A Survey of Intimate Partner Violence Intervention Programs in Saskatchewan, Canada

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Abstract

Extant research demonstrates diversity among intervention programs for people who have perpetrated intimate partner violence (IPV) in terms of theoretical approach, length, and composition. The present study explores community-based IPV intervention programs delivered in Saskatchewan, Canada, a province with a substantial rural population and a high rate of IPV. Twenty-five professionals representing 11 programs provided details of available IPV interventions in an online survey. Findings provide insight into the characteristics of IPV intervention programs and the experiences of professionals who facilitate these programs, including their observations regarding successful interventions and barriers to completion faced by participants. These findings inform recommendations for policy, practice, and future research.

Public significance statement:

People who perpetrate violence against their intimate partners are often mandated to attend intimate partner violence intervention programs. There is substantial diversity in program content and delivery, and little research has been conducted to date; this article provides the first overview of interventions available in Saskatchewan, Canada.

Keywords:

Intimate partner violence, domestic violence, violence treatment, batterer intervention programs

A Survey of Intimate Partner Violence Intervention Programs in Saskatchewan, Canada

The present study explores available IPV intervention programs (also often referred to as batterer intervention programs, domestic violence perpetrator programs, or domestic violence treatment programs) offered in Saskatchewan, Canada. Twenty-five professionals representing 11 intervention programs provided details of available interventions for people who have perpetrated IPV in an online survey.

Saskatchewan Context

The rate of police-reported IPV in Saskatchewan is over double the national average (724 victims per 100,000 population versus 344; Conroy, 2021). Most victims of IPV (80%) in Saskatchewan are women (Conroy, 2021), and the majority of perpetrators (81%) are men (Saskatchewan Ministry of Justice, 2017a, b, c).

The Canadian province of Saskatchewan is unique in that it contains large proportions of both rural and Indigenous populations. The most recent national census indicated that 16.3% of Saskatchewan's population was Indigenous, compared to 4.9% of the national population (Statistics Canada, 2017). Over one-third (35.6%) of Saskatchewan residents live outside a census metropolitan area, compared to the national average of 16.8% (Statistics Canada, 2017). Examples of rural communities in Saskatchewan include small towns and neighboring farms, First Nations reserves, and northern communities, including fly-in communities that do not have road access. Approximately half of Saskatchewan's Indigenous population lives on one of 70 First Nations reserves (Government of Canada, 2021), most of which are rural (Statistics Canada, 2017).

In both rural and Indigenous communities, the rate of reported IPV is notably higher than in other areas in Canada (Allen, 2020; Conroy, 2021). Rural, northern, and Indigenous victims of IPV experience barriers to safety, including transportation, geographic isolation, and distance to service providers (Jeffrey et al., 2019; Wuerch et al., 2019). Further, risks are exacerbated when people in rural areas who use violence in their relationships do not have access to IPV intervention programs due to geographic distance and transportation barriers.

Types of IPV

IPV can include physical, psychological, emotional, verbal, financial, sexual, and spiritual abuse; excessive jealousy and control; and harassment after separation (Provincial Association of Transition Houses and Services of Saskatchewan [PATHS], 2018). IPV is not a distinct criminal offence in Canada, however. When police attend after a violent incident associated with IPV, the accused is most often charged with assault. Other IPV-related charges seen in court include uttering threats, stalking, theft, break and enter, fraud, and possession of stolen property (Beaupré, 2015). Coercive control is not a criminal offence in Canada (despite coercive controlling behaviour being criminalized in other jurisdictions, such as the United Kingdom; *Serious Crime Act 2015*). Researchers and domestic violence death reviews have identified coercive control as a severe and dangerous form of IPV and an indicator of risk for lethality (Campbell et al., 2003; Office of the Chief Coroner for Ontario, 2019; Saskatchewan Ministry of Justice, 2018), however individuals who perpetrate this form of IPV may not encounter the Canadian legal system and, in turn, may not be referred to intervention programs unless other (physical) forms of IPV are also present. Therefore, physical IPV (e.g., assault) is most likely to result in people who have perpetrated violence in their intimate relationships being referred to IPV intervention programs.

Since the 1970s, researchers have sought to classify men who perpetrate IPV into typologies (For a review, see: Ali et al., 2016; Cameranesi, 2016). Two of the most influential empirical typologies, which have each been validated by several subsequent studies, are those by Johnson (2006) and Holtzworth-Munroe and colleagues (2000). In a sample of men and women, Johnson (2006) found three main clusters: intimate terrorism (also known as coercive control), violent resistance, situational couple violence, and a small third cluster of mutual violent control. Holtzworth-Munroe et al. (2000) found four clusters of men who perpetrate IPV: generally violent and antisocial, low-level antisocial, family-only, and borderline-dysphoric. Other researchers have also identified a generally violent and antisocial type of perpetrator who presents a risk for severe and ongoing IPV (e.g., Cunha & Gonçalves, 2013; Eckhardt et al., 2008; Huss & Ralston, 2008; Hilton & Eke, 2016; Thijssen & de Ruiter, 2013). The literature suggests that one subtype of people who use violence confine their abuse to their partner or their partner and children (Eckhardt et al., 2008; Holtzworth-Munroe et al., 2000; Huss & Ralston, 2008; Thijssen & de Ruiter, 2013), whereas others who perpetrate IPV have diverse criminal careers and also engage in non-IPV and/or non-violent offending (Buzawa & Hirschel, 2008; Cunha & Gonçalves 2013; Fowler & Westen 2011; Hilton & Eke, 2016; Huss & Ralston 2008; Loinaz 2014; Piquero et al., 2014).

Despite decades of research, a consensus has not been reached regarding which typology is most applicable or useful for research and interventions with individuals who perpetrate IPV. Further, there is no agreed-upon method for classifying perpetrators by typology in clinical settings. Consequently, typologies are not typically used to inform strategies for risk reduction, such as enrollment in IPV intervention programs, or risk management strategies, such as supervision conditions.

IPV Risk, Need, and Responsivity

The Risk-Need-Responsivity (RNR) Model of Offender Assessment and Treatment (Andrews & Bonta, 2010) and the Principles of Effective Intervention (PEI; Risk, Need, Responsivity, Treatment, and Fidelity; Radatz & Wright, 2016) offer guidance for the delivery of interventions. RNR has been the accepted model of correctional intervention since the 1990s. Briefly, the RNR model guides the assessment of risk to determine which individuals receive treatment, treatment goals, and how treatment will be delivered (Andrews et al., 2006). RNR has been demonstrated to increase the efficacy of interventions for offenders generally (Andrews et al., 2006; Bonta & Andrews, 2017; Connors et al., 2012; Olver et al., 2011); however, few studies discuss the incorporation of the principles of RNR into interventions for individuals who have perpetrated IPV (notable exceptions include Hilton & Ennis, 2020; Radatz & Wright, 2016; Scott et al., 2015; Stewart et al., 2013; Stewart et al., 2014).

