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**Authors:** Tara Mantler, Kimberley T. Jackson, & Marilyn Ford-Gilboe

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# **The CENTRAL Hub Model: Strategies and Innovations Used by Rural Women's Shelters in Canada to Strengthen Service Delivery and Support Women**

**Tara Mantler**

University of Western Ontario  
London, Ontario, Canada  
[tara.mantler@uwo.ca](mailto:tara.mantler@uwo.ca)

**Kimberley T. Jackson**

University of Western Ontario  
London, Ontario, Canada  
[kim.jackson@uwo.ca](mailto:kim.jackson@uwo.ca)

**Marilyn Ford-Gilboe**

University of Western Ontario  
London, Ontario, Canada  
[mfordg@uwo.ca](mailto:mfordg@uwo.ca)

## **Abstract**

Intimate Partner Violence impacts 25% to 30% of Canadian women. Women's shelters were created as the dominant solution to violence; however, there are differences in service in urban and rural areas. This study examined strategies and innovations being adopted to strengthen service delivery and support women who have experienced violence. This descriptive participatory research study used a focus group and in-depth interviews with five innovative rural women's shelters. Using thematic analysis, we found when Community Education, Networking, Technology, Resourceful Able Leaders was enacted using a Hub Model, there was innovation in service delivery overcoming challenges.

Keywords: Intimate Partner Violence; women; service delivery; rural; shelter

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## **1.0 Introduction**

Intimate Partner Violence (IPV) is a global public health concern that impacts an estimated 25% to 30% of Canadian women (Forte, Cohen, Du Mont, Hyman, & Romans, 2005; Tjaden & Thoennes, 2000). IPV is commonly understood as a pattern of physical, sexual, and/or emotional violence by an intimate partner within the context of coercive control (Tjaden & Thoennes, 2000; World Health Organization/London School of Hygiene and Tropical Medicine, 2010). Research underscores the significant, detrimental and often long-term impact of IPV on

women's mental and physical health (Afifi et al., 2009; Ellsberg, Jansen, Heise, Watts, & Garcia-Moreno, 2008; Woods & Gill, 2010). Specifically, depression and post-traumatic stress disorder (PTSD) have been identified as the most common mental-health sequelae associated with IPV (Ellsberg et al., 2008; Ford-Gilboe et al., 2015; Wuest et al., 2007). Moreover, physical health consequences of violence include injury, chronic physical pain, lower functional and perceived physical health status, as well as somatoform disorders (Dillon, Hussain, Loxton, & Rahman, 2013; Edwards, 2015; Wuest et al., 2008). Additionally, poorer mental and physical health among women attempting to leave an abusive partner is also a predictor of women's ability to maintain separation (Abdulmohsen Allhalal, Ford-Gilboe, Kerr, & Davies, 2012), further highlighting the important connection between IPV, options for safety, and health.

Given the well-documented health consequences of IPV, it is concerning that women who had experienced IPV face barriers in accessing health care and other supports. Specifically, women who have experienced IPV report significant levels of unmet need and/or poor fit of services when services were accessed (Ford-Gilboe et al., 2015; Stam, Ford-Gilboe, & Regan, 2015). In a community study of over 300 Canadian women by Ford-Gilboe and colleagues (2015), it was found that women used services at rates of 2 to 292 times that of the general population. When women were questioned about the high service use rates, it was found that they continued to access a variety of services because either the service they accessed did not meet their needs or they were waiting to access the correct service and were trying to find an interim solution. Unmet care needs and barriers to services were particularly salient in mental health services. Research attributes this gap in mental health care service to insensitive attitudes of service providers, costs of accessing mental health services, inappropriate referrals, and transportation problems (Ansara & Hindin, 2010; Edwards, 2015; Ford-Gilboe et al., 2015; Hegarty et al., 2013). Both lack of service and inadequacy of provided services create additional barriers for women who have experienced IPV.

Experience of unmet needs and poor fit of services can be further compounded by geography. It is well established that women living in rural communities have less access to a broad range of supports and services (de Marco & de Marco, 2010). A recent review of the literature (Edwards, 2015) found that women who had experienced IPV in rural contexts experienced more chronic and severe IPV, increased rate of homicide, worse health outcomes due to lack of services/difficulty accessing services, and lived in contexts where attitudes towards IPV undermined health and help-seeking behaviours. These outcomes have been attributed to several prevailing norms in rural contexts. These norms include: (1) community cohesion (wherein everyone knows everyone else's business) and traditional gender roles (wherein women are dependent on men for access to service), which can create an atmosphere that promotes a lack of privacy (Cohn, 2008); (2) limited access to public transportation which can further isolate women (Jones, 2008); and (3) community norms around traditional gender roles and the permanency of marriage (Eastman, Bunch, Williams, & Carawan, 2007; Gadomski, Wolff, Tripp, Lewis, & Short, 2001). These contextual factors may work against women's help-seeking efforts. Thus, it is not surprising that rural women's shelters and the women who seek support from these shelters must contend with unique challenges in addressing safety and health needs (Burnett, Ford-Gilboe, Berman, Ward-Griffin, & Wathen, 2015).

The core mandate of women's shelters in Canada includes the provision of a safe place for women during a time of crisis (Wathen, Harris, Ford-Gilboe, & Hansen, 2014), as well as support for safety planning, advocacy, access to transportation, short-term counseling, and referral to other community services such as housing, employment, healthcare, and addictions (Burnett et al., 2015). Women's shelters did not exist prior to the 1970s and were born out of the feminist movement (Hilbert & Krishnan, 2000). Given the women-centered feminist approach which is foundational in the majority of women's shelters, it is not surprising that shelters have evolved to be responsive to women's changing needs, including the need to address health concerns (Austin, 2008; Brown, Harris, & Fallot, 2013; Kamimura, Parekh, & Olson, 2013) and bridge gaps that exist due to lack of services or lack of appropriate services (Burnett et al., 2015; Hyman, Forte, Du Mont, Romans, & Cohen, 2009). These challenges were particularly salient in rural settings, as more urban shelters traditionally offer a wider range of services and can be more selective in what they offer based on their orientation to understanding the health and social implications of IPV for women (Mantler & Wolfe, 2017). However, comprehensive models such as these may not be feasible in rural contexts, where shelters may have limited staffing. These additional contextual factors further exacerbate the challenges faced by rural women's shelters, which often simultaneously are experiencing funding difficulties due to the vast geographic areas these shelters serve.

