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SUPPLEMENTAL MENTAL HEALTH TREATMENT FOR BATTERER PROGRAM PARTICIPANTS

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Abstract

An association between re-assault and mental health problems among batterer program participants has been increasingly documented by research and implied in batterer program guidelines. The majority of guidelines recommend assessment for such problems and referral to mental health treatment in addition to batterer program counseling. However, there is little documentation of assessment results and treatment outcomes. A research project was conducted to investigate the extent of mental health screening, referral compliance, and treatment effectiveness. The project included a formative evaluation of referral implementation, a service-delivery evaluation of the screening and referral, and an outcome evaluation of supplemental mental health treatment on batterer program completion and re-assault of the men's female partners. The *formative evaluation* exposed a few unexpected disruptive events and inconsistencies in referral procedures related in part to administrative turnover and differing priorities among agencies. The implementation modifications resulted in three stages of referral: voluntary referral, transitional referral, and mandatory referral.

The *service delivery evaluation* showed nearly half of the batterer program participants (N=479 of 1043) screened positive on the Brief Symptom Inventory (BSI) and were referred to a local mental health clinic. A concurrent validity test revealed a correlation of the BSI with a more comprehensive screening instrument and a briefer one (n=93), but the test-retest reliability of the BSI was low with a decrease in positive screens over time (n=98). There was also little association with the BSI subscale results and the clinical evaluations obtained by referred men (n=38), and nearly 40% of the clinical diagnoses were for an adjustment disorder not warranting further treatment. Only 30% of the referred men received an evaluation, and 20% obtained some treatment under mandatory referral. Interestingly, at least a third of the referred men acknowledged a need for treatment and was more likely to obtain treatment.

The *outcome evaluation*, based on a 12-month follow-up with female partners (65% response rate; n=308), produced no apparent effect of "intention to treat," represented by mandatory referral, on program completion or re-assault and other abuse indicators. (Re-arrests for violent and other types of crimes were substantially lower for the mandatory referrals in a confirmatory subsample of 300 subjects.) However, there was some preliminary evidence of a "dose response" for evaluated and treated men. Overall, the referral compliance was relatively low, but did increase under mandatory referral reinforced by a system-coordinator and case-manager. Sanctions for non-compliance remained inconsistent and may have affected referral compliance. The results reinforce recent studies exposing the challenges in establishing coordinated community response, and they question the utility of elaborate referral procedures for mental health referral. Alternatives might consider a more simplified referral or integrated services for self-identified problems.

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The author wishes to thank Candice Petrovich, Chief Executive Officer, and Mark Pudlowski, Chief Operating Officer of the Domestic Abuse Counseling Center (DACC), Pittsburgh, PA, for their assistance in developing and implementing the research project. Also, the DACC office manager, Jennifer Peterson, helped to coordinate the mental health screening at the batterer program and retrieved information on the program attendance and referral compliance. Several DACC counselors conducted the program intake and orientation that included the screening and referral of our research project: Marilyn Arter, Jill Allen Bradley, Joe Carse, and Mark Pudlowski. Jack Simmons, Chief Magistrate of the Pittsburgh Municipal Courts, guided the project's implementation in the courts and provided procedural advice during the course of the research. Marlene O'Leary, the intake coordinator and administrator for the outpatient clinic of Western Psychiatric Institute and Clinic (WPIC), played a key role in developing and administering the procedures for the mental health evaluation and treatment of the referred batterer program participants. Tad Santos offered similar assistance at the mental health clinic associated with Mon-Yough Community Services.

The research project was conducted through the Mid-Atlantic Addiction Training Institute (MAATI) based at Indiana University of Pennsylvania. Special appreciation goes to Crystal Deemer, MAATI Project Director and Administrative Assistant, for her supervision of the screening implementation, data collection, and follow-up interviews. Research assistants, Gayle Moyer, Vera Bonnet, and Tina Gray tracked and interviewed both the men and women in the study. Vera Bonnet also assumed the position of case-manager and system-coordinator during the mandatory referral stage. Nishant Bhattarai assisted ably with data management and analysis, and Megan Kensey worked on data entry and screening scores.

An expert group of researchers offered advice, counsel, and critique throughout the course of the research project and at periodic advisory committee meetings: Edward Mulvey, Director of the Law and Psychiatry Research Program, Western Psychiatric Institute and Clinic, University of Pittsburgh Medical Center; Chuck Lidz, Director of the Center for Mental Health Services Research, Department of Psychiatry, University of Massachusetts Medical School; and Jennifer Skeem, Professor of Psychology and Social Behavior, University of California, Irvine. Several practitioners also served on the advisory committee including Mark Pudlowski, DACC; Marlene O'Leary, WPIC; Lynn Hawker, Women's Center and Shelter of Pittsburgh; Heather Kelly, Assistant District Attorney; and Vera Bonnet and Crystal Deemer, MAATI.

The contributions of these individuals and many others behind the scenes, made this research project very much the result of an extensive team effort and one that represents a wide range of experience and knowledge.

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SUPPLEMENTAL MENTAL HEALTH TREATMENT FOR BATTERER PROGRAM PARTICIPANTS

EXECUTIVE SUMMARY

INTRODUCTION

The relationship between mental health problems and committing domestic violence is a controversial one. Some practitioners in the domestic violence field argue that domestic violence is, at worst, compounded by mental problems but not directly linked to them. Other clinicians assert that domestic violence is more directly linked to psychopathology, and mental problems need to be directly addressed to reduce the reoccurrence of violence. Research on participants in so-called "batterer programs" for domestic violence perpetrators shows men with evidence of psychopathology are more likely to re-assault their female partners, but no distinct profile of psychopathology has been identified. It may be that the psychopathology is directly linked to the violence or that the psychopathology makes perpetrators less responsive to batterer programs.

In either case, there is a growing acceptance that some batterer program participants may warrant supplemental treatment or assistance for mental health problems. The majority of state guidelines for batterer programs currently recommend that batterer program participants be assessed for mental health problems and referred to mental health treatment in addition to attending a batterer program. The guidelines, however, offer little detail on how such an assessment should be conducted, and the practice among batterer programs varies from no systematic assessment to individual clinical evaluations. The prevalence and nature of mental health problems among batterer program participants is, consequently, unclear. Different approaches to assessment using different criteria have produced a range of results. Moreover, there is no empirical evidence that referral for

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supplemental mental health treatment is effective in improving batterer program outcomes, and ultimately reducing re-assault.

