Elisa Niklander
Marianne Notko
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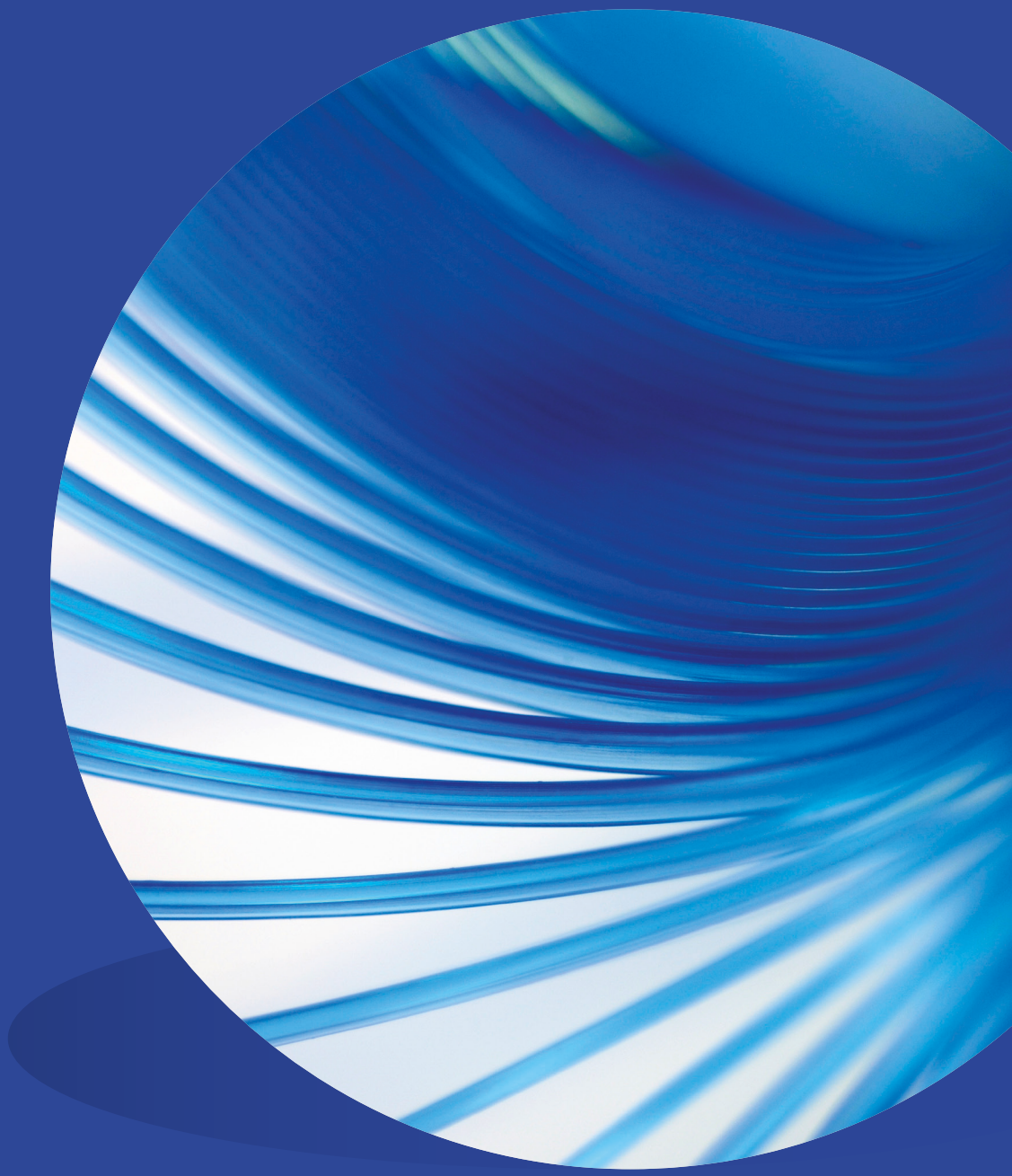
(eds.)

Intervening in domestic violence and training of professionals in social services and health care and the police

Evaluation of the EPRAS project

REPORT



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Intervening in domestic violence and training of professionals in social services and health care and the police

Evaluation of the EPRAS project

UNIVERSITY OF JYVÄSKYLÄ

POLIISI
POLICE UNIVERSITY COLLEGE

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PunaMusta Oy
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Introduction

Lack of knowledge and personal inadequacy often come up in surveys addressed to professionals when they are asked about intervention in domestic violence. There are many reasons for this. Education programmes in social and health care at all levels are lacking compulsory studies relating to the phenomenon of domestic violence. While the offer of training related to domestic violence has increased, it is frequently based on students' free choice and teachers' personal interest. The phenomenon of domestic violence is a theme that evokes many emotions also in professionals. Theoretical and evidence-based knowledge about domestic violence is an important element of a professional's competence, but not sufficient on its own. The prerequisites for recognising domestic violence and intervening in it also include taking stock of your personal relationship with violence. Interprofessional cooperation is required to recognise domestic violence, to take action and to find solutions. Awareness of the services available for those who have encountered domestic violence is essential. The competence of not only social and health care professionals and police personnel but also other professionals who encounter domestic violence in their work should be improved.

In national efforts to develop work on domestic violence, shortcomings related to training on this theme have been apparent for many years. Within the framework of the Action Plan to Reduce Violence against Women 2010–2015, an extensive national training programme for Key Instructors was implemented. Organised in cooperation with the Regional State Administrative Agencies, training was provided in the area of each agency. Once the Action Plan came to an end, resources for continuing the training were no longer available. There was an awareness of the continuous need for such training, however, and other means of responding to it had to be found.

The online training programme Create trust – Stop the violence was created as a response to the training needs related to domestic violence. The purpose of this online training programme is not only to provide participants with information about violence but also, through assignments and questions, to help them reflect on their personal relationship with and attitudes towards violence. The online training also aims to promote co-learning. Joint training and learning together facilitate cooperation and doing things together. The project titled Enhancing Professional Skills and Raising Awareness on Domestic Violence, Violence against Women and Shelter Services (EPRAS) was part of an EU campaign aiming to raise awareness of violence against women at the national level. We were given free hands to decide what the key areas for raising awareness were in Finland. This gave us the opportunity to create an online training programme on domestic violence and to raise awareness of existing shelter services.

We would like to extend our warmest thanks to all those who contributed their experience and knowledge to the online training programme and the campaign on shelters for victims of domestic violence.

Helena Ewalds
Head of Unit/Enhetschef
Development Manager/Utvecklingschef
Other Special Services unit/Enheten för andra specialtjänster
Government Services department/Avdelningen för statens tjänster
National Institute for Health and Welfare/Institutet för hälsa och välfärd

Tiivistelmä

Elisa Niklander, Marianne Notko ja Marita Husso (toim.) Lähisuhdeväkivaltaan puuttuminen ja ammattilaisten koulutus sosiaali- ja terveydenhuollossa ja poliisissa. EPRAS-hankkeen arviointi. Terveyden ja hyvinvoinnin laitos (THL). Raportti 15/2019. 109 sivua. Helsinki 2019.
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Lähisuhdeväkivalta on Suomessa merkittävä yhteiskunnallinen ja sosiaalinen ongelma. Läheisissä suhteissa tapahtuvan väkivallan määrä on länsimaihin verrattuna korkea. Väkivallalla on merkittäviä vaikutuksia yksilöiden, perheiden ja yhteisöiden arkeen ja hyvinvointiin. Lähisuhdeväkivalta aiheuttaa fyysistä ja psyykkistä kärsimystä, taloudellisia ja sosiaalisia ongelmia sekä sen kohteille että väkivaltaa todistaville, kuten omaan vanhempaan kohdistuvaa väkivaltaa havainnoiville lapsille ja nuorille. Lähisuhdeväkivallasta aiheutuu myös huomattavia kustannuksia ja resurssitarpeita erityisesti sosiaali- ja terveysaloilla, poliisin toimialoilla sekä oikeusjärjestelmässä ja kasvatusalalla.

Tutkimukset osoittavat, että väkivaltaan ei Suomessa riittävästi puututa vaan sen annetaan jatkua. Tämä selittää osaltaan kansainvälisissä vertailuissa ja tilastoissa näkyvät korkeat luvut ja pitkään jatkuvat väkivaltakierteet. Lähisuhdeväkivaltaan puuttumiseen on 2000-luvulla kehitetty lukuisia toimintakäytäntöjä ja –malleja ja aihepiirin tutkimus on lisääntynyt sekä kansallisesti että kansainvälisesti. Suomalaisen väkivaltatyön haasteena ovat kuitenkin olleet kehitettyjen mallien heikko juurtuminen osaksi organisaatioiden rakenteita ja institutionaalisia käytäntöjä, väkivaltatyön ja -tutkimuksen projektiluonteisuudesta johtuva lyhytjännitteisyys, rahoituksen epävarmuudet, puutteet eri alojen ammattilaisten saamassa koulutuksessa sekä lähisuhdeväkivaltaa koskevat asenteet ja eriävät näkemykset ilmiöstä.

Euroopan Unionin Rights, Equality & Citizenship –ohjelman vuosina 2017-2019 rahoittaman Enhancing Professional Skills and Raising Awareness on Domestic Violence, Violence against Women and Shelter Services (EPRAS) –hankkeen tavoitteena oli tarkastella lähisuhdeväkivallan kohtaamista ja siihen puuttumista erityisesti sosiaali- ja terveysalojen ja poliisin toimialan näkökulmista. Hanke toteutettiin Terveyden ja hyvinvoinnin laitoksen (THL) koordinoimana yhteistyössä hankkeen arvioinnista ja tutkimuksesta vastaavan Jyväskylän yliopiston sekä Poliisiammattikorkeakoulun kanssa. Hankkeessa kehitettiin Luo luottamusta – Puutu väkivaltaan – verkkokoulutuspaketti, joka on kansallisesti ensimmäinen useille toimialoille suunnattu maksuton ja kaikille avoin koulutuspaketti lähisuhdeväkivallasta ja siihen puuttumisesta. Koulutuspaketti on kansainvälisesti tarkasteltuna merkittävä monialaisuuteensa, sisällöllisen laajuutensa ja saavutettavuutensa vuoksi. Hankkeessa toteutettiin myös kansalaiskampanja lähisuhdeväkivallan kohtaamisesta ja turvakotipalveluista. Lisäksi hankkeessa tuotettiin tutkimustietoa lähisuhdeväkivallasta ilmiönä, väkivaltatyön haasteista, ammattilaisten osaamisesta ja sen lisäämisestä erityisesti väkivallan tunnistamisessa ja siihen puuttumisessa.

Avainsanat: lähisuhdeväkivalta, interventio, sosiaalihuolto, terveydenhuolto, poliisi, verkkokoulutus

Sammandrag

Elisa Niklander, Marianne Notko ja Marita Husso (toim.) Lähisuhdeväkivaltaan puuttuminen ja ammattilaisten koulutus sosiaali- ja terveydenhuollossa ja poliisissa. EPRAS-hankkeen arviointi. [Att ingripa i våld i nära relationer och de professionellas utbildning inom social- och hälsovården och polisen. EPRAS-projektets utvärder.]. Institutet för hälsa och välfärd (THL). Rapport 15/2019. 109 sidor. Helsingfors, Finland 2019.
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Våld i nära relationer är ett stort samhälleligt och socialt problem i Finland. Våld i nära relationer förekommer avsevärt mera än i andra västländer. Våld har en betydande inverkan på individens, familjens och omgivningens vardag och välbefinnande. Våld i nära relationer orsakar fysiskt och psykiskt lidande, ekonomiska och sociala problem både för de våldsutsatta och för de som bevittnar våldet, framför allt barn och unga som bevittnar våld mot sin egen förälder. Våld i nära relationer leder till betydande kostnader och resursbehov i synnerhet inom social- och hälsovården, polisen och rättsväsendet och inom fostran.

Forskning visar att man i Finland inte ingriper tillräckligt kraftfullt vid våld, utan man låter den fortsätta. Till en del förklarar det här de höga siffrorna och den långvariga våldsspiralen i internationella jämförelser och i statistiken. Talrika handlingssätt och -metoder har utvecklats för att ingripa i våld i nära relationer på 2000-talet, och forskning i ämnet har ökat både på nationell och på internationell nivå. Utmaningen för det finländska arbetet mot våld har emellertid varit att metoderna inte integrerats i organisationernas strukturer och institutionella praktiker, eller i det praktiska arbetet. Det våldsförebyggande arbetet och forskningen inom området har genomförts i form av projekt och därför varit kortsiktigt och osäkert finansierat. Luckor i utbildningen kring våld i nära relationer för yrkespersonalen på olika områden samt attityderna mot våld i nära relationer och den avvikande synen på problemets betydelse och hur ingripa utgör en stor utmaning i det våldsförebyggande arbetet.

Syftet med projektet Enhancing Professional Skills and Raising Awareness on Domestic Violence, Violence against Women and Shelter Services (EPRAS), finansierat av Europeiska Unionens program Rights, Equality & Citizenship under 2017-2019, var att granska bemötandet av och ingripandet i våld i nära relationer i synnerhet ur social- och hälsovårdens och polisens perspektiv. Projektet samordnades av Institutet för hälsa och välfärd (THL) och genomfördes i samarbete med Polisyrkeshögskolan och Jyväskylä universitet, som svarade för projektets utvärdering och undersökning. Inom ramen för projektet skapades nätutbildningspaketet "Skapa förtroende – stoppa våldet". Det är avgiftsfritt, öppet för alla och det första fin- ländska utbildningspaketet kring våld och ingripande i våld i nära relationer avsett för flera verksamhetsområden. Utbildningspaketet är internationellt sett betydande

tack vare möjligheten att tillämpa det på flera områden, det omfattande innehållet och tillgängligheten. Inom ramen för projektet genomfördes även en medborgarkampanj om att bemöta våld i nära relationer samt om skyddshem. Därtill produce- rades forskningsdata om våld i nära relationer som fenomen, utmaningar i det vålds- förebyggande arbetet, yrkespersonalens kompetens och fortbildning i synnerhet när det gäller att identifiera och stoppa våldet.

Nyckelord: våld I nära relationer, intervention, socialvård, hälsovård, polis, nätutbildning

Abstract

Elisa Niklander, Marianne Notko ja Marita Husso (toim.) Lähisuhdeväkivaltaan puuttuminen ja ammattilaisten koulutus sosiaali- ja terveydenhuollossa ja poliisissa. EPRAS-hankkeen arviointi. [Intervening in domestic violence and training of professionals in social services and health care and the police. Evaluation of the EPRAS project]. National Institute for Health and Welfare (THL). Report 15/2019. 109 pages. Helsinki, Finland 2019.
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ABSTRACT
Domestic violence is a major societal and social problem in Finland, higher than in some other Western countries.Violence significantly affects the daily lives and well-being of individuals, families and communities. Domestic violence causes physical and mental suffering as well as financial and social problems to the subjects, but also to those who witness violence, such as children and adolescents who observe violence against their parents. Moreover, domestic violence causes significant costs and resource needs especially in the health and social care sectors, in the police and the legal system, and in the field of education.

Research shows that instead of properly intervening in violence, it is often ignored and therefore it also continues. To some extent, this explains the high figures in international comparisons and statistics, as well as prolonged spirals of violence. In the 2000s, new practices and action models have been developed for intervening in domestic violence, and research on the topic has increased both nationally and internationally. However, the work against violence has been challenging because, for example, it has been difficult to integrate the developed models into the structures and institutional practices of organisations. Furthermore, the work and research on violence are mainly project-based, an approach which only allows a short-term perspective. Additional challenges for the work include insecure funding, insufficient training on domestic violence provided for the professionals of different fields, and the attitudes towards domestic violence as well as dissenting views on the significance of the problem and on the means to address it.

The Enhancing Professional Skills and Raising Awareness on Domestic Violence, Violence against Women and Shelter Services (EPRAS) project – funded for the years 2017–2019 under the EU's Rights, Equality & Citizenship programme – focused on encounters with and interventions on domestic violence particularly from the perspectives of the social and health care sectors and the police. The project was coordinated by the National Institute for Health and Welfare (THL) and implemented by the University of Jyväskylä (in charge of assessment and research) in cooperation with the Police University College. The project developed an online training programme (Luo luottamusta – Puutu väkivaltaan / Create trust – Stop the violence), which is Finland's first free, publicly accessible training package on domestic vio-

lence and how to intervene in it, intended for various branches. Because of its multi-sectoral approach, broad content and accessibility, the training package has major international significance. The project also implemented a civic campaign on encountering domestic violence and on shelter services for the victims of domestic violence. In addition, the project produced research data on domestic violence as a phenomenon, the challenges of work against violence, and the competence of professionals and enhancing it especially as regards recognising violence and intervening in it.

Keywords: domestic violence, intervention, social care, health care, police, e-learning

Contents

1 Domestic violence as a phenomenon

Marianne Notko and Marita Husso

Domestic violence is a global phenomenon which affects individuals and societies in numerous different ways. The concept of domestic violence is not unambiguous, however. It is linked to time, place, culture and practices in a manner that often makes recognising it and intervening in it challenging. It is essential to consider what types of acts and behaviours we regard as violence. Who uses violence against whom, and who are the persons the violence affects? How, when and where should we intervene in violence?

A comprehensive analysis of violence should start from defining different forms of violence in a manner that enables us to gauge them scientifically. However, the range of definitions for violence is large. According to the World Health Organisation WHO, violence is the intentional use of physical force or power, threatened or actual, against oneself, another person, a group or a community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation. The WHO definition specifically links violence to the actual act rather than its consequences. Violence can be divided into the categories of violence against oneself, interpersonal violence and collective violence. (Krug et al. 2002.)

When we encounter violence in daily life and different interpersonal relationships, it is important to determine the type of phenomenon we are dealing with. When a person is violent against their current or previous partner, child, close relative or other person close to them, this is referred to as domestic violence. Domestic violence may lead to a physical or psychological injury, developmental disorders, deprivation or death (LeFevre Sillito 2012). In addition to more obvious acts of violence, it also includes abandonment and neglect (e.g. when the victim is an older person or a child). Forms of domestic violence include physical and emotional violence, sexual violence, financial violence, abuse, neglect and cultural or religious violence. (Nyqvist 2001; Husso 2003; Piispa et al. 2006; Notko et al. 2011; Ronkainen 2017.) When discussing violence, it is important to note its different relations to such attributes as gender, age, sexuality, social class and functional capacity (including disability). The relationships between gender and violence have been examined through the concepts of gendered and gender-based violence, among other things. These concepts crystallise an idea of interlinkage between violence and gender at the level of culture, structures and actors. Gender-based violence describes the

end results of processes that make gender significant, for example the fact that statistically, perpetrators of violence are men more often than women, or that women experience violence in different situations than men. Genderisation refers to a dynamic and a process, to constructing gender in a manner in which gender is not a dichotomy. Gender-based violence refers to a continuous struggle and negotiation on the meanings of gender in situations involving violence, practices of assistance and legal processes, as well as in public discussion (Ronkainen 2017). Violence is also always associated with power and social control: violence is a coercive measure by which the perpetrator gains dominance over others and demonstrates their power and strength. The conceptualisation of violence is thus characterised by diversity, a multi-disciplinary approach, context-specificity and even controversy (see Lidman 2015). Violence is a global societal problem, and the harms it causes extend to social, health-related and economic issues: violence results in injuries, suffering and losses (Husso et al. 2017). To quote Arto Jokinen (2000), ”when we look at history, it appears that violence is part of humans’ way of being together, as it has occurred to some extent in all groups of people at all times”.

When we talk about domestic violence, attention is often focused on the figures and gender divisions of violence. Statistics and figures relating to violence as well as the forms, perpetrators and victims of violence have been a subject fraught with tension in the 2000s. Discussions on this theme have been hindered by a global lack of statistics, unsystematic or non-existent documentation of situations involving violence, and the diversity of interpretations. The figures and their interpretations raise questions: what is hidden behind large or small figures? In the context of statistics on violence, we talk about the tip of an iceberg, indicating that the number of acts coming to light is considerably smaller than the actual number (for example, rape statistics). The figures on violence that are collected and available play an important role in what type of societal problem violence is seen as (Piispa & Heiskanen 2017). The first Finnish survey on violence against women was published in 1998 (Heiskanen & Piispa 1998), while the second national survey came out in 2006 (Piispa et al. 2006), but no further surveys of this type have been conducted since that time. Children’s and young people’s experiences of violence have been studied in Child Victim Surveys conducted in 2008 and 2013. (Ellonen et al. 2008; Fagerlund et al. 2014.) A survey was conducted to map violence experienced by men (‘Tuhansien iskujen maa - Miesten kokema väkivalta Suomessa’, Heiskanen & Ruuskanen 2010). Violence experienced in an intimate partner relationship has been studied as part of the National Crime Victim Surveys since 2012 (Danielsson & Salmi 2013; Danielsson & Näsi 2018). Some surveys have thus been conducted to study the violence experienced by women, children and men but, symptomatically, no comprehensive and coordinated long-term charting and regularly updated data on domestic violence experiences are available.

1.1 Domestic violence interventions and preventive work

A key feature of violence in Finland is that, compared to the other Nordic countries, amendments to Finnish legislation related to domestic violence were made relatively late. Rape within marriage, for example, was criminalised in 1994 in Finland (in Sweden, 1962) and a minor assault in a close relationship became an offence subject to public prosecution in 2011 (in Sweden 1982). Significant changes were made to the legislation in the 2000s. The Social Welfare Act adopted in 2014 (1301/2014) defined for the first time domestic and family violence as a situation in which social services must be organised. This faced the municipalities with a new situation in terms of encountering domestic violence and work on violence.

The Istanbul Convention, orThe Council of Europe Convention on preventing and combating violence against women and domestic violence (the Istanbul Convention) , took effect in Finland in 2015. A Committee for combating violence against women and domestic violence has been appointed within the Ministry of Social Affairs and Health for 2017–2020. The tasks of this Committee are to coordinate and monitor actions required to implement the Istanbul Convention, to evaluate the impacts of these actions, and to prepare a plan for the implementation of the Convention to be adopted by the Government. While the Istanbul Convention emphasises prevention, it also contains a number of obligations related to protecting victims of violence and holding perpetrators accountable for their acts under criminal law.

