Shelter +

A Domestic Violence Response Network in Newfoundland and Labrador

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A thesis

submitted in partial fulfillment of the

requirements for the degree of

Master of Architecture

University of Washington

2020

Committee:

Gundula Proksch

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Program Authorized to Offer Degree:

Architecture

University of Washington

Abstract

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A Domestic Violence Response Network in Newfoundland and Labrador

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Chair of the Supervisory Committee:
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Department of Architecture

Access to long term affordable housing and community support is a critical component of providing care for domestic violence survivors. In Newfoundland and Labrador, Canada, many of the industries that have historically sustained rural life are diminishing and leaving these economies behind. Canada is experiencing rising incidences of domestic violence in affected rural communities like those found in the Maritimes. With little geographic access to urban resources, survivors of family and intimate partner violence can become trapped in a cycle of repeated aggression and violence.

This thesis explores issues of domestic and intimate partner violence as affected by rural and environmental stressors. Through research and design analysis, it proposes a domestic violence shelter network to respond to these unique conditions. The center of this network is in Newfoundland and Labrador's capital, St. John's. Understanding domestic violence as a systemic issue that needs to be addressed on multiple levels drives this thesis.

Thank you-

Gundula and Alex : Thank you for your support and efforts to help me develop this project. Thank you for your guidance.

My Parents : Thank you for seeing the value of architecture and the importance of finding my own way in the world.

Adam : Thank you for everything. Without you, I would not have been able to make it here.

SHELTER +

a domestic violence response network in Newfoundland and Labrador

Rosemarie Grégoire

M.ARCH THESIS

Spring 2020

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[1] my mother (far left) with her family in front of her childhood home in Winnipeg, Manitoba

Preface

Domestic violence, family violence, intimate partner violence, intimate partner terrorism, spousal abuse, and violence against women are just a few of the ways in which we have found it possible to describe the extreme trauma, the total upheaval of safety, the loss of autonomy that people (most commonly women, non-binary people, and children) experience at the hands of someone intimately tied to them. The feminist movement, in its many waves and forms, has shed some light on what previously had been a type of violence often deemed acceptable to maintain traditional family values. The rise of feminism shifted cultural attitudes toward this type of violence (though it certainly was not a total shift). Governments put various policies and measures into place that validated the narratives of women in violent households, and it seemed like we were finally beginning to address the problem. But what now? After awareness, there has been a marked stagnation in funding for domestic violence programs, and even awareness has slipped back. Fear of how political correctness is shaping free speech has become a way to protect people who deny the problem and those who would claim gender-based violence is not a big deal.

We are also an increasingly urban society. In North America, it is clear that "progressive attitudes" (ie. those favorable to the rights of women and non-binary people) cluster around urban centers. In polarized times when people feel threatened by differences and loss of power, the most vulnerable experience that harshest facets of life. In Canada, shelters have less and less funding, and increasing rates of violence overall, but this is particularly so in small rural communities. If everyone knows each other, who do you call? Where are you safe?

I grew up in a smaller, but highly-educated, hospital town. This community, with access to information more than most, still struggles with openness to and acceptance of families and individuals experiencing domestic violence. Domestic violence has historically been seen as a personal family problem, which silences the people who would seek help. Sustained trauma also silences people. Domestic and family violence are generational and have impacts that span across long periods of time and communities. I know this because I live with its generational effects. Silence is the enemy of safety and the enemy of growth.

Last year in the state of Washington alone, there were 63 domestic violence homicides, and likely more that were not counted. How do we change a culture around violence? How do we react to generational abuse and take a more proactive stance?

GLOSSARY

DOMESTIC VIOLENCE

There are many terms people use to name domestic violence. In Canada, it might be more common to hear "intimate partner violence" or "family violence". All of these terms refer to a pattern of abuse used to remove the autonomy of an individual by their partner.

SURVIVOR

For this thesis, I will use the term survivor or resident depending on what is appropriate. Much like the term domestic violence, there are many terms used to describe an individual who is experiencing/has experienced domestic violence. I will be using survivor, but I recognize that within the field of domestic violence, there is an ongoing conversation about what is the preferred label. Ultimately, labels should not be used to remove the individuality of people.

To understand more about this language conversation, I suggest checking out *No Visible Bruises* by Rachel Louise Snyder, thehotline.org, or you local shelter.

1.

[2] view into Quidi Vidi, St. John's

Introduction

Introduction

This thesis proposes a new network system for domestic violence shelters in Newfoundland and Labrador. The idea of a network is adapted from current criticisms and conversations around the role of existing domestic violence shelters and how they are falling short for those who need them. Rather than seeking to hide away residents from the public, this thesis will examine how shelters can become critical parts of the communities that they exist in. This new framework sees shelters as spaces for important discussions about gender dynamics and how secrecy around the issue of domestic violence is the enemy of societal growth and personal safety. At the heart of this network, is an emphasis on advocacy and intervention. By understanding how critical preventative measures along with space designed for users to build social connections and a sense of personal autonomy, the proposal will test out design measures that can contribute to a more holistic advocacy-based approach toward the issues of domestic violence and support for its victims. Domestic violence is now being understood as a systemic problem that deeply traumatizes not just individuals and families, but also communities. By inviting the community in, the network proposed here would increase public awareness and participation in advocacy for survivors so that the community can play a key part in preventative and healing measures.

The thesis tests out these strategies in the province of Newfoundland and Labrador. Right now in Canada, domestic violence rates are on the rise; particularly in rural regions. Rural areas have consistently been associated with higher rates of domestic violence, but Newfoundland and Labrador has other characteristics that contribute to its rising domestic violence rates. First, economic pressure and depression are some of the strongest indicators for increased domestic violence. Ever since the collapse of the fishing industry in the Maritimes, Newfoundland and Labrador have struggled to rebuild a consistent and profitable economic system. Second, climate stress and catastrophic weather events are also some of the highest indicators of increased domestic violence. This province, being both very northern and having its unique island villages, has experienced more pressures from changing climate than ever before.

In recent years, belief that domestic violence is an important or even commonplace issue has become contentious. In both Canada and the United States, federal funding for advocacy and shelter work has been slowly grinding to a halt. The American Violence Against Women Act, which has been stalled in congress without being renewed since its expiry in 2019, is a fundamental piece of domestic violence legislation.[1] This act has provided crucial funding for the prevention and prosecution of violent crime against women since 1994, but now its future is uncertain.

On April 20, 2020, the largest and deadliest mass shooting in Canada occurred.[2] This spree began as a direct attack against the shooter's partner. According to research by Rachel Louise Snyder, the vast majority of mass shootings are extreme incidences of domestic violence.[3] The now second largest mass shooting in Canada, the École Polytechnique massacre in Montreal, famously targeted women studying in university.[4] In an era where mass shootings sadly feel commonplace, Louise Snyder points out that "It's not that domestic violence predicts mass shootings. It's that more than half the time, mass shootings are domestic violence."[5] Today, in these uncertain times of a global pandemic when many are forced to shelter in place, many are forced to choose between two potentially deadly options.

[3]

[4]

[5]

[3] headline from G.Q., 2019
[4] headline from CBC, 2020
[5] headline from The Guardian, 2020

2.

[6] view into an outport village from Viceland

Domestic Violence Shelters

[7]

[8]

Beginnings

The history of domestic violence shelter in Canada begins with the Battered Women's Movement.[6] In the 1960s and 1970s, there were still few laws that protected women from abuse or violence from their husbands/partners. Domestic violence, or "wife battering" as it was called at the time, was seen as a personal household issue, and often a failing of the wife.

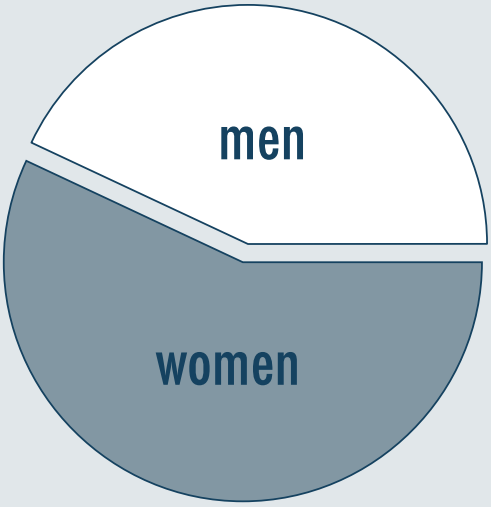
The first ever women's shelter was the Inasmuch House in Hamilton, Ontario. It was originally founded to be a place for women leaving prison to stay as they established their next steps.[7] The shelter eventually pivoted to focus more on domestic violence. It is interesting to note how the idea of shelter originally came from a relationship to the justice system. Criminalized behaviors that are not seen as needing social support, like substance abuse, are a huge barrier to women seeking assistance from domestic violence services. Often women who may have a criminal record or a history of substance abuse can be rejected from staying at a shelter, which only furthers the likelihood that they will become trapped in a cycle of domestic violence.[8]

The Battered Women's Movement gradually made an impact in both the United States and Canada with legislation enacted to protect women from abuse at the hands of their partners. Funding was established for shelters and for domestic violence research, but as soon as visibility of the issue was reached, funding began to slow down. Administrators of most shelters today say that their primary struggle is with making ends meet and staff retention.[9] Funding is so critical because it allows the shelter to do what's important, and spend less time trying to convince people to give them financial support.

Many of the initiatives during the Battered Women's Movement emphasized punishment-based measures for people who commit acts of domestic violence.[10] This attitude aligned with existing approaches to crime and punishment in Canada. However, people who had been working with domestic violence, shelter workers and researchers found that punishment measures were not very effective. What actually is effective is a system that is much more intervention based.[11] This means prioritizing resources that help create safety and support for people before domestic violence becomes their only outlet.

[7] newsclipping about the Inasmuch House, 1965
[8] photo of the Inasmuch House, 1965

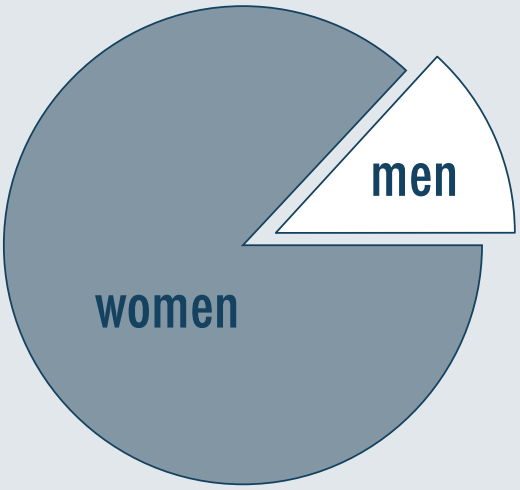
Newfoundland and Labrador - Crime Rates



Police Reported Victims

WOMEN : 52%

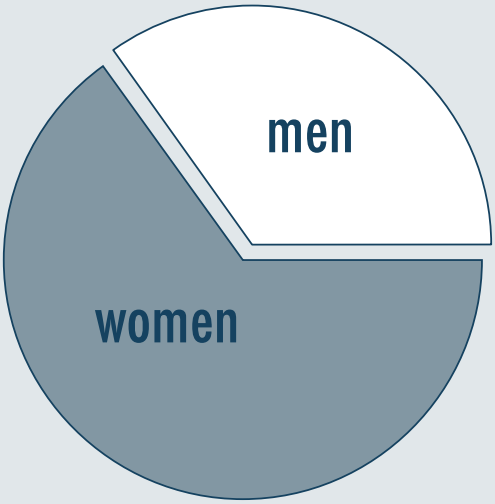
MEN : 48%



Victims of Sexual Offences

WOMEN : 87%

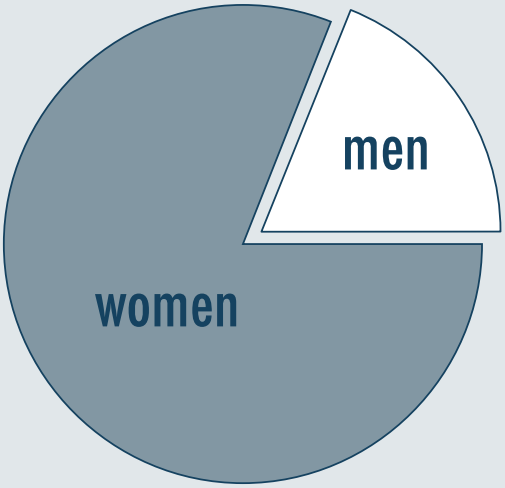
MEN : 13%



Victims of Indecent / Harassing Communications

WOMEN : 65%

MEN : 35%



Victims of Criminal Harassment

WOMEN : 81%

MEN : 19%

[9]

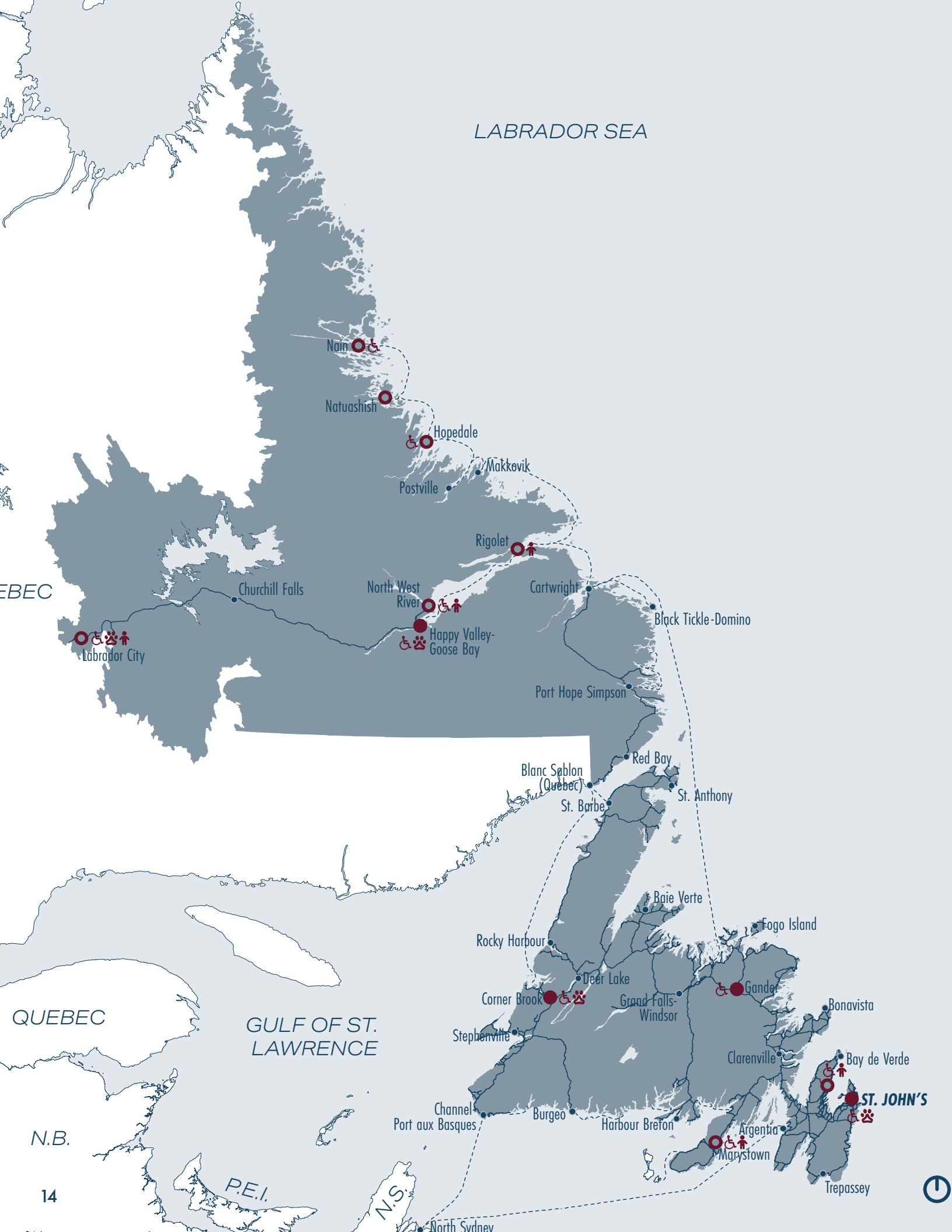
Domestic Violence in NL

With a population of 521,542 people (2019), Newfoundland and Labrador make up about 1% of the population of Canada.[12] This province does not have the highest rate of domestic violence in the country, but the province does have a disproportionately high rate relative to that of the rest of the country.[13] The majority of people who experience this kind of violence are women, and in Newfoundland nearly 1 in every 2 women will experience sexual or gender-based violence.[14] Newfoundland and Labrador is almost entirely comprised of rural communities, so this culture of violence can have a much wider influence on small communities where everyone knows each other. The province's largest city and capital, St. John's, has a population of only 100,000 people.[15]

As for Labrador, Inuit people have some of the highest rates of domestic violence overall. In fact, lack of domestic violence services is one of the key reasons Inuit people leave Nunavut, where the vast majority of the population resides.[16] What that means for Labrador is that these communities are already grappling with issues of domestic violence along with feelings of disconnection and separation. The way that indigenous and First Nations communities respond to domestic violence is often in a way that is counter to standard Western practice. Solutions are often holistic and seen as a whole community effort. This might mean the entire family holding meetings together or the community having a meeting about a specific situation.[17] Having space appropriate for meetings like this is important to allow for healing in a way that is respectful for different practices. Unfortunately, most shelters have little to no services that make accommodations for first nations and indigenous people, and there certainly is no set standard. In fact, most existing shelters use a "pan-Indian" solution that does not adequately understand the importance of cultural individuality within indigenous communities.[18]

In highly rural and subsistence communities, like those found in Newfoundland and Labrador, financial stability is something that can feel fleeting. One of the leading indicators for a domestic violence related homicide is job loss.[19] Not only is a reliable source of income challenging nowadays in the province, but so too is getting into a relationship at all. In many of these small towns, there are significantly more men than women, and in some towns, there aren't any women who are under the age of sixty.[20] For the men of this province, there often is a tense relationship with women because of this. Over time, many of the women have just left because of cultural, economic and other reasons.

[9] NL crime stats from Stats Canada


LABRADOR SEA
Nain
Natuashish
Hopedale
Makkovik
Postville
Rigolet
Churchill Falls
North West River
Happy Valley-Goose Bay
Labrador City
Cartwright
Black Tickle-Domino
Port Hope Simpson
Red Bay
Blanc Sablon (Quebec)
St. Anthony
St. Barbe
Baie Verte
Fogo Island
Rocky Harbour
Deer Lake
Corner Brook
Grand Falls-Windsor
Gander
Bonavista
Stephenville
Clarenville
Bay de Verde
ST. JOHN'S
Channel-Port aux Basques
Burgeo
Harbour Breton
Argentia
Marystown
Trepassey
North Sydney
QUEBEC
GULF OF ST. LAWRENCE
N.B.
P.E.I.
N.S.

