Intervention Programs for Intimate Partner Violence: Insights from Professionals

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Abstract

This qualitative study explores available intimate partner violence (IPV) intervention programs offered in Saskatchewan, Canada, a province with a substantial rural population and a high rate of IPV. Given these unique circumstances, it was necessary to investigate what IPV interventions are currently available and if professionals who work at these programs feel these programs are effectively meeting the needs of men who have perpetrated IPV and working toward reducing rates of IPV in the province. Interview respondents represented IPV intervention programs based in mental health, community corrections, and community-based organizations. Taken together, information shared by the professionals who work at these IPV intervention programs provides an overview of the current state of intervention programs offered in Saskatchewan, including the extent to which interventions align with the Principles of Effective Intervention (PEI). Findings include differences in the delivery of IPV interventions in rural communities and highlight challenges in delivering group interventions for clients who perpetrate different types of IPV, have different criminogenic needs, and have varying levels of risk. Findings inform recommendations for policy and practice, including the need for training for IPV intervention professionals, increased public awareness about IPV interventions, and incorporation of the PEI. Findings also inform recommendations for research, including longitudinal evaluations of outcomes for participants from various programs that incorporate data from multiple sources.

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Introduction

The present study explores available intimate partner violence (IPV) intervention programs (also often referred to as batterer intervention programs, domestic violence perpetrator programs, or domestic violence treatment programs) offered in Saskatchewan, Canada. Nine professionals from different IPV intervention programs were interviewed. These professionals provided details of available interventions for perpetrators of IPV. They also provided insight into challenges working with diverse populations, delivering programming in rural, remote, and northern (RRN) communities, and offered suggestions for practice and evaluation/research to improve the delivery of interventions for people who have used violence in intimate relationships.

Saskatchewan Context

The Canadian province of Saskatchewan has a rural population over double the national average, with 35.6% of residents living outside a census metropolitan area (Statistics Canada, 2017). People who live in rural areas include those who live on farms or in small towns or First Nations. Sixteen percent (16.3%) of Saskatchewan's population is Indigenous, compared with under five percent (4.9%) Canada-wide (Statistics Canada, 2017). Over 9% of people in the province are employed in agriculture, forestry, fishing, and hunting, and nearly 4% work in resource extraction (Statistics Canada, 2017). These jobs typically require workers to live in areas far from urban centers; in some cases, employees live in camps during shifts and may be joined by their partners.

Saskatchewan's rate of IPV is over double the national average (724 police-reported victims per 100,000 population versus 344; Conroy, 2021). The majority of reported victims of IPV (80%) in the province are women (Conroy, 2021), while most of the perpetrators (81%) are men (Saskatchewan Ministry of Justice, 2017). The rate of IPV is notably higher in rural and Indigenous communities compared with other areas in Canada (Allen, 2020; Conroy, 2021).

Types of IPV

IPV includes a range of behaviors: physical, psychological, emotional, verbal, financial, sexual, and spiritual abuse; excessive jealousy and control; and harassment after separation (PATHS, 2018). Physical violence is more likely to be reported to the police than other forms of violence that are not offenses in Canada's *Criminal Code*. Therefore, it is probable that individuals who participate in IPV intervention programs in Saskatchewan have used physical violence, though they may have also engaged in other forms of IPV.

Since the 1970s, researchers have sought to classify perpetrators of IPV into typologies (For a review, see: Ali et al., 2016). The typology solution most commonly found in empirical studies includes a generally violent and antisocial individual with multiple criminogenic needs, a "family-only" perpetrator who confines their use of violence to their partner or partner and children, and a personality-disordered perpetrator (e.g., Holtzworth-Munroe et al., 2004). Another empirically-derived typology includes individuals who engage in coercive control, violent resistance, and situational couple violence, as well as a small fourth cluster of mutual violent control (Johnson, 2006). Tactics of coercive control include isolation, degradation, humiliation, and regulation and control of all the victim’s daily activities using surveillance, monitoring, and threats. In situational couple violence, by contrast, one or both partners are violent, but the violence is not based on dynamics of power and control. Rather, situational

couple violence is a pattern of arguments and conflict that escalate to violence (Johnson, 2006). However, 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 validated method for classifying perpetrators by typology. Consequently, typologies are not typically used to inform strategies for risk reduction, such as enrollment in violence intervention programs, or risk management strategies, such as supervision conditions.

Principles of Effective Intervention for IPV

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) guide interventions for offenders. The RNR Model and the PEI indicate that risk assessment should be used to determine who receives interventions (moderate and higher-risk individuals), determine treatment goals that impact criminogenic needs associated with recidivism, and deliver evidence-based (i.e., cognitive social learning) treatments (Andrews & Bonta, 2010; Radatz & Wright, 2016).

Researchers have discussed the utility of the principles of RNR/PEI for increasing the efficacy of IPV interventions (Hilton & Ennis, 2020; Stewart et al., 2014). A recent meta-analysis by Travers and colleagues (2021) showed that IPV interventions that adhered to the principles of RNR were effective for reducing recidivism. The authors note, however, that additional longitudinal research is needed to evaluate long-term outcomes.

