting affected patients with support resources. Meanwhile, dentists are in a unique position to build longer-term relationships with their patients, can spot injuries in the head regions or sign of neglect.

When DV-training is designed with the unique roles of medical professionals in mind, it becomes more relevant and impactful.

It is important to remember, that the willingness and ability to address DV in health care is also influenced by the personal beliefs of professionals. The way medical doctors, nursing staff, administrative staff, and other health-care professionals react to the topic of DV can be deeply influenced by their personal experiences. Equally, people's beliefs are influenced by values they hold, which can be informed by broader frameworks like human rights, feminism, or a child's best interest. Understandably, this means there may be differences in how various professionals approach and understand issues like domestic violence, trauma, cultural diversity, and communication. Some may already feel confident, while others might feel unsure or unprepared.

Practicality matters too. Training that fits into existing curricula or workplace routines is more likely to be adopted and used. It lowers barriers like time constraints or uncertainty about what to do, and instead offers clear, actionable steps that professionals can actually apply in real situations.

For medical students and trainees, early exposure to DV education is key. It lays the groundwork for developing skills and confidence that

Tailored DV-Training can Increase con-fidence, awareness, and preparedness among healthcare professionals to routinely inquire about DV.

will stay with them throughout their careers. The goal is to prepare everyone—from students to seasoned practitioners—to play an informed, active role in recognising and addressing domestic violence within the healthcare setting.

VIPROM: Stakeholder-Specific Resources

The VIPROM-Training Platform has been designed to support the wide-ranging needs of the medical community when it comes to responding to cases of domestic violence. Whether it's managing a case of DV, conducting medical or gynaecological examinations following a rape or sexual assault, handling physical examinations in emergency care settings, or navigating midwives' roles in relation to screening and ongoing support – our platform offers guidance that reflects some of the practical challenges healthcare providers face. We have also included practical advice on more general questions, such as providing referrals and support for women who have had the courage to disclose DV, or what to consider when you are faced with cases of DV where minors are endangered.

To feel confident and effective in these situations, both students and practicing medical professionals need solid training in specialised trauma-informed care. They also benefit from a clearer understanding of how to work across agencies—knowing what services exist, how to make appropriate referrals, and how to communicate effectively with other professionals involved in a survivor's care.

More specifically, the training curricula for students focused on foundational DV knowledge, early identification techniques, and effective communication skills that are integral for preparing new entrants into the healthcare field. For nurses who are caregivers often spending the most time with patients, advanced training that includes emotional support strategies, legal reporting obligations, and resources available for victims, is of great importance. Finally, physicians (medical doctors and dentists, who are often underrepresented in DV training) need detailed training on the medical indicators of DV, standardised screening protocols, and integrating DV awareness into patient care plans, as well as emphasis on developing a non-judgmental, supportive patient environment and enhanced, patient-centred and respectful communication techniques.

Trainings on DV should take into consideration the barriers related to the organisation of the healthcare settings including the short visit time, extensive bureaucracy, waiting queue, lack of continuity of care, and poor communication between different institutions, lack of screening tests, local conditions preventing the assurance of privacy, lack of support from superiors for doctors and therapists who feel left alone if they identify violence. Under these circumstances medical doctors tend to believe that DV identification is beyond their competencies and many health workers fear for their safety and the legal proceedings involved in the aftermath of a disclosure.

Tailored training can contribute to a culture of prevention by raising awareness among professionals, improving their ability to identify and respond to DV, and promote collaboration among different healthcare providers. Taking this into consideration, the VIPROM training platform includes specialised materials related to identification of DV, communication, and documentation.

RECOMMENDATIONS

07 for ICC aspects

The Interactive Handbook of "Intercultural Competence (ICC) for Domestic Violence Trainers"

In today's clinics and hospitals, every patient interaction is a meeting of cultures, making intercultural competence not a 'nice-to-have' but a core skill for effective DV prevention and support. In healthcare, where compassion and understanding are essential, being able to engage effectively with people from different cultures is key. This capacity is referred to as Intercultural Competence (ICC).

Let's delve a bit deeper into ICC aspects of your ongoing or future trainings!

The **importance of intercultural competence in domestic violence** service provision and training has only recently been recognised. In fast-changing, uncertain and multicultural societies, it is crucial that health professionals can adapt their established ways of thinking in flexible ways.

A long-needed **paradigm shift is under the way in the human services** that expects everyone to acquire and implement **knowledge and skills leading to changes** in practice and policies. Instead of tolerating dysfunctional systems and organisations, changes in individuals resulting from ongoing learning programmes addressing the relationship between the physical body and the socio-cultural body, will lead to trauma-informed and culturally responsive strategies that support individual, societal and organisational health **and well-being.**

Healthcare providers have to understand how **cultural factors shape their own perspectives and experiences as well as the experiences of those they care for**.

Integrating cultural complexity into DV curricula

Cultural complexity is a reality for most people, and it presents unique challenges for healthcare professionals. This is especially true when designing **training programs** on domestic violence that are **culturally meaningful and responsive**.

Culture isn't something **static or isolated** – it's shaped by relationships, interactions, and diverse, lived experiences. To create effective trainings, we need to **move beyond surface-level cultural awareness** and **address deeper cultural dynamics**. This means understanding the subtle nuances of culture, reflecting on diverse experiences and recognising how ***biases*** can influence different situations.

It is essential that you as **trainer develop intercultural competence** to ensure their programs **truly resonate with and respond to the cultural realities** of those you train.

→ *https://training.improdova.eu/en/training-modules-for-the-health-sector/module-8-stereotypes-and-unconscious-bias/*

Culture shapes how we think, act, and feel. Intercultural competence is the ability to understand, appreciate, and respond effectively to cultural differences. Regarding trainings, it is pivotal to move beyond the idea of **"to-do" lists** and focus more on developing "**to-be" mindsets** regarding culture. For **transforming shallow experiences of cultural differences** into more sophisticated ones it is essential to include training items that address and advance deep-level changes in individuals.

→ *ICC Handbook*
https://viprom-cerv.eu/training/training-materials/

→ **ICC Handbook at institutional repository ePLUS**
https://eplus.uni-salzburg.at/obvusboa/11689053

The *ICC Handbook* offers important ideas and practical tools to help healthcare professionals develop Intercultural Competence (ICC) for domestic violence contexts. While not a comprehensive guide, the handbook, along with the training resources on the *VIPROM platform* and the *research article*, offers **valuable insights into the many dimensions** of domestic violence. It seeks to advance and reflect the trainers' level of intercultural competence, **enabling them to highlight relevant cultural aspects** in domestic violence trainings (the handbook can be found by following the QR code in the margin, as well as in the institutional repository ePLUS).