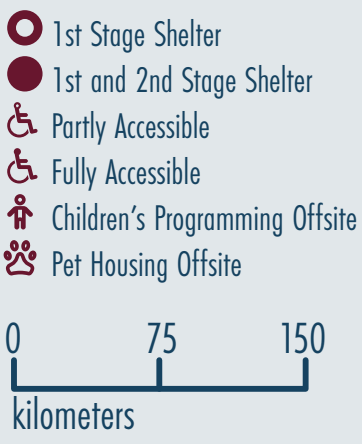
Current System

There are a total of twelve domestic violence shelters in Newfoundland and Labrador. Of these twelve, only four offer second stage housing (housing for longer than a few days; typically up to six months), seven are fully accessible, five offer off-site programming for children, and four offer off-site service for pets.[21] Notably, the shelters and services in Labrador on the whole offer fewer amenities and options for housing. The province overall is severely lacking in options and types of services offered for domestic violence support and advocacy.

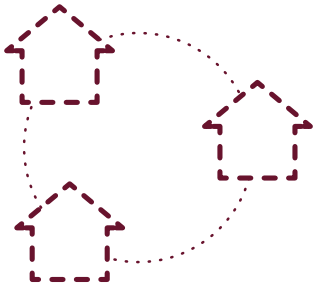
In Canada there are 5 types of shelters - safe homes, first stage housing, second stage, women's and more general emergency shelter.[22] Each province can vary in what services are provided and how much oversight they have. In Newfoundland and Labrador, there isn't a very good public perception of how the shelters are operated. The public often sees the shelters as crime ridden places that are not well-kept.[23] Residents criticize how powerless existing shelters can make them feel, and that shelters can often make them feel like the only thing happening in their lives is the domestic violence.[24]

"There must be some other distinguishing feature about me besides the fact I was hit by my husband."[25]

"I was controlled and pushed around at home. That's why I left in the first place."[26]



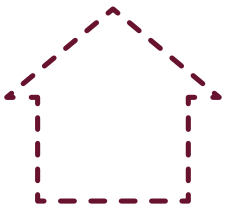
[10] Map of NL showing the locations of existing shelters and the services they provide



SAFE HOME NETWORKS

Stay Duration : 1 - 3 days
Number CAN : 17
Number NL : 0

"A network of private homes in rural or remote areas where there is no full-fledged operating shelter."



FIRST STAGE EMERGENCY HOUSING TRANSITION HOME

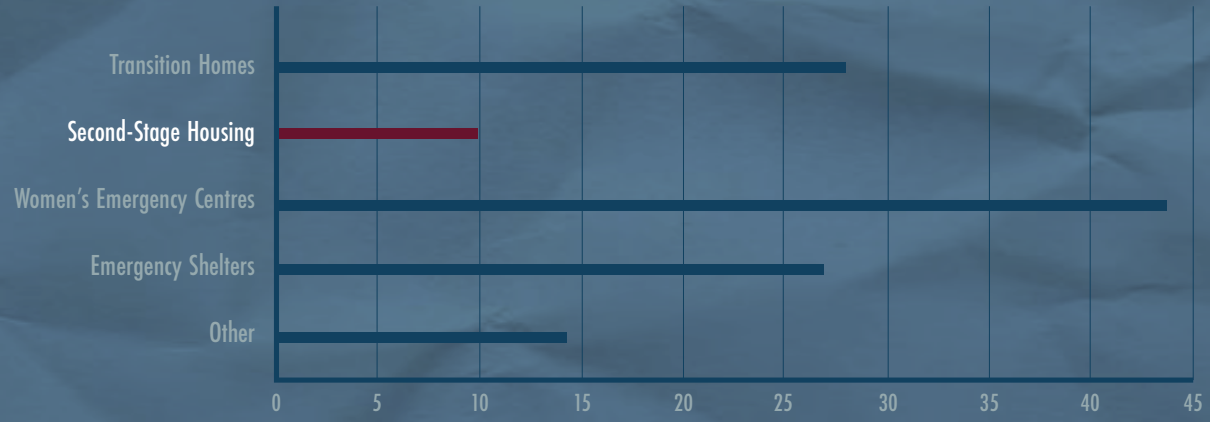
Stay Duration : 1 day - 11 weeks
Number : 281
Number NL : 8

"Facility offering short- or moderate- term secure housing for abused women with or without children."

SECOND STA

Stay Duration : 3 - 12
Number : 123
Number NL : 6

"Facility offering long-term s
and referral services designed
search for permanent housing



GE HOUSING

months

ecure housing with support
d to assist women while they
g."

WOMEN'S EMERGENCY CENTRES

Stay Duration : 1 - 21 days
Number : 80
Number NL : 1

"Facility offering short-term respite for women and their dependent children."

EMERGENCY SHELTERS

Stay Duration : 1 - 3 days
Number : 84
Number NL : 2

"Facility offering short-term respite for a wide population range, not exclusively abused women. Some facilities may provide accommodation for men as well as women. This type of facility may accommodate residents who are not associated with family abuse but are without a home due to an emergency situation."

10 Average Number of Funded Beds in NL (national average is 16)

30 Average Length of Stay in Days

100% Percent of Shelters in NL that need major or minor repairs (national average is 80%)

[11] Diagram explaining the different kinds of shelters

Types of Shelter

SAFE HOME : Safe homes are the most uncommon and often have the shortest stay period. These are typically rooms in someone's house. Safe homes are the most unregulated, and are often a voluntary set-up that someone starts in their home. In the whole of Canada, there are 17, and there are none in Newfoundland and Labrador. Safe homes are definitely more from the time of domestic violence shelters being independently run by families or churches, much like the original Inasmuch house.

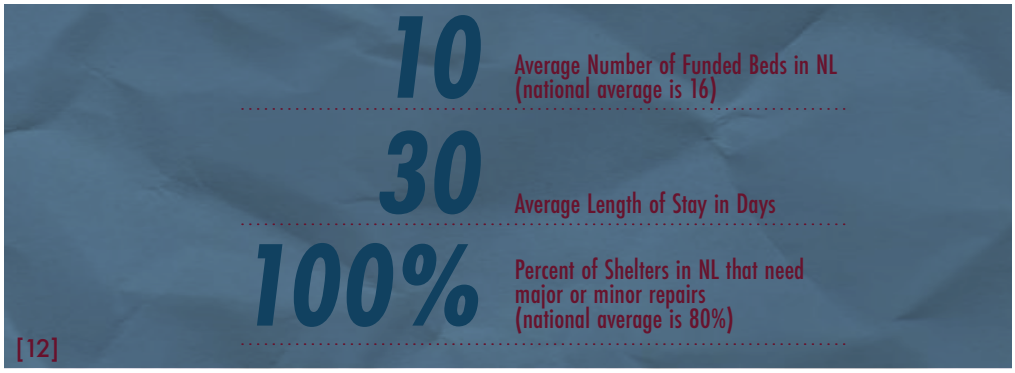
FIRST STAGE : A first stage shelter is what people generally think of when they think about a shelter. The stay at these locations usually maxes out at 11 weeks. They're often restrictive about who is allowed to stay and enforce strict rules that must be followed to stay there. These types of shelter are more or less the standard in Canada. One of the biggest criticisms residents have of these shelters is how demeaning the rules can feel.[27] These restrictions and rules for continued stay remove the autonomy of individuals and further induce shame.

SECOND STAGE : Second stage housing is similar to first stage and sometimes the two may be offered within one shelter. Second stage allows for longer stays which can be up to a full year. Generally, second-stage shelters have a more positive public perception and do experience many of the same criticisms that first stage shelters have. With shelters that have a firm end time for a stay, many people experience difficulty having resources in place to help them transition to the next stage of their lives. Often individuals describe a feeling of being abandoned with no continuing support.[28]

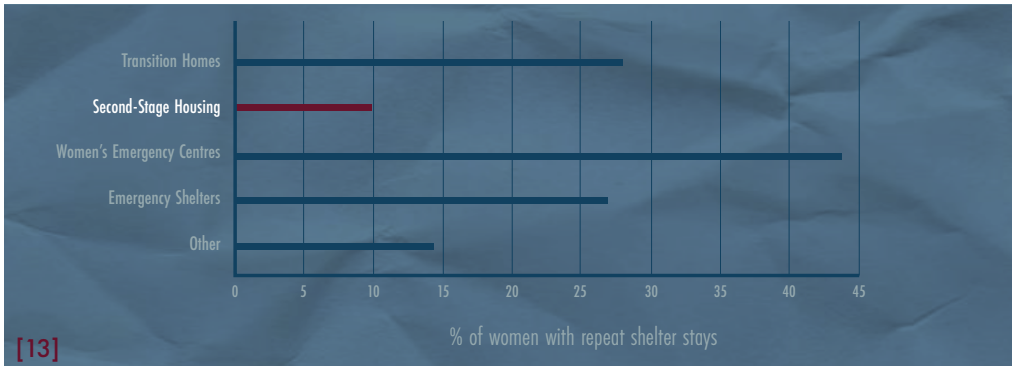
EMERGENCY CENTERS : Women's emergency centers and emergency shelters are less common in the province and may not offer housing. Stays in these locations are usually limited to a few days. Most often these are focused on providing services for people experiencing homelessness. The problem many women experience when going to an emergency center is that the staff are not trained on domestic violence, even though most women who are homeless have experienced domestic violence.[29] On the other hand, domestic violence shelters often do not provide the services that emergency centers do, such as job support e.g. The lack of understanding of the needs of the people using these services can harm any positive reinforcement that residents might be receiving.

The average number of times a survivor will need to stay in a shelter before fully being independent of a domestic violence environment is 7[30], and in Newfoundland and Labrador, these shelters are maxing out in capacity all the time.[31] Additionally, a report that the federal government did on the state of shelters found that 100% of the shelters in Newfoundland and Labrador were in need of major or minor architectural repairs and updates.[32] The shelter system in this province, and in the whole of Canada, lacks funding and support from the government.

This graph [figure 13] shows that Second Stage Housing - with a longer allowable stay period - has the lowest percentage of women returning after the first stay.[33] This information combined with accounts of women who have stayed in shelters tell us that first stage shelters are not doing what they should be; which is to help with establishing financial and social independence and rebuilding a network of support.



[12]

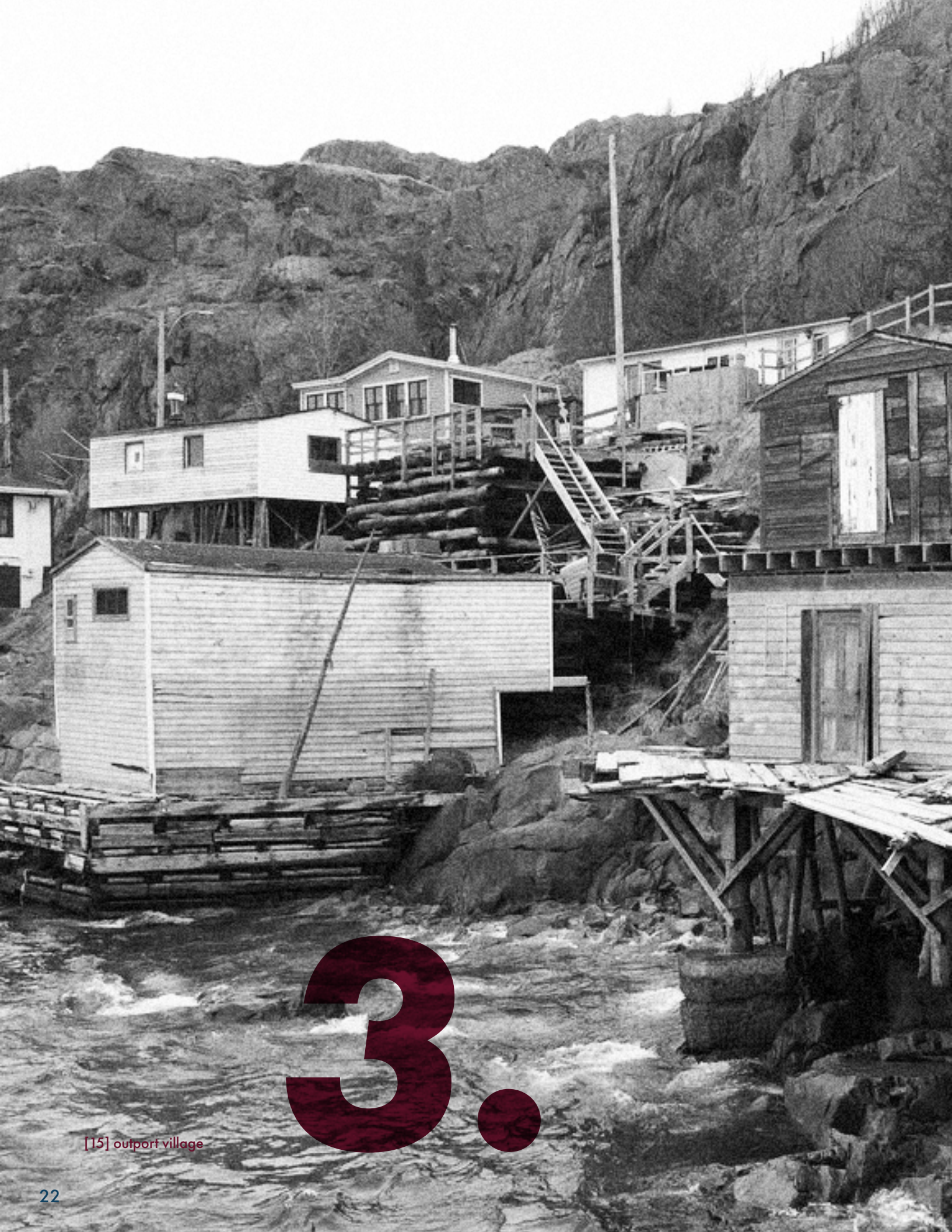


[13]

[12] Numbers regarding usage of existing shelters
[13] Graph showing repeat stay percentages

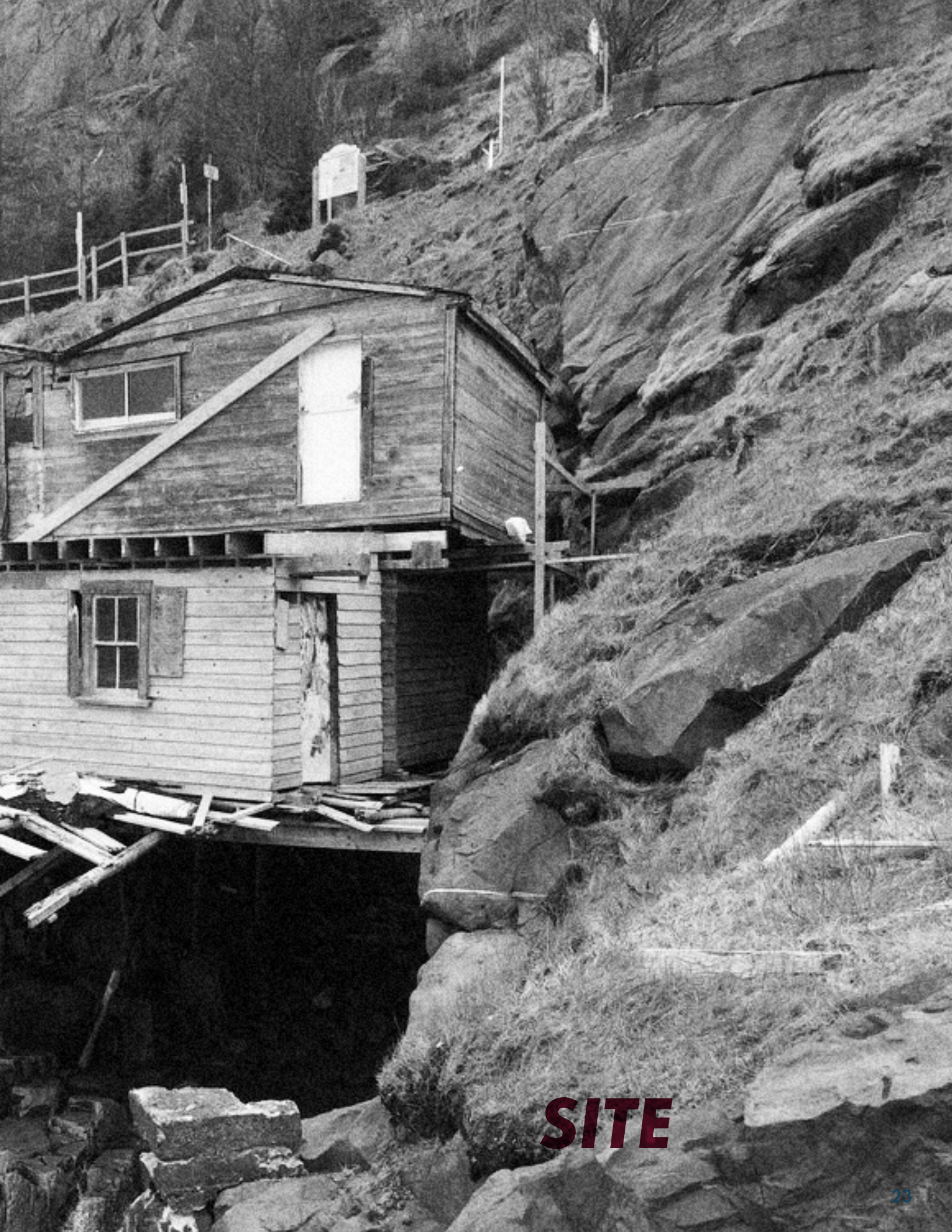
The Way Forward

In Canada, shelters are not doing the work advocates need to or want them to be doing. A common critique from people who have used them is that it feels like they are the person being punished and locked away; not their abuser.[34] Today the goals of domestic violence work and advocacy does not align with the system in place. The biggest take-away from the research undertaken for this thesis is that shelter as we know it is not a sufficient response. People need long-term and affordable housing to establish autonomy, to be financially independent, to be seen and supported by the community. This shift in domestic violence work places emphasis on advocacy, education, and intervention. Essentially it seeks to create a culture shift - requiring more from people and communities, and less from survivors.



3.

[15] outport village



SITE

A Province Divided

The province of Newfoundland and Labrador is on the easternmost edge of Canada. Separated into two wholly different geographic land masses, the province continuously faces the challenge of fairly responding to the unique needs of these two disparate regions. Amongst the Canadian provinces, Newfoundland and Labrador has one of the larger ratios of land area to population. With most of the population living in the largest urban center of the province, St. John's, the remaining populated areas mainly consist of very small towns that have a hard time maintaining a stable economy and preventing population decline.[35]

United initially through early colonization from the Portuguese, British, and French, Newfoundland and Labrador have long been forced to function as one entity, even though there was little cultural connection between the two locations.[36] Labrador, so named for one of its original Portuguese colonizers, is connected to mainland Canada. Surrounded by Quebec and having a northern edge close to Nunavut, this portion of the province varies significantly in terms of culture and the people that live there. Labrador is where the majority of the province's population of Inuit and Mi'kmaq people live. Of all the provinces, Newfoundland and Labrador has the highest percentage of Inuit people outside Nunavut, and this is primarily due to the large population found in northern Labrador.[37] Located primarily along the coast, these indigenous towns and cities face major loss of culture and lifestyle due to repeated trauma from Western colonization and oppression. Most have little connection to one another or the rest of the province. Without roads reaching them, access to outside resources in any time other than summer can be a challenge because they rely on shipment by sea.[38]

Newfoundland, on the other hand, has long been very homogenous in terms of cultural make-up. Post European contact, settlements on the island have consisted of subsistent European fishing villages for generations. The island itself is surrounded by many smaller islands, known as outport villages. Cod fishing was the way of life here and allowed a very distinct and unique culture to grow. When people think of the province, they generally are referring to the island of Newfoundland. The province only recently changed its name to embrace Labrador, but the more sparsely populated northern landmass has long been left out of formal inclusion.