Research with IPV Intervention Professionals

Surveys have been conducted to explore the characteristics of IPV intervention programs. Heslop et al. (2016) reviewed Canadian IPV intervention programs (including six from Saskatchewan), and Cannon et al. (2016) surveyed programs in the US and Canada (including

one Saskatchewan program). The findings of these surveys indicate that there is a great deal of variability in programs, both nationally and within states and provinces (Cannon et al., 2016; Heslop et al., 2016). Qualitative research adds context to information gleaned from surveys; however, few qualitative studies (e.g., Silvergleid & Mankowski, 2006; Morrison et al., 2021), have involved the professionals who work at IPV intervention programs as research participants. Professionals can provide insight into how IPV intervention programming is delivered, including differences between policy and practice, and can describe challenges and offer suggestions for improvements. They bring knowledge from years of professional experience and can provide rich examples from clients that they have worked with.

The Present Study

The project consisted of three steps: (1) an environmental scan of intervention programs in Saskatchewan, Canada for people who have perpetrated IPV, (2) a survey of professionals who work at Saskatchewan's IPV intervention programs (Giesbrecht et al., 2023), and (3) one-to-one interviews with IPV intervention professionals. This article reports the findings of the interviews.

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; Stewart et al., 2014), the present study sought to explore to what extent these principles are incorporated into IPV intervention programs in Saskatchewan. Further, the study sought to add additional context to the quantitative findings of the survey and gain further insight into the variety of intervention programs offered in Saskatchewan, including the range of modalities and approaches used, to inform recommendations and guide future research.

Method

The study was approved by the University of Regina Research Ethics Board (2020-065).

Recruitment

Our initial environmental scan identified 15 unique programs for people who have perpetrated IPV in Saskatchewan, two of which are delivered in multiple communities in the province. Following the environmental scan, programs that had been identified were contacted by email with a request to participate in the survey. A final question in the survey asked respondents to enter contact information (in a file termination survey, not linked to their survey responses) if they were interested in being contacted for an interview. Requests to participate in an interview were also sent directly to the staff of programs identified in the environmental scan via email.

Prior to participating in the interview, respondents signed and returned the consent form via email. Consent was also verbally reviewed prior to beginning the interview. The first author conducted a total of nine interviews using Zoom in December 2020 and January 2021.

Data Analysis

All interviews were audio recorded and transcribed verbatim. Coding involved two cycles. In the first cycle, three coders (second, third, and fourth authors) coded the nine interview transcripts, with each coder coding six transcripts. Each transcript was coded by two separate coders, with each pair of coders paired to code three transcripts each. An inductive, open coding approach (Benaquisto, 2008) with no preconceived codes was used. Most of the codes were descriptive (Miles et al., 2014).

In the second cycle, the first author read all uncoded transcripts and completed integrative coding (Benaquisto, 2008), integrating the codes generated by the three coders in the first cycle. The codes were consolidated into four broader themes: 1) IPV intervention program details (subthemes include, for example, length and format, using risk assessment to assign participants to treatment, and measuring the effectiveness of interventions), 2) IPV interventions in diverse

communities (including RRN and Indigenous communities), 3) IPV Intervention Program Participant Characteristics (including motivation and engagement, barriers, and different types of perpetrators and challenges in group interventions), and 4) challenges and potential improvements to IPV interventions. Following the second coding cycle, the three initial coders reviewed the themes and subthemes derived from the integrative process and provided input regarding selected quotations.

Participants

Interview respondents were nine professionals from different IPV intervention programs. These professionals worked for intervention programs located within mental health (managed by the health authority) (n= 4), community corrections (managed by the provincial government) (n= 3), and community-based non-profit organizations (n= 2) located from the far north to the south of the province. Some professionals had experience working at multiple programs. Years of experience ranged from eight to 24 years (M= 15.8, SD= 6.14). Seven participants were currently employed at intervention programs; two were retired (one had retired the previous year, another had retired three years prior to the interview) (Table 1).

Findings

IPV Intervention Program Details

Table 1. Respondent Experience and Intervention Program Characteristics

	% (*n*)	Range (*M*, *SD*)
Respondents' years of experience		8- 24 (15.8, 6.14)
Intervention program referral sources[i]		
Domestic Violence Court	86 (6)	
Other court	86 (6)	
Other agencies	71 (5)	
Self-referrals	71 (5)	
Intervention housed in[ii]		
Mental health	44 (4)	
Community corrections	33 (3)	
Community-based organization	22 (2)	
Intervention duration[iii]		
# of weeks		10-52 (22.8, 15.24)
# of hours		24-104 (45.0, 29.92)

Notes: [i] Reported for seven programs where respondents were currently working. [ii] Most recent agency where the nine respondents had worked; some had experience working for more than one intervention program. [iii] Reported for six of the programs where respondents were currently working; the seventh is provided solely on a one-to-one basis where length is variable, depending on clients' needs.

Facilitator Training and Collaboration

Overall, IPV professionals have a range of experience, education, and additional training. Some IPV interventions require facilitators to complete a training program to be certified to deliver the intervention (Giesbrecht et al., 2023). The professionals who participated in interviews for the present study had several years of experience—over 15 years, on average (Table 1).