The legislation and its shortcomings have been a key challenge to intervening in violence. According to Suvi Ronkainen (2009), national level action and political commitment to reducing violence, for example as part of Government Programmes, only emerged in Finland as late as the 1990s, even if the great number of murders and also the problem of domestic violence had come to light much earlier than this. Leo Nyqvist (2001) and Marita Husso (2003) have also brought up how, until the 2000s, interventions in violence were characterised by an ad hoc approach, and actions against violence were fragmented. Johanna Niemi-Kiesiläinen (2004) compared the homicide figures to the numbers of house calls and reports to the police in Finland, Sweden and the United States. She argues that in Finland the primary problem is not the high incidence of violence rather than allowing the violence to continue instead of intervening it. Similar findings have been made in reports on Finnish familicides and filicides. A publication by the Ministry of the Interior titled ‘Perhe- ja lapsisurmien ehkäisy ja estäminen ja viranomaisten välinen tiedonvaihto’ (Prevention of familicides and filicides and exchange of information between the authorities, 2014), for example, notes that some of the killings could have been prevented if the authorities had taken the threats and suicidal thoughts that had become known to them seriously and intervened in the violence or threat of violence. Reports relevant to this theme show that the authorities have usually known about the violence but no intervention has been made in it. Intervention or non-intervention in violence are also tied to numerous concrete factors related to the arrangements of daily life

and intimate relationships. Local differences in the offer of services, for example, have been and still are significant factors in accessing help (e.g. Ronkainen 2008; Tunnista, turvaa ja toimi 2008; Lindqvist 2009; Mäkeläinen et al. 2012).

1.2 Training on domestic violence in the social and health care sectors and the police

In addition to legislation, regulations and recommendations, professionals in different fields, including social and health care, the police, courts and education, play a key role in recognising violence and intervening in it. Perpetrators of violence, victims and those who witness violence in their close relationships are encountered as clients of health care, social services and the police as well as at different institutions, such as schools and early childhood education and care. However, training on violence and intervening in it is rarely offered in most fields. Participation in courses themed on violence is often voluntary, and the courses are optional rather than compulsory. At universities, studies on violence themes have been organised as individual courses in the 2010s, for example by the University of Turku's Faculty of Law, the Finnish National University Network for Social Work SOSNET, and as part of Gender Studies at the University of Oulu's Faculty of Education and the University of Helsinki. The largest scope of studies, or a multidisciplinary module of 30 credits on violence research, has been offered at the University of Jyväskylä since autumn 2017. The areas of emphasis in this module, which is open to students in all fields, are violence perpetrated and encountered in daily life, at institutions and in intimate relationships as well as cultures of violence and violence in the media. (Module in violence research 2019.)

In the fields of social and health care, police work, courts and education, however, violence, victims and perpetrators are encountered by a large number of professionals who have completed their degree education but who have major shortcomings and great variations in the scope and quality of their training on domestic violence. The aim of the project titled Enhancing Professional Skills and Raising Awareness on Domestic Violence, Violence against Women and Shelter Services (EPRAS), which was funded by the European Union's Rights, Equality & Citizenship programme in 2017–2019, was to tackle this challenge, especially from the viewpoint of the social and health care sector and police work. This project coordinated by the National Institute for Health and Welfare was carried out in cooperation with the University of Jyväskylä, which was responsible for evaluation and research, and the Police University College. The project developed an online training programme called Create trust – Stop the violence intended for professionals.

2 Enhancing Professional Skills and Raising Awareness on Domestic Violence, Violence against Women and Shelter Services (EPRAS)

Elisa Niklander, Joonas Peltonen, Marianne Notko and Marita Husso

The backdrop to the EPRAS project was a genuine need to build up professionals' competence relating to domestic violence, violence against women and shelter services and to raise awareness among citizens. Domestic violence is a serious problem affecting wellbeing in Finland. Statistically, violence against women is the most common form of domestic violence. According to an EU survey, 30% of Finnish women and girls aged over 15 have experienced physical and/or sexual violence, a figure which exceeds the European average (20%) (Violence against women 2014). Professionals often fail to recognise and report violence, however.

Social and health care professionals and police officers often are the first professionals to encounter victims of domestic violence and violence against women. They play a key role in recognising violence and intervening in it. Studies on violence interventions conducted in the 2010s indicates that the problem associated with recognising and intervening in violence in social and health care is associated with professionals' attitudes towards domestic violence and violence against women and denial of the possibility of violence. (Husso et al. 2012, 2014 & 2016; Notko et al. 2011; Virkki et al. 2012 & 2014.) Professionals too often fail to ask about violence and to recognise or report domestic violence and violence against women (Husso et al. 2016; Lavis et al. 2005; Leppäkoski 2007; Nyqvist 2001). Research also shows that the police need more training, among other things on recording reports of an offence in connection with mild violence, different forms of domestic violence and violence against women, and making more systematic use of information on repeated calls to the same addresses. Attention should also be paid to directing clients to support services offered by actors who provide help. (Fagerlund 2016.)

Legislation related to domestic violence has changed in Finland over the last decade. Under the new legislation, those who have experienced domestic violence or its threat can today make their way to government-funded shelters on their own

initiative, whereas earlier the decision on whether or not a client needs a place in a shelter was made by the municipality. A client may also be directed to a shelter by any professional. No fee is charged to the client for their stay in a shelter. (Shelters for victims of domestic violence 2015, National Institute for Health and Welfare 2016.) The Finnish model of government-maintained shelters is unique by global standards. Both the Istanbul Convention and the Social Welfare Act (1301/2014) oblige municipalities to organise the social services needed by those who have experienced domestic violence or violence against women. The legislation on police action in situations involving domestic violence has also changed in the last few decades. Since 2011, a minor assault in a close relationship has been an offence subject to public prosecution, and the police must consequently record a report of an offence and carry out a pre-trial investigation, and the prosecutor may bring charges for a minor assault in a close relationship, even if the victim did not demand punishment for the perpetrator. Even mild violence perpetrated in a private residence or in a close relationship thus no longer is a private matter in terms of criminal law. (Fagerlund 2016; Kotanen & Smolej 2014.)

Several studies indicate that intervening in domestic violence requires interventions and responses at multiple levels. Preventive actions should target the entire population. While social and health care professionals and the police could play a key role in raising awareness of domestic violence, changing attitudes and recognising violence through their work, earlier research shows that their knowledge and skills related to domestic violence and violence against women are inadequate. This is at least partly due to an absence of studies relating to domestic violence in their degree programmes and in-service training. The need to provide more training for professionals in Finland is obvious.

In addition to professionals' training needs, citizens also have significant gaps in their knowledge about the current legislation, for example on shelter services. Many types of preconceptions and beliefs are associated with shelters. Victims have a negative image of themselves as victims of violence, which may affect the way they see other victims. These beliefs may also result in negative preconceptions about shelters. Information activities about shelters are important, as they can influence the images held by both professionals and citizens of shelters and domestic violence. Correct information may also lower the threshold for coming to a shelter at an earlier stage. (Ojuri & Laitinen 2015.)

Raising awareness and providing information play an important role for making it easier to access the services for those who need help. Through campaigns, information may be provided on who shelters are intended for, how you can become a client of a shelter, what a shelter is like and what type of help and services are available for clients. This information should be easily accessible. Professionals' lack of information about shelters may affect their decisions to direct clients to them. (Ojuri & Laitinen 2015)

The EPRAS project aimed to respond to professionals' training needs and, on the other hand, the need to raise general awareness of domestic violence, violence against women and shelter services. The project met these needs by developing an online training programme for professionals and organising a civic campaign on shelter services. It was important that the online training, in particular, would meet professionals' actual training needs, and research which extracted new information from both professionals and shelter clients was a key element of the project. Research was also conducted to evaluate the success and impacts of project activities.

The EPRAS project received funding from the European Commission's Rights, Equality and Citizenship (REC) programme in 2016. The duration of this national project was 2.5 years, and it was carried out in 2017–2019.

2.1 Objectives of the project

The objectives of the EPRAS project were 1) building up professionals' competence and awareness related to domestic violence, violence against women and shelter services, 2) raising awareness among citizens, and 3) producing new research evidence on these phenomena as well as on professionals' competence in recognising and intervening in violence and building up this competence.

2.2 Project actors and partners

The project was coordinated by the National Institute for Health and Welfare. The project partners were the University of Jyväskylä and the Police University College.

The National Institute for Health and Welfare is a research and expert institute which, in keeping with its strategy, promotes the population's wellbeing, health and safety, prevents illnesses and social problems, and develops the welfare society. It also produces information to support decision-making. At the National Institute for Health and Welfare, the members of the EPRAS project group were Project Manager Elisa Niklander, Head of Unit Helena Ewalds and Development Manager Joonas Peltonen. Riina Karjalainen participated in the project for six months as a project group member while Joonas Peltonen was on family leave. Development Manager Martta October from the National Institute for Health and Welfare was also involved in the project.

The University of Jyväskylä delivers high-quality research and education with the aim of increasing the holistic wellbeing of humans and competence in society. The University of Jyväskylä was responsible for research in the EPRAS project. The Head Researcher, Docent and Senior Lecturer was Marita Husso. Senior Researcher Marianne Notko and Researcher Sisko Piippo were also members of the project group.

The Police University College is the only institute providing police education and training in Finland and an expert of police sector training, research and development. All new police officers in Finland are graduates of the Police University

College. The college sees to recruitment to police education, student admissions, graduate and postgraduate degrees in police studies, in-service training provided at the college, as well as research and development relevant to the police sector. At the Police University College, members of the EPRAS project group were Project Manager Jarmo Houtsonen, Researcher Monica Fagerlund, Chief Inspector Henri Rikander and Researcher Marianne Mela.

The associated project partners were the City of Jyväskylä, JIK Joint Municipal Enterprise for Basic Services, Municipality of Kangasala , Town of Nokia , Basic Enterprise of Saarikka (Joint municipal corporation of social and health services), the City of Tampere, the City of Vaasa, the City of Äänekoski, The Mother and Child Homes and Shelters in Central Finland (Association) The association of mother and child home and shelter of Tampere , Shelter & Mother and Child home of Vaasa , the National Police Board and the Association of Finnish Local and Regional Authorities. The project also worked together with all shelters in Finland, Viola – Free from Violence Association, Central Finland Health Care District and the Ankkuri team in Hämeenlinna.

Director General of the National Institute for Health and Welfare appointed a project steering group, to which members were invited not only from the partners but also from the National Police Board, the Association of Finnish Local and Regional Authorities and the City of Vaasa. The purpose of the steering group was to support the progress of the project in line with its objectives. The steering group was tasked to ensure that the stakeholders' views, experiences and needs lent support to the planning and implementation of the project, to promote the project's networking by establishing contacts between different actors, and to step up information sharing between the project and the organisations which the steering group members represented.

2.3 Project activities

In order to achieve the objectives, the project was divided into five workstreams:

1) management (coordination and administration)
2) online training package
3) civic campaign
4) evaluation and research
5) sharing and dissemination of information.

Each workstream had its specific sub-objectives and activities that responded to both the project's main objectives and the sub-objectives. For a more detailed description of the workstream contents, see section 3 of this report. The University of Jyväskylä was responsible for the workstream related to evaluation and research, whereas the main responsibility for the other packages rested with the National Institute for Health and Welfare.

2.3.1 Online training package for social and health care professionals and the police

Building up the competence of social and health care professionals and the police was a key objective in the project. As there is such a large number of professionals, it is inevitable that no party in Finland is able to meet the training needs of all professionals in the form of contact teaching. This is why a decision was made in the planning phase of the project to make sure that, as a point of departure, everyone could benefit from the training by creating a free, web-based training programme on domestic violence. Through e-learning, professionals' competence can be enhanced rapidly and cost-effectively.

The online training programme was based on a microlearning platform (Valamis) in order to enable professionals to use it diversely and complete the training in smaller parts. Unlike training requiring physical presence, online training is easily accessible from anywhere in Finland. This gives professionals more equal possibilities for obtaining training on domestic violence.

An editorial committee was appointed to develop the online training programme. In addition to senior specialists from the National Institute for Health and Welfare, the committee had members from the Police University College, Viola - Free from Violence Association, Central Finland Health Care District and the City of Tampere. Where necessary, the committee could enlist the help of external experts. The development of the online training programme was also supported by a group of experts by experience who commented on the work, a team of authors and a team of designers. Police University College students also participated in the development efforts, and social and health care professionals and police personnel contributed their expertise.

A key role in the development of the online training was played by research carried out in this project among professionals and clients of shelters, as well as by professionals' experiences of and feedback on the pilot stage of the online training. The results of round I of the research were applied to the efforts to develop the online training and, on the other hand, research was also conducted to evaluate the training programme after it was launched.

The National Institute for Health and Welfare saw to the actual practical development of the online training in close cooperation with the Police University College. The online training can be accessed on the same site as National Institute for Health and Welfare's other online training programmes (verkkokoulut.thl.fi). The process and actions completed to develop the online training programme are discussed in greater detail in section 3.

2.3.2 Awareness raising campaign about shelters

As part of the EPRAS project, a campaign addressed to citizens was implemented, the main focus of which was informing citizens better about shelters. It was considered particularly vital to inform citizens about who the shelters are intended for, in what types of situations clients can make their way to a shelter, what kind of help is available in shelters, and the fact that shelter services are free of charge for citizens. The campaign was to consist of digital marketing and a radio campaign.

The National Institute for Health and Welfare was responsible for the civic campaign in the project. Following a tendering process and based on plans prepared by the National Institute for Health and Welfare's project team, the planning and implementation of the campaign were entrusted to advertising agency Hill and Knowlton Finland Oy. The National Institute for Health and Welfare supervised and directed the advertising agency's work and also carried out actions of its own in connection with the campaign. For more information on the practical implementation of the campaign, see section 3.

2.3.3 Evaluation and research

The purposes of the research included producing new research evidence on these phenomena as well as on professionals' competence in recognising and intervening in violence and building up this competence. Another key objective of the research activities was evaluating the implementation of the project's different workstreams.

The evaluation and research were coordinated by the University of Jyväskylä's Department of Social Sciences and Philosophy. The Head Researcher in the project was Marita Husso, Docent and Senior Lecturer, whereas Senior Researcher Marianne Notko was employed in the project as a full-time researcher and doctoral student Sisko Piippo as a part-time researcher. The research was conducted in cooperation with the Police University College and the National Institute for Health and Welfare. The Police University College was represented in the research group by Senior Researcher Jarmo Houtsonen, Researcher Monica Fagerlund, Researcher, Chief Inspector Henri Rikander and researcher Marianne Mela. The National Institute for Health and Welfare's representative in the research group was Senior Specialist Joonas Peltonen.

Different data sets were gathered in the project for the needs discussed above. The data comprised 1) a survey addressed to social and health care professionals and police personnel (rounds I and II), 2) focus group interviews with social and health care professionals and police personnel, and 3) interviews with shelter clients.

The purpose of the project's evaluation and research activities was to establish the following:

1. In what extent and in what ways do social and health care and police professionals encounter domestic violence (DV) and violence against women (VAW)?
2. What kinds of training on DV/VAW have social and health care professionals and police received during their professional basic education or during their careers?
3. What needs for training and what kinds of working practices do social and health care professionals and police have with respect to DV/VAW?
4. What possibilities and challenges exist for multi-professional cooperation and in recognizing and intervening in DV/VAW?
5. What are the prerequisites for effectively intervene DV/VAW in the fields of social and health care and police?
6. What effects has the EPRAS training package had on professionals' knowledge, skills, multi-professional cooperation, and on the practices for recognizing and intervening in DV/VAW?
7. How visible has the EPRAS Awareness Raising Campaign been and what effects has it had from professionals' perspectives?

Survey participants were recruited from among the associated partners of the project, which were: JIK Joint Municipal Enterprise for Basic Services (Ilmajoki and Kurikka), the City of Jyväskylä, Kangasala municipality, Central Finland Mother and Child Home and Shelter Association, the Association of Finnish Local and Regional Authorities, the City of Nokia, Basic Security Public Utility Saarikka (Kannonkoski, Karstula, Kyyjärvi and Saarijärvi), the National Police Board, the City of Tampere, Tampere Mother and Child Home and Shelter Association, the City of Vaasa, Vaasa Mother and Child Home and Shelter Association and the City of Äänekoski.

2.3.4 Ethical issues

The starting point of research on domestic violence is that it examines sensitive topics, and consequently requires ethical awareness on a number of levels. According to WHO's ethical and safety recommendations for research on domestic violence, the safety of respondents and the research team is paramount, and should guide all project decisions. The study design must include actions aimed at reducing any possible distress caused to the participants by the research. (WHO 2001, Ellsberg & Heise, 2002.) While our study focuses on professionals who work with do-

mestic violence and domestic violence encountered at work, potential personal experiences of domestic violence should also be accounted for in these situations. For example, inconsistent findings have been reported in studies on the impacts that health care professionals' personal experiences of domestic violence have on encountering patients who have experienced domestic violence. A professional's personal experiences of violence that remain unprocessed may, for example, affect his or her willingness to ask patients about violence. (deLahunta & Tulsky 1996.)

On the other hand, violence that has occurred in their personal relationships, or relationships between their family members, may also have a positive effect on recognising violence experienced by clients and encountering victims. (Dickson & Tutty 1996, Christofides & Silo 2005.) Due to research ethics, it is important to take into account, that the professionals participating the study may have experienced violence themselves from the perspectives of victim, perpetrator or witness. Care personnel often are the first persons to meet a victim of violence, and taking into account the possibility of professionals having personal experiences of violence is thus important in order to develop effective ways of providing help (Diaz-Olavarrieta 2001, Garcia-Moreno 2002). It was also important to look at training needs related to these themes that other professionals working with victims, perpetrators and those witnessing domestic violence, including children, may have.

Ethical issues have significance from the perspective of not only the actual research but also the implementation of the entire project. In our research (Notko et al. 2013), we stress how ethical considerations should not be merely limited to mechanically carrying out the mandatory minimum actions. An ethical approach means evaluating and observing your own actions in all stages, including planning and collecting research data, analysing the data, and reporting. Special awareness is also required of researchers when conducting research among work organisations. In processes related to recruiting respondents, for example, voluntary participation should be ensured, and potential power structures between focus group members should be addressed (e.g. Markova et al. 2007; Valtonen 2008; Mäntyranta& Kaila 2008). In the EPRAS project, the participants in development and research cooperation worked closely together. The realisation of ethical principles was also evaluated together with the different project parties.

3 EPRAS project's evaluation

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The project package consisting of different workstreams was evaluated regarding its different phases of development, its implementation and its outcomes. In this Chapter, we describe the online training programme, the civic campaign and the evaluation and research activities.

3.1 Online training programme Create trust – Stop the violence

The online training programme Create trust – Stop the violence for those encountering domestic violence in their work responds to professionals' needs for in-service training on recognising and intervening in domestic violence. The training was designed to complement the education of social and health care professionals and the police, in particular. It can also benefit employees in other fields, for example those working for the education services.

In Finland, studies associated with domestic violence are not a compulsory part of education programmes leading to qualifications in social and health care professions. As in-service training, training on domestic violence is often only available on an ad hoc basis. The training package Create trust – Stop the violence gives all professionals access to training on domestic violence. The online training programme is available free of charge on the National Institute for Health and Welfare's training website (verkkokoulut.thl.fi).

The online training programme also meets an obligation under the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (the Istanbul Convention), which requires the Parties to provide or strengthen appropriate training for the relevant professionals. The training should cover "the prevention and detection of such violence, equality between women and men, the needs and rights of victims, as well as on how to prevent secondary victimisation." The training related to domestic violence should also contain training on co-ordinated multi-agency co-operation to allow for a comprehensive and appropriate handling of referrals in cases of violence. (Istanbul Convention, Article 15, 53/2015.)

The online training programme produced as part of the project was based on a microlearning platform. This means that the training consists of parts with different scopes, it can be completed in small instalments, and the system remembers a user's activities on the platform. The training consists of six modules, of which four com-

prise the actual content. Each module is divided into two to four study packages. The training imparts professionals with adequate basic skills in recognising domestic violence and intervening in it. It also provides a short description of what violence against women means.

The first module, 'Welcome', introduces users to the training and the ways in which it can be utilised. The second module, 'Domestic violence as a phenomenon', discusses domestic violence, its impacts, and a professional's personal relationship with domestic violence. The module also clarifies the concept of violence against women. The third module, 'Duty to intervene', deals with legislation and human rights conventions, discusses the factors that oblige professionals to intervene in violence, and describes domestic violence as an offence, the criminal process related to it, and professionals' reporting and notification duties.

The fourth module, 'Intervening in domestic violence', deals with recognising, encountering and intervening in domestic violence and introduces users to tools created for domestic violence interventions. The fifth module, 'Together we can do more', concentrates on interprofessional cooperation and its essential role in domestic violence interventions. The module also introduces users to violence-specific assistance providers. In the sixth module, the training programme concludes with a test. Once they have passed the test, users can print and save a certificate for themselves on having completed the training.

The online training contains a dedicated sub-page titled 'References and other material'. It lists links to the tools discussed in the online training, a few other online training packages which support the theme of the training, and the websites of actors relevant to violence referred to in Module 5.

3.1.1 Implementation

A large number of specialists from different organisations, professionals and experts by experience were involved in developing the online training. The National Institute for Health and Welfare appointed an editorial committee to support the production of the training programme. The members of the committee were:

Helena Ewalds, Head of Unit, National Institute for Health and Welfare (chair of the editorial committee)
Sirkku Mehtola, Executive Director, Viola – Free from Violence Association
Maria Päivänen, Director of Social Services, City of Tampere
Anneli Kuusinen-Laukkala, Medical Specialist, Central Finland Health Care District
Martta October, Development Manager, National Institute for Health and Welfare
Katriina Bildjuschkin, Specialist, National Institute for Health and Welfare
Kirsi Viitanen, Development Manager, Police University College

Elisa Niklander, Project Manager, National Institute for Health and Welfare (secretary and rapporteur)

The EPRAS Project Manager served as the working group's secretary and rapporteur as well as liaised between the project group and other groups participating in the development work and the editorial committee. Project group member Henri Rikander from the Police University College also participated in the committee's meetings starting from the middle of its term. While the project was in progress, the editorial committee met 10 times between 1 June 2017 and 31 December 2018. The committee members also commented on the content of the online training and produced some content for it.