Because of these differences that are often omitted from political conversation, dealing with the province as a whole often leads to tension. Working in Newfoundland and Labrador means understanding that there are important differences in culture, ecology, and urban life throughout the province. Historical influences have a lot of power here and need to be considered carefully.

[16] map of Canadian east coast with Newfoundland and Labrador highlighted

Economic Hardship

The original name for the island of Newfoundland in Innuttitut is Ikkarumikluak which means the place of many shoals. When Europeans first arrived on the island, they were astounded by the sheer amount of cod fishing there was. This amount of fish was one of the primary reasons that the island was so desirable and continually passed hands from one empire to another. The fishing lifestyle was what really brought people to the province and how the culture that still exists today originated.

In the 1960s and 1970s, commercial and industrial fishing really began to dominate fishing in the area. With few laws in place to ensure controlled and sustainable fishing, the shoals began to disappear until there was hardly any fish to be found at all.[39] Finally in 1992, the Canadian federal government placed a moratorium on all Atlantic cod fishing and with this policy, the economy of Newfoundland and Labrador disappeared.[40] The policy ultimately harmed the province much more than it did the actual perpetrators because it did not penalize global trawlers, but did punish the local fishing community. Slowly the cod are starting to reappear, but the impact of their disappearance has shaped the culture of the province as a whole.

The communities most affected by this were the outport villages. The federal government put into place an urban renewal program known as "resettlement" to try to manage their economic failure.[41] Over the years, there have been three different resettlement programs. The first began in 1954, and the second followed shortly after in 1965. These programs identified the most vulnerable outport villages; focusing on those that were the most economically inefficient to maintain.[42] The federal government decided that these villages were not able to produce enough financial stability on their own and it was too costly to upkeep basic necessities like electricity and clean water. The residents of these villages were forced to move to a nearby mainland town and begin life anew. The social and cultural impact of this policy was enormous. People were forced to abandon their homes and ways of life. The effects of forced policies like these cannot be understated. The people in these situations had no power to fight against this abrupt and monumental change.

[17] a home being resettled to the mainland

Today, resettlement still exists, but under a new government policy and name. In 2010, the Community Relocation Policy began as an updated form of the old practice.[43] Under this strategy, residents of villages now get to vote on whether or not they want to resettle. For a town to resettle, the vote must be at least 90% in support of moving.[44] Until that percentage is achieved, the villages revote every year. Even though the process is more voluntary now, it can still have devastating effects for small communities. Often everyone in town knows who voted and which way they did. Split votes can tear communities apart. Some people feel positively about the policy because the current way of living is hard, but many feel it just as inevitable as the resettlement policies in the fifties and sixties and still extremely disruptive.[45]

As a result of all these resettlement strategies, much of the population of the province now lives in urban areas. The way of life of these fishing villages is vanishing. Resettlement can also be blamed for an overall decline in population. As the culture and economic success of individuals is threatened, more and more people move away from the province in search of a better life.

[18] an abandoned outport village


085186
139581
Quidi Vidi By's
St.John's, NL

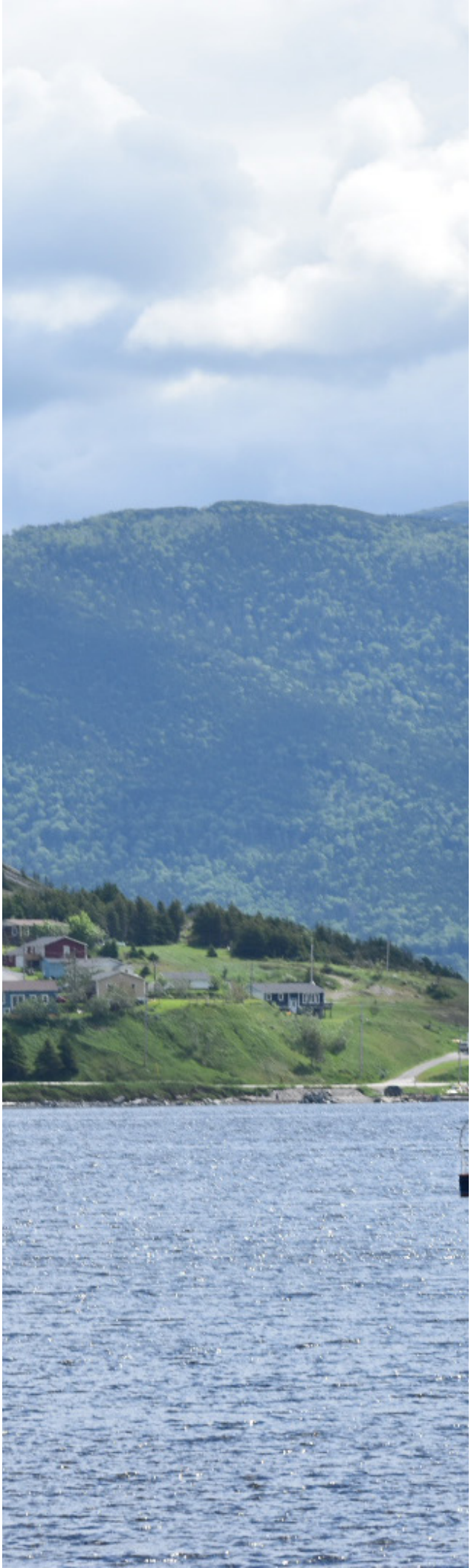
Culture

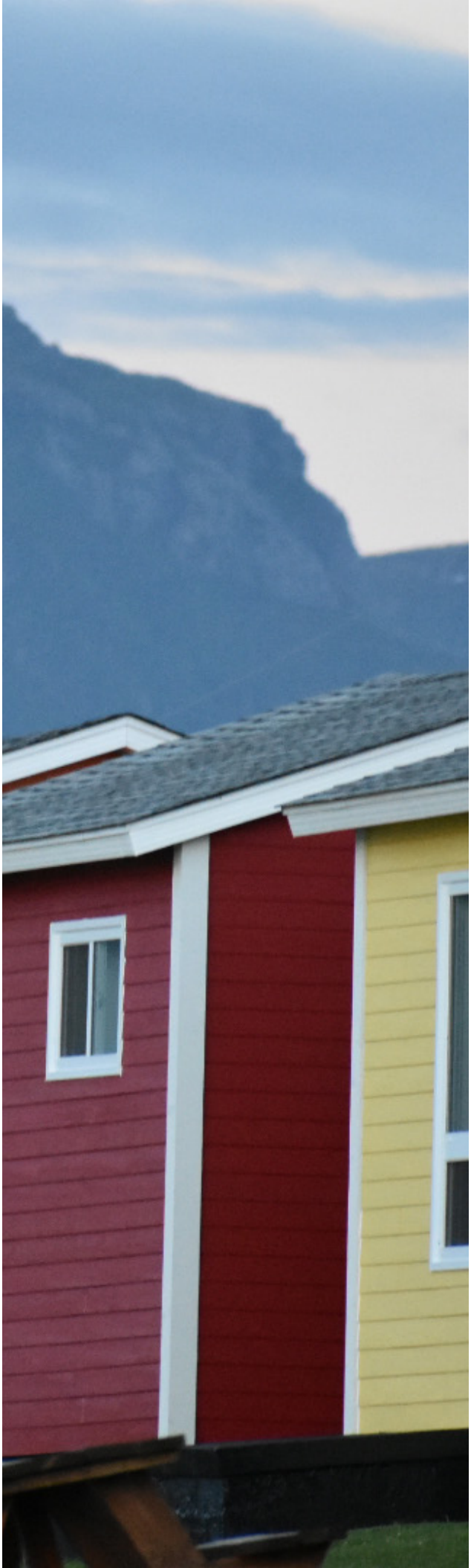
Because of an economic independence thanks to cod fishing and a much later entry to the Canadian federation, the province is very culturally distinct from the rest of Canada and even the Maritimes. Geographic conditions alone can be a factor for distinguishing the region. Newfoundlanders are said to describe anyone who wasn't born on the island as an out-of-towner, no matter how many years they've lived there. This idea of being "in" or "out" is something commonly found in many rural communities, and certainly holds sway here. There is also a unique regional dialect that is a very important part of the culture. It is so distinct from other dialects in Canada that many Canadians who are not from the area say they have a hard time understanding what people are saying - which is really too bad because they are well known for their stories. Despite experiencing a lot of hardship, there is an attitude of joviality and optimism in the province. In the documentary, Abandoned by Vice, a man jokes all too seriously that Newfoundlanders have "laughter in our hearts, poverty in our blood."[46]

One of the big cultural beliefs in the province is an idea of "returning home". Because of the poor economic conditions, people (mostly men) leave these small villages to generate income for their families back home.[47] This practice of leaving to try to find better opportunity is common. In many of these villages, there is a large gender disparity. In others, they are largely comprised of elderly people trying to maintain the way of life there.[48] Villages like these face the danger of being aged into extinction. Often people have to return because of their families, or because they do not feel a sense of belonging anywhere else. People leave the province in hopes of finding better financial support, but often end up feeling lost and placeless because very few people can relate to their experiences outside of Newfoundland and Labrador. Additionally the jobs they find outside the province can be both thankless and unstable. Many go to Alberta to work in the oil industry, but job turnover is very high there.[49] So often people return because these jobs are unsustainable. When they get back, the condition they are in upon return is one of having recently lost a job.

These cultural factors work in tandem; that of being so distinct from the rest of the country, and that of always needing to come back after leaving. However, this distinctive quality can be so powerful that the province really unites around shared experience. At the same time, the issues that lead them to unite can also splinter them apart. These points of tension are spaces in which domestic violence can thrive. Pressures like those being experienced in Newfoundland and Labrador are quite common in places that have rising rates of domestic violence.[50]

[19] an outport village that still persists through today

[20] photos from around the province

NEWFOUNDLAND 1:500,000

For use by War and Navy Department Agencies only
Not for sale or distribution

GRAND LAKE

FIRST EDITION-AMS 1

SHEET NO. 3

A. M. S. A601
First Edition 1943

LEGEND

Population over 5,000 — REDON
Population 3,000 to 5,000 — REDONDIN
Population less than 3,000 — Redondinha
Roads 1st class
Roads 2nd class
Roads 3rd class
Roads 4th class
Trails
Railroads: Narrow Gauge 3'6"
Electric Railroads
Lines of Equal Magnetic Declination — 29°W
Telegraph and Telephone Lines
Transmission Line
Light House
Lighting Facilities at Field — LF
Radio Station, Radio Beacon
Radio Direction Finder Station
Located object (with descriptive notes)
Spot Elevations (Natural Features) — 197
Spot Elevations (Cultural Features) — 1955
Government, Army, Navy
Municipal or Commercial
Auxiliary or Emergency
Airport Beacon
Field — Anchorage

Town names underlined indicate names of airports

Scale 1:500,000

HEIGHTS IN FEET

Contour Interval 500 Feet

Prepared under the direction of the Chief of Engineers, U. S. Army, Washington, D. C. Compiled from Army Map Service Ten Mile Map of Newfoundland, 1:633,600, Department of Natural Resources, 1941. Newfoundland, 1:1,330,560, Imperial Oil Limited, 1940. Newfoundland, 1:633,600, International Paper Co., 1933. Newfoundland, 1:506,880, Canada Department of Mines and Resources, La Poile-Burgeo, Air Navigation Edition, 1940. Newfoundland, 1:506,880, Canada Department of Mines and Resources, St. Georges-White Bay, Air Navigation Edition, 1940.

Isogonic Lines taken from National Topographic Series of Canada, 1940, revised to 1942.

FIFTY THOUSAND YARD WORLD POLYCONIC GRID BAND "D", ZONE "H"

APPROXIMATE MEAN DECLINATION 1942 FOR CENTER OF SHEET
ANNUAL MAGNETIC CHANGE 3' DECREASE

ARMY MAP SERVICE, U. S. ARMY, WASHINGTON, D. C. 1943

SHEET INDEX

GRAND LAKE
N4630-W5600/245x330

Program Exploration & Network

[21] archival map of southern Newfoundland

In Conversation...

This thesis relied on interviews and conversations with individuals who are knowledgeable about the subject as a way to closely interrogate the conditions surrounding domestic violence shelters and design both in Canada and the Maritimes. For understanding programmatic and user-focused design concerns for a domestic violence shelter, I have talked with Margaret Hobart, an advocate with the Washington State Coalition Against Domestic Violence, and Corrie Rosen, an architect at Mahlum. They helped develop design guidelines for shelters in Washington State and developed the Building Dignity website, a tool for advocates and architects.[51] Additional conversations have been had with medical professionals in Canada who have experience working with the Canadian healthcare system and were able to speak about the level of service people experiencing domestic violence are receiving.[52] Through these conversations, I have been able to gain perspectives on design from people who do not regularly work with designers and architects. This has been crucial for building an understanding of the direction that the design of shelters is headed from the perspective of people that work with them.

To understand more about the architectural conditions in northern and rural Canada, I have followed the writing and research of Lateral Office. Their text, *Many Norths,* fills in many of the gaps in existing literature about architectural design in the polar north.[53] While most of the writing excludes the province of Newfoundland and Labrador, many of the considerations involved are still relevant. I have also talked with Ryan Jorgenson, an architect on the Fogo Island Inn design team from Saunders Architects.[54] Referencing the work flow and design process they use to work with these communities is helpful because of a similarity in design goals to those of this thesis. Although the Fogo Island Inn serves a different purpose in its community, a lot of the work around the project was focused on building economic resilience, being climate responsive, and bringing the community together.[55] I aim to learn from Saunders Architects' process of working with local craftspeople as well as designing a space with focused on social welfare.

These conversations can be found in full in the appendix.

[22] the Fogo Island Inn

	Mahlum (Building Dignity)	Prestwood	Review of Second Stage Shelter	More than a Bed
PRIVATE SPACE				
Private Rooms/Apartments (affordable housing)				
Control Environment				
Space for Pets				
Daylight				
Dutch Doors				
Allow Personilization				
Secure Storage				
Flexible Length of Stay				

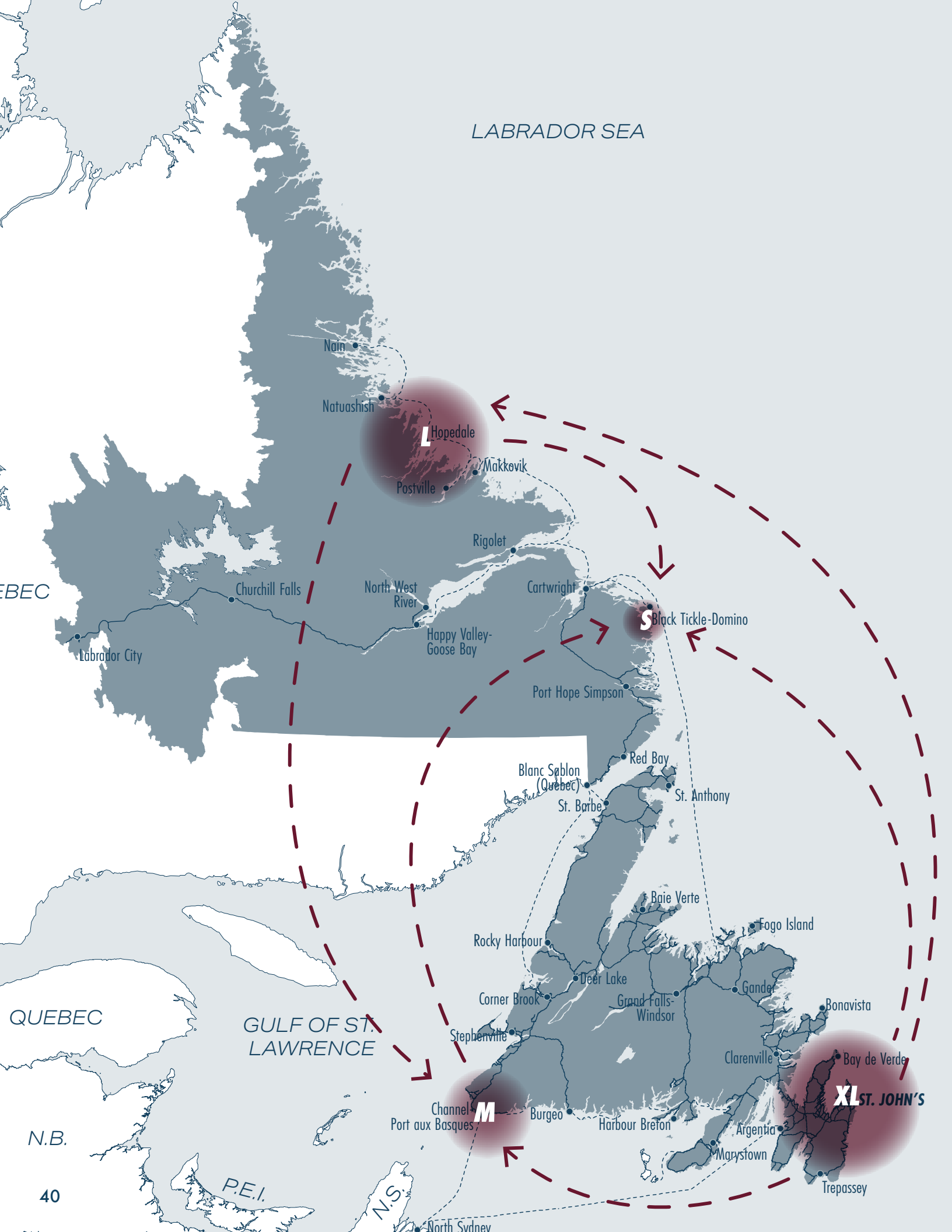
	Mahlum (Building Dignity)	Prestwood	Review of Second Stage Shelter	More than a Bed
COMMUNAL SPACE				
Visual Access				
Easy to Navigate				
Additional Quiet Space				
Alcoves				
Easy Laundry Access				
Library				
Flexibility				
Easy Stair Use				
Daylight and Views Outside				
Operable Shading				
Public Meeting Space				
Private Gathering Space (family visits)				
Computer Work Space				
Children Space (separate from adult				
Teen Space				
Separate Noisy Areas from quiet ones				
Many Private and Family Restrooms				
Control Acoustics				
Lots of Storage				
Fitness (tracks, gyms, pools, aerobic)				
Coffee Shop				
Child Care (flexible hours)				
Participate in Community Activity				
Support for former residents				
ADA				

Design Elements

The building program for this project developed from interviewing experts and analyzing research done by the Canadian federal government, and research done by others in the field. Its elements are compiled in figure 23 for design reference. This crucial research done by others in the field is important to understand what current expectations of shelters are, and where shelter design is headed. This table informs both important site considerations for buildings within this network, but also what the program should be. This design and program table shows the intersections in the research to point out common important elements. Each piece of research has a different emphasis or focus though, so simply because a point in the table is not represented in all of them, it does not mean that it's not crucial for domestic violence advocacy.