Professionals expressed the need for specific training for facilitators, ongoing opportunities for learning. In the interviews, respondents stressed the importance of education for IPV intervention facilitators and other professionals who work with people who have used violence in relationships to understand the complex dynamics of IPV and to work effectively with different types of perpetrators, many with complex needs. Professionals also highlighted the need for expertise in working with coercive controlling perpetrators, recognizing the behavior, and encouraging accountability. One respondent stressed the importance of having training

available and training new facilitators to expand service and fill gaps as experienced facilitators retire. Another noted how programming had shifted from specialized IPV programming to more generalized violence programming in recent years:

> *"There's been a shift [toward] . . . not acknowledging the specific nature of domestic violence as a specific area of expertise that you need a background and knowledge base to be able to work with those offenders."*

Respondents also mentioned the importance of learning from and collaborating with other professionals at interagency meetings and conferences. Respondents noted that in the past, meetings of intervention program staff from different programs (including those delivered by community-based organizations, the health authority, or probation) would meet to discuss their work and current best practices. These meetings no longer take place, nor does cross-training that used to happen between these agencies; respondents expressed that they would like to have opportunities to connect with others who do this work. A *"provincial advisory group"* to investigate approaches to working with IPV was also suggested.

Intake

Respondents explained the importance of screening participants and assessing their risks and needs prior to beginning group interventions. Respondents also shared the need for screening for substance use and mental health disorders, stating that it is necessary for some participants to receive substance use and/or mental health treatment before they are able to engage in IPV programming. Depending on the severity of the problem, some participants can participate in these treatments concurrently, whereas others must work toward stability of their mental health and substance use before beginning IPV treatment.

One respondent explained that when conducting intake with potential clients, *"one of the big factors that we're assessing is the degree of responsibility or accountability;*" however, they

were willing to welcome participants who might not be taking responsibility, with the knowledge that this would be targeted in treatment. Another explained that their intake process sought information on different areas of clients' risks and needs, including:

> *"The history of domestic violence with partners, you look at family background, substance usage, suicide attempts, or any mental illness in families or anything they might have. With family history, I would try to pull out if there'd been a lot of history of domestic violence, if they grew up in domestic violence. I was also looking at . . . how they did in school because I was also looking for cognitive deficits and potentially FASD."*

At some programs, it was the facilitator that conducted screening and intake, at others, this was done by other staff within the agency.

Closed versus Continuous Intake

Respondents shared the benefits of both closed and continuous-intake formats. Respondents in communities with smaller populations shared that while a closed group format may work well in larger centers, they found that groups in rural communities tended to start with a smaller number of participants, leaving few participants after some dropped out. Further, closed intake meant that some participants would have to wait a significant amount of time for enough people to begin a new group. Another respondent shared how running an intervention with continuous intake allowed them to avoid having clients on a waitlist; participants completed the initial education portion of the program and began the treatment portion immediately after. Some respondents remarked that new individuals entering the group could make others less comfortable sharing until they got to know the new member. However, while group cohesion can be better in closed groups, open groups also provide the opportunity for longer-term participants to mentor newer attendees:

> *"Some of the guys that had been there for a while could then say to one of the new guys coming in, 'Well, you might want to look at this differently,' and that was helpful. So, there's. . . mentorship that could also occur."*

Group and Individual Interventions

Several respondents had experience delivering one-to-one programming. Respondents from rural areas shared they deliver the intervention on a one-to-one basis, as they do not have the population to run groups regularly, or their clients face work-related barriers that limit their ability to be involved in regular group interventions (e.g., they work in the resource extraction industry, which requires them to stay in camps for periods of time). In several intervention programs, individual sessions take place before the participant joins the group. Respondents stated that they observed better participation when they had worked with the client individually (in some cases, over a period of months) before they entered group treatment.

Program Content and Therapeutic Techniques

Cognitive-behavioral therapy (CBT) is the most common modality employed. Six of the professionals reported that their program is based on principles of CBT; three of these reported using CBT in combination with principles from the Duluth model. One program incorporated techniques from narrative therapy with CBT and Duluth model strategies. One intervention employs narrative therapy. One program was a process group that began with education and included check-ins on the topics covered each week.

Several programs begin with an educational component, beginning with definitions and explanations of the dynamics of IPV, and covering the stages of change and techniques for *"risk management, self-management."* Speaking of the importance of education about IPV, one respondent recalled: *"Many of the people that go through domestic violence [interventions] . . . would often say 'I didn't realize that I was being abusive.'"* Participants are often not aware that IPV is not "*just [physical] violence, there [is also] psychological and mental, financial, emotional [abuse].*" Respondents talked about addressing abusive behaviors that participants

may not have identified as a problem, such as jealousy, *"game-playing,"* and looking at messages on their partners' cell phones. Other topics covered included the power and control wheel, the cycle of violence, the impact of IPV on partners and children, healthy relationships, accountability, healthy and distorted thinking patterns, and cognitive-behavioral relapse prevention strategies.

Professionals described some of the techniques used in the intervention programs, including reviewing incidents of violence to assist participants in identifying thoughts and feelings immediately before their choice to use violence. Skills taught in groups included creating a time-out plan, working on *"differentiation between thoughts and feelings,"* and learning language to accurately communicate emotions. Respondents noted the importance of empathy and accountability and targeting beliefs and attitudes that perpetuate violence.

