Hearing about the Realities of Intimate Partner Violence in the Northwest Territories from Frontline Service Providers:

FINAL REPORT

Rural and Northern Community Response to Intimate Partner Violence

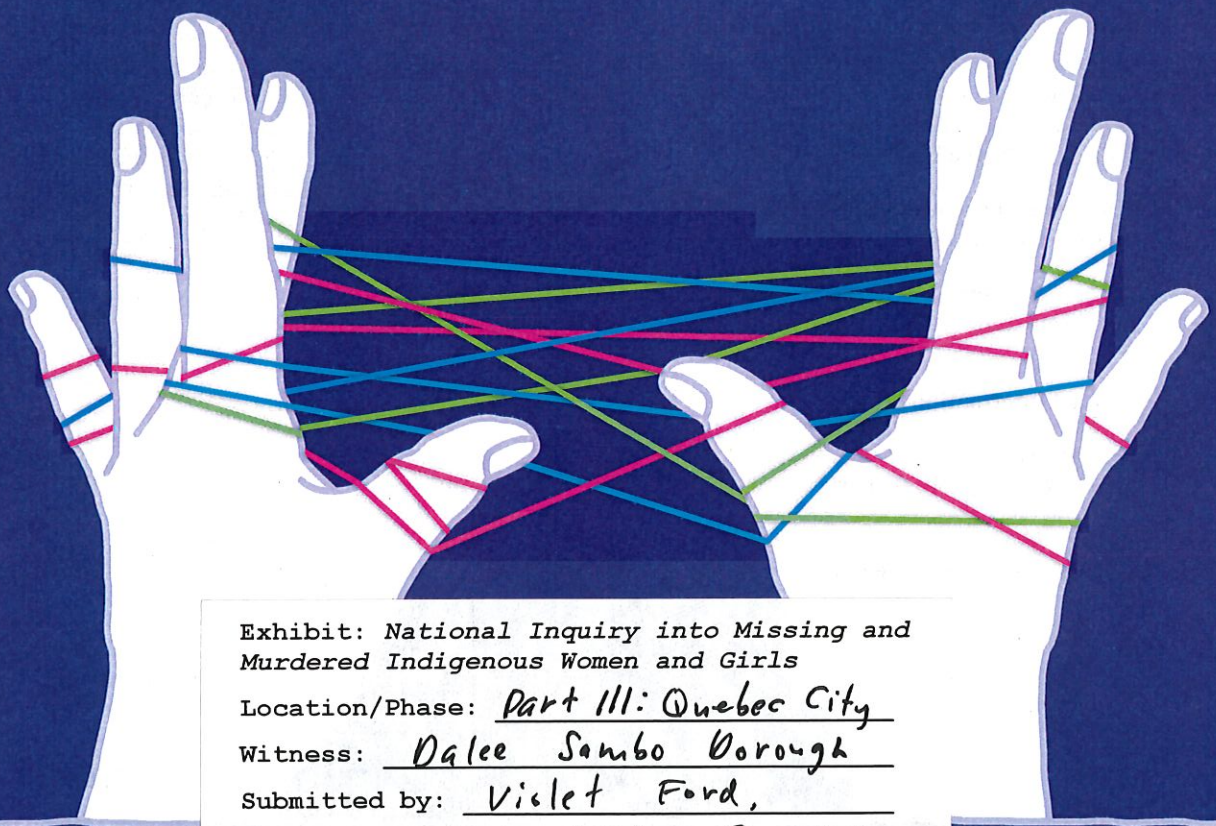


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Hearing about the Realities of Intimate Partner Violence in the Northwest Territories from Frontline Service Providers: Final Report

Rural and Northern Community Response to Intimate Partner Violence

Report for Territorial Stakeholders
January 2017

NWT Research Team

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Forward

This research project was a timely analysis of intimate partner violence (IPV) in the Northwest Territories. I was thankful to be invited to work with the Aurora Research Institute's team to provide an accurate assessment of the issues and realities that victims of IPV experience in remote northern communities. This report proposes an Action Plan that is specific for the Northwest Territories to encourage residents and communities within the NWT to become non-violent communities. It will require a collaborative and coordinated effort from government, community leaders, service providers and community members to reach this goal. This report will a valuable tool to help raise awareness and guide resources towards reducing IPV in the Northwest Territories.

Sgt. Greg Towler, Territorial Reviewer,
"G" Division RCMP

Executive Summary

Police reported violent crime against women is higher in the three territories (Nunavut, Northwest Territories and Yukon) than the rest of Canada. In fact, in the Northwest Territories (NWT), the rate of violence against women is nine times the national rate (Statistics Canada, 2013). There are multiple forces intersecting that lead to these alarming statistics, as was discovered in this five-year study that was conducted to investigate the rural and northern community response to intimate partner violence (IPV) in the NWT. From this investigation, a theoretical model, Our Hands are Tied, was developed that identifies three social processes at work in our territory contributing to violence against women. These include putting up with violence, shutting up about violence, and getting on with life. This response maintains the high rate of violence and explains why social action is needed to untie the forces that have bound violence in the territory. This report detailed theory, voice and experience of the frontline service providers whom participated in the study, which is its first to formally investigate violence against women in the territory. Since the beginning of this study through to its final stages, we have been influenced by the Truth and Reconciliation Commission's (TRC) work and final calls to action. It is our hope that this report will help support our territory's forward movement to reconciliation and non-violence across our landscape.

Findings in this research identify an influential history of colonization and the intergenerational impact of residential schooling that contributes to violence; the impact of which cannot be underestimated. The causal conditions of IPV have grown out of this context and are revealed as trauma, unhealthy relationships, poorly resourced communities, and lack of safety and support. In response, violence continues to be normalized as a way of life. There continues to be shame and blame attached to violence that is most often directed at women who are the survivors of violence not the perpetrators of the act. IPV is exacerbated by the limited resources available to women and their families and by the social isolation women experience. It is complicated and influenced by the many systemic issues and social determinants such as unemployment, poverty, housing, early life, education, gender and race, health services, social exclusion, Indigenous status, substance use and transportation to safety.

Also problematic is a transient workforce making long-term solutions and consistent practices or approaches fall into a crisis management style of intervention. The current goal of frontline workers is to handle the crisis to keep women safe. Although this is a necessary priority, interventions of this nature have limited effect on changing the contextual and contributory factors or circumstance of the situation. Furthermore, funding for many years has been directed at short-term projects that are not often monitored or evaluated.

Moving toward healthy citizenship and non-violent communities is possible. Participants identified education and awareness as one of the most important actions to achieve this vision. Through education: attitudes and language that normalize violence can be changed; healthy relationships and increased knowledge about the effects of IPV on children (parenting knowledge) can be realized and supported; assessment and screening tools can be implemented that provide early detection and resources for help; and individuals within the community can be empowered to employ social support networks that make a difference. Stable and adequate funding is required for shelters so that an effective, consistent emergency response is in place and that current or future effective intervention strategies and programs are maintained. A coordinated response strategy is required amongst frontline workers so that women do not have to shop around for help. Community healing must acknowledge an Indigenous world view, traditional knowledge and culture as well as include Indigenous communities' participation in this journey.

Introduction and Background

Introduction

IPV is a public health concern in Canada. Exposure to IPV has damaging health effects for women and their children (Public Health Agency of Canada, 2010). In the Canadian Incidence Study of Reported Child Abuse and Neglect (2008), children's exposure to IPV was noted as one of the most prevalent and substantiated causes of child maltreatment, accounting for 34% of all investigations (Public Health Agency of Canada, 2010). Additionally, there is significant over-representation of Indigenous children in the child welfare system. Across Canada, Indigenous families are investigated four times more often than non-Indigenous families (Sinha, Ellenbogen & Tromé, 2013) and in the NWT, Indigenous children account for 95% of those involved in the child welfare system (GNWT, 2014). The over-representation of Indigenous families must be understood as arising from social issues such as IPV and substance use as well as systemic risks like housing and poverty (Blackstock & Tromé, 2005; Sinha et al., 2013). IPV has been a focus in health and social sciences research in an attempt to better understand this troubling issue and prevent, reduce and eliminate this form of violence and its effects all together at both the individual and structural levels.

In the literature, violence between people who are or have been in an intimate relationship has often been described as spousal violence/abuse, domestic violence/abuse, family violence and IPV. The World Health Organization (2016) has defined IPV as, "behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours" (para 1). This definition is adhered to within this study and report. IPV is carried out in a myriad of ways and this definition provides a broad understanding of this complex form of violence. However, each category of violent and abusive behaviours listed above contains a subset of violent actions ranging from covert behaviours meant to control and intimidate, such as social isolation and stalking, to more overt physical violence ranging in severity from pushing and grabbing to choking, beating and, ultimately, intimate partner homicide (Breiding, Basile, Smith, Black, & Mahendra, 2015). It is also important to note that IPV is not limited to heterosexual intimate relationships, but that this brief introduction of relevant literature will focus on IPV perpetrated by men against women in intimate relationships.

This study investigates the needs and gaps of women experiencing IPV through the perspectives of frontline service providers. Gender is a factor in IPV and although both men and women are at risk of violence in their intimate relationships, women are consistently found to be most at risk for serious and repetitive incidents of IPV (Romans, Forte, Chen, Du Mont & Hyman, 2007). This is explained by the type, severity and frequency of violence experienced by women as compared to men. In fact, "Women disproportionately experience the most severe and chronic pattern of violence involving highly controlling and threatening behaviour" (Ansara & Hindin, 2010, p.853). Additionally, women are more likely than men to report having experienced a co-occurrence of more than one form of IPV (Romans et al., 2007). Women are also at greatest risk for death from IPV. Statistics Canada (2016) reported that the rate of IPV homicide among female victims was four times higher than male victims.

Age has also proven to be a risk factor for IPV with young Canadians aged 15 to 34 representing the greatest number of police reported cases of IPV in the country (Sinha, 2013). Additional factors that have been found to increase the risk of IPV include: low income (particularly for women), termination of intimate partner relationships, family size (Romans et al., 2007); high rates of alcohol consumption (Ansara & Hindin, 2010; Brownridge, 2008; Graham, Bernards, Wilsnack & Gmel, 2011); and remote communities with few services and low opportunities for employment (Moffitt, Fikowski, Mauricio & Mackenzie, 2013; Schmidt, Hrenchuck, Bopp & Poole, 2015).

Finally, and of immense importance, as Canada formally acknowledges the need to address colonial violence against Indigenous people and its long-term and far reaching effects, ethnicity and, in particular, Indigenous status, cannot be left out of the discussion as a significant risk factor for IPV. The TRC and national inquiry into missing and murdered Indigenous women further acknowledge this. In Canada, Indigenous (First Nations, Métis and Inuit) women are two to three times more likely than non-Indigenous women to be victims of IPV (Brennan, 2011; Brownridge, 2008;). In 2014, 75% of victims of reported incidents of IPV in Canada's northern territories were Indigenous and 93% of these individuals suffered "the most severe forms of spousal violence, that is, having been beaten, choked, threatened with a weapon or sexually assaulted" (Perreault & Simpson, 2016, p. 14). These findings draw attention to an increased risk of IPV for Indigenous women living outside of large urban areas (Brownridge, 2008).

Study Background

IPV is a grave public health problem in the NWT where the rate of IPV is second highest in Canada (Statistics Canada, 2016). This five-year project (2011-2016) was conducted in four jurisdictions (Alberta, Saskatchewan, Manitoba and NWT), focusing on rural and northern communities in each of these jurisdictions. Every community in the NWT is considered northern[1]. Although this is a geographical term, living in northern Canada carries both its romantic notions of wilderness, rugged beauty and adventure along with the challenging aspects of isolation and marginalization. These considerations of north include some aspects of "northern" as barriers for survivors of IPV, but it also means a homeland with all of the significance of place and home that are embedded in the personhood of northern peoples.

This report focuses on research conducted in the NWT and illuminates the voice of frontline workers whom provide services for women experiencing IPV. It is through these understandings that community response[2] to IPV in the NWT has been identified and described as "hands are tied". An explanation of this response will unfold within this report along with actions described by the participants to unlock the binding context of "hands are tied" to empower service providers and embrace new policy. There is little documented about IPV in the NWT and this information is vital to developing and implementing policy direction that will enable vibrant, sustainable non-violent communities. The goals of this study are to create and shape policy change that facilitates support and action in targeted areas and to raise awareness and a positive community response to move toward non-violence.

The research focuses on the following questions:

- What are the unique needs of women who suffer from intimate partner violence in rural and northern Canada?
- What are the gaps that exist in meeting those needs?
- How do we create and sustain non-violent communities in these regions?

1 Northern has been defined by such properties as population density, climate, physical landscape, transportation networks, economic activity, or relative isolation. For the purposes of this study, we are using Statistics Canada Economic Regions map, which incorporates a delimitation of northern areas that is both officially accepted and corresponds to the census data collection units. This means that, in addition to providing an acknowledged standard for identifying northern communities, it will enable us to easily integrate census data into our analysis, as required. Moreover, the Statistics Canada map seems to correspond generally to informal or intuitive regionalizations, as the northern areas so defined correspond to territory beyond the extent of the main road network.

2 Community response is defined as reactions or behaviours of members of a community to encounters of IPV. Responses can be seen as both helping and/or hindering and may include attitudes that influence responses.

Methodology

This study adopted an overall research strategy of community-based participatory action research in all jurisdictions by inviting community partners to work with academic researchers at all stages of the research process. In the NWT, our formal community partner is the Executive Director of YWCA of Yellowknife; we have also consistently and informally partnered with the RCMP G-Division and the Coalition Against Family Violence (CAFV) throughout the project. Principles of community-based participatory action were maintained: collaboration, equitable involvement of all partners, research and action, building on strengths and resources, co-learning and capacity building, long-term process and commitment, local relevance of public health problems, and dissemination of results to all partners and involving all partners in the process (Israel et al., 2003).

Throughout the project, academics and community partners maintained a collaborative approach within each jurisdiction and as a larger project team. In the NWT, we met with the CAFV approximately eight times yearly, and with the smaller research team of academics, community partners and research assistants approximately twice per year during data collection and as preliminary analyses were completed. The larger research project team across all four jurisdictions met annually. At these meetings, we shared our progress and findings to date, worked to develop data collection tools and analytic strategies, and vetted it all through the knowledge and guidance of our Elder.

We have used a variety of methods to elucidate community response to IPV in the territory. In summary, an environmental scan of NWT services as well as statistical data collected from the RCMP national database and NWT Coroner's Office was used by the project's geographers to create Geographical Information System (GIS) maps. Grounded theory[3] was used to generate a theoretical model as a means of understanding what is going on with IPV in the NWT. Other methods were used throughout the research process that included literature, document and media reviews, individual interviews and focus groups.

Ethics Approval

Ethics approval for this project was submitted by the PI, Dr. Mary Hampton, and approved by the University of Regina Research Ethics Board on September 1, 2011. A Scientific Research License, under the *Northwest Territories Scientists Act*, was issued by the Aurora Research Institute (ARI) annually. Summary reports have been submitted to ARI at the end of each project year and a final summary report will be provided to ARI at the end of the project.

Participant Sample and Recruitment

There were a total of 56 frontline service providers who were participants in this study: year two (n=31) and year three (n=25). In year two, the participants included RCMP (n=11), community health nurses (n=6), shelter workers (n=3), victim service workers (n=3), social workers (n=2) and other workers in numbers less than 3 (e.g. teachers, physicians or community wellness workers). Of these 31 participants, 22 were female and 9 were male; 25 were non-Indigenous and 6 were Indigenous. Participants were recruited from 12 communities across the NWT by purposeful sampling with the aid of the GIS IPV incidents and resources map as well as snowball sampling methods.

3 Grounded theory is a qualitative research method that was developed in the 1960s by sociologists Glaser and Strauss (1967). This method is a means of explaining and understanding the social and structural processes that happen in a social setting. For these reasons, this method of study seems a good fit to identify community response.

In year three, we conducted two focus groups (n=12), one in each of two communities as well as individual interviews (n=13) from additional frontline service providers in these same two communities. The two communities were selected using the following criteria: highest IVP incidence rate/lower IPV incidence rate, remote location/regional centre, fly-in only/road-accessible, southern NWT/northern NWT, and under-resourced/resourced. These determinations were made from the GIS maps and the selection was approved by our community partners prior to data collection.

In the third year of the study, participants represented several professions, including RCMP (n=4), community health nurses (n=5), shelter worker (n=1), victim services workers (n=2), counsellors (n=3), social workers (n=1) as well as other frontline service workers (n=9), such as teachers, community justice workers and community wellness workers. Two participants self-identified as Indigenous from the 25 interviewed, 23 self-identified as non-Indigenous; there were 11 male and 14 female participants in the third year. Consistent with the second year, all participants were recruited using purposeful sampling and snowball sampling methods.

