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A rural shelter in Ontario adapting to address the changing needs of women who have experienced intimate partner violence: a qualitative case study

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ABSTRACT

Introduction: Intimate partner violence is a significant public health problem, with shelters offering the predominant community-based solution. Shelters in Canada are mandated to provide a safe place, protection planning, advocacy and counseling among other services. Recently it has been noted the role of the shelter was shifting from an inpatient to outpatient model with a focus on increased integration of health and social services. This changing role of the shelter is amplified within the rural context where resources and cultural norms may be limited or incompatible with help-seeking behaviors. Women's shelters located in rural settings provide services within a specific cultural context that can be at odds with the needs of women who have experienced abuse, because cultural values such as rural pride, lack of anonymity, and lack of services may inhibit access to health and social services.

Methods: The purpose of this in-depth qualitative case study was to examine and explore how one rural Canadian women's shelter role was changing and how the shelter was adapting to achieve the changing role. The theoretical framework utilized was a feminist intersectional lens. Qualitative interviews (averaging 60 minutes) were conducted with shelter service providers (n=6) and women staying in the shelter or utilizing shelter services (n=4). Throughout semi-structured interviews, data-trustworthy steps were taken including member-checking and paraphrasing to ensure data were an accurate representation of participants' experiences. Inductive content analysis of all interviews and field notes was conducted independently by two researchers.

Results: Analysis revealed the shelter's role was changing to include filling gaps, case management, and system navigation. To achieve the changing role, relationship building, community mobilization (both education and empowerment), and redesigning

delivery were implemented as adaptation strategies. Together both the changing role of the shelter and the adaptation strategies being implemented were found to be working toward a larger goal of transformation of cultural and structural norms related to violence against women.

Conclusions: This study uniquely identified the specific changes to the role of one rural Canadian shelter and the adaptations strategies utilized to adapt to the changing needs of women. The changing role of the shelter and the adaptation strategies being utilized have significant implications for the health of women given the increased use of healthcare services for women who have experienced violence. Specifically, the changing role of the shelter has the potential to decrease healthcare service use while increasing the potential fit of services. Further research is required to assess the impact of the changing role of the shelter on the healthcare needs and outcomes for women who have experienced intimate partner violence.

Key words: Canada, health, intimate partner violence, qualitative, women's shelter.

Introduction

Violence against women is understood to be any gendered-based action or conduct that causes physical, sexual, or psychological damage to women and occurs in both public and private settings[1]. Violence against women takes on several forms, with intimate partner violence being identified as one of the most commonly examined types of violence[2]. Intimate partner violence is defined as a pattern of physical, sexual, and/or emotional violence by an intimate partner within the context of coercive control[3]. Global estimates of the impact of intimate partner violence on women range from 15% to 71% with Canadian estimates of 25% to 30%[3-5]. Although leaving the abusive relationship is the dominant proposed solution to violence[6], women who leave an abusive relationship often experience restricted socioeconomic mobility, loss of social and community networks, and ongoing interpersonal violence from the abuser, which can be greater than was anticipated at the time of leaving[7-10]. Given its prevalence and context, intimate partner violence has, not surprisingly, been identified as a significant public health concern[11].

Research underscores the significant, detrimental, and often long-term impact of intimate partner violence on women's mental and physical health both during and after leaving a relationship[4,12-14]. Recently, long-term abuse has been linked to physiological and epigenetic changes[15,16] as well as chronic psychological stress, with depression and post-traumatic stress disorder identified as the most common mental health sequelae associated with intimate partner violence[4,15,17]. Among the associated detrimental health effects, research demonstrated a compounding effect in rural settings[18]. This compounding effect on health is especially important as emerging research has demonstrated poorer mental health as a significant predictor of women's inability to maintain separation from an abusive partner[19]. Given the well-documented health effects of intimate partner violence, it is concerning that women who have experienced it face barriers in accessing health care and other social supports, and report significant unmet needs and/or poor fit of services when services are accessed, an experience further exasperated when living in rural areas[18,20,21].