We conducted a research project to examine the two key practical questions regarding mental health problems among batterer program participants. One, what is the result of assessing for mental health problems and the referral that might accompany it? Specifically, what is the nature and extent of the mental health problems identified in assessment, and what is the compliance and treatment obtained in response to the referral? The second key question has to do with the effectiveness of supplemental mental health treatment in improving batterer program outcomes. Of concern is the effect of referring men to mental health clinics for evaluation and treatment—that is, the "intention to treat,"—as well as the effect of men actually obtaining supplemental mental health treatment—the "dose response." We would expect intention-to-treat and dose-response to improve the outcomes of batterer program completion and the re-assault of one's female partner.

In response to several problems in conducting our research project, we also conducted a formative evaluation describing the implementation of assessment and referral. The evaluation examined, in particular, the impact of three unexpected events on the research design and several organization and structural issues among the collaborating agencies. In sum, our research project consisted of a formative evaluation of referral implementation, a "service delivery" evaluation of the results of assessment and referral, and an outcome evaluation of supplemental mental health treatment.

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REFERRAL IMPLEMENTATION

Screening and Referral Procedures

The research project was conducted in Pittsburgh, Pennsylvania, and investigated a set of assessment and referral procedures developed among the principle batterer program, domestic violence court, and mental health clinic in the area. The procedures were derived from a series of meetings among representatives from the collaborating agencies and from the lessons of a previous referral project that sent men to a variety of additional social services for educational, parenting, employment, and health needs. To assess batterer program participants for mental health problems, we chose the widely-used Brief Symptom Inventory (BSI). The BSI is a self-administered screening instrument focusing on recent symptoms of distress that are associated with active psychopathology. Its 53-items make the BSI a relatively short instrument to complete and well-suited for the time constraints of program intake. This screening approach to mental health assessment was selected also because of its efficiency and cost-effectiveness. Most batterer programs do not have the resources or staff to conduct individual clinical evaluation, and most rely on a group intake or orientation sessions to bring men into a program. The systematic screening was, moreover, a substantial enhancement at the research site, since mental health referrals were previously made haphazardly by the court based on evidence or testimony at a hearing, or by the batterer program based on staff observations in group sessions.

The screening and referral procedures started with the BSI being administered at program intake, along with the Alcohol Dependence Scale (ADS) and a background questionnaire. The ADS was used because of the high association between alcohol abuse and domestic violence, and because the ADS approximates what is considered a diagnosable mental health disorder neglected in the BSI, namely alcohol dependence and the possibility of a “dual disorder.” At the following orientation

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session, the program staff notified the men who screened positive on the BSI or ADS, according to the instrument guidelines, and referred them to one of two mental health clinics for an evaluation and possible treatment. The clinic faxed verification of the referral compliance to the batterer program, and a court liaison from the batterer program reported the compliance with the referral and the batterer program to the court at a court review of the case. The judges were to sanction the batterer program participant further if he was not compliant. We considered these procedures a "mandatory referral" to a mental health clinic in that the batterer program participant was *required* to comply with the mental health referral or receive further sanctions.

The research project was, however, implemented in three stages that established comparison groups for the outcome evaluation. The first stage was "voluntary referral" in which batterer program participants were screened and referred to a mental health clinic but without any requirement to comply or sanctions for non-compliance. This stage represented an "untreated" or quasi-control group for the "mandatory referral" group of batterer program participants. Few men complied with the referral or obtained treatment. In the second stage of "transitional referral," batterer program participants were required to comply with the mental health referral under threat of further sanctions, but inconsistencies in the mandatory procedures were exposed and modifications introduced. This stage illustrates the screening and referral results without systematic coordination and case-management that tend to be lacking in batterer intervention. Under the "mandatory referral" to a mental health clinic, the inconsistencies and breakdowns were largely eliminated through some modifications in procedures and the introduction of a system-coordinator and case-manager. This stage represented the "intention to treat" condition for the research project.

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Batterer Program and Mental Health Treatment

The collaborating batterer program is distinguished by its conventional counseling approach and close linkage to a domestic violence court. The program followed a gendered-based cognitive-behavioral curriculum that conforms to most state batterer program guidelines and the prevailing program models in the field. The domestic violence court conducts a preliminary hearing within a week of arrest, and sends male perpetrators to the batterer program for a minimum of 4 months of weekly group counseling sessions. After program intake and orientation sessions, the men are assigned to one of 20 on-going groups convening throughout the city. The program participation is required as a stipulation of bond and is reviewed periodically by the court. A failure to comply with the program requirements results in jailing, fines, or additional program sessions. Approximately, 10% of the batterer program participants are sent as a condition of probation after prosecution in the criminal courts for more severe aggravated assault or repeated violence offenses.

The mental health treatment was available at one of two mental health clinics affiliated with a major teaching and research hospital. Referrals from the batterer program received the established standard of care for adult outpatients. Upon contacting the clinic, the referred men were evaluated by a clinician, received a diagnosis, and were prescribed appropriate treatment. The treatment generally included up to 12 weeks of individual psychotherapy and the possibility of prescribed medication. Men receiving a dual diagnosis for alcohol dependence and a co-occurring disorder were generally treated in a specialized “dual-diagnosis” unit. An administrator from each clinic was involved in the development of the research project, received the contact calls from the referred men, and assisted with verification of their compliance.

The screening, referral, and treatment together represented an effort towards a “coordinated community response” in which community agencies, including the criminal justice system,

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collaborate in a way that reinforces and extends the initial intervention. Our research project, therefore, also provides a test of coordinated community response in terms of implementation and effectiveness.

RESEARCH DESIGN

The research project intended to evaluate the implementation and outcome of screening, referral, and treatment through the three mentioned components: a formative evaluation of implementation, a "service delivery" evaluation of screening and referral, and an outcome evaluation of mental health treatment. Each of these evaluations was conducted through a series of complementary studies with separate methodologies. The outcome evaluation was based on a quasi-experimental design comparing a subsample of men under a mandatory referral to those under a voluntary referral, and also men who actually obtained mental health treatment to those who were referred but untreated. The former comparison represents an "intention to treat" condition and the latter a "dose response" of treatment.

