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Edward W. Gondolf

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# Implementing Mental Health Treatment for Batterer Program Participants

## Interagency Breakdowns and Underlying Issues

Edward W. Gondolf

*Indiana University of Pennsylvania*

The implementation of a screening and referral system for supplemental mental health treatment among batterer program participants was investigated in a 2-year formative evaluation. The research team conducted direct observation of the agency procedures, participation in training and supervision meetings, debriefing interviews with administrators, and informal conversations with staff and clients. Inconsistencies and breakdowns associated with nearly every step of the screening and referral process were identified, for example, notification of referral instructions and verification of clinical compliance. Court sanctions for referral noncompliance remained inconsistent even during court-mandated referral. Several underlying issues were also exposed: administrative absenteeism and turnover, administrative-staff gaps, client overload, and differing agency priorities. These issues reinforce the challenges facing coordinated community response.

**Keywords:** *batterers; evaluation; mental health; supplemental treatment*

Domestic violence courts and so-called batterer counseling programs are increasingly referring domestic violence offenders for supplemental treatment that specifically addresses mental health and addiction problems (Mederos, 2002). The referrals for supplemental treatment follow recommendations in the majority of state standards and guidelines for batterer programs and the efforts toward collaboration of services with a community coordinated response (Pence & Shepard, 1999). Increased cross training, screening, and collaborations of services have made such referral more feasible. A recent study of enhanced collaboration showed an increase in service referral and delivery to perpetrators and victims in domestic violence cases, albeit with an uncertain impact on the reduction of violence overall (Harrell, Newmark, Visher, & Castro, 2006).

Recent surveys, evaluations, and audits of collaboration of services under the ideal of a “community coordinated response” indicate implementation problems (California State Audit, 2006; Labriola, Rempel, O’Sullivan, & Frank, 2007; Visher, Newmark, & Harrell, 2006). Probation and court response to noncompliance batterer

programs, reporting of noncompliance or heightened risk across agencies, and referrals for additional services and treatment are often inconsistent and ineffective. A recent study of screening and referral for additional needs and problems of batterer program participants found that few men complied with the referrals despite phone follow-up from the batterer program (Gondolf, 2008a). When men did comply, they found parenting, employment, educational, psychological, and alcohol treatment programs had long waiting lists, services not suited for their problems, and staff who were not familiar with domestic violence cases or simply insufficient in number. For instance, employment programs turned referrals over to computer modules for information on job searches and had few jobs actually available for the skill level of the batterer program referrals.

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Despite the continued call for referral to supplemental treatments and services, little direction on how to achieve it exists. A few articles have been published on domestic violence councils that are designed to help develop collaboration of services particularly between the criminal justice system and battered women services (Allen, 2006; Allen, Watt, & Hess, 2008). A few articles interestingly expose the lack of referral from alcohol treatment, psychiatric emergency rooms, and general hospitals to domestic violence services (Schumacher, Fals-Stewart, & Leonard, 2003). No clear directions, maps, or guides have been developed on how to achieve referral collaboration for batterer intervention in particular and, contrariwise, relatively little has been discussed on the obstacles, barriers, and challenges to collaboration under coordinated community response.

We developed a formative evaluation of a referral system for supplemental mental health treatment that explores the implementation of such collaboration. It exposes breakdowns, inconsistencies, and low compliance that are particularly of interest given the collaborative planning and explicit referral procedures. As a result, the compliance to the referrals was initially very low. According to clinical records, approximately 36% of the referred men made an appointment for an evaluation, 28% obtained a clinical evaluation, and 19% received treatment of at least one therapy session (Gondolf, 2007a). Our formative evaluation of direct observation, staff interviews, and referral follow-up exposes reasons for this apparent implementation failure and poses recommendations to address it. In the process, it also raises issues that need to be considered in developing a coordinated community response in general.