Table 1: Participant Sample

PARTICIPANTS	Year Two		Year Three		Total in Study	
	n	%	n	%	n	%
GENDER						
Male	9	29%	11	44%	20	36%
Female	22	71%	14	56%	36	64%
Other	0	0	0	0	0	0
Total	**31**	**100%**	**25**	**100%**	**56**	**100%**
ETHNICITY						
Indigenous	6	19%	2	8%	8	14%
Non-Indigenous	25	81%	23	92%	48	86%
Total	**31**	**100%**	**25**	**100%**	**56**	**100%**
OCCUPATION						
RCMP	11	36%	4	16%	15	27%
Nurses	6	19%	5	20%	11	20%
Shelter Workers	3	9%	1	4%	4	7%
Victim Services Workers	3	9%	2	8%	5	9%
Counsellors	0	0%	3	12%	3	5%
Social Workers	2	0%	1	4%	3	5%
Other	6	19%	9	36%	15	27%
Total	**31**	**100%**	**25**	**100%**	**56**	**100%**

Data Collection and Analysis

Data were collected and analyzed over five-years from 2011 to 2016 (Figure 1). In year one, three sets of data were collected and demonstrated: an environmental scan of resources available to survivors of IPV across the NWT; reported incidents of IPV to the RCMP; and GIS maps that portray resources and incidents. In year two, we conducted individual interviews across the territory and developed a preliminary community response model to IPV. In the third year, we profiled two communities using focus groups and interviews; from this we created community narratives and a model to explain the community response to IPV as well as an action plan to move towards non-violence.

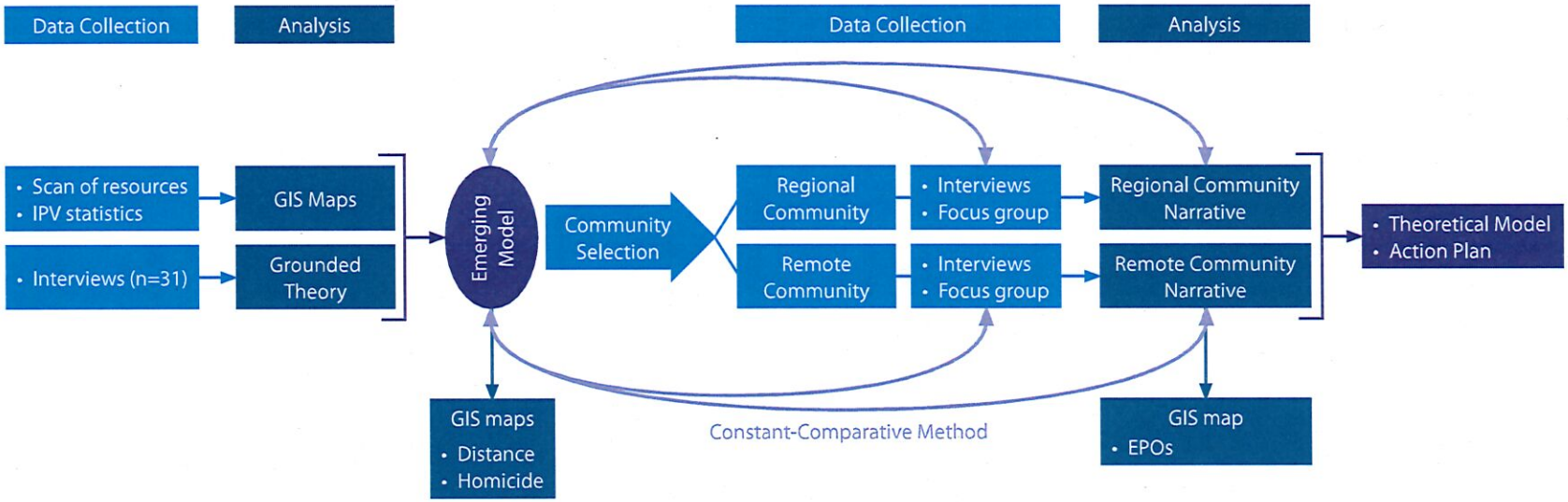
In the first year, student research assistants (RAs) from Aurora College's Nursing and Social Work programs were hired, tutored in data collection procedures and completed the environmental scan through telephone calls seeking specific information. The RAs identified: the location of emergency shelters, number of beds and shelter workers; RCMP stations and number of general duty officers; victim service workers and location; community health centres and numbers of community health nurses; secondary housing; and crisis intervention centres. Contact information for services, accumulated data and a brief narrative was developed in book format. The book was bound, printed and circulated across the north to all stakeholders.

That same year, the NWT research team received the RCMP statistical data of reported IPV in NWT from January 2009 to December 2010. This data was retrieved from the national RCMP database; the request for this data was submitted by the PI and was disseminated to each jurisdiction (Alberta, Saskatchewan, Manitoba and the NWT). A preliminary analysis of the raw numbers was conducted and further analyzed by the project team's geographers, Dr. Paul Hackett of the University of Saskatchewan and Dr. Joe Piwowar of the University of Regina. The geographers were sent both the incidents data as well as the results from the environmental scan. Using this data and Geographical Information Systems techniques[4], they created three territorial GIS maps, including a resources map, an incidents map and a combination map of the resources and incidents. The resources identified were RCMP offices, shelters, victim services and hospitals. The incidents were the two year IPV statistics. The GIS maps provided a visual depiction of services and incidents of IPV across the territory and a signpost to communities as hotspots to conduct interviews.

In the second year, semi-structured interviews were conducted with frontline workers (n=31) in 12 communities following informed consent. The interviews were conducted by the academic researchers and RAs and were 30 to 90 minutes in length. The participants were interviewed face-to-face (n=7) in a location chosen by the participant or by telephone (n=24) from the researchers' offices if the participant was not located in same area. The interviews were recorded on audio recorders and then transcribed verbatim by the RAs and academic researchers. The data is all stored on a password protected computer and confidential drive that can be accessed only by the academic researchers and RAs. There are no identifiers on the transcribed interviews and consent forms are stored separately to maintain anonymity.

4 Geographical Information Systems techniques are "a computer system for the input, storage, maintenance, retrieval, analysis, synthesis and output of geographic or location based information" (Richards et al.1999, p. 360). They have provided an opportunity in this study to visualize data and get a sense of what is going on from a holistic picture of the territory and this, in turn, provides dialogue from a more systems approach. The GIS maps have been a signpost to guide data collection and consider implications of the research.

Figure 1: Overview of Research Design (2011 to 2016)



Data Collection and Analysis cont'd

Data analysis occurred concurrently with data collection as we read and reread transcripts to make sense of what we were hearing and to add questions as they evolved from the data. Each researcher individually examined the transcripts through a process of line by line coding. We then met to share our initial individual analyses, identify categories of data and finalized major themes that emerged. In many cases, the words of participants became the actual themes named. At the end of this year, we had a preliminary model that we then took into the third year of the project and second data collection; the goal was to validate what we had learned in the second year of individual interviews.

In year three, we continued to collect data using both individual interviews (n=13) and focus groups (n=2) that were conducted in two communities for more detailed understanding of a community response to IPV in each. Both focus groups were conducted by the NWT Academic Lead; each had six participants and one was conducted in each of the two selected communities. Each focus group had six participants. Interestingly, tragically and ironically, the date for the focus group in the second community had to be rescheduled because there was a murder and suicide by intimate partners in the selected community just prior to the researcher's arrival. This incident provided an opportunity for the researcher to journal the impacts this had on the community and on our research.

For example, there are limited accommodations for visitors to the more remote communities, so hotel rooms were taken over by the police investigators from headquarters. Planned visits were postponed for several months to give the community time to grieve. All scheduled events were stopped in an effort to respect the grieving community. Everyone in the community was affected by the immense loss experienced through homicide and suicide. Prayers and vigils occurred at the community church. Counsellors were flown in from the regional centre. Elders offered guidance on such things as burial; one particular request made was to have the couple buried beside each other. Local people pitched in to complete the clean-up of the home where the deaths occurred. Since this critical incident involved criminal offences as well as a highly emotional toll to community people and frontline workers, the two researchers decided to postpone this community focus group. As such, this third year focus group was carried into the fourth year of our project.

Questions used with all participants in this phase addressed the overarching research questions as well as validated the emerging model. In keeping with an iterative process, we added additional questions that had emerged from the data analysis and the emerging theoretical model in year two. Examples of these questions included: Have you had similar work experience in an urban setting and/or do you belong to a professional group that provides service in an urban setting? Can you comment on any differences between the response to IPV in northern communities and an urban setting? Working in a northern context often poses unique challenges for service providers. Can you comment on the challenges that you have experienced and on how you have addressed them? Can you comment on frustrations that you have experienced working in a northern community?

Topics that were relevant for GIS mapping also continued to be flagged over the course of this project. For example, in the fourth year, a GIS map highlighting Emergency Protective Orders[5] (EPO) was completed to demonstrate the frequency of use and where across the NWT these are being accessed. Generally speaking, EPOs can be faciliatated by the Allison McAteer House shelter in Yellowknife or by any local RCMP detachments across the NWT.

Throughout the five years, knowledge translation has kept pace with the research methods. Presentations of the findings were made locally, nationally and internationally. In year five, we have completed the final analysis and are now sharing this analysis by way of this report and community presentations with stakeholders across the north. We are writing for publication and this will continue for several years to come. In addition, an action plan that will be shared with policy makers and planners across the territory.

5 Emergency Protection Orders (EPOs) are legal orders that provide emergency protection to victims of family violence (GNWT, n.d.). EPO legislation is under the NWT *Protection Against Family Violence Act*, which was passed in 2005 to access and provide emergency protection. The EPO can be applied for when women fear for their immediate safety. When the EPO is enforced, the abusive partner must leave. The EPO can be valid for 90 days. The length of the orders vary. The application for the EPO is private and is completed with a Justice of the Peace (Cooke, 2015).

Findings: Needs and Gaps

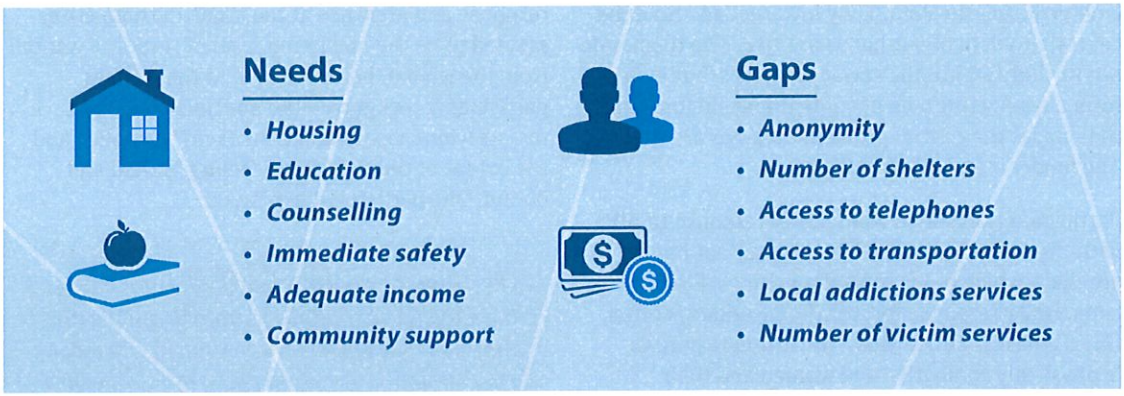
Findings

Five years of study afforded a rich data set that generated knowledge about the needs of women experiencing violence, gaps in services to meet the needs of women experiencing violence and actions for sustaining non-violent communities. Also, we produced a grounded theory addressing the community response to intimate partner violence as expressed by frontline workers. This model offers an understanding of community response in the territory and projects directions to action to create non-violent communities. Furthermore, we created an action plan from the data analyses, published literature and best practice documents.

Needs and Gaps

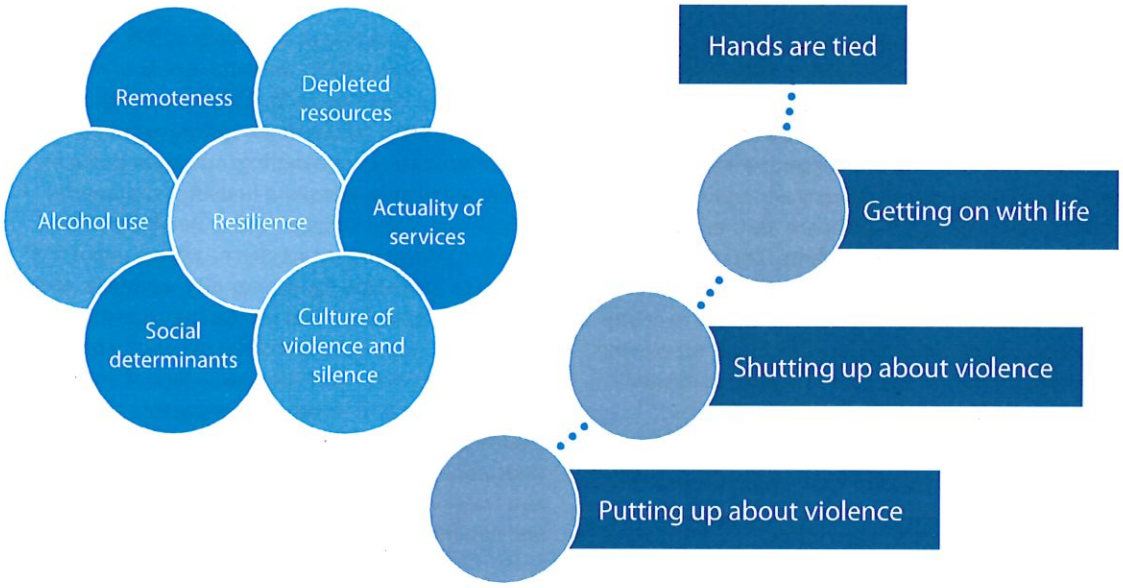
Data demonstrated both the needs of IPV survivors and gaps to successfully meet the needs of these NWT women (see Figure 2). Participants described the needs of IPV survivors as: having access to immediate safety; counselling, adequate income; stable, affordable, adequate housing; community inclusiveness and support. Other needs identified included education for service providers about IPV as well as education for community members about healthy relationships and increasing parenting knowledge. Gaps in meeting the needs of women surviving IPV were identified as: a lack of shelters or safe houses and victim services across the NWT; insufficient addiction services, including residential treatment programs; a lack of access to telephones and transportation; issues of personal anonymity and confidentiality.

Figure 2: Needs and Gaps



Central Problem: Our Hands are Tied

Figure 3: Community Response as Hands are Tied



The identified needs and gaps are embedded in overarching processes, themes and sub-themes that emerged from the data. They intersect and bind the central problem of our hands are tied. The themes do not fit tidily within the social processes, but instead, form a connecting web of context and circumstance that create the central problem of hands are tied. The model is portrayed in Figure 3.

Participants described community response to IPV with the consistent use of the phrase "our hands are tied", which holds several meanings. First of all, community response for frontline workers is often times crisis-oriented where the intimate partner is physically combative and women and their children are in an unsafe and volatile situation. For example, participants explained that the majority of their responses were focused on arresting the alleged perpetrator or removing him from the home temporarily, whether to a different residence or their local detachment until the next morning. They acknowledged that, at times, having a police response and presence at the home in those crises seemed to be the maximum level of response wanted from the woman being abused. At these times, participants recognized the multiple contextual factors women experience that kept the police and the extent of their response feeling limited and bound. One participant explained:

> *I find that the goal for them in the moment is to have the partner removed from the home and that's all they want in that moment. They don't care about tomorrow, because tomorrow 90% of the time he's back in the home, at her invitation.*
>
> (RCMP Officer)

The response by frontline workers is dependent on the women's continued participation in the justice proceedings as well as the resources in the community. IPV survivors have shared with frontline workers that they do not want to see their partner go to jail; rather, they simply want the violence to stop. This increases their reluctance to provide statements or to go to court and, when this happens, the action of the police and Crown prosecutor is obstructed and, again, these frontline workers state our hands are tied. One participant described it this way:

> *I know that there was certainly a history of violence between that couple [community homicide/suicide]... It was the male who was charged, probably several times and it didn't amount to anything in court. It was either again a stayed proceeding or the victim decided not to proceed and went back into the relationship, and it was ongoing, ongoing. And I mean, you can see that still in other relationships. You can see the same dynamics, but your hands are still tied, like you still need support. You still need someone to come forward ... in order to make a change.*
>
> (RCMP Officer)

Furthermore, frontline workers describe the central problem to service provision as having their hands tied when describing a woman's experience of violence within the intimate relationship. They explain that women have a lot to lose if attempts to access safety or leave the abusive partner are made. Women are fearful their children will be apprehended; that they will lose their housing; that they will lose their connection to the community as well as the support of community members. In some cases, women do not have access to a telephone to call for help nor transportation to a safe house or shelter; they may struggle with limited financial resources or be threatened with losing the financial support of the abuser. In communities where there are no police or victim services, the community response is at times, a non-response or one that further alienates women being abused. For example, the community might encourage her to remain silent and that this encouragement may come as the threats of gossip or retribution. Given all of these factors, IPV survivors also find their hands are tied.

