

Toolkit

Improving transfer of learning into practice from training courses on violence against women



July 2015

Contents

1. Definitions and abbreviations	4 - 7
2. Introduction	8 - 10
3. Prevalence of intimate partner violence (IPV) and sexual violence	11
4. Importance of healthcare sector in responding to IPV and sexual violence	12- 13
5. Who is this toolkit for?	14
6. How to use the toolkit	15 - 17
7. Tools:	18 - 50
7.1. Preparatory stage of training	18
○ TOOL 1 – Organisational review of training agenda	18
○ TOOL 2 – Training budget allocations	19
○ TOOL 3 – External training request form	20
○ TOOL 4 – Motivation to attend training (extrinsic)	21
○ TOOL 5 – Email to trainer	22
○ TOOL 6 – Basic contents of a training programme in intimate partner violence and sexual violence	23 - 45
7.2. Starting and developing training and training course (training stage)	25
○ TOOL 7 – Motivation to action (intrinsic)	25 - 26
○ TOOL 8 – Mnemonic planning aid	27
○ TOOL 9 – Training knowledge in IPV and sexual violence	28 - 29
○ TOOL 10 – Training methods	30 - 32
○ TOOL 11 – Managing disclosure	33
○ TOOL 12 – Managing disclosure/no clinical psychologist available	34
○ TOOL 13 – Ethical and legal aspects	35
○ TOOL 14 – Information on vicarious trauma and self-care	36
○ TOOL 15 – Letter to self	37
○ TOOL 16 – “I will implement”	38
○ TOOL 17 – Provide materials	39
7.3. Implementation of training stage	40
○ TOOL 18 – Letter to employer	49
○ TOOL 19 – Policy/adaptation of skills to workplace setting	41
○ TOOL 20 – Observation and shadowing of experts being observed	42
○ TOOL 21 – Champion for the issue in each team/organisation	43
7.4. Post-training stage and follow-up	44
○ TOOL 22 – Supervision	44
○ TOOL 23 – Keeping the issue on the agenda	45
○ TOOL 24 – Share positive stories	46
○ TOOL 25 – Reflective practice meetings	47
○ TOOL 26 – Offer ongoing support	48

7.5. Assessment tools	49
o TOOL 27 – Evaluation	49
o TOOL 28 – Training review form	50
8. Practical examples of tools	51 – 86
o EXAMPLE – TOOL 3: Example of a training request form	51 - 52
o EXAMPLE – TOOL 4: Example of clinical session abstract ‘IPV and sexual violence: Consequences for healthcare’	53
o EXAMPLE – TOOL 5: Example email to trainer	54
o EXAMPLE – TOOL 6: Descriptive document of the development of the training activity	55 - 56
o EXAMPLE A – TOOL 7: Initial questionnaire	57 - 58
o EXAMPLE B – TOOL 7: Breakdown prejudices and myths	59
o EXAMPLE C – TOOL 7: Film / video clip	60
o EXAMPLE – TOOL 8: Assault mnemonic	61
o EXAMPLE A – TOOL 9: Relevant bibliographical material	62
o EXAMPLE B – TOOL 9: PowerPoint presentation	63
o EXAMPLE – TOOL 10: Role playing	64 - 66
o EXAMPLE – TOOL 14: Presentation on vicarious trauma and self-care	67 - 69
o EXAMPLE – TOOL 16: Example work sheet	70
o EXAMPLE – TOOL 17: S.I.G.N.A.L. Intervention steps for IPV	71
o EXAMPLE A – TOOL 27: Example of course evaluation form	72 - 75
o EXAMPLE B – TOOL 27: Example of course evaluation form (specific to toolkit)	76 - 77
o EXAMPLE C – TOOL 27: Final questionnaire	78 - 79
o EXAMPLE A – TOOL 28: Example of training review form	89
o EXAMPLE B – TOOL 28: Example of assessment of transfer into practice	81 - 86
9. Examples of training courses	87 - 91
10. Conclusions	92 - 93
11. References	94 - 95
12. Appendices	
a. Project partners	96 - 98
b. Needs assessment process and results	99 - 109
c. Contact details	110
d. Acknowledgements	111

1. Definitions and abbreviations

Clinical supervision

Clinical supervision provides an opportunity for staff to: reflect on and review their practice; discuss individual cases in depth; change or modify their practice and identify training and continuing development needs.

Domestic violence (DV)

Domestic violence is all acts of physical, sexual, psychological or economic violence that occur within the family or domestic unit or between former or current spouses or partners, whether or not the perpetrator shares or has shared the same residence with the victim. This does not include acts of child abuse (victims under 16 years old).

Expert

A person who works within and is very knowledgeable about or skilful in the field of domestic/intimate partner violence and/or sexual violence.

Evaluation

Set of procedures to measure the quality of structured training initiatives (objectives, contents, methods, results). The purpose of the evaluation is to assess the ability of a training activity to produce changes in knowledge, skills and attitudes. Participants can evaluate training against the course objectives (quality, content, amount or value of training provided) and their confidence in the impact of the training towards their professional development for the future. It is important for the organisations to know the structured feedback from students and when it is possible, to evaluate the transfer of the knowledge to the clinical practice and the potential impact on health services.

Gender-based violence

Gender-based violence against women is violence that is directed against a woman because she is a woman or that affects women disproportionately. See also 'Violence against women'.

Intimate partner violence (IPV)

Refers to physical, psychological, sexual and economic violence by a partner or ex-partner. We also use the term 'Domestic violence' to describe IPV.

Learner

A person who requires or has recently acquired training or skills on supporting victims of domestic or sexual violence. Also see 'Participant'.

Participant

A person who attends/attended training on domestic or sexual violence e.g. healthcare professionals receiving training – also known as learners or trainees.

Patient

A person receiving, or registered to receive, medical, emotional and psychological treatment, care or attention. Throughout this toolkit the word patient is used to mean a victim, client, survivor or patient.

Physical violence

Encompasses any non-accidental act involving deliberate use of force, such as slapping, beating, thrashing, shoving, causing injuries, fractures or burning that provoke or may provoke bodily lesion, harm or pain.

Psychological violence

Deliberate and longstanding conduct that puts in jeopardy the psychological and emotional integrity and personal dignity of the victim, with the purpose of exerting power and control. It materialises in threats, verbal abuse, humiliation or debasing treatment, demand for obedience, social isolation, blame, deprivation of freedom, economic control, emotional blackmail, rejection or abandonment.

Reflective practice

Reflective practice allows professionals to study their own experiences to improve the way they work and support continued learning in the workplace. Within domestic and sexual violence practice it is beneficial for staff groups to undertake reflective practice together, sharing cases and the approaches taken and challenges that were faced. Discussing these with other workers allows the group to share experiences, learn from each other, balance actual practice with theory and learning and therefore enable ongoing learning based upon real experience.

Role play

Act out or perform the part of a person or character, for example, as a technique in training for further analysis of the situation or scene afterwards, generally by a group led by an instructor. This is particularly helpful for learning in domestic and sexual violence as it allows the participant to test out their approach in a simulated way and receive feedback, without the need to involve real survivors. This is particularly important due to the sensitive nature of the issue.

Sexual abuse

See 'Sexual violence'.

Sexual violence (SV)

“Sexual violence is any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person’s sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including – but not limited to – home and work.” (WHO Guidelines, 2013.)

Coercion can cover a whole spectrum of degrees of force. Apart from physical force, it may involve psychological intimidation, blackmail or other threats; for instance, the threat of physical harm, of being dismissed from a job or of not obtaining a job that is being sought. It may also occur when the person it is aimed at is unable to give consent; for instance, while drunk, drugged, asleep or mentally incapable of understanding the situation.

Simulation training

Simulation-based education enables knowledge, skills and attitudes to be acquired in a safe, educationally orientated and efficient manner. Procedure-based skills, communication, leadership and team working can be learnt, be measured and have the potential to be used as a mode of certification to become an independent practitioner. Also see 'Role play'.

Supervision

See 'Clinical supervision'.

Survivor

A victim of domestic or sexual violence who has been able to leave the emotional, mental and physical control of an abuser and moved forward in being in control of their own life and choices. This is not to distinguish a 'survivor' as being better than a 'victim'. Not at all. It demonstrates the right and ability of victims, for themselves and with the right societal and individual support, to move beyond the impact of being a victim of a perpetrator's criminal behaviour.

Tool

A recommended approach, set out in a standard template, to be used as part of the training cycle; either in planning, preparing, delivering or monitoring/evaluating stages of training in domestic or sexual violence.

Toolkit

The full set of tools. Also see 'Tool'.

Trainee

A person ('learner') undergoing training in domestic or sexual violence. Generally, within the Toolkit the term 'participant' is used to describe people who attend training courses. Also see 'Participant'.

Trainer

A person who is involved in delivering training to participants. This includes experts working the field of domestic and sexual violence who might not typically be 'trainers' in their principle profession. They are included within our definitions as participants identified that experts provided valuable input during training enabling participants to gain greater confidence and understanding.

Training

Set of procedures to teach a person certain knowledge, skills and behaviors through different methods, that should be selected depending on the objectives of the specific training activity. This is usually part of a course, session, workshop or ongoing learning. When the goal is to provide tools to perform a function or role it is also called training.

Victim

An individual who has had domestic or sexual violence perpetrated against them.

Violence against women (VAW)

Defined at 1993 United Nations General Assembly as: “Any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life. It includes many different forms of violence against women and girls, such as intimate partner violence (IPV), non-partner sexual violence, trafficking, and harmful practices such as female genital mutilation.” (United Nations. Declaration on the elimination of violence against women. New York, United Nations, 1993.)

Defined by the Council of Europe as: “A violation of human rights and a form of discrimination against women and shall mean all acts of gender-based violence that result in, or are likely to result in, physical, sexual, psychological or economic harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life.” (Council of Europe Convention on preventing and combating violence against women and domestic violence. Article 3a (2011).)

2. Introduction

Victims and survivors of domestic and sexual violence deserve the very best from those organisations, teams and individual professionals who directly and indirectly provide care and support. Professionals, teams and organisations want to provide high-quality, victim-centred care. However, we must recognise that this is a challenging area within which to work. Bridging the gap between the commitment to do right by victims and survivors, and how this is done in practice, is why we embarked on this project and have developed this toolkit.

Our four organisations came together to share our expertise and experiences. Our aim is to provide practical, good quality and adaptable training and learning tools that can be applied widely across many sectors and countries and which will improve the transfer of knowledge from courses into practice. The Leonardo grant stream, which has sponsored this project, is part of the European Union Life Long Learning fund. So this project is based on the principle of shared learning – our direct experiences – and also on the collation of and response to learners’ views in each of our countries and with whom our organisations have worked to provide training. This is not a research project. Its methodology is deliberately based on the experience of learners and trainers in the field, the barriers they have told us they faced when becoming skilled in this subject, and the methods and tools they told us that were most useful to them.

We hope the toolkit will also contribute to raising awareness about domestic and sexual violence, both by its existence and also by widening the knowledge base through those who benefit from using it.

The first stage of evidence gathering was to collate the experiences and views of learners, both those with advanced knowledge of the subject and those new to it. The range of learners included doctors, nurses, counsellors, psychologists, psychotherapists, care workers and advocates. It included those for whom domestic and sexual violence is the principal sector in which they work and those who require baseline information to help identify victims and provide immediate support and ongoing referral and signposting. We wanted to know what had worked well in their training, what had not worked well, what was missing or could have been better, what barriers they faced to implementing what they had learnt and how they had applied it in the workplace.

This led to a series of themes around which we could then develop this toolkit. The important findings were:

- There was a lack of organisational commitment either to understanding the importance of supporting learners in applying their learning in this field or enabling their learning to make a practical difference when back in the workplace.
- The emotional challenges of attending training in this subject could make the learning itself difficult or its application challenging. There was a consistent view that applying what had been learnt in the workplace needed sufficient opportunities for ongoing support, such as clinical supervision and peer review.
- It was felt, particularly at the team/organisational level, that sufficient background data, evidence and information was required to embed the importance of the subject but that

actual training should focus on practical tools and be delivered by experts working in the field with the credibility to speak from knowledge and experience. Notably, although in many areas of training, learners often dislike role playing, ours felt overwhelmingly that learning by doing – being observed and receiving feedback – was essential for this subject.

Our detailed needs assessment is included for reference in Appendix 12b.

Using the core themes in the needs assessment, we developed draft tools focusing on organisation/team needs, trainers' needs and learners' needs. We piloted these across our four countries before finally revising them into the set that now constitutes this toolkit.

We have deliberately kept the range of tools wide and varied. We anticipate users of the toolkit will 'pick and mix' according to the constraints of their training schedules, their own needs and objectives, the extent to which particular barriers exist for them and the learner audience they are addressing.

The tools range from generic ones that could be applied to training in almost any subject, through to those that are specific to training in domestic and sexual violence. Generic tools focus on organisational commitment such as budget allocation and training reviews through to training request forms that identify the justification for learning and its application in the workplace. These have been included because our learner needs assessment identified that the challenges presented by this subject require the basic bedrocks of training management more than most subjects might. Staff attending time management training, for instance, would be highly unlikely to face any barriers to implementing their learning in the workplace. In our needs assessment, learners identified again and again that organisational barriers were amongst the greatest obstacles to following through in their workplace.

At the other end of the spectrum, our subject-specific tools have been designed to identify and provide practical solutions to the emotional and personal challenges that domestic and sexual violence learning can bring. This set of tools is structured to normalise the subject, making it as easy, we hope, to apply back in the workplace as the example of time management training would be. Having trainers who work in the field managing emotional reaction and personal disclosure during training and providing ongoing support post-training is about providing care for the individual learner. This care and support for workers is essential to ensuring we can all be as good for tomorrow's client as we are for today's. Acknowledging the impact that working with the trauma related to domestic and sexual violence can have on the worker, and providing the appropriate support during learning and beyond, is central to our objective of providing the highest possible care for victims and survivors.

Our four organisations have brought different strengths and experiences to this project and the process resulting in this toolkit. S.I.G.N.A.L. e.V. is a Berlin-based organisation which supports and develops interventions in the healthcare sector to address gender-based violence. The University Clinic for Medical Psychology, Psychotraumatology and Trauma Therapy department, Austria, has provided expert psychological input for our project and is leading the rollout of screening and early identification work across nursing teams at the Innsbruck Hospital. Gerencia Regional de Salud, SACYL, is a regional health service. In 2008, it launched a project to detect gender violence and care for victims across primary care services in their region of Spain. The Havens in London are the UK's largest

Sexual Assault Referral Centre service providing direct care to victims of rape and sexual assault, from forensic medical examinations through to medical and psychological follow-up care.

When we refer to intimate partner violence and sexual violence in the following text, we are mainly referring to the situation of women who have experienced such violence. This is because of the differences between the genders regarding prevalence and the consequences of intimate partner and sexual violence and also the differences in how survivors are affected by the violence. In addition, there is limited research evidence available on men who experience intimate partner violence or sexual violence and on their support needs. However, when providing training, the situation of men experiencing violence needs to be considered and – where possible – addressed.

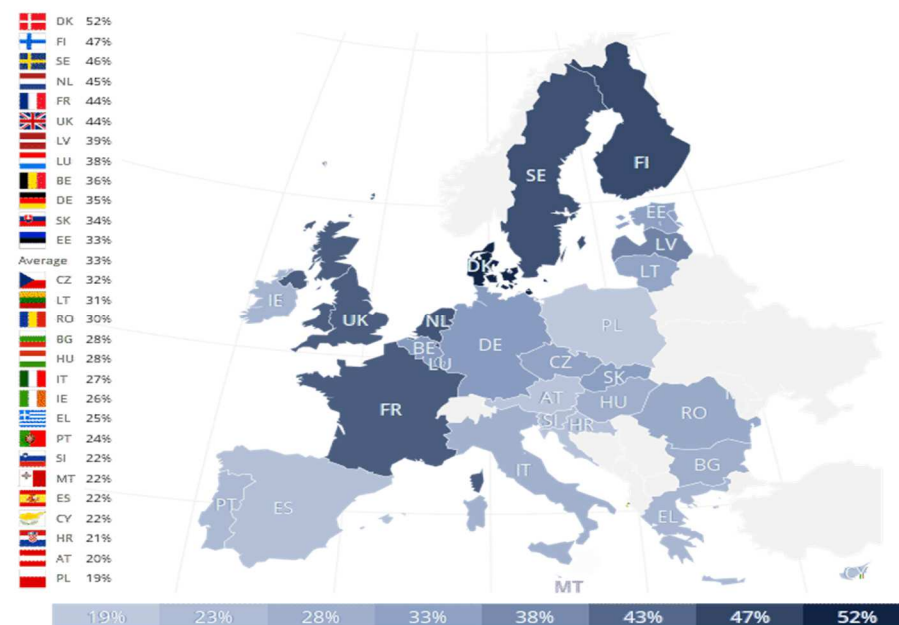
Appendix 12a has more information about the work of our organisations.

3. Prevalence of IPV and sexual violence

Data from the WHO multicountry study on women’s health and domestic violence against women (García-Moreno C et al. WHO multicountry study on women’s health and domestic violence against women: initial results on prevalence, health outcomes and women’s responses. Geneva, WHO, 2005) reveal that: between 13% and 61% of women 15–49 years old report IPV at least once in their lifetime; between 6% and 59% report forced sexual violence, or an attempt at it, by an intimate partner in their lifetime; and 1% to 28% report physical abuse during pregnancy. Studies carried out in participant countries show a high prevalence of IPV and sexual violence.

A 2014 European study found prevalence rates in Europe for physical, sexual and psychological violence/physical and/or sexual violence by a partner or a non-partner against women from the age of 15 to range from 19 to 52% (European Union of fundamental rights).

1. Physical, sexual and psychological violence / Physical and/or sexual violence by a partner or a non-partner since the age of 15



© FRA - All rights reserved - FRA gender-based violence against women survey dataset, 2012 | Yes | All : All

The prevalence of the above for countries who participated in the development of this toolkit was:

- Austria – 20%
- Germany – 35%
- Spain – 22%
- UK – 44%

It is important to acknowledge that domestic and sexual abuse is perpetrated against women and men, by women and men, and occurs in heterosexual and same-sex relationships. A recent study (The Crime Survey in England and Wales, 2012-13) revealed intimate partner violence by women against men, and amongst same-sex couples, both male and female, which needs to be analysed further to provide a suitable professional response.

4. Importance of health care sector in responding to intimate partner violence and sexual violence

The WHO states that intimate partner violence and sexual violence are a major risk to women's health (Krug et al, 2002; Homberg et al, 2008). IPV and sexual violence have manifold effects on women's and their children's health, on decisions and actions related to their health and on their health opportunities (Campbell, 2004; WHO 2013; Bott, 2012).

Somatic and psychosomatic consequences: in particular, bruises, fractures, facial and head injuries, burns, bites, abrasions, unexplained pain, gastrointestinal symptoms, heart- and circulatory problems.

Psychological consequences: in particular, nervousness, strain, weakness, problems sleeping, concentrating and eating, depression, anxiety and panic disorder, post-traumatic stress disorder (PTSD), suicidality (Ellsberg M, 2008) and psychological dependence on the perpetrator.

Survival strategies harmful to health: in particular, smoking, use of alcohol and drugs, and drug dependence.

Reproductive health consequences: in particular, premature birth, miscarriage, complications during pregnancy and birth, low birth weight (Sarkar NN, 2008).

Overall women experiencing IPV or sexual violence report health problems more frequently and make more use of health care services. Compared to women who are not affected by IPV or sexual violence they seek medical help and require medical or surgical treatment more often.