The first principle in the RNR model, the risk principle, states that offenders should be matched to services at varying levels of intensity in relation to their risk level (Andrews et al., 2006; Bonta & Andrews, 2017; Hilton & Ennis, 2020). Risk assessments are used to determine the likelihood that someone who has used IPV will recidivate and can be used to classify individuals by risk level for service delivery and inform risk management strategies by identifying key risk factors to target in intervention (Hilton & Ennis, 2020). Research shows that it is most effective to direct more intensive programming and support to individuals who pose the highest risk (Bonta & Andrews, 2017; Lowenkamp & Latessa, 2004). Further, the risk principle states that individuals assessed at differing levels of risk should not participate in programming together (Hilton & Ennis, 2020; Lowenkamp & Latessa, 2004). Hilton and Ennis (2020) explain that after conducting IPV risk assessment using an empirically validated tool,

high-risk perpetrators should be prioritized for evidence-based treatment, and efforts must be made to ensure these individuals maintain attendance. Research has also demonstrated that those at the lowest risk of reoffending may have better outcomes without intervention (Hilton & Ennis, 2020). Probation services, Domestic Violence Courts (DVCs)[1], victim services, and domestic violence shelters and services in Saskatchewan currently use the Ontario Domestic Assault Risk Assessment[2] (ODARA; Hilton, 2021) with their clients. Given the importance of risk assessment for effective risk reduction and risk management, one of the aims of the present study was to determine if and how risk assessment information is used by the professionals who deliver IPV interventions.

Radatz and Wright (2016) noted that not only do individuals of varying risk levels have different treatment needs and outcomes, differences exist between perpetrator types in terms of attendance, completion, and treatment outcomes. They state, however, that the majority of IPV intervention programs "disregard these differences and continue to treat offenders as a monolithic group" (p. 78).

Needs are dynamic (i.e., change with time and context) and can be criminogenic or noncriminogenic. The need principle indicates that focusing on criminogenic needs is more likely to lead to decreased recidivism. Hilton and Radatz (2018) compared the criminogenic and

[1] Three communities in Saskatchewan have Domestic Violence Courts (DVCs). DVCs are therapeutic courts that offer the DVC Treatment Option, which "allows those who are willing to take responsibility for their actions, who elect to plead guilty, and who will receive a sentence that does not include jail time, to complete a counseling program for domestic violence and address any substance abuse problems they may have. Individuals are not sentenced until after they have had a chance to complete the DVC Treatment Program, and if they meet the requirements of the DVC Treatment Option, individuals will receive a reduced sentence. Participation is voluntary, and individuals have the right to plead not guilty or to choose not to participate in the DVC Treatment Option. Individuals who do not participate in the DVC Treatment Option will proceed as they would through the regular court system" (Saskatchewan Law Courts, 2021). In communities without DVCs, people who have been charged with violent offences against an intimate partner are seen in the regular court system.

[2] The Ontario Domestic Assault Risk Assessment (ODARA) is a 13-item actuarial risk assessment that assesses the likelihood that a man who has perpetrated IPV will assault a female partner again (Hilton, 2021).

noncriminogenic needs of non-violent, violent (non-IPV), and IPV offenders. They discovered that individuals who had perpetrated IPV had higher criminogenic needs than the other groups. In a subsequent study, Hilton and Radatz (2021) found a connection between criminogenic needs (antisocial personality traits, procriminal attitudes, substance use, and work/school problems), treatment intensity categories (assigned using the ODARA), and recidivistic IPV. This finding adds support for using risk assessment to assign individuals to different interventions, based on risk level, with the highest-risk perpetrators receiving the most intensive IPV treatment. Further, these findings indicate that assessing criminogenic needs and intervening to make improvements in these areas will improve outcomes in relation to IPV (Hilton & Radatz, 2021).

The responsivity principle dictates which intervention strategies are employed. This principle includes two facets, general responsivity and specific responsivity. General responsivity relates to the type of programming offered— treatment must be evidence-based. Specific responsivity centres on matching individuals to the most appropriate treatment for their needs and abilities, as well as demographic factors (Andrews et al., 2006).

Little is known about specific responsivity in relation to IPV interventions (Hilton & Ennis, 2020); however, previous research has indicated the relevance of typology to specific responsivity (Hilton & Ennis, 2020; Radatz & Wright, 2016; Stewart et al., 2013). Researchers have also detailed predictors of treatment attrition (Jewell & Wormith, 2010; Radatz & Wright, 2016), many of which are also risk factors for IPV recidivism (Hilton & Ennis, 2020). Stewart and colleagues (2013) explained that tailoring IPV interventions “to the unique needs of offenders, targeting different typologies and motivation levels, may ensure better retention rates” (p. 514). In summary, IPV interventions should be evidence-based and allow for the

accommodation of perpetrators' individual characteristics and challenges (Hilton & Ennis, 2020).

Radatz and Wright (2016) describe the Principles of Effective Intervention (PEI) to improve the efficacy of IPV interventions. They state that, according to the treatment principle, IPV interventions should be cognitive-behavioural, incorporate social learning techniques, and be approximately six months (26 weeks) in length, with weekly sessions of 90 minutes to two hours (Radatz & Wright, 2016). The fidelity principle offers guidelines for the quality and training of facilitators and program evaluation.

Given that researchers have recommended the use of evidence-based IPV interventions that align with the principles of RNR/PEI and take typology into account (Hilton & Ennis, 2020; Radatz & Wright, 2016; Scott et al., 2015; Stewart et al., 2013; Stewart et al., 2014), the present study sought to explore to what extent these principles are incorporated into IPV intervention programs in Saskatchewan.

Effectiveness of Interventions for IPV

Meta-analyses have shown that, overall, IPV intervention programs had a minimal effect on reoffending (e.g., Arias et al., 2013; Cheng et al., 2021; Travers et al., 2021; Wilson et al., 2021). These studies synthesize controlled studies of IPV interventions over a span of several years, including studies from the early days of IPV intervention programming. For example, Arias et al., 2013 included studies published from 1975 onward; Cheng et al., 2021 and Wilson et al., 2021 included studies published from 1986 onward. Travers et al. (2021) examined studies published between 2008 and 2020 to compare the effectiveness of interventions based in RNR versus "one-size-fits-all" formats. Researchers have stated the need for more primary research examining interventions that follow the principles of RNR (Travers et al., 2021) as well as for

research evaluating emerging approaches to IPV treatment (Wilson et al., 2021). It is also clear from these reviews that differences exist in recidivism as captured by police-reported data versus survivors' reports (Cheng et al., 2021; Wilson et al., 2021).