In the context of these limitations, rural women's shelters have been found to stretch mandates (provision of safe place for women during a state of crisis) and provide services to women based on 'gaps' and needs, both within the shelter and by networking with other rural women's shelters to help women access needed supports, including health care (Burnett et al., 2015; Wathen et al., 2014). However, the breadth and type of strategies being used by rural women's shelters to meet this mandate, the conditions and priorities that shape these practices are poorly understood. Furthermore, the extent to which the strategies used by rural shelters impact health and quality of life of women who seek help is an important area for study as well. As such, the aim of this collaborative participatory research study was to examine—from the perspectives of executive directors (ED)—frontline service providers and women who have accessed rural women's shelters in Ontario, the strategies and innovations being adopted to strengthen delivery of services (safety and health) and supports for women who have experienced IPV, and the impact these have on women's health and quality of life.

## **2.0 Method**

### **2.1 Design**

This study design was a qualitative description using a participatory approach. Four rural women's shelters conceptualized the aim for this study stemming from their existing collaboration and the realization that there was something unique happening within rural shelters to strengthen delivery of services and support women who had experienced IPV. These four shelters were involved in designing the goals, objectives, and methods prior to the start of the project. This study drew on data collected using a combination of focus group and in-depth interviews with rural women's shelter executive directors (ED), frontline service providers (FSP) at shelters, and women using shelters services using a feminist intersectional lens. This lens emphasized that gender based violence needs to be understood within

the context of how identity and social location intersect and interact and how systems of power, oppression, and privilege shape women's lives (Crenshaw, 1994; McCall, 2005).

## **2.2 Study Setting**

This study was conducted in five women's shelters located in rural communities in Ontario, Canada; specifically, four shelters that conceptualized this study and one additional shelter that was recruited as they were also deemed to be innovative by the four existing participating shelters. Initially, three rural women's shelters in Ontario were selected (as they were known to be innovative) by the four shelter partners to be invited to participate in the study. The invitation to participate was sent via email to the ED's. From this, one shelter responded to the email and agreed to participate. All the shelters served rural communities defined as having a population of less than 30,000 people and were located a 30 minute driving-time away from census metropolitan areas (CMA) (du Plessis, Beshiri, Boman, & Clemenson, 2002). The shelters ranged from having 10 to 20 funded beds (and 12 to 25 funded/unfunded beds) and all offered a variety of safety planning, housing, system navigation, and counselling services with an average of 12 services offered (ranging from 8 to 16 including counselling, housing support, etc.).

## **2.3 Participants**

Participants were invited to participate in this study from three different sub-groups: (1) EDs (n=5); (2) FSP (n=8); and (3) women using shelter services (n=5). There was one face-to-face focus group conducted with four ED's (the initial rural women's shelter's that conceptualized the study). All FSP and women were invited to participate via posters at the shelters and through social media linked to the shelters (i.e., Facebook). Interested participants contacted the research assistant who screened participants for eligibility and set up a mutually convenient time to complete the interview. There were 14 in-depth one-on-one interviews conducted with all other participants by a master's prepared trained research assistant (ED, n=1; FSP, n=8; women, n=5). The inclusion criteria for the ED was that they needed to be a current, active ED of a shelter in a rural community (see aforementioned definition of rural). The ED's were an average of 49 years of age (range 39 to 61 years), with an average of 14.8 years of experience (range 1.5 to 28 years). The inclusion criteria for the FSP were: (1) current employment at the shelter where the ED participated in the research study; (2) employed for a minimum of 3 months at the shelter; (3) a minimum of 18 years of age; (4) English speaking; and (5) willing to have the interview audio recorded. The eight FSP were an average of 38.1 years of age (range 27 to 61 years) with an average of 8.1 years of experience working for a women's shelter (range 5 to 17 years). FSP included in this study were caseworkers, counsellors, outreach workers, and supervisors.

The inclusion criteria for the women were: (1) currently accessing at least one shelter service (residential or outreach) at the rural shelter where the ED had participated in the study; (2) identified as a woman; (3) used shelter services for minimum of three months; (4) 18 years of age or older; (5) English speaking; and (6) willing to have the interview audio recorded. Participants were women, predominantly Caucasian (80%, n=4), and highly educated (all but one had completed either a college diploma or university degree, n=4). The women were an average of 52.4 years of age (range 36 to 62 years) and had used shelter services for an average of 2.6 years (range 0.5

to 8 years). Two women were using emergency housing services (averaging 25 nights in the last month) and all women engaged with two or more services beyond emergency housing (range 2 to 4 services).

## **2.4 Procedure**

Ethics approval was received for this study from the University of Western Ontario (HSREB 108233). The principal investigator and/or a trained master's prepared research assistant completed the focus group and all the in-depth interviews. The focus group lasted 180 minutes (done in two 90-minute blocks with a break in-between) at one of the rural women's shelters. The purpose of the focus-group was to identify the unique strategies rural women's shelters were using to strengthen service delivery and support of women who had experienced IPV. The first part of the focus group worked to identify challenges unique to the rural context and the second part of the interview identified innovations used. Innovations were asked in relation to the previously identified challenges (i.e., if the challenge is transportation, what is the innovation your shelter is using). Consistency across the group in terms of application was ascertained through member-checking (Sandelowski, 1996). Upon the completion of the focus group the ED's had identified a list of innovations and challenges which was member-checked with the entire group.