Finally, included in this key problem are feelings of frustration, normalization and desensitization. These responses of both frontline service providers as well as community people across the NWT were described as a reflection of what is currently going on, but also what has historically occurred. One Indigenous participant spoke passionately to this:

> *I always swore to myself that my kids would never ever see [violence]. And that means walking the right way of life. Our spirituality as Aboriginal people, it's very simple. At the end of the day, you just have to turn that switch off because the people struggle with that switch. There's too many voices in their heads going, "No, do this, do that." Once chaos sets in, that's it. They can't grasp normality or realism.*
>
> (RCMP Officer)

Such things as the lack of resources across the NWT, severity and frequency of both violence and addiction, remoteness of communities, non-collaborative and crisis-oriented responses, and the disparity of social determinants, such as poverty, housing, education and an Indigenous status, further intersect with the response to IPV and leave service providers feeling as thought their hands are tied. This fosters their sense of tolerance to the violence and desensitization to its occurrence, which results from an inability to effectively support IPV survivors and for community healing to take place.

Social Processes

Basic social processes are core variables found in the data that continue over time. In this case, we identified three social processes that were taken verbatim from the words of participants. We have found that these three processes further describe the central phenomena of hands are tied, which reflects the service provider's descriptions of the northern community response to IPV.

We heard repeatedly that there was nowhere to go and that women feel locked in. Social isolation is a product of feeling locked in along with the shame and blame that is occurring at the community level. With limited options available for victims and an environment of desensitization, the following social processes, contributing to the current community response to IPV are present: (1) putting up with violence; (2) shutting up about violence; and (3) getting on with life. For service providers and community members (including IPV survivors and perpetrators), these sentiments exist as IPV becomes normalized through a situation where their hands are tied.

Putting Up with Violence

There are a complexity of historical and current factors that create a response of putting up with violence. The history of colonization cannot be denied as a leading factor of stigmatization, oppression and marginalization for Indigenous peoples in the NWT. This becomes significant to this study since 51.9% of the population is Dene, Métis and Inuit (Statistics Canada, 2011). They live in small communities across the territory that can, in many cases, only be accessed by air. Indigenous peoples are the recipients of colonial practices that have led to a disproportionate representation of poor health. This is not to say that the remaining 49% of the population do not experience IPV or share the same contexts of power, control and coercion from their partners that contributes to the high rates of IPV; they do. Women of all classes and ethnic groups experience IPV. In fact, the GIS map of incidents and resources identifies widespread IPV in all communities. Yet even acknowledging this, the non-Indigenous populace resides mostly in the regional centres where there are more resources, employment opportunities and housing. In addition, many are not considered marginalized by race and, thus, this paves a more successful path for education, employment, health and social inclusion. The inequities in our remote communities and oppression experienced by Indigenous peoples exacerbates the socio-economic disparities and enables a social process of putting up with violence. In this section, we will describe three factors that merge and culminate in putting up with violence. They include social determinants of health, remoteness and depleted resources.

Social Determinants[6] of Health

There is interplay between social determinants and putting up with violence, particularly in terms of unemployment, poverty, housing, education, social exclusion, Indigenous status, and substance use. Over and over again participants linked these social determinants to conditions influencing IPV and the struggle to move towards non-violence.

Poverty adds stress and limits opportunities. Participants described several barriers facilitated by a circumstance of poverty, including food insecurity, overcrowded housing and/or unsafe housing conditions as well as an overwhelming sense of disempowerment to change their violent circumstance. Violence is a choice that is woven into the fabric of these conditions and can also create barriers for women to leave an abusive relationship.

6 Social determinants of health are the conditions in which people live and have been described abundantly in the literature; for example, it is known that people with higher incomes experience better health than those with low incomes, people with good housing also experience better health, and IPV is connected to social determinants (Gill & Thiéault, 2005).

Some women are reliant on their partner's income or do not have the finances to leave and live independently. IPV survivors must go through an assessment for income support, which can feel intrusive and, at present, does not provide a decent standard of living if they are approved. One participant said:

I think in terms of the system, there seems to be a lot of barriers in place for women. For example, income support. You can't live off income support, so what choices are we giving women? ...You have to go through an assessment [to apply for income support] and there's a lot of questions that get asked and it's really hard for a woman to share everything that she's gone through. And then, even then, at the end of the day, if she's approved, the money is not there to support a family. Like, you and I couldn't live on that. So there's a barrier.

(Victim Services Worker)

Housing is a predominant theme throughout the data. Multiple times participants would explain that some women leave their relationship, but they go back to their abuser because there is nowhere to live. Housing is a challenge for IPV survivors as often times there is no other housing option. There is a shortage of housing in the communities and temporarily escaping an abusive relationship can put their housing in jeopardy upon return. One participant described this barrier when she said:

They have to be on a housing list for six months, or be in the community for six months before getting on the housing list, but there is nowhere to rent… basically there is a shortage of housing.

(Community Wellness Worker)

If women make the choice to leave their partner, they need accessible housing. This is difficult to find in remote communities where, even when you decide to leave the community to attend school, for example, you may lose your housing. This puts women in a precarious situation. Participants described the many concerns of IPV survivors related to housing. One concern for women is the fear their children may be apprehended because there was no housing available to them and the other option is to remain in the abusive relationship. Another concern and reality for some women was described as couch surfing. Participants explained that for some IPV survivors, a couch may be their only option and described this form of homelessness as being as unstable as living on the street.

It's difficult for a women, especially if she's been a stay at home mom. Even if she does get her own place to live, she needs to have access to food, she needs some education to help her learn to live on her own, to manage a household, maybe help her find a job, those kind of resources. And then the length of wait for a home is another gap... I think the average wait for a home is somewhere between 8 and 10 months, which, if you really need to be out of a dangerous situation, is a long time.

(Community Health Nurse)

In addition, there are age restrictions on accessing income and housing, which impact transitional youth, ranging in age from 15 to 24 who are caught between the welfare systems that support children and adults. As one participant stated when speaking of this vulnerable group of girls and women, "There are a lot of gaps within the resources we have, none of our resources work together. If they don't qualify for one, they should be able to qualify for another."

Remoteness[7]

The construct "remoteness" was entrenched in the context of the territory and was described with several sub-themes of geographical location: nowhere to hide and go; socially isolating; no telephones; limited transportation; and expensive to live. Remoteness provokes images of places that are far away with sparse population. NWT communities fit this description. Twenty-seven of the 33 communities in the NWT have a population of less than 1,000 and 15 communities have less than 500 people (Statistics Canada, 2011). Several times, participants noted a barrier for women, particularly in smaller communities, as not having access to telephones nor a centralized emergency number across the NWT. They described how this exacerbated IPV survivors' isolation in an already isolated, remote community. One participant explained:

I have the biggest pet peeve and I don't know if I'll ever be able to do anything about it, but, especially up north where they're so isolated, too many houses don't have phones, and it's such a huge problem. If we looked at it financially, like if they had free phones... okay, don't give them long distance, if they want long distance, ok, pay for it, but if we were to spend the money and give everyone a phone for safety, [it would] help the RCMP and the nurses have a faster response. The money that we're spending elsewhere, would it somehow work its way out, because it's such a huge problem... [Even with a telephone] by the time they tell their story, they're so agitated. Dispatch is having a hard time understanding them, and then by the time they call us and tell us the story, there's a huge lapse of time there. So, by the time I wake up, put my uniform on, call my partner and tell them what's going on and we meet, it can take up to 20 minutes.

(RCMP Officer)

When communities are this small and the nearest community is many kilometers away, an interdependency and reliance on your neighbors grows, and sometimes is cemented by marriage and kinship. For frontline service providers, who local people consider as "not from here" or "from away", they also develop an interdependency on their community of professionals, particularly for friendship and comradery. However, social isolation is a truism for both IPV survivors and service providers. When IPV occurs, women are particularly vulnerable, since there is nowhere to go. Women may become socially isolated when blaming for who is at fault occurs.

7 Remoteness has been described in the literature by Wakerman (2004) in attempts to define remote health. He developed a working definition that is salient to describe here. "Remote health is an emerging discipline with distinct sociological, historical and practice characteristics. Its practice in Australia is characterized by geographical, professional and, often, social isolation of practitioners; a strong multidisciplinary approach; overlapping and changing roles of team members, a relatively high degree of GP substitution; and practitioners requiring public health, emergency and extended clinical skills. These skills and remote health systems need to be suited to working in a cross-cultural context; serving small, dispersed and often highly mobile populations; serving populations with relatively high health needs; a physical environment of climatic extremes; and a communications environment of rapid technological change" (p.213).

Anonymity, confidentiality and privacy are mostly impossible in remote and small communities. Everyone in the community is known to each other unless you are from the outside. You are visible wherever you go in the community. Participants shared their observations and experiences of remoteness in relation to privacy. A community health nurse characterized the remote location that she worked in as "the community of secrets". Because of the lack of confidentiality, gossip, shaming and blaming, women are reticent to share accounts of abuse and violence. They are reluctant to take part in workshops where personal information may be shared and heard about in the community, and when they seek help, they fabricate a story to get in to see the nurse. One participant said:

> *They [IPV survivors] will come in on an individual basis… and say, oh, I need to see [the nurse], I have a sore throat" and then I see them and its nothing like that. So, I do a lot of one on one, and it's mostly listening to them, but I think until the community recognizes that there's a problem and that this is not acceptable, I can't see it changing, and even the Elders, the grandparents, will also speak to the young girls, and even the guys. The guys get abused as well, and it's more difficult for them because they won't press charges… because of the whole stigma of being a male. But the grandparents, the Elders, will tell them "just never mind".*
>
> (Community Health Nurse)

Participants also cited IPV survivor's struggles to leave a remote community to access a shelter. These include financial expense, logistics, anonymity and weather dependence. One researcher reflected on the threatened experience of being "weathered in" when visiting a remote community for this project in this journal entry:

> *For the few hours prior to scheduled departure, it was unclear if transportation out of [community] was going to be available. However, when successfully leaving as planned, I was overwhelmed when considering the impact of this uncertainty on IPV survivors. We had been dropped off at the air terminal by a local RCMP member. He had come in and taken advantage of the opportunity to approach two women who were also waiting for the plane to arrive so they could leave their abusive relationships. He was gentle, caring and, from where I stood, offered a sense of safety and protection in a moment of extreme vulnerability and risk. The two women boarded the plane, along with their young children; one of the women had expressed a significant fear of flying, which for her was another challenge and barrier to overcome. As we took off, I found myself wondering about the women's possible fears, thoughts and realities in those couple hours before departure. I assume they, too, were watching the weather and wondering if the plane would be able to come in, let alone leave. I had my own apprehensions about being weathered in, but I am certain they did too. Where would they go? Would their anonymity be safe? Would the next opportunity to flee the abusive relationship manifest itself? When we arrived safely at our destination and entered the terminal, one of the women was met by a taxi driver who was going to escort her to that next location of safety. I wasn't clear where she was going, but struggled to imagine the sense of fear and loneliness she must have been experiencing in that moment. Equally, however, I was struck by the courage and strength she rallied to flee a violent relationship to a new community where she was alone, but for her infant.*
>
> (Fikowski, journal entry, 2016)

Another participant described the challenges to overcome when attempting to leave a community in order to access a shelter; that the geographic realities of many northern communities create risks over and above those that every IPV survivor faces when leaving an abusive relationship. She recollected one particular woman's story in trying to access the shelter:

> *Well there was one where a client that was coming, her sister called us from another community and said, "Can you hold a space? My sister's coming and the road's breaking up so she can't drive. I'm gonna drive by ski-doo. She's gonna start by canoe and I'm gonna go get her. Will you save her room?" Stuff like that, right? It might have been, and I can't recall whether she tried to phone out and wasn't allowed to or whether she didn't feel safe to go ask. Sometimes you can't in a small community. And they know you're gonna leave; you need to do it so secretly and you put yourself in other risks in order to do that.*
>
> (Shelter Worker)

Remoteness is not as simple as considering only the geographic barriers posed, but the context in which it is experienced by women who are surviving an abusive relationship or fleeing its violence. In essence, we must acknowledge how this contextual experience of remoteness perpetuates the process of putting up with violence.

Depleted Resources

Frontline service workers identified the limited resources available in communities, or broadly within the NWT, that impact the depth of intervention they are able to offer and is experienced first-hand by IPV survivors, particularly those in remote communities, but reinforced the necessity of services to support women and communities. One participant suggested, "They [IPV survivors] need a shelter to go to, rule number one. They need support and they need that immediate rescue." (Shelter Worker) Several sub-themes are included to further explain the theme of depleted resources and how it contributes to the social process of putting up with violence: lack of choice, availability and accessibility of resources; poor outreach from regional centres; lack of funding; and retention of service providers.

Amount of Services

The scarcity of resources available within communities can be acknowledged quantifiably. For example, of the 33 communities across the NWT, 33% are without RCMP presence, almost 80% are without victim services and 85% do not have a women's shelter (of the five shelters operating, they run at full capacity). One participant highlighted the importance of considering remoteness of many communities and how that contributes to fewer resources for people living there:

> *The problem, I think, is just resources, like realistically, if you live in a community of 300 that is fly-in only, it's going to be very difficult to bring up social workers and a safe house, and counsellors, all of which is in such dire need in these communities. But it's so isolated and to allocate these resources to these smaller communities is, you know, it's just such a challenge and yet these communities are their homes and they do not want to leave them to go to a bigger centre where they could potentially access more resources, more education, more jobs, so I think that the location alone is like such a huge issue.*
>
> (Healthcare Provider)

Accessibility and Availability

The numbers of resources become more severe when acknowledging the limited accessibility and availability of existing services. Regarding services that are available in the community, service providers recognized its possible inaccessibility or lack of anonymity for women if a family member or acquaintance was offering the services. One participant explained:

> *It was almost 2 ½ years I was there. There was no victim services worker so what we did, 'cause our policy says to refer people to Victims Services, so we called Victims Services Worker in [the regional centre] and say, this is the situation. The victim doesn't have a phone at home and there's no Victims Services Worker in town, so we call them to notify them. But, in reality, there's no help at all. A quarter of the people we work with in [the community] don't have phones. There's no Victims Services Worker in town. If there was, it'd be someone local that they may not trust 'cause the rumour mill would go around.*
>
> (RCMP Officer)

The above quote discusses the centralization of most IPV resources in the regional centres of NWT. To access these services, women need to know about the services available to them and then do their best to access them. In some circumstances, they are navigating this process on their own or, in other situations, getting assistance from a person who is both the services coordinator and a family member or acquaintance.

One barrier to the regional services outreach to more remote communities was those linkages, in addition to women's lack of knowledge about what resources and what assistance is available to them. One participant stated:

> *I think there's a lot of people who don't know what services are available, and I think in many cases, especially in the smaller communities, there are no services available other than maybe the RCMP or the medical clinic or something like that. But there's a lot of people, especially in the smaller communities, who have no alternatives whatsoever except to continue to live with the person who may be abusive towards them.*
>
> (RCMP Officer)

Lack of Funding

The lack of funding or services operating without established permanent funding was raised as a concern for frontline workers regarding their ability to offer effective services. One participant explained the funding impact and ability to create change when she said:

> *You can't move forward or just do a band-aid for six weeks around partner violence of any kind and expect that to change anything. I think there's really a gap around a financial commitment from the territory. To really look at it from a community perspective, and really look at it from community development.*
>
> (Shelter Worker)

They described the common-ness of short-term or pilot projects; some noted the energy and time spent searching for funds to retain a program that could be better spent supporting community people. A lack of funding, including permanent funding, makes it difficult for service providers and community people to keep track of what is available. Short-term projects come and go frequently and, as a result, people's knowledge of what services exist is impacted. In addition, it was noted that shorter-term funds decrease the ability to effectively measure the success of a program designed to reduce violence or the effects of violence on women and their children.