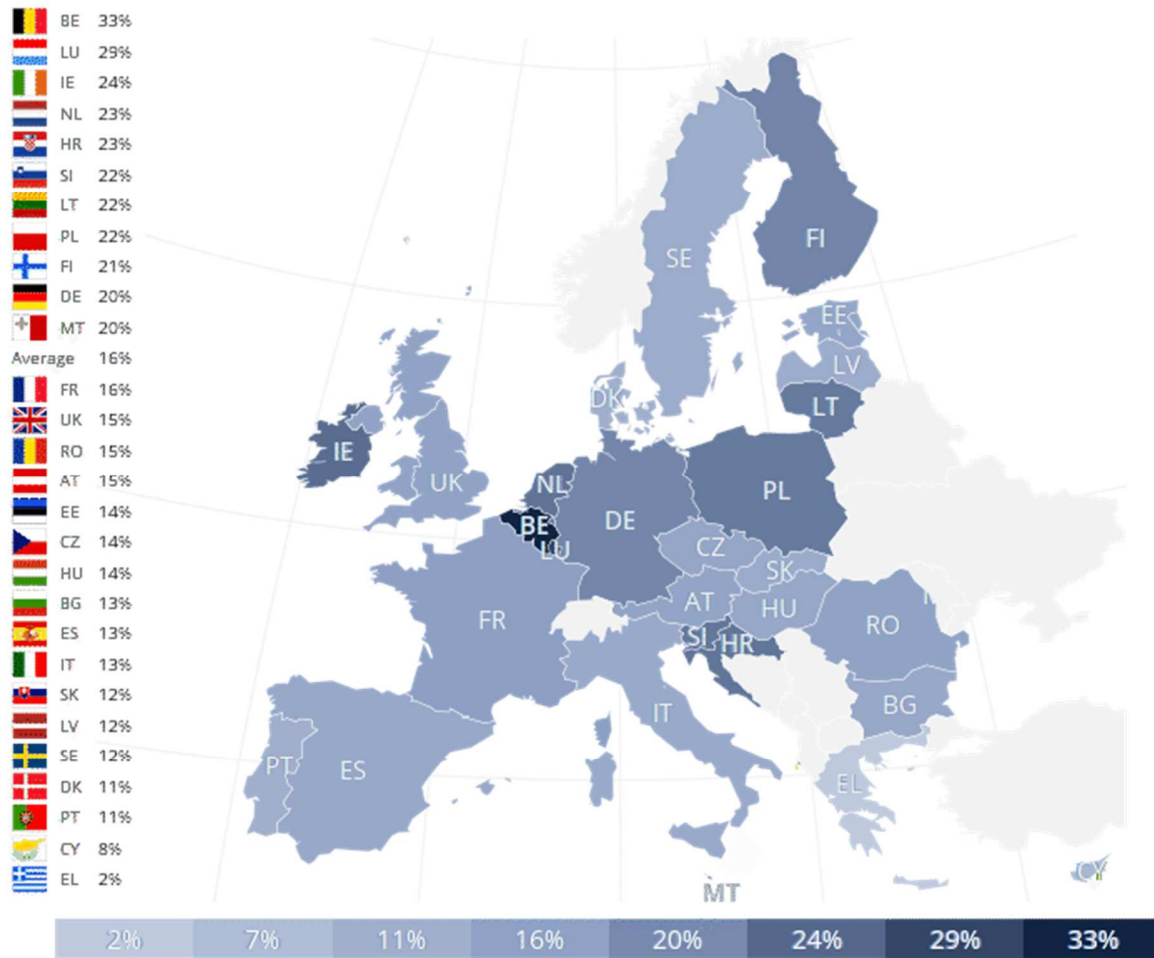
Many women experiencing IPV or sexual violence do not seek support from the police or other organisations. Health care professionals are often the only professionals who have contact with survivors, who note and treat their injuries, health consequences and harmful health strategies.

Studies confirm unanimously that health care services are in an outstanding position to assist women who experience violence and seek help (FRA 2014, Gloor/Meier 2014, Homberg 2008, WHO 2013). Health care providers are the most trusted professionals identified by survivors, amongst other things due to confidentiality (FRA 2014). Consequently, health care providers have a significant intervention and prevention role in IPV and sexual violence.

Systematic inclusion of IPV and sexual violence in the training of health care professionals and in their continuing education is recommended by the WHO (2013). It is vital for their ability to respond appropriately and sensitively to the needs of survivors and their children and to ensure the best possible care.

The map below shows, by EU member state, the percentage of women who answered 'doctor, health centre or other health institution' when asked about 'contacting organisations and services as a result of the most serious incident of physical and or sexual violence by a partner since the age of 15'.

2. Consequences of physical and sexual violence / Contacting organisations or services as a result of violence by a partner



© FRA - All rights reserved - FRA gender-based violence against women survey dataset, 2012 | Doctor, health centre or other health care institution | All : All

5. Who is this toolkit for?

The toolkit is for:

- trainers offering training in domestic and/or sexual violence
- organisations working in domestic and/or sexual violence (with victims or involved in training or raising awareness)
- individuals interested in the training available.

It provides organisations and trainers with more details of how to put sustained learning transfer into practice as well as practical support. For organisations, trainers and learners there is information about support possibilities pre-, during and after training, plus practical advice on how to implement training.

The toolkit provides a range of different tools, examples of how training can be structured, and suggestions for useful training methods and how to manage disclosures from participants with or without a clinical psychologist.

It also offers recommendations for the trainees' and health care services' organisations on how to provide and implement training in domestic and/or sexual violence. Organisations interested in this toolkit can be working with victims of domestic and/or sexual violence, or providing training or raising awareness in this field.

Individuals interested in domestic and sexual violence training can also use this toolkit to get more information about suitable training content and how to put learning into practice.

6. How to use the toolkit

The toolkit offers a set of tools for improving the transfer of learning from training in IPV and sexual violence interventions/support into practice. It should be adapted to the different needs of trainers, participants and organisations, depending on their roles and the tasks they perform:

- the type of targeted participants (undergraduates, staff, professionals)
- the kind of training that will be taught (basic, advanced)
- the speciality the professional is working in (family physician, emergency medicine, nurse, midwife, therapist, others)

It comprises **five parts** that can be used as the trainer/participant or organisation sees fit, depending on the needs identified, See section 7 for tools.

In section 8 we provide examples of some of the tools, to aid comprehension and implementation. The tools can also be chosen as the trainer/participant or organisation sees fit. There is no need to use all the tools and it is possible to combine many of them.

6.1. Preparatory (pre-training) stage of training: planning, design and preparation of the training activity

This section includes those activities that any trainer should consider when they decide to carry out an IPV training activity or programme. We try to motivate professionals to attend IPV/SV training to raise awareness and on the topic.

Things to consider:

- 1) Organisational aspects: structure, logistics, preparation of training programme, teaching staff etc.
- 2) Encouraging professionals to attend training.

For this preparatory stage, there are 6 tools and 4 examples. These are listed in the following table and fully explained in sections 7 and 8.

PREPARATORY (PRE-TRAINING) STAGE OF TRAINING: PLANNING, DESIGN AND PREPARATION OF THE TRAINING ACTIVITY	
TOOLS	EXAMPLES
<ul style="list-style-type: none"> ❑ Tool 1 – Organisational review of training agenda ❑ Tool 2 – Training budget allocations ❑ Tool 3 – External training request form ❑ Tool 4 – Motivation to attend training (extrinsic) ❑ Tool 5 – Email to trainer ❑ Tool 6 – Basic contents of a training programme in IPV and sexual violence 	<ul style="list-style-type: none"> ❑ Example, Tool 3. Example of a training request form ❑ Example, Tool 4. Example of clinical session abstract ❑ Example, Tool 5. Email to trainer. ❑ Example, Tool 6. Descriptive document of the development of the training activity.

6.2. Starting and developing training and training course (training stage)

At the beginning of this phase, it is important to find out the motivation of the participants. The results of this should inform the content and learning outcomes of the training. This should include learners’ attitudes and expectations.

The objectives of this phase are to provide the **knowledge** and **skills** needed and improve the **attitudes** for IPV and sexual violence approach.

Appropriate training **methods** for raising awareness, the acquisition of knowledge and skills are also provided.

For this start-up and development stage, there are 11 tools and 10 examples. These are listed in the following table and fully explained in sections 7 and 8.

START-UP AND DEVELOPMENT OF TRAINING (TRAINING)	
TOOLS	EXAMPLES
<ul style="list-style-type: none"> <input type="checkbox"/> Tool 7 – Motivation to action (intrinsic) <input type="checkbox"/> Tool 8 – Mnemonic planning aid <input type="checkbox"/> Tool 9 – Training knowledge in IPV and SV <input type="checkbox"/> Tool 10 – Training methods <input type="checkbox"/> Tool 11 - Managing disclosures <input type="checkbox"/> Tool 12 – Managing disclosures/no clinical psychologist available <input type="checkbox"/> Tool 13 – Ethical and legal aspects <input type="checkbox"/> Tool 14 – Information on vicarious trauma and self-care <input type="checkbox"/> Tool 15 – Letter to self <input type="checkbox"/> Tool 16 – “I will implement” <input type="checkbox"/> Tool 17 – Provide materials 	<ul style="list-style-type: none"> <input type="checkbox"/> Example A, Tool 7. Initial questionnaire <input type="checkbox"/> Example B, Tool 7. Break down prejudices and myths <input type="checkbox"/> Example C, Tool 7. Film/video clips <input type="checkbox"/> Example, Tool 8. ASSAULT Mnemonic <input type="checkbox"/> Example A, Tool 9. Relevant bibliographic material <input type="checkbox"/> Example B, Tool 9. PowerPoint presentation of the training session <input type="checkbox"/> Example, Tool 10. Role playing <input type="checkbox"/> Example, Tool 14. Presentation on vicarious trauma and self-care <input type="checkbox"/> Example, Tool 16. Example of working sheet <input type="checkbox"/> Example, Tool 17. S.I.G.N.A.L. intervention steps for IPV

6.3. Implementation of training stage

For this implementation of training stage, there are 4 tools. These are listed in the following table and fully explained in section 7.

IMPLEMENTATION OF TRAINING STAGE	
TOOLS	EXAMPLES
<ul style="list-style-type: none"> <input type="checkbox"/> Tool 18 – Letter to employer <input type="checkbox"/> Tool 19 – Policy/adaptation of skills to workplace setting <input type="checkbox"/> Tool 20 – Observation / Shadowing with experts <input type="checkbox"/> Tool 21 – Champion for the issue in each team/organisation 	N/A

6.4. Post-training stage and follow-up

For this post-training stage, there are 5 tools. These are listed in the following table and fully explained in section 7.

POST-TRAINING STAGE AND FOLLOW-UP	
TOOLS	EXAMPLES
<ul style="list-style-type: none"> <input type="checkbox"/> Tool 22 – Supervision <input type="checkbox"/> Tool 23– Keeping the issue on the agenda <input type="checkbox"/> Tool 24 – Share positive stories <input type="checkbox"/> Tool 25 – Reflective practice meetings <input type="checkbox"/> Tool 26 – Offer ongoing support 	N/A

6.5. Assessment tools

For this assessment stage, there are 2 tools and five examples. These are listed in the following table and fully explained in sections 7 and 8.

ASSESSMENT TOOLS	
TOOLS	EXAMPLES
<ul style="list-style-type: none"> <input type="checkbox"/> Tool 27 – Evaluation <input type="checkbox"/> Tool 28 – Training review form 	<ul style="list-style-type: none"> <input type="checkbox"/> Example A, Tool 27. Example of a course evaluation form <input type="checkbox"/> Example B, Tool 27. Example of a course evaluation form (specific to toolkit) <input type="checkbox"/> Example C, Tool 27. Final questionnaire <input type="checkbox"/> Example A, Tool 28. Example of training review form <input type="checkbox"/> Example B – TOOL 28: Assessment of transfer into practice



7. Tools

7.1. Preparatory (pre-training) stage of training: planning, design and preparation of the training activity

TOOL 1 – ORGANISATIONAL REVIEW OF TRAINING AGENDA (CROSS-REFERENCE TO TOOL 21 – CHAMPION FOR THE ISSUE IN EACH TEAM/ORGANISATION)	
Target group	Organisation: service management team or relevant governance group/meeting/committee.
When to apply	Quarterly, at relevant governance group/meeting.
Aim	To review the use of training budget allocations and monitor effectiveness in meeting service objectives. To monitor barriers to and issues with application of training and ensure that any training attended by participants fits service needs.
Materials required	Quarterly report that comprises training attended and service objectives the training is meeting. Ideally to include effectiveness of training in terms of application in workplace and also identify any gaps in key service objectives / risks that training has not been used to support.
Time required	Report creation: 1 to 2 hours, depending on number of staff and number of training sessions attended. Review at relevant governance meeting: 1 hour every 3 months.
Description	<p>A report summarising the training that has been attended (ideally as a result of individual budget allocations tool) would be discussed at a relevant management or governance meeting. This would review the effectiveness of the training and whether it – aggregately – supported service needs, gaps and risk management. It would also review barriers to staff delivering the benefits from the training in the workplace.</p> <p>As a result of this strategic/aggregate review it would:</p> <ul style="list-style-type: none"> • obtain senior/organisational commitment • identify repetitive barriers to implementation of learning • influence organisational identification of future training required and organisational support needs for ensuring training provided benefit to the organisation.

TOOL 2 – TRAINING BUDGET ALLOCATIONS	
Target group	Organisation: managers and team and professional group leaders.
When to apply	Organisational level: at annual budget-setting or equivalent process. Manager and team/professional group leaders: in agreeing use of total budget allocation – by request, by team planning, via outcomes of appraisals and objective settings.
Aim	To delegate a discrete budget to each team lead/manager and create greater focus on the training agreed and therefore achieve greater buy-in for training participation.
Materials required	Record of budget allocation and budget spent, any preferred method (electronic spreadsheet, hard copy etc).
Time required	Variable but not significant.
Description	Departmental/team leads have a discrete training budget for their team. This provides incentives to focus use of the budget on training that supports service objectives. Also, by the manager/lead being involved in and accountable for allocation, it creates greater buy-in by them. Increased ownership will help ensure that, when participants are back in the organisation implementing their learning, there is improved manager support for ensuring the learning can be supported in practice.

TOOL 3 – EXTERNAL TRAINING REQUEST FORM	
Target group	Participants attending training courses on domestic / sexual violence.
When to apply	Before applying to attend an external training course.
Aim	To reflect on their expectations for learning before attending a training course and to describe and promote benefit for participant, colleagues and organisation.
Materials required	Form, pen.
Time required	Approximately 10 minutes.
Description	Participants are asked to complete a form when considering attending training and to obtain agreement from manager before applying for a course. This form is then kept by the line manager and any training leads in order to review training received, dissemination where agreed/appropriate and any further training required. This can be done via 1:1 meetings/appraisals. Expenditure can also be monitored by managers to ensure budgets are adhered to and staff development is possible.
EXAMPLE – TOOL 3: An example of a training request form	

TOOL 4 – MOTIVATION TO ATTEND TRAINING (EXTRINSIC)	
Target group	Participants and trainers interested in domestic and sexual violence training.
When to apply	Before the training course.
Aim	Motivate professionals to attend IPV and SV training.
Materials required	Trainers: training website, posters, attractive training programmes, leaflets, etc. Any form of publication or publicity for training.
Time required	As part of the training schedule: 15 minutes
Description	<p>A few methods can be used to motivate and encourage learners to attend IPV and SV training:</p> <ul style="list-style-type: none"> • Publicise training offered with attractive, practical programmes, which focus on problem-solving. Use of publicity posters, computer systems available to most professionals. Programmes may have abstracts attached, which draw interest and offer a taster of the programme. • Accreditation to be obtained from a professional body for the training, to encourage professional development. • To facilitate access to training activities: carry out training activities during working hours, at the workplace, or having replacements during training time (for staff professionals) • Integration of IPV and SV in the mandatory postgraduate training programme for professionals (eg within teaching curriculums for junior doctors). • To incorporate into the professional skills training in healthcare and related professions. • Formal integration of IPV and SV detection and assistance activities to the service portfolio, so it is deemed necessary to develop those skills, as their performance on them will be assessed (within primary care and hospital settings). • Bibliography or reading list to be sent out to learners for information, prior to attending training on IPV or SV.
EXAMPLE – TOOL 4: An example of the clinical session abstract 'IPV and sexual violence: consequences for health care'	

TOOL 5 – EMAIL TO TRAINER	
Target group	Participants attending training courses on IPV/sexual violence.
When to apply	Before the training course.
Aim	To give participants the opportunity to consider their expectations about the training and to write down their needs. Trainers can also use the information to address any needs not yet covered in the training course.
Materials required	Computer.
Time required	10 to 15 minutes.
Description	<p>Participants are asked by the trainer to write an email to the trainer in which they explain what they want to learn and discuss during the imminent training. This should be done around 2 weeks before the course.</p> <ul style="list-style-type: none"> ● Specify what will happen with the answers (are they confidential? Who will see them?) ● The email could also include a brief questionnaire about motivation and expectations.
EXAMPLE – TOOL 5: An example of an email that trainers can use	

TOOL 6 – BASIC CONTENTS OF A TRAINING PROGRAMME IN IPV AND SEXUAL VIOLENCE	
Target group	Trainers and organisations offering training.
When to apply	Before the training course.
Aims	<p>The main objective is to provide participants with the knowledge and skills needed to detect mistreatment/violence and to be able to provide a comprehensive approach in dealing with victims.</p> <p>To define for each activity specific objectives according to trainees, the activity format and the time available. Objectives include:</p> <ul style="list-style-type: none"> • understand the concept of gender-based violence and its determinants • analyse the causes from a gender perspective • understand the physical, psychological and social effects of mistreatment on women's and children's health • identify the different types of abuse and be able to make early diagnosis in the practice, by identifying risk factors, situations of special vulnerability and symptoms of domestic violence in women • acquire skills for clinical interviews of women suspected of being victims of domestic violence • identify opportunities for preventative action • enable diagnosis of abuse and assess its extent, assessing the immediate physical, psychological and social risk • know the possible actions in a case of confirmed abuse, depending on the situation of the woman (stages of change) • be able to conduct a comprehensive approach to the problem from different facets of intervention (primary care, emergency services, mental health), taking into consideration the woman, the children and the aggressor. • understand the ethical and legal aspects of gender-based violence victim care and be able to complete the mandatory report, if indicated • know the social and health resources available to obtain the necessary help and know the criteria for referral to them. Need for intersectoral coordination. • be able to describe the impact of gender violence on health care personnel and ways of tackling it.
Materials required	Training programme available in different formats to enable their diffusion in different media (website, intranet, paper).
Time required	1 hour.

Description	<p>Design a training programme adapted to the target group profile and their professional role.</p> <p>Those responsible for the training will develop the programme that defines objectives, content and methodology to:</p> <ul style="list-style-type: none"> • raise awareness of and train professionals in the detection and management of IPV and SV situations in their practice • acquire basic competences: knowledge and skills for the detection and management of and interaction/coordination with other professionals and institutions. <p>The programme should include the trainers, organisational aspects and accreditation, if applicable.</p>
<p>EXAMPLE – TOOL 6: Descriptive document of the development of the training activity</p> <p>Also see Section 9. Examples of training courses</p>	

“Most of my patients experienced childhood abuse. Before the training I did not make the connection between domestic violence and childhood abuse. Somehow the topic gets out of sight...”