In-depth interviews lasted between 60 and 90 minutes and were conducted over the telephone at a convenient time for the participants. The interviews with the FSP and the one ED who did not participate in the focus group aimed at gaining an understanding of the challenges and innovations used at the rural women's shelter to support women and strengthen service delivery. For the in-depth interviews with the women the goal was to understand how the services and supports offered impacted her health and quality of life. The interviewer obtained informed verbal consent from all participants as well as permission to audio-record the interviews. Interviews were conducted over the telephone for feasibility reasons based on the geographic sprawl of participants. FSP and women were mailed a \$20.00 honorarium at the time of the interview in recognition of their time. The honorarium was mailed to the participant regardless of whether she completed the interview; however, all participants elected to complete the interview.

For both the focus group and in-depth interviews, a semi-structured interview guide was used and included questions designed to explore challenges, strategies, and innovations in rural shelters that strengthen service delivery and support women. Specifically, questions included: (1) challenges rural shelters face in addressing safety and health concerns of women; (2) strategies rural shelters use to address safety and health concerns of women; and (3) innovative practices used by rural shelters to address safety and health concerns of women. Throughout the focus group and in-depth interviews data trustworthiness steps, including reflecting back responses and paraphrasing, were utilized to ensure data accuracy (Guba & Lincoln, 2000). Additionally, extensive field notes by the interviewer were taken during both the focus groups and interviews. These field notes provided rich contextual data for the focus group/interview process and contributed to the analysis through augmenting the validity of the results (Bryman, 2006; Flick, 2044).

## **2.5 Data Analysis**

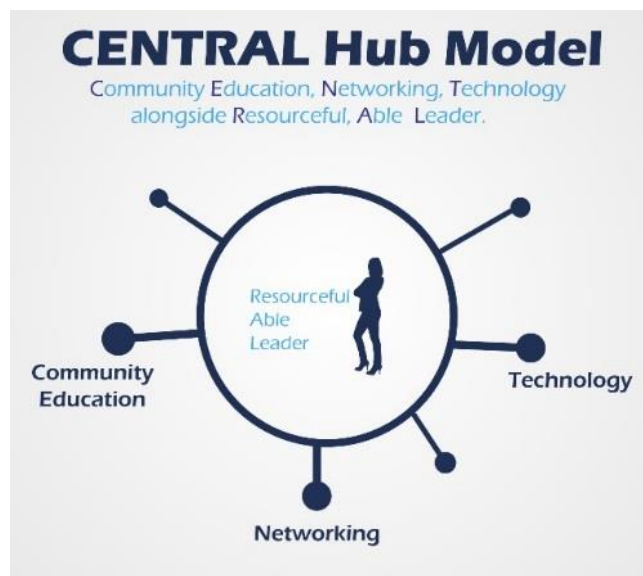
The audio recordings for the focus group and all interviews were transcribed verbatim. Data from all sources (focus group, interviews, and field notes) were included in the thematic analysis aimed at understanding the innovations rural

shelters use to strengthen service delivery and support women. Analysis took place at the end of the research project and was conducted independently and simultaneously by two investigators (T. M., & K. J.) and a research assistant using a thematic analysis approach (Sandelowski & Barroso, 2003). NVivo software was utilized to support analysis, to code, and manage all data sources. Each coder initially became immersed (Morse, 1995) in the data and then started open coding data line by line. Next, when themes began to emerge, they were organized into similar topics and into categories. Each category was then examined to determine the meaning and was provided a working name and flexible definition of the emerging theme. Axial coding was completed next by re-contextualizing the data that was coded into each category to determine consistency within the category (to decrease human bias in selective coding). Lastly, the categories were re-examined to finalize the name and definition as well as to ascertain the underlying meaning of the theme within the context of the findings. Once saturation was reached coding commenced (Morse, 1995). Once categories were finalized they were compared to the list of innovations generated by the focus group with the ED's. Once each researcher finished coding findings were compared and it was determined there was agreement on all major emergent themes, with no significant deviation in findings.

### 3.0 Results

Innovations adopted to strengthen the delivery of services and support women's safety and health in rural Ontario women's shelters revolved around five strategies: Community Education, Networking, (use of) Technology, Resourceful Able Leaders (CENTRAL) and a Hub Model (see Figure 1). Each section explores the theme by defining the category, describing the strategy, and highlighting the impact for women in terms of health and quality of life.

*Figure 1.* The CENTRAL hub mode: community education, networking, technology alongside resource, able leaders as an innovation to strengthen service delivery and support women's safety and health in rural shelters in Ontario, Canada.



Source: Authors.

### **3.1 Community Education**

Community Education is the need to educate and re-educate community members about Violence against women (VAW) through both formal and informal meetings to overcome the political context and prevailing cultural attitudes towards violence. This strategy was used to overcome barriers to service provision in rural contexts through debunking myths regarding VAW, helping community members to recognize signs of abuse, and providing tools to support agencies in interacting with women who had experienced IPV. The lack of understanding of the reality of abuse in rural communities, specifically that it exists, was underscored by all women's shelter ED's and FSP. One provider highlighted the issue saying, "I think that in a smaller community there's a real lack of education around the existence of abuse" (FSP 4). Because of the lack of knowledge, both formal and informal strategies were used. One ED explained she would use education, corrective action, and challenging normative beliefs in a formal approach by asking community service providers whether they thought a woman should stay with an abusive partner and when they answered no, would go on to explaining the importance of "recognizing the signs, understanding how to screen or even be aware of the authority and power [the service provider] has when they speak of the value of marriage, that there's an implication in that" (ED 1). Another frontline service provider discussed the development and provision of educational tools designed to help service providers communicate with women who had experienced IPV. These tools were designed for local law enforcement to support appropriate responses to women who had experienced IPV. "We developed a resource for OPP [Ontario Provincial Police] that says all of the things we should say to women, all of the things we shouldn't say to women when investigating domestic violence, some base education" (FSP 2). Informal approaches to education were used in conjunction with formal approaches. One frontline service provider described a purposeful informal approach of being available and accessible in the community so that organizations had an opportunity to ask questions: "I've been invited in to say a little blurb to this one group, for their closing and just be a special guest and participate in the banquets and the potlucks and then, you know, give people a chance to ask questions" (FSP 6). Positive impacts in relation to women's health were described through the education of local health care practitioners with one ED noted "we reach out to the social worker on the family health team and then she'll get us on one of their lunch and learns. There's a couple doctors that we've just built relationships with, the hospitals, asking to, just kind of getting our nose into the places where we think we can" (ED 4). Further positive impacts on women's health were through frontline service providers attending health appointments with women. During these appointments, the providers not only supported women's health through advocacy but also utilized the opportunity to educate health care practitioners: "so [the outreach worker] accompanying that woman to appointments, taking those opportunities to create conversation like that doctor or whoever, nurse, around her specific needs. And that in itself is an education process." (FSP 2)