→ **VIPROM Platform -**
https://training.viprom-cerv.eu/en/

The focus on **cultural responsivity** of trainings indicates a commitment to **continuous learning**, **reflection and development in relation to culture**, while cultural responsiveness describes the outcome when knowledge and understanding, values and behaviours and emotions and feelings come together and synchronise in harmonious ways of "feeling-thinking-acting-being". The ICC handbook aims at initiating **deep-level changes** in individuals and systems with the help of intercultural competence and cultural responsiveness.

Every healthcare visit is an opportunity to support victims of domestic violence. To encourage them to share their experiences, healthcare providers as you must build trust and respect, creating a safe space for open communication. Achieving this in diverse settings requires **intercultural competence and cultural humility** – a willingness to learn from and respect different cultural perspectives.

Develop transformative trainings with intercultural competencies

This raises an important question about training: what makes a program not just **"informative"** (sharing knowledge) but **"transformative"** (changing how people feel, think, and act) – a training programme that gets people passionate about putting what they've learned into practice?

Transformative trainings aim to **make people "walk the talk"** (i.e. act on their knowledge) in genuine ways, rather than in a "performative" manner (i.e. not "sincere" but intended to promote certain "desired" behaviour). **Transformative trainings cultivate deep-level changes**. Given that input aimed primarily at the cognitive domain does not result in profound changes at the behavioural or affective level (i.e. in deep-level changes), greater attention must be paid to the role of emotions and actions when designing transformative trainings.

The ICC handbook supports the development of intercultural competence in trainers and guides the design of transformational trainings by inspiring people to apply their knowledge in genuine ways for the common good (read more: LINK to research article).

The aim of the ICC handbook was to **improve domestic violence trainings by advancing their transformational potential regarding cultural responsiveness** through creativity, by ensuring that "culture" was not simply an "add-on" but integrated in meaningful ways on various levels (individual, organisational, societal). This meant not adding "culture" at some point in the training, but including **intercultural competence as an inescapable, pervasive dimension from which all actions progress** (i.e. transformational training).

The interactive ICC training items in the handbook (podcasts, audio-visual poetry, video clips, etc.) are **complementary to the items used in the ten VIPROM online modules** (LINK). The ICC items are delivered in a variety of formats using transformational creativity to change mindsets.

Practical Implication:

Why creativity? There are numerous positive effects creativity has on individuals and societies, including:

- **enhanced mental health and well-being** (by, e.g.: providing a positive outlet for emotions and promoting relaxation and creativity is an expression of the imagination and imagination plays a significant role in coping with trauma),
- **increased resilience** (by, e.g.: facilitating self-awareness and introspection and increasing happiness) and
- **improved problem-solving abilities** (by, e.g.: enhancing the ability to view and solve problems in new and innovative ways, fostering a more flexible and adaptive mindset).

CREATIVE TRAINING ITEMS FOR INTERCULTURAL COMPETENCE FOR YOUR DV TRAININGS

For domestic violence trainings to be transformational (encouraging actions) we tapped into creativity's capacity to postpone the desire for cognitive closure (**making individuals more curious and open-minded**) as well as the **positive effect** resulting **from creative training items**. To provide more hands-on examples, the principles of cultural responsiveness in DV trainings are illustrated using interactive training exercises from the *Intercultural Competence for Domestic Violence Trainers' handbook*:

1. **Use an Integrative Framework of Culture:** take an integrative, interdisciplinary approach to culture and link it to cultural responsivity, addressing the central role not only of the cognitive domain but also of culturalised perception, affect and behaviour (see *The Intercultural Competence® Framework* explained in chapter 2).

2. **Take an Intersectional Approach:** it is crucial to address intersectionality, which refers to the interconnected nature of social categorizations interdependent systems of discrimination and disadvantage for individuals and groups. To address this, the ICC handbook gives voices to different individuals: female friends of a domestic violence victim (see item: *Empower Her* in chapter 2), a perpetrator (see item: *Twisted Truths* in chapter 4), a "cultural other" (see item: *White Gowns, Broken Tongues* in chapter 5), children & psychotherapists (see item: *The Forgotten Victims* in chapter 8), and many others.

3. **Include Creative Training Items:** including creative training items is important, as creativity plays an important role in fostering the desire to postpone cognitive closure and in promoting positive affect. In addition, unlocking creativity to promote inclusion can provide a strategy to counteract bias: listen to the audio-visual poem: *White Gowns, Broken Tongues* (chapter 5).

4. **Include Affective Training Items:** It is also pivotal to include affective items since emotions give meanings to situations and motivate actions. In the ICC handbook you will find a multitude of stories woven together in an intricate web of cultures, contexts and systems: listen to the podcast *Breaking the Cycle* (chapter 4).

5. **Forge Empathy for the (Cultural) Other:** The capacity to perceive and resonate with others' suffering allows us to feel and understand their pain, hence trainees should be given various interactive, immersive and imaginative experiences in the trainings, watch the video: *A Digital Story of Survival* (chapter 3).

6. **Integrate Self-Reflection Exercises:** engage in regular self-reflection to recognise and reduce personal biases and assumptions. This ongoing process is critical to fostering an open, empathic training environment. Engaging in self-reflective exercises is necessary for self-awareness, which again is linked to cultural responsivity – try out the *Cultural Reflection Exercise* (chapter 1).

7. **Diversify Training Materials:** Adapt training materials to cultural diversity and professional specificities. Ensuring that the examples, scenarios and resources are relevant but also reflect different contexts that are sometimes considered as 'irrelevant' by the dominant group. Offer 'diverse' perspectives from various angles (e.g.: from the victim, the perpetrator, the physician, the nurse, the social worker, etc.). This prevents creating blind spots in the trainings through culturally and professionally homogeneous groups and fosters an inclusive mindset.

8. **Collaborate with Communities to include Storytelling and Practice the Art of Listening:** VIPROM has partnered with leaders and organizations that serve diverse populations. These collaborations provide deeper insights into specific cultural nuances and needs, that can help trainers to diversify their training design. The DV trainers' challenge is also to spark interest in and appreciation for all the different narratives, to avoid the "danger of a single (dominant) story". Since storytelling promotes psychological safety, knowledge sharing and emergence as well as reflection through shared experience and emotional engagement with the teller and can be a powerful tool for trainings to facilitate mindset shifts at the individual, team and system levels. Listen to the diverse stories throughout the ICC handbook.