Evaluating the overall effectiveness of IPV interventions is challenging, however, given the wide range of programs offered for IPV treatment. Interventions differ in length, principles, and modalities (e.g., cognitive behavioural therapy [CBT], which focuses on treating unhelpful ways of thinking and learned patterns of unhelpful behaviour; psychoeducational interventions, including Duluth model programming that aims to alter patterns of power and control [Domestic Abuse Intervention Programs, 2017]; and narrative therapy that focuses on recognizing problematic thinking and behaviour and "re-authoring" new narratives for their lives [Augusta-Scott & Dankwort, 2002]) among various other factors.

One problem related to the apparent lack of success of IPV interventions is attrition or drop-out rates. For example, a meta-analysis by Olver and colleagues (2011) found considerably higher attrition rates among attendees of correctional IPV programs compared to sexual or general offender treatment programs within correctional facilities. Another reason for the disappointing rates of success among programs evaluated to date may be that none take typology of perpetrators into account (Cavanaugh & Gelles, 2005; Stewart et al., 2013; Stewart et al., 2014). Holtzworth-Munroe and Meehan (2004) suggested that characteristics related to typology (type of violence used, psychopathology, or personality disorder) may be significant predictors of treatment effectiveness. Specifically, they found that different types of people who used IPV were more likely to stay in treatment (family-only perpetrators) and to recidivate (generally violent/antisocial offenders) (Holtzworth-Munroe & Meehan, 2004). Therefore, it may be that

the treatment programs that have been evaluated do not work for some subtypes but would be effective for others.

Furthermore, it appears that the principles of RNR are not incorporated in many programs; Travers et al. (2021) noted "partial" adherence to the principles of RNR in the majority of studies included in their meta-analysis. Stewart and colleagues (2013) also highlighted reasons which relate to RNR for treatment programs' lack of impact on reductions in recidivism, including a lack of accounting for substance use and mental disorders and problems with the delivery of intervention programs (e.g., inconsistency).

Previous Surveys of IPV Intervention Programs

Two surveys of IPV intervention programs have been conducted in North America in the past decade: Heslop, Kelly, David, and Scott (2016) completed a comprehensive review of Canadian IPV intervention programs (including six from Saskatchewan), and Cannon, Hamel, Buttell, and Ferreira (2016) surveyed 238 IPV intervention programs in the US and Canada (one Saskatchewan program participated). Both of these reviews found that the majority of IPV interventions deliver evidence-based programs (most commonly CBT or Duluth Model) and offer group treatment, with individual programming offered in addition to group programs in some locations. IPV intervention programs typically cover content relating to recognizing and understanding abuse, including power/control tactics; the impact of abuse on victims; the impact of IPV on children; and skills such as communication, identifying and managing emotions, and conflict resolution. Heslop et al. (2016) and Cannon et al. (2016) noted that there is a great deal of variability in programs across the country and within regions. Despite this variability, it is generally not possible for participants to choose which type of program they want to attend; most

regions have few options, and different programming options reflect choices made by the agencies that deliver them.

The Present Study: A Survey of IPV Intervention Programs in Saskatchewan

Extant research indicates that there is diversity among IPV intervention programs in terms of theoretical approach, length, and composition (Cannon et al., 2016; Hamilton et al., 2013; Heslop et al., 2016; Scott et al., 2017). Given the considerable variability in treatment programs offered, there was a need to gain insight into the variety of intervention programs available in Saskatchewan, including the range of modalities and approaches used, to make recommendations for policy and practice and guide future research.

Previous reviews have been limited by a lack of information, given that details of many programs are not available online. The present study sought to build upon the review conducted by Heslop and colleagues (2016) by surveying all intervention programs offered in one geographic region, the province of Saskatchewan. The present study also sought to add to knowledge of IPV interventions by exploring facilitators' experience with and opinions regarding relevant factors from the research literature, including the principles of RNR, participant eligibility and readiness, program attrition and participant success, and types of perpetrators.

The project consisted of three steps: (1) an environmental scan of intervention programs in Saskatchewan for people who have used violence in an intimate relationship, (2) a survey of professionals who work at Saskatchewan's IPV intervention programs, and (3) one-on-one interviews with IPV intervention professionals. This article reports findings from the survey, which was conducted between August 2020 and January 2021. Through the survey, we sought to gather details of IPV intervention programs delivered in Saskatchewan, as well as facilitators'

experiences, with the goal of providing recommendations for future research, policy, and practice regarding interventions for people who use violence in their intimate relationships. Given the high rate of IPV in Saskatchewan and the unique context, including the proportion of the population that lives in rural areas, it is necessary to investigate strategies for reducing IPV recidivism in the province.

Method

Procedure

The study was approved by the University of Regina Research Ethics Board (2020-065). The first step of the project included an environmental scan of community-based (i.e., not delivered for individuals who are presently incarcerated) IPV intervention programs in Saskatchewan. The environmental scan included an internet search and connecting with professionals to find out what intervention programs they were aware of. Our environmental scan identified 15 unique programs for people who have perpetrated IPV in Saskatchewan. Two of these programs are delivered in multiple communities in the province. Prior to our environmental scan, there was no comprehensive listing of IPV interventions in the province. Many agencies that offer interventions for people who use violence do not list this service on their websites. Following the environmental scan, programs that had been identified were contacted by email with a request to participate in the survey.

Survey Design

The present study involved an online survey administered using Qualtrics survey software. The survey included both quantitative and qualitative questions. The survey was designed with a short and long version; after respondents completed the initial questions (the short version), they were asked if they wished to quit or continue answering more questions (the

long version). This was done to obtain as much information as possible about intervention programs in the province and include some qualitative questions relating to facilitators' experiences, acknowledging that busy professionals may be unable to take the time to answer all the questions in a longer survey. Over half (15 of 25 respondents) chose to complete the full survey. The short version contained 26 multiple choice or yes/no questions, 19 specific open-ended questions, and an additional five qualitative questions that asked participants to explain responses to quantitative questions or provide further detail if they wished. Participants that completed the long version responded to an additional 12 multiple choice, yes/no, or drag and drop questions, 11 specific open-ended questions, and two optional clarifying qualitative questions.

Respondents

IPV Intervention Professionals

Respondents to the survey totaled $N = 25$. Respondents included program leaders (52%; e.g., directors, clinical supervisors, managers, and program coordinators) and facilitators (56%). There is overlap between these categories, as two leaders also facilitated programs. These professionals worked for intervention programs housed in mental health, community corrections, community-based organizations, and an Indigenous tribal council. One respondent had worked at programs in various organizations. In total, respondents named 15 different programs that they had worked at, with some respondents listing multiple programs (including some that no longer operate). Three-quarters (75%) of respondents were currently employed at IPV intervention programs; the remainder indicated that they had left their positions between one and nine years ago.