Germany, learner

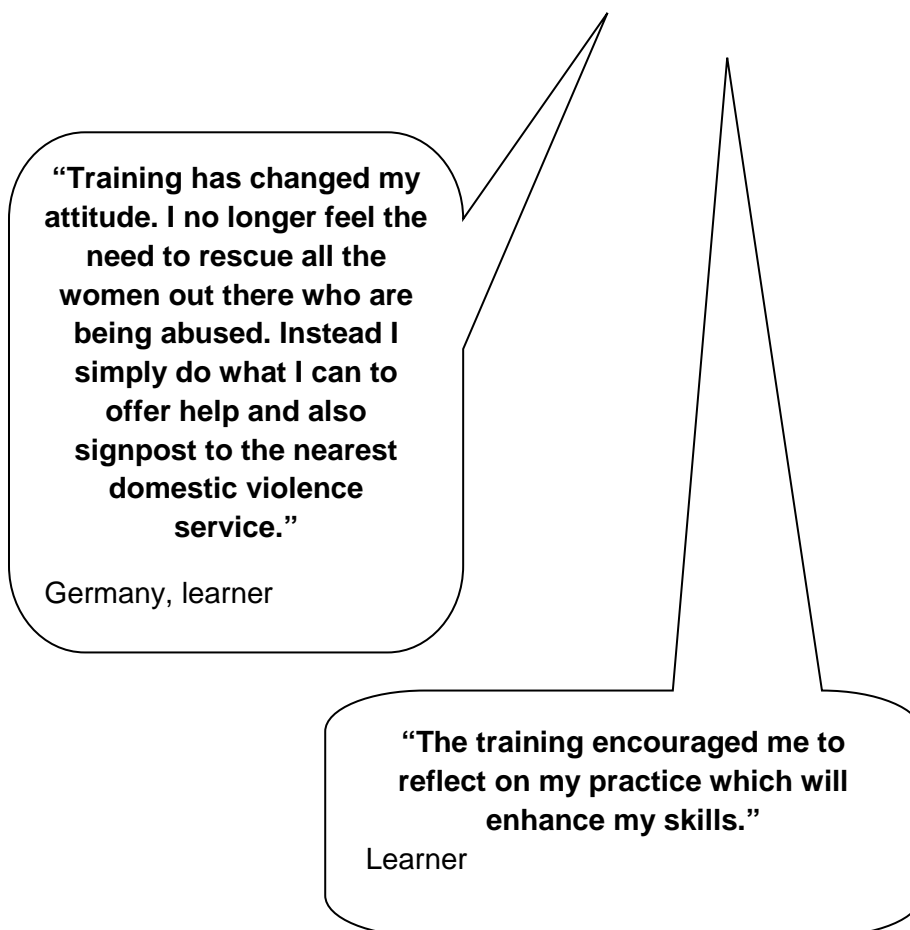
“Dealing with domestic violence was not part of my training as a medical doctor. In my surgery I need to see women who are experiencing domestic violence and I felt overwhelmed. I wanted to learn how to recognise the symptoms, how to ask about domestic violence, how to act on a suspicion and whether to use routine enquiry.”

Germany, learner

7.2. Starting and developing training and training course (training stage)

TOOL 7 – MOTIVATION TO ACTION (intrinsic)	
Target group	Participants attending training courses on IPV and SV.
When to apply	Within the training course.
Aim	<ul style="list-style-type: none"> • Raise awareness of IPV and SV, not only as a violation of people’s rights, but also as a health risk factor; the health care consequences for women and children in their care. • Make participants aware of their role, as professionals, when addressing this problem. • Improve attitude towards IPV and SV, promote empathy for the victims and break down prejudices and myths. • Motivate participants so they understand that IPV and SV care is a competence of healthcare professionals and an ability they need to develop to improve their performance.
Materials	<ol style="list-style-type: none"> 1. Initial questionnaire to explore motivation at the beginning of training activity and to know what participants expect. 2. Key papers on GV magnitude and consequences. 3. PowerPoint software to facilitate presentation. 4. Statements from victims. 5. Film/video clips. 6. Final questionnaire to check changes in attitude, if expectations have been met, and to gather information for future activities.
Time required	1.5 hours.
Description	<p>Explore motivations for and expectations of training, as well as attitudes towards IPV and SV. This can be done by means of either individual presentations or an initial questionnaire at the beginning of training.</p> <p>This will allow trainers to obtain a first assessment of the knowledge and skillset of a participant in regards to contact with IPV, any previous training attended and also any learning needs/requirements.</p> <p>This information will facilitate the trainer’s work and group adaptation. Following this, an explanation about raising awareness of the issue and how to spot the signs of IPV and SV should be carried out.</p> <p>Training techniques can be used such as:</p>

	<ul style="list-style-type: none"> • A PowerPoint presentation showing the main figures of prevalence, consequences for women and those around them, specially children. • Use of bibliography of interest, population surveys from a specific country, or research experience of the teaching team. Remark on the key role of healthcare professionals when tackling IPV. • Use of striking statements from victims, which will allow professionals to empathise with them. <p>At the end of the workshop, explore again briefly by means of final questionnaire, if the expectations stated in the initial questionnaire have been met, as well as the changes in motivation to attend future training activities.</p>
<p>EXAMPLE A – TOOL 7: Initial questionnaire EXAMPLE B– TOOL 7: Break down prejudices and myths EXAMPLE C – TOOL 7: Film/video clips</p>	



TOOL 8 – MNEMONIC PLANNING AID	
Target group	Trainers planning training and/or participants disseminating their learning in the workplace
When to apply	When planning a training programme or schedule (trainers); when planning how to disseminate learning in the workplace with colleagues (participants).
Aim	Decide a memorable word – the letters of which represent key elements required for successful training planning or learning dissemination in your setting
Materials required	One piece of paper; thought about a word that covers your key planning elements
Time required	Variable but not significant.
Description	Select a memorable word – ideally related to the subject – where the first letters of the word can each represent key stages of planning your training or planning your dissemination/application of training in the workplace. e.g. SMART [specific-measurable-achievable-relevant-timebound] is a commonly used mnemonic. You can choose your own mnemonic which is more specific to your subject area. E.g. ASSAULT could be a mnemonic which prompts when planning DV/SV training to think through the stages of: ‘ A im – S pecific – S etting – A udience – U seful – L earning – T ools’.
EXAMPLE – TOOL 8: ASSAULT mnemonic	

TOOL 9 TRAINING KNOWLEDGE IN IPV AND SEXUAL VIOLENCE	
Target group	Trainers
When to apply	Prior to and during the training course.
Aim	<ul style="list-style-type: none"> • Understand IPV and sexual violence concepts and their determinants. • Analyse causal factors from a gender perspective. • Understand physical, psychological and social effects of mistreatment on women's and children's health. • Understand the types of abuse and be able to perform early detection by identifying risk factors, vulnerable situations and symptoms of IPV and SV in women. • Understand the ethical and legal regulations regarding gender violence, in the environment where the training activity occurs, and the resources available.
Materials required	Selected relevant articles, guidelines and protocols, access to web pages of interest (e.g. WHO Violence, local web pages), PowerPoint presentations.
Time required	1 hour.
Description	<p>Prior to the training:</p> <p>A week before the workshop, participants should be sent documents or links to selected online material for prior reading.</p> <p>The trainers could then explain briefly the different updated theoretical aspects relevant in IPV and SV and adapted to the professionals participants, regarding:</p> <ul style="list-style-type: none"> • Concepts. • IPV and SV as a public health problem. • IPV and SV and its determinants (magnitude). • Male and female socialisation. • Mistreatment in the partnership: types, origin and cycle of violence. • Vulnerability factors (socio-cultural, familial and individual) and predisposing factors for the maintenance of IPV and SV. • Approach to IPV and SV prevention: primary, secondary and tertiary prevention. <p>During the training:</p> <ul style="list-style-type: none"> • To facilitate an exchange of statistics, depending on the demographics of the participants, that could be interesting (e.g. prevalence, consequences, figures of disclosures, deaths).

	<ul style="list-style-type: none"> • Explain how the data can be transferred to the practical and everyday aspects of their daily work. For example correlating the actual prevalence in their environment / country with the possible prevalence in the population attended. • Ask questions that serve as a reflection on the aspects that will be exposed and facilitate participation in training from participants.
<p>EXAMPLE A – TOOL 9: Relevant bibliographical material</p>	
<p>EXAMPLE B – TOOL 9: PowerPoint presentation of the training session</p>	

“It was very helpful to hear different perspectives from other professionals.”

Learner

“It was invaluable to experience diversity amongst learners.”

Learner

It was useful to gain practical information I could transfer to my everyday working life.”

Learner

TOOL 10 – TRAINING METHODS	
Target group	Participants attending training courses on IPV / sexual violence.
When to apply	During the training course.
Aims	<p>Methods should be adapted to the objectives pursued:</p> <ul style="list-style-type: none"> • Achieve a positive, empathic attitude towards IPV and SV victims, and raise awareness of the trainer’s organisation and their role in supporting victims. • Acquire or improve competence: knowledge, skills and attitudes, applying them to the detection and treatment of victims.
Materials required	<ul style="list-style-type: none"> • PowerPoint presentations or introductory material for general classroom-type training with tables and chairs. • Actors may be necessary for development; if not available, students and teachers will suffice. • Audiovisual materials. • Flipchart for writing down comments, key aspects and conclusions. • Role-playing with actor / actress using different scenarios.
Time required	Depends on the type of training course.
Description	<p>Different methods are usually used in the same workshop to achieve the teaching objectives relating to knowledge, skills and attitude for the detection and management of cases.</p> <p>Using practical methods that bring the participants to situations similar to their practice are the most valued by students and professionals:</p> <p>To reproduce, analyse and solve clinical cases of IPV and SV through simulation of real or fictitious cases (role playing), or showing video clips of scenarios as examples. It allows participants to work on related aspects, manage emotions, think about clinical decisions, with a reduced pressure as it is game-like.</p> <ul style="list-style-type: none"> • The clinical presentation of case histories of IPV for the analysis and discussion in the group or in small groups, led by the trainer, is also useful. • Role playing is the preferred method in terms of practical training. To use this method, trainers should elaborate a real or fiction case with a script with predefined answers. The dramatised case can have different possibilities, developing different outcomes according to the participant’s questions or actions. This can be done with actors or with students/teachers or with a role playing video recording. <ul style="list-style-type: none"> ○ The trainer defines the content, challenges and aspects they want to tackle. ○ The participant acts as the interviewer/professional, the

	<p>trainer (or a trained assistant) acts as the patient.</p> <ul style="list-style-type: none"> ○ The participant is given some information about what to observe: verbal and non-verbal language, interview contents, fields it explores, their attitude (empathy, warmth, assertiveness) expression and emotions of the woman, her complexities, and the behaviour of those accompanying her (if any) ○ The trainer directing the workshop will make decisions according to the established dynamics, and in a flexible way, in order to reach the objectives. ○ The analysis of the role-play should be carried out afterwards, asking both the trainer/actor their feedback also feedback from the group (if observed for peer learning). Feedback can be given after each scenario has been carried out by each participant or after all the scenarios have been completed. ○ The following topics should be covered: Security / Protection, information on services / help available, decisions, emotional management, exploration, comprehensive assessment, risk assessment, exploration of family context (children, people in her charge, abuser, legal aspects, etc). ○ Another possibility is role playing using a video recording instead of dramatisation. This would allow the content to be fragmented or allow use for more specific objectives (e.g. exploration, aspects of the judicial system). <ul style="list-style-type: none"> ● Cases presented with clinical history. This is suitable for group work: analysing the case, assessment, forming an intervention plan, report writing, referrals, and co-ordination. ● Film clips from a fragment of a film an analysis of the same: to serve more targeted as signs of alarm, possible profiles, it could also occur and make subsequent analysis by asking students. (Exploration, presentation injury, preparation of legal part.). It can be done during the theoretical exposition. (See: Example C Tool 7). <p>Victim's accounts / recording: subsequent group analysis. It allows participants to:</p> <ul style="list-style-type: none"> ○ See decisions from the victim's point of view. ○ Empathise with the victim. <ul style="list-style-type: none"> ● Document analysis (e.g. mandatory reports): review and analyse reports created from either real life or fictional scenarios regarding quality and contents. ● Interviews with professionals experienced in managing victims: <ul style="list-style-type: none"> ○ Work on cases with experts.
--	--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

- Present real cases.
- Discuss intervention possibilities.
- Counselling.
- Reasoned decisions
- Doubts resolution.

There are a number of excellent training manuals and curricula available to assist trainers and organisations in designing training courses and for choosing the appropriate training methods.

Examples of such manuals include:

1. PRO TRAIN (A Daphne II Programme Project)
<http://www.pro-train.uni-osnabrueck.de/index.php/Main/HomePage?userlang=en>
2. HEVI (Social and Health Care Teachers against Violence)
<http://www.palmenia.helsinki.fi/hevi/>
3. Implement (Violence against women Europe - WAVE)
<http://www.wave-network.org/content/implement-training-manual-now-available>

Information on how to implement IPV interventions in different health care settings can be found in the MIGG (medical intervention against violence towards women) manual, which can be found here: <http://www.bmfsfj.de/blaetterkatalog/196246/blaetterkatalog/index.html>

(This manual also contains a section on training.)

EXAMPLE – TOOL 10: Role playing

“From my point of view it was good to get so much information and information materials. Also the film clip was very impressive.”

Austria, learner

“Role play was really scary, but I learnt a lot in the process!”

Learner

TOOL 11 – MANAGING DISCLOSURES	
Target group	Participants attending training courses on domestic/sexual violence who are traumatised by the experience.
When to apply	When participants stops a role play and/or experiencing from a renewal of trauma.
Aim	Stabilisation of the participant and dealing with the distress. Restoring mental security for other participants.
Materials required	Separate room, clinical psychologist or psychotherapist.
Time required	1 to 1.5 hours.
Description	<p>The participant must be able to stop the role play immediately and get relevant support. In a first step the trainer has to try to stabilise the concerned person and to decode together with the participant whether she or he wants to talk to the clinical psychologist or psychotherapist.</p> <p>Therefore it is important that the former traumatisation must not be explored by the trainer. If the concerned participant wants to talk to the psychologist the appointment should be as soon as possible so that the stabilisation can be arranged by the psychologist as well.</p>

TOOL 12 – MANAGING DISCLOSURES/NO CLINICAL PSYCHOLOGIST AVAILABLE	
Target group	Participants attending training courses on domestic/sexual violence who are traumatised by the experience.
When to apply	At the time participant stops a role-play and/or experiences a renewing of trauma.
Aim	Stabilisation of the participant and dealing with the distress. Restoring mental security for other participants.
Materials required	Separate room.
Time required	60 to 90 minutes.
Description	<p>The participant must be able to stop the role play immediately and get relevant support.</p> <p>Contact with concerned participant</p> <p><u>General references:</u></p> <ul style="list-style-type: none"> • do not minimise, underplay or trivialise the things that had happened to them • do not give advice • normalise reactions (“they are normal reactions to an abnormal situation”) <p><u>Dealing with flash-backs:</u></p> <ul style="list-style-type: none"> • the flash-back is a reminder of the bad thing that had happened, not real now • concentrate on the here and now: <ul style="list-style-type: none"> ○ “The danger is over, it happened in the past, not now.” ○ “Now I am in a safe place.” ○ Realise the difference between then and now (“What day is it today?”, “Where are we now?”, “What time is it?”) ○ let the concerned participant describe things in the room (attentional deployment) <p><u>Answer questions, such as:</u></p> <ul style="list-style-type: none"> • “How will it go on with the training?” • “Are there any consequences for my career?” <p>Prepare for the return to the group. Referral to a clinical psychologist or psychotherapist.</p> <p>Contact with the group</p> <p><u>Stabilise:</u> explore potential feelings of guilt</p> <ul style="list-style-type: none"> • preserve confidentiality toward the concerned participant • prepare for the concerned participant’s return to the group

TOOL 13 – ETHICAL AND LEGAL ASPECTS	
Target group	Participants attending training courses on IPV/sexual violence.
When to apply	Within the training course, typically towards the end.
Aim	<ul style="list-style-type: none"> • To understand the ethical and legal aspects in relation to supporting a victim of IPV / SV. • Deliberate on the application of the rules to a practical case, taking into consideration the ethical aspects and legal obligations regarding the victim and the violence occurred. • Explain the reason behind taking a case to court or not - mitigating factors. • Discuss the conflict which may occur between ethics and what the law states. • To understand the relevant mandatory reporting process.
Materials required	<ol style="list-style-type: none"> 1. PowerPoint software 2. Video or audio recording. 3. For critical document analysis: mandatory report written by doctors (anonymised). 4. Laptop.
Time required	45 minutes to 1 hour.
Description	<p>In the decision stage of a case presentation (by means of role-playing, PowerPoint, video or audio recording) group discussion on the decision-taking process concerning:</p> <ul style="list-style-type: none"> • Confidentiality. • Respect for women’s decisions. • Fulfilling of legal responsibilities. • Is there any conflict between the ethical duties of respecting women’s decisions and your legal obligations? • Limits to the woman’s decision: In which situations, and with what justification, could the provider (participant and/or their organisation) act without the woman’s consent? • What risks do we have to take into account? What safety measures could we use? • Critical documentation analysis (mandatory reporting) carried out by doctors. With a laptop, writing down aspects (positive and negative) of each decision and the justification to take one or another, in order to reach the most reliable criteria for the professional’s decision-making and the woman’s well-being. • Reference relevant legal document and if possible have a legal representative for the group work to add credibility.

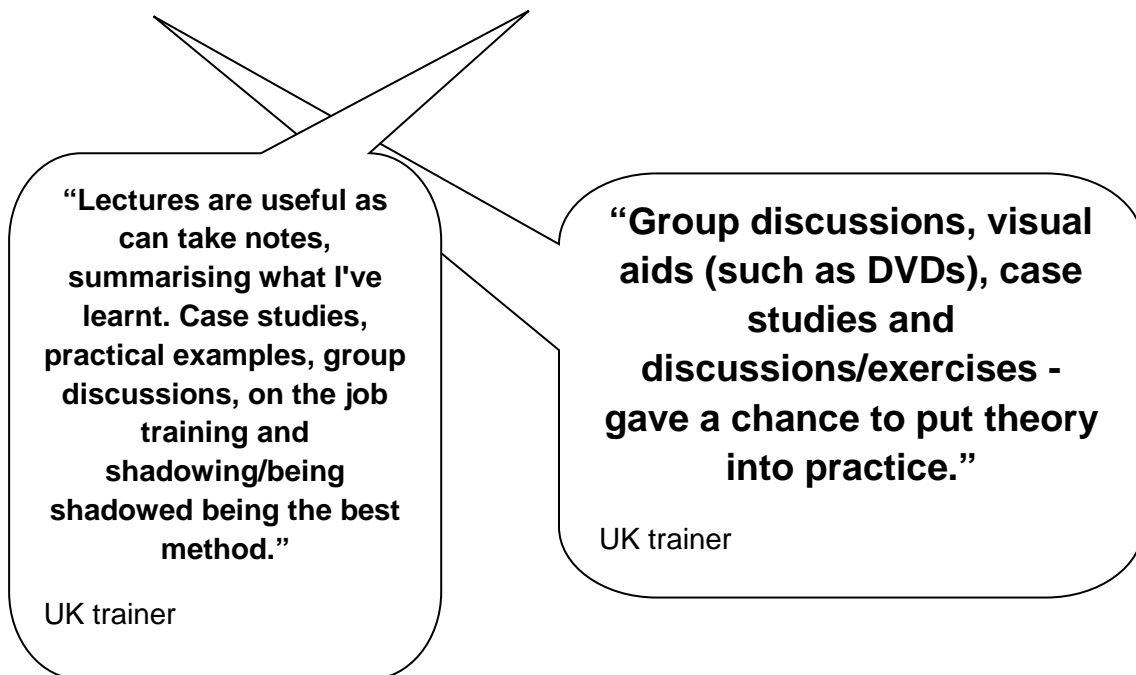
TOOL 14 – INFORMATION ON VICARIOUS TRAUMA AND SELF-CARE	
Target group	Participants attending training courses on IPV/sexual violence.
When to apply	At the beginning of the training course.
Aim	Delivering theory of psychotraumatology and agreement on rules and basic conditions for practical exercises.
Materials required	<ol style="list-style-type: none"> 1. Laptop. 2. PowerPoint presentation. 3. Flipchart.
Time required	30 to 45 minutes.
Description	<p>Participants are given basic information about psychological traumatising, the renewing of a former traumatic event and secondary traumatising. Participants also have to be advised that practical exercises (especially role plays) can renew their own previous traumatic experiences.</p> <p>That is why ground rules (e.g. “do not choose roles based on your own experience”, “the role play can be stopped at any time”) for those exercises have to be defined at the beginning of the training session and written down on a flip-chart.</p> <p>Participants have to be assured that they can consult a clinical psychologist or psychotherapist whenever signs of renewed trauma occurs.</p>
EXAMPLE – TOOL 14: Presentation on vicarious trauma and self-care	

“Knowing the trainers were so experienced in trauma made me feel contained even though it is a difficult subject.”