### **3.2 Networking**

Networking is building connections and personal relationships to support system navigation and fill gaps in service. Women's shelters network to build support within the local community by working with individual organizations and facilitating collaboration among many organizations as well as networking with non-traditional partners. For example, for one ED, networking translated into changes in



service delivery saying, “we were building relationships then with principals and teachers so much so now we see them calling us when they have a case... and last year the principal offered space to our children’s counsellors [on site]” (ED1). Networking was purposefully undertaken via outreach to support collaboration across community services as well. A frontline service provider described a local ‘lunch ‘n learn’ strategy saying, “we have an excellent community worker luncheon up there once a month. And we have found, and each agency takes a turn and then they present on what their agency does... so [other agencies] show up and they take part and we make a lot of connections through that” (FSP 1).

In rural communities, the lack of available partners sometimes necessitated networking with ‘non-traditional partners’ or ‘more difficult’ partners to fill gaps in service. Executive directors noted, that in rural areas, you cannot always choose the best partner but are sometimes limited to the available partner, and as such, there was often a need to work intensively with a partner to bring about understanding of VAW and, hopefully, change. One ED highlighted this saying, “so we’ve had an M.P. [Member of Parliament] that was pretty vocal in his attack on Wynne [Ontario’s then current leader of the Liberal Political Party] and the sex education. And we just had him and his partner for a tour [of the shelter] last week and spoke for three hours at length involving or including our take on why that is such important work, information for rural people to have access to sex education in their schools. And why you can’t make the assumption that kids will get accurate information in their families” (ED 2). Another example was how women’s shelters networked with local hair salons. It was discovered that women were disclosing violence to hair stylists and they were unsure of an appropriate response. One frontline service provider explained, “how appreciative the salon owners and the hair stylists were to have the training and a connection with the shelter. Because they’re getting the questions” (FSP 8).

The primary goal of networking was to increase shelters capacity to connect women with community services including health care. Improved connection to community service was explained clearly by one woman who found accessing services on her own led to great difficulty but with the support of the women’s shelter it resulted in success:

I just think like personally what’s been a challenge is that trying to get other local resources on board, so the women’s shelter has helped me with that, which has been great. So, trying to get the local police on board with helping me with my situation and it was through [the shelter] that I was finally able to get the connections that I needed” (W3).

Regarding health care, one women explained that it was difficult to get access to counselling as the scheduled time for meetings was not flexible making it difficult for her to attend. However, with the support of the women’s shelter, she got appointments at times that were previously unavailable to her, stating:

I feel that [the shelter] really would, they’d find a way to get me the help that I needed. I, I just walk over and [my new therapist] I see, she always

works around my schedule, so noon for, I mean over my lunch she always accommodates that” (W1).

### **3.3 Technology**

Harnessing technology in rural contexts helps to bridge gaps created by geography. Use of technology for this project primarily included basic technology such as telephones and social media to improve access for women. Executive directors highlighted that by using even basic technology they could reach more women: “even just communicating with clients by text messaging” (ED 2) meant that more women were able to connect with the shelter. Due to both weather conditions and lack of public transportation one women’s shelter started offering counselling over the telephone with a frontline service provider saying, “so a lot of our counselling it’s done over the phone” (FSP 7). Using technology meant that women have more options to engage with the shelter despite the inability to be physically at the shelter. One frontline service provider highlighted this with an example explaining, a woman “can be in the bedroom texting or emailing, and [the abuser] was out in the living room” (FSP 2). Another frontline service provider underscored the importance of social media to both connect with women and as an educational tool, saying:

We have to recognize that we’re in the world of social media, that, you know, we really, in order to have a presence with a completely different population we really need to have a Facebook page, we need to have Instagram, we need to be on Twitter. But in order to do that effectively it’s a constant... It’s the role of public education but it’s also the role of raising your profile” (FSP 8).

Although there are limits to what technology can do, technology can open up services to women who historically have not been able to access them. For example, the ease of technology can augment safety. One woman noted feeling increased support through technology as she received texts from many of her service providers:

The legal advocate, who also texted me to say, okay are you safe, where are you going, like it was this, I had like this tremendous support of people saying, are you okay, are you safe, where are you going?” (W5).

However, the EDs and frontline service providers have identified the current use of technology in the women’s shelter was just a start and that there were additional uses that could be harnessed with one ED giving the example “ideally if we could collectively start messaging via social media I think it would have a lot more impact” (ED 4).

### **3.4 Resourceful Able Leaders**

Resourceful Able Leaders are the attributes of frontline workers capable of supporting the needs of women in the challenging rural context. This strategy largely involved looking for specific attributes in FSP. Due to limited funding and

current funding cuts in rural contexts, EDs highlighted the need for frontline service providers to be problem solvers and innovators saying:

We are looking for employees who are able to be flexible with the system and find work arounds” (ED 2).

In these rural towns people are just more open to one another and always looking for solutions. Because I think everybody’s grappling with lack of funding, lack of resources, you know. So, they look more naturally to one another to partner with, to be able to meet those needs” (ED 1).