Formative Evaluation

The formative evaluation was based on direct observation of the screening and referral procedures, and training and supervisory meetings. The principal investigator and research assistant also conducted debriefing interviews with administrators, informal conversations with program staff, and discussions with an advisory committee of researchers and practitioners. The investigator and assistant compiled fieldnotes on these activities and periodically compared their summaries to develop conclusions. The main mode of analysis was to compare the conclusions regarding referral implementation to the procedures and protocols established by representatives from the collaborating

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agencies. In turn, we attempted to identify the inconsistencies and shortfalls of the implementation, as well as modifications to improve the referral over the course of the research project.

Service Delivery Evaluation

The service delivery evaluation was based on three related studies. First, the results of the screening procedures were assessed. The number and portion of those men screening positive was calculated from 1043 men entering the batterer program during 2004-2006. Also, the characteristics of the "positive" men who were subsequently referred (N=479) were compared to the men who screened negative and were not referred for supplemental mental health treatment. This comparison was to help describe and distinguish the referral sample.

Two, reliability and validity tests were conducted with the BSI screening instrument. These tests were in part a response to the unusually high portion of positive screens identified in the previous study. "Test-retest reliability" was examined by comparing the scorings on the initial BSI screening conducted at program intake to the BSI scorings administered at one month to five months later at either a program counseling session or follow-up interview with the men (n=98). "Concurrent validity" was examined by comparing scoring results of the BSI with two other screening instruments used to identify mental health problems and psychiatric disorders: the more comprehensive Psychiatric Diagnostic Screening Questionnaire (PDSQ) and the shorter Personality Assessment Screener (PAS). The instruments were administered to a subsample of 93 men following batterer counseling sessions at 7-10 weeks after program intake. We considered the "predictive validity" of the BSI as well. Cross-tabulations, logistic regressions, and receiver operating characteristics (ROC curves) were computed to determine the association of the nine BSI subscales and global index with batterer program completion and partner re-assault. (Re-assault was based on interviews with the

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men's female partners during a 12-month follow-up period, as explained further under "Outcome Evaluation" below.)

Three, compliance with the mental health screening was examined using three sources of data: case-management interviews conducted 3-4 weeks after program intake with the men referred under mandatory referral (n=33 interviewed), the 5-month follow-up debriefing interviews with the referred men (n=254 interviewed), and clinical records for all the men referred under the mandatory referral (n=148). The extent of compliance to scheduling an evaluation appointment, obtaining an evaluation, and receiving treatment was tabulated, along with the clinical diagnosis and treatment length. Also, the men's self-identified needs and symptoms, their expectations for treatment, and the benefits from treatment were summarized from the men's interview questions. Drawing on characteristics from the background questionnaires and BSI screening at program intake, we also attempted to identify predictors for referral compliance using logistic regressions.

Outcome Evaluation

The outcome evaluation was the most extensive and complex component of our research project. To determine the effectiveness of the "intention to treat," the batterer program outcomes were compared for the three referral stages (N=479), and to examine the effectiveness of a "dose response" to treatment—that is, actually receiving treatment—the outcomes were compared for a) the men who obtained an evaluation or received treatment and b) the men who did not comply to the referral under the mandatory referral stage (n=148). The comparisons were computed using cross-tabulations of the treatment condition with the outcomes, and confirmatory logistic regressions controlling for background characteristics (even though the characteristics across the comparison

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samples were equivalent). Re-arrests rates for a stratified random sample (n=300) were also analyzed as a further confirmation of the re-assault results.

The principal outcome measures were batterer program completion and re-assault during a 12-month follow-up period. "Batterer program completion" was derived from the computerized attendance records maintained by the batterer program with "completion" identified as satisfactorily attending the minimum requirement of 16 weekly sessions. "Re-assault" was measured as any physically aggressive tactic committed against one's female partner during the follow-up period. Several additional indicators of abuse were also used, including threats, severe re-assault, and the women's perception of overall well-being and safety. Research assistants interviewed the men's initial and new female partners by phone at program intake and every three months over the 12-month follow-up period. The response rate for the full 12-month follow-up was 65% (n=308 of 479).

RESULTS

Referral Implementation

Our formative evaluation identified three unexpected events that interrupted the initial experimental design and forced a modification to the quasi-experimental design of comparative subsamples. The district attorney objected to the random assignment of an experimental design because of a high-profile murder by a former batterer program participant. An administrative scandal at the batterer program led to the dismissal of the program director and assistant director under accusations of embezzlement and fraud. The "institutional review board" of the collaborating clinics questioned the ethics of withholding mental health treatment from some men who appeared to warrant it. These events exposed some of the "real world" circumstances that not only make experimental evaluation difficult, but also can interfere with community coordinated response.

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Batterer programs and program context remain vulnerable to administrative disruptions that are hard to anticipate.

We also identified inconsistencies and breakdowns associated with nearly every step of the screening and referral process. For example, some men were not properly notified about referral instructions because of staff or participant absences, and compliance verification from the clinics to the batterer program was sometimes not completed. Procedural modifications corrected these and other problems, but the court sanctions for non-compliance remained inconsistent even during the mandated referral stage. Several underlying issues contributing to the initial inconsistencies were also exposed. Of particular note were the administrative absenteeism and turnover, administrative-staff gaps, client overload, and differing agency priorities. These issues reinforce the challenges facing coordinated community response that have surfaced in other recent studies of batterer intervention implementation.

Service Delivery

The service delivery evaluation showed a substantially high portion of batterer program participants warranting a mental health referral according to screening criteria. However, a relatively low portion and perhaps exceptional group of these men received mental health treatment, even under mandatory referral. More specifically, over 40% screened positive on the BSI; scorings on the ADS and direct referral from judges increased the referrals to nearly 50%. The "positive" screens appeared more at risk for program dropout and re-assault than the negative screens, according to a comparison of background characteristics, and more in need of an expanded intervention. Only 30% of these men obtained an evaluation, and 20% of the referred men eventually received treatment under the mandatory referral. A portion of these "treated" men were already in treatment prior to the

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referral from the batterer program, and less than 5% of the referred men attended 10 or more treatment sessions.

These results translate into less than 10% of the total number of batterer program participants receiving supplemental mental health treatment. However, the portion of compliant men dramatically increased over voluntary referral with less than 7% complying (including men already in treatment). Interviews with the men also revealed an increase in compliance, especially following contact from a case-manager and after a few months from program intake. Enhanced implementation toward increased consistency, accountability and supervisions did appear to improve compliance, as it has with batterer program attendance.