IPV Intervention Programs

The respondents represented 11 unique programs (73% of all IPV programs currently offered in the province, identified in the environmental scan). Of these 11 programs, five (45%) were operated by mental health, one (9%) by community corrections, four by community-based organizations (36%), and one by an Indigenous tribal council (9%). Four programs were delivered in the province's two largest cities, with populations over 200,000. One program was delivered in a small city with a population of under 50,000. Two programs were delivered in communities with populations under 15,000. Another four programs were delivered in small towns or First Nations with populations under 2,500. One intervention was delivered one-on-one in three small communities. Additionally, one program was delivered in ten communities around the province, including the larger urban centres and small communities. Intervention programs do not only serve participants from the community where it is delivered; individuals who live in rural areas and smaller communities without IPV interventions travel to larger centres to attend.

Table 1 provides a summary of intervention program details and participant characteristics for the 11 participating programs that are currently available in the province.

Analysis

Descriptive statistics are displayed for quantitative questions, with numbers of respondents or programs and percentages of the sample displayed to provide an overview of characteristics of IPV intervention programs in Saskatchewan. When analyzing responses to questions that involved facilitators' opinions (e.g., "Do you feel your program is effective?"), responses for all 25 respondents are reported. When analyzing responses relating to characteristics of the program (e.g., "How are clients referred? (check all that apply)"), details

for the 11 unique programs that currently operate in the province are reported. Below, findings indicate if the number reported refers to respondents or programs.

One program had eight staff members respond, and two programs each had two staff respond; these responses were combined and counted as one response for questions relating to characteristics of the intervention. There were very few discrepancies among respondents. In the case of the program where eight staff responded, it was possible to discern agreement among most respondents. For programs where two staff responded, no areas of disagreement were identified.

The majority of open-ended questions asked participants to expand on or explain yes/no, or multiple-choice answers (for example: “Does your program communicate with the participant’s partner/ex-partner? (yes/no)” “If yes, please tell us more about how this is done”) or asked “Please tell us more if you would like” after quantitative questions to allow respondents the opportunity to provide additional detail. Data from qualitative questions were thematically coded using an open-coding method (Auerbach & Silverstein, 2003). Given the specific nature of these open-ended questions, the resulting codes were largely descriptive (Saldaña, 2014) (e.g., “successful completion,” “barriers to completion,” and “communication with participants’ partners”). Some of these qualitative responses are included to add context to the quantitative findings.

Findings

Intervention Program Characteristics

Table 1: Intervention Program and Participant Characteristics

Intervention Program/ Participant Characteristics	% (*n*)	Range (*M*, *SD*)
Intervention Program		
Referral sources		
Domestic Violence Court[1]	82 (9)	
Other court	82 (9)	
Other agencies	64 (7)	
Self-referrals	82 (9)	
Intervention housed in		
Mental health	40 (5)	
Community-based organization	36 (4)	
Community corrections	9 (1)	
Tribal council	9 (1)	
Risk assessment	55 (6)	
Risk assessment used[i]		
Ontario Domestic Assault Risk Assessment (ODARA)[2]	18 (2)	
Violence Risk Scale (VRS)[3]	9 (1)	
Spousal Assault Risk Assessment (SARA)[4]	18 (2)	
Saskatchewan Primary Risk Assessment (SPRA)[5]	9 (1)	
Risk assessment informs implementation of additional risk management and safety planning strategies *(n= 9)*	55 (6)	
Risk assessment used to assign individuals to appropriate intervention group *(n= 10)*	18 (2)	
Addresses perpetration of		
Physical violence	100 (11)	
Sexual violence	64 (7)	
Emotional/psychological violence	100 (11)	
Coercive control	82 (9)	
Informed by Principles of Risk-Need-Responsivity	36 (4)	
Program aims to meet participants' needs differently based on type of violence perpetrated, individual needs, or other factors	55 (6)	
Couples attend together	9 (1)	
Program communicates with participant's partner	55 (6)	
Intervention approach		
Cognitive-behavioural therapy (CBT)	64 (7)	
Narrative therapy	9 (1)	
Includes Indigenous cultural teachings	36 (4)	
Maximum group size *(n= 6)*		10- 18 (12.00, 3.10)
Intervention duration[ii]		
# of weeks *(n= 9)*		8- 52 (22.67, 17.24)
# of hours *(n= 8)*		20- 104 (51.25, 33.50)

[3] The Violence Risk Scale (VRS) is not specific to IPV and can be used to assess the risk posed by individuals who have used various types of violence. The VRS incorporates static and dynamic variables and can be used to identify treatment targets and assess treatment change (Wong & Gordon, 2000).

[4] The Spousal Assault Risk Assessment (SARA) is a 24-item structured professional judgment tool that includes the nature of IPV, perpetrator risk factors, and victim vulnerability factors (Kropp & Hart, 2016).

[5] The Saskatchewan Primary Risk Assessment (SPRA) is a 15-item assessment of general recidivism based on the principles of RNR (Patrick et al., 2013).

Intake		
Closed	36 (4)	
Continuous	18 (2)	
Maintenance program available	18 (2)	
Minimum level of education required to facilitate program *(n= 8)*		
Master's degree	18 (2)	
Bachelor's degree	36 (4)	
Diploma or certificate (1 or 2-year program)	9 (1)	
Combination education/ experience considered	9 (1)	
Factors relevant for assessing participants' engagement[iii]		
Regular attendance	100 (15)	
Homework	100 (15)	
Contributions to group discussion	93 (14)	
Self-reports of behaviour change	93 (14)	
Positive relationships with facilitator(s) (therapeutic alliance)	73 (11)	
Positive relationships with co-participants	73 (11)	
Participant		
Participant ethnicity		
Any ethnicity	82 (9)	
Indigenous	18 (2)	
Participant gender		
Men only	64 (7)	
Any gender	36 (4)	
Participant/ victim gender		
Men/ women victims	100 (11)	
Women/ men victims	45 (5)	
Same-sex relationships	64 (7)	
Drop-out rate[iv]		5%- 100% (40.88, 23.28)
	Total *n*= 11	

Notes: Responses include 11 programs, unless otherwise specified. [i] Five programs provided a response to the questions regarding risk assessment tools; one program uses both the ODARA and the SPRA. [il] One intervention program that participated in the survey only delivers programming to participants on a one-on-one basis; therefore, the length of treatment varies by individuals' needs. [iii] Fifteen respondents answered this question. [iv] Eighteen respondents representing 11 unique programs provided an estimate of drop-out rates.