Some respondents noted that while they used the same program content for all participants in the intervention group, they could individualize the intervention based on participants' violent behaviors and readiness to change by addressing issues in individual sessions before entering group programming. Respondents spoke of the importance of flexibility to address things that came up for group participants:

> *"I also pay attention during check-ins to see what are some of the things people are talking about, and so I may come to the group with something planned to do as a teaching piece, but if out of the check-in I feel that it's important we have some conversation about something else, I'll do that. . . some groups there are themes around trust and jealousy, [others may need more on] parenting [or] the accountability and responsibility piece."*

Another respondent explained that participants report:

> *"the number one thing that they liked was the check-in, which is the thing at the beginning of the group where you go around and talk to them about how their weeks were. Because they said that they've never talked to other men like that. Ever. They can get quite emotional depending on what happened, so guys will see other guys crying, and being vulnerable, and talking about successes or things that went badly, and they've*

> *never had that before. So, they almost always say that the check-in was one of the most valuable things, and then after that, they say learning how to do a proper time-out and then some of the relationship skills."*

Professionals spoke of the importance of building rapport and establishing trust. Respondents described techniques that they employ to *"get them to look in the mirror, see what they see, and what impact [their behavior] is having."* They asked clients to reflect on *" what are you like to live with?. . . 'how could you be better, what could you work on?"* Respondents also explained that they talk to participants about the impact their behavior is having on their children.

Another essential skill for facilitators to have is the ability to challenge clients' erroneous thinking in a helpful manner:

> *"Every time they talked about a certain behavior, you had to keep challenging the behavior, challenging their thinking [...] For example, 'so what were you thinking when this happened?' and they'll tell you what they were thinking, and you say, 'okay, what brought about that thinking, and what can you do to change it?'"*

Another respondent would *"get them step-by-step to say: who are you now [and] what kind of person do you want to be?"* One facilitator described a simple question that they found helped their clients: *"If you are going to make a decision, is this healthy or unhealthy? Helpful or hurtful? Use those lenses [to view] anything you say or do.*"

Length and Format

IPV intervention programs ranged from ten weeks to one year (Table 1). Those that delivered programming one-to-one had flexibility in the amount of time it took them to work through the program content with each client. One respondent explained that they reserve the option to extend the number of sessions, as needed. Respondents had different views on the length, with some explaining the merits of both longer and shorter programs. They noted, however, a lack of empirical evidence for the ideal length of IPV interventions. One program in

Saskatchewan offers the same number of sessions over six months (twice per week) for moderate-risk individuals and over the course of a year (once per week) for higher-risk perpetrators.

Based on these interviews with professionals who work at Saskatchewan's IPV intervention programs, it appears the preferred format for IPV intervention includes: 1) individual sessions prior to joining an intervention group, 2) group-based IPV intervention programming, starting with education about IPV, and 3) follow-up (including one-to-one check-ins) and/or participation in a maintenance group.

Follow-Up and Maintenance

While respondents noted the merits of offering a maintenance program for participants to continue attending after completing the intervention, currently, only one intervention that participated in the present study offers a maintenance program. Others noted a lack of resources to deliver additional programming or a lack of previous participants who would be interested in returning for maintenance programming. A solution employed at one intervention program was to allow past participants to periodically drop into the regular intervention group. One respondent explained that while some clients' probation orders end during or immediately after the intervention, for many clients, remaining on probation offered an opportunity for ongoing follow-up.

COVID-19 & Technology

As interviews were conducted during the first year of the COVID-19 pandemic, respondents were asked how restrictions had impacted their practice or how they had incorporated technology. Following the declaration by the World Health Organization that COVID-19 was a global pandemic in March 2020, things changed rapidly. Intervention

programs, like many other services, had to react quickly, canceling or altering the delivery of in-person services.

One respondent recalled that they had to discontinue delivering their group program when they were three-quarters of the way through; following this, they met with participants one-to-one. Another respondent who delivered programming in a one-to-one format explained technological challenges that arose with the quick shift, including initial privacy concerns about the security of videoconferencing platforms and a lack of time to set up infrastructure for video conferencing (such as equipping staff with separate laptops). This respondent connected with their clients by telephone. They stated that phone calls worked well for some clients, who seemed to open up more easily on the phone. The same respondent noted that phone calls made support more accessible, especially in the rural area where the facilitators deliver services in several communities and clients often travel to the nearest urban center to participate. In an area of the province where many clients worked in the oil and gas sector, attending telephone sessions alleviated the need to take time off work. Some agencies were able to continue delivering interventions throughout the pandemic, adjusting the number of participants per group to allow for physical distancing.