Executive directors were also looking at relational capacities, specifically frontline service providers who are willing to build relationships to achieve goals. This idea was evident as a frontline service provider echoed the importance of relational capacity building as being imperative to building a safer shelter saying, “this is an extremely conservative community, so we try to foster as many good relationships with the other service agencies as we can, because that helps to bolster safety” (FSP 2). Frontline service providers also needed to be flexible with one ED highlighting that although a staff member was hired as an outreach worker, she was also responsible for fundraising and managing the social media accounts saying, “so our outreach program is one staff. She wears three hats” (ED1). This notion of wearing many hats was further reiterated by another ED who echoed that many times key roles such as fundraising or public education was done on “... the backside of somebody else’s job who is doing 27,000 other things” (ED 5). As such, women’s shelter EDs saw how essential it was to have high-calibre frontline service providers who could fulfil many skilled roles to provide necessary services that are tailored to support women’s needs.

### **3.5 Hub Model**

The Hub Model is the ‘gold’ standard of integration that allow rural shelters to support women’s safety and health through collaboration with other services, and with community members to overcome limitations associated with geography and confidentiality. With the four strategies, currently being used by rural women’s shelters (community education, networking, technology, and resourceful able leaders), EDs and frontline service providers felt using these strategies in conjunction with a Hub Model offered the best theoretical means to achieve a ‘gold’ standard for service. The Hub Model was described by one ED as a model “where women can go to one place and get what they need” (ED 1). The Hub Model idea was described further as:

Basically they can have a group where somebody has all of the different agencies come together and coordinate and so they have all the different representatives come; you know, somebody from the hospital and the Children’s Aid and the police force and the health unit and just everywhere, and they typically come together once a month and figure out what’s the ways that we can make sure women are receiving the best service, what are the kinds of issues that are happening in our communities” (ED5).

Executive directors described the Hub Model as a theoretical ‘gold’ standard for service as it had only been executed on a small scale within the communities; specifically, the integration of two or three services at a central location for specific cases. However, in these instances EDs described the power of the hub as two-fold. First, the women do not have to continually retell their story

Well, they’re involving police, victim services, mental health, anyone that’s in CAS [Children’s Aid Society], anyone’s involved in particular women and they’re trying to get them at the same table so that she is not having to repeat her story in several different places” (FSP 2).

Secondly, it is a more economic means for providing women-centered care:

...because there [are] so many social services agencies that can be involved in one woman’s life, instead of having her have five appointments in one week, is there a way that everybody can connect together and make it one appointment for the week, so that if she is paying for transportation she’s not doing it five times. She doesn’t have to make up an excuse to get out of the house five times” (FSP 4).

Although the five rural Ontario women’s shelters were only creating a Hub Model on a small scale with other local services with success, their goal was to eventually integrate within the larger system of health and social services.

#### **4.0 Discussion**

Findings from this descriptive participatory research study demonstrated that rural Ontario women’s shelters are using innovative strategies to strengthen the delivery of services and support women’s safety and health who have experienced IPV. Through a focus group and in-depth interviews with EDs, frontline service providers and women from five rural Ontario women’s shelters we found Community Education, Networking, Technology, Resourceful Able Leaders when enacted using a Hub Model for services was an innovative way to overcome many challenges associated service delivery and providing support for women in rural Ontario. Specifically, community education, networking and technology as outreach innovations were used to overcome geography, prevailing cultural attitudes, politics, and gaps in service. Moreover, by hiring resourceful able leaders rural Ontario women’s shelters could overcome decreased access to service and support successful system navigation. Finally, by undertaking a Hub Model wherein services are brought together to create a women-centered approach to safety and health there were implications for both improved access to safety and health services as well as increased ease in system navigation. However, currently the Hub Model only exists on a small scale (i.e., two or three services and only for specific cases), pointing to a need for further implementation and evaluation research.

There are both similarities and differences among our present findings and previous studies. Regarding networking and the utilization of community education to overcome challenges specific to rural contexts, the findings of this study are in line with findings from previous studies, demonstrating that increased training for law

enforcement and prosecutors resulted in improvements to service (Dutton, Worrell, Terrell, Denaro, & Thompson, 2002; Klein et al., 2009; Pruitt, 2008). However, the findings differ in terms of the use of technology. Previous studies have focused on both the impact of technology on decreasing violence and stalking behaviour among perpetrators (Southworth, Finn, Dawson, Fraser, & Tucker, 2007) and the impact of the use of technology at improving access to health care services in rural areas such as telehealth and e-health initiatives (Hassija & Gray, 2011); however, there has been no research examining the impact of technology on improving access to women's shelter services in rural Canada. Finally, several studies have examined differences in rural and urban contexts in terms of service provision, finding that rural areas have less trained staff, fewer IPV services (including case management, counselling/crisis intervention, hotline services, etc.), and less resources (Eastman et al., 2007; Vinton et al., 2007; Yun, Swindell, & Kercher, 2009). Alternatively, the findings from this study underscore the capacities of the frontline service providers which sheds a new light on an innovative strategy in hiring practices being used in rural areas as a mechanism to address lack of services and access to services as well as gaps in funding.

Existing literature and the new findings from this study point to the Hub Model as an important potential solution for many challenges faced in providing women's shelter services in rural areas. The Hub Model has been utilized in various facets of health care services including dental care and general practice (Huddleston & Zimmermann, 2014; O'Sullivan, Powell, Gibbon, & Emmerson, 2009) with a degree of success. The Hub Models previously utilized and evaluated in health care have resulted in significant increased access to services as well as improved patient outcomes. Additionally, Hub Models have also been applied to, and evaluated in rural areas. For example, an Australian-based study by Dyson, Kruger and Tennant (2012) examined the impact of a Hub Model for provision of dental services in rural and remote areas. The findings from this study suggested that this model resulted in similar patient outcomes delivered in a more cost-effective way, while also overcoming geographical barriers to service. Given the previous success of the Hub Model in both health care settings as within rural areas, as well as the attempts made to create Hubs in the current study on a smaller scale, the applicability and impact of utilizing a Hub Model in the rural violence against women sector is an area that merits further investigation.