Self-Referred vs. Mandated Clients

Nine of the 11 (82%) IPV interventions served both court-mandated and self-referred clients. All programs take participants referred by either a DVC or criminal court; two programs only admit participants referred by the court. Participants are also referred to some programs by other agencies (such as child protection services) (Table 1).

Participants' Gender and Ethnicity

All of the programs served men who had been violent to women that they were in intimate relationships with. Seven (64%) of the 11 programs only provided programming to men; the remainder were open to people of any gender. Seven (64%) had worked with people who

perpetrated IPV in same-sex relationships. One facilitator clarified that their program is available to women as well as men, but participants of different genders are not placed in the same group.

Two programs (18%) were specifically for Indigenous (First Nations or Métis) people; the remainder served clients of any ethnicity (Table 1). Other programs reported that the majority of their clients were Indigenous. There were no programs in Saskatchewan specific to other cultural groups.

Typology

Twenty-three respondents representing all eleven programs responded to a question asking if programs take typology[6] of perpetrators into consideration; four programs reported that typology is considered. Another question asked professionals if, in their opinion, different subtypes of people who perpetrate IPV engage in or benefit from interventions differently. Nearly three-quarters (73% of 22 who answered the question) stated that different types of perpetrators of IPV do engage in or benefit from interventions differently. Although there is no agreed-upon measure for classifying individuals by typology for the purpose of assignment to treatment conditions, five respondents explained in their qualitative responses that they gathered relevant information via clinical interviews or offence pattern analysis.

Qualitative responses also included discussions of the differences in the criminogenic needs of individuals who are only violent to intimate partners and those who are generally violent/antisocial, as well as between perpetrators of coercive controlling violence versus situational couple violence. One respondent noted the importance of "*appropriate screening before someone enters the program"* and of referring participants to IPV-specific interventions

[6] The question provided the following in brackets to help to clarify what was meant by typology: "For example: differences between coercive controlling abusers or people who perpetrate situational couple violence; differences between people who are violent in a variety of settings, versus those who are only violent to their intimate partner."

versus those for general violence. They added, *"situational violence is primarily about education and gaining information that they did not consider before. Individuals who have a pattern of controlling and [coercive] behaviours benefit from the group by having their belief system challenged. . ."*

Risk-Need-Responsivity

Fifteen respondents (71% of 21 who answered the question) representing five programs stated that they were familiar with the principles of RNR. Responses indicated that 36% of intervention programs were informed by the principles of RNR. Over half (55%) of intervention programs stated that they aim to meet participants' needs differently based on the type of violence enacted, individual needs, or other factors (Table 1).

Risk Assessment

Respondents from six programs (55% of 11) indicated that they use validated risk assessments; five of these stated that they conduct the risk assessment. The sixth, which serves clients court-mandated by the DVC, indicated that they receive a copy of the risk assessment with the referral. Not all of these programs use IPV-specific risk assessments; however, two programs use the ODARA, and one uses the SARA (Table 1). All the programs that use risk assessments indicated that this informs risk reduction strategies; two programs also used risk assessment scores to assign participants to the appropriate treatment group. Five of the six programs that use risk assessment indicated that they discuss the results of the risk assessment with the participant.

Individual Programming

One intervention program that participated in the survey delivers programming to participants solely on a one-on-one basis. In addition, six delivered one-on-one programming in

place of group treatment in specific circumstances: three for individuals who are unable to attend group sessions (for reasons such as distance or scheduling), three for individuals for whom group treatment would not be appropriate, and four offered individual treatment in addition to group programming to meet individuals' specific needs. One facilitator explained types of clients that may be offered individual interventions:

> *Our program is generally offered in group format; however, [it] is also offered on a one-to-one basis if clients require the support of one-to-one programming and if they are unable to function effectively in a group format. For example, generally antisocial subtypes of offenders who cannot build cohesion in a group setting may be offered the program on a one-to-one basis with the program facilitator. Borderline offenders with mental health issues such as anxiety may also be programmed individually to remove the stress of a group setting.*

Program Format

Intervention programs ranged from eight weeks to 52 weeks and from 20 hours to 104 hours (Table 1). Two interventions span 52 weeks; one of these delivered two-hour sessions twice per week for individuals assessed as high-risk, who complete the program in 26 weeks, and once weekly for medium-risk clients who complete the program over 52 weeks. Facilitators that delivered programming one-on-one had flexibility in the amount of time it took them to work through the program content with each client.

Six group interventions answered a question regarding intake: four groups were closed with the same cohort of participants moving through the program together; two allowed continuous intake. The maximum group size ranged from ten to eighteen participants (M= 12) (Table 1). Some programs reported that they had lowered the number of group members to six or eight to allow for physical distancing during COVID-19. Five (of the eight programs that answered the question) had a wait list at the time of the survey, indicating additional demand for IPV interventions.

Program Content

CBT is the most common modality employed. Of eight programs that provided a response to the question regarding intervention approach, seven programs are based on principles of CBT; two programs indicated they used CBT in combination with other approaches. One intervention employs narrative therapy. Four interventions indicated that Indigenous cultural teachings are incorporated in the program to some degree, and another indicated that guest speakers are invited to share cultural teachings. Two programs (18%) currently offer a maintenance program for participants to continue attending after completing the intervention (Table 1).

All of the IPV intervention programs (11, 100%) indicated that the perpetration of physical violence and emotional/psychological violence are addressed. Nine (82%) addressed coercive control, and seven (64%) addressed sexual violence. The majority of programs (10, 91%) are delivered solely for people who have used violence in their intimate relationship; at one program (9%), which is rooted in Indigenous teachings and philosophy, couples may attend together (Table 1).

Fifteen respondents answered a qualitative question that asked what they feel is most important for successful IPV interventions. Responses included: identification of warning signs and dynamics of IPV, exit and avoidance strategies, teaching alternative behaviours using CBT, identifying and addressing antisocial thinking and beliefs, creating relapse prevention plans, understanding the gendered nature of violence, motivation to change, acceptance of responsibility, and therapeutic alliance.

A “drag and drop” question asked participants to categorize 20 potential intervention targets as useful or not useful. Overall, the 15 respondents who answered this question agreed

that 17 of these items were beneficial areas to target. All participants agreed that identifying/managing emotions, identifying and challenging/changing jealousy and obsessive and controlling behaviour, communication skills, and substance use issues (referrals to treatment) were important targets. The majority of participants agreed that impulse control skills, anger management skills, identifying power/control tactics, conflict resolution skills, identifying the cycle of abuse, challenging beliefs that support violence, challenging or changing antisocial or irrational thoughts, challenging perceptions about gender roles, the impact of violence and abuse on victims, effects of violence on children, healing from past trauma, general self-awareness, and lack of prosocial activities (work, hobbies, friendships) were also useful treatment targets. Participants were equally divided on whether challenging misogynistic attitudes was useful or not useful. The majority agreed that self-esteem and life skills were not useful targets for IPV interventions.