The reliability and validity tests suggest that the small portion of treated men is not necessarily attributable to over-screening with the BSI. On the one hand, the BSI scorings were highly correlated to those with the PDSQ and PAS. On the other hand, those scoring positive on the BSI retest decreased substantially, but this may be related to a change in men's circumstances or lessons from the batterer program, according to interviews with the men. Moreover, the predictive validity of the BSI subscales was weak. The most disconcerting finding was that nearly 40% of the referred men who did receive a clinical diagnosis (n=38) were identified as having an adjustment disorder and did not warrant further treatment. The BSI subscales, such as depression, did not, as well, match with the clinical diagnoses.

Interestingly, the men reported a sharp decline in compliance across the referral steps from scheduling an appointment to attending treatment sessions. At the same time, at least a third of the batterer program participants initially indicated that they would benefit from mental health treatment, and identified symptoms that might warrant such treatment. These expectations did approach significance in a regression predicting compliance along with probation supervision and a protection

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order. The BSI scorings were not predictive of receiving treatment. The vast majority (86%) who did receive treatment reported that it was helpful to some or a great extent not only in reducing their symptoms but also in improving their batterer program attendance. Despite the low compliance overall, 88% of the men agreed that the mental health referrals should be continued.

Treatment Outcome

We found some tentative evidence that supplemental mental health treatment might improve batterer program outcomes. As for intention-to-treat, the completion rate for the referred men was only slightly lower than that for the men not warranting referral (57% vs. 62%), and the re-arrest rates were similar for the two groups (any crime: 23% vs. 29%) despite the expectation that the referred men would have poorer outcomes because of their additional problems. (Re-assault information was not obtained for the non-referred men.) Also, the re-assault rate of 32% during the 12-month follow-up did not significantly differ across the referral stages (e.g., voluntary and mandatory referral), nor did indicators for other forms of abuse or the women's well-being. The results for program completion and re-assault were confirmed in the logistic regressions controlling for background characteristics. The women's sense of safety and likelihood of being hit were, however, significantly lower during the mandatory referral stage, while re-arrests for violent crimes and crimes in general were 40% less likely during the mandatory stage compared to the voluntary.

Regarding dose-response, the men obtaining a clinical evaluation showed a statistically significant increase in batterer program completion (76% vs. 38%; $p<.05$), as did the treated men (68% vs. 45%; $p<.05$). The evaluated men also were a third less likely to re-assault their partners (22% vs. 31%; n.s.) as were the treated men (19% vs. 30%; n.s.), but these differences were not statistically significant with the small numbers of treated men. Other abuse indicators tended in the

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same direction for the evaluated men but were similar for the treated men. The re-assault tendency was confirmed when controlling for batterer program completion, and both the program completion and re-assault results were consistent when controlling for background characteristics.

In sum, while the intention-to-treat represented by the mandatory referral did not significantly improve outcome overall, the dose-response showed a substantial tendency in the expected direction. That is, men who obtained a mental health evaluation and men who received treatment were more likely to complete the batterer program and less likely to re-assault their female partners. This latter tendency must be viewed with extreme caution because it is not statistically significant and based on a very small number of compliant men under mandatory referral. It is, furthermore, likely to be confounded by motivational differences and other characteristics that were not controlled in the comparison between those men treated and not treated. Even if the apparent treatment effect were replicated in a controlled comparison, the effect size would be very small overall.

DISCUSSION

Screening and compliance for supplemental mental health treatment produced relatively low compliance even under a mandatory referral system. Some preliminary evidence did suggest that treatment was beneficial for the small portion of perhaps exceptional men who did receive it. The mandatory referral may not, however, be worth the additional layer of collaboration, cost, and staff to implement mandatory referral given the relatively small and still uncertain effect. This may especially be the case given that the relationship between mental health problems and batterer program outcomes remains in question, or at least complex.

At the same time, the substantial increase in compliance under mandated as opposed to voluntary referral is worthy of note. It suggests that coordinated community response helps to

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increase service delivery, but a system-coordinator and case-manager seem essential to establishing consistency in procedures. Our research project, however, confirms the challenges in implementing coordinated community response and the incomplete implementation even with extra resources and staff.

The referral compliance may have been increased if the mandatory referral were more completely implemented, namely with more consistency in the court response to non-compliance. The referral may also be more efficient and treatment more clearly effective under a different screening procedure--one that is more selective and considers the men's self-identified needs and motivation. We found, for instance, the men who saw some benefit in mental health treatment to be more likely to seek and receive it. Moreover, a simplified referral system would help reduce inconsistency in implementation and the progressive non-compliance over referral steps. Programs that integrate batterer counseling and mental health treatment are one possibility in this regard, but do raise the likelihood of additional costs and the diffusion of domestic violence education.

Interestingly, the BSI subscale for hostility was the most highly associated with negative outcomes, and resistant and uncooperative men were more likely to receive a "default" clinical diagnosis of adjustment disorder and not be recommended for treatment. This may in part represent a clash between criminal justice and mental health priorities and approaches. That is, the criminal justice system relies heavily on coercion and sanctions and the mental health clinics on voluntary and motivated help-seeking. The men with the most severe mental problems were, moreover, not necessarily the ones to receive treatment. In sum, the men most in need of expanded intervention may have avoided it. More obviously needs to be done to identify and contain those batterer program participants most at risk for re-assault and harming their partners.

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PART I: INTRODUCTION

A mounting movement within the domestic violence field is bringing more attention to the psychopathology of domestic violence offenders, commonly referred to as "batterers." With it has come controversy and even conflict over the role of mental health treatment for batterers between clinical psychologists and many battered women's advocates and batterer counselors working with them. The lead chapter of the book *Current Controversies on Family Violence* (O'Leary, 1993) outlines this controversy and concludes that psychopathology is often a compounding or reinforcing factor in a batterer's violence that warrants specific treatment. Moreover, a recent journal article accentuates the controversy with its severe criticism of conventional batterer programs' failure to adequately consider the psychological problems associated with violence (Dutton & Corvo, 2006). Two recent conferences, convened by battered women's advocates, illustrate the cautions in this regard. The Violence Against Women Office of the Illinois Coalition Against Domestic Violence held a critical conference in November 2002 entitled "The medicalization of domestic violence." National speakers from the domestic violence field raised questions about the utility of mental health treatment for batterers, as well as the consequence of mental health treatment for battered women. In October 2002, the Georgia state coalition sponsored a conference for its batterer program staff and counselors. A contentious debate emerged in the discussion and summary sessions over the role and effectiveness of mental health treatment for batterers.