The question must be asked as to why the observed innovations are being developed and used now to address challenges specific to the rural context of IPV. The rationale includes: (1) more negative health outcomes for IPV victims (Averill, Padilla, & Clements, 2007; Grama, 2000; Pruitt, 2008; Sandberg, 2013); (2) variations in helping seeking behaviours stemming from concerns over confidentiality, as services become more available in digital formats (DeKeseredy, 2011; Logan, Shannon, & Walker, 2005); and (3) poorer community responses stemming from political contexts and prevailing attitudes that sanction violence (Averill et al., 2007; Fitzsimons, Hagemester, & Braun, 2011; Pruitt, 2008; Sandberg, 2013). These challenges necessitate innovation in service delivery. Moreover, the recent shift in focus of the rural-urban divide from a deficit to capacity lens has shaped our understanding of differences in service provision in rural areas (Martin, Brigham, Roderick, Barnett, & Diamond, 2000). This shift in understanding has fostered a more critical look at strategies being used in rural settings that strengthen the delivery of services. Finally, research has demonstrated that EDs of rural women's shelter agencies are highly motivated to provide: immediate responses to help

seeking in crisis, open and ongoing support for victims of IPV, as well as stretching funding and mandates to provide service (Edwards, 2015; Macy, Rizo, Johns, & Ermentrout, 2013; Mantler & Wolfe, 2017). Given the unique service challenges in the rural context, the shift in understanding rural strategies to capacities based (instead of deficit based) model, alongside the feminist culture of VAW in rural Ontario has created a clear social need and defined problem. This clarification in the social need and newly defined problem coupled with advancement in technologies and knowledge has generated new opportunities, creating an ideal environment to drive innovation (Martin, 2013; Nicholas, 2011).

The results of this study need to be viewed considering some important limitations. First, the sample selected to participate in this study was a group of innovative women's shelters in rural Ontario. Given this, although numerous innovations were identified this sample, it is not representative of the practices of all rural women's shelters. Additionally, this study provides only the opinions of EDs, frontline service providers, and women utilizing rural women's shelter services in Ontario, Canada. As such, despite the findings being triangulated between these diverse groups, the findings have not been examined from the perspective of other community services and agencies. To that end, the efficacy of the innovations and implications for the women cannot be clearly connected to the innovations being implemented by the rural women's shelters. Moving forward, a study comparing the challenges and strategies of this study to a random sample of rural women's shelters would help to ascertain a more realistic understanding of the impact of the innovations on service delivery in rural contexts. Likewise, the inclusion of community services and agencies beyond the women's shelter would also make the findings more robust in terms of the impact of the CENTRAL Hub Model on the broader social and health care systems.

Exploration of the innovative practices of rural women's shelters to maintain and augment service delivery in the current climate of funding cuts is critical to advancing the state of knowledge. Moreover, there is the potential for significant learning and collaboration across rural women's shelters if information about the strategies and innovative practices used to address these challenges could be clearly articulated and shared. Specifically, rural women's shelters face unique challenges to support women who have experienced violence including political and cultural attitudes that undermine the need for and access to service, gaps in service due to population size, and limited partners. These unique challenges together create an atmosphere wherein innovation is required to best support women who have experienced violence.

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## **References**

- Abdulmohsen Alhalal, E., Ford-Gilboe, M., Kerr, M., & Davies, L. (2012). Identifying Factors that Predict Women's Inability to Maintain Separation from an Abusive Partner. *Issues in Mental Health Nursing*, 33(12), 838–850. <https://doi.org/10.3109/01612840.2012.714054>

- Afifi, T. O., MacMillan, H., Cox, B. J., Asmundson, G. J. G., Stein, M. B., & Sareen, J. (2009). Mental health correlates of intimate partner violence in marital relationships in a nationally representative sample of males and females. *Journal of Interpersonal Violence*, 24(8), 1398–1417. doi: <https://doi.org/10.1177/0886260508322192>
- Ansara, D. L., & Hindin, M. J. (2010). Formal and informal help-seeking associated with women's and men's experiences of intimate partner violence in Canada. *Social Science & Medicine*, 70(7), 1011–1018. Retrieved from <https://doi.org/10.1016/j.socscimed.2009.12.009>
- Austin, M. J. (2008). Strategies for transforming human service organizations into learning organizations: Knowledge management and the transfer of learning. *Journal of Evidence-Based Social Work*, 5(3–4), 569–596. Retrieved from <https://doi.org/10.1080/15433710802084326>
- Averill, J. B., Padilla, A. O., & Clements, P. T. (2007). Frightened in isolation: Unique considerations for research of sexual assault and interpersonal violence in rural areas. *Journal of Forensic Nursing*, 3, 42–46.
- Brown, V. B., Harris, M., & Fallot, R. (2013). Moving toward Trauma-Informed Practice in Addiction Treatment: A Collaborative Model of Agency Assessment. *Journal of Psychoactive Drugs*, 45(5), 386–393. Retrieved from <https://doi.org/10.1080/02791072.2013.844381>
- Bryman, A. (2006). Integrating quantitative and qualitative research: How is it done? *Qualitative research*, 6(1), 97–113.
- Burnett, C., Ford-Gilboe, M., Berman, H., Ward-Griffin, C., & Wathen, N. (2015). A critical discourse analysis of provincial policies impacting shelter service delivery to women exposed to violence. *Policy, Politics, & Nursing Practice*, 16(1–2), 5–16.
- Cohn, F. (2008). The veil of silence around family violence: is protecting patients' privacy bad for health? *Journal of Clinical Ethics*, 19(4), 321–329.
- Crenshaw, K. W. (1994). Mapping the margins: Intersectionality, identity politics, and violence against women of color. In M. A. Fineman & R. Mykitiuk (Eds.), *The public nature of private violence* (pp. 93–118). New York: Routledge.
- de Marco, A., & de Marco, M. (2010). Conceptualization and measurement of the neighborhood in rural settings: A systematic review of the literature. *Journal of Community Psychology*, 38(1), 99–114. Retrieved from <https://doi.org/10.1002/jcop.20354>
- DeKeseredy, W. S. (2011). *Violence against women: Myths, facts, controversies*. University of Toronto Press.
- Dillon, G., Hussain, R., Loxton, D., & Rahman, S. (2013). Mental and physical health and intimate partner violence against women: a review of the literature. *International Journal of Family Medicine*, 2013, Article ID 313909, 15 pages. Retrieved from <https://doi.org/10.1155/2013/313909>
- Du Mont, J., Forte, T., Cohen, M. M., Hyman, I., & Romans, S. (2005). Changing help-seeking rates for intimate partner violence in Canada. *Women & Health*, 41(1), 1–19. doi: [https://doi.org/10.1300/J013v41n01\\_01](https://doi.org/10.1300/J013v41n01_01)