Rural settings can be understood based on the unique set of values embedded within the context such as rural pride, privacy, and sense of community[22,23]. The sociocultural context of rural settings increases women's vulnerability to intimate partner violence which in turn negatively impacts help seeking and resource availability[24,25]. However, these values are inherently problematic for women who have experienced intimate partner violence as it results in a context that sanctions intimate partner violence through cultural beliefs such as permanence of marriage, importance of privacy, preservation of intergenerational property transfer, and dominance of patriarchal attitudes[26,27]. Also, it fosters stigma, as close-knit community networks not only

prevent anonymity during help seeking for health and social services, but also negatively impact willingness to seek help through the overlapping nature of relationships within social networks[22,28]. The negative aspects of the rural context are further compounded by the most obvious barrier women face when seeking health and social services: geographic distance[29]. Not only does distance adversely impact help-seeking behaviors but it also restricts access to appropriate health care and resources[30,31].

A common social response to intimate partner violence is the use of shelters. The mandate of shelters in Canada includes the provision of a safe place for women during a time of crisis[32,33], as well as safety and protection planning services, advocacy, transportation services, short-term counseling, and housing referrals[32,34]. Shelters remain the primary entry point for health and social services such as emergency and transitional housing, counseling/support groups, advocacy for the attainment of health and social resources, and legal advocacy[35,36]. However, the needs of women who have experienced violence are changing. Specifically, recent research highlighted that women are shifting to utilize shelter resources but are not necessarily staying in the shelter[37] and the services within shelters are shifting to an integrated set of health and social services for women and children that extends beyond the current mandate of shelters[34]. Given the woman-centered feminist approach that prevails in the shelter community, shelters have evolved to be responsive to women's changing needs[34,35,38]. This changing role of the shelter merits further investigation, and as such the purpose of this case study was two-fold: to (1) explore how one rural Ontario women's shelter role was changing, and (2) examine how the shelter has adapted to address the changing role.

Methods

A qualitative case study was used based on a feminist, intersectional framework to ground findings in the lived experiences of participants and provide a basis for the pursuit of social justice[39,40]. Participants were recruited via posters at the rural Ontario shelter. The community where this study took place has a population size of 20 335[41]. The community is 35 km from a large urban center. The percentage of the working population (aged 15–64 years) is 64.2% and the average income per individual was $35,211 and per family was $80,973. Participants interested in the study responded by email or phone to the principal investigator. Participants were screened for eligibility over the telephone (see Table 1 for eligibility criteria) with all eligible participants enrolling in the study. Subsequently, a mutually convenient interview time was set up at the rural shelter where the principal investigator obtained written informed consent and provided an honorarium (of C$25 cash to all participants (service providers and women)) prior to the interview in appreciation and recognition of the participant's time. Data were collected from two subgroups: service provider (n=6) and women utilizing the shelter (n=4).

Each participant completed a semi-structured interview lasting between 30 and 90 minutes (averaging 60 minutes). During the interview, data trustworthiness steps[42] were undertaken including member checking, paraphrasing, and synopses to help ensure data was an accurate reflection of participants' experiences. In addition to the interviews, field notes were taken throughout the interview process by the interviewer to provide context and contribute to the rich descriptions and contextualization of the findings. The interviews were audio recorded and subsequently transcribed verbatim.

Measures

The interview content was divided into four sections: demographics, current status of services, barriers/challenges, and strengths/success. A short questionnaire was used to gain demographic information: highest level of education achieved, marital status, current housing situation, primary work status, personal income, dependent children, and ethnicity. Current status of health and social services use was determined with two open-ended questions: (1) 'What is the current status of services being offered/utilized at the shelter?' and (2) 'What is the history of service use with the rural shelter?' (probe: 'What services have you provided in the past?' or 'What services have you used in the past?').

Barriers and challenges were addressed through three open-ended questions: (1) 'What are the greatest challenges you face?' (probe: 'In delivering or accessing services?'), (2) 'What are the greatest programming/staffing needs?', and (3) 'Where is the greatest gap in health and social service and care provision?' Strengths and successes were asked using three open-ended questions: (1) 'How does the rural shelter encourage or support women to access care?', (2) 'What are the strengths of the rural shelter?', and (3) 'How does the rural shelter address the greatest gap in health and social services?'

Analysis

Two researchers (principal investigator and co-investigator) conducted thematic inductive content analysis of all transcripts and field notes independently[43,44]. In addition to transcriptions and field notes, data triangulation was achieved through examination of website and social media materials, organization pamphlets, and interviewer participation in site programs. Emergent themes were identified and subsequently compared to examine consistency in findings. Arising discrepancies in analysis were discussed until a consensus was achieved in the emergent themes[43].

Ethics approval

Ethics approval was obtained from Western University prior to any communication with participants (REB106335).

