

Developing Better Services for Intimate Partner Violence: Hearing the Voice of Disabled People

Sisko Piippo

Department of Social Sciences, University of Eastern Finland, P.O. Box 1627, Kuopio FI-70211, Finland

Abstract: This article deals with collaborative development work between the public sector and the third sector in an area of Southern Savo, Finland, from the perspective of disabled victims. The purpose was to create structures for IPV (intimate partner violence) work, developing professionals' skills in both tackling IPV and service-user involvement. Five NGOs (non-governmental organizations) for disabled people were involved. Professionals were trained to ask about IPV and to gain more in-depth understanding of the issue (including the special features relating to disabled people) and of how to intervene. Care pathways, linking both basic and special services, were also modeled. A permanent and regional NEIPV (Network of Excellence in IPV) was established and is coordinated by both the public and third sectors, including Experts by Experience. Strong basic structures and care pathways are needed so that the special needs of disabled people can be recognized. Raising awareness of violence, routine enquiries modified according to the needs of organizations, and simple care pathways are needed—both in the public sector and for NGOs representing the disabled. Information gained through training will not necessarily be transferred into direct practice without a strong commitment from the managerial level. Establishing organizational guidelines is necessary. This will also promote professionals' openness toward user knowledge.

Key words: Disabled people, IPV, public services, service-user involvement, Experts by Experience.

1. Introduction

IPV¹ (intimate partner violence) is a world-wide problem and is also seen as a fundamental violation of the victims' human rights [1]. As a marginal group, people with a disability are particularly vulnerable to IPV. The concept of disabled people refers to the definition by the United Nations: those humans with “long-term physical, mental, intellectual or sensory impairments which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others” [2]. The term is used in this paper as it also refers to the social and structural dimensions of disability and includes the view that people may also be disabled by society [3].

Intervening in IPV in public-sector social and

health care is a very complex issue. IPV services have mainly been provided by NGOs (non-governmental organizations). In general, the prevalence of systematic IPV screening is low [3-5]. Barriers were associated with workers' attitudes (e.g. [6]) or with a lack of organizational guidelines in IPV cases, inadequate training, and a lack of understanding regarding IPV (e.g. [7]).

Some experiences of co-training between different IPV agencies have been reported [8] but there are only a few reports of wider, long-term, structural, and collaborative development work between the third sector and public sector. Neither is there much research around the theme of involving service users when developing interventions. Some papers deal with tackling IPV in the context of disabled people (e.g. [9]), but a clear gap also exists on this issue.

In Finland, innovative development work between the public and third sectors was launched between 2014 and 2017 in the form of two projects. The VÄISTÖ Project (2014-2015) originated from the

Corresponding author: Sisko Piippo, MSocSc, University teacher in social work, research fields: social work expertise, intimate partner violence.

¹ IPV refers to the abuse that occurs in close relationships [1]. Additionally, the terms “domestic violence” and “abuse” are used. In this article, we use the term “IPV”.

public sector (see the evaluation report in Ref. [10]). The SAUMURI Project (2014-2017) is coordinated by an NGO called VIOLA—Free from Violence². The basis of co-development work was in developing IPV services from the perspective of both non-disabled and disabled people. To promote a contribution from disabled people, five pilot NGOs for disabled people were involved.

The purpose of the development work was to create structures for regional IPV work and to develop professionals' skills. This consists of raising awareness and developing professionals' skills in recognizing and asking about violence, building referral pathways in organizations, and creating regional, networked, multi-professional structures for the work. As an essential part, Experts by Experience (adult survivors of IPV, service users) were involved. However, this article focused on a part of our development work: a two-level training model targeted both at the public health and social care sector and the third sector.

During the first-level training, approximately 1,700 professionals in health and social care, in early child care, and primary care were trained systematically to recognize abuse and ask about IPV, and then to refer the affected individuals to a designated person. The NGOs were also included.

For the second level of training, over 100 professionals were trained to work in more depth with victims, after IPV had been recognized and asked about, and the victim had been referred to them. Training was conducted as four interactive workshops with writing tasks between modules. As a part of the training, the participants also modeled referral pathways in various organizations. After training, they

were more able to explore victims' service needs and make appropriate referrals to the specialized services.

This two-level model covers both recognizing and asking about IPV as a preventive intervention as well as more in-depth work with victims after IPV has been recognized and asked about. Experts by Experience were involved in designing, educating, and evaluating collaborative educational work with the public sector. We have also paid special attention to disabled people, because, as a very vulnerable group, their role is very weak in the service system (e.g. [11]).

Consequently, a multi-professional NEIPV (Network of Excellence in IPV) was established. It consists of professionals in both the public and third sectors. To ensure collaborative work in the future, the network is coordinated by both the public sector and the third sector. In this article, we first describe the international and national context of the issue. Then we describe: (a) our two-level training system; (b) what our NEIPV is in the area; and (c) how service users, including disabled people, were involved in the development and educational work.