9. **Offer a Multilevel Perspective:** There are positive relationships between individual intercultural competence and systems cultural competence. Trying to understand how inequalities are manifested and exacerbated by organisations and workplaces means openly addressing and challenging systemic failures. Your trainees should begin to understand that the status quo only works for certain privileged groups, start addressing their

own biases and accept their responsibility to act to drive social change. The ICC handbook dedicates an entire chapter to inspiring a new vision for future healthcare (chapter 7 *Inclusive Leadership for Better Healthcare*).

10. **Commit to Ongoing Education:** Commit to continually educating yourself about different cultures, (historical) contexts, societal structures and current challenges. This knowledge often serves as the foundation for understanding the diverse experiences of victims and survivors.

11. **Provide Accessibility through language, communication styles and services as well as implement feedback mechanisms:** ensure that training and advocacy services are accessible to people from all cultural backgrounds. This includes considerations for language, disability access and culturally sensitive communication methods. Accessible communication involves recognising that people communicate differently and providing information in various formats so that all users have equal access.

Let's take a leap: *link to the ICC Handbook*

→ *ICC Handbook*
https://viprom-cerv.eu/training/training-materials/

08

guidelines for organizational Sustainability

You’ve built the skills, tested the platform, implemented a DV training – now it’s time to turn knowledge into action with practical steps to embed domestic violence prevention into the fabric of your own institution! Because sustainable integration of domestic violence prevention and victim support in the medical sector requires more than individual commitment or temporary training initiatives. It necessitates systemic change within medical institutions and its educational structures, but also society more broadly:

“When it comes to tackling DV, the healthcare personal is not the only key actor - DV is societal problem demanding a broad approach”

“Everyone should be trained in DV – not just a few individuals”. Building on multiple case studies and best-practice models from ***Sweden, Germany and Austria***, this chapter outlines lessons from the field into concrete, actionable guidelines to help embed domestic violence education and victim support into medical institutions – for lasting, sustainable change.

→ *https://viprom-cerv.eu/wp-content/uploads/2024/12/VIPROM_Deliverable_2.2_Website_Version.pdf*

Secure and Diversify Resources

A consistent finding across all case studies have been the necessity of sufficient and diversified resources. Sustainable implementation depends on:

Personnel Resources: DV training should be integrated into job descriptions and departmental responsibilities. Roles such as DV coordinators or contact persons must be institutionalized rather than voluntary.

Time Resources: Allocating protected time for staff to receive training, attend interprofessional meetings, or engage in case reviews is crucial.

Financial Resources: Budget lines for DV education and support services must be secured long-term, ideally embedded in core funding streams of medical institutions.

Resources also include **symbolic capital**: i.e. the official recognition of DV-related work. This may take the form of national accreditation requirements, inclusion in quality management frameworks, or formal acknowledgement in institutional reports and communications. Even when funding is limited, policy recognition serves as a critical legitimising tool for change agents within institutions.

Leverage Policy and Legal Frameworks

The formalisation of DV education in national and regional policies creates institutional incentives for implementation. For instance, when educational objectives related to DV prevention are embedded in medical curricula accreditation standards or continuing education requirements, hospitals and universities are more likely to act.

The case studies have shown that **policy-level integration** helps move DV practices from the margins to the mainstream. However, legal mandates alone do not ensure meaningful implementation. The best outcomes occur when mandates are accompanied by practical tools, clear implementation guidance, and continuous support structures.

Build and Distribute Knowledge

Knowledge is one of the most critical resources in multiple forms when it comes to the integration of DV initiatives in the medical sector:

Scientific Knowledge is crucial: Robust research evidence supports the need for DV intervention in healthcare and provides compelling arguments for organisational leaders, department heads, and funders. In particular **in-house expertise** is key for building internal capacity. This includes training staff across multiple departments – medical, psychosocial, paramedical and administrative – to ensure widespread awareness and capability across all departments in a hospital.

Interprofessional networking is a further cornerstone for programs becoming sustainable, i.e. it relies on exchange between different professionals and institutions. Peer learning networks, communities of practice, and collaboration with DV-focused NGOs enhance the reach and quality of implementation.

Furthermore, successful institutions often create **training cascades** using a **train-the-trainer model** – as the one developed in the VIPROM project – allowing knowledge to spread broadly and remain embedded through personnel turnover.

Utilise Change Windows Strategically

Organisational changes such as hospital restructurings, leadership transitions, or reforms in medical education can provide openings for institutionalising DV practices. You should be prepared to act during these time windows by:

- Presenting DV practices as being in line with **new strategic priorities** (e.g. patient safety, gender equity, trauma-informed care).
- Positioning **DV work as part of quality improvement** or **risk management** initiatives.
- Securing **support from new leaders** by emphasizing DV initiatives as a necessity and evidence-based improvements to healthcare.

Timing, in these cases, becomes a critical factor. Institutional readiness and alignment with broader reforms increase the likelihood of successful uptake.

Follow a Two-Track Implementation Trajectory

Analysis has revealed a common pathway to sustainability:

1. **Local Innovation:** Pioneering efforts typically begin with committed individuals or small teams within single institutions. These efforts often rely on local knowledge, informal networks, and experimental approaches.
2. **Recognition and Scaling:** When these practices are recognised through evaluations, awards, publications, or policy endorsement they gain legitimacy and traction. This recognition helps scale efforts across the sector.

Yet scaling brings risks of dilution or box-ticking. Sustaining quality during expansion requires ongoing support, regular evaluation, and engagement with expert organizations.

Follow a Two-Track Implementation Trajectory

But also, external organisations play a vital role by providing validated training curricula and educational tools, offering mentoring and supervision, and facilitating inter-organizational learning. Projects like VIPROM exemplify this model. Through the development of research-based educational materials and train-the-trainer programs, VIPROM supports institutions in embedding DV education in a way that is both scalable and adaptable.

What to Take Back to Your Team and Institution

Sustainable integration of DV education and victim support is multi-dimensional and doesn't happen by accident – it's a coordinated effort. It takes the right mix of committed individuals, institutional support and aligned policies. Further, local champions and expert knowledge are essential catalysts, but institutional and structural embedding is what ensures longevity. The key is moving beyond one-off trainings or isolated efforts. When embedded into everyday structures, routines,

and professional values, DV response becomes part of what quality healthcare *is*. The case studies show: with the right strategy, medical institutions can shift from reactive approaches to building lasting systems that protect and empower patients affected by violence.