The program for this proposal relies on a few different reference points that act as a basis for the overall scheme. The intention is to work with the existing system to acknowledge the current state of affairs of domestic violence shelters, but also to identify parts that are not working for users in an effort to develop a scheme that will be responsive as needs change and become clearer.[56] The program proposes a network that will address domestic violence at varying scales by providing varying access to resources. Working as a larger system will help staff in the network to approach the problem as one that is systemic and not only a problem found in urban places with more resources.

[23] table of design elements, see appendix for complete table


LABRADOR SEA
Nain
Natuashish
L
Hopedale
Makkovik
Postville
Rigolet
Churchill Falls
North West River
Cartwright
S
Black Tickle-Domino
Happy Valley-Goose Bay
Labrador City
Port Hope Simpson
Red Bay
Blanc Sablon (Quebec)
St. Anthony
St. Barbe
Baie Verte
Fogo Island
Rocky Harbour
Deer Lake
Gander
Corner Brook
Grand Falls-Windsor
Bonavista
Stephenville
Clarenville
Bay de Verde
XL
ST. JOHN'S
Channel-Port aux Basques
M
Burgeo
Harbour Breton
Argentia
Marystown
Trepassey
North Sydney
QUEBEC
GULF OF ST. LAWRENCE
N.B.
P.E.I.
N.S.

Urban Network

The idea of a network that prioritizes long term housing, advocacy and intervention, and empowerment heavily references the work done by the District Alliance for Safe Housing (or DASH and NASH) model from Washington DC.[57] DASH has a pioneering vision for the future of shelters and advocacy spaces. They prioritize acquiring long-term affordable housing for individuals trying to leave domestic violence environments and rebuild autonomy and community. Long-term housing has been a priority of their strategy because they understand that short-term housing most often leads to a short-term solution.[58] Their approach addresses the fact that domestic violence is an issue that is affected by many facets of life, including socio-economic stressors.[59]

This program imagines how a shelter network can best work with communication, intervention, and autonomy as primary goals. Although the idea is to develop how this process could work for Newfoundland and Labrador specifically, the hope is that some of the ideas can be transferrable to other systems and locales with necessary adjustments being made for context. The goal is to try to imagine how existing critiques and suggestions for shelter design could be incorporated today, while also always understanding that context and environment are indisputably linked to the issues at hand.

The network will be divided into different sized nodes based on resources and population density. This project develops prototypes of each size to demonstrate that every urban area (city or town) will house a component of the network. For this project's experimental process, the network pieces will be divided by size, number of key programmatic elements, and how many people each node is intended to serve.

[24] an example of how the network can be connected within the province

[25]

S: Lighthouse
total : 100+

The smallest size of shelter comes in the form of the Lighthouse. Really acting as a beacon in dark times, this is a form of emergency service that can be quickly established in areas where there currently is nothing. Many rural regions face an issue of access as part of health care.[60] In areas like this, the amount of service providers for the region is often too small to react to problems in a timely manner. The lighthouse will be a small intervention that can be quickly put together in a house or office space to set up an emergency support area. This would come in the form of tools, resources, and instructions that are distributed by the Hub and the Living Room models. The lighthouse is a transitional element. It exists as a go between a town having no shelters to developing their own Advocacy Home. Being able to diminish the time and distance in which people can get support is critical.[61]

Support is not the only important piece of work being offered here however. These Lighthouses can also be a place to get the conversation started about domestic violence and help perform advocacy and intervention work. Being visible and present in a community, in any way possible, matters.[62]

CRISIS SUPPORT CENTER

Setting up emergency local hotlines and having advocates connected with survivors will be the focus of the Lighthouses.

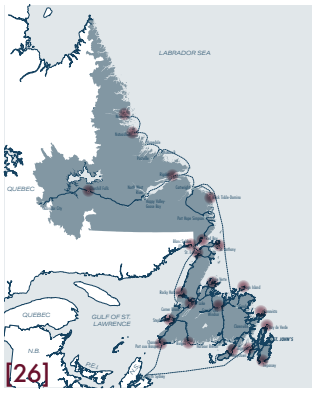
+ mental health services and counseling
+ telephone support
+ offices for individual counselling

DOMESTIC VIOLENCE ADVOCACY

Advocacy will be a function of the lighthouse by making resources available and connecting them to survivors and advocates.

+ short-term housing
+ child care services
+ clothing and food bank
+ housing support

[25] watercolor of a lighthouse
[26] map showing potential Lighthouse locations
[27] photo of a potential location



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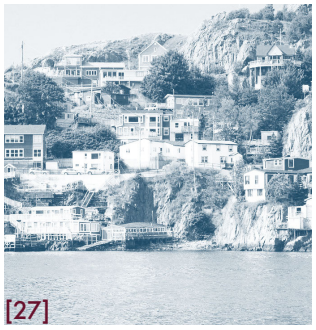

[27]

[28]

M: Advocacy Home

total : 50+

This scale of shelter is the most similar to the standard first and second stage shelters that exists in most places. The idea with the advocacy home model is that existing shelters can be modified with fewer changes to prioritize advocacy and visibility, something that most do not have much room for now. Having a way to develop existing locations is a critical part of this research. In Newfoundland and Labrador and other more rural regions, there often are few shelters and those that exist have few resources. That being said, they are so important to the history of these places and have existing structures in place that are critical to the health of some of these communities. All advocacy and shelter work is a work in progress, so allowing for growth and development as part of the larger system is crucial to the long-term success of it.

By working with the other branches of the network, this component can help be an intermediary to connect rural areas to larger resources and support. Creating a safe place to advocate for the rights of these individuals and their children will be a primary focus. With a larger emphasis on advocacy, these spaces will work to approach domestic violence from an intervention standpoint as well as a healing perspective.

DOMESTIC VIOLENCE ADVOCACY

Staff here will be focusing on intervention, advocacy, and education. Support for survivors is also critical, but space to do effective advocacy is also required.

+ offices
+ volunteer training
+ intervention programming
+ crisis support center
+ short-term housing
+ child care services
+ clothing and food bank
+ housing support

INDIGENOUS COUNSELING

PRIMARY CARE

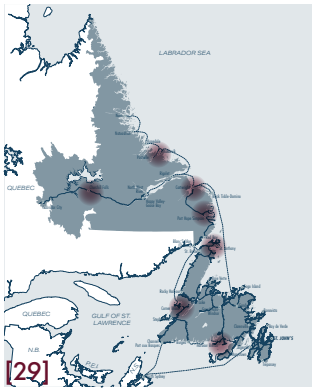
Medical care here will be more limited, but professionals will be trained in identifying abuse. By working closely with the nearest Large model, more specialized care will be available to people who would not otherwise have it.

+ emergency medical support
+ mental health services and counseling
+ addiction services
+ sexual assault care
+ pregnancy care

OFF-SITE APARTMENTS

Houses located throughout the town will be available to survivors through the HUB. These apartments will be operated by the housing wing of the HUB.

[28] watercolor of a lone house on a cliff
[29] map showing potential Advocacy Home locations
[30] photo of a potential location



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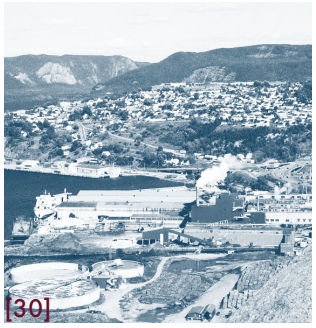

[30]

L: Living Room
total : 4

The Living Room model[63] prioritizes being a community space that functions as a way to unite communities and create awareness around issues of violence and oppression. The goal of the Living Room is to be a public space that services the community and emphasizes connectivity between community members so as to not further isolate survivors.[64] Group healing and removing the stigma around domestic violence, which is often a hidden and taboo subject, will be at the forefront of the conversation for this space.[65] Having gathering space is very important to increasing conversations about domestic and family violence in a community. One thing survivors that have been in the shelter system commonly criticize is how isolating it can be to be separated from family and hidden from the public.[66] Continuing to be able to be a part of the community is essential in feeling like the community cares about these issues. Creating community space that supports autonomy and learning are steps to understand how to better support survivors beyond the moments of abuse.

This piece of the network will be able to access resources from the larger hub, but will also be able to support the other smaller components of the network. Because of its size and resources, the Living Room will be more autonomous than the other sections of the network. This will allow them to function as home bases within smaller regions to further support the network.

COMMUNITY CENTER

The Living Room will prioritize being a regional gathering and community space. Focusing on community unity and reacting to holistic problems will be a large focus of the community work.

+ meeting rooms
+ large gathering space
+ classrooms

HOUSING ADVOCACY

Although housing advocacy is still a very important facet of the program, connecting people to housing is prioritized and acquisition is de-emphasized.

+ offices
+ consultancy

DOMESTIC VIOLENCE ADVOCACY

Advocacy takes a more regional focus at this scale. The Living Room will be working with nearby towns to create a local support network.

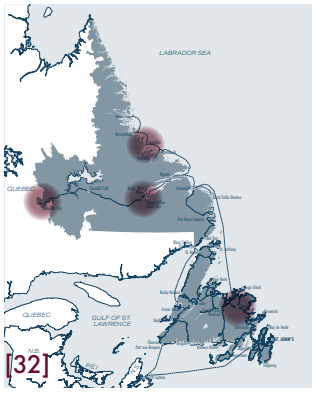
+ offices
+ volunteer training
+ intervention programming
+ legal office
+ crisis support center
+ short-term housing
+ child care services
+ clothing and food bank

INDIGENOUS COUNSELING

PRIMARY CARE

+ emergency medical support
+ mental health services and counseling
+ addiction services
+ sexual assault care

[31] watercolor of a cluster of houses
[32] map showing potential Living Room locations
[33] photo of a potential location



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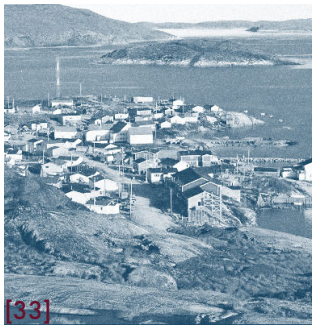

[33]

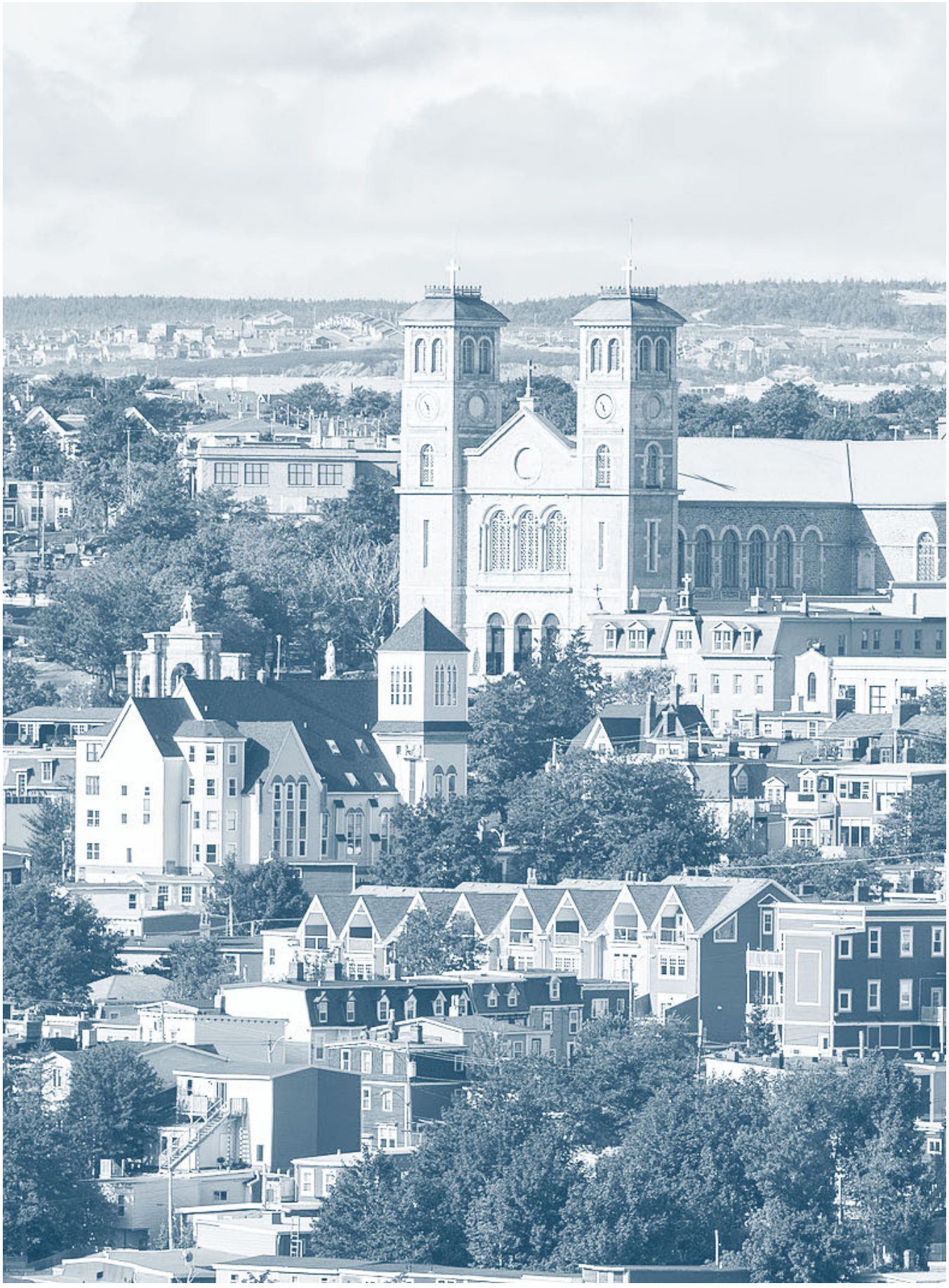
XL: HUB

total : 1

The Hub will be located in St. John's. As the capital, the largest urban center, and the port for shipping construction materials to northern Canada[67], this location will allow the Hub to tap into the local and national resources that are already part of the city. The Hub's primary focus will be to acquire long-term housing – 1-2 year leases – for people escaping domestic violence, and offer it at a lower rate than the market-rate option. Additionally, the hub will be a resource to the rest of the province for providing skills and training to others doing this task around the province. This will be the center of the network and will be a place to provide support in the form of both knowledge and workers for the rest of the province.

Long term affordable housing is so hard to find for people coming from domestic violence environments. The Hub will empower housing advocates to both acquire housing and work with designers to make new housing. Their job will be to work in a regionally holistic sense – meaning responding to housing concerns throughout the process and identifying where the greatest needs are, not just working in St. John's. Focusing on jobs, training, and economic support will also be an emphasis of the Hub. Disseminating knowledge and making it transparently accessible to many people is a way to show that working with these individuals is not just about seeing them as victims of violence, but as individuals who have their whole lives ahead of them.[68]

[34] watercolor looking into St. John's



COMMUNITY CENTER

Community activities will be hosted in the HUB. Visibility and engagement in the community is central to the role of the HUB. Community connection is a branch of domestic violence advocacy.

+ meeting rooms
+ large gathering space
+ classrooms
+ temporary retail space

PRIMARY CARE

The HUB will work in close partnership with the existing medical system. Located near St. Clare's Mercy Hospital, the HUB will provide emergency medical support and education about how care provider's can better identify and care for domestic violence abuse and injury.

+ emergency medical support
+ mental health services and counseling
+ addiction services
+ sexual assault care
+ traumatic brain injury care
+ pregnancy care

HOUSING ADVOCACY

Acquiring long-term affordable housing for survivors is the priority for the HUB. The HUB will operate is the central support system for survivor housing in the province. Acquiring housing, preparing it for use, and connecting survivors to homes are the main functions. The HUB will be overseeing operations throughout the province and sending out materials as needed.

+ offices
+ consultancy
+ training

DOMESTIC VIOLENCE ADVOCACY

Education and advocacy are activities that will be held in the HUB as well as supported across the province. Workshops and training will be more resources that the HUB will distribute.

+ offices
+ volunteer training
+ intervention programming
+ legal office
+ crisis support center
+ short-term housing
+ child care services
+ clothing and food bank

INDIGENOUS COUNSELING

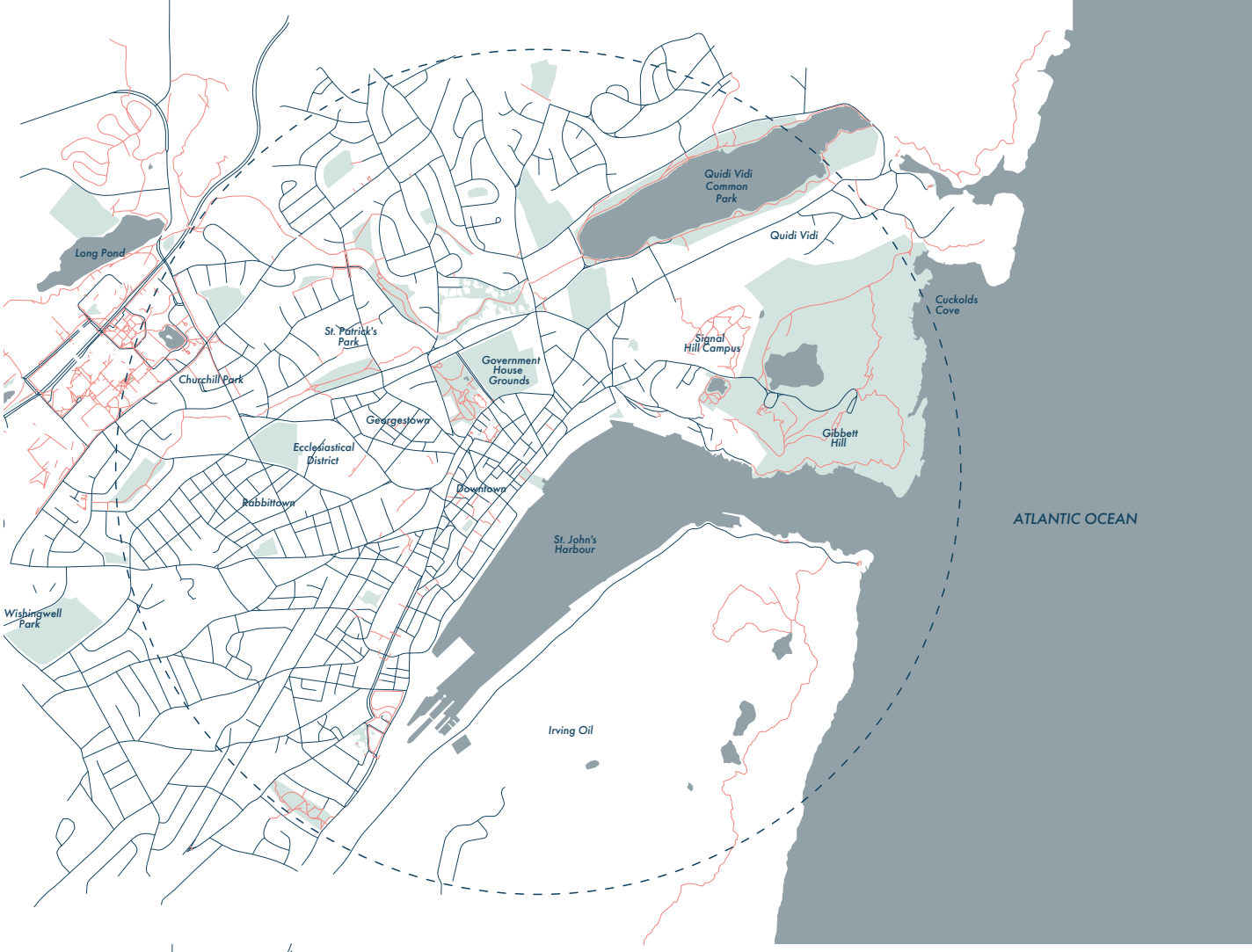
The HUB will work closely the Inuit Nunangat and Qalipu Mi'kmaw Nations to provide indigenous counselling and education on domestic violence. This program is integral to the domestic violence advocacy.