There is at least some preliminary research suggesting that mental health disorders are associated with re-assault and more severe abuse by batterer program participants, as the *Controversies* chapter argues. Many state standards, moreover, require batterer programs to assess the mental health of program participants, but the assessment or treatment is vague for the most part.

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These standards typically indicate, however, that any mental health treatment must be in conjunction with batterer treatment and not a replacement for it. Moreover, batterer programs are increasingly developing their own assessment protocols and integrating treatment for mental health problems. There remains, however, a lack of empirical evaluations of the contribution of mental health treatment on batterer program outcomes. In sum, we need some indication of the mental health treatment that batterers might warrant, and of the effectiveness of such treatment in improving batterer program outcomes.

CONFLICTING VIEWPOINTS

CLINICAL PSYCHOLOGISTS

From the point of view of many clinical psychologists, domestic violence is related to psychopathology. If not an extension of psychopathology, it is at least substantially reinforced by it (see O'Leary, 1993; Dutton & Corvo, 2006). Individual psychopathology may, in fact, be the main reason that some men, living in similar social environments, are assaultive and others are not. The assumption appears to be that violence is compounded or reinforced by some underlying psychiatric disorder or problem. The intrapsychic pain of depression, for instance, may be expressed and perhaps eased in a violent outburst, or the misperceptions of paranoia or delusions might contribute to conflict and aggression. Such disorders could be a reaction to childhood trauma, attachment issues, or borderline tendencies that have been ascribed to many batterer program participants (e.g., Dutton, 1998; Stosny, 1995).

In this view, violence avoidance techniques taught in conventional cognitive-behavioral counseling are insufficient, and the confrontation of social sanctions and personal responsibility could exacerbate underlying emotional pain and frustration. Some clinical psychologists working in the

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domestic violence field have recommended, therefore, more of a psychodynamic approach to batterer counseling in order to address the underlying mental health issues (e.g., Dutton, 1998; Stosny, 1995). More generally, there is a call to systematically assess the mental health needs of batterers and refer them accordingly to supplemental treatments that may include individual psychotherapy or addiction treatment (e.g., O'Leary, 1993; Stordeur & Stille, 1989). Having, at minimum, the batterer counseling focused on behavior seems a basic safety precaution, and even the more psycho-dynamic approaches in batterer programs include those. The overall assumption is that addressing the psychopathology of batterers will reduce the men's violence and lower other forms of abuse as well.

BATTERED WOMEN'S ADVOCATES

Battered women's advocates and victim rights proponents tend to view domestic violence as rooted primarily in learned or socialized behavior and reinforced by cultural norms (Yllo, 1993). Domestic violence is, more specifically, an extension of the "power and control" that men tend to exert over women in our society. Advocates have consequently pressed for decisive criminal justice sanctions to domestic violence offenders that would "teach" them that violence is not acceptable, as well as help contain them from continued violence. This sort of response has been expressed in mandatory arrests for domestic violence and full-prosecution to hold batterers accountable for their behavior. It has resulted as well in a gender-based cognitive-behavioral model of group counseling for batterers that attempts basically to help men "learn" alternatives to violence (see Pence & Paymar, 1993).

Battered women's advocates tend, therefore, to view psychopathology not only as secondary to violence, but also as a possible distraction from the real issues (Bancroft, 2002). They believe that the focus needs to be on the social acceptance and reinforcements of violence and on men's

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rationalizations and justifications for domestic violence (e.g., Russell, 1995). Psychopathology, from this point of view, inadvertently diverts us from the social action that holds individual men accountable. It may even reinforce the years of excusing domestic violence as peculiar to an exceptional subgroup of deviants. Advocates also draw on experience and documentation that mental health services have tended to neglect violence and safety issues in the course of treatment, as studies of mental health treatment have shown (see Gondolf, 1998). Moreover, psychopathology would warrant a more central role for clinical psychologists in the assessment and treatment of domestic violence, and possibly displace the experience and input of battered women's advocates.

INTEGRATIVE APPROACH

A more integrative approach to batterer intervention and batterer programs is also emerging within the field (e.g., Hamberger, 2002; Pettit & Smith, 2002). Researchers and practitioners alike are accepting a more multi-faceted view of domestic violence and the need for a more comprehensive intervention, as a recent review article on the trends in batterer programs promotes (Mederos, 2002). What might be termed "conventional" batterer programs are increasingly identifying and addressing mental health, substance abuse, and childhood trauma issues (Gondolf, in press-b). A national conference on batterer intervention, "From Roots to Wings: The Future of Batterer Intervention," openly confirmed the need to broaden the cognitive-behavioral focus of batterer programs and asserted it as the current direction (Dearborn, Michigan, in November 2006; see www.biscmi.org/documents/biscmi10thconference.html).

There is admittedly a diversity of ways and positions on how best to accomplish this more integrative approach, and the degree of attention and resources it warrants. Some batterer programs require an extensive individual evaluation for each man that enters batterer group counseling; others

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rely on a group screening and observation to identify men that may warrant additional services and supervision. In some domestic violence courts, psychological and substance abuse evaluations are ordered by the court based on the circumstances of the case, and men must complete the evaluations in addition to the batterer program. Men identified with additional problems may be referred to mental health clinics for supplemental treatment, treated in separate sessions by batterer program staff, or given special attention within the batterer group counseling.

Conflicts in orientation and emphasis still beset the field, but these may represent more the extremes rather than the emerging convergence (see for example, Dutton & Corvo, 2006). The experience and observations of this researcher are that the differences are historically rooted. Conventional batterer programs were developed largely in response to a societal critique and safety concerns of battered women's advocates often in contradistinction to clinical psychologists and family therapists who were viewed as neglecting violence against women. The evolution toward a coordinated community response has brought cross-training and service collaborations that have helped to bridge a variety of services and perspectives (Pence & Shepard, 1999). There is little research or evaluation, however, that demonstrates the implementation and effectiveness of the integration, especially in terms of addressing the mental health problems of domestic violence perpetrators.