Using Risk Assessment to Assign to Treatment

One program currently assigns medium and high-risk participants to different intervention groups, which vary in length. Another respondent stated that the program they previously worked at used risk assessment scores to assign participants to treatment conditions. Perpetrators deemed to pose the highest risk would be assigned to more intensive intervention and supervision conditions. One respondent shared that despite intentions to separate participants based on risk level, decision-making often defaulted to program availability:

> *"We were supposed to be putting medium-risk guys in the fourteen-week program. That was what we were supposed to be doing. It kind of morphed into you stuck them into whichever program had openings, which is not the best way."*

Communication with victims/survivors

Respondents indicated that programs have varying policies with respect to communication with participants' partners. While most do not directly reach out to survivors, they stated that they have connections with programs that support victims/survivors, and try to ensure that their clients' partners are connected with professionals at IPV shelters or services that can offer support and assistance with safety planning. Professionals noted the importance of good communication with the agencies supporting the survivor as well as with child protective services as, in the majority of cases, survivors and their children have continued contact with the partners/fathers who had perpetrated IPV. IPV intervention professionals will contact survivors, police, and/or other professionals, as necessary, when they feel that their client poses a threat to their current or former partner. Another respondent noted that, while working within the constraints of confidentiality, they had passed on relevant information to others working with the participant, including letting probation officers know if the individual had breached conditions of release or suggesting that an application for disclosure of information under Clare's Law[1] may be appropriate to inform new partners of the risk posed by the individual.

A community-based program explained that when participants are about 80% of the way through the program, *"we reach out to the ex-partners or current partners, and we ask them informally if they noticed any difference."* Another respondent spoke of involving men's families and also noted how the relapse plan can be shared with them to bolster accountability for the person who has used violence and safety for their family. Some respondents experienced participants' partners contacting them to share what was happening in the relationship.

Measuring Effectiveness

Respondents indicated that some of their programs used pre- and post-evaluations (though results of these evaluations are not publically available). Most programs do not follow up to see if participants cease perpetrating IPV; most programs are only able to identify if participants successfully completed the program. While several professionals noted the utility of assessing recidivism data collected by police, the majority of programs do not have access to this information. One respondent stated that simply counting if participants were referred back to the group was not sufficient for determining if the program was effective; more information, including follow-up with participants and partners, as well as police records, would be needed. They continued:

> *"Is this actually reducing recidivism? We don't know the answer to that question because we can't get access to the records that we really need. . . what some people have said is: 'well, we've hardly had any people come back into the program' or 'we've only had this number of people come back into the program,' but I said, 'that's not a measure of anything."*

Respondents expressed the need for rigorous evaluation research of Saskatchewan's IPV intervention programs, including longitudinal data from multiple sources.

IPV Interventions in Rural, Remote, and Northern and Indigenous Communities

There are many areas of the province that do not have IPV intervention programming or services for victims/survivors of violence, such as domestic violence shelters and counseling centers available. Some communities that have services available for victims/survivors do not have intervention programs for people who use violence; respondents lamented these service gaps. The communities that do have programming generally have only one type of program available, which may not be able to meet the needs of all perpetrators. In small communities, there are often not enough participants to run groups regularly, and the population does not

warrant offering programming for specific groups (such as women, newcomers, or people from different language groups). This is true across the province, but the disparity is especially glaring in RRN areas.

Respondents noted the high rates of IPV in Indigenous communities (Allen, 2020), citing the impact of colonization and residential schools. Some respondents noted that the vast majority of their clients were Indigenous (80% at one program, 90- 95% at another). While there are IPV interventions in Saskatchewan that are rooted in Indigenous teachings and delivered specifically for Indigenous people (Giesbrecht et al., 2023), the nine respondents in the present study facilitated programs that were designed for participants of any cultural background.

One respondent noted the differences in lifestyle in Indigenous communities in northern Saskatchewan compared with urban centers in the south. This professional explained that until the 1950s, community members did not stay in one location year-round but traveled to follow the caribou they hunted. Today, many northern Indigenous people hunt and trap to obtain food that their family and community members need to survive. The respondent explained that when they facilitated a program in a small urban center, they never would have considered it acceptable for a participant to take two months away from the group, but in the north:

> *"we have to be much more flexible in terms of 'yes, you can go on the trap line, [but] come back, hopefully.' If its them not eating and them coming to our program, we'll use Maslow's hierarchy— they can eat first."*

As previously mentioned, some respondents in RRN areas offered IPV interventions on an individual basis. This method also helped to meet the needs of clients who could not attend weekly sessions due to employment that required out-of-town travel, such as work on oil rigs or in mines, as well as Indigenous participants who secured food by spending time on the trap line during the winter.

Perceptions of confidentiality were a challenge for some RRN clients. A respondent explained, *"so many of the men I encountered, they didn't want their neighbors knowing what they're doing . . . people didn't want to disclose within the smaller, rural communities."* In rural communities, challenges also arose when individuals had connections to facilitators or fellow participants.

Respondents explained barriers to attending and completing IPV interventions that participants face, related to geography and poverty. One respondent who worked at a program where the majority of clients were Indigenous explained some of the challenges participants faced getting to the group:

> *"they're between [the city where the program is delivered] and different reserves, they don't tend to have stable homes. Transportation is an issue a lot of time. They don't have their own cars, they don't have licenses, they have to pay other people inordinate amounts of money to drive them to town—it can be a real issue.*"

The respondent continued on, explaining that some of these clients:

> *"live really chaotic lives. . . they're living in houses that are packed with people. They don't have regular income. A lot of them are unemployed. They've got family members scattered all over the place. They have children scattered in different places that they're trying to get to see and there's just lots of factors [that make it difficult for them to attend]."*

IPV Intervention Program Participant Characteristics

Motivation and Engagement

While all respondents noted participants are referred to their programs from Domestic Violence Court (DVC) or criminal court (i.e., court-mandated), five noted that they also accept self–referred clients (Table 1) but that these are rare. Respondents also clarified that participants who are not court-mandated to attend may be referred by other agencies (such as child protective services). One respondent said: *"Even voluntary people, sometimes they're not all that*

[responsive] as well. We sometimes say they're 'partner-mandated' or sometimes it's social services that is wanting them to seek out programming."