## The Referral System

### Rationale and Development

We conducted the formative evaluation of a screening and referral system for batterer program participants in Pittsburgh, Pennsylvania. The system was established as a demonstration project with state and foundation funding to add additional staff at the batterer program and pay for treatment costs not covered by insurance. The formative evaluation was conducted as part of a larger outcome evaluation and in the process exposed some important qualifications to the outcome, which are reported elsewhere (Gondolf, 2007a). Referral procedures for the collaboration were developed in a series of meetings among agency representatives and staff over a 6-month period. The impetus was primarily previous research at the site, which exposed mental health problems as a risk factor for program dropout and reassault and staff concern about enhanced intervention for “high risk” cases (Jones, D’Agostino, Gondolf, & Heckert, 2004). The agency representatives included the executive director and program director of the batterers program, the director of the mental health clinic that would be receiving the referrals, and the court administrator

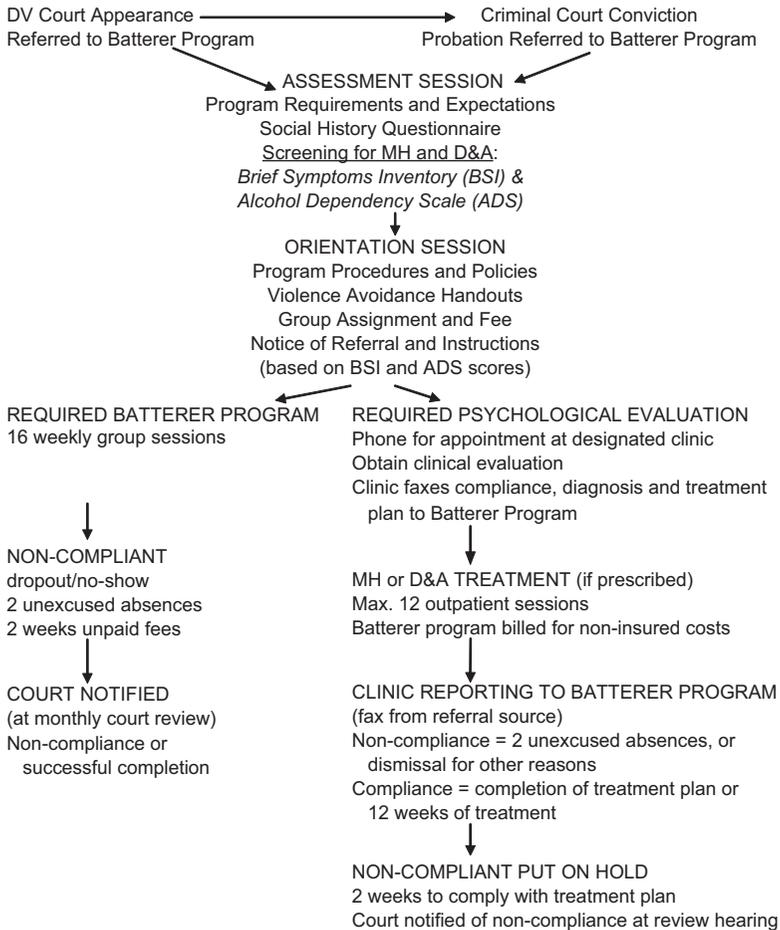
and chief magistrate of the domestic violence court supervising the domestic violence cases. A staff member and counselor of the battered women's center also participated in the meetings and review of material, and the principal investigator and project coordinator of the outcome evaluation convened and led the meetings.

A 15-month periodic follow-up showed that men with "severe psychopathology" according to the Millon Clinical Multiaxial Inventory-III (MCMI-III) were a third more likely to reassault their female partners and twice as likely to repeatedly reassault (Gondolf, 1999a). Moreover, a previous referral project at the site was screened for additional service needs and resulted in fewer than 5% of the batterer program participants complying with voluntary referral to employment, parenting, education, psychological, and alcohol treatment programs (Gondolf, 2008a). According to a formative evaluation of this project, a variety of shortcomings contributed to the low level of compliance: staff's failure to follow screening procedures and properly notify some men of their referrals, inadequate referral services and staffing, and lack of referral oversight and follow-up support (Gondolf, 2008b). These findings led us to consider a referral system particularly for men with mental health problems including tested screening instruments and systematic procedures, documentation of referral and compliance, collaboration among the services and treatment access for the referrals, and program oversight of referral compliance and court sanction for noncompliance.