With regards to funding, there are not enough emergency shelters in the NWT to effectively manage the number of women experiencing IPV. The incidents of IPV are occurring in all communities and at much higher rates when compared to the rest of Canada. With only five shelters operating, each in a different community, there is a void in many communities and an absence of shelters in two regions. Of those shelters that are existing, they are consistently full with single women or those fleeing violence with their children. These shelters have also had minimal repairs over the years and some are in dire need of repair. Funding for the current shelters is insufficient to provide ongoing maintenance and repairs, consistent operations, recruitment and retention of staff as well as offering appropriate training to those working there. For example, there was one instance during our project dissemination, wherein a community with shelter services was shut down because of staffing issues. At that time, we observed women being forced to leave their community for safety elsewhere. So even with the five shelters, these are not consistently available to women for several reasons, including funding shortages, recruitment and retention of staff, or bed space.

Recruitment and Retention

Frontline workers are often retained for short terms in the communities. This is certainly true for the RCMP officers whom are usually in the remote communities for two years. It is also a more typical situation with community health nurses, victim services workers, social workers and teachers who move in and out of communities after having only worked for a short period of time. Participants explained the struggle with retention was rooted in the geographic remoteness of the north, multiple roles that go beyond a job description (in large part because of the depleted resources within communities) and the intensity of direct services work frontline professionals are tasked to respond to. The lag in time to fill vacant positions is significant and these underemployed services increase the stress and workload of those that are trying to compensate for the staffing shortage. Additionally, the disparity and inequalities within the social context, the lethality of violence, the degree of substance use and the historical implications of colonialism influence the longevity (or lack thereof) of staff retention.

One frontline worker spoke to an effect from the transient workforce; she coined it as a loss of *institutional memory*. Every new worker is essentially starting over in the community. This perpetuates stop gap measures that are mostly aimed at keeping everyone safe, limits the opportunities to work on longer term goals of non-violence, and creates barriers to building relationships of trust between frontline workers and community members. One community health nurse shared her perspective of the increased number of nursing locums with the emerging territorial health authority. She coined this the "locum revolution" and expressed concerns about the poorer quality of services to the community due to lack of knowledge about the community, its history, vision and people. This, again, enables the problem, hands are tied, with minimal improvement to the rates of violence occurring in the community. The approach to violence is fragmented, with an unclear pathway for women to travel to overcome the trauma and violence. It becomes understandable that women "put up with violence" and frontline workers making attempts to help are pulled into the same frustrating response.

Shutting Up about Violence

The notion that our community members are shutting up about the violence seems to be harsh, yet it is woven into a complex intersection as one of three social processes creating a sense that service providers hands are tied in their response to intimate partner violence. The intersectional nature of all social processes, themes and sub-themes contribute to the overarching problem of hands tied. The social process of putting up with violence intersects with the process of shutting up about violence. The way in which these intersect and contribute to the central problem is captured by this participant when he said:

> *We do what we can. I mean, we do have victim services, but [in] the communities I've been [in] before, there is no victim service representative living in the community. So, we would call Yellowknife Victim Services to let them know of the situation, but it's up to Yellowknife Victim Services. But there's not a whole lot that they can do. A lot of women in these communities don't have phones and there's even no one in the community to help them. It's not like they can do a phone therapy if they don't have a phone. So, it feels like a lost cause. It's just like another box to tick off of our policy that we have to call Victim Services, which we do. And from what I've seen, it's not a wrap on Victim Services, there is very minimal what they could do. Because when all the ticks are down and all the victim services and RCMP go home for the day, it's still that victim that has to go home to her house or go to a family member's house where she might be rejected because she's getting her husband in trouble. And she still has to live with all these pressures.*
>
> (RCMP Officer)

The theme of a culture of violence and silence is central to the social process of shutting up about violence. It reinforces the sense that women, families, communities and our territory are not speaking out against the violence that is occurring in intimate relationships. Speaking out, however, is a metaphor for people existing in this current crisis of violence. For example, we can look at our most recent territorial elections and acknowledge the way in which a person accused of assaulting his partner was granted early release from jail to run as a member of the legislative assembly and, in doing so, was successful in retaining a seat. This incident can be understood from many contributing factors that we have identified as sub-themes to a culture of violence and silence. Sub-themes to this culture of violence and silence include historic trauma, the normalization of violence, gossip as a tool for silence, community retribution, family and community values and self-preservation.

Historic Trauma[8]

One major sub-theme that every participant in the project acknowledged was the effects of historic trauma, with several key factors comprising its existence. Participants consistently noted the way in which colonization and residential schooling has impacted Indigenous people of the NWT. They talked about ways in which these traumatic historic events have contributed to a disrupted family life and negatively impacted their health and well-being. They explained how these events have impacted the way in which community members understand healthy intimate relationships, parenting strategies and gender roles. One participant remarked on the cumulative nature and intergenerational effects:

> *They grow up with lower self-worth and end up following patterns that they were raised with. So, if they were in a violent family, they tend to have lower self-worth; gravitate towards a partner who will treat them the same way that their family dynamic worked. And the cycle just carries on generation to generation.*
>
> (RCMP Officer)

Participants also suggested that the effects of historic trauma might contribute to women's current hesitance in accessing services or their ability to develop a trusting relationship with service providers at a time when they are experiencing violence and in dire need of support and assistance. One participant remarked:

> *I think [the impact from residential school] is a major divider and a cause of a really prevalent lack of trust that permeates our culture. I think it makes any other type of programming very difficult to get the positive outcome when there is that kind of foundation of a lack of trust.*
>
> (Shelter Worker)

The cumulative nature of historic trauma, its intergenerational transmission and the negative influence it has upon the relationships with service providers create a tangled web through which frontline workers navigate in order to assist women and families who are experiencing violence. Protective and supportive services are more challenging to provide and as participants suggest, feel less successful in efforts to create change for a woman, her family and her community. As such, it contributing to service providers sense that their hands are tied.

8 Historic trauma has been explained as the accumulation of collective stressors and past trauma that continues to impact Indigenous peoples with increased risks for poorer health and social problems (Bombay, Matheson, & Anisman, 2014). The historic trauma event has three characteristics, including it being "(1) widespread among a specific group or population, with many group members being affected, (2) the event was perpetuated by outgroup members with purposeful and often destructive intent, (3) the event generated high levels of collective distress in the victimized group" (Bombay et al., 2014, pp. 321-322). The responses to an event as described continues to undermine the well-being of current group members, the events interact with current stressors that influence the group's present well-being and that these accumulate across generations (Bombay et al., 2014).

Violence Normalized

Participants discussed the history of violence, ongoing nature of violence, and current alcohol use and abuse that exists in the NWT contributing to what has currently become a sense of normal for people. Consistently throughout the interviews and focus groups, participants reflected that this, "Just seems so wrought with traumatic experiences and that it almost seems like, not the norm, but kind of the norm" (Healthcare Provider). They explained that violence in a family is almost expected and accepted; not that people consider violence to be okay, but that it is normalized into what their definition of an intimate relationship is since it is how people have been socialized into the family and community. A participant recalled one visit to a remote community wherein she was witness to an incident of violence and, as well, the lack of response from community members in the moment:

> *I was working in the band office and there was a lady there who was on the computer. It was like about five after 12, and her husband came in and literally dragged her out of there by her ponytail. No one moved! I said, "What are you doing?" And he said, "Well, she didn't have lunch made." And I said, "You still can't grab her by her hair!" And the women there were scared for me because they wouldn't talk back to this man, and I said, "I'm not scared of him. " I should have been, but I wasn't. But no one moved.*
>
> (Social Activist)

One participant spoke to the socialized nature of violence as normal, stating:

> *In my estimation, I think that there is a prevalence of men and women up in the north that feel that domestic violence is just a part of daily life, and they come to expect it and they come to deal with it. And the victimization continues.*
>
> (RCMP Officer)

Many participants remarked on and acknowledged their own desensitization and normalization of the violence occurring in NWT communities. They talked about the stark differences in the frequency and lethality of violence when considering southern Canadian and urban centres they have previously worked in. They acknowledge that the shock wears off over time and that they become desensitized. A participant explained it like this:

> *A different mindset and a different expectation about what a healthy, normal relationship looks like. We saw it in the people as well. I think, that because they live in a situation that's violent, whether it's parents or grandparents, they kind of expect that that's what their relationship will look like, to cope with the higher degrees of violence in the NWT.*

The high rates of violence and the lethality of violence no longer become shocking to those who are providing frontline services, nor is it shocking to those who are living within it. That sense of normal and becoming desensitized to the violence silences people in terms of speaking out against it.

Gossip as a Tool for Silence

We discovered an influential means to further silence women and community people from speaking out against IPV. Participants spoke of the powerful way in which gossip facilitates the silencing of women and others from disclosing IPV and seeking help. They explained that women fear the repercussions of being talked about by community people and have maintained a fear of reprisal from her family, her partner's family and/or the community as a whole. Several stories were shared with us that described the consequences, shorter or longer term, to women and their children for accessing help or following through with charges against their violent partners. These consequences include hurtful gossip in her home community, shame for either being in that situation or speaking out against her partner and the blame for consequences to her partner and/or the family. One participant remarked on the way in which a fear of gossip maintains the culture of violence and silence in NWT communities:

> *I think there's this culture of violence, and then not wanting to disclose any of that information to friends and family. It's a very small community, so I know even speaking with family and health professionals as well, there's this hesitance because they feel that it's not confidential, or that somehow, it's going to get all over town that there's a conflict in their relationship. But I mean, people know. It's something that I guess people speak about in the community, but, like I said, are hesitant to address or at least bring it to the attention of the police, the RCMP or myself or the doctors.*
>
> (Social Worker)

The gossip used against women is a powerful agent in keeping service providers hands tied, as they are unable to move forward with support if women are not willing to disclose the violence they are experiencing.

Community Retribution

The retribution women experience from family or community members stems from their own actions of speaking about the violence and/or accessing help. This retribution is either actual or feared, but another significant contributing factor to the culture of violence and silence, shutting up about the violence and the central theme to this research project, hands are tied. This sense of feeling as though your hands are tied by the community pressure to stay silent was described by a participant using this example:

> *The biggest battle is getting [women] into the courtroom to face the accused again. That plays into it because there's family pressure. There's community pressure. There's political pressure sometimes. And those are the things we face daily.*
>
> (RCMP Officer)

We have separated community retribution from gossip as distinct tools for silencing women and community members about IPV. However, these two sub-themes interact with each other and strengthen the fear women have about taking steps to leave their violent relationship. Many stories were shared with us that detailed the way in which women experienced the retaliation of their own family, their partner's family or other community members for having accessed help. A participant described it like this:

> *So, he did his time, but in the interim, it was so bad for her just because he was affiliated. He was the son of the chief. He was one of the main families in town. It doesn't matter if he would of, I shouldn't speculate. But if he wouldn't of really beaten her senseless or killed her, I'm sure that that family would've stood behind him 100%... It was a true victim and the worst part of it was not the person going to jail and getting convicted and doing his time. The worst part of it was his family, which is a prominent family in town. [They] made her life miserable because of it. Alienated her and she had children and everything. The whole family was alienated.*
>
> (RCMP Officer)

One of the stories that a counsellor shared with us described a woman who was isolated from any supports and when she did take steps to seek out help in what was an extremely violent relationship, she felt the retribution from family and community and, as well, the shame and blame from gossip being spread around:

> *She talked about... not being able to talk to her mother because her mother... would take whatever she said, so spread gossip about her basically. And this woman didn't want to say anything to her mother because she knew it wouldn't be kept confidential and then, of course, his family was totally in support of him, so they would blame her if something happened. And I remember thinking, this woman's sister was killed by her partner several years ago in a violent incident [of IPV] and I just, I can't imagine how she could ever get out.*
>
> (Counsellor)

The retaliation experienced and/or the expectation that such retribution would come to a woman feeds into a culture of violence and silence. This factor inhibits women from coming forward to service providers or following through with charges that have been laid.

Family and Community Values

Women are also encouraged to remain silent and accept violence because of their own, their family's or the community's values of non-interference in relationships and the lifelong commitment to their partner. One participant explained the impact of this in terms of being able to offer support to an IPV survivor:

> *When the victims finally put a stand to it, they can't handle the pressure from the family members and the community to stay in that relationship. They have nowhere else to go. So, basically, there's no way out for victims who are chronically abused.*
>
> (RCMP Member)

Earlier, we spoke about the personal experience as a researcher when having to reschedule a community visit due to a murder/homicide that had occurred. It was a powerful moment to hear how Elders guided the burial by suggesting the man and woman be buried side-by-side and, for us, reflected the values of marriage regardless of the violence going on. In this instance, the degree of violence had lethal consequences, yet the decision to bury them together perpetuates the culture of violence and silence. It circumvents the possibility to offer support or intervention as service providers. These messages to remain silent and accepting of violence in a relationship can come in a more covert manner, such as in the above example. Participants also described the overt messages women receive that reflect this same understanding of intimate relationships. For example, one participant stated:

> *I think the other piece, in terms of the barriers, is even the community response and the family response that, often times, the family will say, "Well, it's your fault. You just need to be a better wife," or "You shouldn't be provoking the violence". So, there's a lot of lateral violence that the woman experiences that keeps her in her place. That's a barrier.*
>
> (Community Health Nurse)

Whether covert or overt, messages to remain silent in a violent relationship create barriers to women's safety. Women may hesitate to initiate that change, speak out or seek help. Frontline workers feel these messages as another factor that is keeping their hands tied to offering support and effectively ending violence in a relationship and family.

Self-preservation

The last sub-theme within this culture of violence and silence is a woman's self-preservation, which also intersects with themes of resilience as part of the social process, getting on with life. It is important to consider both historic and current traumas when understanding self-preservation. These traumas could include such things as residential schooling, exposure to violence in her parents' relationship or abuse from her parent(s). We know that violence against women in the NWT is nine times higher than the national average, including incidents of IPV (Statistics Canada, 2013). So, for many women, they may have experienced more recent traumas, possibly in addition to childhood exposure or experiences of violence. For those women, speaking out about and/or seeking help in the face of violence could further exacerbate her psychological trauma. Remaining silent in this instance is not accepting the violence, but demonstrating insights into what they are or are not capable of. Discussing or taking steps to seek help could possibly increase her trauma to an unmanageable degree and her insights into this is a strength, demonstrating resilience, and allowing her the ability to get on with life even if it means staying in a violent relationship. A participant acknowledged this when she said, "It's just... the layers of trauma are so deep that it's really hard to imagine what those women are faced with when they're making decisions" (Community Health Nurse).

In other instances, women may use violence in the relationship, but not for the purposes of power and control. Rather, it is used in efforts to resist the violence in her relationship, including acts of self-defense. Another participant shared the misconceptions that can occur:

I think there's a lot of negative attitudes out there that some people believe that the stats are skewed, that women are equally violent towards their male partners. But they don't understand that analysis, that violence against men looks very different; that this could be resistance as her way of protecting herself and her children.

(RCMP Officer)

IPV survivors are trying their best to cope with a violent relationship. There is not much support or help for them (nowhere to go, limited resources, fear of retaliation and gossip), so they do the best they can in terms of coping with the situation and, sometimes, not coming forward. Perhaps these are the better options for women when weighing the personal consequences, such as gossip, family or community retribution; or perhaps it is less of a risk than trying to flee the relationship when a victim is geographically isolated and in a community deplete of services to support her efforts toward safety.

Self-preservation as a factor to shutting up about violence goes beyond a woman experiencing IVP. It also spreads to family members and community people who, as well, may be silent as a way of coping with past and/or current traumas they themselves have survived. One participant explained:

The intimate partner abuse is something that's kept quiet. It's not talked about amongst the community and that, I think, is partially self-preservation because this is when you are in a small community, you kind of have to keep the peace and, you know, you don't go out of your way to make more crises in a culture where there's been enough, you know?

(Counsellor)

The historic trauma experienced by many Indigenous people in the NWT, the ongoing trauma of surviving in an intimate relationship containing violence and residing in northern communities that create additional barriers to seeking safety contribute to a culture of violence and silence. These contribute to women shutting up about the violence and contribute to the sense service providers have of their hands being tied.

Getting On with Life

One participant described this process with the following words: "There is nowhere to go, so what's the point. Getting on with life is a way of coping." Getting on with life was validated by all participants as a social process to address IPV. Getting on with life is described through three themes: the actuality of services; alcohol use; and resilience.

Actuality of Services

The services offered and the way they are provided has an impact on the social process of getting on with life. One participant explained service delivery from her perspective:

I guess one of the biggest gaps that I see from my position is departments not working together. So, you know, health does a little bit over here, like they have the social services piece and the foster care piece, and are responsible for the shelters, and then over in justice, we're just responsible for Victim Services, and then the authority through Health and Social Services are responsible for providing some of that case planning for women who have experienced violence and then ECE income support, but none of those departments have like a plan… So, I think there's gaps at that bigger level, um, to provide like a consistent response and services to women.