Participants spoke about differences in engagement among participants who self-refer and those who are mandated to attend the program.

> *"The mandated ones [are] harder to engage. You really had to [get some buy-in] before you put them into programming. . . . Whereas the [self-referred] clients are identifying 'well, I don't like what I did and I want to make changes.' They might not know what changes, but they came in with often a much different attitude than the mandated ones. Mandated ones are often, [for] the majority, fairly resistant . . ."*

Another respondent explained that participants mandated to attend the program delivered through community corrections had often had previous justice system involvement, had substance use issues, *"entrenched thinking,"* and were resistant to participating in interventions.

One respondent said that individuals who are mandated but not yet sentenced appear more motivated to make changes to their behavior compared with those who have already been sentenced. Further, some of the professionals who were interviewed stated that sentences or probation orders can expire before a participant completes intervention programming, thus removing the impetus for them to continue attending. Adjournments and delays within the court process can also delay perpetrators' engagement in IPV programing.

Relationships can influence motivation for some participants: *"If they're looking to stay in the relationship, perhaps there's that motivation that they need to make changes, and so there's motivation that goes beyond satisfying the court system."* Respondents also found that children were a motivating factor for many men.

Professionals discussed perpetrators' acceptance of responsibility when they begin group: *"Usually in the initial couple of sessions, you'll have the guys who plead not guilty who are sticking to their stories so to speak and saying 'it wasn't me, it was her,' but we pretty quickly*

work on that." Professionals explained that some participants would engage in the program almost immediately, others would become more engaged when a particular session resonated with them (a *"lightbulb"* moment), whereas for others:

> *"engagement was fairly minimal. The unfortunate part is sometimes we're kind of forced to keep them on because of mandates and stuff like that, but if they weren't causing any disruption in the group, we held on to them in the hope that maybe they would grab something in the end*."

The same respondent noted that some participants who entered saying *"the judge told me I had to be here"* ended up engaging positively in the program.

A respondent described the challenge of having clients at different stages of change in a group together:

> *"A lot of times we find that once people get into the group process, you do start to see some shift there . . . that's part of why I think I rarely turn people away. But at times, it is a bit of a double-edged sword because sometimes that shift doesn't happen when they're in the group and then it can negatively impact the group. So, that's that balance with the group setting—balancing the needs of the individual versus the overall health of the group."*

Different Types of Perpetrators and Challenges in Group Interventions

The majority of professionals in the study delivered interventions for men's IPV against women; some also had experience facilitating IPV interventions for women. While programs assess participants' risks and needs (including mental health and substance use issues) at intake, there is no available assessment for intervention programs to assess perpetrators of IPV regarding typology (though, as one respondent explained, *"once we get in the group, it usually becomes pretty obvious."*) Respondents provided examples of their work with different types of IPV perpetrators, including those who use situational couple violence or perpetrate coercive control or generally violent and antisocial individuals who have substantial criminogenic needs and engage in other forms of criminal behavior. Respondents also detailed challenges that arise

when participants of varying risk levels and typologies participate in group IPV interventions together.

A respondent clarified differences between IPV perpetrated as a means of controlling one's partner versus mutual abuse and conflict:

> *"sometimes there can be that confusion between anger management and treatment or a thought of, 'its alcohol. . . or its both people' and my thought is . . . in situations where the abusive behavior is part of a desire to control your partner, that's a different motivation and a different thing that needs to be changed.*"

One respondent explained that individuals who engage in situational couple violence seemed to be able to understand and apply the concepts from the program more easily than individuals who perpetrate coercive controlling abuse:

> *"A situation would come up, and then they were able to see within that situation how their thinking . . . impacted their behavior . . . and then they seemed to be able . . . [to recognize] how they were feeling and what the triggers were, that they were able to better deal with the situation whereas the more coercive ones . . . I would find that they would try to find ways to take the information you had given them to . . . coerce their partner to do what they want."*

Another respondent explained the challenges for facilitators working with coercive controlling perpetrators and the negative impact that these individuals can have on the group:

> *"In my opinion . . . people that use highly manipulative, game-playing, mind games and that . . . are doing a lot of the power and control, the different segments of the power and control wheel . . . There's intimidation, emotional abuse, isolation . . . it is very difficult putting them in a group because they know how to manipulate. . . they actually can undermine the effectiveness of the group . . . you can do some stuff one-on-one with them, but you have to be skilled in order to recognize the game they're playing, recognize the subtle ways that they're playing that game with you, and then hold them accountable."*