Participants' Readiness and Engagement

Qualitative responses indicate that, at the majority of programs, participants' readiness to participate and their appropriateness for the group are assessed during intake interviews. Professionals who stated that they measured treatment readiness mentioned Motivational Interviewing[7] and the Transtheoretical Model[8].

Professionals expressed the importance of timely interventions; one specified that they had seen clients begin programming a year after the offence due to delays in the court process.

[7] Motivational Interviewing aims to increase clients' motivation through a process of supportive questioning, which helps to highlight discrepancies between the individual's goals and behaviour with the aim of increasing motivation to change (Rollnick & Allison, 2004).

[8] The Transtheoretical Model (Prochaska et al., 1992) is a five-stage model of treatment readiness, describing the individuals' level of awareness of the problem and openness to making change at each stage (precontemplation, contemplation, preparation, action, and maintenance).

This respondent stated that after this much time has elapsed, clients feel they are no longer in need of treatment and are less motivated to engage.

A "check all that apply" question asked respondents how they determine if participants are appropriately engaged in the intervention. Of the 15 professionals who answered, 100% found regular attendance and homework to be relevant factors. Contributions to group discussion, participants' self-reports of behaviour change, positive relationships with facilitator(s) (therapeutic alliance), and positive relationships with co-participants were also considered relevant (Table 1). When asked, in a qualitative question, how they encouraged participants' engagement in interventions, three professionals indicated that they use motivational interviewing, which was also mentioned in qualitative responses regarding assessing treatment readiness. Other answers included presenting clear guidelines, fostering a safe and respectful group environment, and explaining the benefits that attendees can expect through participation.

Facilitator Training

Seventeen of the 25 respondents provided qualitative responses indicating training required to facilitate their specific intervention, ranging from a week-long course to a five-week training program. In addition, respondents mentioned additional relevant training they had completed, such as classes in facilitation skills, motivational interviewing, narrative therapy, anger management, and other treatment approaches. Responses regarding the minimum level of education required to facilitate interventions varied: four (36%) of programs required a Bachelor's degree, two (18%) required a Master's degree, one (9%) required a diploma or certificate (1 or 2-year program), and another program (9%) stated that a combination education and experience was considered (Table 1).

Facilitator Gender

Six of the 11 programs indicated that two co-facilitators deliver the intervention; the remainder are delivered by a single facilitator. Fifteen of the 25 individual respondents answered a qualitative question that asked if the gender of facilitators was relevant to their program. Ten respondents noted that facilitators' gender is not relevant; three indicated that it is— two of these respondents' noted the importance of modeling respectful communications between men and women. Several respondents commented that the intervention is facilitated by whichever trained facilitators are available, regardless of gender. Two respondents indicated that they would prefer to have co-facilitators of mixed gender but are limited to the trained facilitators that are available.

Communication with Victims/Survivors

Six programs (55%) stated that they communicate with participants' partners (Table 1). In qualitative responses, some programs explained that they do not contact their clients' partners directly but ensure that they are referred to services for survivors of IPV. If they remain in contact, partners are able to provide valuable feedback on participants' behaviour while they are enrolled in intervention programs and if any subsequent use of violence and abuse has occurred. One facilitator from a community-based organization shared:

> *The facilitator reaches out confidentially to the partner or ex-partner by telephone. The purpose of this outreach is to inform the partner or ex-partner of community resources that can support her in a variety of ways. The other purpose is to receive feedback about possible behavioural changes on the part of her partner if she continues to have contact with him after any no-contact orders are lifted. This feedback sometimes helps inform the last session of group therapy . . . Finally, the feedback from the partner or ex-partner ensures that the victim's perspective is kept front and centre in the mind of the facilitator(s) to guide their work.*

Twenty-three respondents provided qualitative responses indicating their process (such as contacting police, connecting directly with victims, and informing support services that are

working directly with the survivor) if they feel that the participant poses a risk to a current or former partner.

Treatment Outcomes

Completion Rates

Respondents were asked how many participants, on average, begin the program each year and how many complete the program each year; combined, the 11 intervention programs serve approximately 215 clients per year, with an estimated 113 (53%) of these clients completing the programs. When asked to estimate the drop-out rate among participants in their program, 18 respondents representing 11 programs provided answers ranging from 5% to 100% (Table 1).

Successful Completion

An open-ended question asked respondents how they define participants' successful completion of the intervention. The most common responses involved attendance (e.g., completing all sessions, attending no less than 80-100% of sessions), active participation in group sessions, and completion of homework. Other indicators of successful completion included: a change in attitude and insight as observed by facilitators and articulated by participants (e.g., *"can articulate which of his beliefs and attitudes got him into trouble and how to re-think them*"), demonstration of applying acquired knowledge and skills in their life outside of the program, commitment to a violence-free lifestyle, development of empathy for victims/survivors, and awareness of their own warning signs; pre-and-post intervention assessment scores; continued obedience of conditions; and completion of probation.

Of course, successful completion of program requirements differs from successfully achieving the goals of the intervention (desisting from using violence in intimate relationships).

Therefore, another potential measure of success could be if participants are not charged for subsequent offences relating to IPV after participating in the intervention. Respondents were asked if their programs followed up to see if participants recidivated and, if so, how this was done. The staff of one program stated that they were able to check for subsequent offences via an electronic database that contains criminal charges and dispositions. A second program stated that they also followed up to see if participants committed another offence, but they did not specify how this was done. A facilitator from another intervention noted that they were aware of some participants' reoffences when they were referred to repeat the program. The remainder of the interventions did not have access to recidivism data and were unable to follow up to see if participants committed another IPV-related offence.

Barriers to Completion

In qualitative responses, respondents listed what they saw as potential barriers to participants' completion of the intervention. The first theme that emerged was geographic and logistical barriers, such as transportation (e.g., participants not having their own method of transportation, participants who lived outside of the urban center where the program was offered), childcare, ability to get time away from work or school to attend, and fear of job loss for taking time off. The second theme pertained to participants' lifestyles and choices, such as moving away from the community before completing the program, transient lifestyles, instability in living situations and housing, "*had jobs and did not want to tell employers about the charges and resulting probation,*" involvement with negative peers, mental health issues, substance use issues, and subsequent custodial sentences. The third theme that emerged related to responsivity issues such as cognitive or learning abilities as well as language and literacy barriers. Fourth, timelines created another barrier. In some cases, this was related to the expiry of sentences or

conditions. One respondent explained, *"The program is 26 weeks. By the time a participant is assessed, referred, and accepted, their sentence usually expires prior to completion. Not a true 'drop out.'"* Another respondent noted, *"It is difficult to retain client's attention and buy-in for that length of time, especially for medium risk clients [for whom] the program takes one year to complete."* The fifth theme related to participants' attitudes, including ability or willingness to accept responsibility, willingness to participate, readiness for treatment, and motivation.