→ *https://viprom-cerv.eu/wp-content/uploads/2025/12/VIPROM_Changemaker_Guidelines.pdf*

Further insights can be found in our VIPROM guideline on becoming a domestic violence changemaker.

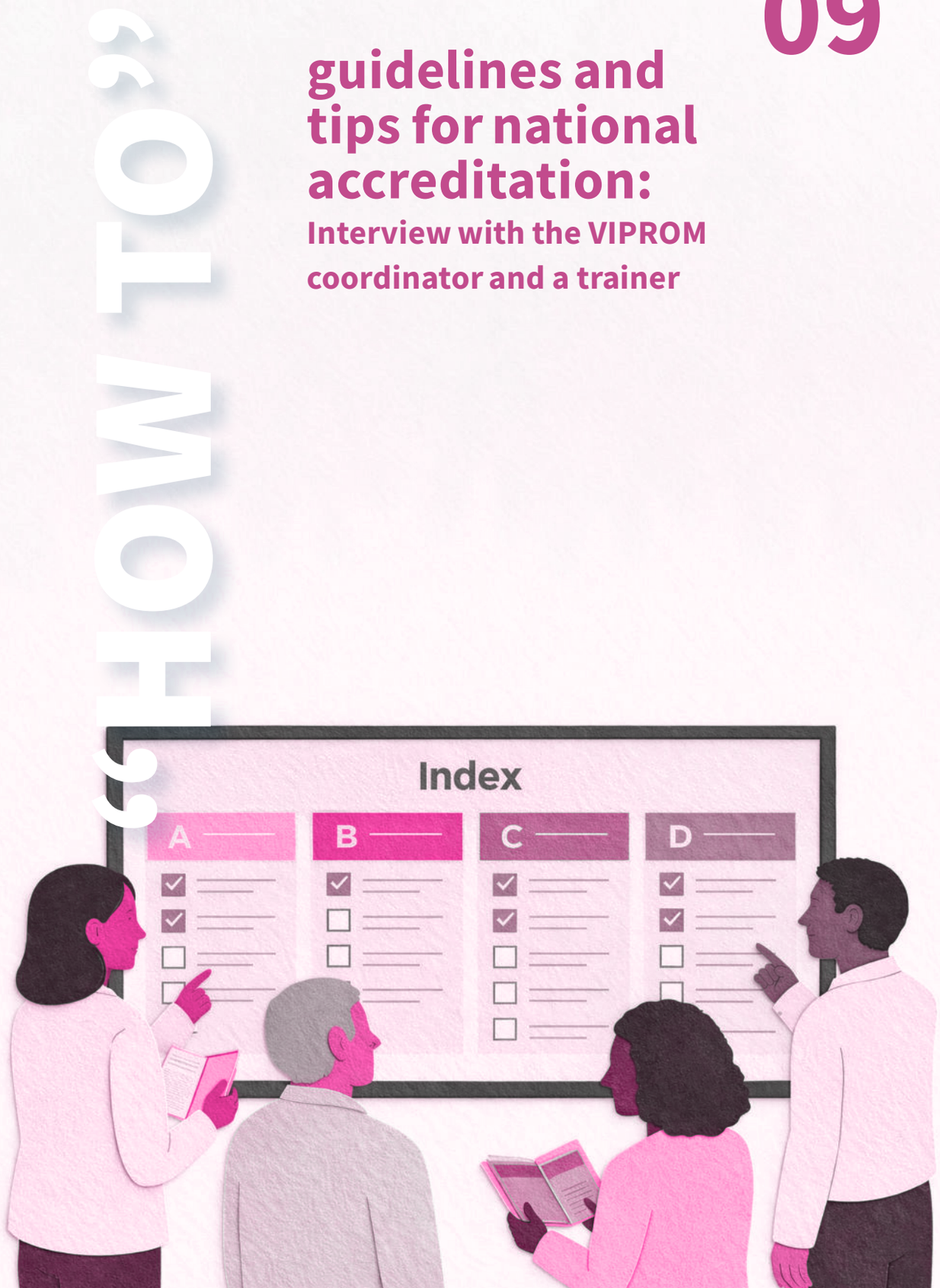
By following the ***QR code***, you can find detailed information on the three individual case studies the VIPROM team conducted throughout its research endeavour, as well as our key findings. These insights provided an important basis to developing the training modules and the VIPROM curricula.

→ *https://viprom-cerv.eu/wp-content/uploads/2024/12/VIPROM_Deliverable_2.2_Website_Version.pdf*

09

guidelines and tips for national accreditation:

Interview with the VIPROM coordinator and a trainer



Once intercultural competence is woven into your approach, the next step is making sure your DV training meets national standards – so it's recognised, accredited, and here to stay.

For this chapter, we interviewed two leading experts from the VIPROM project in the fields of sex- and gender-sensitive medicine and violence prevention in clinical settings. In the following, we provide a short introduction to our two experts:

Bettina Pfleiderer

works as associate professor and head of the research group Cognition & Gender at the Clinic of Radiology of the medical faculty of the University of Münster in Germany. She has been a known expert in the field of domestic violence and medical education for many years and is lecturing on domestic violence globally.

Eva Schönefeld

is a specialist in surgery and a qualified supervisor and offers individual, group and team supervision. Since 2017, she has been working at the Medical Faculty of Münster as a trainer, consultant and group and team leader. Since 2018, she has been focusing on diversity, self-management and presentation, and also offers workshops on these topics.

Both of their perspectives highlight the urgent need for healthcare systems to recognise and respond to the complex intersections between gender, health, and violence. Through their clinical and trainer experience and research, they underscore why it is critical for medical professionals to understand how gender dynamics and experiences of domestic violence shape patient health. Their distinctive reflections provide a foundation for rethinking clinical practice and medical care not as gender-neutral, but as deeply informed by the social realities patients face both inside and outside clinical settings.

UNDERSTANDING THE ROLE OF GENDER AND VIOLENCE IN MEDICINE

Violence – whether physical or psychological – is a significant health issue and must be recognised as such in all medical fields, especially within sex- and gender-sensitive medicine! (Bettina Pfleiderer, coordinator of the VIPROM project)

Training Beyond Knowledge: Why Experience-Based Learning Matters

QUESTION: Why do you think it is important to promote 'training' as a form of intervention in medicine to identify affected patients suffering from domestic violence?