The online training programme also had a team of authors who, among other things, produced content for the training. The team of authors worked together with the editorial committee. The committee guided and supported the team's work related to content production. The members of the team of authors were:

Elisa Niklander, Project Manager, National Institute for Health and Welfare (Chair)
Martta October, Development Manager, National Institute for Health and Welfare
Monica Fagerlund, Researcher, Police University College
Henri Rikander, Chief Inspector, Police University College
Marianne Mela, Researcher, Police University College
Jarmo Houtsonen, Senior Researcher, Police University College

National Institute for Health and Welfare's online training environment was selected as the platform for the online training programme which is based on the Valamis platform. A team of designers was formed to engineer and set up the online training package. This work was carried out in cooperation with the Products unit of the National Institute for Health and Welfare's Information Services department. In addition to the EPRAS Project Manager, the members of the team of designers were Linda Hokkanen and Sara Wickström as well as Tero Lehikoinen, who is responsible for the National Institute for Health and Welfare's online training. The team of designers worked together with the team of authors and the editorial committee. The EPRAS Project Manager participated in the work of all teams and liaised between them.

The contents of the online training were also commented on by a team of developers consisting of persons who have experienced domestic violence. This team produced valuable information on what, from their perspective, it would be important for professionals to know, and gave direct comments on the contents, especially regarding the phenomenon of domestic violence.

3.1.2 Development stages

At the beginning of the project, the idea of creating an online training programme was referred to the National Institute for Health and Welfare's internal evaluation team (ARVI), which assessed its viability. ARVI approved the proposal concerning the online training. The project group and the team of authors began planning the online training in autumn 2017. In the early stages, the team of authors and the editorial committee concentrated on choosing implementation methods for the training and obtained additional information on the possibilities offered by the platform. This was part of the conceptualisation process of the training.

As part of the conceptualisation, a user workshop was organised for the project's associated partners at the University of Jyväskylä in October 2017. The user workshop was planned and organised by Sara Wickström and Linda Hokkanen from the National Institute for Health and Welfare's Products unit. Marianne Notko from the University of Jyväskylä helped with the practical arrangements. In total, 27 persons from municipalities, the police, the Health Care District and NGOs participated in the workshop.

The aims of the user workshop included ensuring that, when designing the online training implementation, users' needs would also be addressed from the perspective of usability. At the workshop, different assignments were tested to find out which ones users of the online training programme would prefer. The users also communicated their wishes regarding the training programme's user friendliness. The possibility of completing the training not only on a computer but also on smartphones or tablets was considered a good idea.

The workshop provided valuable information to support the implementation of the training. For example, we found out that the majority of participants can spend 0 to 60 minutes at a time on completing the training, and that not everyone has access to a personal computer. These facts influenced the scope of the different sections of the training and the decision to also optimise the training package for tablets and smartphones.

The users were additionally asked about the content of the training at the workshop. The responses were to a great extent consistent with the information produced by the research stream of the project. A need to obtain information about the work on domestic violence carried out by other occupational groups as well as about an interprofessional approach and cooperation related to domestic violence came up in one way or another in all groups at the user workshop.

An initial plan for the contents had been discussed at an editorial committee meeting before the workshop. The team of authors launched the active phase of its work in November 2017 once the findings of the user workshop had been analysed. The workshop organisers gave a presentation on the information produced by the workshop to support the implementation of the online training. Issues that emerged

at the user workshop were also discussed briefly at a meeting of the entire project's steering group in October.

The planning of the content continued, and the concrete work of content writing also began gradually. A concise content plan was brought to the project's steering group in February 2018, thus ensuring that all the different groups and parties involved in the project were aware of the plans for the online training programme. The steering group considered it particularly vital that the training programme stress an interprofessional approach and its importance for interventions in domestic violence. The steering group pointed out that the online training programme should also be piloted in interprofessional teams.

During the planning stage, the choice of terms to be used in the training also needed to be discussed. For example, it was decided that the expressions 'those who have experienced violence' and 'victims of violence' would be used in parallel in the training programme, emphasising the term 'victim' especially when discussing issues related to offences. A decision was made to use the term 'perpetrator' for persons who use violence. These selections were primarily influenced by the terms that are most commonly used in Finland. The police and social and health care professionals use different expressions for similar matters; for example, the police use the expression 'preventive actions', whereas social and health care professionals talk about prevention. Discussing the expressions and terms was thus vital.

An online training package developed in Sweden, "Mäns våld mot kvinnor och våld i nära relationer" (https://webbkursomvald.se/) as well as a domestic violence learning package for professionals produced by Central Finland Health Care Districtwere used to plan the online training. The training also drew on the Key Instructor training materials referred to in the Foreword to this report, which have been used in training on domestic violence.

The research conducted as part of the project and the information it yielded on professionals' training needs and preferences played an important role in planning and producing the contents of the online training programme. For more information on the research findings, see sections 3.3, 3.4. and 3.5. in this report. The research group produced concise information on round I data collection to support the planning and content production of the online training programme. The information produced by this research was available as from April 2018. For a detailed description of how the data collected on round I was used to develop the online training, see section 3.3.1. The information produced by the research was also used in the work of the editorial committee and the team of authors.

The requirement to register in the online training sparked long discussions in different groups. A registration was considered important, as it could produce information on user numbers and make it possible to target future marketing efforts of the online training at certain groups of professionals and geographic areas. The registration also allows the system to remember the user's prior studies completed on the

platform and thus facilitates taking the training in sections. On the other hand, it was known that creating user IDs and the login may raise users' threshold of taking the online training. Registration was considered an important element, however.

The structure of the training content as well as the manner and order in which the content is presented was finetuned as the development work progressed. The initial idea was to divide the content into areas intended for all users on the one hand, and material differentiated by occupational group on the other. The editorial committee stressed that all professionals should be familiar with each other's work as well as the legislation and guidelines applicable to other professionals. As a result of discussions in the steering group, the idea of differentiated material was dropped; doing things together, adopting an interprofessional approach and creating an understanding of different professionals' roles in domestic violence interventions were considered vital by the steering group.

The possibility of stronger gamification was also considered in the planning phase. The budget of the online training and the selected platform did not enable gamification, however, but elements of gaming were used as far as possible in the final product.

Linking web analytics to the online training required careful consideration. The training could be automatically linked to the GoogleAnalytics system, which works well in online training packages with no registration. However, online training with registration could not be linked to this analytics tool, as this would give Google access to user data provided at registration. Instead, the online training was linked to Matomo, another analytics tool used by the National Institute for Health and Welfare, which does not transfer user data to outsiders.

3.1.3 Content production

The Police University College was responsible for the content specifically intended for the police and the suitability of this content for police training. The National Institute for Health and Welfare assumed responsibility for the remaining content and its production. The Project Manager served as the editor-in-chief of the online training programme.

The team of authors cut back on and organised the content at its meetings. The editorial committee evaluated the selections and decided what the online training should contain. The actual textual content was produced by the members of the team of authors alone or together, and the content was commented on by the team of authors and the editorial committee as well as experts by experience. Some of the textual content, such as that related to legislation and obligations, was also checked by outside experts.

In addition to textual content, multiple choice questions and discussion assignments, videos, photographs and audio files were produced for the online training programme among other things. Producing the videos was the most labour-intensive

task. The training programme Create trust – Stop the violence contains four types of videos: 1) interviews with experts and professionals, 2) interviews with experts by experience, 3) dramatized videos intended to provoke thoughts that were implemented by students at the Police University College, and 4) existing animations produced earlier.

Ideas and plans for videos were produced both at the National Institute for Health and Welfare and the Police University College, and also in cooperation between the two. The interviews were conducted by the National Institute for Health and Welfare, while the 'thought-provoking' videos were produced by the Police University College. Most of the videos of interviews with experts and professionals were produced in cooperation with camerawoman Harriet Järf from the National Institute for Health and Welfare. The shooting and editing of five interviews was contracted out to Indime Oy as they had to be produced on a rapid schedule to obtain feedback on the pilot version and to facilitate shooting at another location.

All the experts, professionals and experts by experience were interviewed by the Project Manager. Several persons participated in preparing the interview questions. The interviewees also had an opportunity to have an input in the questions. The interviewees were selected on the basis of ideas put forward by the editorial committee and the team of authors. All professionals and specialists invited to do so consented to being interviewed for the online training.

The interviewees received questions and instructions a few days before the interview. The questions had a wide scope, and the instructions added detail to them. The instructions also related what colours or patterns should or should not be worn when the video was shot. Before filming, the interviewees told the interviewer something about what they intended to talk about. The camerawoman and the Project Manager selected the locations in advance, for example based on availability of natural light on the day of the shoot and the suitability of the facilities.

Nearly all of the interviews were filmed two to three times. Almost without exception, the first take was the one selected for editing for online training use. The interviewees had the opportunity of watching and, if necessary, commenting on the edited videos as soon as the editing had been completed. An agreement on appearing on the video was also concluded with all the interviewees. While no fee was paid for participating, the interviewee's travel costs to the shooting location were paid if necessary.

After the pilot stage, two more interviews with professionals were filmed based on the feedback received. One of these interviewees was from the police organisation, and the interview dealt with honour violence. The other was a dentist, and the topic was oral health and domestic violence. Users had requested more content on both of these topics in their feedback on the pilot programme.

The expert by experience was selected for the videos as they had already appeared in public with their name and face, relating their experiences of domestic

violence. Over ten questions were put to the expert by experience, which meant that this interview was longer than the others. The interviewee was also given a longer time than usual to consider the responses. Excerpts from this interview were placed in several sections of the online training. This interviewee also had an opportunity to comment on the video after it was edited to prevent it from accidentally containing material which, on closer reflection, the interviewee would have preferred not to show as part of the online training content.

Henri Rikander, who was a member of the team of authors, planned the short, thought-provoking videos in which the actors were Police University College students. The students gained study credits from their video projects. The ideas for these videos were produced by the team of authors and partly also by the editorial committee. The students shaped the content of the videos based on these ideas. The team of authors and a few other National Institute for Health and Welfare experts discussed the students' ideas and suggested some modifications.

The videos produced by the Police University College were shot in Tampere on three different locations. The students were responsible for the detailed content of the shoots and planned the props for them. A few professionals from emergency care, health centres and shelters for victims of domestic violence participated in some of the shoots. All other persons appearing on the videos are Police University College students. Henri Rikander, a project group member, appears in one of the videos. Indime Oy was in charge of the filming, sound recording, and editing of the videos as well as directing the actors on location if necessary.

The online training also contains a few animations produced by the National Institute for Health and Welfare earlier. One of them is about shelter services and the other about operating models aiming to prevent domestic violence. The videos remain topical, and based on the survey data collected as part of the project, also a necessary part of training for social and health care and police professionals.

In compliance with the accessibility directive, Finnish subtitles were produced for all the videos at the National Institute for Health and Welfare. The subtitles can be turned on directly on the videos. The content of audio files is also available as text. In the concluding stage of the project, a Swedish version of the online training will be produced. Swedish subtitles will also be provided as an option in the videos and audio files.

All the audio files in the online training are excerpts from interviews with experts by experience. The interviews were conducted by the Project Manager, and a recording device belonging to the National Institute for Health and Welfare was used to record them. The experts by experience selected for the interviews were volunteers. An association engaging in work on violence helped to find the experts by experience.

Photographs for the online training were obtained and purchased from a few different sources. The National Institute for Health and Welfare's internal image bank

and a few images from the Police University College's communication materials were used in the online training. The majority of the photographs were taken by photographer Pertti Talarmo. The photographer was provided with instructions for taking the pictures.

3.1.4 Pilot stage of the online training programme

A pilot version of the online training programme released in October–November 2018 and the feedback received on it influenced the further development of the online training content and implementation. The municipalities and joint municipal authorities that had the role of associated partners in the project as well as police officers from the areas of Central Finland and Ostrobothnia Police Departments participated in the pilot programme. The training was also piloted in the Central Finland Health Care District and the Ankkuri team in Hämeenlinna. Persons who were involved in the project's development work in various ways were sent a temporary link to the pilot version, and all Finnish shelters were also offered an opportunity to participate in the pilot stage.

The pilot stage was implemented in different ways in different areas. In late spring 2018, the Project Manager and Henri Rikander toured all the pilot localities and presented the options for participating in the pilot programme. The options were organising an interprofessional pilot on a larger scale, testing the programme in a team, and/or completing the online training alone. Each organisation was able to choose the way of completing the pilot training programme that was the most useful for it during the pilot period. In total, slightly over 400 professionals participated in the pilot stage.

All pilot organisations had a key person who was responsible for the practical implementation of the pilot stage in their areas or organisations. A seminar day on the pilot version was organised for the key persons at the Police University College in Tampere in September 2018. During this day, the online training programme was discussed in small groups, and the participants were given some instructions for implementing the pilot stage.

During the pilot stage, anonymous feedback was collected using a Webropol survey, which contained five multiple choice questions and five open-ended questions. Those who had completed the online training programme were asked to give feedback on the functionality and user friendliness of the programme as well as its content. They were also asked about issues related to the duration of the training, the images and videos contained in it, and areas in which they felt they had improved the most. Some of the organisations had conducted their own surveys to collect feedback from pilot participants.

Additionally, the key persons provided a description of how the pilot was implemented. Some of these descriptions also contained feedback. The key persons additionally related how successful their choices of pilot stage implementation

methods had been and contributed their thoughts about how the training could be used in the future and how its usability could be improved. Some pilot stage participants also e-mailed their feedback directly to the Project Manager.

A great deal of feedback was received on the pilot version. While the feedback was encouraging, it also contained good proposals for improvement. The feedback was mainly analysed by the Project Manager, and information about it was shared with both the project group and the editorial committee. The editorial committee made the decisions on how the feedback should be responded to in online training development.

Plenty of positive feedback was received on the videos, among other things, and respondents asked for more videos. The scope of the online training programme was already large in the pilot stage, as completing it took an estimated 5 to 10 hours on average depending on the implementation method. For this reason, any additional content to be included in the training required careful consideration.

In their feedback, the participants asked for a more clear-cut implementation of one particular section. The section 'Duty to intervene' thus required the greatest deal of development work. In early 2019, the focus was on this further development, in addition to producing new videos. Otherwise the further development comprised less extensive modifications of and additions to the content, making corrections to the certificate, and clarifying the multiple choice questions.

In terms of the implementation methods, clearly the most positive feedback on the pilot version was obtained concerning interprofessional training events, at which the training was completed partly in small and partly in larger groups. This provided an opportunity for professionals to have discussions and to also talk about local level issues, including operating practices and parties providing help in their area. A recommendation of compleating the training in interprofessional groups was added to the online training based on the feedback.

3.1.5 Content design

The content of the National Institute for Health and Welfare's online training package was imported into an online training template constructed on a Valamis platform by content specialists. The template for the online training programme Create trust – Stop the violence was created by the National Institute for Health and Welfare's Products unit. The Project Manager imported the majority of the actual content into the online training template and put together the questions used in the training. The Project Manager was assisted in designing the content and importing it to the platform by a team of designers, and she participated in training related to using the platform organised by the National Institute for Health and Welfare.

Designing the online training package was time-consuming as each item, be it text, an image, a figure, a video or any other content, was imported individually onto the platform. The textual content was produced as PowerPoint presentations, which

were not automatically compatible with the platform in the way the authors had expected when the content was produced on PowerPoint slides. Valamis Group Oy, the company which designed the online training platform, has developed the platform further in general but also in response to the National Institute for Health and Welfare's needs.

Optimising the online training for tablets and smartphones also took time. To some extent, the views had to be designed separately for each device type; while the content appeared in all views, it was not automatically displayed correctly on different devices. This meant, for example, that some of the content could not be viewed at all in the mobile version. As each modification was made, every view had to be checked and, if necessary, modified to make it compatible with the device in question.

3.1.6 Launch and dissemination of the online training programme

The pilot stage of the online training is described in an earlier section of this Chapter. The pilot stage was part of the launch process. In their description of the pilot implementation, the key person in one organisation noted that in the future, the organisation intends to use no other training programme for its in-service training on domestic violence. Some pilot organisations had also added a link to the online training programme to their intranet sites as a programme recommended by the organisation.

The completed online training programme was launched in February 2019. By the end of May, it had more than 1,650 registered users. Not all users had created personal IDs, however, as the training had been completed by a larger group. Only registered users can save or print a certificate on the training for themselves. Not everyone needs a certificate, however, and in this case it is not necessary for the participants to register.

In the area of the South Savo Social and Health Care Authority (ESSOTE), Viola – Free from Violence Association will carry out a project in 2019 to establish how the online programme could be used in future training organised by the authority. The authority intends to also add its own content to the training programme, for example material relevant to the local area. The City of Vantaa will experiment with using the programme at its interprofessional training events in autumn 2019.

The National Institute for Health and Welfare's shelter services have decided to include the online training programme in the workplace induction of new employees. The programme is part of the national training on domestic violence for shelters organised by the National Institute for Health and Welfare.

A brochure on the online training was published in May 2019. The brochure will be mailed to municipalities' domestic violence coordinators through the Regional State Administrative Agencies. These agencies already disseminated information on the online training by e-mail as it was launched. The brochure has been and will be

handed out at different events. It will also be mailed to educational institutions and universities that educate social and health care professionals. Additionally, the brochure will be mailed to the management of police departments and persons responsible for personnel training and development at police departments across the country.

In May, an open seminar organised in Helsinki discussed enhancing competence related to violence and the new online training programme Create trust – Stop the violence as a tool for achieving this. Invitations to the seminar were e-mailed to social and health care and police organisations. Information on the seminar was also shared in the National Institute for Health and Welfare's event calendar and on its Facebook site and Twitter account. More than 100 professionals participated in the event, both employees and management representatives. The event was also live streamed on the Internet, and a recorded version could be viewed on the same site for two weeks after the event. The live streaming was simultaneously viewed by over 100 people for the majority of the seminar's duration. In addition to Finland, the live streaming was watched in Estonia, a country which has expressed an interest in using the online training developed in Finland (benchmark). Information about the streaming was spread through the social media accounts of the National Institute for Health and Welfare, Nollalinja (helpline organised by the National Institute for Health and Welfare) and the Project Manager (Facebook, Twitter, LinkedIn). The National Police Board distributed an invitation to the seminar to the Ministry of the Interior's Police Department as well as to the Deputy Police Chiefs and HR Managers of police departments nationwide.

Before and after its launch, the online training programme was introduced at a few events, including Väkivaltafoorumi (the Violence Forum, 2018), Neuvolapäivät (Maternity and Child Health Clinic Seminar 2018), Expert seminar of the social welfare sector (2019) and TERVE-SOS event (2019). The Project Manager also presented the programme at a training day on mediation in criminal matters and disputes themed on domestic violence, a meeting of social workers at shelters, a training event organised by the City of Helsinki, and a training event in Tampere region. The Project Manager was also invited to present the training at the round table event 'Stop domestic violence' organised by Ministers Annika Saarikko and Kai Mykkänen. The Project Manager participated at a gala seminar organised by the EU's Rights, Equality and Citizenship programme titled "Ending Violence Against Women – Taking Stock and Next Steps" in Brussels. At this seminar, the Project Manager had the opportunity of introducing the online training programme developed in Finland to a great number of participants. A symposium on our project has also been accepted for the European Conference on Domestic Violence (ECDV) held in Oslo on 1–4 September 2019. In our symposium, 'Training professionals for working with domestic violence: e-learning and research on interprofessional collaboration', we will present the online training programme and research carried out

in the project (Helena Ewalds, Joonas Peltonen, Monica Fagerlund, Marita Husso and Marianne Notko).

The launch and dissemination of the online training programme have thus already got off to a good start. This work will continue not only until the conclusion of the project but also following it. As web analytics improve and the online training programme comes into wider use, more information will also be obtained on the areas in Finland where the marketing of the training programme should intensified. The National Institute for Health and Welfare will maintain the programme after the conclusion of the project and update it annually in cooperation with the Police University College. Time will tell how well organisations and professionals will find their way to the training.

3.2. Awareness raising campaign about shelters

In Finland, it is the central government's responsibility to organise shelter services for victims of domestic violence. The National Institute for Health and Welfare sees to the guidance, evaluation, development and national coordination of shelter activities. It also selects the shelter service providers, ensuring that adequate shelter services are available in different parts of Finland. The shelters, which are staffed 24/7, provide victims of domestic violence with crisis help, psychosocial support, advice and counselling. The shelters are intended for all those who have encountered or are living under the threat of domestic violence. The services are always free of charge for clients (Act on reimbursement out of state funds for providers of shelter services 1354/2014).

The numbers of shelters and shelter clients have increased after the responsibility for funding the activities was transferred to the central government in 2015 (Shelters for victims of domestic violence 2017). However, no growth in the incidence of domestic violence has been observed at the national level (Danielsson & Näsi 2018). We may assume that the growth in the client numbers of shelter services is associated with the wider availability of and easier access to the services.

A client's timely access to a shelter partly depends on how well the shelter services are known to citizens, authorities, NGOs and other actors as a free and low-threshold service. The EPRAS project conducted a national campaign addressed to citizens on shelter services. In conjunction with the campaign organised as part of this project, the National Institute for Health and Welfare and the shelters arranged regional information campaigns within each shelter's operating area.

3.2.1. Planning and implementation of the national campaign

The purpose of the national campaign was to improve the recognisability of shelter services and to provide citizens with more information about them. In particular, the campaign sought to spread information about shelter services being free of charge and to clarify how clients can access the services. The planning and implementation

of the campaign were outsourced to Hill and Knowlton Finland Oy following a tendering process. Instructions were issued to the company based on plans prepared by the National Institute for Health and Welfare's EPRAS team.

The primary target group of the campaign was women and, in particular, families with young children, however without forgetting other age and population groups. The duration of the campaign was approximately one month and as its main channels were selected the radio and digital marketing. The campaign also used the social media and the Maternity and Child Health Clinic Seminar to spread information. The radio was selected as one of the main channels, as a radio campaign can reach a wide target group rapidly while also evoking feelings in the listeners through its world of sound. The feelings evoked, on the other hand, ensure that the advertisement is imprinted more strongly in the listener's memory.

The radio campaign was conducted in cooperation with the Nollalinja helpline. The advertising agency treated this cooperation and the radio spots produced by the two actors together as a single campaign. This cooperation helped to maximise discounts for media space and made the campaign more cost-effective. The radio spots of the EPRAS project and Nollalinja were modernised fairy tales. The EPRAS project spot described shelter services through a modernised version of the Big Bad Wolf story.

The full-length, narrative spot in the radio campaign lasted 62 seconds, in addition to which two shorter versions of it were broadcast, which lasted 15 and 11 seconds. The radio campaign was broadcast on all 100 member channels of Radiomedia. The spots advertising shelters went out 3,900 times nationally, as each channel repeated the advertisement 39 times over three weeks.