Barriers to Delivery of IPV Intervention Programs

Fifteen respondents answered an open-ended question inquiring if there were any challenges that they or their agency experienced delivering effective IPV interventions; responses were, again, varied. Several respondents mentioned *"clients that are in the pre-contemplative stage of change,"* challenges with regular attendance, and a shortage of trained staff to deliver the intervention. Other comments included a shortage of available programming (noting wait lists and a lack of other intervention programs in the community to refer to) and sentence length (participants complete their sentence before the end of the intervention program—once the mandatory requirement is removed, participation stops). One respondent noted that the focus on high-risk participants results in a failure to provide adequate interventions for moderate and low-risk individuals. A facilitator from a community-based organization lamented a lack of consistent funding and noted that, at one point, the program was not delivered for nearly one year due to a lack of funding.

Measuring Effectiveness

Most programs represented in the survey results have not been evaluated; respondents from two programs stated that an evaluation had been conducted but that results were not publicly available. Two other programs are relatively new, and evaluations were in progress at

the time the survey was conducted. At most programs, professionals are only able to identify if participants successfully completed the program; they do not follow up to determine whether participants ceased perpetration of IPV.

Respondents were asked if they felt their program was effective. Sixty-seven percent (67%, 14 of 21 who answered the question) responded with "yes." The remainder (33%, 7) replied with "somewhat." In a qualitative comment, one respondent commented on the need for recidivism data—which their program was unable to obtain—to confirm if participants subsequently reduced their perpetration of IPV.

Survey responses also highlight a challenge relating to relying on participants' self-reports of IPV perpetration without corroborating information (such as recidivism data from official sources or reports from partners)—respondents were asked what percentage of the time, on average, they thought their clients were being truthful; responses ranged from 1%- 97% (M = 37.2%, SD= 24.1%).

Discussion

Twenty-five professionals representing 11 intervention programs for people who have perpetrated IPV completed the online survey. This study contributes to our knowledge of the characteristics of available IPV interventions in Saskatchewan and adds to a small body of literature surveying IPV intervention programs in Canada (Cannon et al., 2016; Heslop et al., 2016; Scott et al., 2017). This study also provides valuable insight into the experiences of professionals who facilitate IPV interventions, including their observations regarding successful interventions and barriers to completion of IPV interventions faced by participants.

Consistent with extant research (Cannon et al., 2016; Heslop et al., 2016), the results of the survey highlight diversity among IPV intervention programs. IPV interventions that

participated in the survey were delivered by mental health, community corrections, community-based organizations, and an Indigenous tribal council. Programs vary in approach and length (ranging from eight weeks to a full year). All of the interventions were delivered to men who had used violence in an intimate relationship (approximately one-third were available to people of any gender).

Although only one-third of programs indicated that they were informed by the principles of RNR, over half indicated that they aim to meet participants' needs differently based on the type of violence perpetrated, individual needs, or other factors. Over half of IPV intervention programs surveyed use risk assessment to inform risk management, risk reduction, and safety planning strategies.

A significant challenge in Saskatchewan is the rural nature of the province and the relatively small population. Many areas of the province do not have IPV intervention programming available, and the urban centers that do have interventions available generally only have a single program. Individuals who live in rural areas and smaller communities without IPV interventions must travel to larger centres to attend or simply do not have access.

It is challenging to make programs available to all people who have perpetrated IPV and accommodate participants' different risks, needs, and responsivity factors, and other relevant factors such as the inclusion of self-referred and mandated participants and the incorporation of Indigenous knowledge and cultural teachings. In small communities, there are often not enough participants to run groups regularly, and the population does not warrant offering programs for specific groups of people who have used violence (such as women, newcomers, or people from different language groups).

Six programs stated that they provide one-on-one programming in place of group interventions for individuals who are unable to attend group sessions (due to distance or scheduling), for individuals for whom group programming would not be appropriate, or in addition to group interventions to meet specific needs of individuals. Although IPV interventions are most often delivered in a group format, it is necessary to ensure that support and intervention are available in a timely fashion for people who use violence, regardless of where they live in the province. The ability to provide programming on an individual basis in person, as well as via technology, may help to meet the needs of people living in rural and remote communities, as well as those whose work schedule is a barrier to attendance or whose specific responsivity factors preclude them from being an appropriate fit for group treatment at the present time.

Recommendations for Policy and Practice

Previous research (Hilton & Ennis, 2020; Radatz & Wright, 2016; Scott, 2004) has indicated the need for IPV interventions that adhere to evidence-based practices, and researchers have made a case for the incorporation of principles of RNR/PEI into interventions for people who have perpetrated IPV (Connors et al., 2012; Hilton & Ennis, 2020; Radatz & Wright, 2016; Scott et al., 2015; Stewart et al., 2013). *We recommend the incorporation of principles of RNR/PEI into interventions for perpetrators of IPV in Saskatchewan*; doing so should increase consistency among interventions and increase the efficacy of interventions for people who have perpetrated IPV, as demonstrated by research (Andrews et al., 2006; Bonta & Andrews, 2017; Hilton & Ennis, 2020; Olver et al., 2011; Radatz & Wright, 2016).

Respondents noted the ways that timelines can impact successful outcomes for individuals who participate in interventions. For example, delays in the court system can mean that participants may begin programming a full year after their arrest for an incident of IPV. One

respondent noted that participants might be less motivated by this stage. They felt that offering interventions as soon as possible after an incident of violence would increase the likelihood of participants' engagement. Further, respondents noted that sentences can expire before mandated participants complete intervention programming, thus removing the impetus for them to continue attending. *Efforts must be made to reduce or eliminate delays for people who have perpetrated IPV to be referred to and begin interventions. Further, when intervention programming is mandated for someone who has been charged with an offence relating to IPV, sentences should not expire before this condition is met.*