(Victim Services Worker)

Participants discussed the impact IPV-focused work and northern, remote postings have had on them. They also spoke to the ways in which both community members and frontline workers use services that are available, accessible and manageable for them. Participants described their delivery of services and use of other services available to them as ineffective, crisis-oriented, short term and stand alone.

Ineffective

Participants acknowledged that there has been little shift towards non-violence across the NWT and within relationships. Non-collaborative efforts, limited resources, remoteness, and a culture of violence and silence all intersect to contribute to ineffective services. They also explain this, in part, from the services (or lack thereof) provided to IPV survivors and the community. One factor that contributes to this is a misunderstanding amongst both service providers and community people about IPV itself. One participant described this lack of knowledge:

> *I see women who resist IPV in the whole spectrum of ways that women resist. So, from being violent themselves, using verbal attacks, coping through substance abuse, etcetera, etcetera, as often being very misunderstood and being perceived by community member, including service providers, as being equally as abusive, as opposed to resisting oppression and trying to preserve their dignity. I'd say that there is a lot of blaming victims of intimate partner violence, which I think can also contribute to women staying silent.*
>
> (Shelter Worker)

> *I think it's misunderstood by the service providers in that if you don't understand the cycle of violence, it's very hard to stay non-judgmental when you're dealing with the victim and with the perpetrator. So, I think that's a big problem, you know, when they go to the hospital, when they go to the shelter, they return back home to their abuser. A lot of it is misunderstood because people don't understand the cycle of violence.*
>
> (Community Health Nurse)

Another contributing factor to ineffectiveness of services exists within the larger systems themselves. They reflected an approach that focuses on problems within the individual people, whether that is the perpetrator of violence or the woman surviving IPV, as opposed to a holistic look at the service required and provided in the territory. One participant explained the oppressive nature that this individualized orientation to interventions takes:

> *So, for example, the child protection system. I think that it can be another… in spite of the best intentions that I've seen of the workers themselves, I think that the system might have some flaws that work in a way that can be very coercive and can end up replicating the abuse that women have experienced. I would say the same of our income security program.*
>
> (Shelter Worker)

There is an identified need to understand the risks of IPV as systemic and socio-economic; further, the necessity of taking a structural approach to IPV service delivery would increase its effectiveness. This participant's comments express his concerns about the ineffectiveness of services provided. It also indicates the need to create awareness about the systemic issues and interventions needed to create change.

My experiences, unfortunately, what I've seen is that you know the hands of a department like Social Services, they're hands are tied. They step in and they do the best they can. Like, I'm not gonna knock a partner system that we work with. But, unfortunately, their first approach is to ensure the safety of the children at that moment... But apprehending children to remove them from that situation long-term doesn't happen. It's a cycle that continues. That child, or those children, will be subjected back to, you know, they go back into the family once the investigation reveals there's no immediate threat.

(RCMP Officer)

Crisis-oriented Services

Many participants directly identified or described the predominance of services as crisis-oriented. They explained this as a result of the limited resources available, the volume of work they are responsible for and, at times, from the direction of the IPV survivor.

So, we make sure she's not in a position where she's afraid of him hearing what she's saying, but, ultimately, I find that the goal for them in the moment is to have the partner removed from the home and that's all they want in that moment. They don't care about tomorrow, because tomorrow 90% of the time he's back in the home, at her invitation.

(RCMP Officer)

Those that spoke described the prevalence of their crisis-oriented response to IPV and did not believe it was the most effective way in which to deliver services. Moreover, it is a response they are continuously doing within a plethora of other contextual factors, leaving them feeling like their hands are tied. Participants recognized the importance of prevention work, but given everything, their focus is most typically defaulted to a more crisis-oriented approach.

Non-collaborative Service Delivery

Frontline workers described themselves as working in "silos". They explained that the result of this is offering services that appears to be that of a"patchwork" rather than working together. This was a very prevalent sub-theme throughout our study. No participant who discussed the non-collaborative nature of service delivery felt that individual approaches to IPV was effective. In one of the focus groups, a participant remarked on this; she said, "It was interesting to watch professionals talk to each other, working with this same family who didn't know they were working with the same family. There's something wrong with doing it that way."

Participants explained this lack of collaboration as a result of several factors. One of these is their lack of knowledge amongst each other about what services are available in the community or within the NWT as well as the scope of the services being offered. For example, we heard from several social workers who expressed frustration with the perception of their role when it comes to working with women and families involved in IPV. They said that it seems there is a blanket assumption that their role is predominantly to offer child protective services. The frustration stems from not recognizing the vast array of services and resources that they can offer to families who are in violent relationships. The push was for greater awareness to the scope of social work practice across disciplines and encourage collaborative efforts between frontline workers that takes advantage of their skillset and services.

Other contributing factors include a transient workforce, short-term projects, heavy workloads, limited resources, and poor understanding of the *Access to Information and Privacy Act* (ATIP). Participants expressed a fear of sharing and exchanging information between agencies. One focus group discussed in detail how the ATIP information sessions created a fear amongst workers rather than informing them of ways in which to collaborate with information that is within the confines of this legislation. Another contributing factor to limited collaborative efforts were the different policies, forms and procedures utilized amongst the departments and agencies. Participants explained how this slows down or even blocks collaboration. One participant described his experience like this:

> *The biggest struggle is just getting the medical services out the door to come and help you when somebody suffers that sort of trauma. I'm sitting there arguing with nurses about their policies and procedures and they're pulling their books or blingin' their computers to say, "Our policy says we can't leave the nursing station because it's a safety thing." Well, you know what? Last time I looked I'm an RCMP member with a yellow stripe down my leg. Do you think I'm gonna let any harm come to you?*
>
> (RCMP Officer)

There were mentions of collaboration amongst frontline workers. Participants described these efforts as effective when used; sometimes, it was by chance that it would occur. For example, one participant described a woman who was severely injured as a result of IPV and was confined to the hospital for a significant period of time. This created a central location for all service providers to work together in a group effort of support to her. The participant, a victim services worker, ended this recollection by describing it as a, "Really good example of how everyone pulled in the same direction for her and moved things along pretty quickly." Another example of collaboration occurred during data collection when one researcher observed an incident. She wrote the following journal entry:

> *A woman came into the Co-op [local and only grocery store] and started knocking cans off the shelves. She seemed angry and disoriented. Community members backed away. She had a baby in a carrier on her chest. The Manager called the RCMP to help. When the Mountie saw the baby he did not want to intervene. He said I don't get involved with babies, so the Manager called the health centre for the nurse. The nurse came and convinced the woman to hand over her baby and then the RCMP escorted the nurse with the mother and baby to the health centre for care. The nurses and the RCMP often support one another in both their professional lives and their personal lives. Small communities brings service providers together to resolve common problems.*
>
> (Moffitt, journal entry, 2015)

Collaboration is lacking across service providers in the NWT in their response to IPV. However, it is a practice approach that frontline workers view as effective and something they would be interested in if the contributing factors, such as heavy workloads, limited resources, multiple and overlapping roles of workers, were addressed or made manageable.

Ineffective Regional Outreach

Delivering services or supplementing services that exist in more remote communities is provided from the regional centre. Participants identified the referral process and communication between communities and regional centres to be poor. As an example, a counsellor described, "The referral system from communities to the main centre, which is [regional community centre], is absolutely atrocious. It's terrible." Because there are many communities without Victim Service Workers or these service providers are positioned in a regional centre, the referrals are not always made or they may be offered, but not accessed by women. According to one participant:

> *The RCMP doesn't always know what Victim Services does. They don't always feel that they are in the best position to explain what Victim Services is… Often times women are in crisis and say, "I don't want another person involved." So, sometimes that referral is not made to Victim Services.*
>
> (Victim Services Worker)

The other barrier noted regarding outreach efforts was the consistency and frequency of services being provided to remote communities from the larger regional centres. One participant who was working in the community as a teacher explained, "As the counsellor, [she would] come in every month and, so, how effective is it? How can you have a relationship with your clients? And it has been like that for decades."

Justice Response

A big gap agreed upon by frontline workers is the time delay between charging the perpetrator and going to court. During that time, there may have been a reconciliation of partners or there may have been so much pressure from the family and the community that the victim is reluctant to go to court. One participant explained the impact of such delays on the successful outcome of charges:

> *It takes so long to go through the court system that people get to the victims and say, "What are you doing to your husband?" And, so, I think eventually what happens is way too many of our charges get stayed because the victims either renege or say that it didn't happen or they couldn't remember or everything is good now. And, so, I just think there is not enough support, like there is not ongoing support for the victims.*
>
> (RCMP Officer)

There is a court circuit in the territory where judges travel to the community and work with the community justice committees, sometimes hosting these proceedings in a community hall, which is open to the public. This can be a daunting experience for an IPV survivor who may already have been ostracized by the community. Now she may find herself in a position where she must retell her story, which is, in and of itself, very difficult, but in addition she must do so in a public venue. Because of this, IPV survivors do not show up for court. When they do not show up for court, the local RCMP is sent to find them. This process re-victimizes the woman. A participant described it this way:

> *...There have been cases where "they're not here again". They've [court circuit team] returned two or three times because the witness doesn't want to show up, and the third time the judge will say, "Ok, go get her. Do you know where she is? Go find her." So, you know, I have done that – where I hop in the police truck from court. Court has been adjourned until however long it takes until we find her, and we go down to court because otherwise she is going to get charged for not showing up in court.*
>
> (RCMP Officer)

With limited to no support for women in the court system and one that is conducted in a public venue where gossip and retribution are already a threat, it can exacerbate a woman's feelings of intimidation and the sense that frontline worker's hands are tied.

Another justice response to IPV can come in the form of EPOs. EPOs have been in place since 2005, but are not being used consistently across the NWT. The NWT EPO data is collected by YWCA Yellowknife through their quarterly reports on EPO requests through Allison McAteer House. The data identified the number of EPOs approved for each community across the territory. This data was sent to the project geographers who demonstrated the data with a GIS map. It showed that there was a range of 0 to 8 EPOs issued per 1,000 people, which is contradictory to the incidents of IPV.

Not only do the number of EPOs counter the prevalence of IPV, they do not correlate to the community population. The number of EPOs per 1,000 in Gameti, for example, was greater than Fort Smith or Yellowknife. In addition, the GIS map identified several communities not issuing EPOs, which is inconsistent with the data indicating IPV incidents in every community of the NWT. One suggestion was that there is inconsistent knowledge amongst community helpers, including RCMP officers, about EPOS or that more might be issued in communities that have fewer IPV resources available to women. EPOs are not encouraged for communities without RCMP as there is no immediate enforcement of the order, so it provides little actual protection. There is also some indication that men may be using EPOs in a devious way to get back at women. It appears that when this occurs, this is an act of coercion on the part of the perpetrator. This speaks to disconnect between the theories of IPV and the way in which an EPO can be accessed.

Participants who use EPOs explained the process takes time to implement. To address this, RCMP officers might have the woman use the Allison McAteer Shelter to complete the process, especially in a remote community where there may be only one or two members present. They explained how this is better utilization of their time when faced with an unpredictably of an incident of IPV that requires their presence and attentiveness.

Obtaining an EPO requires screening to see if the person meets the basic criteria. Staff call the Justice of the Peace to set up a hearing by telephone. Usually on the day the EPO is requested staff call the Justice of Peace (JP) and set up a hearing by telephone. Usually, the hearing with the applicant will occur later that day. This is a court process with the JP presiding. Even after the JP has heard the case, he/she may ask for a break to consider the testimony and decide what to do. The applicant is asked to call back at a specified time when the JP rejoins the conversation with a decision. It is understandable that Allison McAteer shelter staff facilitate the majority of the applications, because RCMP often do not have the luxury of devoting so much time to one issue. Sometimes the JP denies the EPO. Also, the JP decides how long to have the EPO in effect, with the

maximum at 90 days. Often the applicant wants an EPO for a shorter amount of time. Because the whole process is by phone, the shelter can take requests from all across the NWT.

EPOs are different than Protection Orders (PO). A lawyer is required to initiate a PO and it is of longer duration. In the NWT, there have been scant POs issued. Contributing factors to this underutilization from IPV survivors is unknown.

Multiple Roles and Heavy Workloads

Working in a northern community typically implies that service providers will take on multiple roles that go beyond the scope of their job description. Participants described themselves as "catch-alls" in the more remote communities. They pick up additional roles that they would not take on in more urban settings. For example, police officers describe themselves as taking up social work or victim service duties when there is no one in these positions; the community members might initiate their help with these responsibilities even if that is not the help they are trained to do. Other participants spoke to the administrative, janitorial and maintenance duties in addition to taking on other professional roles beyond their scope of practice. This participant described his experience and that of his colleagues in the remote community:

> *But, on several occasions, the nursing staff would put up a lady who needs to get out of town in the medical centre apartment. There's three apartments and they're reserved for nurses and hospital staff. My wife's cooked a dinner and brought it over there. I've brought food over there for the lady. To get out the next day, we've paid for a taxi, out of our own pockets, because there's no funding for it. That hasn't happened very much, but a few times.*
>
> (RCMP Officer)

Multiple participants described such experiences and extensions of their roles. Counselling women when it falls outside their scope of practice, providing food or emergency shelter are just a few of the direct services to IPV survivors that they offer beyond their job descriptions and most often on account of depleted resources, staffing or funding. These extensions add to the fatigue and the cost of caring for this vulnerable group of women and children.

Impact on Workers

This data suggests the vulnerability of frontline workers at risk of experiencing effects of vicarious trauma[9] and compassion fatigue[10]. It was interesting that very few participants directly acknowledged the impact of their work and the personal toll of being exposed to lethal and frequent incidents of IPV, hearing women's stories, seeing their injuries and recognizing the context in which they are surviving. However, one participant who spoke openly about its personal impact said:

> *I've lived in a community for four years and, I mean, I could tell you some harrowing stories, but I'm not sure if I'd be crossing the boundaries of confidentiality there, so, just harrowing. I mean, the stuff you hear will turn your hair grey and, believe me, without hair dye my hair is grey. It's not an easy life for any of us who are working on the frontline [doing] direct work.*
>
> (Counsellor)

9 Vicarious trauma is the result of frontline workers being indirectly exposed to a trauma and has been explained as a "normal reaction to the stressful and sometimes traumatizing work with victims" (McCann & Pearlman, 1990, p. 133) in which frontline workers may experience profound psychological effects that are disruptive and painful, cumulative, pervasive and sometimes permanent (McCann & Pearlman, 1990).

10 Compassion fatigue refers to the cost of caring as frontline workers (Figley, 2002). It is profound physical and emotional exhaustion that develops over time as a result of being exposed to the suffering of others and which reduces workers' capacity or interest in connecting with people they are serving. This is a normal consequence of managing heavy workloads in high-stress settings, having little time to debrief and being exposed to too many people experiencing similar problems (Mathieu, 2014). As a result, workers may become desensitized and might impact their quality of service provision.

Almost all participants who shared stories of IPV incidents they were involved with remembered vivid details and images of these trauma events or risky situations they are put in. For example, one participant described his work and the dangerousness of it:

> *Every call we go to, I know every house has a rifle on the porch. They are hunters. I know they are there and every call is high-risk. And it goes through your mind, they are drunk and there's a firearm. It's always on my mind. You go to the calls and everyone is running out and you are running in.*
>
> (RCMP Officer)

RCMP officers, nurses, physicians, victims services workers, counsellors, social workers and shelter workers all spoke about what they have been exposed to. One participant's memory of an event was exacerbated by policy barriers that prohibited a more collaborative response from other professionals in the community to a very gruesome assault:

> *Well, my god, she's got broken bones, man. She's got a punctured lung. She's blowing blood like somebody shot [her] through the lung. And I'm supposed to move her? You know what we had to do? We had to load her in a blanket like a dog that's been run over and carry her in a blanket [to the nursing centre because they were not allowed to leave]. She was beat so bad. She was bare naked. And it looked like somebody gutted a moose in her house. She suffered broken bones. She's got a plate in her arm now. She had a punctured lung and she had a laceration on her scalp that required 50 staples to close the wound. And she's so petrified. I know she knows what happened, but she is so petrified that she will not come out and say exactly what happened.*
>
> (RCMP Officer)

Another participant recollected an IPV survivor she had attended to. She acknowledged that this story has stuck with her for years and one that she will probably remember forever:

> *Probably the worst or the most poignant cases, I guess, was a young girl in her early 20s. She was in the community and her boyfriend beat her with the bottom of a lamp. He beat her so badly there was actually a hole going into her brain, kind of just behind her ear. And he was drinking and left her sort of to bleed out unconscious on the floor while he was on the couch watching television… The neighbours called the RCMP. They came in to find him watching television and her passed out on the floor bleeding out with this hole into her brain.*
>
> (Healthcare Provider)

This example not only demonstrates the sometimes permanent nature the cost of caring has on frontline workers in a healthcare setting, but also what traumas the RCMP officers or other on-scene workers are being exposed to in that incident. Their exposure to traumas are not always in an expected setting, such as a hospital; nor are they always occurring during a scheduled shift. This participant's story describes a violent incident that occurred in a remote community involving his home:

> *I had this woman, oh my goodness, she had an eye out to here and just bleeding and she had to run across the community with one boot on and the weather was atrocious, and like, she could have died. It was -40 something degrees, and like, she's pounding on my door and you open up the door and you see this! Like, oh my god. And then by the time I put my uniform on, all those little things... uh! [She didn't have a phone and] just thinking about it angers me.*
>
> (RCMP Officer)

There are a quagmire of factors that mingle to create ineffective services for women as has been described in the social processes of putting up with violence. A lack of collaboration, crisis-oriented responses, heavy workloads, responsibilities beyond the scope of professional practice and the personal toll of caring for IPV survivors adds to the central problem of feeling as though their hands are tied as frontline workers.