Learner

TOOL 15 – LETTER TO SELF	
Target group	Participants attending training courses on IPV/SV.
When to apply	During the training course.
Aim	To remind course participants of personal aims developed during the training course in order to encourage transfer of learning into practice.
Materials required	<ol style="list-style-type: none"> 1. Postcards or sheets of plain paper. 2. Pens. 3. Envelopes and postage stamps.
Time required	10 to 15 minutes.
Description	<p>Participants are asked to write a letter/card to themselves. In the letter they note down the main thing they have learned on the course and the three things they will change in practice as a result the course.</p> <p>The letter or postcard is given to the trainer, along with a self-addressed envelope. The trainer mails the letters/cards to the participants a couple of weeks later.</p>

TOOL 16 – “I WILL IMPLEMENT”	
Target group	Participants attending training courses on IPV/SV.
When to apply	End of the training course.
Aim	To enable participants to decide about first steps to take to change their practice and incorporate their learning into their workplace.
Materials required	<ol style="list-style-type: none"> 1. Worksheet (see example below). 2. Pens. 3. Flipchart.
Time required	20 to 30 minutes.
Description	<p>Participants are asked to fill in the worksheet provided. This encourages them to decide what they will do next with what they have learnt.</p> <p>After they have completed the worksheet, participants should discuss their individual plan with the person sitting next to them. They can be encouraged to swap phone numbers and support each other during implementation.</p> <p>Wrap-up with the whole group: the trainer asks for brief feedback on what participants will put into practice. The result can be visualised on a flipchart in order for the whole group to see everyone’s plans and to use this for future networking and support.</p>
EXAMPLE – TOOL 16: Example of working sheet	



TOOL 17 – PROVIDE MATERIALS

Target group	Participants attending training on IPV/SV.
When to apply	At the end of the training course.
Aim	To support participants in a practical way with implementing their learning from the training. This is done via provision of practice materials/job aids and information sources including information for patients.
Materials required	Hard copies of leaflets, flyer and poster.
Time required	10 to 30 minutes.
Description	<ul style="list-style-type: none"> • Participants are not likely to have the time, knowledge and resources to develop their own information leaflets, job aids and other materials such as posters – all of which can help to apply learning in practice. Therefore trainers can hand out or provide participants with toolkits, templates, sample materials, references and other practical materials as they see fit: desk card or pocket cards to be used as a brief reminder of e.g. important steps when caring for a woman who experiences IPV (like S.I.G.N.A.L.). • Sample sentences on how to ask about IPV • Referral phone numbers such as hotlines, specialist services for rape victims etc. • Information leaflets to give out to patients such as card with emergency phone numbers, information about trauma and trauma responses, information about children and IPV etc. • Poster and leaflets advertising hospital/clinic support available for domestic and sexual violence. • Information on where to order materials or templates for producing own versions of cards, flyers, leaflets etc.

EXAMPLE –TOOL 17: S.I.G.N.A.L. intervention steps for IPV

“I like that the handouts are so user friendly – I can use them in my own work.”

Learner

“An "idiot's guide" to information learnt - summary of absolutely essential information to take away would be useful.”

UK learner

7.3. Implementation of training stage

TOOL 18 – LETTER TO EMPLOYER	
Target group	Trainers and their organisations.
When to apply	After the training course.
Aim	Provide organisations which have sent participants on domestic/sexual violence training with information about the course and to encourage organisational support for implementation of learning.
Materials required	Letter to employer (official form).
Time required	5 minutes.
Description	<p>Each participant is given a letter to give to their employer at the end of the course. Alternatively participants can be informed about the letter and the letter is sent out directly to organisations (for example to line managers) after the course.</p> <p>The letter contains basic background information on domestic/sexual violence and the content of the training.</p> <p>It invites managers to support the participant’s efforts to introduce intervention strategies for IPV/SV in their work place and/or their own work practice. Some possible next steps are described and further support is offered.</p> <p>It also includes more information about training (e.g. in-house training) and materials (leaflets etc.) as well as a contact person/supporting organisation (if available).</p>

“Would like formal lines of communication for post training integration.”

UK learner - interviews

TOOL 19 – POLICY/ADAPTATION OF SKILLS TO WORKPLACE SETTING	
Target group	Participants who coordinate or are responsible for policies within an organisation or institution.
When to apply	Final part of the training course, ongoing.
Aim	To have a plan for how to implement the policy/service in the participant's organisation /workplace.
Materials required	Guidelines, checklists.
Time required	30 minutes to 1 hour, ongoing.
Description	<p>Participants work at different organisations, which will offer different services (e.g. hospitals, outreach clinics, GP surgeries, own practice).</p> <p>Most intervention skills are applicable to all settings, but some may require personnel, financial or time resources that are beyond the organisations' capacity. So every organisation needs to come up with an intervention program that also considers their specific work place and resources.</p> <p>To develop an implementation plan specific to their needs and organisation, participants are encouraged to reflect on:</p> <ul style="list-style-type: none"> • the potential to implement intervention skills within their healthcare organisation • the specific conditions and resources / limits within their organisation or institution • the way intervention skills and steps need to be adopted in order to be implemented within the organisation • the situations and conditions in which patients will benefit from a referral to another organisation (i.e. cases beyond the scope/skill/resources of that particular setting). <p>Participants may discuss their results, so differences between the services become apparent and ideas about how to adopt skills and services can be exchanged. Future networking or joint working between the organisations represented at the training course can be initiated.</p>

TOOL 20 – OBSERVATION AND SHADOWING OF EXPERTS AND BEING OBSERVED

Target group	Participants who have attended training on IPV/sexual violence.
When to apply	After the training course.
Aim	To increase participants' confidence, to further develop intervention skills and knowledge.
Materials required	List of professionals/ institutions that offer positions.
Time required	According to prior agreement, e.g. one day.
Description	<p>Participants get the opportunity to shadow an experienced healthcare professional during their work routine. This can be expanded into the trainee being observed by an expert so they can get feedback on their skills.</p> <p>Participants can observe how intervention strategies are put into practice and how complex situations can be managed. Communication skills may be improved through listening to an experienced professional discussing the sensitive issues of IPV/sexual violence.</p> <p>Participants are asked to reflect on their observations and on their feelings during consultations. They may write down what inspired them and what they wish to adopt within their own work.</p> <p>Where the participant is being observed, the expert should give feedback to the participant about what worked well and what they could improve. If possible, the exercise should be repeated until the participant has confidence and empathy.</p> <p>Where possible participants and experts are asked to report briefly on their experience for trainer's or organisational feedback. Participants schedule and manage the shadowing/ observation themselves.</p> <p>Experts and experts' organisations benefit from this exercise too as they too get to reflect on their practice. They may also benefit from the participant's external point of view, which could offer a new/fresh perspective.</p>

“Learners have learned through discussions with senior doctor.”

Spain, learner

TOOL 21 – CHAMPION FOR THE ISSUE IN EACH TEAM/ORGANISATION (CROSS-REFERENCE WITH TOOL 1 – ORGANISATIONAL REVIEW OF TRAINING AGENDA)	
Target group	Organisations or health care teams within an organisation.
When to apply	Shortly after domestic violence/sexual violence staff training or earlier, depending on the organisation's/team's action plans for addressing these issues.
Aim	To positively influence the organisational commitment to reducing IPV and sexual violence. The appointed champion can provide leadership within the organisation, represent the organisation externally regarding IPV and sexual violence and support the development of appropriate policies and practices as well as the allocation of resources.
Materials required	None.
Time required	Regular time within work hours, depending on size of organisation/team and patient group(s) served.
Description	<p>There needs to be a person with a designated commitment and portfolio to implement domestic/sexual violence intervention programmes in an organisation/team.</p> <p>This person should raise awareness of IPV and sexual violence and has to induce or support implementation of intervention skills and programmes on different levels.</p> <p>They will act as a contact person for the whole team or organisation concerning the implementation of intervention strategies and will take care of a sustainable development.</p> <p>This may include:</p> <ul style="list-style-type: none"> • advocating for support from management, including for resources • organisation of in-house training • ordering materials such as patient information leaflets • adoption of strategies • networking. <p>Champions can also create a best practice network with champions from other organisations.</p>

7.4. Post-training stage and follow-up

TOOL 22 – SUPERVISION	
Target group	Participants who have attended IPV/SV training and have contact with patients experiencing such violence.
When to apply	After the training course at regular intervals (adjusted to setting, need and frequency of cases).
Aim	To emotionally support staff working with patients experiencing domestic/sexual violence.
Resources required	<ol style="list-style-type: none"> 1. External supervisor (or internal if available and not compromising confidentiality/staff management etc.). 2. A private room. 3. Staff need to be able to attend in work time.
Time required	<p>1 hour per meeting.</p> <p>Regular sessions should be offered, depending on frequency and need. They should be offered regardless of initial take-up/interest expressed as take-up/need often increases over time.</p>
Description	<p>A suitably trained supervisor (also knowledgeable in violence against women issues) provides 1-2-1 supervision sessions. During the sessions participants can talk about their emotions and how the issue may affect them personally. Ways of coping can be developed and supported. Difficult cases or situations may be discussed too, however the focus should be on the participants' feelings and coping strategies.</p> <p>Unless there is a cause for concern the issues discussed should remain confidential to the supervisor and participant. Supervision should be paid for by the organisation.</p> <p>Where suitable group supervision may be helpful too.</p>

“The trainers have provided peer support supervision to the learners.”

Spain, learner

“Clinical supervision from an external person and talking to peers is really helpful for dealing with emotions”.

UK learner

TOOL 23 – KEEPING THE ISSUE ON THE AGENDA	
Target group	Participants who have attended IPV / sexual violence training.
When to apply	After the training course, a couple of times per year.
Aim	To remind staff of the issue and importance of addressing it appropriately.
Materials required	Depends on action taken (see below), including flowcharts, press cuttings/links to articles, computer pop-ups, flyers, speakers at team meetings etc.
Time required	Depends on action.
Description	<p>The service/department / organisation’s lead on IPV / sexual violence needs to think of creative ways to remind staff of the issue. This can be done in a variety of ways, such as:</p> <ul style="list-style-type: none"> • IT department uploads a screen saver reminding staff of facts e.g. 1 in 4 women are affected by domestic violence • at a team meeting external speakers are asked to talk about their services e.g. a refuge worker, staff from a rape crisis centre, the police • short articles are published in internal newsletters • reminders for staff about ordering patient flyers/system for checking stock levels • sharing of audit results at academic and team meetings.

“It is important to be reminded of all aspects of SV/DV even if it is not all new info.”

UK delegate

TOOL 24 – SHARE POSITIVE STORIES (CROSS-REFERENCE WITH TOOL 25: REFLECTIVE PRACTICE MEETINGS)	
Target group	Participants who attended IPV/sexual violence training and have contact with patients experiencing domestic violence.
When to apply	After the training course at regular intervals (informally when possible, formally via regular meetings).
Aim	To make intervention effects visible and encourage professionals to intervene in domestic/sexual violence cases.
Materials required	Distribution by email or newsletter, information sheet or allocate a time slot in a meeting.
Time required	Minimal.
Description	<p>It is often frustrating for health care staff to not know if their intervention or help has had any effect on a patient affected by domestic or sexual violence.</p> <p>It may not be very easy to obtain information about successful/positive interventions and outcomes, but it is important to share such stories whenever possible. Doing so can increase the motivation of health care staff to intervene.</p> <p>Information about positive outcomes may be obtained from:</p> <ul style="list-style-type: none"> • colleagues • networks, e.g. domestic violence coordinators, working groups • counselling centres or domestic violence hotlines, if data protection requirements are observed or data sharing protocols are in place • lawyers, who can explain the importance of documenting injuries • studies that report interviews with survivors. <p>It is important to be aware of confidentiality issues when making requests for information.</p>

TOOL 25 – REFLECTIVE PRACTICE MEETINGS
(CROSS-REFERENCE WITH TOOL 24: SHARE POSITIVE STORIES)

Target group	Participants who have attended IPV/sexual violence training and have contact with patients experiencing such violence.
When to apply	After the training course at regular intervals (adjusted to setting, need and frequency of cases).
Aim	To continuously improve own practice of caring for patients experiencing domestic/sexual violence.
Materials required	<ol style="list-style-type: none"> 1. Paper and pen (if the group agrees to document results). 2. Privacy/space to meet.
Time required	1 to 1.5 hours per meeting.
Description	<p>Beforehand – one person takes the lead and organises a room and meeting time and invites participants. Participants should be asked to confirm their attendance. The meeting should be offered, even if little interest/need is expressed initially. The lead person should be experienced in supporting patients experiencing IPV/sexual violence. The meeting can be multidisciplinary.</p> <p>During the first meeting – ground rules should be agreed and the aim of the meeting reiterated. A supportive and safe atmosphere is essential. Confidentiality should be agreed, with the exception of any patient-related follow-up actions (e.g. a referral to another service is suggested, this would need to be put in practice and documented) or other issues of concern such as child protection issues.</p> <p>During each meeting – all participants take responsibility for preparing for the meeting and bringing cases/situations with which they would like support. Feedback rules apply. The lead person should structure the meeting to ensure all participants have a chance to speak about/discuss their practice and cases, as required.</p> <p>After the meetings – summary notes are written up and shared, if agreed by the group. Documentation of such meetings may be important for cases with criminal proceedings.</p>

“The European program has raised my awareness of tools that provide peer support and supervision”
 Spain, learner

“Talking to colleagues was most helpful. Reassurance and offers to speak to someone if found something upsetting.”
 UK learner - interviews

TOOL 26 – OFFER ONGOING SUPPORT	
Target group	Participants who have attended training on IPV / sexual violence.
When to apply	After the training course.
Aim	Sustainability of training, changes to practice, support new skills.
Materials required	<ol style="list-style-type: none"> 1. Phone. 2. Email.
Time required	5 to 20 minutes.
Description	Participants might not feel confident with intervention steps or want to reflect that domestic /sexual violence cannot be addressed by just one person; health care professionals belong to a network, where they can get support whenever this is necessary.

“I suggest you (the trainer) ask all participants 3 months after the training about how attendees are doing with regards to implementing their learning from the course. I would be very interested in case discussions and mini-updates.”

“Following up after training allows time for inquiries, motivates people again and helps to remind the trainers”

Spain, trainer

“There should be a 3 monthly follow-up and an offer of regular updates. Would like to meet people in the field.”

Germany, learner interview

7.5. Assessment tools


TOOL 27 – EVALUATION	
Target group	Participants who have attended training on IPV / sexual violence.
When to apply	At the end of a training course.
Aim	To obtain immediate feedback from participants about the training they have received. This would serve as a tool for the trainers/training organisation to make any improvements in training.
Resources required	Evaluation form.
Time required	5 to 10 minutes for participants to complete form. 1 to 2 hours compiling evaluation results. Undetermined time to make changes, depending on feedback and suggestions.
Description	Participants are asked to complete an evaluation form at the end of training. Topics, trainers, methodology and other logistical aspects of the training could be reviewed by the trainer / organisation providing the training, to gauge the success of the training and the level of learning obtained by the participant. Changes could then be made for future training sessions.
<p>EXAMPLE A – TOOL 27: Example of course evaluation form</p> <p>EXAMPLE B – TOOL 27: Example of course evaluation form (specific to toolkit)</p> <p>EXAMPLE C – TOOL 27: Example of final questionnaire</p>	

“The evaluation process really enabled me to assess what I have learnt and what I need to develop.”

Learner

TOOL 28 – TRAINING REVIEW FORM	
Target group	Participants who have attended training on domestic / sexual violence.
When to apply	One month after training course.
Aim	To remind course participants of personal aims developed during the training course and review transfer of learning into practice, highlighting any barriers in implementing outcomes into their organisation/role.
Materials required	<ol style="list-style-type: none"> 1. Letter to self (optional, see “letter to self” tool). 2. Training review form. 3. Pen/computer. 4. Email.
Time required	10 to 15 minutes.
Description	<p>Participants are asked to complete a training review form one month after the training course. They can be reminded of the ‘letter to self’ they wrote during the training (if applicable) and reflect on what they have learned and their transfer of learning into practice. This would act both as a tool for self-reflection for the participant and an organisational tool for implementation.</p> <p>Any barriers to implementation can be addressed via a letter to their employer (if external participants), offering ongoing support or supervision (internal participants) or further training.</p>
EXAMPLE A – TOOL 28: Example of training review form	
EXAMPLE B – TOOL 28: Assessment of transfer into practice	

8. Practical examples of tools

EXAMPLE – TOOL 3: EXAMPLE OF A TRAINING REQUEST FORM		
 EXTERNAL TRAINING REQUEST FORM		
Employee name:		Title of your post at the Haven:
Contact telephone number:		Email address (PLEASE USE CAPITALS):
Title of course:		
Location of course:	Date(s) of course:	Total study days required:
Institution / organisation running course:		
Cost:		Amount of funding in last 12 months:
Amount of study leave in last 12 months:		Training category (see below):
Training categories: A = Trust mandatory training B = Training matrix C = Personal development (PDP)		
Please state your expectations of this course and how you think it will improve your role:		
Is anyone else from the Havens attending this course or has attended this course in the past?		
Yes / No / Don't know		
How do you plan to implement learning into your role?		

Any external learning could be beneficial to other colleagues at the Havens. How do you plan to cascade information to the wider Havens team? (Eg, team meeting, PRM, 1:1)

Date of above agreed with line manager: Yes / No

Employee signature

Date

AUTHORISATION CHECKLIST

Study leave authorised

Course costs authorised Cost code:

Plan for learning cascade agreed with employee

Line manager's signature

Date

EXAMPLE – TOOL 4: EXAMPLE OF CLINICAL SESSION ABSTRACT 'IPV AND SEXUAL VIOLENCE: CONSEQUENCES FOR HEALTH CARE'

Abstract session. University Hospital Rio Hortega. Valladolid (SACYL)
(distribution via intranet or other usual site)

Title:

“Instability and diplopia. Chronic headache. Palpitations and chest pain. Tympanic haemorrhage. Cervical cancer. Depression”

Different presentations of the same health problem. On the subject of several cases.