Results

The results of this study can be split into two sections: the changing needs – and subsequent role change – of the rural Canadian shelter, and the adaptation strategies being utilized by the shelter to fulfil those changing roles (Fig1). In the first section, the historical role of the shelter was examined and subsequently compared to the current role of the shelter as described by participants. This process highlighted the emergence of three unique changing roles within the rural shelter: filling gaps, case management, and system navigation. In the second section, three adaptation strategies emerged that the rural shelter was using to fulfil the change roles, including relationship building, community mobilization, and redesigning delivery. Ultimately the goal of the adaptation strategies was to not only fulfil the new role of the shelter but to also create larger social change by transforming the cultural and structural norms surrounding violence against women. Each of these themes will be discussed in turn.

Changing Role

The changing role of the shelter centered around three specific themes: filling gaps, case management, and system navigation. All three of these additions to the historical role of the shelter were based on either the shifting needs of the women utilizing the shelter or the shifting population utilizing the shelter.

Filling gaps: One of the changing roles of the shelter stemmed from an increased necessity to fill gaps left by other community and health services such that women's needs were not left unaddressed by the current systems. Part of the need to fill gaps was due to the rural context and the continuous erosion of health and social services and funding, with service providers saying 'I think it is partly that we're in a rural place and that we need to do things different because our environment necessitates that' (provider (P)2) and 'I think we try to cover as much as we can 'cause we're rural' (P3). This highlighted the notion that there were gaps left in health and social services due to geography and the rural shelter aspired to address those gaps. This addition to the role of the shelter to fill the gaps was recognized by service providers as essential: 'What it means to me is kind of the no wrong door philosophy. So I would hate for a woman to come in and for us to say, well we don't do that so find somebody who does. My hope is when she indicates a need or an area that she wants further exploration, growth or to get needs met that we would help her connect with that' (P2).

Table 1: Study inclusion criteria by subgroup

Subgroup	Inclusion criteria
Service provider[†] (*n*=6)	Provided services at the shelter (administrators or program providers (ie counselling or support groups)) Aged 18 years or more Spoke English
Women[¶] (*n*=4)	Currently using shelter services (either staying at the shelter or actively engaged in programs in the past month) Aged 18 years or more Spoke English Experienced a traumatic event – assessed through answering yes to the question 'A traumatic event is one that is very distressing and upsetting such as being assaulted, having your house burn down, being raped, or having a car accident. Have you experienced a traumatic event (or events) in your past?'

[†] The sample size for services providers was representative of the cross-section of services offered.
[¶] For the women a final sample size of four represented all participants who were willing to participate in the study. Note that all participants staying at the shelter were interviewed (*n*=3) in addition to one participant who was actively engaged in shelter programs as an outpatient.

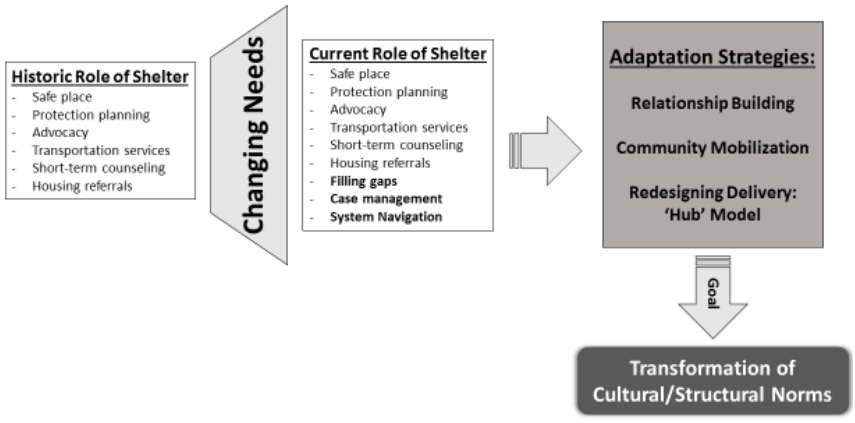

Figure 1: Changing roles and adaptation strategies of one rural shelter.

This filling of gaps was salient for women who had received services, as they were able to recount many instances where service providers at the shelter went above and beyond the defined role of the shelter. Particularly, one woman noted that a service provider walked with her to a healthcare appointment and waited while she was in the appointment as ' they knew I wouldn't walk there by myself because I wasn't ready to do that one on my own' (woman (W) 1). Another woman identified myriad support she had received that she knew was a clear extension of what shelters normally do, such as '… microloans, food, through the Circles program [about social boundary creation] … I actually got a used vehicle through the program for free' (W4). This filling of gaps was recognized by women and much appreciated.