## Procedures

The procedures for the mental health screening and referral were as follows (Figure 1): At the program intake, the men ordered by the court to the batterer program were administered a background questionnaire, a mental health screening instrument (i.e., Brief Symptom Inventory; Derogatis, 1993), and an alcohol screening instrument (i.e., Alcohol Dependence Scale; Skinner & Horn, 1984) as part of the standard assessment procedures. After the orientation meeting the following week, the batterer program staff met with the men who screened positive for psychological problems or alcohol addiction. Staff presented justification and instructions for the referral, a simplified list of procedures, contact information for the mental health clinics, and compliance verification forms to present to the clinic. The referred men were to call the mental health clinic within a few days and schedule an appointment for a mental health evaluation. They were directed to an administrator, who was familiar with our referral project and involved in its planning, for further screening over the phone and scheduling for clinical evaluation. At the evaluation appointment, the men presented forms to the clinic intake staff explaining the referral and requesting verification for compliance. The clinic was to fax a form indicating the diagnosis, prescribed treatment, and date of the evaluation to the main office of the batterer program. There was also a form to fax later indicating treatment compliance.

**Figure 1**  
**Mental Health Screening and Referral Procedures**



After an initial start-up period of voluntary referral, the referrals were to become “mandatory.” That is, the men were informed that the referral to supplemental mental health treatment was part of the court requirement to attend the batterer program. The court would consider compliance to the mental health referral, as well as to the batterer program, in monthly reviews over a 4-month period and issue additional sanctions for any noncompliance: jailing, fines, or extended counseling, depending on the circumstances of the case. Under the mandatory referral, the office

manager of the batterer program would inform the court liaison about referral compliance, along with batterer program attendance, and that person would present the compliance information at the court review.

The referral process, as it turns out, relied on a long chain of communication. Screening results needed to be shared between the main office of the batterer program and the program intake staff, referral information between the program staff and the participants, compliance verification between the mental health clinics and batterer program, compliance results between the batterer program and the court liaison, and recommendations for noncompliance between the court liaisons and the judges.

## Screening Results

This screening and referral approach was selected because of its efficiency and cost-effectiveness. Most batterer programs do not have the resources or staff to conduct individual clinical evaluation and in-house treatment, and referral to existing services precludes a duplication of services available in the community (e.g., the batterer program offering alcohol treatment when alcohol treatment facilities are available). Many programs already rely on a group intake or orientation sessions to bring men into a program and help reduce costs. We chose the widely used Brief Symptom Inventory (BSI) to screen for mental health problems that warranted a clinical evaluation because its 53 items make the BSI a relatively short instrument to complete and well suited for the time constraints of program intake. The Alcohol Dependence Scale (ADS) was also used because of the high association between alcohol abuse and domestic violence, and because it approximates a diagnosable mental health disorder, namely alcohol dependence. As we discuss at the conclusion of this article, other approaches to supplemental mental health treatment may offer advantages to this approach despite their increased costs and staffing.

Nearly half of the 1,043 batterer program participants over a year and a half (2004-2006) screened positive on the BSI ( $N=479$ ). Interestingly, only 4.5% of the participants ( $n=46$ ) screened positive on the ADS, and two thirds of these men were already identified by the BSI. A previous study using the Michigan Alcohol Screening Test (MAST; Selzer, 1971), which identified alcohol-related behaviors "ever in the past," indicated that more than half of the men had possible problems with alcohol addiction (Gondolf, 1999b). The lower identification with the ADS is likely influenced by the narrow focus on current active symptoms associated with the diagnosis of alcohol dependence and the lack of indexes to account for underreporting and denial.

Approximately the first third (38%;  $n=182$ ) of the positive screens were referred "voluntarily" with no threat of additional sanctions if they did not choose to comply as part of a start-up phase of the project and also to create a quasi-control group for the outcome evaluation. The next third (35%;  $n=166$ ) were referred under what might be considered an unintended transitional stage toward mandatory referral. Our formative evaluation exposed numerous breakdowns in notification of the men to be referred, verification of compliance from the mental health clinics, and reporting to

the courts. The final quarter (27%;  $n = 131$ ) of the referrals were made under a relatively complete implementation of the mandated procedures as a result of modifications prompted by the ongoing formative evaluation. Over the course of the implementation, the percentage of referred men who obtained a clinical evaluation rose from less than 5% under the voluntary referral to more than a quarter (28%) of the men under the full mandate, according to clinical records.