2. IPV and Disabled People

IPV is a severe and global problem that has effects on humans and their well-being, regardless of race, economic status, sexual orientation, religion, or nationality. Internationally, in the United States, every year about 4.7 million women report intimate partner victimization [12]. In the EU, one in three women (33%) have experienced physical and/or sexual violence since she was 15 years old [13].

IPV causes significant economic costs. According to the European Institute for Gender Equality [14], the cost of IPV to the EU was EUR 122,177,800,785 of which EUR 109,125,574,091 was the cost of IPV against women. It is also important to bear in mind that in addition to these major financial costs (like special services in child care, child custody, psychiatric care, hospitalization), the human costs and suffering are unmeasurable.

² VIOLA—Free from Violence is a regional unit that offers services for people encountering violence in their close relationships. Services include counseling and individual and group therapy for women, men, and children. VIOLA also aims to strengthen regional collaboration and coordination to prevent and eliminate violence in close relationships. Thus, VIOLA offers consultations and supervision to the authorities and constantly develops new, effective methods suitable for use in the field (www.violary.fi/in-english).

As a marginal group, people with a disability are particularly vulnerable. Disability is by no means a protective element against domestic violence, instead it reduces women's physical and mental defenses, and thus the risk of being abused is even greater among disabled women compared to non-disabled women [15]. The risk is also heightened among men with disabilities [16]. The risk of victimization is much higher among disabled adults, with a particularly high risk for children with disabilities and for those adults with a mental health disability [17]. Disabled women reported the same kinds of violence as their non-disabled counterparts did, but specific forms of violence exist relating to their injuries and to institutional forms of violence by their carers or assistants [18]. Sin et al. [19] state in their study that "forced intake of medication and excessive use of physical force in custodial and hospital settings have been reported by people with mental health conditions."

Several barriers exist when it comes to getting help as a disabled victim of IPV. As Oswald and Powers [20] see it, the vulnerability of persons with disabilities can be explained by their dependence on other people for their long-term care, by the abusers having a lower risk of getting caught (e.g. when assistants act violently toward their clients), by the victim lacking believability, and by the victims' lack of sexual education. The victims may be treated as asexuals, and the attitudes on disability regarding to the disabled persons' ability to protect themselves, and denial of the disabled persons' human rights also add to their vulnerability. In addition, the capacity of professionals in understanding disability is poor. The position disabled people hold is weak in terms of the service system when attempting to get help as a victim of domestic violence [11].

What is more, disabled people may not be aware of their own rights and sexual boundaries, as they may think, for instance, that the abusive behavior of their assistant is normal care practice, and neither are they

informed about how to get help or who they should contact [18].

3. The Situation in Finland

Finland is an example of a Nordic welfare state, where equality and the equalization of people's circumstances are essential issues [21]. As an EU member, Finland ratified the Istanbul Convention on Preventing and Combating Violence against Women and Domestic Violence in 2015. This convention is the first international, European-level convention to tackle this issue. In addition, the Social Welfare Act in Finland highlights citizens' equal access to services, as well as the municipalities' responsibility to collect users' experiences from the service system and organize specialized services for victims of domestic violence. The necessary services and support, as well as equality and participation, are the principles of Finnish disability policy, and disability services are stipulated in the Disability Service Act and in the Law of Intellectual Disability.

However, like in other countries, there have been various challenges in Finland when it comes to tackling this multi-dimensional problem, whether IPV is seen as a problem for disabled or for non-disabled people. To date, IPV services have been scattered and provided mainly by NGOs. Municipalities lack equal services for the victims of IPV.

A domestic violence enquiry and assessment form has been developed by the National Institute of Social Welfare and Health, but the need to spread its use still exists. According to the Family Murder Report [22], violence is not asked about in the service system. There are various reasons behind this finding. As can be seen from the multi-disciplinary frame analysis by Husso and her colleagues [23], limited skills in recognizing and in asking about IPV were reported. Social and health care staff found the issue very important, but for them, it was the task and duty of "someone else". Professionals do not necessarily have information about local IPV services, which limits

making appropriate referrals. Neither were there clear care pathways in organizations [23].

As an example of development work carried out in the field of public services, experiences of emergency care regarding women victims have been explored [24]. A large public-sector project called VISH aimed at developing IPV interventions in specialist health care from 2009-2010; however, practices varied widely across municipalities or health or social care units [23]. Besides public services, the third sector provides IPV services in Finland, but there are no research reports regarding this kind of collaboration. Neither is there much research information on IPV in the context of disabled people or on involving service users in IPV service-development processes.

4. An Example of Innovative Development Work

The purpose of this development work was both to create structures for IPV work and to develop professionals' skills in tackling IPV. Experiences of earlier development work (e.g. the VISH intervention in special health care, see [23]) were utilized. Work was carried out in an area of Southern Savo in Finland. The SAUMURI Project from the third sector was funded by the Funding Centre of Social Welfare and

Health Organizations (STEA). The VÄISTÖ Project from the public sector was a part of the National Development Plan for Social Welfare and Health Care (the KASTE Program), funded by the Ministry of Social Affairs and Health. In addition to the VIOLA—Free from Violence Unit, five pilot NGOs for disabled people were involved as a pilot for the development work. The collaboration between the third sector, the public sector, and Experts by Experience is illustrated below in Table 1.