[35] photo of historic St. John's

5.

The HUB

[36] watercolor collage exploration


Quidi Vidi Common Park
Quidi Vidi
Long Pond
Cuckolds Cove
St. Patrick's Park
Signal Hill Campus
Government House Grounds
Churchill Park
Georgestown
Gibbett Hill
Ecclesiastical District
Downtown
Rabbittown
ATLANTIC OCEAN
St. John's Harbour
Wishingwell Park
Irving Oil

[37]

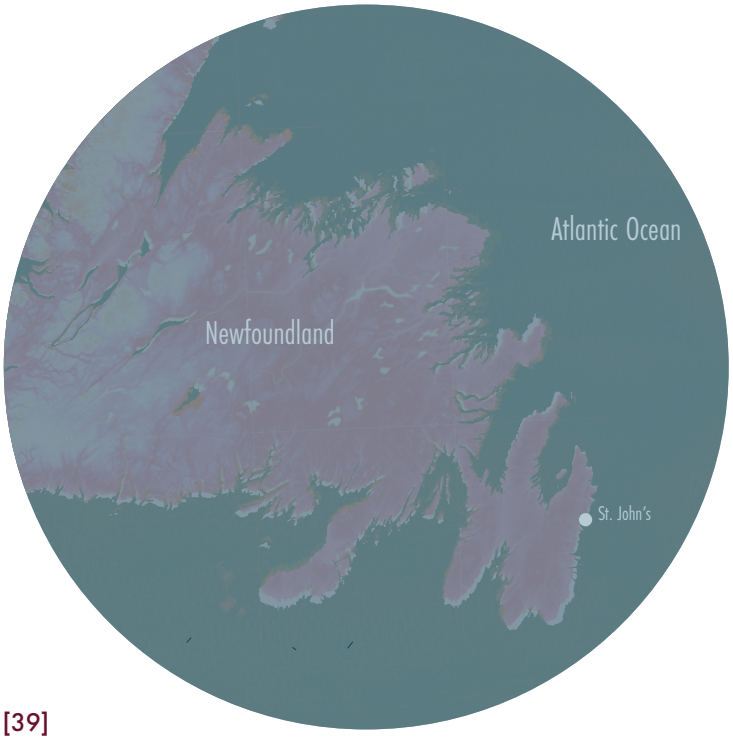

HIBERNIA
TERRA NOVA
St. John's Harbour
WHITE ROSE
HEBRON
MONTREAL
HALIFAX

[38]

Site Selection

The site chosen for the HUB is in downtown St. John's. St. John's is a critical site location for a number of reasons, in particular because the city is both the largest urban location and the capital of the province. Also, the existing body that oversees the province's shelters is in St. John's, so locating the HUB near it will allow for a smoother transition for the people working there. Being able to connect with the provincial and federal government is a crucial aspect of advocacy work. Finally, visibility—both in terms of an architectural characteristic but also how involved in media and policy the HUB will be—is a very important design consideration.

Downtown St. John's is the main port of harbor for the entire province. Much of the province is accessed via ship because of the number of islands and the inhospitable winters.[69] Access to shipping is crucial for having a strong supportive network that can provide aid to the reaches of the province. A key function of the HUB is to help with renovations and repairs of existing buildings (in hopes of overall spending reduction), so closeness to shipping will be very beneficial.



[39]

[37] map of downtown St. John's
[38] map of transit in St. John's
[39] location of St. John's in Newfoundland

SITE

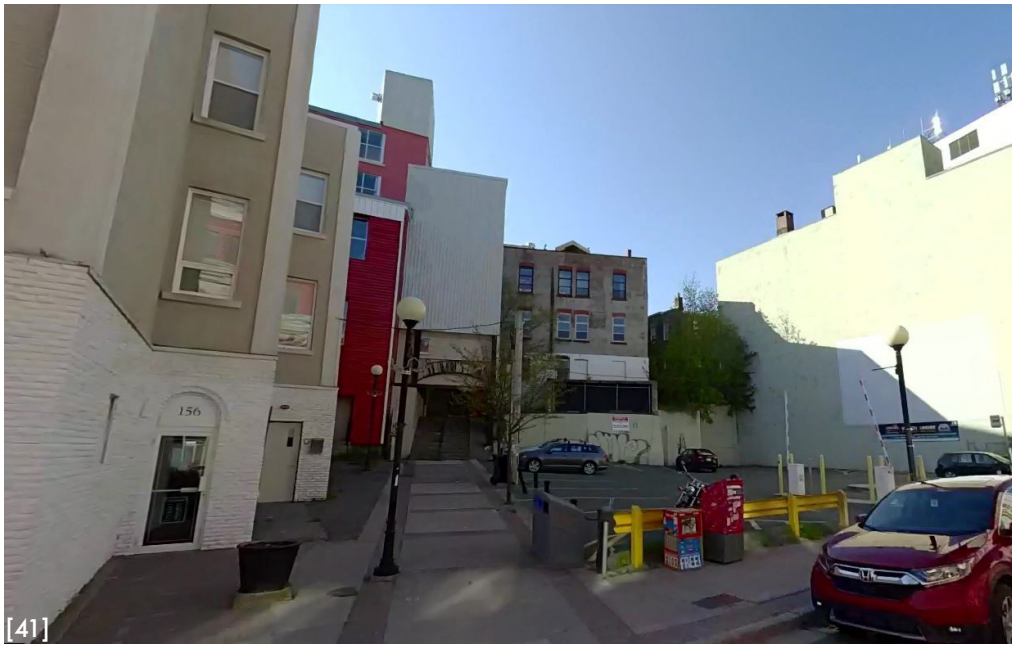
[40] view into downtown St. John's


Choices for Youth
Recreation
Law Office
Transition House Association
Duckworth St
Water St
Harbour Dr

[40]

Site Characteristics

The site is on Water St.; one street away from the harbor. This part of the city is still fairly commercial and as such has useful amenities nearby. Some of these amenities include Choices for Youth (a center for youth affected by homelessness), recreation facilities, and a law firm. Across from the site is the existing Transition House Association, the governing body of all of the existing shelters.[70] In St. John's, they have a poor public image and are not seen as reliable.[71] With a new location and larger staff dedicated to this work, increased visibility will help to improve their public relationship.



[41]

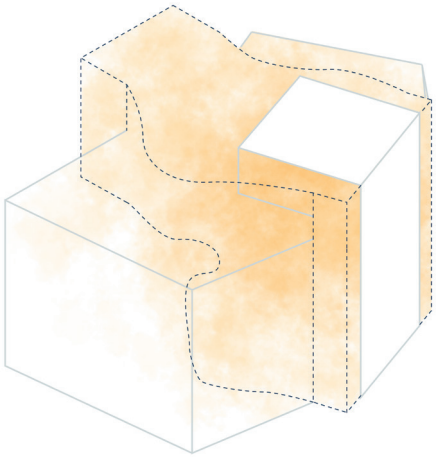
[41] area site map
[42] photo of the site

[43]

Concept

As mentioned previously, the existing domestic violence support network in Newfoundland and Labrador is disconnected and lacks resources. Domestic violence is a complicated and multi-faceted issue. Shelter alone is not enough. Included in the HUB, are resources for housing security, advocacy, and community engagement. This building is a collection of these different program elements working together to respond to domestic violence as a systemic problem. The program and network are so crucial to trying to make a change within the province.

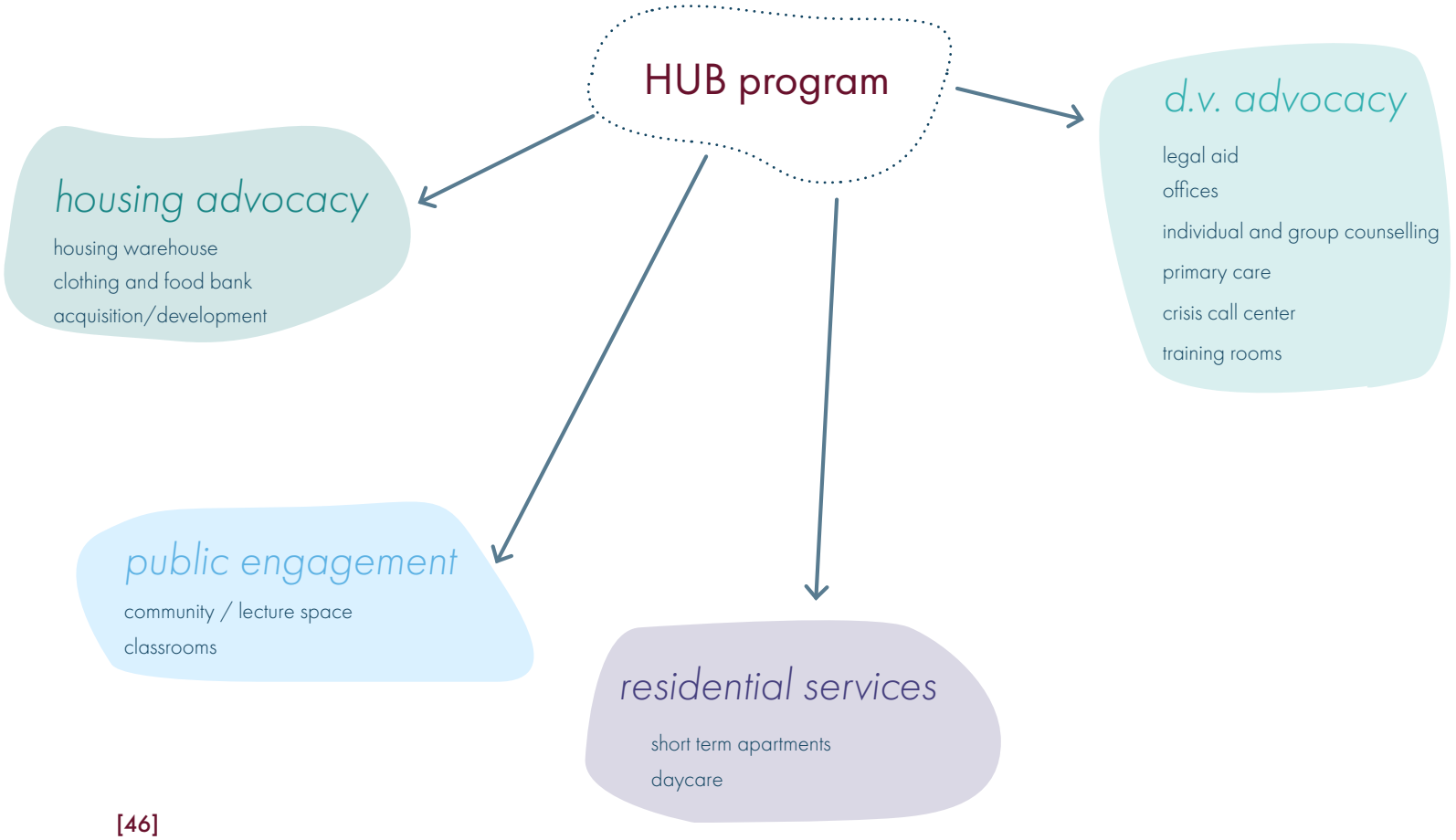
But, at the human and emotional level, a thorough program is not enough to make a place feel welcoming. One of the most common things that survivors criticize in shelter spaces is a lack of autonomy and independence. This thesis proposes that creating space to rest, make choices, and be alone or with others, to transition between life events at whatever pace, is essential. These spaces are assigned no specific program, but rather are space for survivors and advocates to own. By creating an undulating transitional zone, residents and advocates can make space for themselves. The goal of this area is to allow for human life to pause and relax. Room to think. Room to breathe.



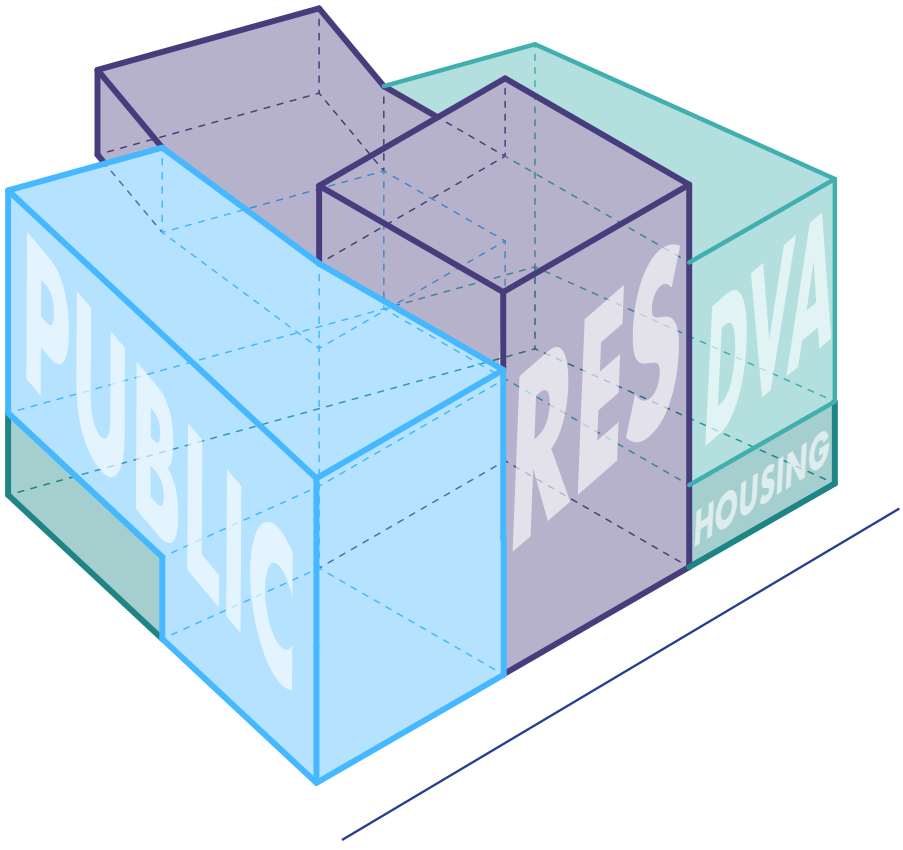
[44]

[45]

[43] watercolor collage exploration
[44] concept diagram
[45] concept sketch


HUB program
housing advocacy
housing warehouse
clothing and food bank
acquisition/development
d.v. advocacy
legal aid
offices
individual and group counselling
primary care
crisis call center
training rooms
public engagement
community / lecture space
classrooms
residential services
short term apartments
daycare

[46]


PUBLIC
RES
DVA
HOUSING

[47]

Program Elements

Housing justice and advocacy is one of the most important and historically overlooked elements. This includes a housing warehouse where staff can help to support the renovations and material needs of the existing shelters. As mentioned previously 100% of shelters in the province are in need of major/minor repairs.[72]

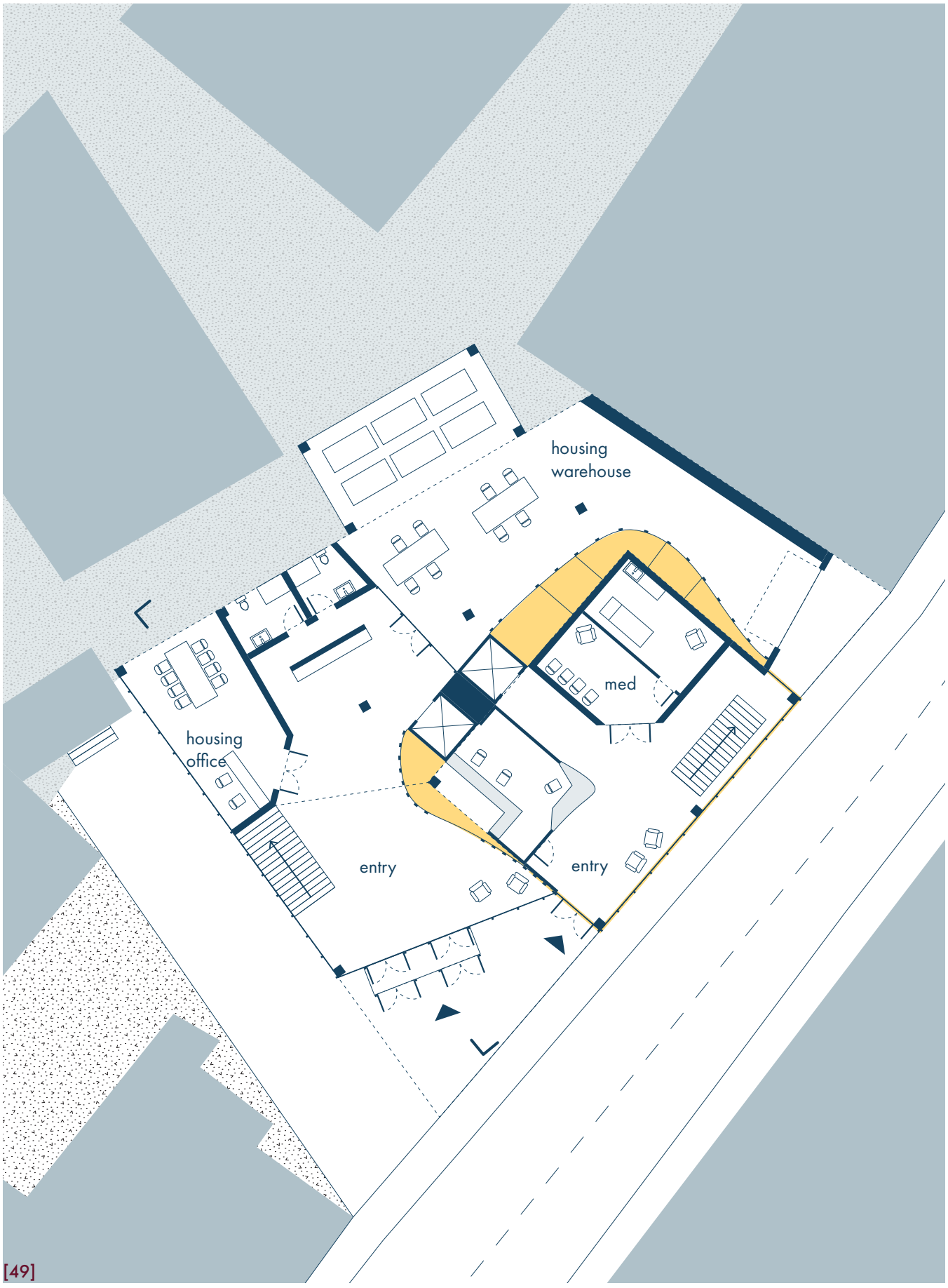
Public engagement is important to welcome in the community and so build an understanding that this is a place they are a part of. Not only will the HUB have volunteers from the community, but will also offer classes and education for the public.