## Setting

The collaborating batterer program is distinguished by its conventional counseling approach and close linkage to a domestic violence court. The program follows 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 ongoing groups convening throughout the city. The program participation is required as a stipulation of bond and is monitored by the court through monthly reviews in which a court liaison from the batterer program documents the man's attendance and makes recommendations to the court.

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. On 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. As mentioned, 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.

## Method

Our formative evaluation drew on direct observation of the agency procedures, participation in training and supervision meetings, debriefing interviews with administrators, and informal comments from program staff and participants. The principal investigator and a research assistant compiled fieldnotes on all of these aspects; separately summarized the main issues, challenges, and themes in the notes; and discussed and compared our summaries to help verify our conclusions. These conclusions were further clarified, focused, and validated through the latter two of three advisory committee meetings. The committee was comprised of representatives

from each of the collaborating agencies and three researchers from the mental health field specializing in the treatment of violent psychiatric patients.

In terms of observations, there were two trainings of batterer program staff, periodic observations of the screening at program intake, and visits to the domestic violence court with the batterer program liaison. During the mandatory referral stage, we met four or five times with administrators at the two mental health clinics to review the referral and reporting procedures and discuss feedback from the other agencies. The principal investigator and research assistant conducted joint interviews with clinic administrators, batterer program staff, and one court representative. We were also in regular contact with participating staff at each agency about the referral procedures. A case management introduced in the final mandatory referral stage exposed lapses in the notification reporting procedures that were in turn discussed in person or by phone with various agency staff. Examples include positively screened men not being notified of their required referral and clinic verification of a man's obtaining a mental health evaluation not being sent to the batterer program.

In a sense, the implementation of the mandatory referral represented a kind of "system audit" of the referral system to identify inconsistencies and breakdowns (see Pence & McDonnell, 1999). The information was then used as feedback to various agency staff to help correct or adjust their practices. It also exposed to the research team other remedies to improve the implementation, such as additional training, meetings, or procedures, including eventual placement of a case manager. In this way the formative evaluation was very much participatory or "action research" (Greenwood & Levin, 2006). The information being collected was used as feedback to modify what was being observed.

Finally, our analysis was based largely on the screening referral procedures that were developed over the course of about 6 months in consultation principally with batterer program and court administrators (see Table 1). The collected information was contrasted with these intended procedures to expose inconsistencies and breakdowns and generate possible modifications to the "referral system." The procedures remained relatively intact with minor changes in the means of reporting (e.g., sending e-mail verification of compliance to the case manager rather than faxing forms to the batterer program office staff) and increased monitoring of referral notification following screening.

## Results

### Implementation Problems

We identified a variety of inconsistencies and breakdowns of the referral procedures, especially during the initial implementation of the mandatory referral (Table 1). There were problems in nearly every step of the process—from the initial screening at program intake to court sanctions for noncompliance. Following the initial training with batterer program staff, the four staff conducting program intake began to vary their screening approach. Some were more authoritative than others; others wanted to accommodate the men's questions and resistance to screening and

**Table 1**  
**Challenges in Implementing Mandated Mental Health Referral**

Referral Procedures	Implementation Challenges
Assessment	Consistent screening at four intake sites
Notification	Consistent notification of assessment results and referral procedures
Mental health evaluation	Establishing a central contact and timely response
Billing	Following procedures for insurance coverage and an alternative coverage
Treatment prescribed	Obtaining a diagnosis that qualifies for treatment
Verification of evaluation and treatment	Getting documentation of compliance
Informing the court of compliance	Need for batterer program to report and assert noncompliance
Court response to noncompliance	Issuing sanctions for noncompliance

research follow-up. Also, the number of men appearing for the weekly intakes at four different locations fluctuated and changed the level of interaction between the staff and program participants. Fewer men usually resulted in more informal and extensive conversations. The staff also questioned the utility of the screening and other paperwork, such as the background questionnaire and research consent forms, and they resented the burden that screening placed on them. They had other tasks associated with program intake such as determining the sliding fee for each man and assigning him to an appropriately located counseling group.

The men who screened positive on the BSI administered at program intake were to be notified of the test results and the referral procedures at the orientation meeting scheduled for the following week. The notification was initially inconsistent because of men missing the orientation session and going directly to an ongoing program group. Also, if a staff member was absent or the meeting room was occupied, the intake orientation sequence was thrown out of order and several men would miss their screening or notification. Furthermore, intake staff occasionally delayed submitting the completed BSI materials to the main office for scoring, and consequently no test results were available in time for the orientation meeting that convened the following week.