The aims of this collaboration can be crystalized as follows:

- (1) Developing
 - skills of professionals in asking about violence and
 - organizational structures for care pathways;
- (2) Involving
 - the knowledge and experiences of service users including disabled people in the shared development work of the third and public sectors;
- (3) Creating
 - a permanent, regional network of workers around IPV.

From the perspective of disabled people, to develop better IPV services, we found it important to focus on both their own organizations and on the public sector.

Table 1 Partners in shared development work.

	Participants	Special contribution to the development work
Public sector	Social and health care, also including shelter	Defining and legitimizing roles and structures and coordination for public IPV work
Third sector	<i>VIOLA—Free from Violence</i> Professional and specialized help for people who have experienced IPV <i>Mikkelin Seudun Invalidity</i> Invalid people in Mikkeli <i>The Alzheimer Society of Mikkeli Area</i> People with Alzheimer's disease <i>The Finnish Deafblind Association</i> Deaf-blind people <i>The Finnish Association of the Deaf</i> Deaf and sign language users <i>VIRIKE ry</i> People with substance use and mental health problems	Professional knowledge about IPV A channel to capture and involve disabled people and other service users
Experts by Experience	The group of adult survivors of IPV consisting of both disabled and non-disabled people, including clients, students, and professionals from social and health care and early child care	Experiences and experimental knowledge about violence and getting help, knowledge about gaps in the service system

First, it is essential to increase understanding about IPV in their own NGOs so that they can educate their members about IPV. Second, at the same time, it is vital to increase understanding about the special features of IPV among the professionals in the public sector.

5. Two-Level Training Program

The target groups were personnel in public social work, health care, student care, primary care, and early child care, as well as five organizations for disabled persons (NGOs). Also social and health care students in Kymenlaakso University of Applied Science (XAMK) were trained in Level 1. The first

level of the program is presented in Table 2.

After this first-level training, the participants' willingness to continue to the second level was explored. Those who wanted to develop their skills more and take a more active role as a developer in their organizations were recruited to the training for IPVKPs (key persons of intimate partner violence). The managers were committed and they informed their personnel that they saw training as very important. At this stage, workers in the public-sector project negotiated actively with the managers of social and health care to legitimize the work of IPVKPs so that their work in the future would be written into their job descriptions.

Table 2 The first level: recognizing abuse and how to ask about IPV (1/2015-present).

Aim	Increasing understanding about IPV and giving tools to ask about IPV.
Number of trained persons	Approximately 1,700.
Responsibility of organizing	Until 10/2015, training was mainly conducted by the VÄISTÖ Project that originated from the public sector. After that, the SAUMURI Project from the third sector organized the training.
Methods	Lectures and practical exercises on how to ask about IPV.
Educators	Qualified social worker (MSocSc), Qualified social worker (MSocSc, University Teacher), Psychotherapist VET (of a demanding special level), and Psychotherapist.
Content	IPV as a phenomenon and how to use the domestic violence enquiry and assessment form ³ ; 2-3h/per session.

Table 3 The second level: IPVKP (1/2015-present).

Aim	<ul style="list-style-type: none"> • Gaining a more in-depth understanding about the phenomenon of violence (also paying attention to the special features if the victim was a disabled person). • How to model the care pathways in their own organizations. • Being able to train their staff in the future to recognize abuse and how to ask about IPV.
Number of trained persons	A total of 104 trained professionals.
Responsibility of organizing	The first 54 IPVKPs were educated in collaboration with the VÄISTÖ Project that originated from the public sector. After that, the SAUMURI Project was the main educator.
Methods	Lectures and drama (such as the Forum Theatre) as a participative teaching technique was widely utilized, as well as service-user experiences as case examples.
Educators	Educating team: <ul style="list-style-type: none"> • Qualified social worker (MSocSc), • Qualified social worker (MSocSc, University Teacher), • Psychotherapist VET (of a demanding special level), • Psychotherapist, • As a representative of people with disabilities, worked in a project also as a deaf part-time worker (Master of Education), and • Experts by Experience.
Content	Described in Table 4.

³ The form was developed by the National Institute for Health and Welfare. See the form at: http://www.thl.fi/attachments/kasvunkumppanit/vakivalta/THL_lahisuhdevakivalta_lomake_ENG.pdf.

Table 4 The content of the IPVKP training.