The digital campaign used an animation about shelter services in Finland, which had been produced for the National Institute for Health and Welfare as early as in 2015. The Finnish version of the animation has been viewed 3,647 times, the Swedish version 213 times and the English version 751 times. Before the launch of the campaign, the concluding texts of the animation and the links displayed in it were updated. The three language versions (Finnish, Swedish and English) were then posted on YouTube as new versions. This also made it easy to monitor the viewer numbers. The shelter animation was viewed over 350,000 times as a result of the campaign.

The shelters in Vaasa, Tampere and Central Finland, which were associated project partners, participated in planning the civic campaign. The advertising agency produced three different visual looks for the campaign, of which the National Institute for Health and Welfare's EPRAS team and the Communications unit selected two for further development. The advance instructions given to the advertising agency stated that the visual look of the campaign should not rely on dramatic pictures of battered women or a broken glass, for instance. The idea was that the visual look would communicate hope, sensitivity and, on the other hand, the fact that cli-

ents can access shelter services even before they have undergone physical violence. A mere threat of violence is a reason for coming to a shelter.

The employees and shelters were given an opportunity to comment on the edited versions. In cooperation between the advertising agency and the National Institute for Health and Welfare, a webropol survey on the visual look was conducted, to which shelter clients and employees could respond anonymously. Figures 1 and 2 show the visual looks on which comments were requested.

Figure 1. Campaign image 1 proposed by the advertising agency.
You Are Not Alone.
Help Is Available If You Experience Violence Or A Threat Of Violence.
Shelter. Protects you from violence.

Figure 2. Campaign image 2 proposed by the advertising agency.
You Are Not Alone.
Help Is Available If You Experience Violence Or A Threat Of Violence.
Shelter. Protects you from violence.

The survey attracted 14 responses. Most of the questions were open-ended. The results were analysed by both the National Institute for Health and Welfare and the advertising agency. The responses received influenced the selection of the visual look and further modifications of the image and the font. The version shown below was finally selected as the visual look for the campaign, among other things because of its neutrality. The text was considered to be sufficiently short and to the point, appropriate and well matched with the image. The colours used in the image were liked because they are not 'in your face'.

Figure 3. Image selected for the campaign.
You are not alone.
Help is available if you experience domestic violence or its threat.
Shelter. Protects you from violence.

Among other things, the comments on the visual look selected for the campaign noted that the image creates the impression of shelters being exclusively for women. As a counterbalance, an image showing a man was suggested. Some also found the image boring. However, the test of the visual look did not include all the images to be used in the campaign.

As permanent elements in the visual look were selected the text "Shelter. Protects you from violence" as well as the chosen fonts and colours. In the actual campaign, six different images with two combinations of text were used. In addition to the one shown above, the campaign contained an image of an older woman, an immigrant, a man, a toddler and two pre-school age children. By using different images, the campaign wished to get across the idea that shelters are intended for all those who experience domestic violence or a threat of violence, regardless of their age and gender. The visual look created for the campaign was also used at different training events and seminars where shelter services were presented.

The purpose of the campaign was to improve the recognisability of shelters, especially among ordinary citizens. Another objective was directing visitors to the campaign's homepage to find out more about shelters. The campaign's homepage (www.nollalinja.fi/turvakoti/) was set up as part of the Nollalinja helpline's homepage. This was underpinned by the idea that rather than only being open for the lim-

ited duration of the campaign, the campaign site would remain a permanent part of the Nollalinja homepage and provide additional information on shelters also in the future. The National Institute for Health and Welfare also has a website on shelter services intended for professionals (thl.fi/turvakotipalvelut).

As the digital marketing channels of the campaign were used AdWords pay-per-click advertising, Google Ads display advertising and YouTube advertising. The digital marketing continued between 1 January and 30 November 2018. The final digital marketing budget was optimised based on metrics collected during the first campaign week. It was concluded that a larger share of the budget should be allocated to YouTube marketing, which proved to be the most cost-effective of all digital channels in this campaign.

As the project was being planned, the idea was to emphasise social media marketing, especially on Facebook. During the detailed planning stage of the campaign, however, Facebook changed is algorithm in a way that prevented this channel from reaching the projected results. The digital media budget was consequently modified, the main emphasis was placed on pay-per-click, display and YouTube advertising, and a decision was made to optimise the allocation of the digital marketing budget based on the results reached during the first campaign week. Publications which required no advertising funds were also produced on the social media during the campaign.

3.2.2 Planning and implementation of regional campaigns

As part of its efforts to develop shelters, the National Institute for Health and Welfare worked with shelter service providers to produce regional information campaigns. A decision was made to carry out these campaigns simultaneously with the information campaign of the EPRAS project. Each shelter was responsible for the information activities in its operating area. The objective of the regional information campaigns was to raise awareness of shelter services among professionals and residents in the area, thus lowering the threshold for accessing the services. Similar campaigns on shelter services have not been implemented before, and the campaign was thus also used to test how centralised communication between the National Institute for Health and Welfare and the service providers would work. The visual look of the EPRAS project and the social media messages prepared for the civic campaign were used in the regional information campaigns.

A particular target in the regional campaigns was municipalities with no shelters for victims of domestic violence. Residents with no shelter in their municipalities use the services considerably less than those who have a shelter in their municipality of residence (Table 1; Shelters for victims of domestic violence 2017).

Table 1. Shelter use per 1,000 residents in 2017

Entire country	Municipalities with no shelter	Municipalities with a shelter
0.76	0.49	1.09

The regional campaigns were directed and coordinated by the Other Special Services unit at the National Institute for Health and Welfare's Government Services unit. The National Institute for Health and Welfare and the shelters participated in the planning of the campaigns. The regional campaigns were conducted by the shelter service providers, and they were implemented without separate funding as part of the national work to develop shelter services. The joint planning efforts of the shelter service providers and the National Institute for Health and Welfare began in March 2018 at a working meeting to which the social workers responsible for client work at all shelters had been invited. At this meeting, the participants worked in groups to collect examples of good practices that individual shelters had used earlier. An edited list of good practices was put together for all shelters to use in their work.

At a working meeting held in October 2018, to which the social workers responsible for client work at all shelters were invited, the objectives and methods of the campaign and the respective roles of the National Institute for Health and Welfare and the shelters were clarified. The National Institute for Health and Welfare supplied the service providers in advance with social media images and messages for the entire month of November, which the service providers shared using their own channels. These images and messages were the same as the ones used in the civic campaign carried out in connection with the EPRAS project. The service providers conducted the campaign in their own areas in November, using the list of good practices, the material provided by the National Institute for Health and Welfare, and other communication methods devised by them.

Using a survey addressed to shelter service providers, the National Institute for Health and Welfare sought to establish how many and what types of communication actions the shelters had implemented, what impacts the communication had and how the shelters experienced the activities. Responses were received from 20/27 shelters. Based on the survey results, the shelters communicated actively, for example by sending press releases to their partners and the media, organising events and producing new communication material. The main message from the service providers was that the campaign organised in November increased their workload and that it was found useful. The shelters' regular information and communication activities will be stepped up as part of the national development programme for shelter services in 2020–2023.

3.2.3. Campaign results and findings

Shelters attracted a great deal of visibility in different media in November 2018. Other parties also organised campaigns associated with domestic violence in that month. The UN celebrates its International Day for the Elimination of Violence against Women on 25 November. An annual campaign against violence is also organised in Finland by the Observatory on Violence (vakivaltaobservatorio.fi).

For the EPRAS project's civic campaign, a video advertising the animation 'Shelter services in Finland' was produced, and the advertisement was viewed 1.17 million times during the campaign. Approx. 31% of those who viewed the advertisement ended up watching the actual animation about shelters. The animation was viewed over 363,000 times during the campaign, with the Finnish video attaining the highest number of views. The price of a single viewing of the animation worked out as EUR 0.015.

AdWords pay-per-click advertising drew less than 1,700 visitors to the campaign homepage, the majority of these (1,617) as a result of the Finnish AdWords campaign. The low efficiency of pay-per-click advertising in this campaign came as a slight surprise, as the National Institute for Health and Welfare has had good experiences of this type of advertising, for example when marketing the Nollalinja helpline. The advertising agency pinpointed some potential factors that may have influenced this situation, including the low volume of relevant searches in November 2018. This was particularly true for the Swedish and English campaigns. Pay-per-click advertising is influenced by many factors, including the daily price of clicks, which may range as widely as from EUR 0.10 to EUR 10 per click. In the course of the campaign, the greatest part of the budget intended for pay-per-click advertising was diverted to YouTube marketing. Pay-per-click advertising and, in particular, search word optimisation may in fact be better suited for campaigns of a longer duration or for use as a permanent part of an organisation's or an activity's digital marketing.

In display marketing, the banners prompted 11 million views. In total, they brought 13,520 visitors to the campaign homepage. The cost of bringing one visitor to the homepage through display advertising was approx. EUR 0.31. It was noted during the campaign that the average prices per click increased continuously towards the end of the campaign period. The advertising agency in charge of the campaign believed that this was due to competition for marketing space as Black Friday and Christmas were approaching.

The digital campaign may be considered highly successful. In particular, YouTube worked well as a channel for the shelter campaign. The testing and optimisation of the digital budget was worthwhile as the campaign period was short.

The radio campaign reached 73% of Finnish people aged over 18, or 3.28 million listeners in total. The average individual listener heard the advertisement 5.5 times. Of women aged 18 to 64, the campaign reached 81.7% or 1.35 million, as well as

81.7% of families with children, or 0.96 million. While the radio campaign was addressed to the entire population, its particular target groups were women and families with children. These figures are based on statistics compiled by Radiomedia. The radio campaign was planned and implemented by Hill and Knowlton Finland Oy together with SLP Studio.

Radiomedia conducted an attention value survey on the radio campaign, which attracted 222 respondents. The respondents were evenly spread around Finland, excluding the Åland Islands. The method used was an online survey (Norstat Finland Oy's consumer panel) conducted in week 48 in 2018. Of those who responded, 26% remembered hearing a radio spot about shelters. The respondents listened to the radio spot as they responded to the survey. The respondents found that the message of the radio spot was clear (92%) and important (89%), and that it stood out from other advertising (83%).

80% of the listeners liked the advertisement at least somewhat. In their open-ended answers about liking the advertisement respondents said, among other things, that they liked it because it was matter-of-fact, used storification, was clear, stood out, the narrators' voices were pleasant, it was short, to the point and insightful, and it evoked emotions. Some respondents also brought up the importance of the subject matter (shelters).

> "I liked it because it may give someone, who needs to come to a shelter, information about the existence of shelters or encouragement to go to one. I experienced violence in my marriage, and I and the children would have needed a place in a shelter. In those days shelters were not talked about. I did hear rumours, though. But if I had heard an ad like this at the time, I would have gone to a shelter." (Respondent, aged 43).
> Quotation: Attention value study/Radiomedia

The open-ended responses also revealed why some listeners did not like the advertisement. As causes for their dislike, these respondents cited the voice of the story's narrator; the fact that they do not like advertisements in general, that the advertisement was not relevant to their life situation or topical for them, or that the advertisement was not good or engaging; or they found the advertisement boring or frightening. 19% of respondents had either been shelter clients themselves, or someone close to them had been a client.

> "It is not nice to listen to, but it is good that they are advertised on the radio so that people dare look for help." (Respondent, aged 28).
> Quotation: Attention value study/Radiomedia

"The ad indicates that something is really wrong in our society." (Respondent, aged 55).
Quotation: Attention value study/Radiomedia

The respondents were asked about the image of shelters the advertisements evoked in them. They were given a list of properties among which they could choose the most descriptive images. The following options were the most popular: important (86%), gives hope (71%) and creates trust (57%). The images were mainly desirable: shelters were considered credible (43%) and intended for everyone (37%). The advertisement also created undesirable images, as some respondents also considered shelters frightening (16%), inaccessible (4%) and unnecessary (2%).

To sum up the survey results, we can note that the respondents mainly experienced the communication in the radio advertisement as clear, informative and appropriate for the subject. A sensitive issue was approached in a memorable and comprehensible way. The advertisement mainly evoked desirable images in the listeners.

In addition, the National Institute for Health and Welfare engaged in social media marketing during the campaign. The campaign posts on Nollalinja's Facebook account were viewed by 8,500 people. LinkedIn publications were viewed approximately 2,000 times and Twitter publications almost 4,000 views on the Project Manager's social media accounts, meaning that almost 6,000 views were achieved through the Project Manager's posts.

A post on the National Institute for Health and Welfare's blog was also published in the final days of the campaign on 26 November 2018. Based on media monitoring over a period of two weeks, the blog was read 143 times, whereas its visibility through the National Institute for Health and Welfare's Facebook account was 4,299 readers and on Twitter 1,530 viewers. The national campaign thus attained 20,300 views of the social media posts.

In the planning phase, the idea was to create dedicated social media accounts for the project, on which project news would be updated during the project term. This was not cost-effective for a project of a relatively short duration with a definite end date, however, as the accounts would have disappeared at the project's conclusion. We thus ended up using Nollalinja's Facebook account and also communicating through the Project Manager's personal accounts. In addition, a few updates were posted on the National Institute for Health and Welfare's organisation account on Facebook and Twitter.

We expected the campaign to reach a total of 700,000 citizens. According to a computed estimate obtained from the advertising agency, the radio advertisement alone reached 73% of men and women aged over 18, or 3.28 million radio listeners in total. While we had expected to reach approx. 50% of women and families with children, these targets were exceeded (Table 2).

Table 2. Listeners reached by the radio campaign

Listeners reached	%	Number (million)
Women and men aged over 18	73.0	3.28
Women aged 18 to 64	81.7	1.3
Families with children	81.7	0.8

The radio advertisement was repeated 39 times on 100 different radio channels and was consequently broadcast 3,900 times in total during the campaign. The advance estimate was that an individual listener of each radio channel would hear the advertisement five times. This estimate was quite accurate, as the actual number of times the advertisement was heard by an individual listener was 5.5 times on average.

The cost of a single view of the YouTube video was estimated at EUR 0.23, and we expected to spend EUR 5,000 on it to achieve 200,000 views. This proved to be the most cost-effective channel, however, and the final cost of a single view worked out as EUR 0.015. We spent EUR 5,540 on YouTube marketing and achieved considerably more views than we expected, or over 350,000. YouTube was thus quite a successful marketing tool in this campaign.

Initially, we intended to spend EUR 10,000 on pay-per-click advertising. We ultimately ended up only spending slightly more than EUR 2,000 on this channel, however, and the remainder of the original amount was divided between display advertising and YouTube marketing. This was based on budget modifications approved in advance by the funding provider (the EU). We originally estimated that we would draw approx. 10,000 visitors to our homepage with our social media budget. However, display advertising alone, which was used instead of social media, attracted more than 13,000 visitors to our homepage.

Nevertheless, it should be noted that we cannot tell which part of the visibility was due to the civic campaign conducted by the EPRAS project, the shelters' regional campaigns, and simultaneous actions of other parties. The LianaMonitori service used by the National Institute for Health and Welfare indicates that the shelters' media visibility increased somewhat in November and December ('shelter' was entered as the keyword in LianaMonitori, after which the monitor searched for hits in online and social media, Table 3).

Table 3. Media hits related to shelters found by LianaMonitori in autumn 2018

Period	Hits (number)
3 September – 4 September 2018	27
14 September – 14 October 2018	87
14 October – 14 November 2018	139
14 November – 14 December 2018	232
14 December 2018 – 14 January 2019	144
14 January – 14 February 2019	179
14 February – 14 March 2019	165

In view of the estimated figures as compared to the actual results, the planning and implementation of the national campaign can be considered successful. It reached a larger number of citizens than was initially expected. However, the actual impacts of a short campaign cannot be examined separately from the local campaigns implemented in the same period by the shelters. Based on feedback received from the shelters, the information activities of November 2018 had little or no effect on the shelters' client numbers. The campaign of November 2018 did not have national impacts on the utilisation ratios of the shelters (Table 4, data source: Shelters for victims of domestic violence 2018).

Table 4. Monthly averages of the shelter's utilisation ratios in 2018 (%)

	Month						
	June	July	August	September	October	November	December
Shelters' average utilisation ratios	58.0	61.0	58.0	66.0	65.0	66.0	64.0

3.3 Survey addressed to social and health care professionals and the police

Two separate surveys were conducted as part of the project. The first survey was carried out between autumn 2017 and early 2018 before the online training programme was implemented, and the second one after the launch of the online training package in winter 2019. In this section, we discuss the implementation and results of rounds I and II of the survey.

3.3.1 Round I of the survey: initial mapping

The objective of round I of the survey was to form an idea of the initial situation regarding the training received and training needs related to domestic violence in the pilot organisations and to collect information about their wishes, concerns and ideas relevant to the training from professionals, who are the best experts of the prevailing situation and the reality of their work. In addition, the aim was to prepare for round II of the survey and facilitate the evaluation process regarding one of the project's objectives: How has participation in the ERPAS project increased professionals' knowledge and skills related to identifying domestic violence, intervening in it and engaging in interprofessional cooperation?

Round I of the survey was distributed regionally, focusing on the associated partners as pilot localities and organisations: the Association of Finnish Local and Regional Authorities, the National Police Board, the Cities of Tampere, Vaasa, Nokia and Äänekoski, the municipality of Kangasala, JIK Joint Municipal Enterprise for Basic Services, and Basic Enterprise Saarikka. The survey was additionally disseminated in the Central Finland Health Care District, especially in the maternity and foetal units and the outpatient gynaecology clinic, among delivery room staff (midwives and nurses) and to emergency care units. At the University of Jyväskylä, the survey was distributed through the specialisation programme in social work. AtCentral Finland Police Department, information activities concerning the survey focused on Jyväskylä Police Station and Tampere Main Police Station. The survey was also distributed to the Ostrobothnia Police Department: the project staff visited Vaasa Main Police Station and the aforementioned police stations to talk about the survey. The survey was mainly shared by e-mail through supervisors and the project's contact persons.

Due to the shift rotation of police officers in the field and schedule-related challenges associated with the beginning of the year, it was agreed to begin the survey addressed to the police personnel in late November 2017 and to continue it until 31 January 2018. Social and health care professionals were able to respond to the survey between 1–31 January 2018.

Responses to round I of the survey were received from 379 persons. Table 5 presents the distribution of the respondents according to sector. 209 of the respondents

represented health care, 78 social care, 79 the police and 13 other fields where, apart from two persons, the respondents worked in different social services.

Table 5. Respondent's current sector

Current sector	*n*	%
Social welfare	78	20.6
Health care	209	55.1
Police	79	20.8
Other, please specify	13	3.4
Total	379	100.0

78.1% of the respondents were women and 20.1% men. The majority of respondents, or 78.9%, were employed by a municipality, a city or a joint municipal authority, whereas 20.8% were central government personnel.

Table 6. Respondent's job title

Job title	*n*	%
Physician	10	2.6
Police officer	79	20.8
Psychologist	14	3.7
Nurse	48	12.7
Social worker	25	6.6
Public health nurse	67	17.7
Other, please specify	136	35.9
Total	379	100.0

The most frequently cited job title was 'other'. 79 of the respondents were police officers, 67 public health nurses, 48 nurses, 25 social workers, 14 psychologists and 10 physicians. Those who selected the category 'other' had the following more specific titles, among others: dental hygienist, dentist, practical nurse, instructor, manager or supervisor.

Table 7. Time worked in the current occupation

Time worked in the current occupation (years)	*n*	%
less than 1	27	7.1
1-5	68	17.9
6-10	69	18.2
11-20	103	27.2
over 20	112	29.6
Total	**379**	**100.0**

The majority of respondents had extensive professional experience (Table 7). The greatest share (29.6%) had worked in their profession for over 20 years. An almost equal proportion, or 27.2%, had worked in their profession for 11 to 20 years. Shorter professional experience was reported by 19.9% (1 to 5 years) and 7.1% (less than a year) of the respondents. There was no correlation between the length of time respondents had worked in their professions and their sector or gender.

The respondents' average age was 44.5 years, while the median for age was 44 years. The youngest respondent was 22, while the oldest was 65, and the remainder represented almost every age between these minimum and maximum values. The respondents were placed in four groups based on their age; for their age distribution, see Table 8. The largest group was respondents aged between 35 and 44, who accounted for 29.3%. 27.4% of the respondents were aged over 55, while 22.7% were aged under 35. The smallest age group was respondents aged between 45 and 55, who accounted for 20.6% of those who participated in the survey.

Table 8. Respondents' age groups

Age group	*n*	%
less than 35	86	22.7
35 to 44	111	29.3
45 to 54	78	20.6
over 55	104	27.4
Total	**379**	**100.0**

We asked the respondents how often they dealt with tasks related to domestic violence. The final analysis only includes those respondents who said they encounter

tasks related to domestic violence at least 'less often than once a month'. The total number of such respondents was 339 (Table 9). 42.7% of the respondents dealt with tasks related to domestic violence less often than once a month, while 24.3% had such tasks on a weekly basis, 16.6% once or twice a month, and 5.8% daily. 10.6% of the respondents said they never encounter tasks related to domestic violence.

Table 9. Frequency of tasks related to domestic violence

Frequency of tasks related to domestic violence	*n*	%
Daily	22	5.8
Weekly	92	24.3
Once or twice a month	63	16.6
Less often than once a month	162	42.7
Never	40	10.6
Total	**379**	**100.0**

There was no correlation between age and the frequency of tasks related to domestic violence. On the other hand, the respondent's sector and gender were linked to the number of such tasks. Of the police officers who responded to the survey, 63.3% worked with domestic violence daily or weekly. In social and health care, these figures were 34.6% and 23.3%. 51.4% of men and 24.4% of women said their tasks involve domestic violence daily or weekly. These results are partly explained by the fact that of the male respondents, 75% worked with the police, 18.4% in health care and 5.3% in social welfare, whereas of their female counterparts, 64.9% worked in health care, 24% in social welfare, and 7.4% with the police.

As a group, the respondents have a high level of education. We re-classified the 9 open-ended answers and placed the respondents in the education classes given in the survey. 61.1% of the respondents had at least a Bachelor's degree, while 36.6% had an upper secondary vocational qualification, a further qualification or a specialist qualification. 8 had completed the matriculation examination and 11 had researcher training. (Table 10).