There are few health problems that can by themselves be so rich in signs, symptoms and consequences as gender violence.

In the last 25 years the scientific literature leaves no doubt that this is a first order public health problem. Some data of it are:

- Estimated prevalence in our country (Ministry of Health – Spain 2011): 10.9%.
- It is cause of death and disability worldwide among women of reproductive age (16 to 44 years) at the same level as cancer, and generates greater morbidity than traffic accidents and malaria combined. (World Development Report 1993 Investing In Health).
- In 1998 WHO declares it an international priority for the health services (1998).
- It is associated with many somatic symptoms and chronic diseases such as hypertension, diabetes, asthma, chronic pain, rheumatic diseases, gastrointestinal disorders, ischemic heart disease, chest pain, recurrent neurological disease, repeated abortions, risk pregnancies with preterm delivery, new-born low weight birth, increased prevalence of invasive cervical cancer, anxiety and depression, among others. (The Lancet 2002, Arch Intern Med 2002, The Lancet 2004, The Lancet 2008, J Obstet Gynaecol 2008, Headache 2011.)
- Suicide risk increased up to 4 times in women who suffer it against those who do not. (The Lancet 2008).
- Estimates of attributable costs to this health issue regarding primary care consultations, specialized care, pharmaceutical expenditure, complementary tests and Emergency services in an Autonomous Community as Madrid, amounted to 27,264,897€ of annual cost (Technical Documents of Public Health. 2008. Madrid Health Service).
- Finally, WHO states that "No health service, no health practice, deserves excellent condition, if do not incorporate the attention of this priority health problem" (WHO, 2012)

But in addition to the above, not to think about this problem, not to investigate it in women attending the hospital, can lead to many mistaken diagnoses, unnecessary hospital stays, and inadequate or incomplete answers to their symptoms or problems, by not addressing the real cause of them.

We would appreciate your attendance

EXAMPLE – TOOL 5: EXAMPLE EMAIL TO TRAINER

Name of the person to whom it is addressed:

Dear learner

We have received your application to participate in the gender violence workshop.

We understand that you have applied for this workshop because you are interested in learning more about this serious health problem. We are very interested in knowing more about your needs and expectations and we would like to know which topics you are more interested in. Are you worried about how to communicate with the victims? How to assess the risks? What approach to take? What resources you have?

To be able to respond to your needs we need to know them. That is why we are asking you to fill in this brief questionnaire and give us your suggestions.

We thank you for your help in advance.

We are sending you some bibliography that may be of interest in case you want to get in touch to find out more before the workshop.

Thank you

NAME OF THE SENDER

(RESPONSIBLE OF THE TRAINING OR TEACHER)

Notes:

In the email the sender must be quoted.

It must be sent 10 days before the workshop.

It must be returned in 4 days.

EXAMPLE. TOOL 6: DESCRIPTIVE DOCUMENT OF THE DEVELOPMENT OF THE TRAINING ACTIVITY

In every training activity we simultaneously use diverse contents and methods but there is agreement on some aspects that any training activity on IPV and SV should include:

- They must be interactive and oriented to the practice.
- They should start from the analysis of their current performance and meet their needs as the identification of critical points which generate difficulties for the management: ethic and legal aspects, confidentiality, resources, emotional impact, over-implication and coordination among others.
- They should have as a relevant aim the acquisition or improvement of competencies (knowledge, skills and attitudes) in order to apply them to the attention to the victim in their practice.
- The global training activity must facilitate trainees to make a critical reflection about their practice, they can express their shortcomings, difficulties, barriers and their vision of improvement possibilities.
- Feedback must be possible as well as the follow up of its applicability to the practice by means of activities like case analysis, consulting, reinforcement and support for management of problems, emotions and conflicts.

This document describes, in general terms, the sequential development of the training activity and necessary assistance tools that appear in other sections of this document. Although this example is the development of a basic face-to-face workshop, the different contents proposed could also be used in other formats (courses, modular training).

Development of a basic workshop proposal with the following steps:

1. **Welcome and presentation** of trainees and trainers. Organization and distribution of available time.
2. **Pretest:** it seems important to have an idea of the initial situation of the trainees in terms of knowledge, attitudes, expectations and motivation. This can be explored by a short questionnaire (example of initial questionnaire in section 8), which can be done online via email (example of email to trainer in section 8) or, if this is not possible, it can be done at the beginning of the face-to-face workshop following the presentation.
3. **Presentation of the objectives of the workshop.**
4. **Set aside prejudices and misinformation:** once we know the attitude of the trainees about the problem of IPV and SV. If predominant attitude is refractory or poor motivation, the first serious intervention will be to dismantle myths and prejudices interacting with the group. Also, promoting empathy for the victims, raising awareness after the information provided about their role to face the problem using motivational interviewing and promoting intrinsic motivation.
5. **Training knowledge** about IPV and SV: there are a set of basic contents in any activity that should be include (TOOL 9. Section 7).

Proposed training methods:

- Interactive presentation by trainer with a support of power point with the principal knowledge (e.g. available powerpoint in the digital version)

- Selected bibliography

6. **Training skill and attitudes about IPV and SV:** this proposed basic workshop will tackle issues that allow improvement of skill and attitudes regarding this problem (see sections 7 and 8).

Proposed training methods:

- Role playing.
- Case presented with clinical history
- Fragment of movie. Analysis and debate.
- Audio recording victims' account.
- Working in groups
- Interviews with expert professionals.

7. **Management of emotions.** During the course, trainees could show emotions toward this problem that trainers should know how to manage (TOOL: 11, 12, 14)

8. **Ethical and legal aspects.** Decision-making in situations of violence against women and sexual assault, face professionals with situations where ethical duties and legal obligations may sometimes enter in conflict. (TOOL 13).

Proposed training methods:

- Role playing.
- Analysis of medical history and practical cases made by doctors.
- Analysis of mandatory reports (two documents selected anonymously) (mandatory reporting).

9. **Feedback and final questionnaire:** at the end the workshop a post-test will be carried out to evaluate changes, the fulfilment of the expectations, achieving goals, and suggesting ideas for improvement (Example of final questionnaire in section 8)

10. Ideas and proposal for implementation in the practice: joint proposal or working group

11. Satisfaction survey: a satisfaction survey workshop will be carried out. It will include: achievement of goals, evaluation of teachers, usefulness of the course, organizational and logistical aspects of the course, provided materials and suggestions and proposals for improvement.

EXAMPLE A – TOOL 7: INITIAL QUESTIONNAIRE

BASIC DATA OF THE PROFESSIONAL:

1. Profession: Physician: ; Nurse: ; Psychologist: ; Other:
 SPR Staff
2. Gender: Male: ; Female:
3. Age:
4. Working experience. Number of years as professional:
5. Training in Gender Violence in the last two years:
 - YES NO .
 - If the answer is positive, total of hours: ≤5h 6h-12h 13-30h ≥30h
7. Do you consider that Gender Violence is a problem?
 - Social: YES NO
 - Health: YES NO
 - Private: YES NO
8. Do you consider that training in Gender Violence should be taught in:
 - Pregraduate: YES NO
 - Postgraduate: YES NO
 - Continuous training; YES NO
9. Do you consider that training in Gender Violence should be:
 - Compulsory: YES NO
 - Voluntary: YES NO
10. Grade your perception of difficulty when dealing with a case of Gender Violence from
 0-10 (min-max): 1 2 3 4 5 6 7 8 9 10

QUESTIONS ON MOTIVATION FOR PARTICIPATING IN TRAINING:

1. What has motivated you to attend this course on Gender Violence?
2. What competences and skills would you like to acquire through this training course?
3. Does any particular aspect concern you when dealing with this problem?
4. Have you known of, or attended any case of gender violence in your professional experience? YES NO
5. Do you know of any case of gender violence outside your work environment? YES NO
6. Do you believe that gender violence is a competence of the health professional? YES NO
7. Do you believe, to the contrary, that it is a problem which concerns social services, except if there are physical injuries? YES NO
8. Do you consider that other violence situations which we can detect in the surgery must be dealt with by health professionals?
 - Elderly mistreatment: YES NO
 - Child mistreatment? YES NO
 - Work harassment: YES NO
 - Bullying: YES NO
9. Do you believe that you know the legal obligations of the professionals when they detect a

case of gender violence? YES NO

11. Grade from 1 to 5 the following motivational aspects for attending a training activity:

- That it will be a merit for the curriculum: 1 2 3 4 5
- That it will be done during working hours: 1 2 3 4 5
- Personal satisfaction of improving my competence: 1 2 3 4 5
- Improving the self confidence in my practice: 1 2 3 4 5
- That it is included in the Portfolio of Services and I will be evaluated on it:
1 2 3 4 5
- I am aware of my lack of training and I recognize the need to receive education:
1 2 3 4 5

12. Others:

REGARDING GENDER VIOLENCE

1. Grade from 1 to 10 the self confidence degree you have when you deal with the following aspects regarding mistreatment of women:

(Being: 1= totally insecure / 10= totally sure)

- Identification of risk factors or warning signs ___
- Interview when suspecting mistreatment ___
- Decision on whether to file the Mandatory Report or not ___
- Filling in of Mandatory Report ___
- Knowledge of the resources where to refer the victim ___
- Psychological support to the victims ___
- Coordination with other Professionals and Institutions ___
- Dealing with the perpetrator when he is also my patient ___
- Assessment of extreme danger of the victim ___
- Doctor-patient relationship with the victims of mistreatment ___

2. Grade from 1 to 10 the agreement degree with these sentences. (Only respond if you have attended any case of gender violence).

(Being: 1= totally disagree / 10 = totally agree)

- Dealing with mistreatment victims causes me much anxiety ___
- I feel very embarrassed when I deal with victims of mistreatment ___
- I get emotionally involved with this kind of patients ___
- Dealing with the victims causes ethical conflicts in me ___
- I tend to identify with the victims ___
- Dealing with this kind of problems causes rejection in me ___
- I have not this kind of problems in my surgery ___
- I avoid dealing with this kind of problems ___
- I am afraid of the medical-legal consequences ___
- I do not think about it because I have not incorporated it as a health problem ___

EXAMPLE B- TOOL 7: BREAK DOWN PREJUDICES AND MYTHS

1. Myths, prejudices and misinformation

- Minimisation of the problem:
 - Ask about their experience
 - Magnitude: facts and unquestionable official figures
 - Solid bibliography
- Doubt about its seriousness as a health problem:
 - Solid literature on health consequences, data
 - Testimonials
- Lack of scientific evidence
 - Relevant literature
 - Documents and consensus of scientific organizations (WHO, Soc. Scientific, US Task Force, Canadian Task Force, PAPPS)
- False allegations:
 - Facts and figures
 - Documents, studies
- Prejudices (only affects people with low socioeconomic level, immigrants ...):
 - Facts and testimonies of people from any cultural level
 - Studies of Prevalence in health care professionals
- Non-recognition of psychological abuse:
 - Testimonies (films)
 - Evidence from studies
 - Suicides

Promoting empathy for the victims:

- Record testimonies
- Movies

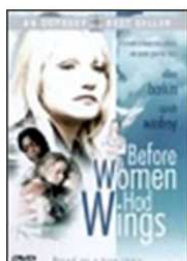
Raising awareness after the information provided about their role to face the problem of IPV and SV using motivational interview

2. Now that we have a role as healthcare professionals in GV, how do you think we could help victims during consultation? Do you think the process is too complicated? Are you afraid of it? That's why you're here.

Promoting intrinsic motivation:

- Our role is very important (testimony of women) Just sharing the problem with a professional has a therapeutic effect.
- We are in a privileged place for the detection and care
- We can do what we consider ourselves trained for.
- We are not alone: we can share (peers, consultants). We can make referrals to other professionals. We have other resources.

EXAMPLE C– TOOL 7: FILM / VIDEO CLIP



Using films that depict violence against women in a realistic way can be a didactic, complementary resource, very useful for group work with trainees.

Options:

- 1 Asking them to watch the movies at home, and then analysing them and reflecting on some selected issues, or those aspects that impressed them.
- 2 Watching selected excerpts in order to work on specific aspects (psychological abuse, stages of change, impact on children, etc).

Some useful Films for IPV training:

1. “TE DOY MIS OJOS” (Take My Eyes):

It is one of the films that treats the problem adequately, and allows us to analyse various aspects: types of mistreatment, the difficulty of making psychological abuse visible and communicating it, the role of the family –mother (tolerance), sister (support), friends, the impact on exposed children; stages of change, the mourning, the relapse, the perpetrator’s profile, the hardness of escaping the process, among other issues. It is an extraordinarily useful film for training.

2. “BEFORE WOMEN HAD WINGS” (Spanish: Alas cortadas):

This film may be useful to discuss the impact of abuse on children exposed to IPV or directly mistreated, and the value of support, love, and resilience mechanisms. It can also be used to treat the consequences of continued abuse on women, the process of psychological destruction in these circumstances, the refuge in alcohol or the abuse towards their children

3. “SOLAS “

A film about the everyday abuse tolerated and not identified as such, which nevertheless has consequences for children. It describes transgenerational violence, tolerance, confusion and finally rejection and help to turn the tide of his life.

EXAMPLE – TOOL 8: ASSAULT MNEMONIC

A _{IM}	To increase the levels of access to appropriate support and services for women accessing Emergency Departments who are victims of domestic violence, whether their reason for accessing the Emergency Department is due to a domestic violence incident or some other presenting issue
S _{PECIFIC}	Provide nurses working in Emergency Departments with the knowledge and tools to identify the signs of domestic violence and be confident in sympathetically offering appropriate support
S _{SETTING}	Emergency Departments
A _{UDIENCE}	Nurses working in triage and assessment part of Emergency Department pathways
U _{SEFUL}	Undertake a needs assessment survey of nursing staff to identify the barriers they face in identifying signs of domestic violence and the most practical ways of enabling them to offer appropriate support
L _{EARNING}	Develop a training course addressing the needs assessment and an ongoing package of support to ensure that participants have learnt new skills and can be supported to review and continue their learning in the workplace.
T _{OOLS}	With participants, during training, develop, for instance, a screening tool (short set of questions) to help them identify domestic violence, an aide memoire to help them remember the signs of domestic violence and a support package (leaflet, support organisation details) for them to provide to victims of domestic violence.

EXAMPLE A – TOOL 9: RELEVANT BIBLIOGRAPHIC MATERIAL

It is recommended to provide guides and protocols into the training of recognised entities (international and national) and prestigious journal articles as:

- **ARTICLES:**
 - Campbell J. Health consequences of intimate partner violence. *The Lancet*. 2002; 359:1331-6
 - Jewkes R. Intimate partner violence: causes and prevention. *Lancet*. 2002; 359:1423-9
 - Golding JM. Intimate partner violence as a risk factor for mental disorders: a meta-analysis. *J Fam Violence* 2002; 14: 99-132
- **GUIDES:**
 - WHO. Health care for women subject to intimate partner violence or sexual violence. A clinical handbook. Geneva. Switzerland. 2014. Available at www.who.int
 - WHO. Responding to intimate partner violence and sexual violence against women. WHO clinical and police guidelines. Geneva. Switzerland. 2014. Available at www.who.int
 - ABC of Domestic and Sexual violence. Bewley S and Welch J (eds). BMJ Books Oxford. 2014. www.abcbookseries.com
- In different countries: Protocols and local guides.
 - EXAMPLE: SPAIN:
 - Common Protocol for action against violence against women 2012. http://www.msssi.gob.es/organizacion/sns/planCalidadSNS/pdf/igualdad/COMMON_PROTOCOL_2012_Accesible.pdf
 - Autonomous Community of Madrid Guide (CAM); action guide of Castilla y León government
 - Instituto de la Mujer. Macroencuesta 2015. Violencia contra las mujeres. <http://www.inmujer.migualdad.es/mujer/mujeres/cifras/violencia/macroencuestaviolencia.htm>

EXAMPLE B – TOOL 9: POWERPOINT PRESENTATION.

Sample presentations can be downloaded from: www.stfs.org.uk/faculty/training-about-sexual-and-domestic-violence
and www.pro-train.uni-osnabrueck.de/index.php/TrainingProgram/MultiProfessional

EXAMPLE – TOOL 10: ROLE PLAYING

Friday, June 15th 2014

Rosa

31-year-old patient, 20 weeks pregnant, comes to the primary health centre due to hematuria with macroscopic blood in urine and she tells us that she thinks she's got a "cystitis" that has started 24 hours before.

Family and work background

- Both parents killed in car accident when she was 7.
- One brother
- Occupation: school teacher, sporadic work
- Married at age 25 .
- Husband work as a salesman.

Personal background:

- Two previous miscarriages.
- Depression after second miscarriage, one year ago. Undergoing treatment for depression until beginning of present pregnancy.

<p>START OF INTERVIEW</p> <p>Doctor: Please, tell me, what's the matter with you?</p> <p>And how would you describe the urine?</p> <p>Does that happen every time you urinate?</p> <p>Even if you don't urinate, as during periods?</p> <p>Questions related to urinary syndrome:</p> <ul style="list-style-type: none"> - Pain: - Burning sensation: - Itch: - Fever - Frequency: - Tenesmus: - Renal or flank pain irradiated to the pelvic zone 	<p>Patient: I've noticed blood in the urine since yesterday morning and as it didn't stop I've come in search of a treatment. This happened to me another time and I was told it was a cystitis. They gave me some medication and it disappeared some days later.</p> <p>I'm telling you, the urine is red with blood and I have even seen some small blood clots</p> <p>Yes, since yesterday it happens every time I void my bladder</p> <p>No, no, I don't pass blood as during periods or when I had previous miscarriages. It is only when I urinate.</p> <ul style="list-style-type: none"> - No. - No. - No. - No. - No. - No - I feel some tenderness in this side (she points to the right flank) and hardly any more than that.
How long have you notice it ?	Since yesterday morning
How did it start?	Suddenly, since mornig
Any other symptoms?	No. Nothing else.
Are you on any medication?	Yes, I am on folic acid

PHYSICAL EXAMINATION

She brings a urine sample: hematuria with macroscopic blood and some blood clots.

Mild tenderness in right flank.

Clearly positive right costovertebral angle tenderness

She has an elongated bruise on her right back (a distinct shoe mark):

- Bruises in different evolutive stages on the back of her forearms (defensive zones) besides bruises in both arms (well-marked finger imprints)
- Normal vital signs.



Rosa's consultation. Some issues to be analyzed

1. Interview analysis
2. Interview management
3. Woman's attitude and emotional state (verbal and non-verbal language)
4. Manner of asking. Listening. Silences.
5. Respect. Empathy. Warmth (emotional proximity). Expressing emotions (both)
6. Therapeutic distance
7. Retrieval of information.

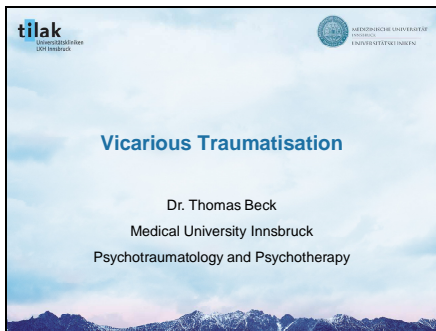
Rosa's consultation. Some issues to be analyzed

1. Identify risk factors and situations of weakness
2. Warning signs
3. Mistreatment criteria
4. Chances of intervention :
 - First intervention
 - Risk assessment
 - How to explore the risk of injuries sustained (physical and psychological).
 - How to explore the risk of new aggressions.
5. Legal responsibilities and legal duties
6. Other interventions concerning diagnosis

"I would like more role-plays. I think it was important to slip into the role of the victim and the practitioner."