Workshops (3-4 h)	The role of Experts by Experience
Workshop 1: "Getting in touch with the reality I: The story of the service user" <ul style="list-style-type: none"> • Deeper understanding about IPV • Case-based teaching • Starting to model care pathways 	They told their story, which was the case and the basis of the group work, where participants started to model care pathways. Educators brought the view of disabled people into discussions. Experts by Experience reflected and commented on care pathways from the basis of their own experiences as victims.
Workshop 2: "Tools and methods in IPVwork" <ul style="list-style-type: none"> • Domestic violence enquiry and assessment form • Safety plan and • MARAC risk-assessment form⁴ 	The participants commented on the tools, and whether they were client-friendly and suitable for disabled people.
Workshop 3: "Getting in touch with the reality II: The Forum Theatre" <ul style="list-style-type: none"> • Case-based teaching: From the basis of victims' experiences, educators construct various short (2-4 min) plays • Generating ideas for solutions • Reflective dialogues • Care pathways 	The stories for the plays were gathered from the victims. The view of disabled people was included. For instance, the following situation was played out: a deaf woman, abused by her spouse, meets a doctor who ignores the violence experience. Also, substance abuse and mental health problems were included.
Workshop 4 was integrated into regional training events for the public sector, third sector, and service users/Experts by Experience to promote networking .	They gave speeches based on different themes such as examples of good experiences from the service system.

The IPVKP training was planned within the framework of experimental learning [25]⁴ with features of problem-based learning, too. In an earlier study [26], theatrical performances were seen as an engaging way to present sensitive topics such as IPV. Accordingly, in addition to the traditional lectures, participative drama-based teaching techniques such as the Forum Theatre (previously used in this context by [26, 27]) and case examples were used. The content of the training is described in Table 4.

A total of 104 professionals completed this second level. The majority (83) were workers in social care or in health care. Twenty-one were from the third sector.

In the first group in 2015, there were only social and health care workers (total 54 persons). In autumn 2015, the training program was piloted in the third sector, when five disabled peoples' organizations (10 persons) were trained. A separate group was organized for them because we wanted to test whether the training was suitable for NGOs and what their development needs would be. After a preliminary evaluation, mixing the groups that were already in training was, in many regards, found to be a better way to promote

networking and the professionals' consciousness of the third sector. Accordingly, the spring 2016 group consisted of both public-sector and third-sector professionals. In the autumn 2016 group, there were also five professionals from the field of student care.

During 2017, the third level (the so-called Training for Trainers) of this program will be piloted. The aim of this level is to educate persons to train new IPVKPs in units.

The evaluation of this training program has not yet been completed. After every session, feedback was collected. In addition, a more in-depth questionnaire as a small-scale study ($n = 42$) seeking both quantitative and qualitative data was conducted [28]. As a preliminary result, 60% of respondents agreed totally and 39% agreed partly with the statement "Training is useful for me from the perspective of my work." Almost 80% reported that their viewpoints on IPV changed during training. They identified the changes as follows: changes in attitudes, a broader understanding about the network, the phenomenon of IPV, and tools with which they work with victims (see more details in Ref. [28]).

6. The NEIPV in an Area of Southern Savo

Each participant on our second-level education

⁴The MARAC (Multi Agency Risk Assessment Conference) is a multi-agency victim-focused meeting for the highest risk cases.

program joined the larger structure that was built in the area through these two projects. This multi-professional network consists of both authorities and workers from the third sector and the church. Over two years, various network activities were organized. For instance, an educational event regarding abuse and its effects on children from the perspective of child psychiatry was organized in collaboration with Kymenlaakso University of Applied Sciences (XAMK) and SAUMURI Project. Almost 200 professionals and students participated. In addition, education was organized under the theme of IPV and how to cope with stressful work. A more focused, longer-term co-training process including care pathway modeling for child care, shelter, and VIOLA—Free from Violence was also organized by SAUMURI.VÄISTÖ Project organized trainings regarding working with child and abusers, e.g., a website to act as a portal for connecting network partners in the area will be established, too.

This networked structure ensures the development of IPV work in this sparsely populated area. This network needs coordination to integrate different activities and also to ensure the development of regional IPV work in the future. For example, currently, the coordination of the NEIPV is multi-dimensional, which aims at participation, partnership, and cost effectiveness in nurturing, disseminating, and further developing the projects' results.

First, the NEIPV is overseen by a steering group with representatives from both the public and third sectors. The role of the group relates to strategic oversight, decision making, advising, and guiding. For example, even if the members are mainly managerial-level workers, an Expert by Experience is also a member.

Second, there are two coordinators. The public-sector coordinator is responsible for nurturing and further developing IPV work in the social and health care units, and also works as a pair in very

demanding cases. The main responsibility of the *third-sector coordinator* lies in disseminating professional knowledge regarding IPV, service-user involvement, and the special needs of people with disabilities, as well as peer groups and the development of IPV [10].

Third, on a practical level, IPVKPs are in a central role in their working units where it comes down to training personnel and keeping IPV as a visible, important issue in their units.