Table 10: Respondent's highest qualification

Respondent's highest qualification	***n***	**%**
Doctorate or licentiate	11	3.2
Master's degree	47	13.9
Bachelor' degree	15	4.4
Master's degree (University of applied sciences)	15	4.4
Bachelor's degree (University of applied sciences)	119	35.1
Vocational qualification, further qualification or specialist qualification	124	36.6
Matriculation examination	8	2.4
Total	**339**	**100.0**

Of the respondents selected for further analysis, 50.1% had received training on domestic violence as part of their degree programme. 40.1% had not received such training, and 8.8% could not remember. The more frequently respondents deal with domestic violence in their work, the more likely they also are to have had training related to it. 77.3% of those who work with domestic violence daily had received training on this theme.

When we also include training received as part of other education and training than the degree programme and make a rough estimate of the duration of this training, the situation looks better. Approximately one out of five (21.5%) respondents had not received any training on domestic violence (Table 11). However, these respondents said they work with domestic violence issues. More extensive courses and study modules were rare, only 5.6% of the respondents had participated in such studies. Those who work with domestic violence on a daily basis had, on average, received longer training, which included courses or study modules. The differences were not major, however. There were no differences between women and men.

Table 11. Total duration of training on domestic violence in the degree programme or other subsequent education

Duration of training	***n***	**%**
Individual lectures or similar of a few hours	146	43.1
Training events, seminars or similar of a day or two	101	29.8
More extensive courses, study modules or similar	19	5.6
No training	73	21.5
Total	**339**	**100.0**

77.9% of the respondents found they had benefited from the training somewhat or a great deal (Table 12). Only two respondents felt that the training they had received was of no benefit to them. Men were more critical about the benefits of training than women, as 22.2% of them found that the training was 'no benefit' or 'little benefit' for them, while this proportion for women was 12.1%.

Table 12. Benefit derived from training on domestic violence

Benefit derived from training	***n***	**%**
No benefit	2	,6
Little benefit	39	11.5
Some benefit	121	35.7
Great deal of benefit	94	27.7
Cannot say	20	5.9
Total	**276**	**81.4**
No training	63	18.6
Total	**339**	**100.0**

For the purposes of producing the training content, we mapped the respondents' attitudes towards victims of domestic violence, in particular. We also asked about the respondents' knowledge, skills and motivation in four areas: forms of domestic violence occurring among the population; legislation, regulations and instructions directing work against domestic violence; tools for recognising domestic violence, including risk assessment and mapping forms; and actors focusing on domestic violence and cooperation with them. The data on competences and attitudes was only reported on in detail following round II of the survey. In short, we can say that the attitudes and competences revealed training needs related especially to using tools for mapping and asking about domestic violence and interprofessional cooperation.

We also mapped the use of formal and standardised tools developed for recognising and asking about domestic violence. The three tools in the most widespread use are a check list for asking about violence (15.3%), a personal safety plan (15.3%), and a screening and mapping form for domestic violence (21.1%). The least frequently used tools were the Acute assistance for a rape victim folder (2.7%), form for mapping harassment and stalking (3.8%), and assault and body map form (4.4%). 9.4% of the respondents had used a MARAC risk assessment form, 10.6% had used a tool specific to their organisation, and 12.4% some other tool.

Table 13. Use of tools for mapping and asking about domestic violence, % (n = 339)

Tool	Yes	No
Personal safety plan	15.3	84.7
Form for mapping harassment and stalking	3.8	96.2
Screening and mapping form for domestic violence	12.1	87.9
Assault and body map form PAKE	4.4	95.6
'Acute assistance for a rape victim' folder RAP	2.7	97.3
Risk assessment form (MARAC)	9.4	90.6
Check list for asking about violence	15.3	84.7
Organisation-specific tool	10.6	89.4
Other tool	12.4	87.6
No tool	46.9	53.1

As organisation-specific tools were mentioned Haipro, Keinu forms, report of an offence, assessment of need for protection and an established way of asking about violence, among other things. As other tools were cited Haipro, an interrogation form, and an established way of asking about violence, but also other forms and screening tools.

There were differences in the use of tools and forms between sectors. A personal safety plan was used in the social welfare sector, in particular (35.5%). 19.3% of respondents in the health care sector said they used the screening and mapping form of domestic violence. The assault and body map form (PAKE) and the 'Acute assistance for a rape victim' (RAP)folder were rarely used in any sector. A MARAC risk assessment form was used in social welfare (15.8%), in particular, but also by the police (10.7%) and in health care (6.3%). The check list for asking about violence was used in the social welfare sector (30.3%), but it was also relatively common in health care (14.8%). Organisation-specific tools for mapping and asking about domestic violence were used rather evenly in all sectors. The police (16.0%) and health care (13.1%) stood out as users of the category "other tool". 54.7% of respondents in

the police, 48.9% in the health care sector and 38.2% in social welfare said they did not use any tool for mapping and asking about domestic violence.

We asked the respondents if they had directed their clients to other services. The services listed were a health centre and a physician, social services (including a family counselling clinic, emergency social services and child welfare), police investigation and a shelter. For the results, see Table 14.

Table 14. Have you directed your clients to the services of other actors in the context of domestic violence? % (n) (n = 339)

Service	Yes	No
Health centre and physician	49.6	50.4
Social services	62.5	37.5
Police investigation	34.8	65.2
Shelters for victims of domestic violence	46.6	53.4
Other services	20.9	79.1
Have not directed clients to other services	23.9	76.1

The most frequently mentioned other actors were the social services (62.5%), health services and a physician (49.6%) and shelters (46.6%). 34.5% of the respondents had directed clients to a police investigation. While 20.9% of the respondents had directed clients to other services, 23.9% had not directed clients to any other services in the context of domestic violence. In the category of 'other services', the most frequently cited services were NGOs and third-sector actors, Victim Support Finland, Setlementti organisations and different violence clinics and crisis work services.

Examined by sector, some idea can be formed of networks between actors or chains linking the services. In proportion, police personnel had directed their clients to a health centre and a physician the most often (76%). They were also the most likely to direct clients to social services (81.3%). Social welfare professionals were the most likely to direct clients to a police investigation (51.3%). Clients were directed to shelters the most often by the police (81.3%). The highest number of respondents who had not directed clients to the services of any other actors in the context of domestic violence was found in the health care sector (31.3%). Of police officers, only 4% had not direct clients to the services of other actors.

We also had a closer look at the reasons for not directing clients to shelters. The professionals who had not directed clients to shelters accounted for 53.4% of all survey respondents, or 181 persons.

Table 15. Why have you not direct clients to a shelter? % (n = 181)

Reason	Yes	No
I do not know in what situations I could direct clients to a shelter	12.2	87.8
Directing clients to a shelter is somebody else's job	5.0	95.5
I work in a shelter	0.0	100.0
Other reason, what	57.5	42.5
Cannot say	28.7	71.2

12.2% of the respondents did not know in what situations they could direct a client to a shelter. More than one out of four (28.7%) respondents could not state a reason. Over one hundred other reasons were listed. The most frequent answers were that they had not yet encountered a situation of this type, there was no need to direct the client to a shelter, or the clients were of the type (older persons, children, residents at an institution) that are not usually directed to a shelter. The differences between sectors regarding the reasons for not directing clients to shelters were minor.

Table 16 describes the respondents' training needs related to domestic violence in their work. The large majority (78.5%) felt they needed additional training.

Table 16. Need for additional training

Training need	*n*	%
No	73	21.5
Yes	266	78.5
Total	**339**	**100.0**

Differences between sectors came up in this question, as up to 86.9% of respondents in the health care sector felt they needed additional training, whereas these figures were 75.0% for social welfare and 64.0% for the police.

In connection with the last open-ended question of round I, the respondents were given the following instructions: "Should you wish, you may provide here more information about your wishes concerning training on domestic violence and issues related to practical work or give your comments on this survey." 290 responses were received to this question, of which 172 from the health care, 55 from the social welfare and 51 from the police sector (other sector, 12 responses).

When the open-ended responses were analysed for the purpose of developing the online training programme, a particular focus was on wishes and needs related to

training, concerning which a large number of responses was received. The comments reveal that this question was also responded to by other professionals apart from those who, enabled by their employer organisation or through their own efforts, had been able to improve their special competence in domestic violence intervention. Observations of training on domestic violence being necessary on the one hand, and the scant availability of such training on the other, were repeated in the responses. Even those whose degree education had addressed domestic violence in one way or another would have liked easier access to in-service training on this topic, up-to-date guidelines and regular opportunities to refresh their knowledge.

The wishes and needs related to training themes that came up the most often concerned practical ways of asking about violence and, in particular, violence risk assessment tools and other forms developed to support the work. Respondents in all sectors would have liked more information about the forms and their use. 'Wishes for training concerning particularly vulnerable groups, such as elderly, children and people with immigrant background, came up repeatedly in the open-ended responses. Understanding the service system as a whole, or knowing where a victim or a perpetrator of violence can be directed to and who the key regional actors are, was also an essential training and information need. To support concrete interprofessional cooperation and information exchanges, information on legislation as well as the duties and practices of other authorities was called for. This was one of the factors that, in the planning stage of the EPRAS online training implementation, pointed the direction towards promoting interprofessional work on violence. Based on the open-ended responses, even persons motivated to learn more about this topic had difficulties accessing training on domestic violence. The survey conducted as an initial mapping thus produced not only information on thematic content requiring special attention but also strong justifications for developing an online training programme that would be accessible in all areas of Finland.

3.3.2 Implementation of survey round II

The objective of survey round II was to gather information on the training and training needs related to domestic violence of professionals in the social and health care sector and the police and to assess how participation in EPRAS online training had improved their knowledge and skills related to recognising and intervening in domestic violence and participation in interprofessional cooperation. The response time on round II extended from 15 February till 15 April 2019.

With the assistance of the National Police Board, information on round II of the survey was published on Sinetti intranet, the main internal communication channel of the police, on 15 February 2019. In the first two weeks, as few as 37 responses were received, and a request was thus e-mailed on 6–7 March 2019 to persons in supervisory roles in criminal investigation divisions at the Police Departments of Ostrobothnia, Central Finland, Helsinki and Oulu to encourage the personnel to participate in the survey. On request of the Police University College, the National Police Board's communications unit published a news item about the online training on the national Sinetti intranet in week 11, attaching to it a reminder of the survey and a link to it. The internal communications unit of the National Police Board distributed the news item concerning the EPRAS survey published in February 2019 to the police departments' Heads of Communications and asked them to disseminate it on their intranet sites. As these steps failed to increase the number of respondents in the police sector, a request to participate in the survey on domestic violence was e-mailed on 22 March 2019 to a total of 8,015 police personnel members using the mailing lists of the police organisation.

Round II of the survey was distributed to the social and health care sectors by the associated partners of the EPRAS project, or the Association of Finnish Local and Regional Authorities, the Cities of Tampere, Vaasa, Nokia and Äänekoski, Kangasala municipality, JIK Joint Municipal Enterprise for Basic Services and Basic Security Public Utility Saarikka. The survey was also sent to 27 shelters and to the Central Finland Health Care District. Additionally, the survey was distributed through the Regional State Administrative Agency of Northern Finland to six joint municipal authorities in the social and health care sector, one local government co-management area in the social and health care sector, and 15 municipalities. The Regional State Administrative Agency of Northern Finland distributed the survey to 38 municipalities in total. The contact persons for domestic and family violence in 15 municipalities or co-management areas were also informed of the survey. The Regional State Administrative Agency for Eastern Finland informed nine municipalities, four joint municipal authorities in the social and health care sector, and 15 contact persons for domestic violence of the survey. The Regional State Administrative Agency for Western and Inland Finland informed 29 domestic violence coordinators in municipalities and joint municipal authorities (excluding the municipalities participating in the EPRAS project, which were informed through other channels). Additionally, individual contact persons at the Regional State Administrative Agencies for Southwest Finland, Southern Finland and Lapland were informed of the survey, but no confirmation was received of whether or not they had passed the message on.

The survey was also distributed to Talentia Union of Professional Social Workers, the Union of Health and Social Care Professionals in Finland TEHY (no confirmation of the message being passed on), the Finnish Psychological Association, the University of Jyväskylä (specialisation programme in social work) and the Centres of Excellence on Social Welfare: Koske, Poske, Socca, SONet Botnia, ISO, Verso, Vasso, Sosiaalitaito and Socom. Of these, Verso (Päijät-Häme), Pikassos (Kanta-Häme, Satakunta and Pirkanmaa) and Vasso (Southwest Finland) confirmed that they had passed the survey on.

3.3.3. Respondents on round II

The survey attracted 1,717 respondents in total. We only selected for closer analysis those 1,642 respondents who said they had work tasks related to domestic violence.

Of the 1,642 respondents, 11.6 deal with tasks involving domestic violence daily, 31.1% weekly, 23% once or twice a month, and 34.2% less often than once a month (Figure 1).

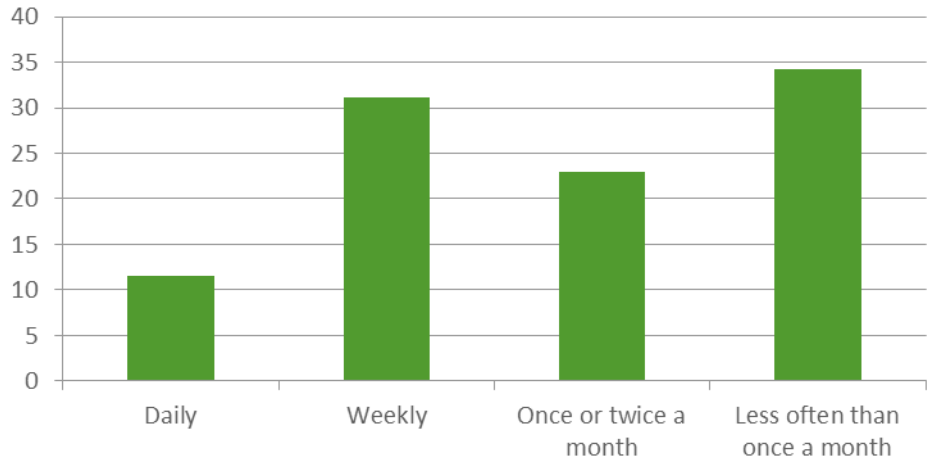

Figure 1. How often does the respondent deal with tasks involving domestic violence, % (n = 1,642)

Examined by sector, the greatest number of respondents represented the police (42.3%). The proportion of respondents working in social welfare (27.8%) slightly exceeded the proportion of those working in health care (22.6%).

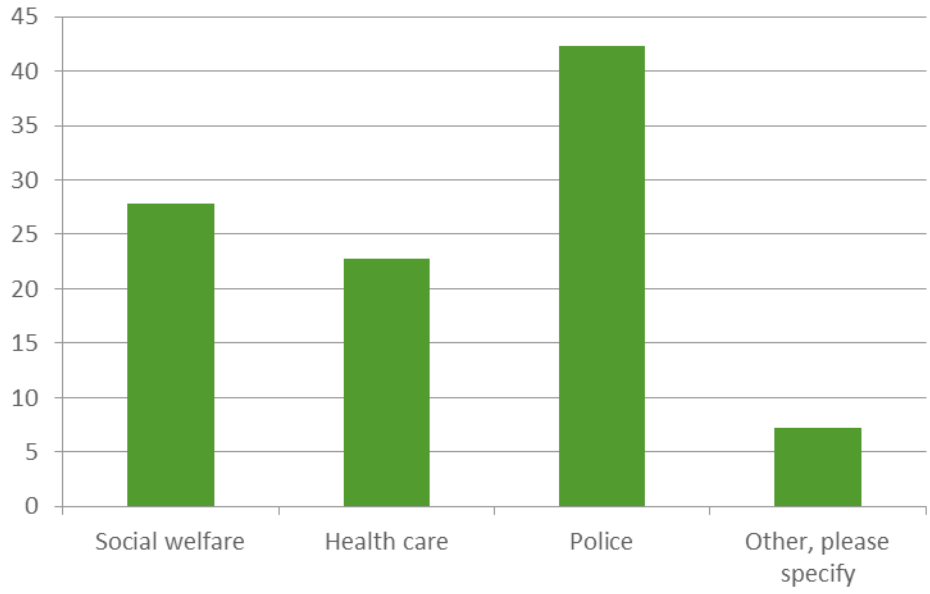

Figure 2. Respondets' current sector, % (n = 1,642).

The category 'other, please specify' accounted for 7.2% of the respondents. The sector cited by these respondents in their open-ended answers contained the following terms: 'welfare', 'care', 'service', 'protection', 'work', 'institution', 'agency', 'administration'. The responses in the category 'other, please specify' were linked to the following, more common categories: Education, teaching; Welfare, persons with disabilities, families, older persons; Children, pupils, youth; Crisis, shelter, social and health; Administration, development, planning, research; Police, criminal sanctions. (Figure 2)

The majority of the respondents were highly experienced, as 29.5% had worked in their current profession for 11 to 20 years, and 27.5% for over 20 years. As few as 4.5% of the respondents had worked in their profession for less than a year. 20.9% had worked in their profession for 1 to 5 years, while 17.5% had worked in it for 6 to 10 years. (Figure 3)

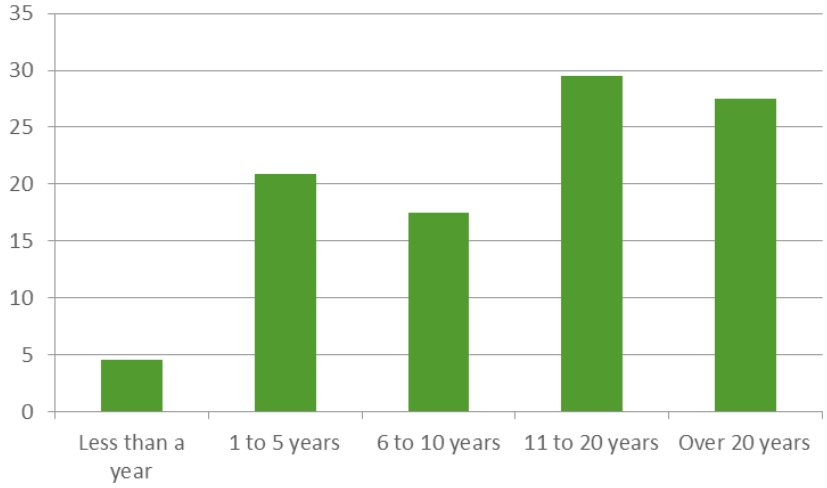

Figure 3. For how long have you worked in your current profession? % (n = 1,642)

The age variable was obtained by deducting the respondent's year of birth from 2018. The respondents' ages were then recoded into four groups. The largest group (25.1%) was those aged 41 to 50. 16.0% of the respondents were aged under 30, 28.3% were aged 31 to 40, and 25.1% were over 51. (Figure 4)

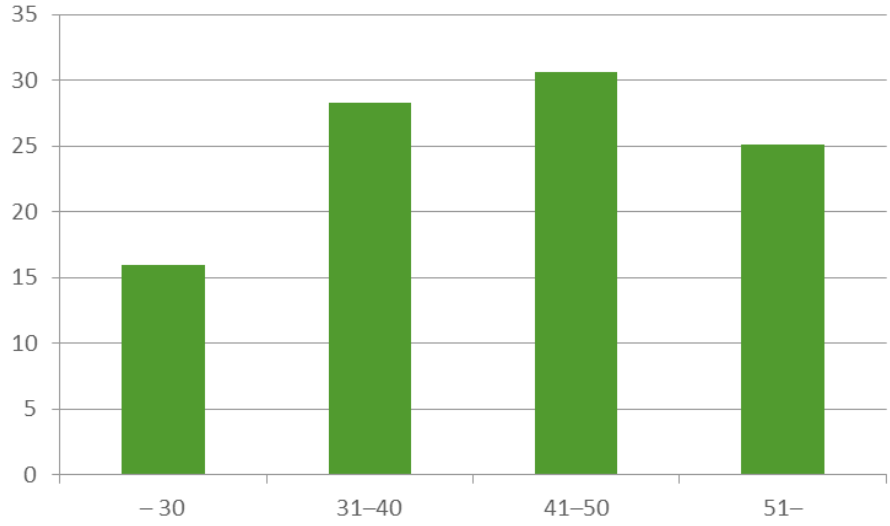

Figure 4. Respondents' age groups, % (n = 1,642).

65.7% of the respondents gave their gender as female and 32.9% as male (Table 17).

Table 17. Gender, % (n = 1,642)

Gender	*n*	%
Female	1078	65.7
Male	541	32.9
No answer	23	1.4
Total	**1,642**	**100.0**

The respondents had a high level of education, as two out of three had at least a Bachelor's degree, while 30.3% had at least a vocational qualification, and 3% had completed the matriculation examination. The category 'other, please specify', includes different secondary level qualifications, vocational qualifications and supervisory level qualifications. (Table 18)

Table 18. Highest qualification

Highest qualification	*n*	%
Doctorate or licentiate	50	3.0
Master's degree	318	19.4
Bachelor' degree	62	3.8
Master's degree (University of applied sciences)	69	4.2
Bachelor's degree (University of applied sciences)	557	33.9
Vocational qualification, further qualification or specialist qualification	498	30.3
Matriculation examination	50	3.0
Other, please specify	38	2.3
Total	**1,642**	**100.0**

Of the 1,642 respondents, only 33 (2.1%) definitely remembered responding to round I of the survey. 68.9% had not responded, and 29.0% could not remember or did not know if they had responded to round I. (Table 19)

Table 19. Did you respond to an earlier EPRAS project survey in 2018?

Had responded to EPRAS project survey round I	*n*	%
Yes	34	2.1
No	1,131	68.9
Do not know/Cannot remember	477	29.0
Total	**1,642**	**100.0**

3.3.4 Responses concerning the online training programme Create trust – Stop the violence

Tables 20 to 23 present the results on the evaluation of the online training programme Create Trust – Stop the violence. 4.8% of the respondents had had time to complete the full EPRAS online training programme, while 2.1% had completed a part of it. Of the respondents who had completed the training, 50 worked in the social welfare sector, 31 in health care, 20 with the police, and 12 in other sectors. (Table 20)

Table 20. Completion of the online training programme Create trust – Stop the violence

Completion of the online training	*n*	%
Yes, fully	78	4.8
Yes, partly	35	2.1
No	1,529	93.1
Total	**1,642**	**100.0**

Of the respondents who had completed the training fully or in part, 90% considered it at least somewhat useful. 40.7% of these respondents considered the online training programme very useful, 51.3% somewhat useful, and 7.1% felt it was of little use. (Table 21)

Table 21. Usefulness of the online training

Usefulness of the online training	*n*	%
Little use	8	7.1
Somewhat useful	58	51.3
Very useful	46	40.7
Cannot say	1	0.9
Total	**113**	**100.0**

31.0% of those who had completed the online training considered it highly versatile, while 58.4% felt it was sufficiently versatile. 6.2% said it was not sufficiently versatile. (Table 22)

Table 22. Versatility of the online training

Versatility of the online training	*n*	%
Not known	5	4.4
Not sufficiently versatile	7	6.2
Sufficiently versatile	66	58.4
Highly versatile	35	31.0
Total	**113**	**100.0**

The online training implementation was also successful, as almost 90% found studying easy or very easy. One out of ten respondents did not consider the online training particularly easy to use (Table 23).