Austria, learner

EXAMPLE – TOOL 14: PRESENTATION ON VICARIOUS TRAUMA AND SELF-CARE



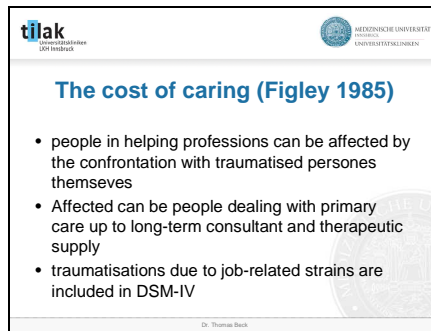
tilak
Universitätsklinik
Innsbruck

MEDIZINISCHE UNIVERSITÄT
INNSBRUCK
UNIVERSITÄTSGEBÄUDE
INNSBRUCK

Vicarious Traumatisation

Dr. Thomas Beck
Medical University Innsbruck
Psychotraumatology and Psychotherapy

This slide features a light blue sky background with a silhouette of a mountain range at the bottom. The text is centered and includes the logos of 'tilak' and the 'Medizinische Universität Innsbruck'.



tilak
Universitätsklinik
Innsbruck

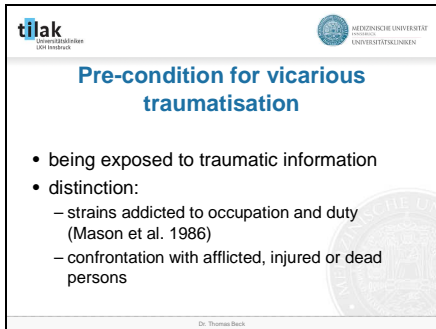
MEDIZINISCHE UNIVERSITÄT
INNSBRUCK
UNIVERSITÄTSGEBÄUDE
INNSBRUCK

The cost of caring (Figley 1985)

- people in helping professions can be affected by the confrontation with traumatised persones themselves
- Affected can be people dealing with primary care up to long-term consultant and therapeutic supply
- traumatisations due to job-related strains are included in DSM-IV

Dr. Thomas Beck

This slide has a white background with a faint circular seal of the university in the bottom right corner. It lists three bullet points regarding the impact of caring for traumatized individuals.



tilak
Universitätsklinik
Innsbruck

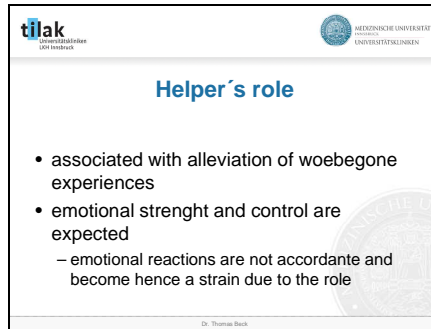
MEDIZINISCHE UNIVERSITÄT
INNSBRUCK
UNIVERSITÄTSGEBÄUDE
INNSBRUCK

Pre-condition for vicarious traumatisation

- being exposed to traumatic information
- distinction:
 - strains addiccted to occupation and duty (Mason et al. 1986)
 - confrontation with afflicted, injured or dead persons

Dr. Thomas Beck

This slide features a white background with a faint circular seal of the university in the bottom right corner. It lists two main bullet points, with the second one having two sub-points.



tilak
Universitätsklinik
Innsbruck

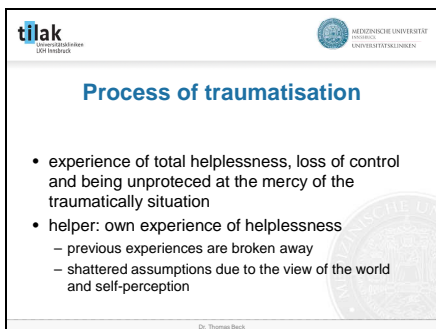
MEDIZINISCHE UNIVERSITÄT
INNSBRUCK
UNIVERSITÄTSGEBÄUDE
INNSBRUCK

Helper's role

- associated with alleviation of woebegone experiences
- emotional strenght and control are expected
 - emotional reactions are not accordante and become hence a strain due to the role

Dr. Thomas Beck

This slide has a white background with a faint circular seal of the university in the bottom right corner. It lists two bullet points, with the second one having a sub-point.



tilak
Universitätsklinik
Innsbruck

MEDIZINISCHE UNIVERSITÄT
INNSBRUCK
UNIVERSITÄTSGEBÄUDE
INNSBRUCK

Process of traumatisation

- experience of total helplessness, loss of control and being unprotected at the mercy of the traumatically situation
- helper: own experience of helplessness
 - previous experiences are broken away
 - shattered assumptions due to the view of the world and self-perception

Dr. Thomas Beck

This slide features a white background with a faint circular seal of the university in the bottom right corner. It lists two main bullet points, with the second one having two sub-points.



tilak
Universitätsklinik
Innsbruck

MEDIZINISCHE UNIVERSITÄT
INNSBRUCK
UNIVERSITÄTSGEBÄUDE
INNSBRUCK

Meaning of empathy for vicarious traumatisation

- empathy is the ability to:
 - make other persons' perspective accessible for oneself
 - to put oneself in the emotional constitution of other persons (Figley 2002)
- that's why empathy is the basis for vicarious traumatisation

Dr. Thomas Beck

This slide has a white background with a faint circular seal of the university in the bottom right corner. It lists two main bullet points, with the first one having two sub-points.

tilak
Universitätsklinikum
Lübeck

HEIDENSCHE UNIVERSITÄT
LÜBECK
UNIVERSITÄTSKLINIKUM

Concussion of the view of the world and the self-perception as the consequence of vicarious traumatization/1

- models marking internal worlds are developed during person's life
- they include assumptions about ourselves, the circumjacent world and the relation between both of them (Fischer, Riedesser 1998)

Dr. Thomas Beck

tilak
Universitätsklinikum
Lübeck

HEIDENSCHE UNIVERSITÄT
LÜBECK
UNIVERSITÄTSKLINIKUM

Concussion of the view of the world and the self-perception as the consequence of vicarious traumatization/2

- Janoff-Bulman (1992):
 - concept of „assumptive worlds“
 - illusions and over-generalisations are necessary for coping with every-day life to a certain extent
 - assumptions stay unreflected during every-day life, but they are questioned during traumatic experiences
 - the own vulnerability becomes apparent suddenly
 - the traumatic situation can't be averted by controlling actions
 - assumptions (e.g. benevolence of the world, sense and meaning of the world) can be destroyed this way

Dr. Thomas Beck

tilak
Universitätsklinikum
Lübeck

HEIDENSCHE UNIVERSITÄT
LÜBECK
UNIVERSITÄTSKLINIKUM

Important assumptions

- benevolence of the world
- sense and meaning of the world
- helper's self-perception

Dr. Thomas Beck

tilak
Universitätsklinikum
Lübeck

HEIDENSCHE UNIVERSITÄT
LÜBECK
UNIVERSITÄTSKLINIKUM

Benevolence of the world

- we know about death, violence, illness and damage generally
- adjacencies are estimated as calculable and benevolent and attachment figures as caring and protective
- We assume that we are not concerned with bad experiences ourselves unexpected
- concussions especially by „man-made-disasters“ (e.g. violence)

Dr. Thomas Beck

tilak
Universitätsklinikum
Lübeck

HEIDENSCHE UNIVERSITÄT
LÜBECK
UNIVERSITÄTSKLINIKUM

Sense and meaning of the world

- assumption:
 - things happening have sense and they are in context
- contact with traumatised persons confront helpers often with the contrary

Dr. Thomas Beck

tilak
Universitätsklinikum
Lübeck

HEIDENSCHE UNIVERSITÄT
LÜBECK
UNIVERSITÄTSKLINIKUM

Helper's self-perception

- positive contortion of helper's self-perception:
 - we believe ourselves to be good, honest and brave (Janoff-Bulman, McPherson 1996)
 - procures security that things turn out all right (Antonovsky 1997)
- especially helpers believe in a overreaching trust in their capacity
- problem:
 - illusion gets appreciable
 - consequences: senses of failure, shame and self-doubts

Dr. Thomas Beck

tilak
 Universitätsklinik
 LKH Innsbruck

HEIDENSCHE UNIVERSITÄT
 INNSBRUCK
 UNIVERSITÄTSKLINIKEN

Defense mechanisms and psychodynamic defense

- concussions of assumptions is a deep cut: unconscious defense mechanisms are activated
- appreciable strain is kept away or reduced in this way
- but defense can be repealed by specific stress factors

Dr. Thomas Bach

tilak
 Universitätsklinik
 LKH Innsbruck

HEIDENSCHE UNIVERSITÄT
 INNSBRUCK
 UNIVERSITÄTSKLINIKEN

Stress factors

- „anonym distance“ can't be maintained
- identification with the victim
- colleagues are affected directly
- ties to own traumatic experiences
- the help given can't be experienced as effective
- it is not possible to complete the situation

Dr. Thomas Bach

tilak
 Universitätsklinik
 LKH Innsbruck

HEIDENSCHE UNIVERSITÄT
 INNSBRUCK
 UNIVERSITÄTSKLINIKEN

Consequences of vicarious traumatisation/1

- correlate to stressreactions in primary traumatisations
- emotional level:
 - overwhelmed by flash-backs and intrusions
 - feelings of guilt
 - anger, bad temper, enragement
 - sense of shame
 - sense of powerlessness and helplessness

Dr. Thomas Bach

tilak
 Universitätsklinik
 LKH Innsbruck

HEIDENSCHE UNIVERSITÄT
 INNSBRUCK
 UNIVERSITÄTSKLINIKEN

Consequences of vicarious traumatisation/2

- self-perception and view on the world :
 - loss of basic security
 - life is evaluated as vulnerable
 - loss of esteem, aims and decision
- social level:
 - social withdrawl
 - increased distrust to other people
 - reduction of relationships
 - other persons' troubles and problems are not taken seriously based on the own traumatic experiences

Dr. Thomas Bach

tilak
 Universitätsklinik
 LKH Innsbruck

HEIDENSCHE UNIVERSITÄT
 INNSBRUCK
 UNIVERSITÄTSKLINIKEN

Consequences of vicarious traumatisation/3

- somatic symptoms:
 - exhaustion
 - fatigue
 - sleeping problems
 - states of stress
 - inner agitation


Dr. Thomas Bach


tilak
 Universitätsklinik
 LKH Innsbruck

HEIDENSCHE UNIVERSITÄT
 INNSBRUCK
 UNIVERSITÄTSKLINIKEN


Thank you for your attention!


From today's course, I will implement.....

1  **What will I implement?** _____
Topic(s): _____


 **Methods:** _____

2 **How?**

3 **When?**
 _____

4 **With whom?**
 _____

5 **What preparation** is required? _____

6 **Which materials** do I need? _____
 _____

7 **Exchange with** _____

Name: _____ Phone _____

Address: _____ Appointment: _____

EXAMPLE – TOOL 17: S.I.G.N.A.L. INTERVENTION STEPS FOR IPV

S. I. G. N. A. L. (Berlin, Germany) is an intervention programme based on internationally proven intervention models, such as RADAR7. It includes suggestions for actions to take and a list of measures for establishing an intervention programme within a hospital. The acronym is an easy to remember reminder of the important steps and goals that form the intervention programme:

- S** Speak with the patient and show that you are willing to listen. Women (and men) are inclined to speak more openly when they sense that their situation will be understood.
- I** Interview the woman (or man) by posing simple, concrete questions. Listen, without passing judgement. Most women find it difficult to talk about their experience with violence.
- G** Gründlich (thorough) examination of old and new injuries. Injuries in various stages of recovery can be an indication of domestic violence.
- N** Note and document all of the findings and information provided, so that they can be used in court.
- A** Assess the current need for protection. The protection and safety of patients is the goal of every intervention.
- L** List of emergency telephone numbers and support options should be offered. Women will make use of them when they feel the need.

EXAMPLE A – TOOL 27: EXAMPLE OF COURSE EVALUATION FORM

**ADULT SEXUAL ASSAULT EXAMINATION AND AFTERCARE COURSE
EVALUATION FORM**

Date(s) of course

Please state your Job Title

Please score each box, commenting on the presentation skills, the content of the lecture and the lecture's relevance to the programme, scoring as follows:

1 = Very Poor; 2 = Poor; 3 = Satisfactory; 4 = Good; 5 = Very Good

Please add comments, especially if you score 1 or 2

SPEAKERS	PRESENTATION	CONTENT	RELEVANCE	COMMENTS
Trainer name <i>Role of the sexual offences investigation trained officer</i>				
Trainer name <i>The role of the crisis worker Assailant relationship quiz</i>				
Trainer name <i>Consent and confidentiality</i>				
Trainer name <i>Good practice in forensic examination</i>				
Trainer name <i>The forensic significance of injuries</i>				
DAY 2				
Trainer name <i>Acute clinical care of survivors of rape and sexual assault</i>				

Trainer name <i>Understanding psychological reactions following sexual assault: What helps?</i>				
Trainer name <i>The Law on Sexual Offences</i>				
Trainer name <i>Surviving the courtroom</i>				

OVERALL EVALUATION <i>Please tick box</i>	Very Good	Good	Satisfactory	Poor	Very Poor
Course structure					
Clarity of the presentations					

HOW EFFECTIVE WAS THE COURSE IN TERMS OF YOUR PROFESSIONAL DEVELOPMENT?	Very (Plan to modify my practice in a major way)	Quite (Will consider modifying my practice after seeking further information)	Ineffective (Learnt nothing relevant to my practice)
<i>Please tick box and add comment(s)</i>			

OVERALL SERVICE – Please score each box as follows:

**1 = Very Poor 2 = Poor; 3 = Satisfactory; 4 = Good; 5 = Very Good
Please add comments if scoring 1 or 2**

BEFORE THE COURSE	SCORE	COMMENTS
Advertising of training course		
What medical publication do you regularly read?		
Registration handling		
Information provision		
FIRST DAY OF COURSE	SCORE	COMMENTS
Staff at Reception Desk (venue)		
Registration (Haven / Sapphire staff)		
CATERING	SCORE	COMMENTS
Refreshments		
Food		
Staff		
LECTURE ROOM	SCORE	COMMENTS
Seating		
Audiovisual		

Temperature		
VENUE	SCORE	COMMENTS
Location		
OVERALL	SCORE	COMMENTS
Overall organisation of the course		

Any other comments you would like to make:

.....

.....

.....

**Many thanks for completing this form.
We hope you have enjoyed the two-day course. Have a safe journey!**

EXAMPLE B – TOOL 27: EXAMPLE OF COURSE EVALUATION FORM (SPECIFIC TO TOOLKIT)

Please evaluate the training course on domestic and sexual violence by circling the appropriate scores:

1. On a scale of 1 – 10, how much did you know about domestic and sexual violence in the UK before your training?

Very little 1 2 3 4 5 6 7 8 9 10 A lot

2. On a scale of 1 – 10, before the training, how confident did you feel about identifying a patient who is / has experienced domestic or sexual violence?

Not confident 1 2 3 4 5 6 7 8 9 10 Very confident

3. Did you feel emotionally supported by the course trainers?

Not supported 1 2 3 4 5 6 7 8 9 10 Very supported

4. Do you feel this training has given you more confidence to speak to clients about domestic or sexual violence?

Not confident 1 2 3 4 5 6 7 8 9 10 Very confident

4. How confident do you now feel about recognising a patient who is/has experienced domestic or sexual violence?

Not confident 1 2 3 4 5 6 7 8 9 10 Very confident

5. How confident do you feel you would know what to do if someone disclosed they were a victim of domestic or sexual violence?

Not confident 1 2 3 4 5 6 7 8 9 10 Very confident

6. What barriers did you experience that hindered your learning on this topic, if any?

7. From the 'Improving transfer of learning into practice from intimate partner and sexual violence training courses' toolkit, the trainer implemented tool numbers xxx. Do you feel the tools the trainer used aided your learning?

Not little 1 2 3 4 5 6 7 8 9 10 Very
much

8. Which tools did you use that you found useful? Why?

9. Which tools did you use that you didn't think were useful? Why?

10. Would you recommend this course to colleagues or other health professionals?

Yes No

BASIC DATA OF THE PROFESSIONAL:

1. Do you think Gender Violence is a problem?

- Social: YES NO
- Health: YES NO
- Private: YES NO

2. Do you think training in Gender Violence should be taught in:

- Pregraduate: YES NO
- Postgraduate: YES NO
- Continuous training: YES NO

3. Do you think training in Gender Violence should be:

- Compulsory YES NO
- Voluntary: YES NO

4. Grade your perception of difficulty when dealing with a case of gender violence from

0 to 10: 1 2 3 4 5 6 7 8 9 10

TRANSFER TO PRACTICAL QUESTIONS:

- Is there anything in this training course that you would change or incorporate to facilitate its application in practice?
- What do you consider missing from this course
- What would have helped you?
- If you could receive more training on Gender Violence , how would you like its contents and methods to be?
- Would it seem important to you to treat emotional aspects or the emotional impact in yourself as a professional?
- Does the course respond to your needs? **YES** **NO**
- If not, what do you believe is missing?
- What other contents would you propose?

ORGANISATIONAL ASPECTS:

- Previous diffusion?
- What worked well ?
- What was missing?

Questions regarding objectives and later practice:

- Do you remember what the objectives of this training were?
- Which of them could you apply into practice?
- What barriers do you consider could appear?
- What aspects do you think will be more useful in your practice?

- What training methods do you consider more useful in order to the practice application?
- How long training do you consider enough to feel yourself educated in order to apply the training? (1 day, 1 week...)
- Do you consider that any part of the training has been unnecessary?

REGARDING GENDER VIOLENCE:

1. Grade from 1 to 10 the self confidence degree you have when you deal with the following aspects regarding mistreatment of women (being: 1= totally insecure / 10 =totally sure)

- Identification of risk factors or warning signs ___
- Interview when suspecting mistreatment ___
- Decision on whether to file the Mandatory Report or not ___
- Filling in of Mandatory Report ___
- Knowledge of the resources where to refer the victim ___
- Psychological support to the victims ___
- Coordination with other Professionals and Institutions ___
- Dealing with the perpetrator when he is also my patient ___
- Assessment of extreme danger of the victim ___
- Doctor-patient relationship with the victims of mistreatment ___

2. Grade from 1 to 10 the agreement degree with these sentences. (Only respond if you have attended any case of gender violence). (being: 1= totally disagree / 10 = totally agree)

- Dealing with mistreatment victims causes me much anxiety ___
- I feel very embarrassed when I deal with victims of mistreatment ___
- I get emotionally involved with this kind of patients ___
- Dealing with the victims causes ethical conflicts in me ___
- I tend to identify with the victims ___
- Dealing with this kind of problems causes rejection in me ___
- I have not this kind of problems in my surgery ___
- I avoid dealing with this kind of problems ___
- I am afraid of the medical-legal consequences ___
- I do not think about it because I have not incorporated it as a health problem ___

EXAMPLE A – TOOL 28: EXAMPLE OF TRAINING REVIEW FORM



TRAINING REVIEW FORM

You recently attended the course on

A copy of the course programme is attached for your information. We hope you found the training useful and just wanted to carry out a review on how the learning has been implemented within your organisation/role.

Please spare a few moments to answer the following few questions. This form should take approximately 5 minutes to complete.

1) Please state 5 things you learnt from the course

2) Have you been able to implement this learning into your daily practice?