Case management: Service providers and women alike highlighted the changing role of the shelter in terms of case management. The need for case management was seen as the result of the ever-increasing complexity of women's lives and healthcare needs alongside the increased barriers for health and social service: 'we see the complexity increase for the women that we experience [at our service] and the barriers to good service, we don't see that decreasing' (P2). As such, service providers were increasingly taking on a case management role whereby they supported women in seeking and accessing health and social services: 'we give women some supports and help them find resources in the community' (P3). Women highlighted this support, saying service providers were 'very supportive and helpful, you know printing off applications and just, you know making things as easy as possible so I didn't have to do a lot of the footwork to get what I needed' (W3) and 'the staff here is terrific, they help me take care of everything like find a place to live, buying food, making friends. Everything' (W2).

Additionally, the changing needs of women were also the results of the changing population the shelter was serving, with one service provider identifying 'we're not serving as many families as we used to be. We're serving single women who are more transient in nature. They may have intersectionality with addictions, trauma, mental health, that kind of thing' (P2). This shift in population increased the complexity of the health and social services needs for women. In order to facilitate the successful intersection of the system with the women, service providers were adopting a case management role to bridge existing gaps.

System navigation: A final important new role of the rural shelter was system navigation. Supportive system navigation was understood in two ways: identifying providers who understood the context of violence, and preparing women to interact with systems that did not understand the context of violence. For the former, service providers were working to help women effectively navigate the system by helping to identify service providers who would provide care and understand the violence context, which was difficult in the rural setting. One service provider highlighted this by examining the difference between knowing what a service provider was like versus not: 'I can give you a phone number and say, call these people, right. It's a whole different feel if I say, you know I know those people and this is some of the service. I think you might benefit. Do you want to invite them here? Or I can go there with you. Or something like that. A warm transfer I think is much more effective than here, cold call this number and see how that goes' (P1). This informal system navigation to 'preferred' service providers was important given the rural context, as one service provider highlighted that within the rural context 'doctors don't know about trauma, and have an old fashioned idea about who is using the [shelter]' (P1). As such, utilizing informal system navigation has the potential to increase the success of the interaction of the system with the women. Informal system navigation was identified as a key to success by women as their access to health and social services was expedited, with one woman saying 'I had made an appointment [with a counselor] within the first week of being here for that same week' (W3). This expedited service was particularly salient for this woman as she had been trying independently to access the healthcare service prior to the shelter for months with no success.

In the rural context, when a service provider could not be found who understood the context of violence, shelter service providers would help women to navigate the system by preparing them for the interaction, with one service provider identifying 'I always try to warn them ahead of time, like even though you're going [to the hospital] because you're feeling suicidal they're still going to take all your vitals. So they're going to be hands on with you. Sometimes they'll ask, sometimes they just kind of do it. Just make sure you're ready for that …, and try to prepare them for those things if I can't go with them as well' (P1). Another woman identified this system navigation piece as paramount in her finding a family doctor. There was a lack of family doctors in the rural region and so the service provider highlighted the need to continually follow up in order to get rostered. The woman recalled 'it was taking so long so we got together and called them again and again, and we kept on them to get me a doctor because it was important' (W1).

Adaptation strategies

To fulfil the shelter's changing roles (ie filling gaps, case management, and system navigation) several adaptation strategies were utilized, namely relationship building, community mobilization, and redesigning delivery. By adopting these new strategies not only was the rural shelter able to address the changing needs of the women but also to advance the larger mission of transforming cultural and structural norms as a means of contributing to the end of violence against women[45-47].

Relationship building: A key adaptation strategy utilized by the rural shelter was relationship building. One service provider highlighted this focused endeavor, saying 'I would say that over the past couple [of] years we've been working at developing deeper relationships with organization like Children's Aid, Community Mental Health, addictions services, and sexual assault center, the family health team and with the local hospital. We're recognizing that there's barriers there and perhaps those other organizations aren't aware of the barriers in the same way we are. And so just building relationship to have more difficult conversations' (P2). The importance of building relationships was underscored as it had a positive impact on the work being done both in the shelter and within the community, with one service provider saying, 'the relationships, nurturing the relationships are so important so I'm seeing this theme you know it's good work, good relationships follows good work' (P1). Furthermore, all the service providers identified that system navigation was best achieved through relationship building, saying 'building those relationships still needs to kind of happen, and makes, the referral process easier, knowing what you are referring to' (P1).