Table 23. Ease of using the online training

Ease of using the online training	*n*	%
Not known	2	1.8
Not particularly easy	12	10.6
Quite easy	55	48.7
Very easy	44	38.9
Total	**113**	**100.0**

3.3.5 Earlier training on domestic violence

We asked the respondents about their earlier training on domestic violence and its scope. The question included lectures, seminars and modules completed in degree education, continuing education or in-service training or other education and training. The objective was to map the scope of the training at different levels.

As precise numbers of hours are difficult to remember, we presumed that courses were the most extensive units, seminars less extensive and lectures the briefest forms of training. The respondent could only choose one option indicating the type of training with the largest scope completed by them.

Slightly more than one out of three respondents had received no training on domestic violence as part of their degree programme. Only 5.9% had completed a more extensive course or study module. On the other hand, 48.4% had participated in lectures on domestic violence, and 19.2% in seminars as part of their degree programmes. (Table 24)

Table 24. Duration of training on domestic violence in the degree programme

Duration of training on domestic violence in the degree programme	*n*	%
None	436	26.6
Lectures (hours)	794	48.4
Seminars (days)	315	19.2
Course (module)	97	5.9
Total	**1,642**	**100.0**

More than one out of three (35.2%) had received no training on domestic violence as part of their professional continuing education or in-service training. On the other hand, 36.7% had attended lectures, 22.0% had participated in seminars, and 6.1% had completed a larger module on domestic violence. (Table 25)

Table 25. Duration of training on domestic violence in continued education or professional in-service training

Duration of training on domestic violence in continued education or professional in-service training	*n*	%
None	578	35.2
Lectures (hours)	602	36.7
Seminars (days)	362	22.0
Course (module)	100	6.1
Total	**1,642**	**100.0**

51.3% of the respondents said they had also received other training related to domestic violence. On the other hand, 49.7% had not received any continuing education or in-service training related to domestic violence, while 5.2% had completed more extensive courses. (Table 26).

Table 26. Duration of training on domestic violence in other than continued education or professional in-service training

Duration of training on domestic violence in other than continued education or professional in-service training	*n*	%
None	816	49.7
Lectures (hours)	472	28.7
Seminars (days)	268	16.3
Course (module)	86	5.2
Total	**1,642**	**99.9**

The responses predict a steady demand for the online training programme produced as part of the EPRAS project, as 72.2% felt they needed additional training on domestic violence (Table 27).

Table 27. Need for additional training on domestic violence

Need for additional training on domestic violence	*n*	%
No	457	27.8
Yes	1,185	72.2
Total	**1,642**	**100.0**

However, there are differences between groups of respondents concerning the need for training. We first established the volume of tasks involving domestic violence the respondents dealt with by sector (Table 28).

The police officers among the respondents had clearly the highest volume of tasks involving domestic violence, as 68.6% of them deal with such tasks daily or weekly. Approx. one out of three (31.8%) of the respondents working in the social welfare sector encountered tasks involving domestic violence daily or weekly, whereas those working in the health care sector dealt with such tasks clearly less often. 15.0% of the respondents in this group said they had tasks involving domestic violence daily or weekly. 60.6% of the respondents in the health care sector, 40.1% in the social welfare sector, and 12% in the police encountered tasks related to domestic violence less often monthly.

Table 28. Tasks related to domestic violence by sector, % (n = 1,642)

Tasks related to domestic violence	Your current sector				
	Social welfare	Health care	Police	Other	Total
Daily	9.2	2.7	18.6	8.4	11.6
Weekly	22.6	12.3	50.0	12.6	31.1
Monthly	28.1	24.4	19.5	20.2	23.0
Less frequently	40.1	60.6	12.0	58.8	34.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

While police officers had a high volume of tasks relating to domestic violence, 44.5% of them said they did not need additional training. On the other hand, more than 80% of the respondents in all other sectoral categories felt they need more training on domestic violence to support their work. (Table 29)

Table 29. Training needs by sector, % (n = 1,642)

	Your current sector				
Need for additional training	**Social welfare**	**Health care**	**Police**	**Other**	**Total**
No	15.4	15.3	44.5	17.8	28.0
Yes	84.6	84.7	55.5	82.2	72.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Question 17 examined asking about domestic violence and using tools developed for mapping experiences of violence. If necessary, respondents could select several tools. 54.1% of them said they do not use any tools for mapping domestic violence and asking about it. The survey listed seven tools (see https://thl.fi/fi/web/lapset-nuoret-ja-perheet/tyon_tueksi), in addition to which the respondents could mention organisation-specific or other tools. The most frequently used tools were a MARAC risk assessment form (18.6%), a personal safety plan (17.5%) and a check list for asking about violence (11.6%). The Acute assistance for rape victims folder (1.9%), the assault and body map form (5.5%), the form for mapping harassment and stalking (5.7%) and the screening and mapping form for domestic violence (6.6%) were used the least often. (Table 30).

Table 30. Tools relating to domestic violence used by respondents, % (n = 1,642)

Tool	**Used**	**None**
Personal safety plan	17.5	82.5
Form for mapping harassment and stalking	5.7	94.3
Screening and mapping form for domestic violence	6.6	93.4
Assault and body map form	5.5	94.5
Acute assistance for a rape victim folder	1.9	98.1
Risk assessment form (MARAC)	18.6	81.4
Check list for asking about violence	11.6	88.4
Organisation-specific tool	9.3	90.7
Some other tool	10.8	89.2

Organisation-specific tools were referred to in 9.3% of the responses, and assessment of the interested party's need for protection, report of an offence, MOVE and HAIPRO were mentioned several times. Of the other tools (10.9%), interviews, asking about violence and discussions were mentioned several times.

There were sectoral differences regarding the use made of the cited tools. 35.1% of respondents in the social welfare sector and 25.2% in the category 'other' used

personal safety plans. The form for mapping harassment and stalking is used particularly in the social welfare sector (10.7%). The form for screening and mapping domestic violence was used in the social welfare sector (12.9%) and the health care sector (8.8%), whereas the assault and body map form (PAKE) was used especially by the police (8.5%). The MARAC form was used particularly often by respondents in the social welfare sector (25.2%), while 17.1% of police personnel also said they used this form. The check list for asking about violence is used more often than average by respondents in the social welfare field (21.9%). In health care, it was used by 11.8% of those who used some tool. Respondents in other sectors are more likely than average to use a tool or a form developed in their organisation or some other tool or form (14.3% and 16.0%).

The more often the respondents encountered tasks relating to domestic violence, the more likely they were to use tools for asking about and mapping domestic violence. However, 38.7% of those who dealt with tasks relating to domestic violence daily did not use any tool. When we exclude organisation-specific tools or others than those listed, the proportion of professionals who work with domestic violence daily and use some of the tools listed in the survey was less than 49.2%. While it may be that tools are not used because they are not required in the respondents' tasks, this was impossible to establish based on our data. However, the training should have a focus on different tools and procedures for mapping and asking about domestic violence. Domestic violence should be mapped and asked about systematically, rather than at the discretion of an individual employee.

It may be presumed that an employee with a higher level of competence is capable of work performances that are of a higher quality, more efficient and more effective than others. Competence is regarded as including an employee's skills as well as the knowledge, attitudes and values related to them (motivation). Competence is about the employee's ability to achieve the desired end result in the real world. It thus refers to the employee's adeptness and capacity as well as creativity and tenacity in striving for an objective or end result considered valuable. (see Crick 2008.)

A precondition for the actualisation of competence in the workplace is that the employee is able to realise their capabilities in their work. If supervisors and colleagues do not consider the work to be done or a goal important, individual employees can only achieve inadequate results, even if their competence is good. The employee's possibility of realising their capabilities can thus also be included in competence, as without support and appreciation, it is difficult for an employee to achieve results. In question 24, we asked the respondents about how important the organisation's top management, their immediate supervisors and their colleagues consider intervention in domestic violence.

In questions 18, 19 and 20, we asked the respondents about their knowledge, skills and interest related to four dimensions of domestic violence: domestic violence as a phenomenon, norms and legislation directing work on domestic violence,

the working methods and tools of work on domestic violence, and cooperation with other domestic violence professionals. 56.9% of the respondents said they had good or excellent knowledge about the forms of domestic violence occurring in the population, including special groups. On the other hand, 41.2% said they knew little or nothing about the forms in which domestic violence occurs.

75.2% of the respondents had good or excellent knowledge about the norms, legislation, regulations and guidelines directing work on domestic violence, whereas 26% had little or no knowledge about them. Fewer respondents had good knowledge about the tools for recognising domestic violence, including risk assessment and mapping forms: 71.3% felt they had little or no knowledge about the tools for recognising domestic violence. Only 27.7% felt they had good or excellent knowledge about these tools. 67% of all respondents had good or excellent knowledge about other authorities and providers of support and services relating to domestic violence. One out of three, or 35.3% of the respondents, had no or relatively little knowledge about the other actors working against domestic violence in their area.

Respondents appeared to be relatively confident of their skills: 80.4% felt they were relatively well or well able to recognise the different forms of domestic violence. Only 17.3% found their ability to recognise the phenomenon poor or non-existent. 68.9% considered their knowledge about the norms and legislation good or excellent, whereas 28.5% believed they had little or no knowledge about them. On the other hand, the proportion of those who had good or excellent knowledge of how to use tools and methods was as low as one out of three (33.7%), and 62.5% felt they had little or no skills in using tools and methods. In this respect, corrective action is clearly needed. On the other hand, 65.2% felt they knew how to collaborate with other actors working on domestic violence, even if one out of three experienced their collaboration skills as inadequate.

The respondents had a high level of interest in work against domestic violence: 86.3% were quite interested or highly interested in issues related to recognising domestic violence. 90.1% of the respondents were quite interested or highly interested in the application of legislation to their work, whereas 75.4% of all respondents were quite or highly interested in using tools and methods related to domestic violence in their work. One out of four (25.6%) were not interested in these areas.

In terms of knowledge and skills, the greatest need for training relates to using tools. Training needs are also associated with the knowledge and skills related to services provided by other authorities and inter-authority cooperation. On a positive note, large proportion of the respondents expressed an interest in these areas.

In question 24, we asked the respondents about their ideas of how important their top management, immediate supervisors and colleagues consider intervention in domestic violence. Well over one half of the respondents (58.5%) believed the top management finds intervention in domestic violence relatively or highly important. Notably, 28.7% were unable to assess their top management in this respect. On the

other hand, as few as 2.1% believed that the top management 'attach no importance' and 10.7% that they 'attach relatively little importance' to domestic violence interventions. The situation concerning immediate supervisors and colleagues was different, as 75.5% of the respondents believed that their immediate supervisors, and 87% that their colleagues, 'attach some or a great deal of importance' to domestic violence interventions.

3.3.6 Attitudes towards domestic violence

In question 21 of the survey, the respondents were asked to assess the extent to which they agreed or disagreed with the listed statements about attitudes towards domestic violence. The responses to eight statements were used to map the respondents' attitudes towards not only the victim's position (4 statements) and the private nature of domestic violence (1 statement) but also children's position (1 statement) and their own work (2 statements). For the statements and results, see Table 31.

78.2% did not find it difficult to ask a client about domestic violence. 90.1% considered intervention in domestic violence an important part of their work. Only 2.5% felt that domestic violence in an intimate partnership is a private matter for the partners. 91.6% did not find that the victim is often partly to blame for the violence, while 7.2% said that the victim of domestic violence is often partly to blame for the violence. 90% understood that domestic violence may make the victim feel powerless, in which case seeking and receiving help may be difficult. As many as 13.9% found that a victim who remains in a violent relationship is personally responsible for the continuation of the violence.

The statement concerning children divided the respondents. 24.6% felt that violence against children is not overshadowed by violence between adults, whereas 64% believed the opposite to be true. 11.5% of the respondents did not comment on this statement.

42.3% said it was hard for them to understand why the victim stays in a violent relationship. It was particularly difficult for respondents who work with the police, as 60.9% of them somewhat or fully agreed with this statement. As a comparison, 30.7% of respondents in the social welfare sector and 37% in the health care sector somewhat or fully agreed with the statement "I find it difficult to understand why the victim stays in a violent relationship". There was also a clear difference between men and women: 34.7% of women and as many as 62.8% of men felt it was difficult for them to understand why the victim stays in the relationship.

Table 31. Statements related to attitudes, % (n = 1,642)

Attitudes	FD*	SD	SA	FA	DK
I find it difficult to ask a client about domestic violence.	42.0	36.2	16.7	3.9	1.2
I find that intervening in domestic violence is an important part of my work	2.5	7.2	27.1	63.0	1.2
I find violence in an intimate relationship is a private matter between the partners.	86.4	11.0	1.2	1.3	0.1
The victim of domestic violence often is partly to blame for the violence.	60.4	31.2	6.1	1.1	1.3
Domestic violence leaves the victim feeling powerless, which may make seeking and accepting help difficult.	2.2	1.5	19.9	5.1	1.3
If the victim of domestic violence does not leave a violent relationship, he/she are themselves responsible for the continuation of the violence.	45.2	39.1	12.5	1.4	1.7
I find it difficult to understand why the victim stays in a violent relationship.	20.4	33.8	33.2	11.1	1.5
Violence against children is often overshadowed by violence between adults.	5.1	19.4	41.5	22.5	11.5

* FD= fully disagree; SD= somewhat disagree; SA = somewhat agree; FA= fully agree; DK= don't know.

We also asked the respondents if they had directed clients to other actors' services, in particular to a health centre or a physician, social services, a police investigation, a shelter or other services. As we can see in Table 32, only 11.6% of the respondents had not directed clients to some other actors' services in the context of domestic violence. Most frequently (72.7%), the client was directed to social services, including emergency social services, a family counselling clinic and child protection services. 53.7% of the respondents had directed their clients to a police investigation, 58.6% to a health centre or a physician, and 63.8% to shelters. Other services mentioned included Ankkuri teams, MARAC, different projects cited by name, NGOs and established practices, crisis centres and, cited by a particularly high number of respondents, Victim Support Finland.

Table 32. Have you directed your clients to other actors' services in the context of domestic violence, % (n = 1,624)

Actors/Services	Yes	No
Health centre or physician	58.6	41.4
Social services (e.g. emergency social services, family counselling clinic, child protection services)	72.7	27.3
Police investigation	53.7	46.3
Shelters for victims of domestic violence	63.8	36.2
Other services, which	24.2	75.8
I have not directed clients to other services	11.6	88.4

The answers of respondents in different sectors differed in the extent to which they had directed their clients to other actors' services in the context of domestic violence. Respondents who worked for the police were particularly likely to direct clients to health services and a physician (78.0%). Police personnel also frequently directed their clients to social services (87.9%). Clients were directed to a police investigation especially by other police personnel (62%) but also by social welfare professionals (57.2%). Of respondents in the health care sector, 38.6% said they had directed clients to a police investigation in the context of domestic violence. While police personnel had been the most likely group to direct their clients to a shelter (77.8%), a large number of respondents in the social welfare sector had also done so (66.4%).

One of the EPRAS project's objectives was raising awareness of shelter services. We also asked about professionals' reasons for not directing clients to a shelter. A total of 594 responses relevant to this question was received. (Table 33).

Table 33. Why did you not direct clients to a shelter, % (n = 549)

Reason	Yes	No
I do not know in what situations I could direct clients to a shelter	9.1	90.9
Directing clients to a shelter is somebody else's job	5.2	94.8
I work in a shelter	0.2	99.8
Other reason, what	63.3	36.7
Cannot say	24.4	75.6

Very few respondents said that they did not know in what situations they could direct clients to a shelter (9.1%) or that directing clients to a shelter is somebody else's job (5.2%). In these responses, as the other actor was almost always mentioned the social services or a social worker. On the other hand, a total of 376 other reasons were given, accounting for 63.3% of the responses. The most common reasons cited included that "there is no need", "there is no shelter", "the issue was resolved", "the

client does not want to go", "clients are children/older persons", "the client lives at an institution". The differences in the reasons for not directing clients to shelters between sectors were minor.

3.3.7 Open-ended responses on round II of the survey

The last question of the survey on round II (26) was a free-text comment field, for which the respondents were given the following instructions: "Should you wish, you may provide here more information about your wishes concerning training on domestic violence and issues related to practical work or give your comments on this survey." This question attracted 489 responses; in other words, approx. 29% of those who participated in the survey responded to the freely worded field of the last question. The figure also includes those who responded to say that tasks relating to domestic violence are not currently part of their work. There were 211 respondents from the police sector and 119 from the social welfare sector, while 117 represented the health care sector and 42 other sectors.

A high number of responses (133) referred to a need for training on domestic violence in general. Repeated and regular training was emphasised, especially in the responses of social welfare sector professionals. In particular, the respondents would have liked tailored training (100 references) in order to recognise the needs and challenges of different client groups (immigrants, children, persons with disabilities, older persons, those with substance abuse problems, perpetrators) and to develop the competence and services of their own organisations. In particular, training needs related to interviewing children and recognising domestic violence against children as well as identifying special cultural features, including honour violence, were emphasised.

Needs for training and development related to interprofessional cooperation, information exchanges between the authorities, and service counselling for clients were cited 77 times in total. A total of 58 respondents would have liked training on using different tools related to domestic violence, including risk assessment tools and forms, and to mapping violence, while 16 respondents would have liked training on asking about domestic violence in different situations.

3.3.8 Open-ended responses of those who completed the online training programme Create trust – Stop the violence

Of all those who responded to the last question, 34 said they had completed the online training programme Create trust – Stop the violence either fully or in part. When these responses are examined separately, the highest number of wishes (mentioned 7 times) focused on recognising domestic violence against children and asking a child about domestic violence, preventing the reoccurrence of violence in families with children, and supporting parents. One of the respondents would also have liked information about cooperating partners on maternity and child welfare clinics

in cases of suspected domestic violence. Other wishes regarding training were practically oriented and detailed and, for example, concerned organising events where the partners in interprofessional cooperation would be physically present and obtaining information on an individual municipality's partners. Individual respondents would also have liked training on asking about violence, but these wishes concerned specifically more practical training based on different interview techniques and going through client cases, which would also help to understand the client path better.

In other words, the wishes of those who had completed the online training programme fully or in part were more detailed than those of other respondents. Only one respondent expressed a wish for training in the use of different tools helping to recognise and guide victims of domestic violence. Responses received to a similar free-text comment field on round I, in which respondents could itemise their wishes regarding the training, had been accounted for in the development of the online training programme Create trust – Stop the violence. These responses are discussed in section 3.3.1 Round I of the survey: initial mapping. The most frequently repeated wishes and needs related to training themes in responses on round I concerned practical methods of asking about violence; violence risk assessment tools and other forms developed to support the work; training related to special groups, including children, older persons and immigrants; and information needs relating to local actors and partners as well as information exchanges. Developing a section which would comprehensively cover local cooperation parties and service systems and keeping it up to date have not been possible as part of an online training programme intended for national use, at least not so far.

The free-text responses related to the mapping of training needs and wishes concerning training were very similar on rounds I and II, excluding those who had completed the online training fully or in part, in whose responses were highlighted detailed wishes for training on recognising domestic violence against children, interviewing a child and working with families, as well as for practically oriented training on asking about domestic violence based on going through client cases. All in all, those who had completed the online training programme either in part or fully stood out among other respondents with their more practically oriented training needs expressed in greater detail. The responses of this group did not include general wishes for training on domestic violence, asking about domestic violence at a general level, risk assessment tools or interprofessional cooperation and information exchanges, excluding individual respondents who said they would like practically oriented training. Covering comprehensively such issues as techniques for interviewing children in an online training programme that offers information on domestic violence is not possible. A separate training programme titled Create trust – Protect the child, which is also maintained by the National Institute for Health and Welfare, may provide a better response to this need. Based on the open-ended responses, we may presume that the online training responded well to the training needs col-

lected on round I of the survey regarding basic level knowledge of domestic violence.

3.4 Focus group interviews with social and health care professionals and police officers

Earlier studies have shown that recognising experiences of violence is difficult without systematically asking about it. Establishing why the client really accesses services and offering appropriate help is important from the perspective of not only helping victims of violence but also quality management. Especially in association with intimate partner violence, ideas of how the victims are to blame for the violence still live on strongly (Husso 2003; Husso et al. 2014; Notko et al. 2011; Virkki et al. 2011).

The obstacles to intervening in violence and the justifications for non-intervention are both structural and based on attitudes. For example, they are associated with individual and communal mechanisms of denial in the face of violence and a lack of clarity in division of responsibilities (Husso et al. 2012, 2014 and 2017c; Taket et al. 2003; Virkki et al. 2011). It has also been noted that a precondition for developing effective practices for recognising and encountering those who have experienced violence and breaking the vicious circle of violence is a redefinition of professionals' practices, beliefs, responsibilities and rights (Husso et al. 2012).

A key objective of the EPRAS project was to map the possibilities and challenges of domestic violence intervention in the social, health care and police sector. Both Finnish and international studies show that clients mainly contact social and health care services and the police for help with injuries caused by violence and problems and symptoms associated with violence. These sectors thus play a key role in domestic violence interventions. A study conducted in specialised medical care (Notko et al. 2011) on the incidence of domestic violence experiences, the forms of violence experienced by victims and their treatment needs indicated that domestic violence has a significant impact on patients' wellbeing. Being a victim of violence, especially violence in a close relationship, is a destructive and wounding experience, which results in many types of psychological and somatic problems that restrict the victim's life and functional capacity. Victims of violence seek help for not only their physical injuries but also such problems as depression, anxiety and sleeplessness, but not the actual violence.