Trainer's Perspective (Eva):

Reading only about discrimination, violence, or exclusion is not enough. Real learning happens when participants *experience* social dynamics first-hand—such as being excluded or favoured in group settings. These emotional experiences lead to meaningful reflection on personal biases and values, especially around complex topics like racism or structural violence. It helps shift the mindset from *"others are the problem"* to *"how might I be part of the issue too?" (Eva Schönefeld, trainer and medical doctor and is part of the VIPROM project)*

Medical Educator's Perspective (Bettina):

In medical education, we must go beyond cognitive knowledge. It's crucial to train students in practical skills—especially in recognising and responding to violence or discrimination. This can't be taught by lectures alone. Workshops and hands-on training are essential to build confidence, sensitivity, and the ability to act. Even though it would be ideal to start earlier (e.g., in schools), medical training is a critical window. And the impact is visible: students actively seek mentorship, propose thesis projects on domestic violence, and engage deeply with the subject. That's when real change starts. *(Bettina Pfleiderer, medical doctor and coordinator of the VIPROM project)*

"True change happens when learners don't just know the facts—but feel the discomfort, recognise their role, and find the courage to act." (Eva Schönefeld)

Practical Implications for Training Programs:

- Use **experience-based workshops** to teach empathy and aim for shifts in perception.
- Combine **cognitive learning** with **skills-based training**—both are essential.
- Engage medical students early and create safe spaces to reflect, question, and act.
- Provide mentorship and visibility on difficult topics like domestic violence.

Building Awareness First: Why a Learning Platform is Indispensable

QUESTION: What was your starting point – what could you build upon and what role does the VIPROM training platform play?

Bettina: The platform operates primarily on the cognitive level – it provides knowledge. But that's exactly where we have to start. Our platform has high quality: it's well-evaluated, based on solid literature, and reviewed by experts. Many other teaching tools may lack sometimes this foundation. The platform also offers self-learning modules that encourage users to reflect on personal risks, like burnout, or recognise violence-related biases. Sure, there's room for improvement, especially in making the modules fully interactive but we've already come a long way.

Eva: And it's not just about knowledge. It's about making people aware. As a project and as engaged professionals, we could pour our efforts into reforming medical law or lobbying for systemic changes, but we've chosen to focus on consciousness-raising. Why? Because it's the most sustainable path.

Bettina: Exactly. As a neuroscientist, I know people change only when they're reached emotionally. If you don't touch them on that level, the brain just forgets. Legal arguments won't move most people in medicine. But self-awareness will – recognising how we see ourselves and others is the key to lasting change.

Eva: As a supervisor and trainer, I see it the same way - I've seen how transformation begins in values, beliefs, and reflective dialogue. Political shifts may follow, but only if the people involved start questioning themselves first.

Bettina: And that is why Change Starts on the Ground! This isn't about classic medical law or pushing legislation in parliament. The real impact comes from working directly with people on the ground – in outpatient clinics, emergency rooms, and hospitals. As medical professionals, we're problem-solvers by nature. We understand and respond to concrete situations. That's where real, sustainable change happens not in policy documents, but in day-to-day practice, mindset, and care with real people!

COORDINATOR SPOTLIGHT

***Bettina Pfleiderer** was also serving as President of the World Medical Women's Association (2016-2019), where she has led impactful international initiatives to address gender-based violence in healthcare. Her work began with on-the-ground medical workshops in Africa, where she collaborated with local colleagues to confront the challenges of genital mutilation. Recognising the need for structured education early on, she spearheaded the development of a training platform, and a case library focused on domestic violence. Her leadership extended to active involvement in European research projects such as IMPRODOVA, IMPROVE, and VIPROM (in all of these projects the training platform was expanded, enriched, more nuanced and stakeholder specified), all aimed at enhancing the so-called frontline responder's capacity to recognize, respond to, and prevent violence. The VIPROM project is the only one that focuses specifically on improving the healthcare sector's capacity for affected patients.*

Eva Schönefeld: ***We don't change systems by law alone – we change them when medical professionals begin to see, feel, and question their own role.***

Bettina Pfleiderer: ***Genuine change in medicine begins when medical professionals bring new attitudes into real situations with real people.***

Practical Implications for Implementation:

- Use the **platform** as a foundation for knowledge and structured self-reflection.
- Pair it with **interactive, emotional learning experiences** (e.g. workshops) for lasting impact.
- Focus on **early sensitization of medical professionals** – reflection leads to sustainable change.
- Policy change is important, but **attitude change** is initial and longer lasting.

Why Accreditation is Important: Establishing Trust and Quality in Medical Training

QUESTION: What are the structural challenges involved – and why is accreditation such an important step? Could you tell us a little more about the accreditation process?

Bettina: In Germany and likely in similar educational systems training programs gain real recognition only when they carry an official stamp of approval. Accreditation isn't just bureaucracy; it's how credibility is signalled. Universities, hospitals, and institutions are far more likely to send their staff to a course if it's formally certified. This is especially important when trying to embed innovative topics like sex- and gender-sensitive medicine or domestic violence response into medical education. Programs like ours, already established in places like Münster, benefit from being institutionalised through accreditation. It strengthens not only external trust but also internal development. The process forces you to refine your content, clarify your methods, and elevate your teaching to the next level.

Eva: And having an external panel with experienced, certified trainers who give feedback, makes the entire program stronger. That external lens ensures quality, consistency, and professional evolution.

Practical Implications for Program Development:

- **Pursue accreditation** early when designing training courses, especially for medical professionals.
- Recognize it as a **dual benefit**: external validation and internal refinement.
- Accreditation increases **institutional anchorage**, especially in formal university or hospital settings.
- Use the process as a moment to evaluate and strengthen your own training design.

Stakeholder-Specific Training: Why Structural Change Starts with well-trained Educators

QUESTION: What formal and informal support were you able to mobilise? And what were/are the major obstacles you encountered? What strategies did you find to overcome them?

Bettina: In countries like Sweden, centralised institutions like the NCK (The National Centre for Knowledge on Men's Violence Against Women) oversee standardised training on gender-based violence for all relevant stakeholders supported by government funding. In Germany, however, we lack that national coordination as in many other participating countries of the VIPROM project. As a result, it's critical that we build capacity from within the universities and professional groups by training specialised educators.

Not everyone is equipped to teach sensitive topics like domestic or sexualized violence. It requires specific knowledge: trauma sensitivity, psychological safety, and advanced didactics. For example, midwives are showing strong interest in professional "Train-the-Trainer" courses because they recognise the real need in their field, but many faculties lack staff trained to deliver this content effectively.