Yes / No

3) If not, please explain why

Have there been any barriers into implementing learning outcomes in your organisation?

Yes / No

4a) If yes, please explain why

4b) What further support do you require for implementation?

4c) Do you require any further training from the Havens?

Many thanks for taking the time to complete this form.
Please return this to *trainer name* at *email address*

EXAMPLE B- TOOL 28: ASSESSMENT OF TRANSFER INTO PRACTICE



Instructions:

This questionnaire is an example to assess the transfer of learning after a basic course on violence against women. Your submission is 6 months after having completed the course. Shipping mode: online or by mail. Approximate performance time, 15 minutes.

Example:

Estimated participant, you attended a gender violence (GV) and SV training workshop six months ago.

As we told you then, we would like to assess if the offered training was useful for your performance. The objective is to assess its applicability and to carry out those actions necessary to complement and reinforce such training.

Because of this, we would be grateful if you could complete this questionnaire and send it to this address.

After training:

1. Did it change your behaviour regarding gender violence in the consultation?
2. Do you do something new in your consultations concerning this issue?
3. Did it help you about GV detection?

4. Please mark from 1 to 10 how much you think it helped you with the following activities:
(1: nothing , 10: very much)

4a.-Interview techniques taught at the Workshops helped me about how to ask a woman about GV.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

4b. Doing the exploration and assessment of a case once it is detected.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

4c.- Identifying types of mistreatment.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

4d.-Identifying risk and vulnerability factors to GV.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

4e.-Assessing the needs of the woman and her children.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

4f.- Knowing what to do and guiding the woman towards the needed resource/professional.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

4g.- Offering advice on basic protection measures.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

4h. Knowing my legal duties.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

4i.-Knowing when to do a mandatory report.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

4j.-How to fill the mandatory report.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

4k.-Knowing other resources to which the victim can be referred if necessary.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

5. Please say to us how much do you agree with the following sentences:

(1: I totally disagree, and 10: I totally agree)

5.a. Intimate Partner Violence (IPV) is a social problem.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

5.b. IPV is a healthcare problem.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

5.c. IPV is a couple's private problem.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

6. Please say to us how much you agree or disagree with the following sentences:

(1: I totally disagree,... and 10: I totally agree)

6.a. Perpetrators usually suffer from some psychopathological disorder.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

6.b. If a woman is unfaithful to her partner, it is understandable that he feels hurt and mistreats her.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

6.c. Alcohol consumption is a frequent cause of a man mistreating a woman.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

6.d.- Frequently, after years of mistreatment, there lies beneath a couple relation with a sadomasochistic element.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

6.e.-It is frequent that there are violence precedents in perpetrators and victims' families.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

6.f. If a man controls the calls, the Money or the friendships of a woman, or does not let her work, we can affirm that there is mistreatment.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

7. Please say to us how much you agree or disagree with the following sentences:
(1: I totally disagree, and 10: I totally agree)

"The provider, in relation to GV":

7.a.- Providers must ask every woman over 14 that attends the doctor's consultation?

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

7.b. Providers must intervene only when the patient so demands it.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

7.c. Providers must act only if there are lesions.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

7.d.This is a really complex problem, so providers should only inform the patient and refer her to a specialized services.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

7.e. Providers must assist every family members including the perpetrator, with help from other professionals from Primary Care and Social Services.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

8. If a patient victim of GV has little children, please answer the following sentences:
(1: never, 10: always)

8.a. I investigate if they are victims of violence too.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

8.b. If they witnessed the assault, but were not direct victims, I do not act.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

8.c I inform the paediatrician.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

8.d. I inform the social worker

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

8.e. I inform the Child Protective Services.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

9. If your patient is a victim of GV, please mark which of the following actions is not correct.

- I assess if there is a great risk because of physical injuries.
- I assess the risk of suicide.
- In case of psychological mistreatment, no mandatory report is needed.
- I inform her about social resources.
- I inform her about how to protect herself in case of a new aggression.

10. Some contexts are considered as implying a higher risk of suffering IPV. Answer YES or NO

- Having an alcoholic husbandYES NO
- IPV precedents in the victim's familyYES NO
- IPV precedents in the perpetrator's family.....YES NO
- Unemployment or job insecurity of the perpetratorYES NO
- Being pregnantYES NO

11. The presence of any of these symptoms should make us think about the possibility of IPV. Answer YES or NO.

- Anxiety disorders YES NO
- Frequent attendance of the consultation for trivial reasons..... YES NO
- The miscarriages of repetition..... YES NO
- Depression..... YES NO
- Cystitis..... YES NO

12. It is Friday afternoon and you are on call and have to treat a victim of sexual aggression (rape) Choose which option you would take (only one):

- First, I would treat the injuries, washing and disinfecting the victim; then I would refer her to the hospital.
- After the first emergency assistance, I would carry out the infection prophylaxis, and the pregnancy prevention with the postcoital pill, then I would write the mandatory report and I would send her home, after making an appointment for her with the social worker.
- I would assess the situation, do a first emergency assistance, refer her to the hospital immediately, by ambulance and write the mandatory report

13. Concerning the perpetrator, choose the correct option:

- Most perpetrators suffer from psychopathological disorders.
- A man's excessive alcohol consumption seems to increase the likelihood of mistreatment.
- Couples therapy is recommended.

14. Do you feel safe when you deal with victims of GV?

(IF YOU HAVE NOT DETECTED ANY CASE DURING THIS PERIOD, DO NOT ANSWER QUESTIONS a, b, c, and d)

14.a.-Mark from 1 to 10 (1: none y 10: maximum) your level of assurance BEFORE THE WORKSHOP

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

14.b.- Mark from 1 to 10 (1: none y 10: maximum) your level of assurance AFTER THE WORKSHOP.

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

14.c -In which aspects of managing a case do you feel SAFER?

14.d.- In which aspects of managing a case do you feel UNSAFE?:

14.e.-Mark from 1 to 10 the degree of assurance with the different aspects:

1: none y 10: maximum

1-Identifying risk factors or alarm symptoms: __

2-During the interview, if you suspect there could be mistreatment: __

3-Deciding if I have to write the report: __

4-Writing the report: __

5-Knowing the resources to which the patient may be referred: __

6-How to offer psychological support to the victim: __

7-How to manage the issue of the perpetrator when he is my patient too _

8-Assessing the risk for the victim's life: __

9- Patient-doctor relationship to victims of IPV: __

15. Listening to GV victims' accounts has an emotional impact on providers

15. a. Do you ever suffer this impact on yourself, on your clinical practice? YES / NO

15. b. What have you done to deal these emotions?

16. Please mark from 1 to 10 how much you agree with the following sentences:

1= I totally disagree 10 = I totally agree

a.-Treating victims of IPV is very stressful for me __

b- I feel awkward when treating victims of IPV: __

c- I get deeply emotionally involved with this type of patients: __

d- Treating victims is a source of ethical conflicts for me: __

e.-I tend to identify myself with the victims: __

f- Treating this type of problems causes rejection in me: __

g- I do not have this type of problems in my consultation: __

h.-I avoid treating these problem: __

i.-I am afraid of the healthcare-legal consequences: __

j.-I do not think about it as a health problem. _ _

17. Which obstacles did you find to tackle this problem in your practice?

18. Rate the usefulness of the training received in VS for your practice

Assess it from 1 to 10 (1 of very little use- 10 really useful.)

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

19. Materials and bibliography in Electronic format were supplied during the workshop.

- Were you able to read something of it? YES / NO
- Was it useful? YES / NO

Comments on it:

20. Assessing whether the training is adjusted to your needs

1	2	3	4	5	6	7	8	9	10
---	---	---	---	---	---	---	---	---	----

21. Which ways of improvement would you suggest?

Personal data

Profession

Primary Care	Hospital	Emergency Ward	Mental Health	Other
-----------------	----------	-------------------	------------------	-------

Doctor

Family doctor	Psychiatrist	Gynaecologist	Other
------------------	--------------	---------------	-------

Nurse

Postgraduate training professionals: medicine, nurse, midwife, psychologist...

Time in your position:

Age:

Gender:

We are really grateful for your cooperation and support

9. Examples of training courses

Austria – Course 1

Identification and naming

Duration: 1 .5 hours

Target group: Health care professionals

Contents

- Introduction of the victim protection team.
- Facts and figures.
- Basic attitude towards victims of violence.
- The legal framework.

Aims

- To get detailed information about the victim protection team.
- Raising awareness of DV / SV.
- Acquiring knowledge and communication techniques with victims of violence.
- Further competence in legal matters.

Austria – Course 2

Negotiation and acting with confidence when supporting patients who have experience IPV or SV

Duration: 4 hours

Target group: Health care professionals

Theoretical components

- Psychology and evident symptoms.
- Recognising symptoms of violence.
- Impact of violence on body and mind.
- Specific injuries.
- Retraumatization, triggers.
- Reactions of patients (dissociation, neurobiology).
- Consequences of violence on children (mental, morphologic).

Practical issues

- Exercise Silke.
- Role plays (demonstration of good and bad practice).

Aims

Participants will:

- expand their knowledge regarding the physical and psychological impacts domestic or sexual violence can have on a person
- engage in practical training and try out of communication techniques
- feel more secure and confident when supporting victims of DV or SV.

Germany – course 1

Basic (multiprofessional) training course for health care staff

Part I (6 hours)

Detection of IPV

- Definition, prevalence and forms of domestic and sexual violence.
- Dynamic of IPV, risk factors and survivors support needs.
- Health consequences of IPV and importance of health care sector for intervening.
- Warning signs/ 'Red flags'.

Responding to IPV

- S.I.G.N.A.L. - Intervention steps and -sequence of steps.
- Pro-active asking about IPV and interviewing techniques.
- Importance of documenting for court.
- Further support, counselling, care and safety services available.

Part II (2.5 hours)

- Documentation.
- Assessment and diagnosis.
- Documentation for court purposes.
- Presentation of the S.I.G.N.A.L. documentation of injuries pro-forma.
- Legal and professional aspects.
- Methods: Inputs, practice exercises using case examples, discussion.

Germany – course 2

S.I.G.N.A.L. e.V. and Ärztekammer Berlin: Documentation of domestic violence and sexual violence suitable for use in court (17.00 – 20.30 h)

- Securing evidence and documentation of injuries (presentation).
- Morphological findings in cases of domestic violence (presentation).
- Morphological findings in cases of sexual violence (presentation).
- Discussion.
- Exercise - filling in a documentation proforma based on photo documentation, body charts and a case description.
- Review, discussion and finish.

Spain – course 1

Training workshop on IPV and sexual violence for health professionals in postgraduate training

Course objectives

To provide participants with the knowledge and skills needed to detect situations of mistreatment and to be able to provide a comprehensive approach in dealing with victims.

Specific objectives

- Understand the concept of gender-based violence and its determinants.
- Analyse the causal factors from a gender perspective.
- Know the health consequences for women and children, types of abuse and to be able to make early diagnosis in the practice, by identifying risk factors, situations of special vulnerability and symptoms of domestic violence in women.
- Acquire skills to enable clinical interview of women suspected of being victims of GV.
- Be able to diagnose abuse, assess its extent and the immediate risk.
- Know the steps and possibilities for action in a case of confirmed abuse (stages of change).
- Be able to conduct a comprehensive approach to the problem.
- Understand the ethical and legal aspects of IPV victim and regarding mandatory reporting.
- Know the social and health resources available to channel the necessary help, and needs coordination.
- Describe gender violence impact on health personnel and ways to tackle it.

Target group: Postgraduate professionals (MIR- resident)

Teaching method: workshop. An interactive methodology will be used, which will permit the discussion and interaction, with expositions and case studies through role play and work in groups

Duration: 18 hours

Participants: 22

Venue: Registration

Organiser: SACYL

Timeline

Day 1

- Gender Violence as a Public Health Problem. GV and its determinants. Male and female socialisation. GV: types, genesis and cycle of the violence. Vulnerability factors. Factors favouring the maintenance of maltreatment.
- Physical, psychological and social consequences of GV on women's health, on children's health.
- Plan of care for victim women in consultation.
- Primary Prevention. Early detection and clinical interview for the detection. How to ask?
- Comprehensive care. Acting according to the stages of change. Assessment of the risk.

- Initial plan of care and follow-up with woman. Assessment of needs other resources.
- Needs intersectoral coordination (health, social, legal resources). Social and health resources in Castilla y Leon for the care of victims of abuse: Social resources and other devices to support victims of IPV and SV (emergency centers, shelter, legal programs and job counselling, psychological care programmes etc). Phoenix Care Programme, men who abuse.
- Attention to sexual assault. Immediate attention and monitoring. Psychological care and legal advice.

Day 2

- Psychological care for women victims of domestic violence and their children.
- The role of security forces. Care and prevention of IPV and SV. An experience of coordinated intervention.
- Care for women victims of violence in more complex situations (severe mental disorder, pregnant, disabled, immigrants, ethnic minorities).
- Ethical Aspects. Rejection of the proceedings or legal aid Respect for the decisions of the person when reporting. Can there be conflict between the ethical and legal?
- Legal Aspects of care for women victims of abuse. The mandatory reporting.
- Emotional impact on the professionals who attend victims of IPV and SV feedback.

UK – course 1

Adult sexual assault examination and aftercare

This is a two-day course for health care professionals who want to update their forensic skills or improve their knowledge of the care and management of recent victims of sexual assault.

The course covers:

- an introduction to different models of care
- communication with clients and other agencies
- the role of specialist police officers
- the role of the crisis worker
- confidentiality and consent
- the latest forensic techniques, swabbing and preserving evidence
- describing injuries accurately
- the law relating to sexual assault
- the role of prosecution and defence
- STI prevention and good practice in aftercare
- psychological responses to trauma.

UK – course 2

Paediatric acute sexual assault examination and aftercare

This is a two-day course for paediatric clinicians interested in the care of child victims of sexual assault.

The course covers:

- an introduction to sexual assault referral centres
- gaining confidence in working with children
- the role of specialist police officers and other agencies
- confidentiality and consent in relation to children
- the latest forensic techniques and describing injuries accurately
- the chain of evidence in relation to STI samples
- the prevalence and identification of acute cases of child abuse
- the law relating to child protection and sexual assault
- working with adolescents/young people
- STI prevention and good practice in aftercare
- demonstration of colposcopy.

UK – course 3

Courtroom skills/witness familiarisation training

This one-day course, led by professional barristers and former police officers, is aimed at clinicians who may have to present evidence in courts or tribunals – either as an expert or a professional witness.

The course covers:

- an introduction to the courtroom and the different roles
- your role as a witness
- examination-in-chief and cross-examination
- how to present evidence confidently, effectively and ethically
- tailored case studies and focused role play
- one-to-one feedback on your strengths and weaknesses.

10. Conclusions

This project has identified several areas of learning regarding domestic and/or sexual violence.

The project

The experiences and daily work of all involved partners have shown clearly that transfer of learning into practice can be supported and that it can work.

Working together on this toolkit highlighted some important factors for a successful transfer from learning into practice:


- An accurate, focused and also careful planning of the courses focusing on the target group has great significance. Right from the beginning the transfer from learning into practice has to be kept in mind.
- Good contact with participants is essential. Contents and main focuses of trainings are determined by empathy, knowledge about the trainees' needs and the consideration of their workplace conditions (e.g. barriers).
- Learning does not end with the course. It is important to communicate to the trainees that the course is a part of the journey from transfer from learning into practice.

Another important result of this Leonardo partnership is the perception that different target groups and different organisations need different approaches and different tools. That is the only way to guarantee that the contents of courses are accepted and that a transfer to practice can happen. This requires from all trainers that they are very reflective. They have to decide which tools they use dependent on the target group and which tools lead to the best practice transfer.

The Leonardo partnership attached great importance during the development of this toolkit to a great diversity of tools to reach out to a preferably great number of target groups. So not only trainees but also the trainers have to continue their education and to continuously develop themselves.

The other main findings are:

- practical approaches are important
- organisational commitment helps
- learning is more important than training.



“We were able to share experiences with professionals from other countries and discussions with senior doctor.”

Spain, trainer

The toolkit

The toolkit represents a collocation of experiences during the partnership in large parts. So in common work of all partners a clearly arranged and practical toolkit could be developed. The suitability of daily use could be proved by all partners in several cycles. These practical implementations have shown clearly that the transfer from learning can be successful, even in such a sensitive area like IPV and/or sexual violence.

The factors (great significance of accurate, focused and careful planning; good contact with trainees and learning does not end with the course) mentioned above are supported by the developed tools in a very practical way. Irrespective of whether we are talking about organisations or trainers everybody will easily find the way through all tools and select the needed tool.

Prospect

The toolkit can represent a practical help to implement training courses dealing with IPV and/or SV in the health sector. It would be very interesting to observe how the tools are working in practice in several countries and to check for necessary adjustments.

11. References

- United Nations. Declaration on the elimination of violence against women. New York, United Nations, 1993.
- Council of Europe Convention on preventing and combating violence against women and domestic violence. Article 3a (2011.)
<http://www.conventions.coe.int/Treaty/EN/Treaties/Html/210.htm>
- Krug EG et al., eds. World report on violence and health. Geneva, WHO, 2002.[1]
- García-Moreno C et al. WHO multicountry study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses. Geneva, WHO, 2005.
- WHO. Responding to intimate partner violence and sexual violence against women. WHO clinical and policy guideline. Geneva, 2013.
- WHO. Health care for women subject to intimate partner violence or sexual violence. A clinical handbook. Geneva, 2014.
- Sarkar NN. The impact of intimate partner violence on women's reproductive health and pregnancy outcome. J Obstet Gynaecol. 2008 Apr; 28(3):266-71.
- Bewley, S, Welch, J. ABC of Domestic and Sexual Violence (2014).
- Campbell, J.C. (2002). Health consequences of intimate partner violence. The Lancet, 359(9314), 1331-1336.
- Ellsberg M, Jansen H, Heise L, Watts Ch, Garcia-Moreno C. Intimate partner violence and women's physical and mental health in the WHO multicountry study on women's health and domestic violence: an observational study. The Lancet. 2008. Volume 371, Issue 9619, Pages 1165 – 1172.
- In English (Germany): Hornberg et al (2008), RKI, Heft 42, Gesundheitliche Folgen von Gewalt unter besonderer Berücksichtigung von Häuslicher Gewalt gegen Frauen. Gesundheitsberichterstattung des Bundes. Berlin.
- FRA – European Union Agency for Fundamental Rights (2014), Violence against Women: an EU-wide survey. Results at a glance. Luxembourg.
- The World Health Organisation (WHO) states that intimate partner violence and sexual violence are a major risk to women's health (Krug et al. 2002; Homberg et al. 2008).
- Gloor D, Meier H (2014) My hopes for the future: Just a normal life. How victimised women experience intervention in partner violence.
http://www.nfp60.ch/E/projects/family_private_household/domestic_violence_interventions_victim_perspective/Pages/default.aspx
- Brzank, P (2003). Häusliche Gewalt gegen Frauen: gesundheitliche Versorgung. Materialien zur Implementierung von Interventionsprogrammen. Berlin: Bundesministerium für Familie, Senioren, Frauen und Jugend.
- Elliott L., Nerney M, Jones T, Friedmann PD (2002). Barriers to screening for domestic violence. Journal of General Internal Medicine, 17, 112-116.