- Dutton, M. A., Worrell, A., Terrell, D., Denaro, S., & Thompson, R. (2002). *National evaluation of the rural domestic violence and child victimization enforcement grant program*. U.S. Department of Justice.
- Dyson, K., Kruger, E., & Tennant, M. (2012). Networked remote area dental services: A viable, sustainable approach to oral health care in challenging environments. *Australian Journal of Rural Health*, 20(6), 334–338. doi: <https://doi.org/10.1111/j.1440-1584.2012.01318.x>
- Eastman, B. J., Bunch, S. G., Williams, A. H., & Carawan, L. W. (2007). Exploring the perceptions of domestic violence service providers in rural localities. *Violence Against Women*, 13(7), 700–716. doi: <https://doi.org/10.1177/1077801207302047>
- Edwards, K. M. (2015). Intimate partner violence and the rural-urban-suburban divide: Myth or reality? A critical review of the literature. *Trauma, Violence, & Abuse*, 16(3), 359–373. Retrieved from <https://doi.org/10.1177/1524838014557289>
- Ellsberg, M., Jansen, H. A., Heise, L., Watts, C. H., & Garcia-Moreno, C. (2008). Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and doestic violence: an observational study. *Lancet*, 371(9619), 1165–1172.
- Fitzsimons, N. M., Hagemeister, A. K., & Braun, E. J. (2011). Interpersonal violence against people with disabilities: understanding the probelm from a rural context. *Journal of Social Work in Disability & Rehabilitation*, 10(3), 166–188.
- Flick, U. (2014). *An introduction to qualitative research*. Sage. Triangulation in Qualitative Research. A Companion to Qualitative Research, 20, 432. Retrieved from <https://books.google.ca/books?hl=en&lr=&id=HB-VAgAAQBAJ&oi=fnd&pg=PP1&dq=Triangulation+in+Qualitative+Research.+A+Companion+to+Qualitative+Research,+20,+432.+&ots=kDr-0QoXZj&sig=SQNcETXDGexfqcR9GAhoePeY4iE#v=onepage&q&f=false>
- Ford-Gilboe, M., Varcoe, C., Noh, M., Wuest, J., Hammerton, J., Alhalal, E., & Burnett, C. (2015). Patterns and Predictors of Service Use Among Women Who Have Separated from an Abusive Partner. *Journal of Family Violence*, 30(4), 419–431.
- Forte, T., Cohen, M. M., Du Mont, J., Hyman, I., & Romans, S. (2005). Psychological and physical sequelae of intimate partner violence among women with limitations in their activities of daily living. *Archives of Women's Mental Health*, 8(4), 248–256. Retrieved from <https://link.springer.com/article/10.1007/s00737-005-0093-9>
- Gadomski, A. M., Wolff, D., Tripp, M., Lewis, C., & Short, L. M. (2001). Changes in health care providers' knowledge, attitudes, beliefs, and behaviors regarding domestic violence, following a multifaceted intervention. *Academic Medicine*, 76(10), 1045–1052.
- Grama, J. I. (2000). Women forgotten: Difficulties faced by rural victims of domestic violence. *American Journal of Family Law*, 14(3), 173–188.



- Guba, E. C., & Lincoln, Y. S. (2000). Paradigmatic controversies, contradictions, and emerging confluences. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (2nd ed, pp. 163–188). London: Sage Publishers Inc.
- Hassija, C., & Gray, M. J. (2011). The effectiveness and feasibility of videoconferencing technology to provide evidence-based treatment to rural domestic violence and sexual assault populations. *Telemedicine Journal and e-Health*, 17(4), 309–315. <https://doi.org/10.1089/tmj.2010.0147>
- Hegarty, K. L., O’Doherty, L. J., Chondros, P., Valpied, J., Taft, A. J., Astbury, J., ... Gunn, J. M. (2013). Effect of type and severity of intimate partner violence on women’s health and service use: Findings from a primary care trial of women afraid of their partners. *Journal of Interpersonal Violence*, 28(2), 273–294.
- Hilbert, J. C., & Krishnan, S. P. (2000). Addressing Barriers to Community Care of Battered Women in Rural Environments: Creating a Policy of Social Inclusion. *Journal of Health & Social Policy*, 12(1), 41–52.
- Huddleston, P., & Zimmermann, M. B. (2014). Stroke care using a hub and spoke model with telemedicine. *Critical Care Nursing Clinics of North America*, 26(4), 469–475. doi: <https://doi.org/10.1016/j.ccell.2014.08.014> .
- Hyman, I., Forte, T., Du Mont, J., Romans, S., & Cohen, M. M. (2009). Help-seeking behavior for intimate partner violence among racial minority women in Canada. *Women’s Health Issues*, 19, 101–108. doi: <https://doi.org/10.1016/j.whi.2008.10.002>
- Jones, L. (2008). The distinctive characteristics and needs of domestic violence victims in a Native American community. *Journal of Family Violence*, 23(2), 113–118. doi: <https://doi.org/10.1007/s10896-007-9132-9>
- Kamimura, A., Parekh, A., & Olson, L. M. (2013). Health indicators, social support, and intimate partner violence among women utilizing services at a community organization. *Women’s Health Issues*, 23(3), e179–e185. doi: <https://doi.org/10.1016/j.whi.2013.02.003>
- Klein, A., Brown, M., Small, M., Tucker, D., Fischer, R., & Walsh, C. (2009). *Evaluation of the rural domestic violence and child victimization grant program special initiative: Faith-based and community organization pilot program*. Washington D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics.
- Logan, T. K., Shannon, L., & Walker, R. (2005). Protective orders in rural and urban areas: a multiple perspective study. *Violence against Women*, 11(7), 876–911. Retrieved from <https://doi.org/10.1177/1077801205276985>
- Macy, R. J., Rizo, C. F., Johns, N. B., & Ermentrout, D. M. (2013). Directors’ opinions about domestic violence and sexual assault service strategies that help survivors. *Journal of Interpersonal Violence*, 28(5), 1040–66.
- Mantler, T., & Wolfe, B. (2017). A Rural Shelter in Ontario Adapting to Address the Changing Needs of Women Who Have Experienced Intimate Partner Violence: A Qualitative Case Study. *Rural and Remote Health*, 17(1), 3987–3999.