Residential services will include apartments for survivors. Another key service that will be provided is daycare. One of the largest barriers to leaving a dangerous situation is a lack of reliable child care.

And of course - advocacy. The HUB will include legal aid, offices to facilitate coordination throughout the province, plus counselling and medical services for survivors.

[46] program bubbles
[47] program massing

[48] exterior perspective of the HUB



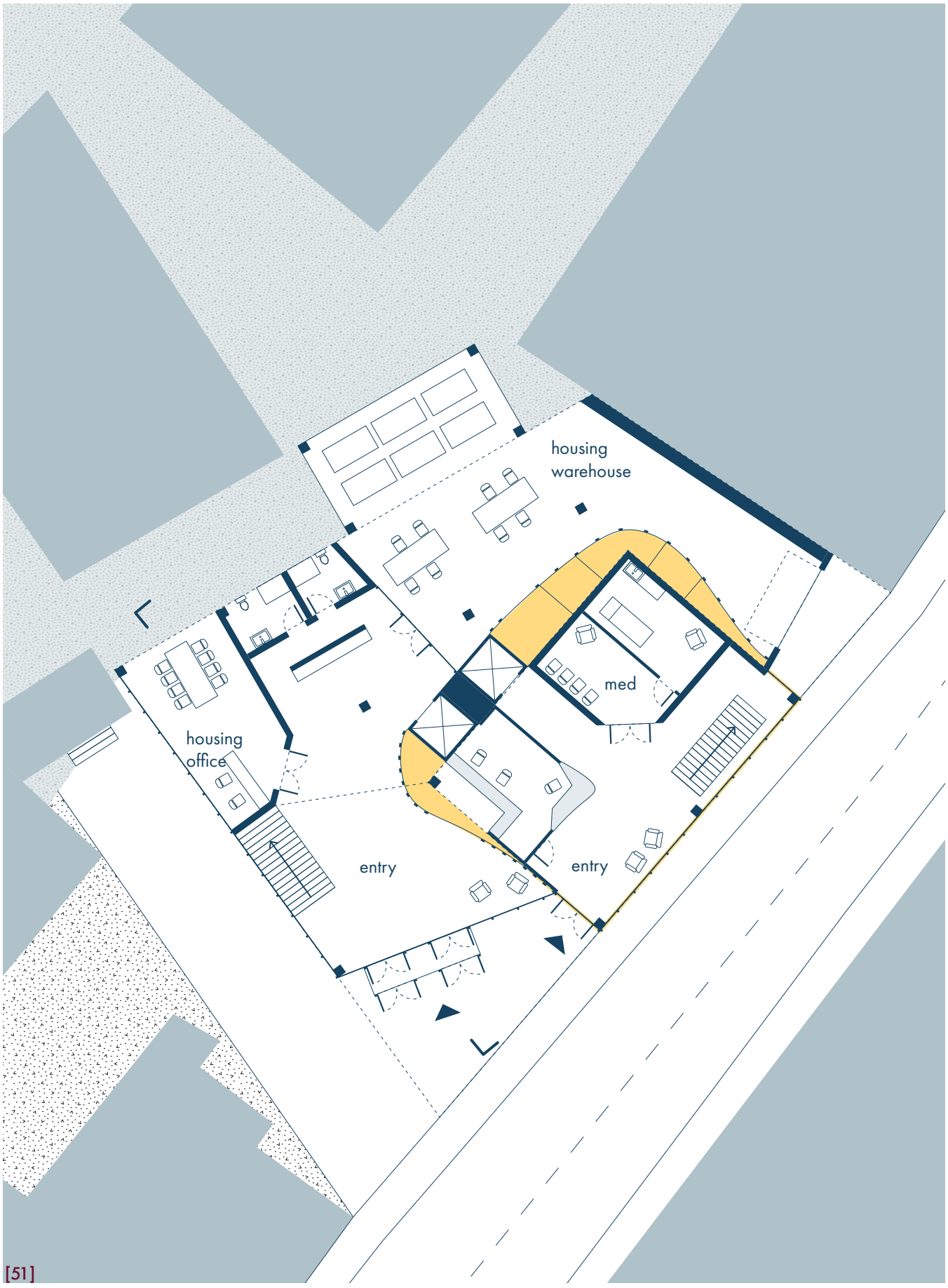
[49]

Public Connection

The highlighted plan areas are part of the spaces of transition and pause. On the ground floor, the left side is the public entry with a view into the housing development area. Here visitors can go to the housing office to work with the staff or volunteer with the warehouse crew to help develop and remodel other network buildings. Staff of the housing office actively work to acquire new properties to build out the network. In the core, residents can check in for appointments or head straight up to the floors above. This view is what a person would see upon entering through the public entrance. To the right is the articulating boundary of the core as it begins to rise.

[49] ground floor plan
[50] public entry perspective

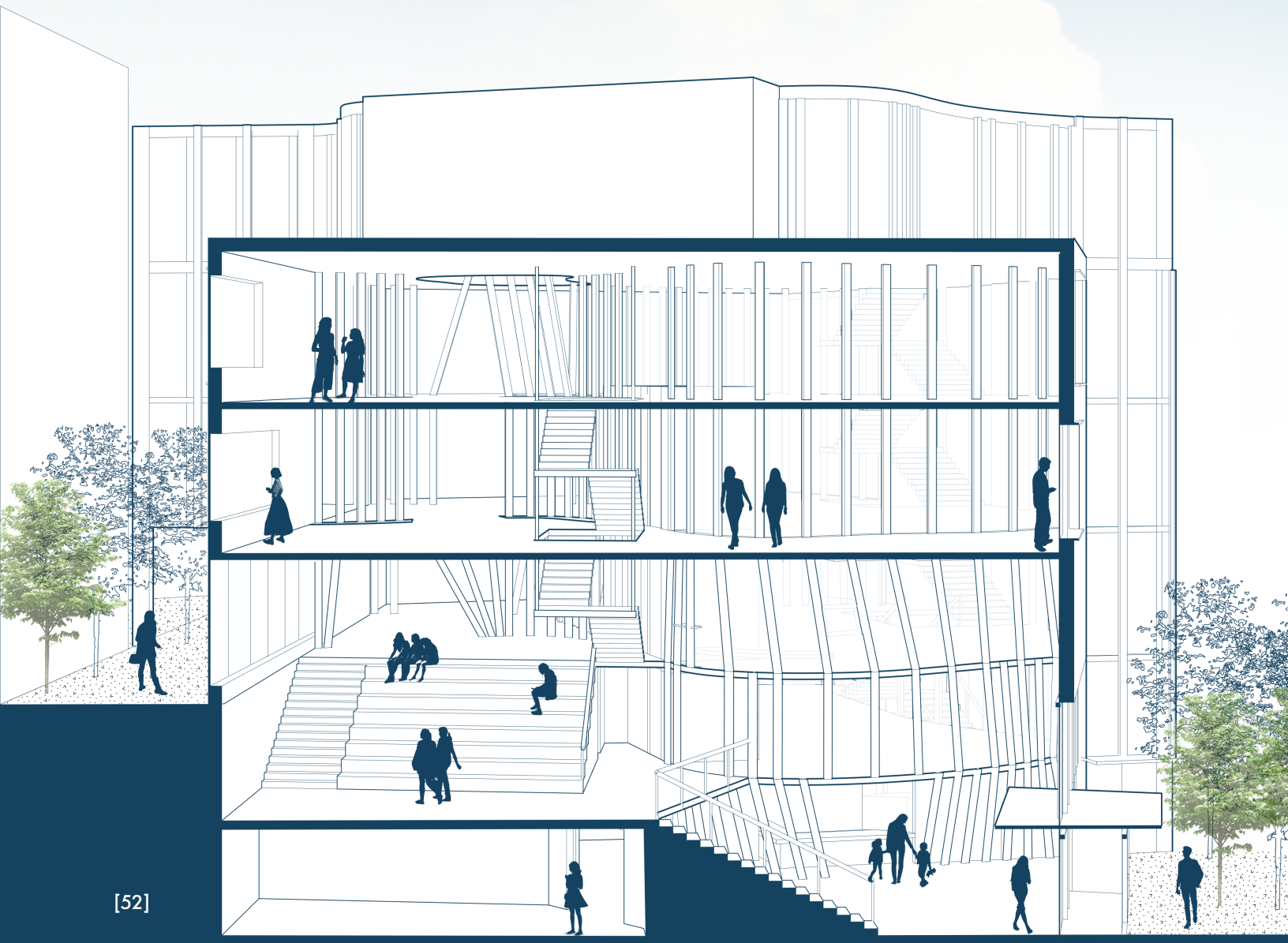
[50]



[51]

In this section, the public area of the building wraps around the core to come up to the second ground level. The in-between floor can be a casual meeting area, or it can be used more formally for presentations by advocates or by community members. The core is a threshold space for residents and advocates to control their level of engagement with the public.

[51] ground floor plan
[52] section perspective



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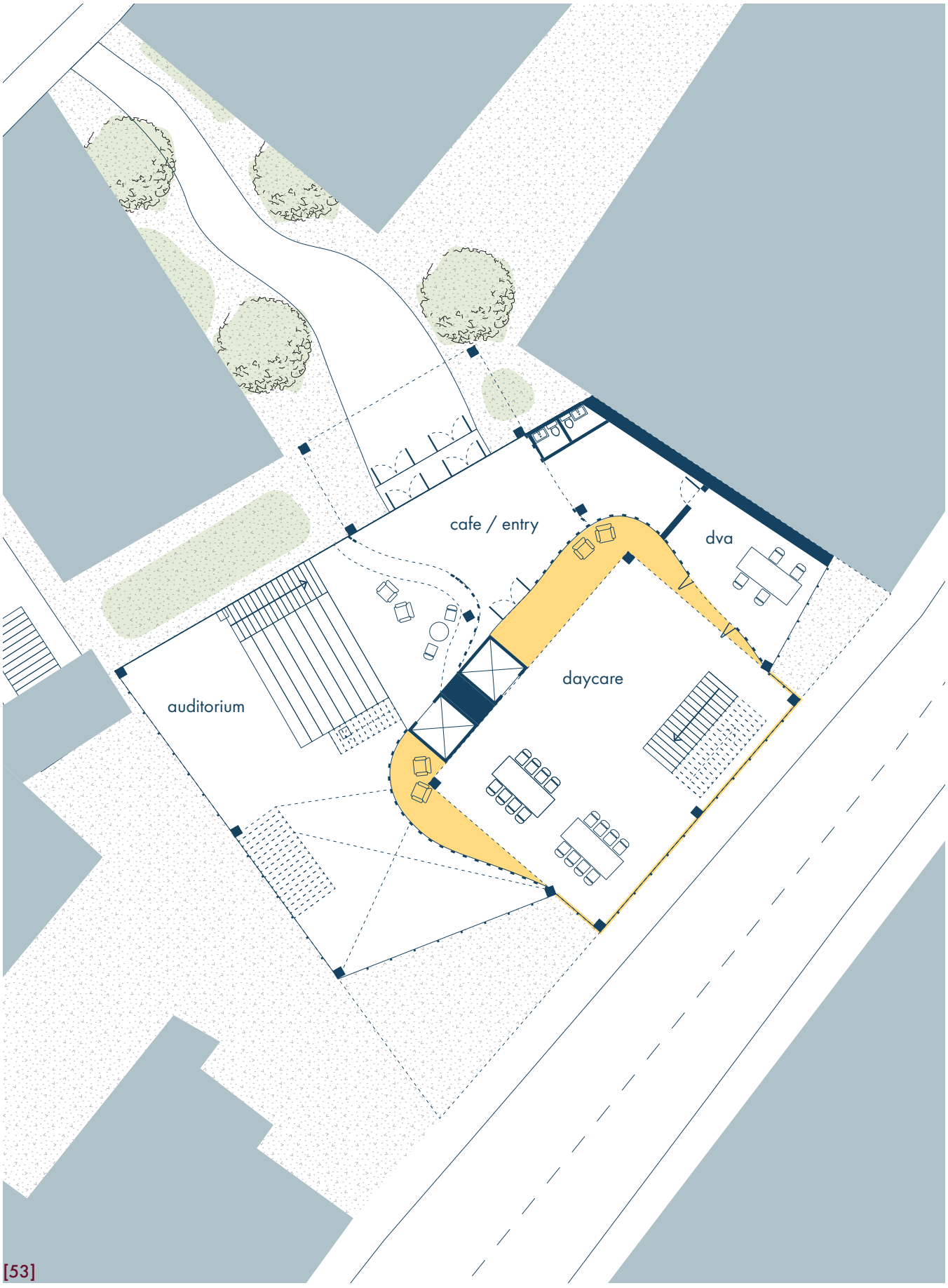


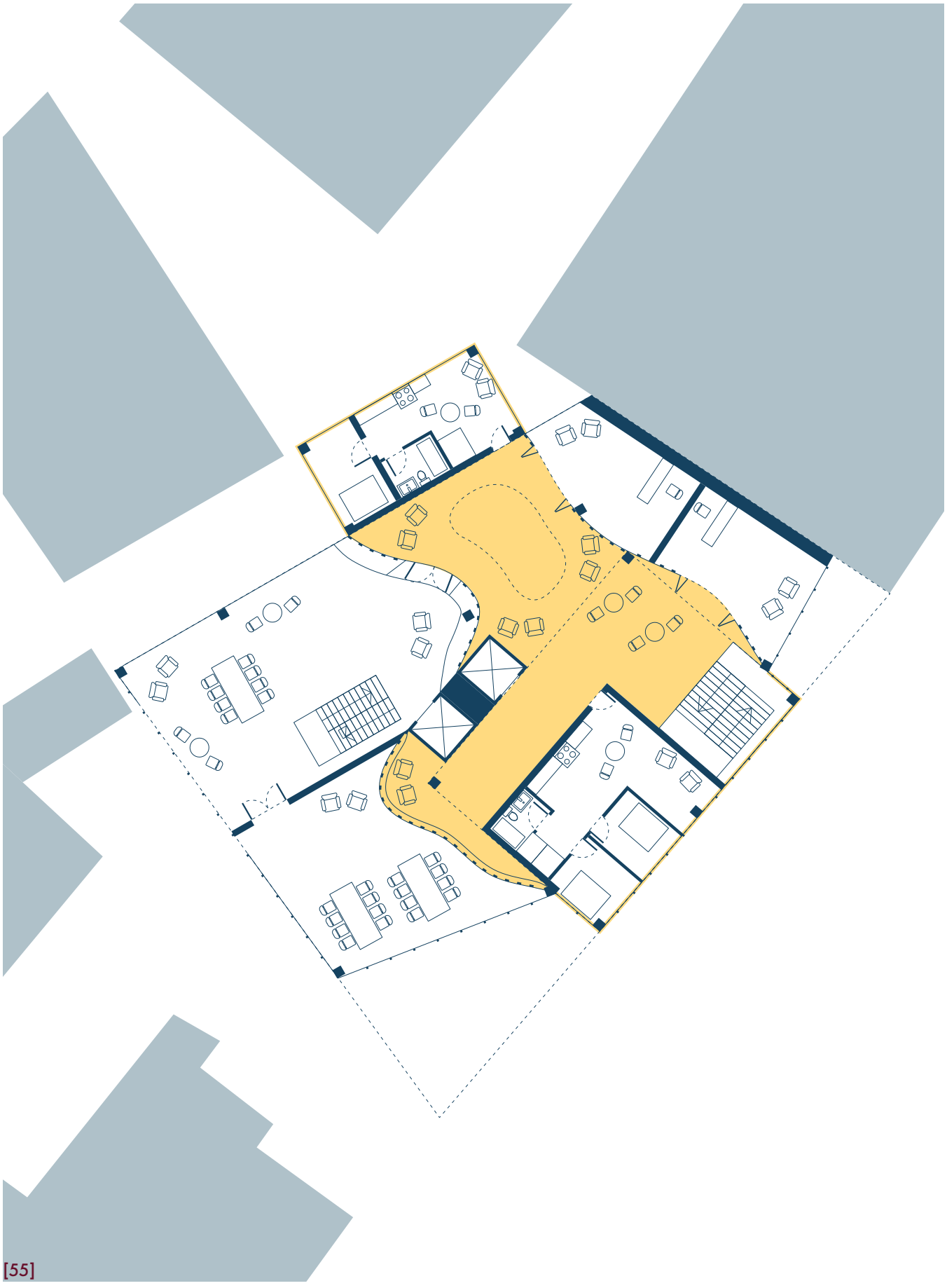
[53]

Garden & Refuge

Here, a previously undeveloped alley has been transformed into a garden, which can be seen in the view on the right. The garden is a space to bring calm to the residents and advocates. It is also close to the daycare, so children can play supervised outside as well. An additional building entry leads to a cafe. This can serve the people who work nearby while also providing jobs and income. The daycare is on this floor to allow easy access to the outdoors.

[54]

[53] second floor plan
[54] garden entry perspective



[55]

Education & Respite

The third and fourth floors become more private, with educational space, offices, and apartments. The classrooms are flexible and can allow for multiple programmatic uses. The transitional space grows and pushes into other program areas. Figure 56 shows the potential of what the transitional space could be, a space for groups to spend time together or individuals to hang out alone.

[56]

[55] third floor plan
[56] relaxation nook

[57]

Community & Release

The top floor is a space only for residents and members. The undulating transitional core is at its largest. The apartments have space for privacy, and residents may choose to interact with each other as they please. A rooftop deck opens up to a view of St John's. It is a place to relax and be above it all.

[58]

[57] fifth floor plan
[58] roof terrace view

[59]

Conclusion

It is important to remember that the HUB is only a part of this network. Each element is in service of the community, the province, and, most importantly, survivors- to bring people home, or help them on their journey to a new home. This network is not a destination, but rather a stop along the way.

Domestic violence advocacy is changing to better address the needs of survivors and the communities that they are from. Intersectionality is so crucial because survivors alone are individuals with complicated needs, but seeing the community as something that needs support too requires even more diversity of thought. We must strive for reinforcing the autonomy, individuality, and dignity in every person in our communities. Survivors are more than their experiences with domestic violence. Communities suffer when, at the most basic level, women are forced to forfeit their lives and livelihoods because there is not a stronger system to support them.

This thesis has taught me that although creating empathetic and respectful space for survivors of trauma is both a powerful and deep challenge, perhaps more important is being able to think about architecture's role beyond the footprint. Working on this project has inspired me to further interrogate my own assumptions about what people need and want, and also what it means to be an architect and steward of the built world.