7. How Were Service Users Involved?

7.1 DG (The Developer Group)

Shared development work with public services started in 2014. Before finishing the planning work and starting the training for professionals and for five NGOs for disabled people, there was a clear need to gather information about service users' experiences as IPV victims. Naturally, experiences of not getting help from social and health care were important in showing the dead space in the service system. However, perhaps more valuable were experiences of good care, because they can be developed and spread as good practices. The project personnel also wanted participants to be involved in the entire training process, so the participants were informed of the possibility of them assisting the main educators in the training sessions.

The group was not therapeutic in nature, even though the dimension of peer support existed. A project worker with the educational background of a psychotherapist participated as a facilitator and wanted to emphasize their roles as participants in shared IPV-development work. Accordingly, the group was named the "DG". Naturally, Experts by Experience were the core of the group. Professionals from social and health care who were interested in the phenomenon of IPV and wanted to develop more client-focused services also participated. As we can see from Fig. 1, there were several levels of participation and members were free to express their

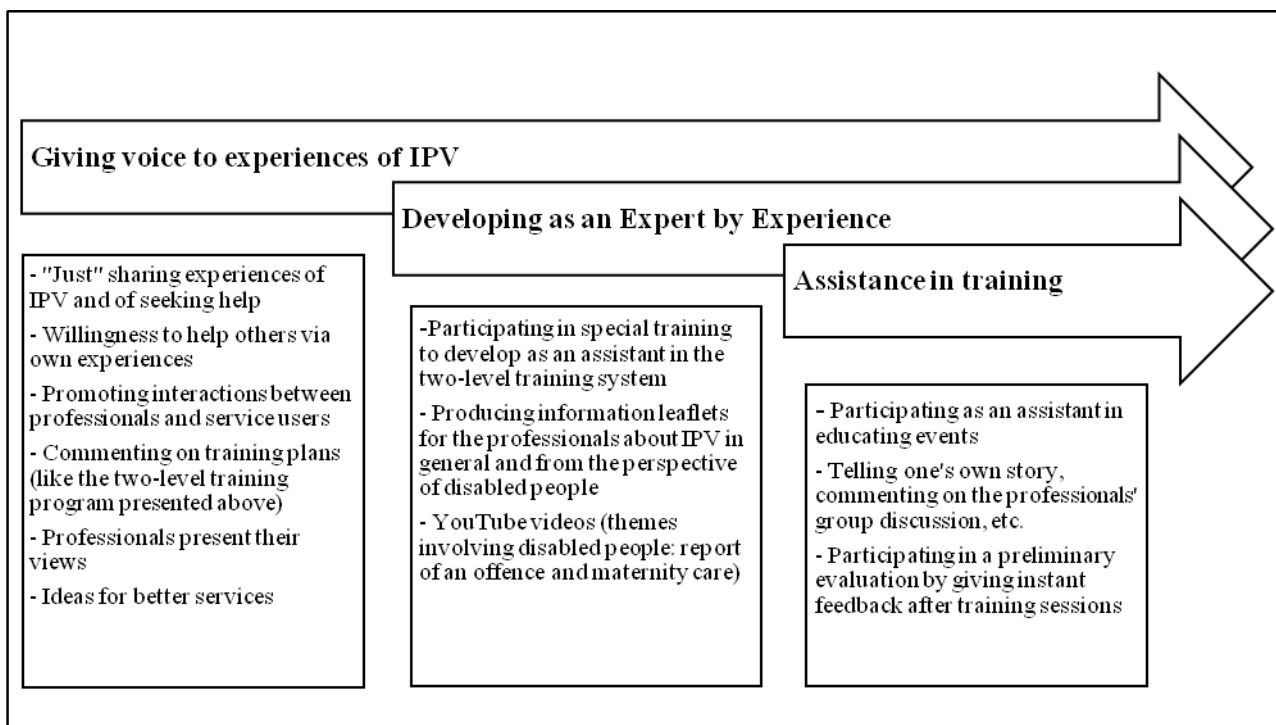


Fig. 1 The levels of participation in DG.

ideas around IPV without feeling pressured or being personalized as Experts by Experience.

For those who wanted to develop as Experts by Experience, special training was in place to prepare them for the educating sessions. Also, after every educating session where Experts by Experience had participated, educators organized a short debriefing session where the Experts by Experience voiced their thoughts. Supervising the work was also organized. Some participants wanted to specialize in material production. These groups were very productive. For instance, two informative videos and information leaflets for authorities in the context of disabled people and IPV were completed. All in all, the focus was on participative development work. Over two years, the group involved 62 participants. Meetings were held approximately once per month. The methods used for group leading were the learning café, literature therapy, and drama methods [29].

7.2 Stages of Launching DG

(1) Informing clients: In addition to the

representatives of five cooperative NGOs for disabled people, the first members were invited from volunteer workers and clients of VIOLA—Free from Violence and social and health care in Mikkeli.

(2) Non-focused group: The first group meetings were launched as open events without a clear focus and with the idea of exploring experiences and gathering information for more specific work. Group members were free to discuss any issues that they found interesting around the IPV topic.