Eva: To embed this into medical and health science curricula, we need certified, reflective, and methodologically sound educators. A two-day training alone won't fix everything, but it will definitely open doors. In places like Münster, this approach is already established and could serve as a model for others.

Eva Schönefeld: ***Accreditation isn't just a stamp – it's a catalyst for trust, quality, and long-term integration into medical education.***

Practical Implications of Building Sustainable Healthcare Education:

- Focus on **specific stakeholder groups** like midwives, emergency responders, and medical educators – they are the multipliers.
- Provide **formal, accredited educator training (train-the-trainer programs)** to ensure quality, consistency, and institutional uptake.
- Structural change requires **structural readiness** and trained educators are the foundation for sustainable integration into curricula.
- Build a **pool of certified trainers** who act as door-openers in faculties and health professions nationwide.

Bringing Sensitive Topics into Medical Curricula: What It Really Takes

QUESTION: What key tips and/or assistance would you give to a colleague who is seeking accreditation in their own country?

Bettina Pfleiderer: ***Midwives, doctors, and other medical first responders can't teach what they haven't been trained to handle. Thus, certified educator training isn't optional, it's the key to structural change.***

Bettina: Integrating issues like gender-based violence into medical education requires far more than good intentions, it demands strategy, persistence, and the right people. Change begins with local champions: individuals who understand the institutional landscape and can navigate the bureaucratic hurdles. Equally essential is a trained cohort of educators who can deliver content in meaningful, practice-oriented ways. Support from faculty leaders, such as department heads or curriculum committees, is crucial to move from informal interest to more institutional adoption and anchorage.

Eva: Advocacy for this kind of change is rarely linear. It is personal, relational, and ongoing. Progress is made not only in classrooms but also in hallways, podcasts, conferences, and committee meetings, wherever there is an opportunity to raise awareness and build momentum. It's about steadily creating demand and visibility and showing how gender-sensitive content directly supports better patient care.

Bettina: Of course, structural barriers remain. Medical curricula are already dense, and introducing new material usually means omitting something else from the curriculum. Power often lies with a small group of senior faculty or deans, and without a national mandate – as exists, for example, in Sweden – progress relies on local leadership and long-term commitment.

Bettina Pfleiderer: ***Curriculum change isn't just all about content – it's political. You need insiders who know the system, certified trainers, and persistent advocacy to get past gatekeepers.***

Eva: Still, there are promising entry points. Train-the-trainer programs in fields such as nursing, midwifery, and medicine can create ripple effects. Embedding violence prevention into existing formats, like case discussions or clinical simulations, can ease integration. And critically, institutional backing from department heads is often key to getting pilot projects off the ground.

Practical Implications and Possible Entry Points:

- A local **advocate** who knows the bureaucratic procedures.
- A **trained group of educators** to conduct effective workshops.
- **Key faculty stakeholders** (e.g., heads of departments) willing to support inclusion of DV curricula.
- Train-the-Trainer programs, especially **stakeholder-specific** ones, such as in and for **fields like midwifery, nurses and general medicine**.
- Aligning with **existing teaching formats and also aim for interactive ones** (e.g., integrating violence prevention into case discussions, simulation training).
- **Leveraging institutional backing**, e.g., support from deaneries or departments, is critical for pilot phases.

10 Annex & practitioner resources

In this annex, we have collected a set of useful resources for medical professionals that are designed to support you in everyday clinical practice. You will find a quick overview of the most important links to the training platform and relevant handbooks, a brief risk assessment for clinicians, and ready-to-use Med.DocCard and Dent.DocCard versions that you can cut out and laminate for immediate reference. In addition, the annex includes a concise guide highlighting key aspects to address when discussing and developing a safety plan with people experiencing violence.

Taken together, these materials are intended to serve as a practical companion—easy to consult, easy to use, and supportive when time, complexity, and responsibility converge in clinical encounters.

MOST IMPORTANT LINKS

VIPROM Training Platform
https://training.viprom-cerv.eu/en/

VIPROM Training modules for the health sector available in multiple languages
https://training.improdova.eu/en/training-modules-for-the-health-sector/

VIPROM Training materials for the health sector
https://viprom-cerv.eu/training/training-materials/

Training materials for each VIPROM Module
https://training.improdova.eu/en/training-modules-for-the-health-sector/training-materials-for-the-health-sector/training-materials-for-the-health-sector-modules/

Train-the-Trainer Handbook (EN)
https://viprom-cerv.eu/wp-content/uploads/2024/07/VIPROM_TTT-Handbook-English.pdf

Intercultural Competence for Domestic Violence Trainers Handbook
https://eplus.uni-salzburg.at/obvusboa/download/pdf/11689053

Both Handbooks, as well as the Med.DocCard and Dent.DocCard, alongside several videos can be found in further national languages
https://viprom-cerv.eu/training/training-materials/

MED.DOCCARD & DENT.DOCCARD

The Med.DocCard and Dent.DocCard respectively present the most important aspects of medical and dental intervention in cases of domestic violence and summarise the requirements for court-proof documentation of injuries. They are intended for medical practitioners who have already completed training on domestic violence, serving both as a reminder of the key steps to follow and as practical support for documenting injuries, including assessing their size using the integrated scale. Both cards have been included on the next pages at the correct scale and are ready to be cut out and laminated for immediate use in clinical practice.

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Medical intervention in cases of Domestic Violence

What do I need to know?

Domestic Violence, whether psychological, physical or sexual, affects many people and can have serious health consequences, particularly within close relationships. Routine, sensitive questions about the cause of injury can encourage those affected to talk about violence, or allow them to remain silent if they wish, and this must be respected.
If explanations and your findings do not match, encouraging open communication without the presence of others can facilitate a willingness to talk.
In addition to medical care, victims may require protection and psychosocial support from specialised counselling centres, for example.

Some sample wording to get the conversation started:

- "Do you feel safe in your current home environment?"
- "Since Domestic Violence is unfortunately so common in our society, I ask all my patients about it."
- "If you wish, you can talk to me in confidence. I can inform you about further counselling and support services."

Counselling and help for professionals and those affected:

- Women who have been victims of violence will receive help and advice free of charge across Europe: **EU-wide hotline: 116 016**

Med.DocCard©

Medical documentation of findings in cases of Domestic Violence

- Document everything carefully in case it is needed for legal purposes.
- Always use a standardised documentation form and evidence collection kit.
- Obtain consent from the person concerned or their guardian prior to carrying out the investigation.