PREVIOUS RESEARCH

MENTAL DISORDERS AND VIOLENCE

A long line of research with community and general population samples has shown a higher incidence of violence among those with mental health disorders. The inference of some researchers and clinicians is, therefore, that we can expect a high prevalence of mental health disorders among

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clinical samples of domestic violence perpetrators (e.g., Dutton & Corvo, 2006). As early as 1986, Bland and Orn (1986) assessed a random sample of an adult urban population (n=1200) using the Diagnostic and Statistical Interview Schedule and found that those with one of three major diagnostic categories (i.e., antisocial personality, major depression, alcohol dependence) were twice as like to have abused a family or nonfamily member in the previous year than those adults without a diagnosis. Other researchers have shown that the mentally ill do not pose a high risk in absolute terms. Only about 7% of those with major mental disorders (but without substance abuse) engage in any assaultive behavior in a given year (Swanson, 1994), and only about 20% of those who heavily drink in a given year (Kantor & Straus, 1987).

More recent evidence from longitudinal population studies indicates, however, that family violence is associated with a broad array of psychological and social factors during one's childhood and adolescent development (Ehrensaft, Moffitt, & Caspi, 2004; Moffitt, Caspi, Rutter, & Silva, 2001). Additionally, studies drawing on the National Comorbidity Survey have shown that a fairly stable portion of the population shows evidence of a mental health disorder—about 30% and only about a third of these receive some form of treatment. Recently, psychiatric researchers have identified intermittent explosive disorder (IED) as responsible for the violence of as much as 30% of domestic violence perpetrators (Kessler, Coccaro, & Fava, 2007). Conventional cognitive-behavioral batterer programs may, however, be appropriate and adequate for IED (Gondolf, 2006).

Some fundamental issues make it difficult, however, to extend findings from general population samples to clinical samples (e.g., men in a batterer program). Only about 1-2% of those men who are physically aggressive toward their partners within a year are arrested and sent to a batterer program (based on estimates from Tjaden & Thoennes, 2000). This small percentage is not necessarily representative of the general population, especially given the social factors related to

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severe violence and being arrested. Moreover, the relationship of mental disorders to violence is a complex one, as psychiatric studies with violent patients have shown (e.g., Monahan et al., 2001). The violence may be "associated" with a certain disorder or merely a "complication" of it. We are left, therefore, with the practical question of whether the prevailing cognitive behavioral batterer programs adequately or effectively reduce the violence of men with mental health problems, and whether supplemental treatment that specifically addresses the additional problems is warranted.

MENTAL DISORDERS AND BATTERERS

There has been a substantial amount of research investigating the personality and psychological characteristics of batterers. Several of these studies have used the Millon Clinical Multiaxial Inventory (Millon, 1994) to identify psychopathology among batterers (i.e., DSM-IV Axis I disorders or DSM-IV Axis II disorders). This research suggests a substantial prevalence of major disorders and their association with batterer program dropout and re-assault (Hamberger & Hastings, 1991; Hamberger et al., 1996; Gondolf, 1999b). Other research addressing distinguishing personality traits, batterer types, and risk assessment have also indirectly raised questions about psychopathology (e.g., Dutton, 1998; Holtzworth-Munroe & Stuart, 1994). The two most violent batterer types, for instance, are in part differentiated by depressive/compulsive and narcissistic/antisocial tendencies. The prevailing risk assessment instruments (i.e., SARA and DA) include indicators for major depression and thought disorder, or at least suicidal threats and attempts (see Dutton & Kropp, 2000; Roehl & Guertin, 2000).

A few of these studies specifically indicate a high prevalence of psychopathology (i.e., DSM-IV Axis I disorders or DSM-IV Axis II disorders) among batterer program participants (Hamberger et al., 1996; Gondolf, 1999b). According to studies with the MCMI-I, as much as 40% of men entering

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programs show evidence of psychopathology, much of which might be expressed in the form of personality tendencies or disorders (Hamberger & Hastings, 1991; Hamberger et al., 1996). The vast majority of the personality disorders, according to the MCMI interpretative manuals (Choca & Van Denburg, 1997), would most appropriately be addressed by highly structured cognitive-behavioral treatment much like those commonly used in batterer counseling (White & Gondolf, 2000). In our previous studies with the MCMI-III, a quarter of the men in four cities (N=854) appeared to have Axis I disorders (i.e., the MCMI "clinical syndromes" or "severe syndromes"), excluding alcohol dependence and anxiety disorders, and as much as 40% had evidence of an Axis I disorder when anxiety disorder and alcohol or drug dependence were included (Gondolf, 1999b). The main limitation with this line of research is that the MCMI generates profiles of a variety of personality dimensions that may approximate DSM-IV disorders but do not directly match them. The MCMI is not a DSM-IV diagnostic tool in itself.

The question remains whether the mental health disorders are related to re-assault and especially to continuous or extremely harmful assaults. Batterer program completion (of a minimum of 3 months) is substantially lower among men appearing to have an Axis I disorder on the MCMI (49% vs. 67%; $X^2[1]=9.93$; $p>.001$). Those with severe pathology are also a third more likely to re-assault their partners (29% vs. 41%; $X^2[1]=7.96$; $p>.01$), and twice as likely to repeatedly re-assault during the 15-month follow-up (8% vs. 17%; $X^2[1]=9.93$; $p>.01$). We used a specialized regression model (i.e., Generalized Estimating Equations) to control for demographics and previous behavior, and to account for program dropout and longitudinal measures. In this analysis, severe psychopathology doubled the risk of re-assault during the follow-up (Jones & Gondolf, 2001). The only other significant predictor, among demographic, behavioral, and other personality measures, was a history of non-domestic violence arrest. In a multinomial logistic regression for multiple outcomes

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including repeated re-assault; none of the personality, mental health variables, or various classifications of batterer types were significant predictors of re-assault or repeated re-assault (Heckert & Gondolf, 2005). This finding leaves questions about the impact of mental health disorders on severe re-assault, but does not deny the possibility that the effects of psychopathology might be indirect, as mediated by conditional factors, in some underlying causal model.

The most striking finding in the longitudinal analysis was that drunkenness during the follow-up was the most influential predictor of re-assault, increasing the likelihood of re-assault by four (Jones & Gondolf, 2001). Men who were drunk on almost a daily basis, according to their partner's reports, were 16 times more likely to re-assault. Measures of drinking frequency and alcohol dependenceat program intake were not significantly associated with the re-assault outcome (e.g., Michigan Alcohol Screening Test, Selzer, 1971; MAST>4). Alcohol and drug treatment in the previous follow-up interval reduced the probability of re-assault by roughly 30-40%, although this effect was not statistically significant at conventional levels. The failure of this effect to achieve statistical significance might be due in part to insufficient measurement, since the treatment measure did not account for extent or nature of treatment.