It is through this specific focused strategy that change started to emerge both in an attitude of the community and in women's ability to partner with agencies. The attitude change was evident as the rural shelter was able to facilitate a conversation with several local agencies that work with women who have experienced violence, with one service provider saying 'we had police, children's aid manager and frontline, mental health, family counseling, sexual assault center, victim's services, our agency [rural shelter], our First Nation community – really a gamut of people … we developed a coordinating committee' (P1). The purpose of this committee was to examine options to improve service delivery to meet the changing needs of women who access services. It was through this collaboration and relationship building between service providers and community partners that the perception of violence against women was starting to change within the community both for the women utilizing the shelter and the community partners alike. Specifically, the ameliorated relationships increased comfort for women in accessing various services, particularly services that were typically difficult for women to work with: 'It is hard to have good relationships with some of the people who are supposed to help you like [children's aid], but at least when someone here says yeah so and so is good, it makes it a bit easier to trust them' (W3).

Community mobilization: Another adaptation strategy was facilitating community mobilization through education and engagement. Community education was an important gap the rural shelter was trying to overcome. This included a general lack of knowledge around violence or the impacts of violence for community members, with one service provider saying 'there is a gap in our community about violence and we are trying to fill that gap' (P1). This was further underscored when a lack of knowledge about the impacts of violence, such as homelessness, by community service providers was highlighted: 'We were at a community event where the psychiatrist, the only psychiatrist at the hospital said there was no homelessness in rural [settings]' (P1).

It is through this education piece that the rural shelter was able to foster community engagement, as highlighted by one service provider who noted the emerging change within the culture of the community, saying ' so we see a community sort of mobilizing around a shared understanding of what the problems are' (P1). The importance of community engagement was identified as foundational in promoting community ownership of violence within the community and the need to facilitate change. One service provider described

this, saying 'so I think the community engagement piece [is] really asking our community like putting it out there and making them take ownership that violence is not just our agency's work' (P3). Another service provider said 'so I love that we're engaging community and I think that the fact that we, when we see a need we try our best either to provide it or talk to other agencies and say … these are the trends we're seeing, … what are we going to do as community agencies to address this' (P3). It was through education and engagement that the rural shelter was able to mobilize a community around the need to change responses to violence.

Moreover, filling gaps in service was partially achieved through community education specifically utilizing outreach strategies. A service provider noted that she was only able to engage children of women who were actually in the shelter or referred for the shelter, and had little ability to connect with other children whose families had been in contact with police for violence issues (but had yet to be referred). To address the lack of service for other children who could benefit from her services, she would often reach out, '… introduce myself, our role and say, this is what we do here. This is something you might be interested and come on and meet me for an hour and let's have a coffee and talk about what's going on' (P4). This informal strategy was used to generate knowledge about the shelter's services. Another service provider noted the lack of preventative work with young girls in the community and filled through additional programing, '… so we're doing kind of self-esteem building, advocacy stuff, education with school boards around how to support teens' (P5). Both of these initiatives underscored a need to be proactive in the rural context as there were gaps in services resulting in women's needs not being met, and the rural shelter was working to overcome these gaps.

Redesigning delivery – 'hub' model: The third adaptation strategy identified by the rural shelter was the emerging change in service delivery that was naturally occurring. The service providers highlighted there was a switch from an inpatient to an outpatient care model, saying 'it seems to be less and less accessing shelter, but wanting the same services while still remaining in the community' (P5). The shift in delivery was an important adaptation as it better aligned with the mission of the shelter of 'prevention, education, and support' (P1) as this service provider highlighted, noting that historically prevention and education were being neglected. Moreover, by switching to this 'hub' model the rural shelter was better able to 'serve this whole community and understand and respond to this issue [of violence], beyond picking up the pieces' (P3).