(3) Focused group: According to the themes that arose from non-focused group sessions, some thematic group sessions such as “Severe Violence” and “The Professional Power” were conducted as closed and focused events. At this stage, professionals from public social and health care also participated. If necessary regarding safety issues, the group could also be closed and conducted on the basis of invitations. Groups also focused on material production. They produced two YouTube videos about the special features of IPV and disabled people under the themes “Report of an offence” and “Maternity care”.

(4) Training for Experts by Experience: Those who wanted to assist in training sessions and develop, for instance, as educators in telling their story, were offered an opportunity to participate in a special training period. Eight persons completed this training in 2016.

(5) Representatives of DG melded as a part of the NEIPV and its steering group as a channel for service-user involvement in regional IPV work [29].

8. Discussion

This article presented collaborative IPV-development work between the public and third sectors. The article is an overview on conducting work from the perspective of disabled people. Development work was launched through two projects: one from the public sector (VÄISTÖ) and one from the third sector (SAUMURI). As can be seen from the evaluation report of the VÄISTÖ project [10], the role of the public sector has been essential in enabling the creation of structures in public services. For instance, in the public sector, work as an IPVKP is added to job descriptions so that time is allocated for the work. The role of the third-sector project was in involving professional knowledge from IPV organizations and knowledge of service users in this development work. Project SAUMURI is still on-going; however, some conclusions can be drawn.

8.1 Lessons Learned

8.1.1 Strong structures in public-sector IPV work are needed so that the voices of disabled people can be heard

A significant structure to promote IPV interventions has been launched. In the training program, the focus was not only on educating personnel about the phenomenon of IPV. Instead, we highlighted system changes such as referral pathways around IPV, which is mentioned as essential when aiming to bring about improvements in services [30]. A channel was modeled regarding how to involve Experts by

Experience in this training program in terms of planning, educating, and preliminary evaluations.

This collaborative work was also a powerful opportunity for disabled people to be heard in the service system and to participate. Asking about IPV and having knowledge regarding referrals should be routine in organizations, just as care pathways for substance abusers already exist. These routines are also prerequisites for disabled victims to get help.

8.1.2 The importance of both levels in the two-level training program

The levels of the two-level training system complete each other. The first level deals with routinizing asking about IPV: It emphasizes recognizing and asking about IPV among all basic-level workers in social and health care, early child care, and student care. Thus, there is also a preventive dimension. However, as presented in previous studies [30], raising awareness and developing one's understanding is not enough, because this new knowledge gained from training is not necessarily always transferred to direct practice. That is why we found this second level of training crucial, because together with the first level, it is a part of the IPV referral pathway. After IPV has been asked about, there are designated persons in units for basic-level workers to refer victims to, or with whom basic-level workers can co-operate during demanding cases. The personnel are more likely to ask about IPV if referral guidelines and a relevant structure exist in their organization [5]. However, designated IPV persons are only relevant if IPV is recognized and asked about at a basic level. Otherwise, there will be no referrals to the designated IPV persons.

8.1.3 Establishing the coordination of the NEIPV

The coordination levels of the network are the steering group, coordinators in both the public sector and third sector, and IPVKPs in organizations. This non-centralized, more open model of coordination has strengths: It is a cost-effective way to organize coordination and it is not so vulnerable to

coordination being reliant solely on one coordinator [10]. However, the roles of both coordinators are essential and these posts should be established. Currently, the public-sector coordinator is a part-time job position melded on a supervising-level social worker's post. The question remains that a part-time post may not be reasonable to fully enable the duties involved.

8.1.4 The meaning of increasing public awareness and understanding about IPV in the disabled peoples' organizations

Raising awareness in disabled peoples' organizations was found to be very important but challenging, and the barriers were partly the same as in the public sector. However, some special features exist. There were several signs that IPV may be an even more invisible problem in their own communities than it is among non-disabled people. A psychotherapist working with deaf-blind people described it as follows: "What will happen when the sleeping bearwakes up?" She considered the consequences of breaking the taboo, of increasing awareness, when disabled people would realize the horror of what they had been forced to experience from their abusers. She also wanted to highlight the severity and broadness of the problem, as well as the inability of the current service system to respond. Therapists using sign language are in the minority. The practice of using a professional interpreter in IPV services is not necessarily routine. This is problematic for many reasons, but also from the perspective that deaf and blind communities are small. The risk is that victims will not know that they can access an interpreter or therapist in their everyday lives. Also, due to small communities, interpreters or therapists may be persons, whose victims already know beforehand. These are issues that may restrict getting help.

Asking about IPV was felt to be very complex in their NGOs. One reason may be the lack of strong professional roles and bureaucracy. On the one hand,

the existence of these questions usually restricts interaction, but on the other hand, these may also provide a kind of "shield" for workers so it may be easier to ask and talk about IPV as a professional. Thus, it may be easier to give some distance to the topic. For instance, routine enquiring questions (from the Enquire and Assessment Form of Domestic Violence by the National Institute of Health and Welfare) were not found to be suitable. They preferred more informal ways to ask about IPV, like "Do you have to scare something?"