[60]

[59] watercolors of NL
[60] exploration of home

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End Notes

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5. Snyder, *No Visible Bruises*, 7.
6. Janoviček, *No Place to Go*, 21
7. Ibid.
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46. Ibid.
47. https://www.cbc.ca/news/canada/newfoundland-labrador/long-commute-huge-rewards-alberta-oilpatch-changing-n-l-labour-force-1.650537
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51. https://buildingdignity.wscadv.org/
52. See appendix for interviews.
53. Sheppard, *Many Norths.*
54. See appendix for interviews.
55. Saunders, *Architecture in Northern Landscapes.*
56. McDonald, *A Review of a Second Stage Shelter,* 7.12.
57. https://www.dashdc.org/who-we-are/mission/.
58. Ibid.
59. Ibid.
60. See conversations with Phillip Gregoire and with Erin Balcom in the appendix.
61. See conversation with Phillip Gregoire in the appendix.
62. See conversation with Margaret Hobart in the appendix.
63. For the Living Room, I am referencing a project by Saunders Architects in Nain, Labrador. Seeing the building as a community living room space was one of their primary strategies.
64. https://buildingdignity.wscadv.org/
65. See conversation with Margaret Hobart in the appendix.
66. McDonald, *A Review of a Second Stage Shelter,* 4.46.
67. Sheppard, *Many Norths,* 265.
68. McDonald, *A Review of a Second Stage Shelter,* 4.46.
69. Sheppard, *Many Norths,* 265.
70. https://thanl.org/
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72. Maki, "More Than a Bed", 17.

Figure List

All images are created by the author unless otherwise noted.

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29. map showing potential Advocacy Home locations
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    source: https://www.britannica.com/place/Humber-River
31. watercolor of a cluster of houses
32. map showing potential Living Room locations
33. photo of a potential location
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35. photo of historic St. John's
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Appendix

These tables gather information from :

+ https://buildingdignity.wscadv.org/ by Mahlum
+ Laura Prestwood's Dissertation, "Architectural Design Factors of Domestic Violence Shelters That Affect Outcomes for Female Domestic Violence Victims: A Naturalistic Inquiry to Establish Grounded Theory for Future Research"
+ "A Review of a Second Stage Shelter for Battered Women and Their Children" by Lynn McDonald
+ "More Than A Bed", a report compiled by Women's Shelters Canada

	Mahlum (Building Dignity)	Prestwood	Review of Second Stage Shelter	More than a Bed
PRIVATE SPACE				
Private Rooms/Apartments (affordable housing)	■	■	■	■
Control Environment	■	■		
Space for Pets	■			
Daylight	■	■		
Dutch Doors	■			
Allow Personilization	■	■		
Secure Storage	■	■		
Flexible Length of Stay			■	■

	Mahlum (Building Dignity)	Prestwood	Review of Second Stage Shelter	More than a Bed
KITCHEN				
Each Family has own kitchen	■	■		
Flexible Group Dining Areas	■	■		
Commercial Kitchen	■			
Secure Storage	■	■		

	Mahlum (Building Dignity)	Prestwood	Review of Second Stage Shelter	More than a Bed
SITE				
Access to Public Transportation				
access to groceries				
access to health care				
access to education				
access to exercise/ recreation				
pedestrian / bike friendly				
feel safe				
cultural relevancy				
outdoor space				
views of nature				
garden				
pet areas				
limit visibility to interior				
controlled access				
outdoor gathering space				
differing programmed outdoor space (accommodate multiple ages)				
year round use				
multiple security check points				
design should consider adults and children				
Resident Parking Private/ Staff Parking Public				

	Mahlum (Building Dignity)	Prestwood	Review of Second Stage Shelter	More than a Bed
STAFF SPACE				
Private Space to meet with Residents (Confidential and Secure)				
Flexible				
Secured Access				
Child Space within View of Meetings				
Welcoming				
Client Services Easily Accessed				
Counselling Center (easy to access but				
Remote Delivery Area				
Clothing Bank				
Programming is not mandatory for				
Counselling should have flexible time				
Legal Aid				
Culturally Sensitive Services				
Addiction Services				
Gender Accommodation				
Housing Updates for Aging Shelters				
Public Education				

	Mahlum (Building Dignity)	Prestwood	Review of Second Stage Shelter	More than a Bed
COMMUNAL SPACE				
Visual Access	■			
Easy to Navigate	■			
Additional Quiet Space	■	■		
Alcoves	■	■		
Easy Laundry Access	■	■		
Library	■	■		
Flexibility	■			
Easy Stair Use	■			
Daylight and Views Outside	■	■		
Operable Shading	■			
Public Meeting Space	■	■		
Private Gathering Space (family visits)	■	■		
Computer Work Space	■	■		
Children Space (separate from adult	■	■	■	
Teen Space	■	■	■	
Separate Noisy Areas from quiet ones	■	■		
Many Private and Family Restrooms	■			
Control Acoustics	■	■		
Lots of Storage	■	■		
Fitness (tracks, gyms, pools, aerobic)		■		
Coffee Shop		■		
Child Care (flexible hours)			■	
Participate in Community Activity			■	
Support for former residents			■	
ADA				■

Corrie Rosen : Architect at Mahlum
Margaret Hobart : Advocate with the Washington State Coalition Against Domestic Violence
February 4, 2020

Corrie Rosen & Margaret Hobart

Rosemarie :
I was wondering if we could get started by talking about the Building Dignity program. I read through the whole website, but if you wanted to talk a little bit about how your partnership works, and where it started from, and what your role was.

Margaret :
So I was working at the Washington State Coalition Against Domestic Violence. One of the rules of the Coalition is to help programs in the local areas do good work and provide good training. So one of the things that we started looking at was the issue of shelter rules. What we were noticing was that a lot of our programs had these extensive multi-page legal contract-like shelter rules, which really didn't fit in with their philosophy and were pretty awful. So I started doing some work around shelter rules and tried to help programs rethink their rules. During the course of that, I thought "you know part of the problem is that there are wonderful people here and they are enforcing these unfortunate rules. So much of it has to do with the fact that they are trying to deal with physical spaces that are not optimal for what they are trying to do. So the rules were coming out of the fact that the buildings they're in just weren't designed for the thing that they are doing. Most shelter programs acquired buildings in ways that are very improvisational or random.

So that was what started me thinking about the design aspects. How could we create buildings where people were more likely to do better work as advocates and where residents are more likely to feel comfortable? That is what led to this path of, "what are we doing? What's happening? How do survivors feel about it? How do staff feel about it?"

I got a little tiny bit of funding to do some inquiries. And I went around and did these participatory workshops with shelter residents and with staff. So I just got all this information, and then asked, "what now?" That is when I started looking for design help. You know, I'm googling feminist architecture, and that is how I found my way to Corrie and Mahlum because I just posted something on the 1% for architecture website. One day Corrie called me, and the rest was history.

Corrie:
Right around that time our office was committed to OnePlus. We have a firm value called commitment to community. And when I first started here I asked, "What does

that mean?" At the time the managing partner said, "I'd like to hear what you think it means", And I said I think I just opened the door to that which was great. So we identified three aspects of Commitment to Community. One: charitable donations, another: volunteering (not necessarily tied specifically to our profession, but as supporting our community). Working with Margaret gave us an opportunity to say, "What value can we bring to this?"

What we ended up doing was creating a reverse RFQ. Asking, "How are we shaping the communities we live in? How are we proactively identifying the challenges and then how can the built environment actually be supportive?"

So we started by targeting healthcare and mental wellness. We looked through a whole slew of organizations in Seattle where we found an alignment of values and narrowed that down to 10 or 12. Then we reached out by saying, "Would you be interested in this?" We sent the RFQ to about 10 organizations that were interested, Margaret being one, and then invited folks into our office. We wanted to ask, "What are ways that we could think about the project?" It isn't necessarily to build a shelter because there isn't just one shelter type. So that's where our conversation with Margaret really evolved. And then how wonderful that someone who is not an architect, but is asking how the built environment can actually support the work that Margaret was doing. So that's how we came together.

Rosemarie :
It's so exciting because as a student of architecture you always wonder, "How do these relationships form and how do people take a more active stance in architecture?" And not necessarily to try to solve problems but to be a member of the community and be diligent.

What are some of the things that have come out of that research? Have you seen how people using it?

Margaret :
You know, dissemination is really unsatisfyingly slow. We put that website out in early 2012. We did a lot to get the information out to people, but even if you have somebody that is totally gung-ho, there are so many steps that slow down the whole process. It can easily take 8 years of readiness, even if you have a good idea for

something as major as rethinking how you're shaping your building. This last year, we've gotten a few calls from people and it's so surprising how long it takes. The executive director of the Coalition at the time has said to me several times that they have really seen the impact of the work.

Corrie :
I wonder if it would be good to talk about Federal funding and the future of shelter?

Margaret :
So the shelter field is really shaped by federal funding. During the Obama Administration, there was a lot of really great thinking going on. The rules as they stand right now for the FPSA money, the Family Violence Prevention Services Act (which gets less attention than the Violence Against Women Act) but that is actually the core funding for domestic violence shelters. It's the most consistent funding for shelters nationally. So those rules are pretty influential.

I participated in rewriting and updating those rules during the Obama administration. We're trying to push a notion of a more flexible notion of sheters and to think about sheltering as a verb. How providing shelter with more of an emphasis on housing first works. Recognizing that short-term isn't necessarily the key to the problem.

Rosemarie :
One of the things I was reading about recently was the DASH Washington DC model of housing justice, and I think that gets to what you're talking about. This idea of longer-term, more affordable housing.

Margaret :
Exactly. If you're interested, at the Coalition there has been some big research with Chris Sullivan funded by The Gates Foundation on what they're calling domestic violence housing first, which is really helping programs transform how they're doing their work. We have to find other ways to house people, keep them in their house, make their housing safer, and create long-term housing. So that is some of the stuff that the Coalition has been looking at. The New Beginnings shelter here in Seattle has moved into a new building, so they can move away from shelter as their main focus. So they have some of those apartments for short-term housing, but they put a lot more resources into other kinds of support, like rent subsidies, helping people

stay safe where they are, just helping people not get evicted because their abuser showed up and made a scene. And so if there's some way to solve the problem and stay where you are. It's probably much better, but then you have the whole question of better accountability and community engagement to build safety

Similarly there are challenges about housing in rural communities. And it's also very hard to keep a location secret in a rural community. So whether that's the shelter or the new house that the survivor moves to. It raises some questions like, "how do you create that and without having the survivor have to pay the price of just leaving everything they know behind?"

Rosemarie :
That's something that has been coming up a lot in my research, about the difference between urban housing and rural housing in relation to domestic violence. I've been really thinking about, "what is the role of this shelter or this domestic violence advocacy organization within a community?" Especially if you're working with more remote and rural areas. I thought you made a good point that you can't be totally hidden. So what then is your role at that point?

Corrie :
There was a shelter that moved from being in a long, dark, alley. And so what does that say about that experience? Why would you want to to go there?

Margaret :
It was supposed to be safe, but places like alleys don't feel safe.

Corrie :
They ended up building housing above a public space on the first floor which brought the community through the new building. A couple things were happening. One, it was actually bringing traffic through the building making it safer. Where they located the building, there are a ton of eyes on the street. And in fact that I remember there was a hospital or medical office building across the street. So the person in that building saw someone sort of around the building because they could actually see because it wasn't down an alley. And they called to say I just want you guys to know there's someone outside.

So again, the community is actually keeping the community safe. And that sense of accountability and responsibility from others, not just those that may be either working or living there. It also created opportunities to have a birthday party for a child that might be living there.

But it becomes visible so that it is also something that the community is aware of. Instead of trying to say shelter doesn't happen here or there is no domestic violence. Again instead of trying to hide it and keep people out. It was actually about "how is the community addressing this?" And so they actually found that neighbors were feeling safer because there were more eyes on the street.

Margaret :
You always have to make friends with the neighbors and the neighborhood. It's kind of like catching up with the current reality of where we are, which is that in the 70s and early 80s shelters were much more embattled in their communities. They were treated with much more hostility. And so it makes sense that you get this fortress mentality, but now we have kind of won the battle that people think domestic violence is bad. I mean, they still don't know what it is when they see it.

But because they had a public meeting space, the community wanted to be there. They were able to offer more to their residents without any additional expenditures. How can we really support and challenge the field? To think about that relationship to community a little differently?
If you're going to build a building, what are the multiple ways you can leverage it for prevention for economic development, for community building? Not just intervening at the most extreme end of domestic violence, but earlier in the cycle. What can a program be doing to build a community that is an accountable community, that is a safe community? Where vulnerable people have options? So like an economic space?

Corrie :
You had asked, what should architects prioritize when designing domestic violence shelters? And I think it begs this whole larger question about shelter. Is that the right answer? is there always a need for some level of some emergency shelter?
The thing that became incredibly clear from working with Margaret was this question of privacy.

Where's that balance between providing space for more people and then providing the dignity to actually heal and break cycles. What becomes clear with that data is the need for privacy. With individual apartments, they were finding that survivors were inviting each other over for coffee and engaging with the advocate because it was their choice. You're trying to undo the feeling of secrecy.

Margaret :
People really conflate domestic violence shelter and domestic violence services. Most programs are doing much more than just the shelter, and only a fraction of people get to shelter. But they devote a large percentage of their budget to shelter. So it's kind of a mis-match between where are the resources going and who's getting to use it.

Rosemarie :
There are a lot of conversations about this one aspect but it's important to think about the holistic nature of people. There's so much more to be helping or reinforcing. I think the conversation about the role of advocacy and a more engaged perspective is so important, so if you have any final big thoughts on those.

Margaret:
How do we make a structure of a conversation so that a lot of people can participate; survivors, staff, other people? Create a space for people to really think. Because for non-profits and shelters who really run a lot on scarcity, they never feel like they have enough of anything. Even though it might seem kind of large, most shelters turn away 9 out of 10 of the folks that are asking for shelter. So you just don't feel like you're doing the job right.

So for those folks when they get a large capital investment, it's a big freaking deal, but it's hard to get the pause to really think, "Is this really how we want to use this money" or "How can we think creatively about using this money?" Versus just saying, "Let's just build a bigger house."
Making the time to engage the question. What problem are you trying to solve versus what building are you trying to build?

Ryan Jorgensen : Architect at Saunders Architecture
February 26, 2020

Ryan Jorgensen

Rosemarie:
I am familiar with the Fogo Island Inn project, and one of the things that is so cool about it is how important economic resilience is. I know that it was established by the founder of the Inn, and I wonder what your process was working with someone like that, and how different it was working on a project that was so much more than just the program itself? So much about the community and how it is supposed to be fitted into this environment?

Ryan:
So Zita Cobb is really the driver of this project. She is extremely skilled. One of her main things was that the project had to be really of the place. She's from Gander, Newfoundland, so she's really familiar with the culture, history, and everything. One of the reasons it was so successful is because she's an amazing business woman. She involved a lot of different people from the federal, provincial, and local government. As well as getting a huge buy-in from the local residents. One of the ways that she did that was by using local craftspeople. It was a way to keep part of the history here.

Rosemarie:
I hadn't realized there was such a relationship with the government for this project. I thought it had been pretty much independently driven.

Ryan:
She spearheaded the entire project, and it doesn't hurt that she can say, "I have a lot of money and I know that this money can help make money." She knew there were possibilities for tourism. So she knew she wanted to improve the infrastructure of the island, roads, and solar energy.

Rosemarie :
That's so interesting. I had thought this was a separate initiative but working with the government is obviously so important for this kind of resilient strategy.

This project is exciting because you get to work on this beautiful architecture in this incredible landscape, but the part that I think is so fascinating for me is this aspect of working with the community to build resilience. Because I've been researching this area I know about the resettlement policies and all of the issues with the economy

and the fishing disappearing. It's been interesting to see governmental approaches versus these magical individual approaches.

Is that the first time this firm had started working in Newfoundland and Labrador? I know that Todd Saunders is from Gander.

Ryan:
We did a couple personal projects down in Nova Scotia, but predominantly our work is in Scandinavia. There was another project that we worked on in Salt Spring Island.

This project really started with the artists' studios as a way to generate a little bit of buzz, and to test building in the area and test the availability of skill sets. We hired locals to build this. We wanted to see what we can learn from them. How we can have a symbiotic relationship.

Rosemarie:
So it was a phased project?

Ryan:
Yeah, and some of the studios were completed after the inn too. It's been really cool to follow this project and see how it grows. To see younger generations coming back and having kids there. It makes me want to live there.

Rosemarie:
It's great to hear that people feel like they can return to this island. It must be really exciting to see changes like these.
So what was it like beginning this project, assumptions you had, and things you learned? And what was it like working with local craftspeople?

Ryan:
We started by reading a lot of literature from people from the area; about historic towns from around the province. And also just going there and being with people. You just walk down the street and people love to tell you stories. Then we started inviting lots of artisans to interact with the land in their own way.

Rosemarie:
I know that construction can be really challenging because of the climate and also just getting material to a location. So when you were sourcing materials was that coming from other parts of Canada?

Ryan:
Oh definitely. The majority of the building was built in wood. Sometimes we would choose to use off-the-shelf materials, but in an interesting way. And working closely with builders was very important for getting parts made too.
Another cool thing is that a lot of people on the island take ownership of the project.

Rosemarie:
So what were some of the priorities of the project for the design?

Ryan:
In terms of programming, one simple goal was that everyone gets a view of the water. The very top of the building is public with a spa and sauna. Having a sense of being at home. It had to have the local touch. Every single person on the island got to have a night to stay in the inn.

Phillip Gregoire : Doctor in Toronto, Canada
January 20, 2020

Phillip Gregoire

Rosemarie :
I think it can actually be really useful to know what the "lay doctor" knows about domestic violence services as related to urban and rural issues. You can start with your general thoughts if you'd like.

Phillip :
So, there's like two dynamics. There's the north-south dynamic, and then there's the rural-city dynamic. And both are equally potent, and both are interconnected. As you go north you become more rural. But it's a different dynamic because there's rural and then there's remote. And if you're thinking about, for example, Yellowknife, which is in the Northwest Territories. That's about a twenty hour drive to Edmonton. Yellowknife is the biggest city in the Northwest Territories which is this huge geographic area. And it's like 20,000 people, a relatively small number of people. If you are from Yellowknife, that's fine, but if you're from anywhere else in the entire Northwest Territories, you have to fly to even get to Yellowknife. If you want to get anywhere other than there, then you have to fly to get to anywhere else, anywhere in Saskatchewan, anywhere in Manitoba, in BC, or in Alberta. So from a resource perspective, what happens if you're in one of these remote communities? There's basically nothing. It's literally a fly-in community. Whatever is there, is there. That's all you got, you know. If you have some kind of issue, you can't escape it. You're stuck there. So that's a very potent dynamic that is different than in the states. There's really no place in the states,except maybe really remote Alaska, that is like that; where you just can't pick up and drive away. You can't just leave. You're stuck, and you have no resources because nothing can come to you either.

Rosemarie :
Well that issue of access to resources is one of the biggest barriers facing work in Northern and rural Canada. I read recently that the largest reason why there are Inuit people leave Nunavut and the Territories is as a result of family and domestic violence.

Phillip :
Yeah, 100%.

Rosemarie :
Which I found alarming because that means there's like nothing in Nunavut in terms of DV and IPV services.

Phillip :
It's a huge problem. There's obviously many factors that led to this, but nevertheless it remains this enormous problem. One of the things is that when people come off reservations to cities, it's a situation of cultural displacement. On top of being isolated and having to escape from this place that you are born and raised. And so the homeless population is a high percentage of First Nations people. It's a very prevalent dynamic. In the Canadian media for the past two year, there has been a conversation about the epidemic of teen suicide on these far North reservations. Endemic poverty, endemic abusers, people who have the most severe substance abuse problems imaginable, all in these tiny communities. No external support really. The challenge is because these communities are so isolated, thinking from a problem-solving standpoint, you're in the middle of it. How do you combat it when it is just around? This just happens and there seems to be few consequences or any way of really even creating consequences for it.