Alcohol Use

When compared to the national average, the NWT has the highest rates of residents (33%) who reported to be heavy drinkers (Statistics Canada, 2013). Alcohol use was described by one participant as being "overt alcoholism". She was referring to the openly intoxicated people who are seen throughout communities, littered bottles on the streets or alcohol being consumed and shared in public spaces. Almost all participants acknowledged the significance of alcohol use and its presence in incidents of IPV. RCMP participants report that it is a contributing factor in most cases of IPV. It was also identified as a coping strategy to manage historic trauma or the experience of being in a relationship with violence. Describing women's alcohol use, one participant said:

> *Some women drink so it doesn't hurt; if they drink they get beaten up and if they don't they get beaten up. [IPV] is almost always related to drinking. They get harassed all the more if they drink into a stupor.*
>
> (Community Health Nurse)

Bootlegging[11] was identified as a contributing factor to the high alcohol use in the NWT. Bootleggers are profiting from the addiction problems of local people. As an example from 2013, the RCMP seized over $42,000 in liquor in Tulita (APTN, 2013). In fact, police officers describe a "pipeline" of alcohol distribution in the Sahtu. This starts in Norman Wells, goes north to Fort Good Hope and then south to Tulita and Deline. A CBC journalist asked if unlimited liquor sales were fueling the bootlegging in the NWT (Monigue, 2015). At present, there are no purchase restrictions or required licenses for the purchase of large quantities of alcohol. The article reports that recommendations were made to limit the purchase of alcohol, but to date, no changes have been made. A police officer described their work to combat bootlegging and the high rates of alcohol use like this:

> *So, what we're doing is we're trying to stop the flow of alcohol into the community by bootleggers, but it's the tip of the iceberg. A lot of stuff gets by us, so we're spending a lot of effort and energy and time and resources trying to do this and we're having some successes. But bootleggers being who they are, are clever, and they have a lot of time to be able to bring alcohol into the community in ingenious ways and we're always a step behind them. And, combine that with the acceptance of the community of alcohol and alcohol abuse, it makes it very difficult for us to try and make a sustainable dent to the use of alcohol in the community. So, when you have alcohol and drugs coming in the community and some degree of acceptance, that aggravates the situation and that becomes a way when family violence is going to take off.*
>
> (RCMP Officer)

11 Bootlegging is a behaviour in the north whereby people smuggle legally purchased alcohol into the communities. It is brought in their luggage via airplane, by boat, skidoo, road or ice road for re-sale at much higher prices. It is also sold on the streets of the regional centres after normal store hours.

Some police suggest that arresting inebriated people helps to keep the IPV incidence rate lower. Other police officers feel that arresting them does not address the problem, but rather, is a means of escalating deleterious behaviour. It also puts the police at risk if something untoward happens to this inebriated person while he is in a cell. There were no mentions of successful ways the NWT is currently addressing alcohol use, but almost all participants noted the dire need for effective services to reduce this problem.

Many participants spoke about the availability of resources to support people suffering from addictions. They acknowledged a gap in local services that would better address the severity of addictions in an acute and rehabilitative way. One participant provided an example:

> *For example, to take a family member who is struggling with addiction out of the community and send them to a 28-day treatment program and then they come back to the community and they are in no kind of after-care support or an ongoing support for the whole family to cope and change as a system. There's a real kind of lack of continuity in the healing that started in treatment.*
>
> (Shelter Worker)

Continuity of local services, from treatment to longer-term rehabilitation and support was noted as a necessity to successfully address addictions in the NWT. Participants expressed concern that this lack of resources is negatively impacting the person suffering addictions, increasing rates of violence and impacting the whole family.

Resilience

Frontline workers described IPV survivors as strong women who demonstrate resilience. A victim services worker stated that "Some women are such strong fighters, they're like, '*Okay, I'm going to figure this system out' [in regards to getting help].*"
It takes strength to *get on with life* while facing abuse and violence. It takes courage to come forward and tell your story to a police officer, shelter worker or victim service worker. It also takes great fortitude to request an EPO against your partner.

Women's Resistance

Some participants talked about a lack of understanding from the community about violence. All violent acts are deliberate and women respond to violence through resisting. A participant said, "Violence is always resisted and women don't just put up with this stuff; even if it is in their minds, they do things in their actions to resist violence" (Victim Service Worker). We were told that some women wear their battered and bruised faces like badges of honour. They do not try to cover up and they are speaking out against the violence. Some women are openly resisting in other ways. In Yellowknife, one researcher observed violence between an intimate couple who frequent the streets:

> *The woman and man were staggering down the sidewalk and, at times, holding each other up. Their gaits were awkward and faltered, their voices were raised and angry, and their speech slurred. They were yelling vulgar comments. The woman was screaming "f-off" to the man. He took off his belt and started beating her with it. As he did this, he began coarse name calling, "Useless c… (word), you get what you deserve." A fight ensued between the two of them. She was on the ground receiving the beating and eventually got up, took the belt from the man, punched him in the face, pushed him to the ground and kicked him.*
>
> (Moffitt, journal entry, 2016)

Community Resilience

Members of the Status of Women and one researcher went to a community to deliver a 'What will it Take[12]' workshop and disseminate findings from this project. Elders attending the session came forward to share words from the past and concerns from the present. A male Elder addressed the meeting with the following words:

> *It is very important to talk to the unborn baby so the baby hears the language and voice of the mother. The baby needs to hear the sound of the drum and know where he comes from. The husband needs to take good care of the pregnant mother and not speak harshly to the baby.*
>
> (Words of Elder, Moffitt, journal entry, 2016)

Another Elder had a private conversation with us and shared her insights and knowledge about violence and the impacts it has on all family members. She asked that something be done for community members in regards to appropriate behaviour and sexual health. The Elder was concerned that children were witnessing sexual acts and some of these acts are violent. She said that people did not seem to be aware of the impact this would have on children if being put in a position of witnessing these violent acts. She also expressed concern that children are experiencing trauma at young ages and not having an opportunity to talk about the incident or have counselling.

In the evening after this event, a spa night was held by the local victim service worker and volunteers. A community member who was participating in the event suggested that the opportunity "brought Elders and youth together in terms of self-care." That evening, women were supported and treated to a resource that is not typically available in the community. A community member provided her hairdressing skills and supplies were ordered from the city. It was an opportunity for women young and old to get their hair cut and/or dyed, to try new make-up, to have a pedicure or manicure. It was an opportunity to feel supported and connect socially; women were laughing, telling stories and sharing food.

Other forms of community resilience include the informal safe houses for women who are fleeing violence and who reside in one of the 28 communities without a shelter. Participants also described the informal support networks in the communities. For example, a participant explained one community wherein she became aware of this support. She described the response of family members when alcohol is being consumed by the parents of their nieces, nephews or grandchildren:

> *They pick up the children from school and take them to whoever is not working that day or, if someone is hurt, they will hide them somewhere they think the husband won't find them until they get out of the community.*
>
> (Social Activist)

Resilience was noted as both something women demonstrate and that the community demonstrates. For women, it was acknowledged as a form of resistance or in silently surviving IPV. In communities, it was seen as creatively offering informal services or Elders sharing insights to the importance of healthy relationships and child-rearing.

12 What will it Take is a targeted campaign against family violence created by the Department of Health and Social Services and the Coalition Against Family Violence. The goal of the campaign is to empower bystanders, people who witness family violence, to take action against what they are observing to make communities safer (GNWT, 2015). Staff from the NWT Status of Women Council along with a student from Aurora College and a researcher from this project visited several communities in 2015.

Moving Forward

A long-term objective of this project is to create a model and action plan (see Figure 4) for sustaining non-violent communities in northern Canada. In this section, we share seven themes identified through data analysis and giving voice to the participants in this study. Relevant research, literature as well as documents and government initiatives on how to transition to non-violent communities was also considered. The seven themes include: knowledge mobilization; education and awareness; stable and adequate funding; coordinated response strategy; assessment and screening; social supports; and community healing.

For the last several months, we have been meeting with frontline workers across the territory, sharing the content of this report and getting further clarity to what we have surmized. It was in one of these meetings that we heard from a frontline worker sharing an important message:

We [as frontline workers] are a canoe that's running in the wrong direction of the river, getting nowhere, no matter how hard we are paddling.

The message was heartfelt. Before moving forward, it is a strong reminder to policy-makers and departments that this research and suggested actions do not get caught up in the never-ending circles of committe-level dialogue, but that more immediate, tangible actions be provided to workers who are bogged down in the responsibilities and issues they are constantly faced with.

Knowledge Mobilization

Knowledge mobilization, moving the knowledge from this project into active use by communities and stakeholders (Levin, 2008), has been an important part of the NWT research team's agenda from the start of the project. From the first year, we have spread the word of our preliminary findings and the progress of the research locally, nationally and internationally. Not only has this highlighted the problem locally, but has provided an opportunity for dialogue, which in itself, has already contributed to change. (For a listing of the activities, please see appendix A.) In addition to this report, we plan to continue knowledge mobilization in the last phase of this project through a dissemination process that hopes to reach several remote and regional centre communities.

The researchers are members of the Coalition Against Family Violence (CAFV). This membership has enabled ongoing dialogue throughout the project. It has acted as a process of mobilizing the results, actioning some findings as well as establishing an agenda for future research take up by members of the CAFV. The findings, as described in this report, will be built into the Coalition's strategic actions to continue to advocate for the end of violence against women and within families. One noteworthy collaborative initiative between the CAFV and the School of Health and Human Services at Aurora College was the launch of (a now annual) Safety School with students from the nursing and social work programs. This afternoon event facilitates the interaction of future frontline workers with those who are already practicing in the northern communities to address IPV. The objective is to increase their knowledge of IPV and the services currently offered to support change as well as develop relationships with future employers and/or interdisciplinary colleagues in the field of violence.

Throughout the knowledge mobilization process, we have also partnered with government officials and non-profit organizations to promote the project's findings at community events and activities. These opportunities have provided a different venue for knowledge translation and showcases the findings to community members who are less likely to receive this information in more formal presentations and publications. For example, we attended a community fair in Ndilo in August 2016, where we engaged with the public using a plain language document to help share our findings and an interactive self-reflective exercise to invite their thoughts and commitments toward non-violence. One question we asked was, "What can you and your community do to end violence?"

Figure 4: NWT Action Plan

NWT Action Plan



1 Knowledge Mobilization

- Present findings and action plan to the GNWT social envelop (Health and Social Services, Justice and Education, Culture and Employment)
- Incorporate findings and actions into NWT Coalition Against Family Violence strategic plan
- Disseminate NWT Final Report to research participants and community stakeholders
- Deliver NWT Final Report workshops to community stakeholders across NWT
- Oral presentations (public and academic), publications, media events

2 Education and Awareness

- Build on existing partnership with the NWT Coalition Against Family Violence to continue developing awareness and prevention campaign materials regarding sexual violence and the negative impacts of community gossip as well as educational materials focusing on healthy relationships
- Support post-secondary Health Services Programs workshop on violence against women issues
- Develop and deliver IPV training workshops to RCMP, Crown counsel, health care professionals, social workers and victim services workers

3 Stable, Adequate Funding

- Secure permanent funding for all women's family violence shelters across the NWT utilizing a funding formula for appropriate financial support for their operation
- Provide long-term funds for intervention strategies and programs

4 Coordinated Response Strategy

- Create and maintain a living e-archive of Territorial resources and services
- Enhance information-sharing between service providers
- Review Interagency Case Assessment Team Best Practices: Working Together to Reduce the Risk of Domestic Violence Protocols document (Ending Violence Association of BC, 2015)
- Integrate frontline services within larger health care services authorities
- Pilot coordinated services team meetings regularly that targets high-risk cases of IPV

5 Assessment and Screening

- Conduct literature review on frontline screening tools for IPV
- Develop intervention pathway model
- Create and facilitate educational workshop to frontline workers
- Pilot frontline screening tool
- Report on intimate partner homicides in the NWT Coroner Service Annual Report
- Establish Death Review Committee
- Investigate a more gender-free and culturally relevant RCMP risk assessment tool
- Research the utilization and effectiveness of EPOs across the NWT

6 Social Supports

- Direct programming towards children who witness and/or experience violence
- Increase available and accessible trauma-focused programs
- Utilize telehealth resources with Victims Services and other emotionally supportive programs to ensure all communities have access
- Advocate for in-house court support social work position for survivors of IPV throughout court process

7 Community Healing

- Encourage more land-based healing programs and fully utilize available funds
- Support local people to facilitate non-violence strategies and events
- Advocate for commitments to the Truth and Reconciliation Calls to Action
- Lobby for restrictions on the purchase of large quantities of alcohol

Education and Awareness

Participants agreed that education and awareness is necessary if we are to reduce incidents of IPV. Education needs to happen at all levels; they identified the need for education at the individual level, within communities, territorially and for themselves as service providers. At the individual level, people need to understand that IPV is a social problem that stems from a social context and affects younger girls who are in intimate relationships through to elder women.

Women, men and children need to know that they are not alone. There is help. First of all, as demonstrated previously, the normalization of violence has silenced women and created a tolerance towards violence that needs to be changed. We need to combat attitudes created by normalization so that we change the mechanisms of blame and shame that are occurring. Even in communities that have women's shelters, and where frontline workers are providing a safe haven for women who are fleeing violence, there is a discourse counter-productive to the service being provided. This situation was described by a participant in this brief narrative:

> *There's still a stigma against it [shelter]. It seems like some people say, you know the parents of the son [perpetrator] would always say, "Oh, that shelter. They're just trying to break up families. They really don't try." So, education is always the way to go.*
>
> (Shelter Worker)

A comprehensive territorial education campaign is required that addresses the multifaceted social and public health problem of violence. IPV affects youth, young adults and older adults. This plan needs to be thoroughly developed and target prevention. We need to focus on healthy relationships for all family members and parenting supports to provide a healthy start for children. Many participants expressed the need to target younger children and youth with information about healthy relationships, self-regulation of emotions and coping strategies for stress. They reflected that this would empower the younger generation to engage in intimate relationships that are free from violence. One participant stated:

> *Start with the young people… in a stronger way and building up that strong confidence in the youth. Give these young women the tools that they need so that they can know that whatever violence happened in their family as they grew up isn't the norm and shouldn't happened to them.*
>
> (RCMP Officer)

Improving service providers knowledge about the dynamics of IPV would better equip them to support women, effectively use services and tools and respond appropriately at the frontline or when in a judicial setting. One participant described the effectiveness of their response using EPOs:

> *As of right now, when I go to a call, I have my duty bag and I have the Allison McAteer number on there. Well, nobody wants to call 1-800 numbers, but when you have one number for the EPO, and I explain it to somebody, they're hesitant to talk to the police. We know something's happened. It's one of those situations. And a few times, they've gone through with it, the EPO. …It takes it away from that they don't have to – nobody wants to lie to the police. Sometimes they just don't want to talk at all, which is fine. So, in the EPO, they call Yellowknife and they say what happened. They sign the form, we get it, we serve it [to the perpetrator]. That, right now, is our best solution to the immediate problem because they don't want the husband in jail. They don't want him to stop paying. But they need a break. They need to be safe for a while… People are ecstatic because for 90 days… There's a feeling of safety simply because a court order has been served, usually within an hour or two after the application is made.*
>
> (RCMP Officer)

There is an obvious spectrum of knowledge keepers within professions and between the different disciplines. For example, some members of the RCMP demonstrated significant theoretical understanding about IPV, whereas others reflected common myths when describing it. Similarities were found amongst other professionals as well. In addition to requiring education about IPV, frontline workers identified a lack of understanding or misunderstanding of ATIP. They explained that being provided information about ways in which they can collaborate and share information between departments, programs and agencies would improve the services being delivered.