Respondents had experience working with participants with a variety of concurrent substance use, mental health concerns, and other needs (such as fetal alcohol spectrum disorders or acquired brain injuries), some of which created additional challenges for participation in IPV interventions. Participants also vary in terms of age—and related to age, the length of time that they have perpetrated IPV:

> *"Some of the perpetrators were highly resistant, and they didn't survive in group most of the time. The ones that were willing to attend and see what it's about, they were the ones that moved ahead. I found that the younger you caught them and the less perpetrating they had done, the easier it was to get them to maybe come to group and do the program. Whereas, some of the ones that were what I used to call the 'die-hard abusers,' it was very hard to get them to buy in a lot of times because it had been a way of life for them for so long."*

Respondents noted that when participants of varying risk levels participate in group interventions together, information shared tends to be targeted to higher risk individuals and may not resonate with younger and/or lower-risk participants. Professionals also described challenges that arise when perpetrators of different types participate in group interventions together:

> *"If you've got between 8-12 guys in a group and you've got 2 or 3 vocal, persistently resistant guys, it becomes increasingly harder for the group to actually move through not just the content, but the processing of the content. . . [If] you've got a couple of resistant participants, and you've got another participant who's one of those domestic terrorists. . . You're just about dead in the water. You end up having to kick somebody out of group.*"

The same respondent explained how they would have a conversation and try to encourage participation, removing participants from the group intervention only as a last resort. Another respondent explained that they always tried to find ways to encourage individuals to participate, *"but if it's just not working, we found that pulling them out of the group, we see an immediate benefit to the rest of the group."*

Additional Challenges and Potential Improvements to IPV Interventions

Respondents shared challenges they encountered in their work and offered suggestions for future directions. Professionals referenced the recommendations in Saskatchewan's Domestic Violence Death Review Report (Saskatchewan Ministry of Justice, 2018), including some that, to date, have not been implemented, and expressed the need for responses to IPV to be made a priority by various government sectors, including health.

Respondents expressed the need for research to inform practice. One respondent also noted the importance of researchers distinguishing perpetrators by type of violence and risk level, explaining that extant research that indicated high recidivism rates among men who had participated in IPV interventions "*wasn't putting these guys in the categories of high, low, and moderate risk . . . they were 'globbing' them all together and that was washing out the treatment effects."* In addition, professionals noted the need to explore, implement, and evaluate Indigenous approaches to working with people who use violence in relationships.

Funding is an ongoing challenge for many programs. While some programming is delivered by the provincial government or health authority, other programs are delivered by non-profit organizations. Some of these organizations do not receive consistent funding for the delivery of intervention programming and must continually apply for limited-time grant funding to maintain the program. Respondents noted not only the need for increased funding to expand the availability of interventions for people who use violence; they also mentioned the need for additional funding to support survivors.

Respondents stated that family court and social services should prioritize children's safety when making decisions regarding parenting time; fathers who perpetrate IPV should be required to attend IPV interventions and parenting programs.

Discussion

This study adds to knowledge on aspects of IPV intervention programs in Saskatchewan, Canada. Saskatchewan has a rate of IPV that is over double the national average (Conroy, 2021). Over one-third of the province's population lives outside a census metropolitan area, a rate that is also double the national average (Statistics Canada, 2017). Given these unique circumstances, it was necessary to investigate what IPV interventions are currently available and if professionals

who work at these programs feel these programs are effectively meeting the needs of men who have perpetrated IPV and working toward reducing rates of IPV in the province. This research was a necessary first step to inform future evaluation and research efforts. Interview respondents included nine professionals from different IPV intervention programs based in mental health, community corrections, and community-based organizations from the far north to the south of the province. These programs differ in length, delivery format, and funding models. Taken together, information shared by the professionals who work at these IPV intervention programs provides an overview of the current state of programming and differences among clients and communities.

Findings from this study provide insight into the format of IPV interventions delivered in the province and potential areas for improving practice, including in the areas of participant follow-up, program evaluation, and training for professionals. Findings from this study also highlight challenges in working with diverse clients who perpetrate different types of IPV and have varying levels of risk and treatment readiness. This study was one of the first to investigate delivery of IPV interventions in urban and rural communities in Canada.

Recommendations for Policy and Practice

The importance of specific knowledge and training related to IPV was noted by the majority of respondents. *We recommend the development of a standard foundational course for professionals who facilitate IPV interventions. This training should also be made available to others who work with perpetrators of IPV, such as probation officers. Continuing professional development opportunities should be offered regularly.* This training should be in line with the Fidelity principle, detailed by Radatz and Wright (2016), and should include training on different types of perpetrators of IPV, the principles of RNR/PEI, prediction (and prevention) of attrition,

risk assessment, and responsivity factors relevant for preventing IPV recidivism. Such training would ensure facilitators have up-to-date knowledge of current best practices and enhance consistency among intervention programs.

We recommend an awareness campaign that informs members of the public that IPV interventions are available and that people who are using violence (or experiencing challenges or conflict in their relationships) may self-refer to interventions, with the goal of preventing IPV from escalating and making intervention and support available earlier without a need for criminal justice system involvement. Respondents in the present study indicated that the majority of their clients are court-mandated, and it is rare for participants to self-refer; therefore, it will also be necessary for *public awareness efforts to de-stigmatize reaching out*.