Recognising experiences of domestic violence is difficult if violence is not asked about systematically. Studies indicate that clients are not asked about violence and violence is not recognised, even in cases where signs of violence are clearly visible (Krug et al. 2002; Bacchus et al. 2003; Lavis et al. 2005; Robinson & Spilsbury 2008.). It is also difficult for employees and authorities to recognise the consequences of violence and the traumas caused by it and to understand the victims' behaviour which may, for example, appear passive. The depression, passivity or inability to

resolve the situation of those who have experienced violence are often seen as causes rather than consequences of violence. In other words, the destructive effects of violence and its impacts on human behaviour are overlooked. Victims are expected to show strong agency and act as though the violence had never taken place. As a consequence, few victims of violence are strong enough to seek help for the problems caused by the violence. The destructive nature of violence also sets specific challenges for intervention in violence.

In an earlier study, we named the most common viewpoints referred to by professionals to justify non-intervention in violence as a practical, medical/professional, individualistic and psychological frame (Husso et al. 2012; Virkki et al. 2011). In the practical frame, non-intervention is justified by a lack of opportunities and tools. The medical/professional frame emphasises issues related to the professional's job description and field of specialisation as grounds for non-intervention. In the individualistic frame, violence is interpreted as a private matter for which the adult parties are personally responsible. From the perspective of the psychological frame, a fear of victims being re-traumatised if the violence is asked about forms an obstacle to intervening in it. (Husso et al. 2012; Virkki et al. 2011.)

A situation in which violence is encountered may be seen through many different frames. The interpretations arising from various frames and different actors' assumed roles essentially define their actions, their emotions associated with the situation, and their possibilities of intervening in violence. In other words, the different frames determine how employees understand their tasks. The selected frame and interpretation have an essential impact on how employees act. Regardless of professional differences related to the job description, the most common frames through which violence is seen were in evidence in all the professional groups interviewed for the study. (Husso et al. 2012; Virkki et al. 2011.) Overlooking violence is thus associated with institutional practices and attitudes, which have excluded the duty of intervening in violence and assuming responsibility for it (Ronkainen 2008). International studies have also shown that professional practices as well as ideas and attitudes associated with domestic violence have for a long time formed a barrier to effective methods of intervention (Short et al. 1998; Maiuro et al. 2000).

A research project carried out at the Police University College in 2015–2016 (Fagerlund 2016; Fagerlund et al. 2018) drew attention to the fact that legislation on domestic violence interventions of the police has changed significantly over the last twenty years. The most essential one of the recent changes took place in 2011 as minor assaults became subject to public prosecution in cases where there is a close relationship between the perpetrator and the victim. The legislator has thus, with considerably greater clarity than before, striven to make violence subject to criminal proceedings, even if it takes place in a private place and there is a close relationship between the parties to the violence. The police are informed of domestic violence

through a number of different channels, the key one of which is emergency call tasks categorised as family violence.

A study on police tasks related to family violence (Fagerlund 2016) examined particularly police interventions in domestic violence and the practices of recording the violence in a report of an offence following a task involving family violence. The findings indicate that in some cases, the status of minor assaults as offences subject to public prosecution and the definition of a close relationship had remained unclear for the police. While the same addresses and names kept coming up in the context of call-out tasks, the police did not feel they had any means of intervening in the situation and, for example, the practice of directing clients to different assistance services was relatively random. From the perspective of training needs, the study highlighted not only the up-to-date legislation but, among other things, also addressing the diversity of violence without gender stereotyped assumptions of perpetrators and victims, and the need for more training on encountering children. In addition to recording a report of an offence and launching a criminal process, attention should also be paid to other actions, in particular the accessibility of assistance services offered to parties to domestic violence and directing clients to such services.

Similar development areas have also been identified in the social and health care sector. Professionals are unwilling to, or do not dare, record violence as the reason for the client or patient visit, or making such entries is experienced as awkward. The failure to record information on violence is partly explained by the incompatibility of information systems or other technical reasons, but also by a lack of routines and permanent practices, and sometimes also a climate of attitudes where recording this information is not considered important. Not recording violence in patient and client situations has far-reaching consequences in today's society. Symbolic and verbal documents are significant creators of social reality. If not documented, phenomena disappear. They are not preserved as part of an organisation's memory. (Ferraris 2013.) This affects the structural solutions of service organisation and also influences views of how widespread violence is as a social and health-related problem. When violence is overlooked as a phenomenon, its incidence and impacts are also not understood.

From the perspective of these earlier findings, the project's objectives, key research questions and evaluation, the focus group interviews addressed the following questions (see the detailed interview framework attached to this publication as Appendix 2):

1. Encounters with domestic violence in the interviewees' professions
2. Training on domestic violence in degree education and during the career
3. Training needs relating to domestic violence
4. Domestic violence and interprofessional cooperation
5. Preconditions and possibilities for intervening in domestic violence in the professionals' work

3.4.1 Implementation and findings

The focus group interviews were led by 1 to 3 researchers from the University of Jyväskylä. There were 10 groups consisting of social and health care professionals, while 6 groups were made up of police personnel. Each group had 2 to 7 participants. The total number of participants was 67, of whom 13 were men and 54 women. The focus group interviews with social and health care professionals took place between May and October 2017, while the groups consisting of police personnel were interviewed in January and February 2018. The professionals' discourse in the interviews was analysed using thematic content analysis, discourse analysis, framework analysis and positioning theory. (see e.g. Goffman 1974; Harre & Van Langenhove 1999; Silverman 2006; Tuomi and Sarajärvi 2018).

The following table contains central themes concerning the training. The focus group data and results will be reported more closely in project's publications (see chapter 4.3).

Table 34. Training on domestic violence received by social and health care professionals and police officers

Studies related to violence in the profession's education programme	• Little or no training • Also those whose main task involves assistance provision or work on violence rarely have any training on domestic violence included in their degree programmes
Training on violence organised by the employer or other later training	• Few or no interviewees had training offered by the employer • Training on domestic violence is often only provided for a small part of the employees, while most do not receive training • The training often takes place too late: an opportunity for participating in training is offered to professionals after they have already worked in their role for several years
Training needs	• Practices and models for encountering domestic violence and asking about violence • Effective interventions and means of stopping domestic violence • Information on domestic violence as a phenomenon and the impacts of violence on different parties and their actions • Emotions evoked by violence in employees and their impacts • Clarifying the division of duties between different professional groups • Identifying the diversity of situations involving violence and forms of violence • Motivating the client/patient in accepting help • Multiculturalism and the challenges it creates • Digital violence and online harassment

As training needs were discussed, the interviewees stressed the scarcity of training on this theme. When asked about training on encountering domestic violence the interviewees found it difficult to remember if they had even heard the topic mentioned during their studies. According to most participants, training on this topic had been very scarce and quite insufficient. In this respect, the findings made in the interviews are essentially different from the responses in the survey data, which indicate that some training has been available. In their responses, the interviewees also

stressed the importance of interprofessional cooperation and action at local level, stepping up cooperation and knowing the actors, and they would have liked training on this theme. The majority of the interview participants would also like training on domestic violence as a phenomenon and, in particular, on why leaving a violent relationship is so difficult and how children who have experienced and witnessed violence should be encountered and treated. The need for processing and understanding the emotions domestic violence evokes in employees arose in almost all groups, and the participants would like to have discussions on this topic in their work organisations. More information and tools would also be needed for encountering victims of violence, perpetrators, and family members who witness violence. Multiculturalism and the new challenges to intervening in domestic violence it creates also emerged in the interviews. As new challenges were also experienced various forms of digital harassment and violence. Sufficient information or operating models are not available for recognising and intervening in them.

The scope of studies completed by the interviewed police officers was greater than the studies completed by the social and health care professionals. However, police personnel brought up shortcomings and development needs related to the training on work with violence. While police personnel had usually received some training for call-out tasks related to domestic violence, there had been little or no training on investigating cases of domestic violence. The interviews also revealed the important role played by the centralisation of training organised by the employer. For example, those who work with children have often received targeted special training on investigating offences against children. Shelter workers who focus on work with violence have also received special training for this work organised by the employer.

Table 35. Interprofessional cooperation in domestic violence interventions

Inter-professional cooperation	• A variety of experiences ranging from severe problems to smooth cooperation • Problems with information flows and unclarity of job descriptions and tasks as challenges • Frequently, none of the actors are familiar with the entire process • Different actors have inconsistent views and aspirations • Different professionals' incompatible goals are a challenge

As key factor relating to intervention in violence emerged interprofessional cooperation, but different professional roles and starting points, and the varying expectations and assumptions create challenges. The interviewees brought up the importance of smooth information exchanges between occupational groups, clarity of job descriptions, knowledge of different institutions' operating practices as well as the essential nature of a common goal in violence interventions. In discussions on smooth cooperation, personal contacts between employees and mutual familiarity between actors were also emphasised. On the other hand, the groups also stressed the importance of clear practices, operating models and instructions, and considered the excessive profiling of certain persons in domestic violence matters a problem and a tendency that made the activities more vulnerable.

3.5. Interviews with shelter clients

The project also aimed to gather information on shelter clients' experiences of the process of seeking help and the service system. Five shelter clients were interviewed for this purpose. The clients were recruited through the participating shelters, where the shelter employees offered their clients the possibility of taking part in a voluntary interview. The interviews at the shelters were conducted by an EPRAS project researcher.

3.5.1 Implementation and findings

The following themes were covered in the interviews with clients:

1. The interviewee's background information
2. Preconceived ideas about the shelter
3. Accessing of shelter services
4. Asking about and recognising domestic violence outside the shelter
5. Interprofessional cooperation from the client's perspective.

The client's life situation, stages of and reasons for accessing shelter services were discussed during the interviews. One of the themes was the preconceived ideas the interviewee had had before coming to the shelter.

Table 36. Preconceived ideas about the shelter

Preconceived ideas about the shelter	• All shelter clients are victims of very severe physical violence • The interviewee's personal experiences of violence were not severe enough to warrant going to a shelter • In addition to experiencing severe violence, shelter clients also have substance abuse problems

Victims' tendency to belittle and minimise their experiences of violence, normalisation of violence and doubts about their experiences being severe enough to entitle them to a shelter place, which studies show as being common for victims of violence, emerged in the interviews (Husso 2003; Kirkwood 1993; Lundgren 1998). However, the interviewees mainly described their feelings after coming to the shelter as positive. The communal atmosphere and peer support at the shelter were mentioned several times as a positive and welcome surprise and an important resource.

Table 37. Accessing shelter services

	Financial Factors	**Personal factors**	**Social factors**
Accessing shelter services	- Previously difficult for many due to the requirement of a payment commitment from the municipality - There is still uncertainty about how and in what situations you can access the services - Finding information about the services being free of charge, for example by googling, is not easy - Chat rooms offer outdated information	- Normalisation and minimisation of violence has led clients to belittle the seriousness of the violence they encounter and doubt their entitlement to shelter services - Interviewees had often thought about going to the shelter for a long time, and starting to look for help is a long process	- Finding a shelter close to your home is important when going to the shelter - On the other hand, clients escaping stalking have gone to another locality for safety reasons to prevent the perpetrator from finding out where they are - Essential factors in coming to the shelter were assistance and information provision by professionals

The findings indicate that the service being free of charge was a key factor enabling clients to come to the shelter. The interviewed shelter clients said they had been uncertain, or found incorrect information in such sources as the internet, about the situations in which you can come to a shelter, and how. From the clients' perspective, the shelter as a service and the actions of the professionals working in it were almost without exception experienced as effective. Problems associated with help sought elsewhere included the inadequacy of different professionals' knowledge and the inconsistency and fragmentation of instructions. The interviewees said they had found information about the shelter in several sources, for example online using a search engine as well as through radio advertisements and online videos

Table 38. Asking about and recognising domestic violence outside the shelter

Asking about and recognising domestic violence outside the shelter	• Clients' experiences of being asked about violence varied; sometimes help had been provided fast and effortlessly, whereas at other times clients had to seek for help for a long time, or their attempts to get help had failed • In some cases, the violence has been 'common knowledge', but help has not been offered, or its timing or content have not been appropriate • Looking back, clients have sometimes sought help for different ailments caused by experiences of violence, including depression or somatic symptoms, but the professionals have not asked about violence or the client's family situation or wellbeing.
Challenges to recognising domestic violence	• Clients have been asked about domestic violence, for example at the maternity and child health clinic, but they have not dared to tell anyone about their situation, for example because the perpetrator has said that the children will be taken into custody if the victim reports the violence • According to the interviewees, some professionals have stereotyped expectations of families and relationships in which violence occurs; violence in highly educated and wealthy families, for instance, may go unrecognised, and asking about it may be considered embarrassing • The interviewees found that the impacts of witnessing domestic violence between adults and against a parent on children often are overlooked, and problems occurring at school or in day care, for example, have not been linked to what the children have experienced at home
Special challenges to asking about violence	• Different ethnic backgrounds are a challenge to professionals, and according to the data, violence in the Roma culture or in the family relations of clients with different ethnic backgrounds or religions cause uncertainty in employees and make asking about violence more difficult. • The client's cultural background and family relationships may also be an obstacle to seeking help and reporting violence. All groups and individuals do not have a strong trust in the authorities

The shelter clients interviewed for the study found that asking about violence and bringing the issue up important. According to them, more information about domes-

tic violence and its consequences should be available. The clients found that different services asked about the violence to highly variable degrees. For example, they said that they had sought help for different symptoms related to violence but had not been asked about violence. Their encounters with professionals had varied. While one of the interviewees had been asked about violence at the maternity and child health clinic, they had not been ready to report the violence they experienced when asked about it for the first time. Feelings of shame that is usually associated with being a victim of violence can hinder accepting help (esim. Husso 2003).In addition to shame, clients explained their reluctance to report the violence by their fear of child protection measures, including having the children taken into custody, and negative consequences for themselves or persons close to them. They also said their cultural background made it more difficult to seek help. Some had negative experiences of the authorities and of talking to outsiders about problems in their intimate relationships. One of the interviewees said that talking about the violence to the authorities put the lives of both the victim and persons close to them at risk.

Table 39. Interprofessional cooperation from shelter clients' perspective

Challenges of interprofessional cooperation from the clients' perspective	• Information is not always passed on from one authority or actor to another in real time • Different professionals have inconsistent ideas of the correct procedures • Domestic violence is associated with overlapping processes, including drawn-out criminal investigations and court processes, process of the social services and child welfare services, the divorce process, housing arrangements and children's guardianship issues as well as separate health care processes • Professionals often are unaware of any other processes except those in progress in their own area, so it is possible that no-one has an overall idea of the client's situation and needs • The lack of an overall idea may result in friction in different service processes, which may cause the client additional trouble and, in the worst case, be a serious obstacle to receiving concrete help

According to the interviewees, professionals outside the shelter only rarely knew the big picture of the client's other on-going processes and forms of support requiring services from different fields. The interviews with clients thus revealed similar problems in interprofessional cooperation as the group interviews with social and health care professionals and police personnel. The data indicate that shelter employees were particularly important actors in situations where the clients also needed other services. The interviewees also emphasised the significance of support provided after their stay in the shelter and the interprofessional cooperation for surviving violence and recovering from it. The interviews with shelter clients stressed especially the need for evidence-based knowledge and development of practices related to culture, ethnicity, honour violence, stalking and digital violence.

4 Overall evaluation of objective achievement in the EPRAS project

Marianne Notko and Marita Husso

Objective achievement in the EPRAS project was evaluated using mixed-methods evaluation, or triangulation (see e.g. Creswell & Plano Clark 2007; Myors et al. 2015; Tuomi and Sarajärvi 2018). The materials used in the evaluation, or the qualitative and quantitative data, gave rise to diverse viewpoints, which supported both the development of project outputs and the evaluation of their implementation. Evaluation studies aim to form an idea of the value, significance and merits of the activities being evaluated through systematic data collection. They are often divided into formative and summative evaluations. Formative evaluation focuses on an activity as it is unfolding, and as the project progresses, data is also produced for its implementers. Summative evaluation is based on evaluating the project's implementation and, in most cases, also the impacts achieved by it. Summative evaluation usually takes place after a project's conclusion and, as a rule, data is produced for the party funding the project. (Jokinen 2017; Rossi et al. 1999; Scriven 1991; Alkin 2012; Clarke & Dawson 1999)

As often is the case in evaluation studies (Jokinen 2017; see also Husso et al. 2015), the methods of formative and summative evaluation overlap in the current study. The essential difference between formative and summative evaluation studies lies in whether they emphasise enhancement-led evaluation or a final evaluation. A final evaluation is often based on an idea of the project's specific impacts as compared to other types of actions or absence of actions (Jokinen 2017).

Table 40. Plan for evaluation stages, objects and data

Stage	Object	Data and data collection method
1.	Mapping of the experiences, ideas and training needs relating to domestic violence of social and health care and police professionals	Focus group interviews I: a) shelter employees b) social workers c) health care professionals d) MARAC team members e) police officers
2.	Shelter clients' experiences of the service	Individual interviews with shelter clients
3.	Mapping of the experiences, ideas and training needs relating to domestic violence of social and health care and police professionals	Survey I Initial mapping of participants who could complete the EPRAS project's training package before the training begins
4.	Mapping of the experiences, ideas and prior training of social and health care and police professionals who completed the EPRAS project training package	Survey II Final mapping of those who completed the training package produced in the EPRAS project after the training
5.	National awareness raisingcampaign of the EPRAS project	Text/audio/image publications of the information campaign Evaluation of visibility from the perspective of the occupational groups involved in the project (as part of the final mapping)
6.	Reporting on the evaluation of the project as a whole	Report Academic publications

4.1. Reaching of target groups

The project aimed to reach the following numbers of professionals: social and health care sector n = 1,000, police n = 700, clients of the shelters participating in the project n = 1,200. A total of 2,094 people participated in the different stages of research in the project: 380 respondents on survey round I, 1,642 respondents on survey round II, 67 participants in focus group interviews (10 groups from the social and health care sectors and 6 from the police) as well as five shelter clients from two

different shelters, who were interviewed individually. In addition, dozens of people from partner organisations in the social welfare, health care and police sectors, the participating municipalities and cities and other organisations (including the health care district) contributed to the efforts of the project's different working groups (online training programme's editorial committee, team of authors and team of designers of the online training programme, steering group, project group). The goals regarding visibility were also attained in the civic campaign (see section 3.2 of this report). To sum up, we can say that the project reached its target groups and attained the targeted numbers of participants, partly even exceeding the numbers projected in the planning phase.

4.2. Schedules and project management

The project was divided into the following workstreams (WS): WS0 project management, WS1 online training. WS2 campaign for citizens, WS3 evaluation and research, and WS4 dissemination and mainstreaming of the findings and online training programme.

The project mainly progressed on the planned schedule. If necessary, the schedules were adjusted to match the schedules of the target groups and other activities and, for example, the holiday seasons of social and health care professionals and police personnel were taken into consideration when setting the periods of data collection for the survey and focus group interviews.

The main responsibility for managing the project rested with the Project Manager, who coordinated the work of different parties (partners and different action groups, including the project group and the team of authors, editorial committee and team of designers for the online training). Considering the up-to-date and highly successful outcomes of the project, project management met and partly exceeded the targets.

In terms of timing, the online training was launched as planned; however, to enable a more comprehensive evaluation of the online training programme, a higher number of responses should have been obtained from respondents who had completed the training than the 113 actually received on round II of the survey. In research activities related to evaluation, the permit processes associated with data collection (survey, focus group interviews with professionals and interviews with shelter clients) and the ethical evaluation took slightly more time than expected. In development and research projects associated with domestic violence, ethical evaluation is a necessary part of the project entity, however.

4.3. Printed and digital materials

The project aimed to produce the following printed and digital outputs: 1) a project plan, 2) an online training manual, 3) an online training implementation report, 3) an information leaflet, 4) campaign material, 5) an evaluation strategy, metrics and

manual, 5) a survey addressed to professionals, 6) a final evaluation report, 7) three publications in professional journals, 8) three academic publications, and 9) a concluding seminar.

The printed and digital materials were produced as planned. The online training package and campaigns for citizens were completed as planned. The targets were also reached and even exceeded in the data collections for the evaluation and research activities, for example regarding respondent numbers on survey round II. The targets concerning academic publications will be reached and exceeded towards the end of the project period. In the survey, respondents who had completed the online training programme Create trust – Stop the violence fully or in part (n = 113) said that the online training was a highly successful package, both in terms of its usability and its content.

The EPRAS project has turned out theses and research articles to be published in scientific journals. The studies have analysed the survey and interview data collected as part of the project.

Article manuscripts (about to be completed/undergoing academic publication evaluation processes):

Notko, Marianne, Husso, Marita, Fagerlund Monica, Houtsonen, Jarmo, Piippo, Sisko: Working with domestic violence: Interprofessional cooperation among social and health care professionals and police.

Fagerlund, Monica, Houtsonen, Jarmo, Notko, Marianne & Husso, Marita: Conceptualising violence in close relationships: contradiction between police perceptions and the letter of law.

Husso, Marita, Notko, Marianne & Piippo, Sisko: Institutional and affective practices of violence interventions.
Piippo, Sisko, Husso, Marita & Notko, Marianne: Finnish and Indian social workers' professional agency in domestic violence interventions. A frame analysis.

Doctoral dissertation (about to be completed):
Sisko Piippo (Social work, University of Eastern Finland): Sosiaalityöntekijöiden ammatillinen toimijuus lähisuhdeväkivaltainterventioissa. [Domestic violence interventions and social workers' professional agency]

Master's theses at University of Jyväskylä:
completed in April 2019, Noora Leinonen (Psychology and social work): Ammattilaisten lähisuhdeväkivallan kohtaamiseen liittyvien tunteiden yhteys väkivallan kokijalle, tekijälle ja ammattilaisille rakennettuun toimijuuteen.

About to be completed:
Anna-Greta Pekkarinen (Social sciences): Parisuhdeväkivallan kehystäminen poliisien ammatillisesta näkökulmasta.

Jani Merjeslampi (Social work): Parisuhdeväkivallan kohtaaminen sosiaalityössä.

Selina Laitila (Social work): Sukupuoli, väkivalta ja toimijuus sosiaali- ja terveysalan ammattilaisten väkivallan kohtaamista koskevissa haastatteluissa.

4.4. Dissemination and implementation of project outcomes

The online training programme was disseminated according to plans. The training programme was launched in February 2019 and has more than 1,850 registered users (in June 2019). As discussed in section 3.3, the feedback received on the training programme even before the project's conclusion indicates that the training will be widely used for professionals in different social and health care organisations. Also using the training as part of higher education studies, for example at the University of Jyväskylä and the Police University College, was discussed at the project's concluding seminar.