1. Basic documentation

Patient details: Name, date of birth, address
Details of the examination:
Where? Place of examination (practice/emergency room clinic)
When? Date & time of the examination
Who? Name of the examiner
Other persons present?

2. Event/patient details

Create a calm and undisturbed environment for discussion and examination (be alone with the patient). Ask open, direct questions and respect any refusal to provide information. Take verbatim notes of the statements.

- **Where** (place) and **when** (date, time) has **what** occurred?
- **Perpetrator:** unknown/known? Number? Who?
- Body height and weight
- **Habitus; mental condition (describe, do not judge); special features (e.g., pregnancy, disability, illnesses).**

www.viprom-cerv.eu

Med.DocCard©

Medical documentation of findings in cases of Domestic Violence

3. (Physical) Assessment

- **Where?** Exact location on the body, based on anatomical structures.
- **What?** Describing the findings (e.g., haematoma, cut)?
- **How?** Provide a detailed description of the size, shape, colour, depth and edge. Include a sketch, drawing or photos if possible.
- **How** the injury was done (e.g., object)?
- (Suspected) **diagnosis**
- **Age** of the injury(ies).
- **Evaluation of findings** in the context of the medical history: agreement with information provided (yes/no), and severity.

▶ Special rules apply to documenting Sexual Violence.

4. Further measures

- **Follow-up appointment** at the practice (date):
- Blood, urine or other samples (e.g., swabs for sexual assault): which tests are required?
- Further **diagnostic measures**?
- **Further referral** (e.g., to a specialist physician, counselling centre or legal support)?
- **What further steps were discussed** (e.g., drawing up a safety plan)?

5. Photo documentation

Photos support the medical documentation of injuries, as well as documentation of damage to clothing and medical aids. Written consent from the patient is required, and this can be withdrawn at any time.

- Photographs should be taken confidentially and discreetly, and only include the breasts and genitals if there are visible injuries.
- Code images anonymously and archive them securely.
- Take photos ranging from overview to detail without changing the camera position. For detailed shots: Position the scale (e.g., the scale on this card) in line with the findings and avoid mirroring.

6. Assessment of protection needs

- Inpatient admission (appropriate, possible or desired?)
- Is a place of refuge desired (women's shelter, men's shelter or relatives)?
- Are children involved?

▶ If you suspect that a child's welfare is at risk, you must take further steps. The steps to be taken are country-specific!

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Med.DocCard© by GESINE Intervention, Revision 2025 by Bettina Pfleiderer, and Madeleine Stöhr, VIPROM – Victim Protection in Medicine in close cooperation with GESINE Intervention. www.viprom-cerv.eu

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Dentistry – intervention in cases of Domestic Violence

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What do I need to know?

Domestic Violence, whether psychological, physical or sexual, affects many people. Child neglect is a common, yet often overlooked, form of domestic violence and a significant cause of child endangerment.
Dentists play a special role in identifying those affected: they see their patients regularly, often alone. Examining the head, neck and mouth area can reveal early signs of potential violence.

This card provides information on relevant indicators and the appropriate procedures to follow in suspected cases, as well as guidance on legally compliant medical documentation of findings. Photos support the medical documentation of injuries, as well as damage to clothing and medical aids. Written consent from the patient is required and can be withdrawn at any time.

Important indicators in the head, neck and mouth area:

▶ **Facial trauma:** Be aware for signs of previous trauma to the teeth or face, such as healed fractures on X-rays, tears in the frenulum that have no obvious cause, fractured or dislocated teeth, and injuries in various stages of healing.

▶ Untreated tooth decay may indicate dental neglect in children.
Indicators include:

- conspicuous behaviour (e.g. aggressiveness or passivity).
- inadequate care and malnutrition
- early childhood caries from the time of tooth eruption onwards

Some sample wording to get the conversation started:

- "Do you feel safe in your current home environment?"
- "Since Domestic Violence is unfortunately so common in our society, I ask all my patients about it."
- "If you wish, you can talk to me in confidence. I can inform you about further counselling and support services."

Counselling and help for professionals and those affected:

- Women who have been victims of violence will receive help and advice free of charge across Europe: **EU-wide hotline: 116 016**

Dent.DocCard©

Forensic Dental Documentation in Domestic Violence

▶ Document everything carefully in case it is needed for legal purposes.
▶ Always use a standardised documentation form and evidence collection kit.
▶ Obtain consent from the person concerned or their guardian prior to carrying out the investigation.

www.viprom-cerv.eu

Dent.DocCard©

Forensic Dental Documentation in Domestic Violence

1. Basic documentation

- **Patient details:** Name, date of birth, address
- **Details of the examination:**
- **Where?** Place of examination (practice/emergency room clinic.
  When? Date & time of the examination
- **Who?** Name of the examiner
- **Other persons present?**

2. Event/patient details

Create a calm and undisturbed environment for discussion and examination (be alone with the patient). Ask open, direct questions and respect any refusal to provide information. Take verbatim notes of the statements.

- **Where** (place) and **when** (date, time) has **what** occurred?
- **Perpetrator:** unknown/known? Number? Who?
- Body height and weight
- Habitus; mental condition (describe, do not judge); special features (e.g., pregnancy, disability, illnesses).
- Conversation with patient about violence (yes/no)

3. Extraoral findings

- **Facial skin:** haemorrhages, wounds, abrasions, pattern impressions and petechiae
- **Eyes, eyelids, conjunctiva and eyeball** (monocular haematoma, petechiae, spectacle haematoma, extensive haemorrhages and visual disturbances/double vision)
- **Nasal swelling** (nosebleeds, nasal obstruction)
- **Neck; Ears**/behind ear region (blood underflow, hearing impairment)
- **Lip mucosa/red lip** (haemorrhages, tears, petechiae)
- **Fractures to the skull and face** (e.g. zygomatic bone or jaw)

4. Intraoral findings

- Tooth fractures, dislocations and prosthesis fractures
- Maxillary or lower jaw fracture (e.g. crepitation or luxation).
- Injuries to the buccal and pharyngeal mucosa and tongue (possibly causing swallowing disorders).
- **Dental status**

5. Additional observations and findings

Record any visible or described injuries outside of the oral cavity, such as haematomas, wounds, swelling, bite marks, visual disturbances, limping, dizziness and nausea.

- **Where?** Localisation (especially the head, face and neck area).
- **What?** Type of injury (e.g. haematoma or laceration).
- **How?** Size, shape, colour and depth.