All IPV intervention programs that participated in this study receive referrals from the courts; five also allow participants to self-refer. Respondents noted differences in motivation and engagement between court-mandated and self-referred clients. Respondents also noted other types of diverse individuals that may participate together in group interventions. These included: participants of varying risk levels, different types of perpetrators (such as generally violent and antisocial perpetrators with multiple criminogenic needs who posed a high recidivism risk, coercive controlling perpetrators who were highly manipulative, and lower-risk individuals with a less severe IPV history and fewer criminogenic needs), or participants who were psychopathic, or had serious mental health concerns or substance use issues. Findings of the present study indicate that it is difficult for facilitators to meet the needs of such diverse individuals in group programming and that facilitators felt disruptive participants negatively impacted the experiences of others. Further, extant research indicates that intervention outcomes may not be met when participants of varying risk levels, typology, and other factors attend together (Hilton & Ennis,

2020; Radatz & Wright, 2016). *We recommend the incorporation of the PEI into present interventions for perpetrators of IPV in Saskatchewan*. Specifically, we recommend using risk assessment to match individuals with appropriate treatment intensity, assessing criminogenic needs and targeting needs and risks associated with IPV recidivism, delivering structured, evidence-based cognitive-behavioral intervention while allowing for accommodations for individuals' learning styles and specific responsivity factors (Radatz & Wright, 2016). Maintenance programming could also provide ongoing support for some participants after completion of the intervention.

Recommendations for Future Research

Currently, most programs do not have the ability to follow up to determine if participants cease perpetration of IPV and are only able to identify if participants successfully completed the program. Professionals were clear on the difference between completion and success (that is, preventing future IPV recidivism), however, and offered suggestions for improving the evaluation of outcomes that include longitudinal data from multiple sources. There is substantial diversity among IPV intervention programs, both across the country (Heslop et al., 2016) and within the province, as demonstrated by the findings of the interviews in the present study, as well as the survey (Giesbrecht et al., 2023). As such, *it is necessary to evaluate Saskatchewan's various IPV intervention programs with regular outcome and process evaluations* (Radatz & Wright, 2016). *Interventions facilitated by different agencies (e.g., heath authorities, provincial government, non-profit community-based organizations, and Indigenous tribal councils) should include standardized elements in their evaluations, allowing results to be compared and analyzed together. Evaluations should include data collected pre- and post-intervention as well*

as longitudinal follow-up data from multiple sources (e.g., recidivism data, self-reports from participants, information from participants' partners, and facilitators' assessments).

Presently, there is no validated method of assessing people who use violence for typology, and thus, typology is not used to assign participants to different intervention programs or to bolster IPV interventions with individual support. *We recommend research to inform a practical way to assess participants for typology, in line with the PEI. Further, we recommend examining other variables (e.g., risk level, type of violence, self-referred versus mandated) as well as typology when assessing outcomes of IPV interventions to investigate potential differences in outcomes among different types of participants.*

During COVID-19, phone calls made support more accessible. Respondents suggested ways that telephone or online support could bolster intervention programming, especially in areas where facilitators or participants have to travel and when participants are working out of town. *We recommend evaluating outcomes for individuals who receive one-to-one IPV interventions* (instead of group interventions). Findings will inform the delivery of interventions for perpetrators of IPV who receive individual interventions, specifically those who live in RRN areas. It is also necessary to evaluate the use of individual interventions in conjunction with group programming to meet participants' specific responsivity needs. Another suggestion made by an interview participant was to deliver IPV interventions similar to telehealth, where clients in RRN areas come to a central location (such as a health center) to participate in a group intervention with a facilitator and co-participants in other communities. *We also recommend investigating and evaluating the use of technology (e.g., videoconferencing or telehealth) to deliver group sessions.*

Conclusion

This research provides insight into available interventions for people who have perpetrated IPV in Saskatchewan. Qualitative interviews with professionals who facilitate these IPV intervention programs add additional context to knowledge gained from a survey conducted in the province (Giesbrecht et al., 2023). This study adds to a small body of literature describing IPV intervention programs in North America (Cannon et al., 2016; Heslop et al., 2016) and is one of few qualitative studies involving professionals who facilitate IPV interventions (e.g., Silvergleid & Mankowski, 2006; Morrison et al., 2021), and the first conducted in Canada.

This study provides insight into the characteristics of available interventions and the experiences of IPV intervention professionals and provides recommendations for policy and practice and future research.

Notes

[1] The *Interpersonal Violence Disclosure Protocol (Clare's Law) Act* is provincial legislation that authorizes police to disclose information to current or potential intimate partners for the purpose of informing and protecting individuals who are at risk. "There are two routes to access Clare's Law: 1) 'Right to Ask,' triggered by a member of the public applying to a police service for a disclosure and 2) 'Right to Know,' triggered by the police service making a proactive decision to disclose information to protect a potential victim." "This legislation is not designed for individuals that are already in established relationships where abuse is occurring, as they already know they are at risk. Rather, it serves to interrupt the impact of repeat perpetrators of intimate partner violence by informing subsequent and/or potential partners of the risk posed by the individual they are becoming involved with" (PATHS, 2020).

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