The alcohol finding suggests that severe addiction, which is unresponsive to treatment, should be of great concern to batterer programs. At least 45% of these cases were compounded with co-occurring Axis I diagnoses according to the MCMI. A three-way cross-tabulation (re-assault x drunkenness during follow-up x Axis I disorder on the MCMI) shows that these "dual-diagnosis" cases were four times more likely to commit severe re-assault (according to the Conflict Tactics Scale; Straus, 1979), as opposed to twice as likely if drunk without an Axis 1 disorder. The trend in the alcohol treatment field has been to separate dual-diagnosis cases for specialized treatment since they tend to be unresponsive to conventional addiction treatment and exhibit problematic behavior.

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The multi-site evaluation of patient-matching funded by the National Institute of Alcoholism and Alcohol Abuse (NIAAA; Project MATCH, 1997), for instance, found that the addiction patients with "severe psychiatric disorders" did not perform well in any of the 16 treatments being tested.

TREATMENT REFERRAL

Across the country, state standards for batterer programs have raised the issue of mental health problems but are generally vague on how they should be addressed. Our review of the batterer program standards available on-line (www.biscmi.org) showed that 89% of the 36 states currently with standards recommend some consideration of mental health problems during program intake. This mention varied from formally assessing psychiatric disorders or mental health status (49% of the states) to merely noting psychiatric or mental health history (35%). However, only 59% of the state standards specifically designate a treatment response to these problems, and that varies from screening out men with severe disorders to referral to mental health clinics. There is a prohibition or caution against mental health treatment in place of batterer counseling throughout the standards.

A few states, such as Florida and Washington, do require an individual psychological assessment for all men convicted of domestic violence and concurrent mental health treatment when appropriate. The prevailing problem here is that referrals are not consistently made, treatments vary widely, and compliance is not monitored. There is no unified summation of the clinical diagnoses and prescribed treatments applied to court-ordered batterers. Moreover, the apparent inconsistency of, and non-compliance to, mental health treatment makes it difficult to assess treatment utility and impact. The contribution, if any, to batterer counseling outcomes and the safety of women, more specifically, remains undocumented and unclear. The controversy over mental health treatment intensifies without some empirical basis to sort out the assumptions and claims. It is especially

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important to address mental health disorders if they are related to batterer program outcomes, as the previous, albeit limited, research suggests.

RESEARCH QUESTIONS

The first and most fundamental need is to implement and assess a screening and referral process for supplemental mental health treatment—that is, mental health evaluation and prescribed treatment in addition to attending a batterer counseling or educational program. This step would begin to address the minimum recommendation of state standards and also pose a middle-ground response to the controversy regarding mental health treatment for domestic violence. What portion of batterer program participants would warrant referral under conventional screening protocols? What is the nature of their mental health symptoms, problems, or disorders? What is the men's response in terms of referral compliance and treatment received? In sum, what are the results of screening and referral in terms of "service delivery"?

A second and more crucial need is to test the effectiveness of supplemental mental health treatment. Does it improve batterer program outcomes in terms of reducing program dropout and re-assaults of one's female partner? What is the additive effect to conventional batterer programming both in terms of the intention-to-treat and actually receiving treatment (i.e., dose-response)? In other words, does screening and referral improve outcomes (i.e., intention-to-treat), and, if not, is there evidence that doing more to ensure treatment produces an improvement (i.e., dose-response). It would also be helpful to determine which men are the most responsive to such treatment—what screening scorings or clinical diagnoses are associated with receiving treatment and improved outcomes?

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Research on these questions might initially address psychopathology, or mental health problems, in terms of DSM-IV Axis I disorders (e.g., major depression, bipolar, delusional, posttraumatic stress, anxiety disorders), including dual-diagnosed addiction. Axis II personality disorders may also be of concern but the most prevalent of these disorders among batterer program participants (i.e., antisocial, narcissistic, and passive-aggressive disorders) are generally prescribed the kind of structured, cognitive-behavioral counseling used in the majority of batterer programs (Rice, 1997; White & Gondolf, 2000). Moreover, some clinical researchers suggest that many of the extremely antisocial men are unresponsive to counseling in general, and typically do not comply to batterer counseling, let alone supplemental mental health treatment (Dutton, 1998; Jacobson & Gottman, 1998). The focus on Axis I disorders, therefore, would treat those most in need of additional treatment and most likely to benefit from it.

The effort to screen, refer and treat batterer program participants for mental health problems represents, moreover, an answer to the call for "coordinated community response" in the domestic violence field (e.g., Pence & Shepard, 1999). Coordinated community response refers to the collaboration and cooperation among social services and agencies in a way that expands and reinforces intervention in domestic violence cases. The sanctions and oversight from particularly the criminal courts—what is often referred to as "accountability"—assume a central component of this sort of response. They help to coerce especially resistant batterers to comply with service referrals and to contain men who are not responsive to the intervention. Research on supplemental mental health treatment might, therefore, be considered a test of coordinated community response as well as of treatment effectiveness by itself.

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PART II: RESEARCH METHODS

RESEARCH DESIGN

To answer these basic questions, we conducted a research project on the "service delivery" of screening and referring batterer program participants to mental health treatment, and on the outcomes of receiving such treatment. We first assessed the "service delivery" in terms of the portion of men who screened positive for referral, the characteristics and profiles of the referred men, the extent and nature of their compliance to referral, and the men's response to referral. Our initial findings also led us to examine the validity and reliability of the screening and possible alternatives to the screening approach. Moreover, we encountered inconsistencies and breakdowns in the referral process that prompted a formative evaluation to better understand the implementation of referral and help qualify and interpret the outcome evaluation.

Secondly, we conducted the outcome evaluation by comparing the batterer program completion and re-assaults against one's female partner for three subsequently recruited subsamples of referred program participants: 1) a subsample of men voluntarily referred to supplemental health treatment which represented a "no-treatment" or quasi-control group, 2) a subsample of men under a mandatory referral, including oversight from a case-manager which represented the "experimental" or treated group, and 3) a subsample of men referred during a transitional period in which the mandatory referral was not consistently implemented or enforced. As our implementation demonstrated, only a very small portion of men referred on a voluntary basis (i.e., with no court sanctions or consequences if they did not comply) received treatment, or even made an appointment for a clinical evaluation. The transitional subsample, moreover, enabled us to consider the service delivery and outcome over a gradation of referral implementation and requirements. This subsample

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also is likely to represent the "real world" conditions of most batterer program referral, where the ideal extent and consistency of a court-supported mandate is not feasible.