Rosemarie :
A lot of the research that I've been reading really points to erasure of culture and lifestyle as being a big reason for a lot of these issues, and obviously it's a big systemic and structural issue. But, and this is not something that you probably can comment as much on but, I've been reading a lot about the change of architectural typology in the north. If you impose really bad architecture on a people who do not live the way that you live, there can actually be fatalities as a result of that. If you force people to live in a way that they have not historically or want to live, that's a pretty fast way to erase a lifestyle.

Phillip :
Right. Yeah. I mean the residential schools for example were a systemic genocide executed to erase those cultures. The results of which are still experienced today.

Rosemarie :
Absolutely. Well let me ask you some of the more targeted broader questions that I prepared. What would you say are the primary barriers to providing medical care

in Northern Canada? Obviously access is a big one. I was wondering if you can speak to anything else, or if you think that's the main point.

Phillip :
So the issue with the Far North is that they have very few doctors that live up there, and they have very limited resources. Depending on how remote you go, a lot of the time it's nursing outpost stations and they can do basic services. Getting testing is challenging because everything has to be flown out to be evaluated. For sexually transmitted infections that's a big problem. Pregnancy care is a big thing as well. How are you going to get birth control? Well, you have to go to the pharmacy. Where are you going to find a pharmacy? Those are huge problems. What ends up happening is people will have to fly to Yellowknife or Iqaluit from some remote place which costs an enormous amount of money. Then they get there and then whatever they came to do, whether it's an abortion or some other pregnancy related care, and they have to fly back. You can see how that's an enormous barrier to people. It cuts both ways because on the one hand, you can provide long-term pregnancy solutions like an IUD or something when you're down in Yellowknife. But, let's say the person wants to get pregnant later. Who's going to take out the IUD? There's all of these dilemmas that are created by every step of the distance. An issue for which any day of the week you or I could go to the doctor for. If you have to fly to the doctor, or fly to a pharmacy, or someone has to fly in medications, it's totally different.

There's also a very rapid turnover of medical staff because people don't want to work up there as much as they do in Toronto. So people might do a one-day-a-week period up there and then do that for a little while. Then that's it. The overall rate of poorly controlled medical problems is higher. Then there are specific problems. Tuberculosis is an epidemic in the far north, and a lot of that is housing-related as well. We don't really have tuberculosis very much in southern Canada, but it's a huge problem up there because you have a bunch of people living in these really small buildings that are poorly ventilated through the winter and everyone's just breathing the same air all day long. So there are really high rates of TB there. Before they had treatment for TB, you basically had to wait it out in the sanitarium for two years. A lot of these people from Iqaluit would come down and live in sanitariums in Quebec City just be down for a couple of years just sitting in this hospital.

Rosemarie :
There used to be all these low cost housing initiatives in Far North Canada. One of these designs, called Matchbox houses because of their rudimentary design, had such a high incidence rate for tuberculosis. The fatality count on this design is astounding. And it's because they would design them in southern Canada and then just ship them off there with no thought at all to how it will perform in a totally different climate.

Phillip :
Yeah I'm familiar with this idea. Let's say you want to build a building in the far north. So you plan it all out. You have to get all your supplies from Southern Canada and it takes them a whole season to ship up. Then they all get there, and you find out it's the wrong size of screw. You can't build it. You have to just wait until the next shipment comes through and it's six months later. That dynamic forces people to try to prefab things as much as possible, so they don't have to deal with what is ultimately a big problem, where you send materials up and you just can't use any of that.

Back on the medical conversation. Generally speaking, health outcomes across many fronts are much worse in the far north for things that are really manageable in the well-populated South. The resources aren't there. There's a whole wide variety of issues.

Rosemarie :
Okay, so do you know about anything people are doing, initiatives or movements, to change like this divide between northern and southern, rural and urban?

Phillip :
There's many layers to this dynamic. One thing that you often hear is that healthcare in Canada is like pillars of excellence in a sea of mediocrity. Which is a statement made by people who don't want to fix problems. But, what they're getting at is the idea that there is such an incredible disparity even in just any kind of rural setting. If you live in Toronto and you need an MRI, you'll be able to get it in about an hour.If you're three hours outside of Toronto, you may not get it for who knows. It very much depends on where exactly you are. The country is just so gigantic. The problem of geographic scale becomes a big issue. It doesn't make sense for you to put an MRI machine in every little town because that's really expensive, and there's really not the

population to support it. On the other hand, it means people who live in those towns don't have access to it in the same way someone in the city does. People in small places automatically get this rationing effect. The way it happens is that people have to think really hard about what things do they really need for that community. What is going to make the biggest difference? You have to have an enterprising person who is going to lead an initiative around a certain kind of equipment. You can't just have the doctor; you have to have a system setup and the problem with this is that it becomes a very disjointed thing where people have a lot of local knowledge about the things that are available around them. This can create conflicts from a local level with initiatives from the provincial level. That dynamic is super frustrating for people on the ground.

Erin Balcom : Doctor in Edmonton, Canada
February 5, 2020

Erin Balcom

Erin :
I'm not an expert by any means. Some of the screening tools that are used I kind of picked up because I did some work on human trafficking when I was in medical school. The idea behind that is trying to integrate curriculum about human trafficking into the medical school curriculum. But of course human trafficking is really tied in with intimate partner violence. It's essentially a form of it. A lot of the training we did was about IPV. And when I started doing clinical work, especially in emergency positions, is where you are more likely to encounter somebody who has actually had training in this. A lot of emergency physicians did screening so I learned from them too. It's super common. Once you start looking for it you see it all the time. And it's missed pretty often.
That's where my background is.

Rosemarie :
Well, okay. So the stuff that I'm specifically looking into is related to shelter design which is changing a lot right now. And so one thing I'm thinking a lot about is urban versus rural and areas that have a lot of resources versus areas that don't. So like in Northern Canada versus Eastern Canada where there are different economic situations. Any kind of commentary you have on those kinds of things from your experiences being a medical care provider or anything that you have learned in your studies, or life experiences?

Erin :
I mean, I think it's common in urban and rural communities. I also did a little bit of reading about this - not surprisingly in remote communities in Alberta. Poverty and substance abuse is more prevalent in those communities, so violence is more common in those communities.

I think one of the challenging things in cities, even when you do have resources, it is largely because it's under-reported and it's missed by providers. I think there are a lot of missed opportunities.

I think in smaller communities – particularly among indigenous populations – there's more normalization of violence. Often multiple generations have been subject to violence so that's one of the barriers.

I looked up women's shelters in Albert, for example. Edmonton has two. Calgary has three. And there are a bunch of medium to small towns that have at least one. But it's like nowhere near the amount needed. There are so many communities in Northern Alberta and the Territories that do not have a dedicated women's shelter. So there's a lack of resources there. And then there's also – in smaller communities – a fear of gossip and that information spreading. There's more anonymity in a city.

Rosemarie :
That's something I've been reading about lately. Is this kind of issue when you're in a smaller community of this idea of being secret versus having a public face. Obviously that's a very complicated issue.

The other thing I see is as I've been looking at options for shelters – there are the ones that offer just emergency short-term housing. It's pretty much like that's the only option in smaller communities so that means you're there for a few days, and then what do you do after that?
I think that's a pretty tough situation to be in.

Erin :
I think what's interesting about the model right now, which is - there's no evidence to support universal screening. Which is true. There have been a few pretty poor quality studies which haven't been statistically significant. But, the CDC recommends universal screening and the SRGC, and the OBGYN society recommend universal screening for common sense reasons, and it doesn't take that long. The women that end up in dedicated shelters or people that are claiming domestic violence are in crisis. They have reached crisis. Most of them likely had been in front of a general practitioner, an emergency department, or some other healthcare provider probably multiple times before that crisis moment where there were opportunities to intervene. If the first time that they are seeking help is when they are fleeing to a shelter, there's a problem. Because they're not going to have a place to go after a day or two which is probably when they are going to be discharged from that shelter.

Rosemarie :
From the research that I've done so far, it seems like most of the people that find their way to a shelter usually go there through interactions with the police department. Or

they go there through an experience with a medical care provider. So if you're not screening for it, it becomes an issue much larger than it could have been.

Erin :
Well there's no training for this at all in medical school. Outside of the organization that I was part of, there was an extracurricular lecture offered at 6pm on IPV after mandatory lectures, and it was attended by probably 12 women out of a class of 260.

Rosemarie :
Wow.

Erin :
One of the things I learned there is there's this concept of risky occupations. Statistics focused on women in heterosexual couples. Women who are partnered with men in these three occupations are at a very high risk of domestic violence. They kind of polled us – asked what do you think it is? Blue collar jobs or truckers or whatever. And it was policemen, physicians, and lawyers. And you're like great – who do you need to help you if you're experiencing intimate partner violence? Possibly all three of these professions.

Rosemarie :
Definitely a disheartening thing to read about. And I think a lot of the firsthand accounts people have about getting access and support is that the legal system or the medical system is just not equipped to understand the problem.

For example, one thing I was reading about was the signs of someone who is in crisis mode in an IPV situation is very different from other crisis mode signs so if you're not trained to see those, you might dismiss them.

Erin :
For sure. One of the things is that – it's in emergency departments but it's also in general practitioners offices – the women who return to care often with super vague complaints. Frequent colds or not sleeping well or whatever. The more vague their complaint, the more that person should be screened for domestic violence because that's actually very common. Some of it is just help-seeking behavior. They go to a

place where they can get help although they are not specifically asking for help for that. The thing is that sometimes that's the only way they can justify getting out of the house and getting time away from their partner is to go to the doctor. So that happens not uncommonly. That's usually how GPs find it. It's not because somebody is coming in with bruises or injuries that are very obviously caused by somebody else. It's somebody just seems off and that they're here all the time.

Rosemarie :
That is so interesting and it makes so much sense too. You know as basic medical training I feel like that's not the type of thing you are trained to intuit.

Erin :
I think one of the problems in getting physicians engaged in this is, frankly, there are just too many men. Truly – too many men in medicine. Great people. There are just too many of them, and so there's kind of this blindness to it. "It's rare. I don't know any men that abuse." Whereas every woman knows somebody that has been abused. We just need more women in medicine first of all, but I think there's also this attitude in medicine of – and this is literally something that they say to us when we're learning to take histories – don't open a box that you can't close again. Don't ask about trauma if you're not assessing this person for trauma because you're going to retraumatize them and cause harm and then you won't be able to help them. There's some truth to that. There are times when I've sensed – not necessarily violence – but this is probably a really traumatic issue for them and I don't necessarily need this information right now so I can just skip this and go to the medical stuff and get them an antibiotic or order the right tests or whatever. There are no tests that you can order for domestic violence and there's not a treatment necessarily so there's this feeling of hopelessness around it. Physicians are just like, "Why would I have this really difficult and potentially traumatizing conversation with this patient - who's coming in with something else – when I don't know how to fix it?" The idea is that physicians, our role here is not actually to fix the problem, it's to find the problem and connect that person to resources. We're not the ones who fix it. And that's hard for doctor brains to understand.

Rosemarie :
So in a clinic when you are screening somebody and you identify them as somebody who needs services or next steps, what happens? You identify these

signals and then what happens?

Erin :
So it depends. So in my notes I walked through what I would do in this situation. Basically you have to be kind of flexible with it, but there are a couple things that you keep standard. You always interview the person alone and sometimes you need strategies for that. And you always start casual. "Who is at home?" "Are you in a relationship?" Then there are some easing into it questions like: "Is your partner supportive?" Especially family doctors, if they know of a particular stressors like job loss or illness. You can ask how they are coping with this. "How do you guys deal with conflict?" "Do they have a temper?" Those are pretty sensitive screening questions. If the person answers ,"Yeah, they have a temper," then you can ask for examples.
Or maybe "Yeah we don't deal with conflict very well. He gets angry." Or if they kind of shut down in trying to answer that, it's a red flag, and then you push it further. Sometimes, you screen when you have a really low suspicion and then those screening questions are negative and you just drop it. Another one is speculum exams – you just kind of normalize it. I've seen doctors that do speculum exams on the regular and every time they do it – every woman – they ask, "Has all the sexual contact you've had been consensual?" They can justify that because there's sort of a medical reason to ask it because sexual assault or abuse is associated with a condition called vaginismus that can make speculum exams really painful. I've seen that question casually be asked as a screening question, and it's been positive multiple times.

I'm digressing a bit, but you kind of normalize it. You say, "Because violence is so common, I need to ask this question and I would ask it to anyone who presented with your injury or your issue. Were these injuries caused by someone else?" The important thing is that you don't necessarily single out the partner. If you really jump on the partner, the person is going to get defensive and shut down, but if you casually ask the question you are more likely to get a true response. Once that's positive you have to ask about triggers for mandatory reporting because domestic violence isn't a mandatory reporting issue, but it is mandatory to report to children services if there are children in the house who are either subject to the violence or who are witnesses to the violence. And you ask about substance abuse as well in that context. And if any of that is positive you have to report that to child services.

You have a duty as a physician. So in a sad way when that turns out to be positive, it's actually a relief for providers. It's like thank goodness there is a material thing that I now have to do. Once you trigger child services you're also triggering social services for the woman. Social work will get involved. They'll get support that way. So I think physicians are relieved, unfortunately, when that's the case.

If that's negative – you don't have mandatory reporting and you have to respect patient privacy. In that conversation, you have to name what it is. You have to make it very clear that what they describe is as abuse and you have to do a safety screen. You have to ask "Has your partner every threatened your life?" "Are you worried that your partner will kill you?" "Have they ever threatened you with a weapon?" "Are there weapons in the home?" "Are you being forced to take substances or do things you don't want to do?" That kind of stuff.

You have to do a safety screen and talk about a safety plan. "What will you do if the violence gets worse, which it most likely will?" "Do you have a friend or family member that you can stay with in case of emergency?" "Do you have a go bag?" A go bag would have keys, money – if they are able to put money aside – copies of important documents like children's birth certificates, their birth certificate, passport, important things like that. You can even encourage them to keep that go bag at the friend or family's place where they might be going to. Encourage them to open their own bank account if that is possible for them.

And then you offer social work in the emergency department but if the woman declines social work, you cannot force it. And then that information has only been shared with you and you cannot share it with a social worker. You could ask for their advice, but you can't bring in other people to the circle of care if the patient doesn't consent to it. And if you do that – and I think it probably happens all the time with good intentions – the sense of loss of control and fear will probably just discourage the person from seeking help in the future. It's really important to be like "You're in control. We're doing only the things that you want us to do right now, but I need to give you this advice because it can save your life."

Rosemarie :
That makes a lot of sense. For example, in your clinic, if you are screening somebody

and they say, "I want help, I don't feel safe." and you have gone over these action plan steps. Would your clinic have a social worker that they work with, shelters that they have a relationship with? Are there steps that are established? Or is it just that you have to figure it out?

Erin :
I think it's mostly the latter. It depends on the clinic. Some clinics have social workers and many don't. Geriatric clinics often have social workers. HIV clinics often have social workers. In neurology it's not common. Our ward has a social worker, but most of the clinics don't except for certain diseases. A lot of family doctors don't. Women's College Hospital in Toronto does this and I think there are a couple clinics in Edmonton as well that do it. I think for the most part it's – here's a hotline number, here's a shelter number. Very piecemeal stuff. If you're in a clinic that didn't have a social worker which is probably more likely, I think you would have to refer to social work. And you might be able to refer to social work in the hospital, but I think you actually would end up referring them to an organization that is staffed by social workers. There are a couple that are mostly based in cities, so if you were in a rural area I think you would be really hard-pressed to find that social worker locally. I think it would be almost impossible.

Rosemarie :
A great challenge to rural safety and health it seems like. So I know you are working on these initiatives in medical school, but do you have any sense that there is a push to make it standardized - like you were talking about Universal screening – or is it kind of clinic by clinic for the most part. What's the temperature on this stuff?

Erin :
I think there's more interest then there's probably ever been in the issue. One of the reasons for that is the populations that are practicing medicine now are very incrementally changing – there are more women, there are more minorities. In Canada, there are slightly more indigenous folks that are studying medicine. So there's kind of more emotional intelligence in medical training to be honest. A lot of medical schools and a lot of training programs will have initiatives but I still think it's seen very much as a niche issue.

I would say it's incrementally changing, but still bad.

Rosemarie :
I'm sure part of that change is also associated with this urban-rural kind of dynamic too.

Erin :
Yeah, I think so. Very true.

Rosemarie :
I'm kind of astounded that there isn't more interest in or more accepted strategies and knowledge about this because it is a basic human health thing, and it so deeply impacts the health of a person.

Erin :
And it's so common. If you ask any internal medicine resident in Toronto about pheochromocytoma, which you almost never see in your career, they all know about it – and they all know what the signs are and the treatment and the tests that you order. Whereas intimate partner violence which is literally 1 in 6 – they don't know anything about it. It's so common, and they are presenting in healthcare settings and we're doing nothing about it. It's very frustrating.

Rosemarie :
Well even if you show up to a hospital and your issue is some kind of internal medicine issue. If you're in a household where there is violence, that is only made worse - made more extreme. So to me what it seems like part of healthcare is saying, "Well obviously there is this other big thing that is making things so much more challenging."

Erin :
Yeah, I agree. And there are so many issues with this. There are systems based issues. There's a billing model in medicine – and maybe this is too cynical – but a lot of doctors may think "I can't bill for a domestic violence screen, and I get billed per patient so why would I take an extra 30 minutes with this patient for something that I can't even bill for when I got 20 people in the waiting room." It's sad and it's frustrating. There are changes on multiple levels of the system needed.

Rosemarie :
Especially if you have a room full of male and white doctors how do you advocate for this thing that is so widespread and such a systemic health problem.

Erin :
Here is the classic problem with that argument. The Cochran Reviews is the big source of information for: is there evidence to do this thing. The Cochran Reviews really favor randomized controlled trials because that's statistically the ultimate source of evidence, but it's very hard and maybe doesn't make a lot of sense to do a randomized controlled trial for domestic violence for multiple reasons. Cochran Reviews did a meta-analysis of six studies on Universal Screening and intimate partner violence, and it found that it doesn't reduce intimate partner violence and that, to them, meant there's no evidence to recommend Universal Screening. And all the doctors felt really good about the fact that they're not screening, but the studies themselves – the screening protocols which actually exist aren't evidence based, in a sense that their sensitivity and specificity has been studied and showed that they're quite specific and reasonably sensitive – so it should be enough that we are picking it up – picking up cases of IPV and therefore directing them to services. But, they are too focused on how Universal Screening doesn't fix the problem, so don't do it – it's a really stupid argument.

Rosemarie :
Yeah, that seems so wild because if you're already a healthcare professional and your attitude towards domestic violence is that it's somebody else's problem to deal with and you won't screen for it. It's like saying, "well I know I can't fix it, but I also refuse to do anything to help it."

Do you have anything else that maybe isn't obvious to ask about that you think is really important? Or something that we haven't talked about yet that you think should be discussed?

Erin :
I think one issue that is relevant in the designing of shelters, is pregnancy. Intimate partner violence is more common during pregnancy and more likely to escalate during pregnancy. But I don't know structurally what that would look like, but it might be something to keep in mind.