Lastly, it was apparent from the data that very few of the participants identified the possibility or actuality of experiencing vicarious trauma and/or compassion fatigue. They spoke about the exposure, but did not connect this to the way in which it has or could psychologically impact them. Education about these costs of caring, what it is, the effects and coping strategies to reduce its occurrence or the impact if it occurs would be valuable. This would assist them in providing effective services and may improve retention of staff once hired into positions.

Stable, Adequate Funding

Participants identified the need for stable and adequate funding as a requirement to provide all services. This is particularly felt within the shelter community whose programs are sparsely funded and in one shelter, under the financial control of an agency that has no knowledge or connection to social services. This inhibits the growth needed to support the number of women requiring emergency shelter that appropriately targets those fleeing violence. It also inhibits the shelter's ability to offer services beyond the basic necessities, such as in-house counselling services for women and their children.

In addition to shelters, adequate and long-term funding is needed for other programs that offer support to IPV survivors, their children and the perpetrators of violence. Too often, the funding provided to programs are short term, which lacks consistency, but as well, inhibits the ability to properly evaluate the program's outcome indicators. One focus group participant described this frustration and need for a commitment to program funding:

> *And the other part, too, is that when we get funding to do creative things, give it to us for 10 years so that we can actually know if it made a difference. These two-year models, we are just barely getting going and then we are shutting down.*
>
> *(RCMP Officer)*

Funding a 911 call system across the NWT would assist RCMP in providing more timely responses. It would also reduce the woman's experience of IPV with the immediacy this call system creates.

Coordinated Response Strategy

Service providers in this study identified that we need to transform our crisis-oriented approach to a more coordinated response and purposefully incorporate preventative services as well. We need to have RCMP, victim services, shelter services, child welfare and social services, counselling services, health services and the corrections system responding collaboratively. In the remote communities, where these resources are few, this collaboration amongst those services present and between the community and regional centre is crucial. Their ability to communicate, cooperate and provide best practices together will better work towards an end to violence. This would also involve the development of protocols in response to IPV that are understood and are synchronous within all departments and agencies, as much as possible. Currently, one regional centre is using a monthly meeting to share information about resources and issues related to violence. Using this format for other communities should be considered.

An investigation into the effectiveness of a case management approach to service delivery with IPV survivors, as described in a BC report (Ending Violence Association of BC, 2015) is worthwhile. Using this information as a guide to creating an approach that fits the uniqueness of each community and region would be valuable. Collaboration amongst frontline workers using a case management approach, with consent from all workers to communicate, will also improve the consistency with services that IPV survivors receive. It would also reduce or eliminate the need for women to re-tell their stories with each worker. Support was identified by a participant in this way:

> *I don't think we supply enough support for victims of domestic violence. They need that one-on-one and they need not just one session, but they need that constant interaction with someone that they can share with and they can talk about their situation and help them through it.*
>
> (Social Worker)

However, collaboration can be as simple as purposefully gathering key frontline workers within a community and sharing the services that can be offered and inform each other of their skills and abilities to help. Our communities smallness is an advantage in this instance. High-risk families can be identified and a unique collaborative strategy, formal or informal, can be arranged amongst each other.

Collaboration means sharing resources between programs, agencies and services. As an example, victim services might be able to utilize telehealth services that exist in the health care system so as to reach women in more remote community settings. Such forms of collaboration would circumvent the barriers of anonymity and confidentiality, community retribution and gossip, which prohibit women from coming forward and accessing support.

Long-term needs for survivors of violence need to be focused on calculated and consistent responses to women experiencing violence (rather than reactive responses that only address immediate needs for safety). Prevention and harm reduction should take precedence in actions. This involves a comprehensive and structural approach as identified through this action plan. Within our legal system, we need to change the punitive discourse that surrounds women and create a system that changes the power dynamics from one that is currently held by abusers and lawyers to a system of support, equity and sensitivity.

Within the child welfare system, there needs to be a community response that collaborates across ministerial jurisdictions to "address poverty, substance misuse and inadequate housing that drive the overrepresentation of Aboriginal children in care" (Blackstock & Tromé, 2005, p. 115). Women facing violence are often also dealing with these social determinants and one of their primary concerns is the welfare of their children. The Auditor General of Canada wrote a report on child and family services detailing many deficiencies in the territory (Office of the Auditor General, 2014). We acknowledge the government's response and recommend further attention for programming for children who witness violence. This is another area where stable funding is required and action to address the needs of children required.

Assessment and Screening

Participants recommended assessment and screening for IPV risk as a focus for territorial planners and policy makers. Currently, the Ontario Domestic Assault Risk Assessment (ODARA)[13] is being used by some service providers (RCMP, Victim Services, shelter workers) in the NWT. Some RCMP officers suggest that the ODARA is not culturally relevant and it provides a static score that does not change over time. For these reasons, they described it as an ineffective way in which to assess risks of IPV in the NWT. A coordinated response and case management style of service delivery would improve knowledge amongst frontline workers in a less structured style of assessment. However, it is also recommended that a new risk assessment tool option be explored and evaluated for effectiveness in this jurisdiction.

Another important approach that is more prevention-oriented is universal screening. It is a different way in which to assess women's risk for IPV that is not crisis-oriented, as is the case of tools such as the ODARA. Several strategies have been recommended in the action plan towards universal screening with all women who present for a health appointment. This includes, for example, visits to the Community Health Centre, Public Health Unit, Emergency Department of a hospital or a visit with the Nurse Practitioner or Physician in a family clinic setting. This action towards universal screening involves further research, implementation and evaluation including: (1) literature review on assessment and screening tools; (2) developing an intervention pathway model that informs healthcare providers of how to respond if women are at risk; (3) creating and facilitating an educational workshop about IPV and the screening tool; and (4) piloting the tool with a formal evaluation.

Additionally, another area of assessment to elucidate more information about IPV is the Coroner's Report on IPV homicides in the NWT. When a homicide occurs, the coroner reports and recommends actions from the particular case. If a homicide is addressed from a systemic perspective, the information learned may help prevent future homicides from occurring. Although every IPV homicide differs, there may be patterns of behaviours or contexts that are similar. Participants in this study shared a recommendation surrounding domestic homicide. They recommend completing death reviews to understand the circumstance and context of IPV homicides in order to prevent them from happening. For example, one participant stated:

> *I think anytime there is a homicide or suicide, I think we need to be paying really close attention… What I would love to see is a death review committee that looks at those and says "Okay, so what was going on in that woman's past." And it is not to blame service providers to say, "Oh, you didn't do your job." …but to review and say how could we have made it better for this woman so this doesn't happen in the future. Because how many suicides are out there where there was violence in that woman's life, or that teenager's life… And I think those are kind of going under the radar right now and it's like, no, we need to start looking at those and making those connections because I think, yes, homicide is awful, but we're also losing a lot of people in the north due to suicide and what they've experienced as a kid.*
>
> (Victim Service Worker)

An action emanating from this narrative is to monitor the circumstance and context of each homicide. A special committee should be established to take this work on, with access to administrative planners and policy makers so that recommendations can be acted on, indicators and outcomes for evaluating and acting on IPV can be established, and progress monitored.

13 The ODARA is the result of a collaboration between the Ontario Provincial Police Behavioural Sciences and Analysis Section and the Research Department at Waypoint. It was created from research on nearly 600 cases from OPP and municipal police records. The ODARA is easy to score, either from documents alone, or from documents plus an interview with a female client who is the victim of the offender's most recent domestic assault. A police record check is always advised. The ODARA can be scored reliably, and has been validated in several jurisdictions. It is the first empirically developed and validated domestic violence risk assessment tool to assess the risk of future domestic assault as well as the frequency and severity of future assaults. For all of these reasons, the ODARA is an important part of efforts to promote a coordinated cross-sector response against women. Retrieved from http://odatra.waypointcentre.ca

Social and Formal Supports

In NWT communities, there are informal supports at work that bolster women's personal resiliency and community resiliency. Evidence to suggest this is offered at community events where traditional activities such as sewing circles, feasts and berry picking bring people together and re-establish their identity, survivorship and strength. In some communities, there is also a hidden network of women helping women when they are fleeing violent situations or in their everyday lives, caring for their children or offering a safe place to stay. Most women in NWT communities hold a shared reality of depleted resources. However, this additionally portrays their individual resourcefulness by helping each other through crises of violence or other circumstances in which they are struggling to cope.

There are limited formal supports for survivors of IPV and from the literature we know that post-traumatic stress and depression accompany IPV (Campbell, 2002). As a participant stated, "They have longer term needs, I feel, where they need psychological and emotional support to build up their sense of self- worth" (RCMP). There is currently no consistent or established follow-up for women experiencing IPV across the NWT. How many women are affected in the NWT in this way? We need to take action by recognizing the psychological and socio-economic impacts of IPV and ensuring consistent, collaborative, effective, accessible and available interventions for the duration they are needed by each woman and child impacted. These include emotional and economic supports as well as ensuring women and their children are safely housed in the immediate moment and long term.

Children in the NWT require formal support from within the health care and social services system, in the schools, and through enhanced capacity for parenting in their homes. This was a recurrent message from the interviews and the focus groups. One participant explained:

> *When children are involved, it's more than just the two people that are involved in that altercation. It impacts children, what they see growing up, and… it becomes a cycle. A learned behaviour… Apprehending children to remove them from that situation long-term doesn't happen. It's a cycle that continues. That child, or those children, will be… back into the family once the investigation reveals there's no immediate threat.*
>
> (RCMP Officer)

Children who are witness to the violence are equally vulnerable to the psychological effects of trauma. There needs to be a comprehensive understanding and appropriate personal and structural response to the magnitude of the problem that extends beyond the woman who is experiencing violence in her relationship. As well, treatment and programming for children who have witnessed and/or experienced violence is required; what is available now should be supported and ensure that positions are filled where vacant. If progamming is not available, funds targetted to provide this focused support should be established.

Community Healing

Strategies to combat historic trauma that Indigenous peoples in the NWT have and continue to experience must be established. One participant said, "I think that the process of understanding and healing the legacy of colonization from residential schools is really important in our community" (Shelter Worker). These include strategies targeted to individuals, but most participants also stressed the importance of taking a structural approach that addresses housing and poverty. Participants also stressed the need to address substance use that is prevalent in all communities across the NWT. They noted that this is required for healthy communities to emerge, with one participant stating:

> *This [community] has such huge potential, so many good things about it. But it is mired in additions and violence, where people can't get a step above that."*
>
> (Counsellor)

It is important to ensure that effective services are also being offered across the NWT to men, with hopes of helping reduce the violence that is occurring against women. In Yellowknife, there are two programs directed towards perpetrators of violence. The Wek'eahkaa: A New Day men's healing program[14] is "available to men over the age of 18 years of age who have been violent toward their wife, common-law, girlfriend or partner. Participants may be self-referred, referred by an organization or agency, or mandated by the courts. Referrals are determined on a case-by-case basis" (GNWT, n.d.). An evaluation of this program's effectiveness is currently underway and it is hoped this document is made available to stakeholders. We recognize the importance of offering such opportunities for men to self-refer. However, understanding the etiological theories of violence, we must also recognize the majority of men who abuse are likely not self-referring to such a program. This includes extending services to men who are at higher risk of violence and capturing those that do not voluntarily seek treatment. We must consider initiating mandated programming for men who are at higher risk to engage in violence with their partners.

Finally, participants told us that, to create community healing and non-violence, there must be action and healing at the local level. A participant identified that:

> *You have to get commitment from the power within the communities. So, you need to find out who has the power and where the power is coming from and what's driving it… You need to connect with the community, you need to get people who are currently in the community and get them… working towards what's in the community… You've got to find a way to do it to include the men… If you are working in a small community, you don't want to start dividing them by gender if you truly want to change how they see violence and create other ways of approaching things.*
>
> (Shelter Worker)

They explained that community healing would only be successful if it originates from the community and is tailored to the uniqueness that each emulates, as explained by the following participant:

> *The communities' needs are different. You can't just use a blanket approach. You know, you have Inuit, you have Dene. They all have different processes and ways of healing; they all have variations to their experience. I think you cannot ignore that.*
>
> (Shelter Worker)

Individual services such as trauma-informed counselling for the whole family (women, children and men), a more thorough delivery of local addictions services and an Indigenous approach to community healing was identified by participants as ways in which to move toward non-violence at a community level. They also noted the equally important need to create structural change; this includes available and affordable emergency and permanent housing as well as adequate financial resources.

14 The men's program is offered in Yellowknife by the Tree of Peace Friendship Centre.

Discussion

Our findings are premised on an explication of a grounded theory to explain community response to intimate partner violence faced by women, and recommendations from frontline workers about what actions they believe will help. This is the first study to explore the community response to intimate partner violence in the NWT, and in northern Canada. It is an important contribution to understanding the community response and unique contextual considerations of violence in the territory. As well, the action plan offers direction to policy planners and decision makers. A particular strength of this study is the knowledge mobilization process that was engaged to action our findings and contribute to territorial strategic planning in regards to IPV.

The theory demonstrates three social processes: *putting up with violence, shutting up about violence* and *getting on with life* used in community response to IPV. Because of these three processes, frontline workers expressed that their hands are tied in terms of effectively addressing IPV survivors, and their children, as well as its frequency and lethality. One could argue that these are disparaging findings that give northerners a sense of hopelessness and despair. We contend that these findings are within the theory which illuminates what needs to be addressed to move towards non-violence.

It was not a new discovery to learn about the intersection of social determinants of health that contribute to putting up with violence. There is considerable literature about poverty and IPV (Davies et al., 2015; Goodman, Smyth, Borgess & Singer, 2009), homelessness in the NWT (Christensen, 2012) and the co-occurrence between homelessness, unemployment and poverty with IPV (Sev'er, 2002 , Tutty et al., 2014). These findings add to the growing body of knowledge about systemic inequities for Indigenous people in the territory. It is necessary to engage in a paradigm shift that focuses on structural inequities and the equivalent level of response to housing shortages across the NWT, as described by Christensen (2012), poverty and addictions. We must recognize that the combination of these disadvantages, in conjunction with the geographic remoteness of the NWT, negatively impacts the accessibility and availability of services, the effectiveness of services and information about services amongst IPV survivors (Sandberg, 2013). This will more effectively address the complexity of IPV, the depth of issues women are struggling with, the systemic factors that drive high rates of Indigenous children in the child welfare system (Blackstock & Tromé, 2005, p. 115), and the frequency and lethality of violence NWT women are experiencing in their intimate relationships, as noted in this report.

In addition to the social determinants, our findings indicate a relationship between historic trauma and higher rates of IPV. This is substantiated by Sandberg (2013), Schmidt, Hrenchuk, Bopp, and Poole (2015), and Shepard (2001), who recognize that Indigenous women's current experiences of abuse and trauma are related to a history of colonization and the impact that this has had on them. A discussion of the impact of historic trauma and its interaction with IPV survivors, perpetrators and NWT communities needs to be included in training opportunities for frontline workers. Providing more specific education will result in a more competent response, particularly with such complex histories and the northern context (O'Neill et al., 2016).

One of the main findings of this research is the normalization of violence in this territory that is creating a culture of violence and silence. The ways that people respond within their local communities is an important component to this normalization. As we disseminate the research in NWT communities, frontline workers are validating what we uncovered and are adding further comments regarding ways in which this community response to violence contributes to the high rates of violence in the NWT. Additionally, they validate the need for community healing and that it needs to begin from within. For example, an Inuvialuit counsellor in the far north explained that people are looking out for themselves rather than helping each other. This feedback is

supported in a study from Nunavut (Richmond & Ross, 2009), which found that Community Health Representatives (CHRs) described significant change in their communities. CHRs identified that there is less trust and reliance between community members and there is competition for the limited resources available to local people. In the past, community ties and cultural obligations reinforced reliance upon each other. Today, helping each other is economically driven. This links to a disruption in the concept of social cohesion in communities. This community shift away from social cohesion and the corresponding risks for violence was further established in Perreault and Simpson's (2016) report, which identified that when people in neighbourhoods are not helping each other or are not socially cohesive, the rate of victimization doubles.

We found that IPV survivors experience social isolation, as captured in the social processes of *putting up* and *shutting up about violence*. Sandberg (2013) suggests that when IPV occurs in a small community and victims are not helped, victims feel alienated. We discovered a similar experience in communities across the NWT. We described the way in which community retribution and gossip are contributing factors to the culture of violence and silence, and a woman's sense of isolation. This is reminiscent of what Neill (2015) suggests as informal social controls within the community. These social controls are important when considering a woman's experience of IPV in the NWT. "Isolation, including emotional, social and physical isolation, is a central issue to victims of IPV, not only in rural areas, but everywhere. Yet, the geographical isolation that rurality implies tends to exacerbate other forms of isolation in cases of IPV" (Sandberg, 2013, p. 352). Not only do social controls impact an IPV survivor directly, but they also exacerbate frontline workers' inability to effectively intervene with that family as well as shift our NWT communities toward non-violence.