Representatives of these five pilot organizations for disabled people developed their own forms to ask about IPV, as well as referrals for care. For this, collaboration with the public sector was important. To inform their own communities and authorities, material was produced (videos, leaflets). However, it is clear that much more informing should be done such as wider media-awareness campaigns. At the same time, adequate and barrier-free services should be ensured for disabled IPV victims.

8.1.5. Personnel in the public sector should be trained more in the special features of IPV in the context of disabled people

The special needs of disabled people were integrated as a part of the two-level IPV-training program. In the public sector, more disabled people-focused information and training is needed. In future, the NEIPV needs to organize continuing education around this theme for personnel. The role of universities as a part of the NEIPV is also important when it comes to producing knowledge about IPV in the context of disabled people.

8.1.6 Tensions between the public sector and the third sector

Experiences of co-training revealed tensions between public-sector and third-sector agencies. Like Nuzzkovski et al. [8] state, agencies operate independently and sometimes even in conflict with each other. These tensions were connected to the different missions of agencies and to power

differentials (see also [31]). However, in group discussions, the need to establish structures (e.g. permanent group meetings, co-training for multi-agency working) to support working between agencies came out.

8.1.7 Participative drama-based teaching methods

Interactive educating methods such as the Forum Theatre enabled dialogue between Experts by Experience, public-sector professionals, and third-sector workers. These methods also promote creating innovative solutions to case examples (see also [26]). Considering the sensitivity of our topic, this method was found to be a good one, for instance, when we wanted to highlight the special needs of disabled people during the training. A great number of personnel in the public sector have been educated about IPV in general and also from the perspective of the special features and needs of disabled people as victims. Educating work was also targeted at the disabled peoples' organizations, aiming at raising awareness of IPV and the possibilities of seeking help. The latter was found to be very important, because in the communities of disabled people, IPV may be taboo, and an untold, serious problem.

References

- [1] WHO. 2013. *Global and Regional Estimates of Violence against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence*. Report. Accessed January 3, 2016. http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf.
- [2] United Nations. 2014. *Convention on the Rights of Persons with Disabilities*. Report. Accessed January 3, 2016. <http://www.un.org/esa/socdev/enable/rights/convtexte.htm>.
- [3] Tam, D. M. Y., Schleicher, K., Wu, W., Kwok, S.-M., Thurston, W. E., and Dawson, M. 2015. "Social Work Interventions on Intimate Partner Violence against Women in China." *Journal of Social Work* 16 (2): 228-49.
- [4] Sims, C., Sabra, D., Bergey, M. R., Grill, E., Sarani, B., Pascual, J., et al. 2011. "Detecting Intimate Partner Violence: More than Trauma Team Education Is Needed." *Journal of the American College of Surgeons* 212 (5): 867-72.
- [5] Kaplan, S., and Komurcu, N. 2017. "Evaluation of Effectiveness of Health Services Training Given with Different Methods in Combating of Intimate Partner Violence against Women: A Pilot Study." *Journal of Family Violence* 32: 69-77.
- [6] Virkki, T., Husso, M., Notko, M., Holma, J., and Mäntysaari, M. 2015. "Possibilities for Intervention in Domestic Violence: Frame Analysis of Health Care Professionals' Attitudes." *Journal of Social Services Research* 41 (1): 6-24.
- [7] Wood, L. 2016. "Simulation as a Training Tool for Intimate Partner Violence Screenings." *Clinical Simulation in Nursing* 12 (1): 8-15.
- [8] Nuzzkovski, M. A., Coben, J. H., Kelleher, K. J., Goldcamp, J. C., Haxen, A. L., and Connelly, C. D. 2007. "Training, Co-Training, and Cross-Training of Domestic Violence and Child Welfare Agencies." *Families in Society* 88 (1): 35-41.
- [9] Olsen, A., and Carter, C. 2016. "Responding to the Needs of People with Learning Disabilities Who Have Been Raped: Co-Production in Action." *Tizard Learning Disability Review* 21 (1): 30-8.
- [10] Husso, M., Mänttari-van derKuip, M., Mäntysaari, M., and Kotiranta, T. 2015. "Väkivaltatyö Itä-Suomessa. VÄISTÖ-hankeenarviointi. [IPV work in Eastern Finland. Evaluation of the VÄISTÖ Project]." Accessed January 3, 2016. <https://www.julkari.fi/handle/10024/127151>.
- [11] Bradbury-Jones, C., Breckenridge, J. P., Devaney, J., Duncan, F., Kroll, T., Lazenbatt, A., and Taylor, J. 2015. "Priorities and Strategies for Improving Disabled Women's Access to Maternity Services when They Are Affected by Domestic Abuse: A Multi-Method Study Using Concept Maps." *BMC Pregnancy Childbirth* 15: 350.
- [12] Black, M. C., Basile, K. C., Breiding, M. J., Smith, S. G., Walters, M. L., Merrick, M. T., et al. 2011. *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report*. Report for the National Center for Injury Prevention and Control. Accessed October 11, 2016. http://www.davidpublisher.org/Public/uploads/file/20150327/20150327163040_56549.pdf.
- [13] "Violence against Women—An EU-wide Survey. Main Results." European Union Agency for Fundamental Rights. Accessed December 10th, 2016. <http://fra.europa.eu/en/publication/2014/violence-against-women-eu-wide-survey-main-results-report>.
- [14] European Institute for Gender Equality. 2014. *Estimating the Costs of Gender-Based Violence in the European Union*. Report. Accessed November 29, 2016. <http://eige.europa.eu/MH-04-14-745-EN-1>.
- [15] Nosek, M., Foley, C., Hughes, R., and Howland, C. 2001.