The campaign also reached its targets. An attention value study (by Radiomedia) showed that the radio campaign had reached the audience extensively. Other digital information activities (Facebook, Twitter, YouTube, pay-per-click advertising, Google Ads display advertising) had also successfully reached their target groups. More than 100 people participated in the concluding seminar of the project, which was held on the National Institute for Health and Welfare's facilities in Helsinki on 14 May 2019, and a further 100 watched live streaming of the event. In June, social and health care sector and police organisations also began handing out information leaflets describing the project.

In addition, the research carried out as part of the project was presented at the following international scientific conferences: Interpersonal Violence – Social and Cultural Perspectives (IPVI) 14–16 June 2017, University of Jyväskylä; Stockholm Criminology Symposium, 10–12 June 2018, Sweden; European Network on Gender and Violence (ENGV), 27–29 June 2018 University of Bristol, United Kingdom; European Society for Family Relations (ESFR) 5–8 September 2018, University of Porto, Portugal; Local governance and human rights in the world of wicked problems, 6–7 June 2019, University of Zagreb, Croatia, and Copenhagen Street Level Bureaucracy, 11–13 June 2019, Denmark.

As a whole, the dissemination and implementation of the project outcomes has got off to a rather good start.

5 Challenges and opportunities of domestic violence interventions

Marianne Notko and Marita Husso

Many types of progress and development have taken place in domestic violence interventions in Finland during the 2000s. However, challenges to work on violence in this country have included poor mainstreaming of the developed models in organisation structures and institutional practices, the short time span of work and research on violence carried out in projects, uncertainties of funding, shortcomings and gaps in training on domestic violence received by professionals in different sectors, as well as attitudes towards domestic violence and dissenting opinions on the significance of the problem and the interventions. Work on domestic violence is also often centralised to certain persons in an organisation. As the data from focus group interviews with social and health care sector professionals and police personnel showed in this project, excessive profiling of certain individuals makes the activities vulnerable, and the risk is that the work is interrupted or comes to a halt when persons or tasks change. In an earlier study (Husso et al. 2014), we looked at the practices of encountering violence, and especially the pitfalls associated with them in the social and health care sector. We focused on an EU-funded development and research project, Violence Intervention in Specialist Health Care (VISH) implemented in 2009–2010, and the use of the operating models and tools developed by it two years after the project's conclusion. Our findings on the VISH project indicate that mainstreaming development project outcomes in practice is challenging. There is a great risk that the use of such operating models declines or comes to an end once the funding period and coordination of activities stop. The concrete use of an operating model is not necessarily transferred to new employees if the continuity and development of practices and models is not seen to, and the practices that have been developed are not supported. Professionals may also experience project fatigue, and without models permanently embedded in structures, it is likely that practices developed in projects will be dropped or forgotten about. A high number of individual, short-term projects which yet require commitment of the employees may result in overlooking issues, even ones considered important, by professionals whose tasks are demanding as such and who have a heavy workload.

Research has used the concept of a wicked problem to analyse and describe domestic violence. Wicked problems (Rittel & Webber 1973) are complex in nature, and they do not lend themselves to a single, straightforward solution that could be mastered by a particular actor or professional body. While interprofessional cooperation thus plays a key role in domestic violence intervention, it is fraught with a number of challenges. Professionals who encounter violence may have a large variety of educational backgrounds, their basic tasks may have major differences, and there are great disparities between organisations' operating cultures. An essential role is also played by what is defined as a problem and what are regarded as key objects and goals of the work in the professional's own organisation or tasks (see Horn & Weber, 2007; Rittel & Webber, 1973; Kadzin 2011). If a task is experienced as superfluous or not part of the professional's job description, tackling it and participating in interprofessional cooperation may be problematic (Head & Alford 2015, Weber & Khademian 2008).

Attitudes towards and differing opinions on the significance of domestic violence as a problem and the means of intervening in it have been a particular challenge to interprofessional cooperation (cf. D'Amour & Oandasan 2005). Marianne Hester (2005) has used the concept of three planets to describe a situation where professionals of different sectors work on the same issue but as though from different planets, in which case their starting points, objectives, understanding of the phenomenon and the ways of structuring the problems are not the same. It should also be noted that in the changing field of service systems, wicked problems and complex issues, such as domestic violence, often risk being overlooked in favour of tasks that are more easily managed and can be limited to the professional's own job description.

What type of solutions could then be found for wicked problems and interplanetary cooperation? Many international studies indicate that training and, optimally, forms of shared and interprofessional training are a significant factor (e.g. Ambuel et al. 2013; Campbell et al. 2001; Minsky-Kelly 2005). In their recent study, Sisko Piippo, Leo Nyqvist and Mari Suonio (2019) looked at the learning diaries of students who participated in the first national online course on encountering domestic violence professionally in social work. The learning took place within four frames, which were professional competence, reflection on experiences, violence-specific boundaries, and a change of attitudes. In terms of professional competence, the reflection on learning focused on improved capabilities for encountering a client who has experienced domestic violence. Reflection on experiences referred to experiences relating to domestic violence that the students themselves or persons close to them had had, but also their professional experience. Violence-specific boundaries referred to the employee's position in terms of the phenomenon of domestic violence and the client. In the area of change of attitudes, the students' personal attitudes, preconceived ideas and changes in these attitudes and ideas were

examined. Piippo et al. (2019) noted how, as one of the changes occurring within the frame of professional competence, the students had developed basic capabilities for encountering domestic violence and helping the victim. The change at the level of attitudes was also an important learning outcome.

Piippo et al. (2019) found e-learning an effective form of teaching, and according to them, it appears that online teaching can be used to develop students' clinical skills, also in relation to a sensitive topic such as domestic violence, even if there is no direct contact with the client and the teacher. These findings are consistent with the findings of round II of our EPRAS survey, according to which 90% of the respondents who had completed the Create trust – Stop the violence training programme fully or in part considered it at least somewhat useful. Of these respondents, 40.7% found the online training programme highly useful. 90% of the respondents also regarded studying as relatively or extremely easy. Consequently, when planned carefully and with specific consideration for the target groups, e-learning can work quite effectively.

5.1. Looking ahead: development, research and training relating to domestic violence in the 2020s

The EPRAS project coordinated by the National Institute for Health and Welfare was carried out in cooperation with the University of Jyväskylä, which was responsible for research and evaluation of the project, and the Police University College. As a key objective and a significant factor, also in terms of evaluating project implementation, emerges interprofessional cooperation, which the project engaged in at all stages, including the building of the project organisation, creation of the training package, research related to evaluation, and the production of information campaigns. Based on international research and practical operating models, as critical points of cooperation may be identified information flows and information sharing, effective institutional practices, organisation and managerial level commitment, finding common goals and a shared language, knowledge of different actors' responsibilities, duties and tasks, as well as mutual respect. (D'Amour et al. 2002; Hall 2005; Inkilä et al. 2013; Petri 2010.)

Preconditions for reaching these goals are not only a genuine connection between the organisations and commitment to shared goals in domestic violence intervention at the management level but also supporting professionals with this sensitive topic that often evokes emotions. It is crucial to provide professionals with training on recognising domestic violence and encountering diverse situations involving violence. Without sufficient awareness of the impacts of violence, it may be difficult to understand the clients' needs (Dichter & Rhodes 2011; Pratt-Eriksson et al. 2014) or the multiple and separate processes that the clients are going through simultaneously and which may affect their behaviour and choices (Nikupeteri 2017; Bacchus et al.

2003). Versatile, continuous and up-to-date training plays a major role in responding to these challenges.

As part of the EPRAS project, an online training programme titled Create trust – Stop the violence was created for social and health care sector professionals and the police. This online training programme is the first training package on domestic violence and interventions in it in Finland that is free of charge, intended for a number of sectors and openly accessible. The training programme is significant, even by international comparison, because of its multidisciplinary approach, the large scope of its content and its accessibility. The project also carried out a civic campaign on encountering domestic violence and shelter services. Additionally, an extensive set of research data on the challenges relating to work on violence, professionals' competence in recognising and intervening in violence, and the enhancement of this competence was collected and analysed.

The project successfully attained its objectives, and the project outcomes lay a foundation for new development and research projects and the further development of training. Preconditions for preventing and intervening in domestic violence include permanence of the developed operating models, up-to-date materials, and an adequate response to changes in the field of interprofessional work on domestic violence. The project contributes to supporting the emphases of the Istanbul Convention on prevention of violence and the obligations related to protecting and helping victims of violence and holding perpetrators accountable for their acts under criminal law. The Convention also requires the signatories to coordinate the fulfilment of the obligations imposed by it. (Action plan for the Istanbul Convention 2018–2021.) In work against domestic violence, the transition to the 2020s will involve plenty of work on many fronts, but also bring new hope. Projects conducted in genuine cooperation that support the operation of organisations in different sectors and professionals' work, such as EPRAS, are important steps on the way towards the common goal of reducing violence.

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Appendix 1.

Domestic violence, interprofessional cooperation and training needs

Welcome to round II of the survey conducted as part of the EU funded **EPRAS*** project. Round I of the survey was conducted in 2018. It is vital that both those who responded on round I and new respondents participate in this survey. We aim to gather as much information as possible on operating practices, cooperation and training relating to domestic violence in the social and health care sector and the police.

In addition to scientific research, this joint project of the National Institute for Health and Welfare, the University of Jyväskylä and the Police University College has developed an online training programme intended for social and health care sector professionals and the police. The responses to this survey are also important for evaluating the accessibility and uptake of training on domestic violence among professionals.

You can respond anonymously, and the data will only be analysed as sufficiently large sets, ensuring that individual respondents cannot be identified. Responding to the survey will take around 10 minutes. Please note that you cannot save the survey without completing it, and you must finish it at a single session.

Privacy notice: The research group of the project ***Enhancing Professional Skills and Raising Awareness on Domestic Violence, Violence against Women and Shelter Services (EPRAS)** consists of researchers from the University of Jyväskylä, the Police University College and the National Institute for Health and Welfare. The research is coordinated by the University of Jyväskylä, where the Head Researcher is Marita Husso, Docent, Senior Lecturer, Department of Social Sciences and Philosophy, tel. +358 40 8054226, marita.husso@jyu.fi No personal data that would make it possible to identify you directly will be collected in this research. The data gathered in the survey and the research findings will be handled confidentially in compliance with the data protection legislation. Scientific publications and theses will be published as outcomes of the research project. Identifying the respondents' data in the findings, reports or publications associated with this research will not be possible. Address of the University of Jyväskylä: Seminaarinkatu 15, P.O. Box 35, 40014 University of Jyväskylä. Exchange (+358 14) 260 1211, business ID 0245894-7. Data protection officers at the University of Jyväskylä: tietosuoja@jyu.fi tel. +358 40 805 3297. For more information on data subjects' rights, visit: https://www.jyu.fi /fi/yliopisto/tietosuojailmoitus/rekisteroidyn-oikeudet

1. Your current sector *

- ☐ social welfare
- ☐ health care
- ☐ police
- ○ other, please specify _____

2. Your current employer *

- [ ] municipality, city or joint municipal authority
- [ ] government or government agency
- [ ] third sector actor (NGO)
- [ ] private actor (company)
- ◯ other, please specify _____

3. Your current occupation *

- [ ] dental nurse
- [ ] practical nurse
- ◯ physician
- [ ] counsellor (social, service, client or other similar counsellor)
- [ ] police officer
- [ ] psychologist
- [ ] nurse
- [ ] social worker
- ◯ other, please specify _____

4. For how long have you worked in your current occupation? *

Round up your answer to the nearest full year. Please note that the question concerns working in your profession, regardless of whether or not your tasks have changed during this time.

- [ ] less than a year
- [ ] 1 to 5 years
- [ ] 6 to 10 years
- [ ] 11 to 20 years
- ◯ over 20 years

5. Your year of birth *

6. Your gender *

- [ ] Woman
- [ ] Man
- ◯ No answer

7. Highest qualification you have completed*

- [ ] Doctorate or licentiate
- ◯ Master's degree
- [ ] Bachelor's degree
- [ ] Master's degree (University of applied sciences)
- [ ] Bachelor's degree (University of applied sciences)
- [ ] Vocational qualification, further qualification or specialist qualification
- [ ] Matriculation examination
- ◯ Other, please specify _____

8. Did you respond to the earlier survey of the EPRAS project in 2018 ('Domestic violence, interprofessional cooperation and training needs')? *

- [ ] Yes
- [ ] No
- [ ] Do not know/Cannot remember

9. Have you completed the online training programme 'Create trust – Stop the violence'? *

- [ ] Yes, in full
- [ ] Yes, in part
- [ ] No

10. How useful did you find the 'Create trust – Stop the violence' programme in terms of your professional competence? *

1 No use	2 Little use	3 Somewhat useful	4 Very useful	Don't know
◯	◯	◯	◯	◯

11. How versatile did you find the contents of the 'Create trust – Stop the violence' online training programme? *

1 Not at all versatile	2 Not sufficiently versatile	3 Sufficiently versatile	4 Highly versatile	Don't know
○	○	○	○	○

12. How easy did you find it to study in the 'Create trust – Stop the violence' online training programme? *

1 Not at all easy	2 Not particularly easy	3 Quite easy	4 Very easy	Don't know
○	○	○	○	○

13. Should you wish, you can use this field to tell us about your thoughts of the online training programme 'Create trust – Stop the violence', for example concerning your learning, the training material and the ease of studying.

14. Please list everything that you consider to be in close relationships. *

2000 characters remaining

15. How often do you deal with tasks involving domestic violence in your work? *

- ☐ Daily
- ☐ Weekly
- ☐ Once or twice a month
- ☐ Less often than once a month
- ☐ Never

16. Estimate the total duration of training on domestic violence you have received in your current profession. Select among the following options the ones that best describe the scope and duration of the training you received. *

	I have had no training on domestic violence	Individual lectures of a few hours or similar	Training events, seminars or similar of a day or two	More extensive courses, study modules or similar
As part of the degree programme *	☐	☐	☐	☐
During continuing education or in-service training *	☐	☐	☐	☐
In other than degree or continuing education or in-service training *	☐	☐	☐	☐

17. Do you use the following tools developed for asking about domestic violence and mapping experiences of violence in your work? You may choose one or more options. *

- ☐ Personal safety plan
- ☐ Form for mapping harassment and stalking
- ☐ Screening and mapping form for domestic violence
- ☐ Assault and body map form (PAKE)
- ☐ Acute assistance for a rape victim folder (RAP-folder)
- ☐ Risk assessment form (MARAC)
- ☐ Check list for asking about violence
- ☐ Other form/tool developed in my organisation, please specify _____
- ☐ Something else, please specify _____
- ☐ I do not use any tools for mapping domestic violence

18. How much knowledge do you have about*

	1 None	2 Not much	3 Good knowledge	4 Excellent knowledge	Don't know
forms of domestic violence occurring in the population, including special groups (such as sexual minorities, ethnic and cultural minorities and older persons)?	☐	☐	☐	☐	☐
norms applicable to domestic violence that guide your work, including legislation, regulations and operating instructions?	☐	☐	☐	☐	☐
tools for recognising domestic violence, including risk assessment and mapping forms?	☐	☐	☐	☐	☐
actors relevant to domestic violence in your area (authorities, providers of support and services)?	☐	☐	☐	☐	☐

19. What level of skills do you have in

*

	1 None	2 Not much	3 Good skills	4 Excellent skills	Don't know
recognising different forms of domestic violence in your tasks?	☐	☐	☐	☐	☐
applying the legislation, regulations and operating instructions on domestic violence in your work?	☐	☐	☐	☐	☐
using the tools and methods related to domestic violence?	☐	☐	☐	☐	☐
working together with other actors relevant to domestic violence?	☐	☐	☐	☐	☐

20. In terms of your work, how interested are you in *

	1 Not interested	2 Slightly interest	3 Quite interested	4 Highly interested	Don't know
recognising the forms in which domestic violence occurs in different population groups?	☐	☐	☐	☐	☐
applying legislation, regulations and operating instructions relating to domestic violence?	☐	☐	☐	☐	☐
using tools and methods relevant to domestic violence, including risk assessment and mapping forms?	☐	☐	☐	☐	☐
working together with other actors relevant to domestic violence?	☐	☐	☐	☐	☐

21. To what extent do you agree or disagree with the following statements about domestic violence? *

	1 Fully disagree	2 Somewhat disagree	3 Somewhat agree	4 Fully agree	Don't know
I find that intervening in domestic violence is an important part of my work.	☐	☐	☐	☐	☐
I find it difficult to ask a client about domestic violence.	☐	☐	☐	☐	☐
I find that violence in an intimate relationship is a private matter between the partners.	☐	☐	☐	☐	☐
The victim of domestic violence often is partly to blame for the violence.	☐	☐	☐	☐	☐
Domestic violence leaves the victim feeling powerless, which may make seeking and accepting help difficult.	☐	☐	☐	☐	☐
If the victim of domestic violence does not leave a violent relationship, he/she are themselves responsible for the continuation of the violence.	☐	☐	☐	☐	☐
I find it difficult to understand why the victim stays in a violent intimate relationship.	☐	☐	☐	☐	☐
Violence against children is often overshadowed by violence between adults.	☐	☐	☐	☐	☐

22. Have you directed your clients to other actors' services because of domestic violence? You may choose one or more options. *

- [ ] Health centre of physician
- [ ] Social services (for example, family counselling clinic, emergency social services, child welfare)
- [ ] Police investigation
- [ ] Shelter
- [ ] Other services, which _____
- [ ] I have not directed clients to other services

23. Why have you not directed clients to a shelter? You may choose one or more options. *

- [ ] I do not know in what situations I can direct my client to a shelter
- [ ] I find that directing clients to a shelter is a task for some other actor, which _____
- [ ] I work in a shelter
- [ ] Other reason, please specify _____
- [ ] Cannot say

24. In proportion to the other tasks, how much importance do the following in your organisation attach to intervention in domestic violence? *

	1 None	2 A little	3 Quite a lot	4 A great deal	Don't know
Top management	☐	☐	☐	☐	☐
My immediate superior	☐	☐	☐	☐	☐
My closest colleagues	☐	☐	☐	☐	☐

25. Do you feel you need more training on domestic violence from the perspective of your work? *

- [ ] No
- ◯ Yes

26. Should you wish, you may provide here more information about your wishes concerning training on domestic violence and issues related to practical work or give your comments on this survey.

Appendix 2.

Enhancing Professional Skills and Raising Awareness on Domestic Violence, Violence against Women and Shelter Services (EPRAS)

FRAMEWORK FOR FOCUS GROUP INTERVIEWS

In the group interview, the following themes are discussed under the guidance of one or two researchers, with 4 to 8 participants in each group. The interview themes will be used as a guideline for the discussion.

At the beginning, background information will be collected from the participants:

What professional qualifications do you have, in which different fields? For how long have you been working in your current professions; do you have any previous work experience in other sectors?

1. Encountering domestic violence in the interviewees' professions

How do you define domestic violence in your work, what does it contain, and what meanings do the different concepts have? In what way is domestic violence relevant to your work? How often and in what ways do you come across it? What forms of domestic violence do you encounter? What are your experiences of the challenges and possibilities of work on domestic violence in your tasks? What thoughts and emotions does the domestic violence you encounter in your work evoke in you? What work practices and instructions do you have for situations involving domestic violence? Do you find that the support and instructions provided by your work community and organisation for encountering domestic violence are sufficient?

2. Training on domestic violence in education programme and during the career

Did you receive training relating to domestic violence in the education programme for your profession? Have you received other training relating to domestic violence (for example as in-service training)? If you have, what was it like (duration, organiser, voluntary/mandatory)? Have you participated in interprofessional training? What experiences do you have of participating in training (benefits, disadvantages)?

3. Training needs relating to domestic violence

What wishes and needs do you have concerning training on domestic violence? What should the training contain; which issues are particularly important in your sector and organisation? How should the training be implemented (contact teaching, online courses etc.)?

4. Domestic violence and interprofessional cooperation

Which other occupational groups and actors have you cooperated with in the context of work on domestic violence? Which challenges and good practices have you come across in this cooperation? Which factors facilitate or hinder effective cooperation?

5. Three wishes to a good fairy: this would be the best way of intervening in domestic violence in our work

If you could have three work-related wishes fulfilled by a good fairy, which are the key aspects that would help to optimally resolve the issues relating to domestic violence?

Appendix 3.

EPRAS PROJECT (Enhancing Professional Skills and Raising Awareness on Domestic Violence, Violence against Women and Shelter Services)

Framework for interviews with shelter clients

1. BACKGROUND

Could you tell us something about your background; what age are you, and if you are working or studying? Do you live in the country or in a city? What types of intimate relationships/what type of a family do you have?

2. IDEAS ABOUT THE SHELTER

What kind of an image did you have of the shelter before you arrived? What did you think about the shelter as a place and its physical facilities? What information did you have about coming to a shelter; for example, who did you think the service was intended for (how was the form or severity of violence defined)? Did you wonder about what staying at the shelter would cost or how it would be paid for? What did you think about shelter clients before you became a client yourself (ages, backgrounds, family situations)? What did you think about the personnel at the shelter (educational background)? What were you thoughts about what happens at the shelter or what the atmosphere there is like? And now that you have been a client of a shelter, would you say your experience matches your preconceived ideas?

3. ACCESSING SHELTER SERVICES

Could you describe the situation in which you came to the shelter? What type of violence or threat of violence did you experience? Was accessing the shelter easy? Where did you find information about shelter services? How did you decide to come to the shelter, on whose initiative did you come? Did you think getting to the shelter was easy or difficult? How and where did you hear about the shelter for the first time? Where did you look for additional information, and was finding it easy? Which form was the information offered in? Which form would you have preferred to get it in (videos, images, text etc.)? Was the information clear, or was it incoherent? Which factors influenced your decision to go to the shelter? Which factors facilitated your decisions, and which obstructed it? What would have speeded up your decision to go to the shelter? Do you find that you came to the shelter at the right time?

4. ASKING ABOUT AND RECOGNISING DOMESTIC VIOLENCE OUTSIDE THE SHELTER

If we think of being asked about violence, what are your experiences of it? Have professionals outside the shelter asked you about domestic violence? If yes, who were they/in which sector did they work? Have you come across situations in which a professional did not wish to talk about the issue? If you have experiences of this, who/which party should have asked you about violence, in what situation and how? What kind of service experiences do you have, did you feel that you were understood? Has somebody else, including a friend, a relation or a neighbour, asked you about the violence?

5. INTERPROFESSIONAL COOPERATION FROM THE CLIENT'S PERSPECTIVE

What experiences do you have of well-functioning support and help? In your experience, how does cooperation between different professional groups and actors (social work, health care, the police etc.) work in issues relating to domestic violence?

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