- Fausch S, Wechlin A (2007). Anleitung für das Vorgehen im Gesundheitsbereich. In Fachstelle für Gleichstellung, Zürich (Hrsg.): Häusliche Gewalt erkennen und richtig reagieren. Handbuch für Medizin, Pflege und Beratung. Bern: Hans Huber, 135-173.
- Gerlach K (2013). Häusliche Gewalt. In Grassberger, M., Türk, E., Yen, K. (Hrsg.): Klinisch-forensische Medizin. Interdisziplinärer Praxisleitfaden für Ärzte, Pflegekräfte, Juristen und Betreuer von Gewaltopfern. Wien: Springer, 227-242.
- Hellbernd H, Brzank P, Wieners K, Maschewsky-Schneider U (2004). Häusliche Gewalt gegen Frauen: gesundheitliche Versorgung. Das SIGNAL-Interventionsprogramm, Handbuch für die Praxis, Wissenschaftlicher Bericht. Berlin: Bundesministerium für Familie, Senioren, Frauen und Jugend.
- PRO TRAIN (A Daphe II Programme Project) <http://www.pro-train.uni-osnabrueck.de/index.php/Main/HomePage?userlang=en>
- HEVI (Social and Health Care Teachers against Violence) <http://www.palmenia.helsinki.fi/hevi/>
- Implement (Violence against women Europe - WAVE) <http://www.wave-network.org/content/implement-training-manual-now-available>
- Information on how to implement IPV interventions in different health care settings can be found in the MIGG (medical intervention against violence towards women) manual, which can be found here: <http://www.bmfsfj.de/blaetterkatalog/196246/blaetterkatalog/index.html>

12. Appendices

Appendix a: Project partners

University Clinic for Medical Psychology, Psychotraumatology and Trauma Therapy department, Austria

The Psychotraumatology and Trauma Therapy department is part of the University Clinic for Medical Psychology at Innsbruck Medical University. Besides a psychotherapeutic treatment of patients suffering from posttraumatic stress disorders, the members of this department do several research. So the effects of specific trauma-therapeutic treatment in patients with complex post-traumatic stress disorders and in patients with dissociative disorders. In this project the group works together with European research groups.

The members of this group were also involved in the foundation of the victim protection team at the University Hospital of Innsbruck. The mission of this team is the sensitisation of the hospital's staff domestic and/or sexual violence and the identification of victims of violence. In this connection the effects of training measures to sensitize medical professionals for domestic violence are reviewed in the project "identification of domestic violence in health service system" and possible negative consequences of traumatic events are surveyed regarding the prevalence for illnesses.

S.I.G.N.A.L. e.V., Berlin, Germany

S.I.G.N.A.L. e.V. Intervention im Gesundheitsbereich gegen häusliche und sexualisierte Gewalt (Intervention in health care against domestic and sexual violence), supports and develops interventions in the healthcare sector to address gender based violence. S.I.G.N.A.L. e.V. was the first Germany NGO to focus on domestic violence prevention and interventions in the health care sector. S.I.G.N.A.L. e.V. is a not for profit organisation and offers training, train-the-trainer seminars, support for hospitals implementing IPV and SV intervention programs, develops materials for health care staff and patient information leaflets, provides seminars for student nurses, medical schools, vocational trainees in health, gives lectures and presentations and provides networking and information services. Target groups are health care providers (hospitals, clinics, physicians, medical practices and public health services), health care policy makers, health insurances and medical associations, teachers, trainees and students as well as women and men who have experienced gender based violence.

S.I.G.N.A.L. e.V. has taken part in and led a range of European and German projects. The organisation continues to lobby for improving the health sector's response to IPV and sexual violence. S.I.G.N.A.L. e.V. has recently translated the WHO guidelines (2013) and handbook (2014) for responding to IPV and sexual violence against women into German

Please refer to www.signal-intervention.de for more information.

SACYL, Spain

SACYL is the Public Health Service of Castilla and Leon, and the Regional Health Management is its provider agency and manager of the health services as it is part of the NHS.

Our Autonomous Community addressed the development of the comprehensive law against gender violence from the national level since late 2004 and has its own regional plans for equality and against VG. Protocols and guidelines against GBV were developed and protocols of coordination between different levels as well. In 2006, a training plan in GV for health care professionals was launched, establishing priorities for intervention (Primary care professionals, emergency services, obstetrics services and mental health). A network of trainers was created to bring training in GV to the workplace. Since then, more than 9,000 professionals Sacyl professionals, mostly Primary Care , have received some training in GV, and has been a priority to sensitize professionals, enable them for detection and involve them in the process of caring.

In 2008, the portfolio of Primary Care Services incorporated the screening services (asking a question systematically to all the women over 14 years old) and the care for victims of GBV and their children. In the last years, a healthcare guide for the detection and attention to GBV has been incorporated in the electronic medical records, that although is a very promising and useful tool, still needs wider use in all the consultations.

The Spanish team is formed by several medical health professionals of Primary Care and other different specialties, nurses and midwives, who belong to SACYL, some of them belong to the regional team of trainers in GV and others are under training on this subject actually. We have counted on the help and the cooperation of a doctor of the National Society of Family Medicine (silent member of the project), which has become a member of the team and has given valuable support for the communication and translation with the other members of the team. We have also had the collaboration of an English student of the University of Valladolid for the translations.

In addition, our working group has experience an intersectoral collaboration between primary care professionals and high school students, and security forces in community interventions. One of these experiences have had the recognition of a Good Practice for the NHS Quality Agency (2012)

Our team is also participating in a primary care research group in these lines of Gender Violence and Mental Health; we have developed several projects on these issues and various publications.

Sacyl: www.saludcastillayleon.es/es

Gender Violence: <http://www.saludcastillayleon.es/profesionales/es/violencia-genero>

The Havens, United Kingdom

The Havens are the sexual assault referral centres (SARCs) for London, funded and commissioned by NHS England and the Mayor of London's Office for Policing & Crime (MOPAC). They are run and managed by King's College Hospital NHS Foundation Trust.

The Havens' multidisciplinary team provides holistic and non-judgemental services to complainants who present within one year of the allegation. This may include forensic medical examinations, acute and follow-up sexual health care, counselling, psychology and advocacy. Where the Havens are unable to offer the service a complainant needs, we offer to liaise with and refer to other services.

The Havens provide their services to adults and children: our youngest patient was a few weeks old, the oldest over 90. This reflects the ethos of the NHS: providing care from the cradle to the grave and free at the point of delivery.

Clinical governance is the responsibility by which all NHS services must ensure the quality and continuous improvement of their services. Amongst other things this is underpinned by education and training, continuing professional development (CPD), audits and research. The Havens run a number of training courses so their staff are educated and trained appropriately and further supported by CPD. They also deliver teaching and bespoke training to police, lawyers and other healthcare staff.

Along with audits and research, The Havens' training programme aims to provide properly equipped staff to deliver the best care to their patients and clients. Please refer to the Havens website www.thehavens.org.uk for more details.

Appendix b: Needs assessment process and results

Summary of the interview results

Method

Using the same guided interview in all four participating countries, attendants in training sensitising for domestic and sexual violence were asked about their needs and expectations of the trainings.

Following a literature research it was hypothesised that:

- a. Barriers such as a lack of knowledge about domestic violence, the needs of the victims of violence, information about support services, own uncertainty of dealing with victims and bad basic conditions are existing. These factors hinder medical staff to deal with victims of violence in an appropriate way (Elliott et al. 2002, Hellbernd et al. 2004, Gerlach et al. 2013).
- b. Helpful training methods for implementation are role plays, interactive exercises and information about support and counselling (Brzank 2003, Hellbernd et al. 2004).
- c. After training, medical staff feel more secure referring to the contact with victims of violence and they feel less anxious (Hellbernd et al. 2004).
- d. After training, medical staff are more able to inform about support and counselling and to clarify the safety of the victim (Hellbernd et al. 2004).
- e. The confrontation with victims of violence can cause feelings like fear, anger or indignation or even refresh own former traumatic experiences (Fausch, Wechlin 2007).

Based on this hypothesis, an interview guide was drafted and carried out with the help of two pretest interviews. The results of those two pretest interviews caused eight categories (a to h) and one open category (i):

- a. motivation and training aims
- b. useful aspects of the course
- c. useful training methods and suggestions
- d. support for dealing with emotions
- e. readiness to implement training in practice
- f. employer's support to implement
- g. barriers to practical implementation
- h. changes to practice
- i. other ideas.

The four participating countries chose a variety of approaches of data collection, so it was collected via face-to-face interviews, emails or phone calls.

Participants

Overall, 42 people (13 UK, 12 Germany, 10 Spain and 7 Austria) were interviewed in the four participating countries. Most of them were female medical doctors aged between 26 and 60.

Results

Motivation and training aims

A lot of different factors were mentioned as motivations and aims for the training in the four participating countries. That it was mandatory to attend training was the most common answer in all countries (21), followed by wanting to learn more about how to assist patients suffering from domestic violence (15), and enhance their own competence and expertise in domestic violence and voluntarily attending training (13).

Some very personal motivations such as “knowing someone affected” or “difficulty in controlling own aggression” were also mentioned (for details, see table 1 below).

	n	% (n = 116)
mandatory to attend	21	18.1
how to assist DV patients	15	12.9
own competence and expertise	13	11.2
voluntary to attend	13	11.2
learn to recognise symptoms	11	9.5
update knowledge	11	9.5
formation of networks	7	6.0
personal interest	7	6.0
train the trainer	5	4.3
facts and figures	3	2.6
prevention of violence	2	1.7
knowing someone affected	2	1.7

CPD points	2	1.7
increase competency in court	1	0.9
topic is taboo	1	0.9
DV not prevalent in surgery	1	0.9
difficulty in controlling own aggression in regards to DV / SV	1	0.9

Table 1: motivation and training aims

Useful aspects of the course

Facts and figures (16), followed by role plays (14) and good course materials (14) were the most useful aspects of the course in the respondents' opinion. It is interesting that aspects such as "identifying domestic violence", "to develop empathy/understanding" and "how to deal with the violent partner" were mentioned rarely (for details, see table 2 below).

	n	% (n = 106)
facts and figures	16	15.1
role plays	14	13.2
good course materials	14	13.2
asking about DV / SV	12	11.3
documentation of injuries	11	10.4
case discussions	8	7.6
identifying DV / SV	6	5.7

legal aspects	5	4.7
information on support services	5	4.7
to develop empathy/understanding	4	3.8
spend time on this issue	3	2.8
increase confidence	2	1.9
patient leaflets/cards	2	1.9
film sequences	2	1.9
how to be more neutral	1	0.9
to understand why women don't leave	1	0.9

Table 2: useful aspects of the course

Useful training methods and suggestions

Role plays were identified as the most useful training method (18), although two respondents said that they felt they were not useful. By a large margin, small group work (10) and presentations (8) were seen as useful by the respondents (for details, see table 3 below).

	n	% (n = 45)
role plays	18	40.0
small group work	10	22.2
presentations	8	17.8
variety of methods	4	8.9

film clips	4	8.9
advice on how to ask the partner to leave	1	2.2

Table 3: useful training methods

Suggestions for improving training

The most common suggestions for improving training was to offer more discussion of cases (12), more practical tools (8) and more frequent training (6). Only one respondent mentioned the need to get more information about help seeking behaviour (typical behaviour displayed when people seek help) and how to build a relationship with the victim. Also, one respondent said that there was no need for further training (for details, see table 4 below).

	n	% (n = 44)
more discussion of cases	12	27.3
more practical tools	8	18.2
more frequent training	6	13.6
take pictures of flipcharts and make available on learning platform	5	11.4
more case examples	5	11.4
use of actors for role plays	2	4.6
more film clips	2	4.6
produce handout for witness skill course	1	2.3
more about help seeking behaviour in DV/SV cases	1	2.3
how to build a relationship with the victim	1	2.3

no need for further training	1	2.3
------------------------------	---	-----

Table 4: suggestions for improving training

Support for dealing with emotions

Respondents said the most important support for dealing with their own emotions is a peer support group at work (11) and having access to supervision if needed (11). They also said other participants were supportive (9). Many respondents (7) said that they did not need support for dealing with their own emotions because they felt safe (for details, see table 5 below).

	n	% (n = 49)
peer support group at work	11	22.5
could attend supervision if needed	11	22.5
participants were supportive	9	18.4
none needed, felt safe	7	14.3
important to talk about emotions during course	5	10.2
informal support from friends	4	8.2
clarity of trainers helpful	1	2.0
uncomfortable with participant who disclosed	1	2.0

Table 5: support for dealing with emotions

Readiness to implement training into practice

There were 24 respondents who said they considered themselves ready to implement training into practice and 18 said they were not fully ready after attending training. One person said: "You are never ready about this issue." (For details, see table 6 below.)

	n	% (n = 43)
ready to implement	24	55.8
not fully ready	18	41.9
"you are never ready"	1	2.3

Table 6: readiness to implement

Employer support with implementation

Asked about their employers' support with implementing training, 17 respondents said their organisation was supportive. This was followed by two critical statements indicating that there was no guidance and protocols in place (9) and no formal structure for feeding back on training courses (6). One person said they did not tell their employer about the course (for details, see table 7 below).

	n	% (n = 43)
organisation is supportive	17	42.5
no guidance or protocols in place	9	22.5
no formal structure for feedback from training courses	6	15.0
n/a as self-employed	4	10.0
consultants need to offer support but do not	2	5.0
no support available, no awareness	2	5.0

would discuss with senior doctors	1	2.5
need for more structural support, issue is linked to people who can move	1	2.5
no support for patients identified through asking	1	2.5

Table 7: employer support with implementation

Barriers to practical implementation

The most common barriers expressed were the respondents' own insecurity (12), having less time to deal with patients once domestic violence was identified (8) and having less time to ask about domestic violence (5). Three respondents had experienced no barriers, while three said they had never seen or identified cases (for details, see table 8 below).

	n	% (n = 43)
own insecurity	12	27.9
less time to deal with patients once DV identified	8	18.6
less time to ask about DV	5	11.7
no barriers	3	7.0
has not seen/identified cases	3	7.0
inconsistencies within the team	3	7.0
lack of information on support services	2	4.7
not enough practice	2	4.7

fear of disclosing own history of violence	1	2.3
not a one person show, requires a network	1	2.3
no online materials available	1	2.3
lack of workplace protocols	1	2.3
risk of becoming oversensitised	1	2.3

Table 8: barriers to practical implementation

Changes to practice

The most important changes after attending training were identified as improved communication skills (5) and being generally more aware of domestic violence (5). Respondents also reported better documentation skills (3) and being able to take a new role at work (3) (for details, see table 9 below).

	n	% (n = 25)
better communication skills	5	20
generally more aware of DV	5	20
better documentation skills	3	12
new role	3	12
displays patient information leaflet	2	8
implements all aspects of the training	2	8
has referred a survivor for support	1	4

training reinforced previous knowledge	1	4
can explain better to PTS about court	1	4
detailed work on what the practice can and can't offer survivors	1	4
acts in a more neutral way, less fear of documentation and involving the police	1	4

Table 9: changes to practice

Other ideas

For details, see table 10 below.

	n	% (n = 17)
interested in mini updates	5	29
considering repeating the training	3	17
implementation should be easier	3	18
suggest a 3-month follow-up after the course	2	12
questions about child protection	1	6
difficult to remember things at 3am	1	6
some inconsistencies	1	6
emotions	1	6

Table 10: other ideas

Conclusions

The results of the survey show consistent factors in all participating countries. It is interesting that 58% of the respondents felt ready to put training into practice and 42% did not. It is not clear whether those who considered themselves not to be fully ready thought they needed more training or that they were unsettled by the training. Both options should be respected.

In terms of motivations, apart from training being mandatory, three factors seemed to be important. Most of the respondents wanted to learn how to assist DV patients, to enhance their own competence and expertise referring to SV / DV, and to learn how to recognise the symptoms of SV / DV. So these three topics seem to be the most important cornerstones of training.

Facts and figures, role plays, communication skills and the documentation of injuries, case discussions and course materials are the most useful aspects of the course.

Dealing with their own emotions was also identified as important. Most of the respondents preferred a peer support group or supervision. Peer support groups need appropriate training to be able to provide effective support. There is no doubt that there needs to be mandatory supervision of peer support groups. The allocation of trained peer support groups and supervision should be an employer's duty.

The employer's support is seen ambivalent in general. The employer is experienced to be supportive on the one hand, but on the other hand structural weaknesses are criticised.

The most common barrier to practical implementation is own insecurity. This shows that there is a need to optimise the offered trainings.

Summing up a training should consist of theoretical inputs dealing with communication skills how to assist SV / DV patients and how to recognise symptoms of SV / DV, information about SV / DV to be able to enhance the own competence and expertise referring to SV / DV, and how to document in a correct way. Good course material has to be provided, too. Those theoretical contents should be practised with role plays and case discussions. Concurrent peer support groups and the possibility of supervision has to be guaranteed.

Appendix c: Contact details

Austria

University Hospital for Medical Psychology
Schöpfstraße 23a
A-6020 Innsbruck
Tel: +43 512 504 26117
Email: lki.ps.opferschutz@tirol-kliniken.at
Website: www.i-med.ac.at/patienten/kliniken/med_psychologie.html

Germany

S.I.G.N.A.L. e.V.
Sprengelstraße 15
13353 Berlin
Tel: +49 30 275 95 353
Email: info@signal-intervention.de
Website: www.signal-intervention.de

Spain

Gerencia Regional de Salud de la Junta de Castilla y Leon
Paseo de Zorrilla, 1
47070 Valladolid
Tel +34 983 328000
Email: mcfernandeza@saludcastillayleon.es
Website: Sacyl www.saludcastillayleon.es/es
Gender violence: <http://www.saludcastillayleon.es/profesionales/es/violencia-genero>

UK

The Havens
King's College Hospital
Denmark Hill
London SE5 9RS
Tel: +44(0)20 3299 1599
Email: kch-tr.havenseducation@nhs.net
Website: www.thehavens.org.uk

Appendix d: Acknowledgements

This toolkit was developed in order to support the implementation of learning from violence against women training, delivered to all those working in the healthcare sector and supporting women who have been victims of sexual or domestic violence.

From Gerencia Regional de Salud de la Junta de Castilla y Leon, Spain:

Carmen Fernandez Alonso

with help from Sonia Herrero Velázquez, Yolanda Valpuesta Martin, Susana Sánchez Ramon, Raquel Gómez Bravo, Marta Menéndez Suárez, Mar de la Torre Carpena, Irene Repiso Gento, Mar González Fernández-Conde and Abel Sánchez Fernández.

From the Havens, UK:

Victoria Poon-McFarlane

with help from Kate Bowler, Bernadette Butler, Simon Cordon, Kath Evans, Sukhmeet Sawhney and Muriel Volpellier.

From S.I.G.N.A.L. e.V, Germany:

Marion Winterholler

with help from Hilde Hellbernd, Karin Wieners and Katrin Wolf.

From University Clinic for Medical Psychology, Psychotraumatology and Trauma Therapy department, Austria:

Thomas Beck

with help from Astrid Lampe, Ulrike Smrekar, Iris Trawoeger, Sabine Abenthung and Deborah Verdorfer.

Special thanks to:

- All participants in the project interviews from the four countries
- Sexual Offences Exploitation and Child Abuse Team at the Metropolitan Police, London, UK
- Mag. Markus Wirtenberger, Dr. Manfred Krampfl: Ministry of the Interior, Austria
- Dr Heiderose Ortwein and Heike Rössig, Charité Universitätsmedizin
- Venetia Clarke, the Havens
- The Spanish Society of Family and Community Medicine (semFYC)
- Rosa Lopez Rodriguez from the Ministry of Health, Spain
- Luisa Velasco Riesgo, Salamanca Police Department
- The Centre of European Studies at the University of Valladolid
- All colleagues and students who have participated in training as part of this project