- Martin, A. B. (2013). Rural populations and health: Determinants, disparities, and solutions. *Journal of Rural Health*, 29(4), 432–432. Retrieved from <https://doi.org/10.1111/jrh.12036>
- Martin, D., Brigham, P., Roderick, P., Barnett, S., & Diamond, I. (2000). The (mis)representation of rural deprivation. *Environment and Planning A*, 32(4), 735–751. Retrieved from <https://doi.org/10.1068/a32130>
- McCall, L. (2005). The complexity of intersectionality. *Signs: Journal of Women in Culture and Society*, 30(3), 1771–1800. doi: <https://doi.org/10.1086/426800>
- Morse, J. M. (1995). The significance of saturation. *Qualitative Health Research*, 5(2), 147–149. doi: <https://doi.org/10.1177%2F104973239500500201>
- Nicholas, T. (2011). What drives innovation? *Antitrust Journal*, 77(2011), 787–809. Retrieved from <https://heinonline.org/HOL/LandingPage?handle=hein.journals/antil77&div=35&id=&page=>
- O’Sullivan, J., Powell, J., Gibbon, P., & Emmerson, B. (2009). The Resource Hub: an innovative e-information service delivery model addressing mental health knowledge management. *Australas Psychiatry*, 17(5), 371–374.
- du Plessis, V., Beshiri, R., Boman, R. D., & Clemenson, H. (2002). *Definitions of rural*. Ottawa: Statistics Canada, Agriculture and Rural Working Paper No. 61, Catalogue. no. 21-601-MIE.
- Pruitt, L. R. (2008). Place matters: Domestic violence and rural difference. *Wisconsin Journal of Law, Gender & Society*, 23, 347–414. Retrieved from [https://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=1276045](https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1276045)
- Sandberg, L. (2013). Backward, dub, and violence hillbillies? Rural geographies and intersectional studies on intimate partner violence. *Journal of Women and Social Work*, 28(4), 350–365. doi: <https://doi.org/10.1177%2F0886109913504153>
- Sandelowski, M. (1996). Focus on qualitative methods. Using qualitative methods in intervention studies. *Research in Nursing & Health*, 19(4), 359–364. doi: [https://doi.org/10.1002/\(SICI\)1098-240X\(199608\)19:4%3C359::AID-NUR9%3E3.0.CO;2-H](https://doi.org/10.1002/(SICI)1098-240X(199608)19:4%3C359::AID-NUR9%3E3.0.CO;2-H)
- Sandelowski, M., & Barroso, J. (2003). Classifying the findings in qualitative studies. *Qualitative Health Research*, 13(7), 905–923. doi: <https://doi.org/10.1177/1049732303253488>
- Southworth, C., Finn, J., Dawson, S., Fraser, C., & Tucker, S. (2007). Intimate partner violence, technology, and stalking. *Violence against Women*, 13(8), 842–56. Retrieved from <https://doi.org/10.1177/1077801207302045>
- Stam, M. T., Ford-Gilboe, M., & Regan, S. (2015). Primary health care service use among women who have recently left an abusive partner: income and racialization, unmet need, fits of services, and health. *Health Care for Women International*, 36(2), 161–187.
- Tjaden, P., & Thoennes, N. (2000). *Extent, nature and consequences of intimate partner violence: Findings from the National Violence Against Women Survey*. National Institute of Justice and the Center for Disease Control and Prevention. Research Report (NCJ 181867). Washington, DC: US Dept of Justice. Retrieved from <http://www.ncjrs.gov/pdffiles1/nij/181867.pdf>

- Vinton, L., Wilke, D., Griffith, A., Starks, J., Heffner, M., & Mack, J. (2007). *Florida's domestic violence needs assessment for 2006-2007*. Retrieved from <https://www.dcf.state.fl.us/programs/domesticviolence/publications/docs/NeedsAssessment0607.pdf>
- Wathen, C. N., Harris, R. M., Ford-Gilboe, M., & Hansen, M. (2014). What counts? A mixed-methods study to inform evaluation of shelters for abused women. *Violence Against Women*, 1-22.
- Woods, S., & Gill, J. (2010). Family violence: Long-term health consequences of trauma. In Humphreys, J., Campbell, J.C., (Eds.), *Family violence and nursing practice* (pp. 29–50). New York: Springer.
- World Health Organization/London School of Hygiene and Tropical Medicine. (2010). Preventing intimate partner and sexual violence against women: taking action and generating evidence. Geneva: World Health Organization.
- Wuest, J., Merritt-Gray, M., Ford-Gilboe, M., Lent, B., Varcoe, C., & Campbell, J. (2008). Chronic pain in women survivors of intimate partner violence. *Journal of Pain*, 9(11), 1049–1057. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=2010118410&site=ehost-live>
- Wuest, J., Merritt-Gray, M., Lent, B., Varcoe, C., Connors, A. J., & Ford-Gilboe, M. (2007). Patterns of medication use among women survivors of intimate partner violence. *Canadian Journal of Public Health*, 98(6), 460–464. Retrieved from <http://search.ebscohost.com/login.aspx?direct=true&db=c8h&AN=2009735898&site=ehost-live>
- Yun, I., Swindell, S., & Kercher, G. (2009). Victim services delivery: A comparison of rural and urban communities. *The Southwest Journal of Criminal Justice*, 6(2), 145–162.