To respond to the changing needs of women and successfully adapt to this role there was a marked transition to a 'hub' model of service. One service provider highlighted this change saying there was a 'real commitment to this model – pushing towards the hub model' (P1). This 'hub' model would allow women to access services through a centralized location although all the services would not necessarily be housed at the shelter. The 'hub' model was identified as innovative and a response to the changing needs of women, with one service provider saying 'I think we're pretty innovative. I think we recognize that things are changing. So thinking we're looking at how we can change and better serve all the women' (P2). Moreover, one woman highlighted the strength of this model: 'You don't have to retell your story here, you just tell it once and work with the other people so you don't have to do it again' (W4). This 'hub' models offered an alternative to the inpatient approach.

Discussion

The purpose of this article was to explore the changing role and the adaptation strategies of one rural Ontario shelter utilizing a qualitative case study approach from a feminist intersectional framework. The inductive content analysis of the in-depth interviews with service providers and women revealed the role of the rural shelter was changing to include not only historic roles (safe place, protection planning, advocacy, transportation services, short-term counseling, and housing referrals) but also filling gaps left by existing community supports and health/social services, case management for the evolving complex health and social needs of women accessing the shelter, and system navigation to

improve access and outcomes for health and social services. In order to accomplish the changing role, the rural shelter was utilizing three adaptation strategies: relationship building, community mobilization, and redesigning delivery. Relationship building through purposeful connection with existing health and social services facilitated community mobilization through education and engagement which fostered community ownership over solutions to violence against women. Both relationship building and community mobilization dovetailed with the redesign of service delivery wherein the shelter was shifting to act as a 'hub' for health and social services.

The principal findings of this study regarding the expansion of the role of the shelter and the adaptation strategies utilized align with the current discourse of extending scopes of practice and shifting the design of services to a model of integration[48]. Specifically the need to coordinate health and social services across sectors was highlighted as a necessity to improve the system's response to violence against women[49], a finding that was reiterated with the case management and systems navigation role along with the relationship building and community engagement adaptation strategies. Community mobilization through education, awareness, and actions has been highlighted as foundational in addressing intimate partner violence[50] and was a strategy being utilized by this rural shelter. In addition to confirming previously published knowledge in the area, this study highlighted the specific ways in which one rural shelter was changing its role, and adapting to address the shift in needs of women and the community. This case study underscores an important insight into how one Ontario shelter was evolving from the original shelter mandate to an integrated and women-centered service driven largely by second-wave feminism[35,36,48].

This study is not without limitations. Specifically, the case study methodology resulted in a relatively small population to draw on for this research. Despite interviewing a cross-section of shelter service providers and all women who were staying at the shelter, and one woman utilizing the shelter on an outpatient basis during the time of the study, the research methodology along with the sample size resulted in decreased generalizability of findings, a common criticism of case study methodology[51]. Future studies should attempt to verify the changing role and adaptation strategies of shelters with additional rural agencies and women.

The principal implication of this study is the specific knowledge of the changing role of the rural shelter and how the shelter is achieving that change. This changing role is being shaped by a decrease in traditional service use[7,20] in favor of an outpatient approach. This shift has important implications for policy makers; namely, the current metrics being utilized to assess the health and social services provided by shelters and determine the amount of funding are not capturing the full picture of what rural shelters are doing and providing[52,53]. Moreover, this has implications for service providers as it underscores the need to have an openness to education and a need to create a culture that fosters attitude changes that support knowledge attainment alongside collaboration across services. Given that people who live in rural contexts are less supportive of government involvement in intimate partner violence, this creates an atmosphere that both supports grassroots initiatives for collaboration but also undermines formal supports[18].

The changing role of the shelter and the adaptation strategies being utilized have very real implications for the health of women. Specifically, given the increased use of healthcare services for women who have experienced violence[7] the changing role of the shelter has the potential to decrease healthcare service use while increasing the potential fit of services[54]. With the shift in role to include filling the gaps presented by the current system, case management, and system navigation, the rural shelter is essentially taking on the role of helping women to manage healthcare and social services access, which has been demonstrated to improve health outcomes[55]. The changing role of the rural shelter alongside the new adaptation strategies has the potential to have real positive implications in terms of acceptability of health and social service use for women who have experienced violence. Further research is required to ascertain the potential and extent of this change.

Conclusions

One rural shelter in Ontario is adapting to and changing its role to meet the needs of women who have experienced violence. Through the changing role and adaptation strategies the rural shelter was challenging prevailing social norms and fostering an atmosphere that was promoting collaboration and system redesign. This is in line with the cultural context of rural settings in Ontario and provides valuable learning opportunities for other shelters, rural context, and agencies who provide services for women who have experienced violence.

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