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This project was co-funded by the CERV 2022 DAPHNE programme of the European Union under grant agreement no. 101095828.

BRIEF RISK ASSESSMENT FOR CLINICIANS

The DA-5 is a brief, evidence-based risk assessment designed to identify individuals at heightened risk of severe injury or homicide by a current or former intimate partner. It is a shortened adaptation of the validated Danger Assessment (Campbell, 2003); while the full Danger Assessment with weighted scoring provides the most precise risk estimation, the DA-5 offers a practical option for time-limited clinical and practice settings.

The DA-5 and related Danger Assessment tools are intended for use with survivors to support education about lethality and reassault risk and to inform safety-related decision-making. It is appropriate for use when intimate partner violence has been identified in emergency departments, other health care settings, protective order or child custody proceedings, and similar brief-intervention contexts. The presence of identified risk factors may indicate imminent danger of serious injury or homicide.

Please note, however, that risk assessment should be conducted in conjunction with survivor self-determination and professional clinical judgment to collaboratively determine appropriate next steps. Moreover, the use of the DA-5 requires specific training and expertise. If you are interested in aquiring such expertise, the Johns Hopkins School of Nursing offers online training on the use of the danger assessment, which you can find by following the QR-code in the margin.

→ *https://www.dangerassessment.org/TrainingOptions.aspx*

Additional information on the validation and adaptation of the DA-5 is available in published literature, such as the study linked here: *https://pubmed.ncbi.nlm.nih.gov/28921610/*

DANGER ASSESSMENT-5 (DA-5)
BRIEF RISK ASSESSMENT FOR CLINICIANS

The DA-5 is a brief risk assessment that identifies victims at high risk for homicide or severe injury by a current or former intimate partner.[1-3] It should be used when intimate partner violence has been identified in the Emergency Department or other health care settings, protective order or child custody hearings, or other brief-treatment/practice settings. Presence of these risk factors could mean the victim is in danger of serious injury and/or homicide. Evidence-based risk assessments should be used in combination with survivor self-determination and practitioner expertise to collaboratively develop the best way forward for each individual.

Mark **Yes** or **No** for each of the following questions.

_____ 1. Has the physical violence increased in severity or frequency over the past year?
_____ 2. Has your partner (or ex) ever used a weapon against you or threated you with a weapon?
_____ 3. Do you believe your parent (or ex) is capable of killing you?
_____ *4. Has your partner (or ex) ***ever tried*** to choke/strangle you or cut off your breathing?
4a. If yes, did your partner ever choke/strangle you or cut off your breathing? check here: ____
4b. About how long ago? ____
4c. Did it happen more than once? ____
4d. Did it make you pass out of black out or make you dizzy? ____
_____ 5. Is your partner (or ex) violently and constantly jealous of you?
_____ **Total "Yes" answers**

*can be asked instead of or in addition to: Have you ever been beaten by your partner (or ex) while you were pregnant?

Scoring Instructions	Brief Strangulation Protocol
4 or 5 "yes" responses: • Tell the victim they are in danger. Give them the choice of reporting to the police and/or a confidential hotline (800-799-7233). Make the call with the victim and/or complete an in-person hand-off to a knowledgeable advocate. **3 "yes" responses:** • If the victim is female and you are trained to use the DA: ○ Complete the full DA using the calendar and weighted scoring. Inform the victim of her level of danger. Do safety planning based on the full DA results. • If the victim is female and you are NOT trained to use the DA: ○ Refer and hand-off the victim to someone certified to administer the full DA (in-person or voice-to-voice hand-off is preferable). **2 "yes" responses:** • Tell the victim there are 2 risk factors for serious injury/assault/homicide. If victim agrees, refer and hand-off to a knowledgeable advocate (in-person or voice-to-voice hand-off is preferable). **0-1 "yes" responses:** • Proceed with normal referral/procedural processes for domestic violence.	If the victim answered **yes to 4a**, follow this strangulation protocol for further assessment and/or refer to someone who is trained to conduct the following assessment. **If the strangulation was less than a week ago:** • Examine the inside of the throat, neck, face, and scalp for physical signs of strangulation. • Refer to the strangulation assessment and radiographic evaluation information at www.strangulationtraininginstitute.com • Proceed with emergency medical care for strangulation, especially if loss of consciousness or possible loss of consciousness (victims are commonly unsure about loss of consciousness) particularly if they became incontinent—ask if the victim "wet themselves". **If there were multiple strangulations:** • Conduct a neurological exam for brain injury or refer for examination. Inform the victim of increased risk for homicide. **If the victim wants, notify police and/or prosecutors** • Know state/local law on strangulation and mandatory reporting and inform the victim. For more information, visit www.dangerassessment.org

[1] This is a brief adaptation of the Danger Assessment (2003). The full DA with weighted scoring provides the most accurate assessment of risk. The DA and its revisions are evidence-based risk assessments intended for use with survivors to educate them and their supports about their risk of lethality or reassault and to inform their decision-making. [2] Snider, C., Webster, D., O'Sullivan, S.C., & Campbell, J. (2009). Intimate partner violence: Development of a brief risk assessment for the emergency department. *Society for Academic Emergency Medicine, 16,* 1209-1216. [3] Messing, J.T., Campbell, J.C., & Snider, C. (2017). Validation and adaptation of the Danger Assessment-5 (DA-5): A brief intimate partner violence risk assessment. *Journal of Advanced Nursing,* 73, 3220-3230.

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QUICK REFERENCE GUIDE FOR MAKING A SAFETY PLAN

We have also included a brief quick-reference guide to support medical professionals in discussing safety planning with patients experiencing domestic violence. This resource outlines six key aspects that should be addressed as part of a safety plan and provides suggested phrasing to help introduce and explore these topics in a clear, sensitive, and patient-centred manner.

MAKING A SAFETY PLAN

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Safe place to go	*"If you need to leave your home in a hurry, where could you go?"*
Planning for children	*"Would you go alone or take your children with you?"*
Transport	*"How will you get there?"*
Items to take with you	*"Do you need to take any documents, keys, money, clothes, or other things with you when you leave? What is essential?"*
Financials	*"Do you have access to money if you need to leave? Where is it kept? Can you get to it in an emergency?"*
Support of someone close by	*"Is there a neighbour you can talk to about the violence, who can call the police or come help you if they hear sounds of violence coming from your home?"*

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VIPROM - Victim Protection in Medicine
(No.101095828)

viprom Roadmap

for **Victim Protection** *in* **Medicine**
and **Domestic Violence - Informed Medical Care**

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