Frontline workers in the NWT described concern for the number of children witnessing IPV and the lack of programming to effectively support them. This concern reverberates in the literature. Short and long-term consequences are described as occurring in a dose-response[15] way for children who witness IPV (Blair, McFarlane, Nava, Gilroy & Maddoux, 2015; Wood & Somers, 2011). These researchers recommend that interventions must be based on evidence about children who witness such violence. This includes consideration of the following: gender[16], home assessment, alcohol use, and school performance. Researchers also identified that children who both witness violence and experience child neglect are at risk for continuing the violence either as a victim or a perpetrator (Wood & Sommers, 2011). This is an important consideration in light of the fact that child neglect is tied with exposure to IPV (34% respectively) of substantiated cases of maltreatment across Canada (Public Health Agency of Canada, 2010). The complexity and variations of children's experiences, the lack of tested interventions, and the cultural and societal differences make it difficult to propose effective interventions. However, the place to begin is to offer more formalized supports for children who witness and experience violence, such as Project Child Recovery offered by YWCA Yellowknife.

In the NWT, children have been assessed for school readiness and learning through the Early Development Instrument using five domains: physical health and well-being; emotional maturity; communication skills and general knowledge; social competence; and language and cognitive development (GNWT, 2014). Through this assessment, it was ascertained that "from 2012 to 2014, 38% of NWT children are 'vulnerable' in one or more EDI domains and that this is the case for 53% of children in small communities" (Proactive Information Services Inc., 2015, p. 3). One has to ask, what is the influence of witnessing violence on that statistic? As well, what future risks does this pose for the child as they mature to adulthood? Focusing on children's overall health and well-being is a necessity.

15 Dose response is explained as the more exposure to a stressor, such as witnessing IPV, the greater the response to this stressor in behaviour. There is an increased rate of victimization and perpetration (Blair, McFarlan, Nava, Gilroy & Maddoux, 2015).

16 There is a gendered response between boys and girls that witness IPV. There is a trend that boys are more likely to act out violent behaviour towards others, while girls are likely to internalize what they have seen and may have symptoms of depression.

Offering effective trauma-informed services to help them cope with the effects of IPV exposure, supporting their efforts to successfully complete their education and, within that educational system, helping them to better understand healthy relationships and emotional self-regulation is of value. However, it is not enough to focus only on children. Without structural supports to the family (for example, income assistance and stable housing), positive responses to the IPV violence they are being exposed to, better assisting their mothers, and shifting the community's silent response to violence, change will be slow and less likely.

It is salient to note that service provision is inadequate in most communities. Recruitment and retention of service providers is a concern. Although there is some permanent staffing, it is common to hear of constant movement amongst agencies and other service providers or positions that are left vacant or experiencing significant time to process through human resources. It creates a sense of transiency in the workforce for community people. For women, they are often speaking to a newcomer who may have limited experience in small communities and a generalist practice that ill-prepares them to deal with northern complexities of IPV. Transience was identified as a factor that diminishes the effectiveness of services (O'Neill, Koehn, George, & Shepard, 2016; Wakerman, Curry, & McEldowney, 2012) as well as increasing the challenges of an already challenged workforce (Wakerman, et al., 2012; Wuerch, Zorn, Juschka, & Hampton, 2016).

In addition to remoteness and a lack of resources, there is complexity in northern practice and service provision for both helping professionals and clients. This requires adequate formal education, awareness and professional development for those working within these communities (O'Neill et al., 2016; Wuerch, et al., 2016) with such learning directed to the specific and unique needs of the region. Wakerman et al. (2012) and Shephard (2011) notes the necessity of having undergraduate level training to better prepare remote workers in assisting IPV survivors. In light of this, we recommend that funding for the nursing degree program offered through Aurora College continue and that funding is established to secure an undergraduate degree in social work that is currently offered as a two-year diploma.

Brownridge (2008) found a significantly higher risk of Indigenous women experiencing violence in rural areas as opposed to urban areas. This study identified the transportation difficulties, the lack of shelters, the lack of victim service workers, the lack of a police force in all communities, and the lack of social workers in the territory. All of these deficits are found in a remote context, which has the greatest lethality and frequency of abuse and violence and where there are great distances to services, long waits for referrals, and lack of anonymity and confidentiality in the small communities (O'Neill et al., 2016; Wuerch, et al., 2016). Of the services being offered to women and their families, research supports training in and application of trauma-informed practice, a strengths-based approach (Schmidt et al., 2015) and culturally appropriate solutions (Shepard, 2001).

Additionally, earlier detection screening tools used with women might help improve their health and risks for IPV. Mason and Pellizzari (2006) suggest that "advocates argue such screening provides an opportunity for women to receive support, discuss their options, develop strategies to improve their personal and family safety, and receive referrals for counselling, shelters or other resources" (pp. 20-21). They recommend these be implemented with all female youth and women. Implementing a universal screening tool was also recommended by the Office of the Chief Coroner (2013). This report also recommended that risk assessment tools within the RCMP be more proactively used. Our findings indicate that these are effective when accessed, but that they are inconsistently accessed across the NWT and the number issued do not correlate with the IPV incidents within a particular community. It was also reported that the ODARA might not be the most suitable instrument to use and, as such, we recommend that a more appropriate risk assessment tool be investigated and that the RCMP be educated to its effectiveness and use.

Regarding incidents of IPV homicide, we located a gap in information being reported. Current NWT Coroner Service Annual Reports do not classify IPV-specific homicides. This data would be valuable and, as such, we recommend it be reported as a method of homicide wherever possible. This information can better speak to the lethality of violence and help understand the risk factors or necessary interventions to reduce its occurrence in the future.

Findings from this research is substantiated from other work that highlights the importance of providing local supports to women experiencing IPV (Schmidt et al., 2015). Additionally, it is more effective if fly-in services work to support local resources and programs, that professionals providing such supports spend an appropriate amount of time in a community and develop strong relationships with community people if offering services that are fly-in (Wakerman et al., 2012). These will help mitigate the risks for survivors of IPV.

Coordinated responses are also instrumental to a more effective service response. This includes both informal and formal resources within the communities (Pennington-Zoellner, 2009) as well as interagency communication and collaboration between key partners, such as the RCMP, court system, probation, health care workers, community wellness workers, victim services, social workers (Neill & Hammatt, 2015; Office of the Chief Coroner, 2013; Pennington-Zoellner, 2009; Sandberg, 2013; Weurch et al., 2016). One way in which this collaboration could be further addressed is positioning a support worker (for example, social work) in the courthouse to liaise with the RCMP, Crown counsel and the woman who was involved in the incident before the court. This might improve the emotional stressors that compound the effects of trauma to the woman involved, improve court outcomes, more effectively manage the communication to the IPV survivor between resource providers and reduce the additional work responsibilities of RCMP officers. Additionally, it is important to note that tackling IPV with a coordinated, collaborative approach across professionals and community people will also work to change the silent and socially normalized response to violence (Pennington-Zoellner, 2009).

As this research project heard from frontline workers, we recognize the unique context for practice in the north as well as themes of stress on service providers, such as vicarious trauma and compassion fatigue. We heard multiple recollections of stories that have "stuck" with our participants, some of whom provided vivid accounts of what they were witness to, either directly coming upon a scene or in hearing from the IPV survivor directly. Increased opportunities for peer consultation has been noted in the literature as one way to better increase the longevity of professionals as well as improving the services being provided (O'Neill, Koehn, George, & Shepard, 2016). O'Neill et al. (2016) also note the importance of quality supervision, professional development and education to better equip workers. Areas to include in this training would be: cultural competence; generalist practice; trauma-informed practice; and creativity in working within communities that have limited resources (O'Neill et al., 2016). As an example, Sandberg et al. (2013) suggests one strategy could include identifying the informal support networks that exist in the smaller communities and mobilizing these to help stop violence. We suggest that local, territorial and Indigenous self-government continue to offer opportunities for community members to gather and increase social cohesion as being one route to decreasing violent victimization in our communities.

Public education in schools and communities is also necessary to strengthen a supportive response to IPV survivors. O'Neill et al. (2016) recommends this focus on healthy relationships, sexual respect and the negative effects of substances on families and communities be discussed. Findings from our research support this; many participants strongly endorsed education across the lifespan to these targeted areas. In the spirit of collaboration, we recommend that departments and agencies share any educational tools they have created with workers across the territory so these can be used when running programs.

Finally, this study is meeting a gap in research studies on community response to IPV in remote and northern areas of Canada. Our larger research team, composed of partners investigating IPV in northern Alberta, Saskatchewan and Manitoba, are describing similar contexts in northern parts of these provinces. The Saskatchewan team recently described a lack of health care services, lack of shelters and long distances to safety as core factors in delivering timely responses for women experiencing IPV (Wuerch et al., 2016). These findings corroborate with findings from the NWT. It is important to synthesize the findings from all of these northern locations to further our understanding of what is occurring in these contexts with similar commonalities.

Conclusion

Community response to IPV in the NWT was articulated by frontline workers, as "hands are tied". This description explains a frustration with the contextual and causal realities that service providers experience on a daily basis with their work with victims of violence. The knowledge generated through this model will enable future targeted strategies to address the needs of women experiencing IPV and gaps in the current services to meet their needs.

The lack of continuity of frontline workers, along with the depleted services, creates a crisis response to IPV incidents. Many communities are without RCMP, victim service providers and emergency women's shelters. Programs and funding are short-term and, although these efforts provide some assistance for victims, they make little long-term difference to the violence that persists. There continues to be both a normalization of violence and a doggedness of individual and community attitudes of blame and shame towards victims. Women are isolated and left to their own capabilities in addressing personal abuse and violence from a partner and within their communities; they demonstrate resilience and tenacity in terms of keeping their children and partner together in some semblance of family.

We cannot underestimate the effects that violence is having on children. They are witnesses to unspeakable events when the parents they know strike out at each other. Historical trauma and systemic inequities are propagating these high numbers of children in child protection. This further leads to poor school attendance and the intergenerational effects of that trauma, which continues.

The perpetuation of violence is affected by the intersection of many factors; for example, poverty, unemployment, housing issues, lack of access to transportation to safety and a lack of communication (no telephones) for safety purposes. These factors of disparity are well known in the territory and, for that matter, in the country. There are initiatives being created to address the inequalities, but they do not seem to be taking place in a timely or effective way considering the daily havoc they create in the lives of local people. We need to continue to advocate for initiatives to overcome and address poverty, better housing and emergency planning for victims.

Of utmost importance is addressing and overcoming colonialism and colonial practices that have resulted in historic trauma of Indigenous people in the territory. Reconciliation is a key step to addressing historic trauma (Truth and Reconciliation Commission of Canada, 2015). Knowledge generation (like this study) is a way of validating historical trauma and the effects of this on healthy relationships. This is an important step to well-being. Equally salient to historic trauma is finding effective culturally appropriate treatment options to foster healing. Providing education opportunities about the collective history of peoples residential schooling experience is key to understanding historic trauma, the issue of violence, and the pain and suffering that is transmitted in an intergenerational manner.

There is no doubt that alcohol use and abuse is a factor in self-medicating to forget the pain of historic trauma and, unfortunately, alcohol is coexistent with incidents of violence. In consideration of the historic trauma, alcohol use and disabilities that are present in the territory, mental illness is a grave concern. Addiction to alcohol and other substance is a major influence on poor health. Little is known about the help-seeking behaviours of northerners and the constraints to achieving sobriety. This merits investigation. For example, there is a great deal of local concern that treatment for addictions is hampered by no territorial treatment centres, limitations in accessing local programs, the high cost of southern treatment facilities, being disconnected from family, community and culture when having to seek treatment outside of the territory as well as little on-going professional support and programming for residents who have returned from treatment programs. Bye (2007) conducted an investigation into alcohol consumption and violence in Norway, demonstrating that an increase in alcohol consumption over time produced an increase in violence over time. It is vital that alcohol policy strategies be developed and implemented to assist our territory in reducing the violence rate, while at the same time improving the health of local people.

This study contributes an understanding of intimate partner violence in the NWT and an action plan for decision makers, community activists and policymakers to take forward. The research itself was instrumental in profiling the need to act on the issue of violence in the territory. It is hoped that this study can be the backbone for change as our communities and the territory at large moves toward non-violence in a united effort that truly recognizes Indigenous knowledge and that of our frontline service providers.

Let this report facilitate emerging policies that support non-violence, tangible strategies and resources to reach the hands of frontline workers and for a paradigm shift to occur that moves our understanding of this territory from one that is struggling to one that considers itself capable.

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Appendix A

Knowledge Mobilization

Invited Presentations

Moffitt , P. (2016) Let's Talk Housing Roundtable, Ottawa, ON.

Moffitt, P., Fikowski, H., & Fuller, L. (2016) Ledge Talk. Community Response to Intimate Partner Violence in the NWT.

Presentations

Moffitt, P. (October 17, 2016). Remoteness in the Northwest Territories: A barrier for IPV survivors. Qualitative Health Research (QHR) Conference, Kelowna, BC.

Moffitt, P. (October 4, 2016). Untying the forces and moving forward: Perspectives on intimate partner violence from frontline workers in the NWT. Research and Education for Solutions to Violence and Abuse (RESOLVE), Calgary, AB.

Moffitt, P. (September 14, 2016). Member of Panel on Family Violence. Safety School. Yellowknife/North Slave Student Body.

Fikowski, H., & Moffitt, P. (June 2016). Frontline Respsponse to IPV in Canada's North. Joint World Conference on Social Work, Education and Social Development 2016, Seoul, Korea.

Moffitt, P., & Fikowski, H. (2016). Mapping rural and northern community response to intimate partner violence. Edmonton, AB: Transforming Health Care in Remote Communities Conference.

Fikowski, H., & Moffitt, P. (April 2016) Northern community response to intimate partner violence. Teleconference with Yukon Victim Service Workers.

Fikowski, H., & Moffitt, P. (November 2015). Frontline response to intimate partner violence in the NWT. Association of Social Workers in Northern Canada Annual Meeting, Yellowknife, NT.

Fikowski, H., & Moffitt, P. (September 2015). Narratives of frontline workers community response to intimate partner violence in the NWT. 14th Conference of the Canadian Rural Health Research Society, Edmonton, AB.

Moffitt, P. & Fikowski, H. (2015). Shadows, silence and secrets: A narrative of an isolated community's response to intimate partner violence. Qualitative Health Research Conference, Toronto, ON.

Fikowski, H. & Moffitt, P. (2015). Narratives of frontline workers to community response to intimate partner violence in the NWT. 14th Canadian Rural Health Research Society (CRHRS) Conference, Edmonton, AB.

Moffitt, P., & Cash, P. (2015). Language and intimate partner violence. Webinar. InspireNet.

Moffitt, P. (2014). The contextual issues of intimate partner violence in the NWT. Research and Education for Solutions to Violence and Abuse (RESOLVE), Winnipeg, MN.

Moffitt, P. (2014). Northern community response to intimate partner violence in the Northwest Territories. Safety & Health in Agricultural & Rural Populations (SHARP), Saskatoon, SK.

Moffitt, P. (2014). Intimate partner violence in the Northwest Territories. NWT Science Showcase, Yellowknife, NT, November 3, 2014.

Moffitt, P. (2013). Mapping northern and rural community response to intimate partner violence. Qualitative Health Research Conference, Halifax, NS.

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Moffitt, P. & Mauricio, M. (2012). Intimate Partner Violence in the Canadian Territories. 15th International Congress on Circumpolar Health, Fairbanks, AK, USA.

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Moffitt, P., Fikowski, H., Mauricio, M., & Mackenzie, A. (2013). Intimate partner violence in the Canadian territorial north: Perspectives from a literature review and a media watch. International Journal of Circumpolar Health, S72: 21209. Retrieved from http://doi.org/10.3402/ijch.v72i0.21209.

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Moffitt, P. (Spring, 2012). Research notes: Rural and Northern response to intimate partner violence. Northern Public Affairs Magazine, 1, 62.

Peer Reviewed Posters

Fikowski, H., & Moffitt, P. (June 2016). Culture of violence and silence: A context of service provision in Canada's Arctic. Joint World Conference on Social Work, Education, and Social Development 2016. Seoul, Korea.

Fikowski, H. & Moffitt, P. (2015). Community response to intimate partner violence north of 60. Safety School Poster Presentation. Family violence Awareness Week. Yellowknife, NT.

Media Engagement

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