We initially planned an experimental evaluation comparing the outcomes of conventional batterer counseling supplemented with mental health treatment to batterer counseling alone. Batterer program participants who screened positive for referral were to be randomly assigned to the two treatment options. If properly implemented, this design would provide a controlled test of the effectiveness of supplemental mental health treatment, or at least the *intention* to treat the men assigned to it. For reasons discussed in "Part III: Formative Evaluation," this design was replaced by the quasi-experimental design comparing three subsamples sequentially recruited as more stringent referral requirements were established.

Our sample of referred program participants was drawn from the population of court-ordered men to 16 weeks of required batterer counseling in Pittsburgh (N=1043). Over a two year period beginning in 2004, 479 men were positively screened for mental health problems at batterer program intake, and referred to one of two collaborating mental health clinics for an evaluation and appropriate treatment. For the assessment of service delivery, the screening results were tabulated, a debriefing interview was conducted with the men, information was collected during the case-management during the mandatory referral, and clinical records were obtained from the mental health clinics. For the outcome evaluation, the men's female partners were interviewed by phone at program intake and every three months over a 12-month follow-up in order to determined the extent of re-assault. Batterer program completion was determined from computerized attendance records available from the program.

This research project actually represents a series of studies addressing the overall objectives. Each study is therefore separately presented in two parts summarizing the results: "Part IV: Screening

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and Referral" that focuses on the service delivery, and "Part V: Batterer Program Outcome" that examines the impact or effectiveness of the supplemental mental health treatment. These parts include the rationale, methods, and results of each study, rather than this methods section compile all the separate studies together. We believe that the results of the studies are easier to assess when they directly follow the methods that produce them. The results of the separate studies are then summarized, integrated, and qualified in "Part VI: Summary and Discussion." Qualifications, implications, and recommendations conclude that final part.

In this part of the report, the setting of the research project is described along with the referral system being investigated. This description of setting and system enables a comparison to other intervention programs and systems that might indicate their representativeness, as well as exposes features or components that might help in interpreting the outcomes. The procedures for subject recruitment are also outlined and the methods for the outcome evaluation are discussed in some detail. The outcome evaluation is the most extensive and complex study within the overall research project. It involves a series of follow-up interviews with the female partners of the batterer program participants to assess the outcome in terms of re-assault. Also, the analysis of the relationship of supplemental treatment to batterer program outcome requires some elaboration and is therefore presented below.

SETTING

BATTERER COUNSELING PROGRAM

The setting for the research project was the Domestic Abuse Counseling Center (DACC) in Pittsburgh, Pennsylvania. DACC offers weekly sessions of 1½ hours to groups of 13-15 men for a required duration of 16 weeks. A staff counselor follows a primarily instructional or didactic

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approach that conforms to the gender-based cognitive-behavioral curriculum prevalent in the field (e.g., Pence & Paymar, 1993; Stordeur & Stille, 1989), and consistent with most state program guidelines (Austin & Dankworth, 1999). A structured curriculum is presented in a manual available on-line and on CD-rom, and monitored bi-monthly by a clinical director. The main topics include the nature and impact of abuse, the consequences and costs of abuse, taking responsibility for one's abuse, ways to avoid abusive behavior, and beliefs and attitudes that sustain abusive behavior.

Program involvement begins with a group intake session at one of four locations across the city. Program staff collects necessary background information from the men, review the program and its policies, and present abuse and violence avoidance skills. The following week is an orientation session at the same location. The staff further discusses the avoidance skills and program expectations, and then assigns each man to one of 20 counseling groups nearest his home. A weekly fee is set on a sliding scale ($5-$50 per session; 37%<$20; 32%=$20; 31%>$20). Two unexcused absences, delinquent payments, or an arrest for re-assault result in the man's dismissal from the program and his return to court.

The participants are ordered to the batterer program at a preliminary hearing in a specialized domestic violence court as part of a bond stipulation. The court procedures ensure a "swift and certain" response to domestic violence arrests. Not only are the men in court within 10 days of arrest, but they are also subject to periodic oversight from the court. The men must demonstrate compliance to the batterer program at a court review hearing 30 days after the initial referral and again at 90 days. The program office staff compiles reports of non-compliant men and presents them to the court via a program court liaison. The court liaison is present at each court session to receive men ordered to the batterer program and present compliance information for participants under review. The court issues bench warrants and additional sanctions (i.e., fines, extended counseling, jailing) to the non-

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compliant men. This "judicial oversight" is in contrast to the slow and uncertain response of the vast majority of probation offices to non-compliance (see Gondolf, 1999b). In addition, approximately 10% of the batterer program participants are sent to the program by the city probation office. These are men who were forwarded to a higher criminal court because of severe violence or previous offenses.

The batterer program has been evaluated extensively, showing an effect in reducing the rate of re-assault over court intervention only. As part of a prior multi-site evaluation, "instrumental variable" structural equations and propensity scores were used to identify a moderate "program effect"—program completion reduced the likelihood of re-assault by 50% (Gondolf & Jones, 2001). Also, a previous comparative evaluation showed that the three-month Pittsburgh batterer counseling was as effective as longer six-month and nine-month programs with similar curriculum approaches (Gondolf, 1999b). This equivalent effectiveness was in terms of re-assault, calls to the police, the women's perception of safety, and the women's quality of life.[1] (The Pittsburgh program is currently four-months in length.)

MENTAL HEALTH OUTPATIENT CLINICS

The mental health treatment was provided by one of two outpatient clinics affiliated with the University of Pittsburgh Medical Center (UPMC). Western Psychiatric Institute and Clinic (WPIC), a branch of UPMC, administers and coordinates these clinics. WPIC is a large, urban teaching hospital, known internationally as a research and clinical center on the cutting edge of psychiatric care. The two clinics provide general outpatient services, as well as specialized services for patients with co-occurring Axis I and substance use disorders. The clinics' relationship to a university research hospital helped to ensure that the treatments followed the prevailing standards of the field and were