- “Vulnerabilities for Abuse among Women with Disabilities.” *Sexuality and Disability* 19(3): 177-90.
- [16] Mitra, M., Mouradian, V. E., and Diamond, M. 2011. “Sexual Violence Victimization against Men with Disabilities.” *American Journal of Preventive Medicine* 41 (5): 494-7.
- [17] Hughes, K., Bellis, M., Jones, L., Wood, S., Bates, G., Eckley, L., McCoy, E., Mikton, C., Shakespere, T., and Officer, A. 2012. “Prevalence and Risk of Violence against Adults with Disabilities: A Systematic Review and Meta-Analysis of Observational Studies.” *Lancet* 379 (9826): 1621-9.
- [18] Mandl, S., Schachner, A., Sprenger, C., and Planitzer, J. 2014. *Access to Specialised Victim Support Services for Women with Disabilities Who Have Experienced Violence*. Report from the Ludwig Boltzmann Institute of Human Rights. Accessed January 3, 2016. http://www.gla.ac.uk/media/media_394354_en.pdf.
- [19] Sin, G. H., Mguni, N., Cook, C., Comber, N., and Hedges, A. 2010. “Targeted Violence, Harassment and Abuse against People with Learning Disabilities in Great Britain.” *Tizard Learning Disability Review; Brighton* 15 (1): 17-27.
- [20] Oschwald, M., and Powers, L. E. 2004. *Violence and Abuse against People with Disabilities: Experiences, Barriers, and Prevention Strategies*. Report from the Center on Self-Determination, Oregon Institute on Disability and Development, Oregon Health & Science University. Accessed January 3, 2016. <https://www.thl.fi/documents/470564/817072/AbuseandViolenceBrief.pdf/2916412c-6c3f-423c-a255-7f4afd25bdac>.
- [21] Kvist, J., Frizell, J., Hvinden, B., and Kangas, O. 2012. *Changing Social Equality: The Nordic Welfare Model in the 21st Century*. Bristol: Policy Press.
- [22] Piispa, M., Taskinen, J., and Ewalds, H. 2012. Selvitys lapsen-ja perhesurmien taustoista Suomessa vuosilta 2003-2102 [Report from the Backgrounds of Child and Family Murders in Finland from 2003 to 2012]. Report 19. Helsinki: Institute of Social Welfare and Health.
- [23] Husso, M., Virkki, T., Notko, M., Holma, J., and Laitila, A. 2012. “Making Sense of Domestic Violence Intervention in Professional Health Care.” *Health and Social Care in the Community* 20 (4): 347-55.
- [24] Leppäkoski, T., Paavilainen, E., and Åsted-Kurki, P. 2011. “Experiences of Emergency Care by the Women Exposed to Acute Physical Intimate Partner Violence from the Finnish Perspective.” *International Emergency Nursing* 19: 27-36.
- [25] Kolb, D. A. 1984. *Experiential Learning: Experience as the Source of Learning and Development*. Englewood Cliffs, NJ: Prentice-Hall.
- [26] Yoshihama, M., and Tolman, R. 2015. “Using Interactive Theater to Create Socioculturally Relevant Community-Based Intimate Partner Violence Prevention.” *American Journal of Psychology* 5: 136-47.
- [27] Dill-Shackleford, K. E., Green, M. C., Scharrer, E., Wetterer, C., and Shackleford, L. E. 2015. “Setting the Stage for Social Change: Using Live Theater to Dispel Myths about Intimate Partner Violence.” *Journal of Health Communication* 20 (8): 969-76.
- [28] Piippo, S., 2017. “Training for Key Persons in Intimate Partner Violence work.” Manuscript in preparation.
- [29] Huisman-Laine, B. 2016. “Shared Expertise. Expert by Experience as a Part of Development Work of IPV.” Unpublished manuscript.
- [30] Ansari, S., and Boyle, A. 2017. “Emergency Department-Based Interventions for Women Suffering Domestic Abuse: A Critical Literature Review.” *European Journal of Emergency Medicine* 24: 13-8.
- [31] Bennet, L., and O’Brien, P. 2007. “Effects of Coordinated Services for Drug-Abusing Women Who Are Victims of Intimate Partner Violence.” *Violence against Women* 13 (4): 295-411.