A challenge for measuring the effectiveness of IPV interventions is that *successful completion* of the program is different from *successfully meeting the goals of the intervention*; that is, ceasing the perpetration of IPV and maintaining non-violence following completion of the intervention. David Mandel (2020) has stressed the importance of IPV intervention programs, courts, and other systems reporting and acknowledging meaningful changes, as opposed to simply assessing attendance and completion. Mandel (2020) proposed a three-point rubric for evaluating participant change after participation in IPV interventions: admitting to a meaningful portion of what they have done, demonstrating the ability to talk about the impact of IPV perpetration, and exhibiting relevant changes to their behavior pattern. Although some respondents indicated that they follow up with program participants, most programs do not currently collect follow-up data to see if participants are successfully integrating and applying what they learned in the intervention in their lives or, most importantly, if they have continued to use violence toward current or former partners. *We recommend that IPV interventions collect data upon completion of the intervention as well as longitudinal follow-up data to evaluate participant change.*

Educational requirements for facilitating IPV intervention programs varied across the province, as did facilitators' credentials. Of course, it is a challenge for professionals who live in rural, remote, and northern communities to access post-secondary education. Further, there is no specific degree or post-secondary course related to IPV—professionals tend to have education in the social sciences (social work, psychology, or justice studies) and gain additional skills through conferences or workshops. Several respondents in the present survey had been trained to facilitate their specific intervention programs; some had taken courses up to five weeks in length. *We recommend a standard foundational course be developed and made available to all professionals who facilitate interventions for IPV.* Such a course could include background on the dynamics and gendered nature of IPV; different types of IPV; training in specific treatment modalities, counseling approaches, and facilitation techniques; and training in specific skills, such as developing relapse prevention plans. Training would ensure a more consistent level of knowledge among all facilitators. Further, survey respondents indicated that there was a shortage of trained staff to deliver the intervention programming—the development and delivery of a training course may help to increase the number of available facilitators, therefore increasing the availability of interventions for people who use violence in intimate relationships.

Recommendations for Future Research

Although a small body of previous research has examined the effectiveness of intervention programming for people who have used violence in intimate relationships, this evidence is not necessarily applicable to all jurisdictions, including Saskatchewan. A challenge is that IPV programs vary significantly in terms of treatment approaches, content, length, and other factors. As such, more research is needed to determine if and how these variables impact

participants' experiences in IPV intervention programs (including engagement and attrition) and outcomes (such as reducing recidivism and desisting from the perpetration of IPV).

Relating to measuring meaningful change as well as program completion, intervention program staff reported that indicators of success include changes in participants' attitude and insight, pre- and post-intervention assessment scores, continued adherence to conditions, and completion of probation. Therefore, future research and evaluation of IPV interventions should take these various forms of data into account. Most programs are unable to access recidivism data contained in official records, including police reports (intervention programs delivered by the provincial government are able to access this data). Therefore, the majority of IPV interventions are unable to use recidivism as a measure of the effectiveness of the intervention. *We recommend that follow-up data be collected and analyzed to measure the impact of intervention program participation on IPV recidivism.* Further, we know that many incidents of IPV do not come to the attention of the police (Burczycka, 2016), and a lack of further police involvement does not necessarily mean that there has been no further violence. *We recommend that future research regarding IPV intervention programs include input from participants' partners (victims/survivors), as well as self-reports from participants and facilitators' assessments; doing so will provide the opportunity for a much more accurate assessment of the effectiveness of interventions.*

All IPV intervention programs receive referrals from courts; the majority also allow participants to self-refer. This may result in programs accepting participants of varying risk levels, as well as participants at different stages of change. Previous research (Cunha & Gonçalves, 2013; Hilton & Ennis, 2020; Lowenkamp & Latessa, 2004) has indicated potential risks of combining high and low-risk offenders in the same group. Research also indicates that

motivation levels and engagement during programming—and subsequent outcomes—may differ between self-referred and mandated participants (Bowen & Gilchrist, 2004). *More research is needed to explore the inclusion of mandated and self-referred participants in group IPV interventions.*

Nearly three-quarters of respondents felt that different types of people who perpetrate IPV engage in or benefit from interventions differently. Some programs explained how individual support can be provided in addition to group interventions to meet participants' specific risks, needs, and responsivity factors. In other interventions, *"everyone is placed in the same program regardless of risk level and the degree of the abuse."* In their qualitative responses, professionals noted differences between individuals who behave violently outside the family and those who confine their abuse to their intimate partner, as well as those who perpetrate coercive controlling violence versus situational couple violence. Despite previous research demonstrating the existence of different subtypes of men who perpetrate IPV (Ali et al., 2016; Cameranesi, 2016; Cunha & Gonçalves, 2013; Eckhardt et al., 2008; Ennis et al., 2017; Holtzworth-Munroe et al., 2000; Holtzworth-Munroe & Meehan, 2004; Huss & Ralston, 2008; Johnson, 2006; Loinaz, 2014; Thijssen & de Ruiter, 2011), there is no agreed-upon method for classifying perpetrators by typology in clinical settings, and thus, typology is not used to triage participants to different intervention programs or to bolster IPV interventions with individual support. *We recommend conducting research into intervention programming that takes typology into account; specifically, we recommend research to inform a practical way to connect typology to the principles of RNR/PEI, using this information to assign participants to appropriate IPV interventions.*

Maintenance programs provide an optional second step for participants who have completed intervention programming to connect with other group members and work on maintaining skills for non-violent behaviour. Two programs that responded to the survey offer a maintenance phase after participants complete the initial intervention program; others provide ongoing support and follow-up individually, as needed. There is little mention of maintenance programming in the extant research literature (Giesbrecht, 2018; Wangsgaard, 2000). *We recommend researching the efficacy of maintenance programming for improving participant outcomes, reducing recidivism, and maintaining non-violence in relationships.*

Two of the IPV intervention programs that participated in the survey were specifically for Indigenous people. Other interventions are open to people of any ethnicity but do incorporate Indigenous teachings. Research relating to interventions specifically for Indigenous men who have used violence in intimate relationships is limited, despite evidence of the effectiveness of cultural interventions for Indigenous people (specifically, survivors of violence and trauma) and a small body of research examining IPV interventions for participants from different cultural backgrounds (Emezue et al., 2021). *Research and evaluation of interventions that specifically serve Indigenous people who have used IPV will significantly add to the body of knowledge on evidence-based interventions.*

Most of the intervention programs represented in this survey have not been formally evaluated; however, two interventions indicated that program evaluations are currently in progress; these results will add to what we know regarding the effectiveness of IPV interventions, specifically unique models created in Saskatchewan.

Conclusion

This research adds to a small body of literature surveying IPV intervention programs in Canada and was the first step toward determining what interventions are currently available in Saskatchewan for people who have perpetrated IPV. This study provides insight into the characteristics of available interventions and the experiences of intervention facilitators and provides recommendations for policy and practice and future research. Additional research into the effectiveness of IPV interventions (including research that incorporates recidivism data) and examining differences in outcomes for different types of perpetrators is needed to build the evidence-base and improve the delivery of interventions for individuals who use violence against their partners.

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