The caseload and priorities at the mental health clinic contributed to some lapses in communication and linkage. Some referred men complained about the difficulty in contacting the clinic for an initial appointment or about problems with clinic billing procedures (i.e., evaluation and treatment costs were to be covered through various insurance, welfare, and compensation plans and further subsidized by a separate foundation grant). The clinic also did not always fax the forms verifying compliance to the batterer program. The men lost the forms, the clinic staff forgot to fill them out, or the man was not identified as needing verification. In addition, the referred men were often uncooperative and resistant to the evaluation and difficult to diagnose as a result. Such men were not recommended for treatment but were considered compliant to the referral for an evaluation.

The final area of problems was with the courts. For one, the batterer program office secretary was to communicate the referral compliance, along with batterer program attendance, to the court liaison. This information was sometimes not available or the liaison was absent or failed to collect it. One liaison stopped presenting the compliance information to the court because the judges did not necessarily respond to it. Another occasionally withheld the information if he thought the man was otherwise in good standing with the batterer program. Various district attorneys would sometimes waive noncompliance to move cases along and resolve outstanding charges.

The main and persistent challenge was the judges' inconsistent response to the referral noncompliance. The leverage or "accountability" of the mandatory referrals was thus weakened. What amounted to the lack of sanctions for noncompliance was the result of two related circumstances. As the mandatory referral began, the city consolidated its judges (actually "district magistrates") as a cost-cutting measure and laid off the judicial administrator who coordinated the domestic violence and other specialty courts. The number of judges rotating through the domestic violence court therefore expanded from 5 to more than ten. The new judges were less familiar with domestic violence issues and exercised more discretion in case decisions than the previous experienced and supervised judges.

In sum, the complexity of the communications required for the mandatory referral made it vulnerable to inconsistency and breakdown. The number and diversity of frontline staff across different agencies also appeared to add to the problems. The supervision of the staff was initially somewhat lax and our coordination of the collaborating agencies also sporadic. The research team had inadvertently assumed that the independent agencies would manage the referral process and adjust as need be. We also assumed that our contacts primarily with the agency administrators would be sufficient to implement the mandatory referral and maintain consistent procedures among their respective staffs. The coordination and communication required for the mandatory referral clearly warranted more than establishing procedures, instruments, and forms.

## **Underlying Issues**

It is difficult to construct a causal model for the implementation problems. Several issues are likely to be interrelated and variable. We were able, at least, to identify organizational and structural issues that appeared to contribute to the inconsistencies and breakdowns discussed above. Interestingly they resonate with other observations of efforts to develop a "coordinated community response" to domestic violence cases (e.g., Gondolf, 2008b; Visher et al., 2006). Of particular note were administrative absenteeism and turnover, administrative-staff gaps, client overload, and differing agency priorities.

Administrative turnover was a major issue because our screening and referral relied on key staff at each collaborating agency. The "key staff" were administrators who helped develop the referral procedures and protocol and who served as the

representative of their respective agencies. When they were absent from their position or left the agency for other work, breakdowns were more likely. Early in the implementation of the mandatory referral, the judicial administrator was laid off under city cost cutting, and the batterer program director was dismissed for financial mismanagement and fraud. The judicial administrator was not replaced, but an experienced staff member of the batterer program did assume the program director position. Also, the district attorney overseeing the specialty courts was promoted and a replacement from a different court was appointed, and the clinic director was absent for a couple of months because of surgery and later given additional responsibilities that stretched her further.

Fortunately, the new batterer program director replaced the former assistant director and office staff with other program employees and maintained the continuity of the services. The research team was heavily involved in the transition to help and observe the program operation for the outcome research project. From what we could observe at the batterer program, in staff interviews, and in follow-up interviews, there was no interruption or consequence to the batterer program sessions or staff performance during the administrative overhaul. The administrative changes did, however, initially weaken the attention and supervision of the screening and referral process as did the absence or departure of other agency administrators.

Related to the administrative turnover was the gap between administrators and the frontline staff enacting the screening and referral procedures. We relied heavily on the knowledge and commitment of the administrators to implement the mandatory referral at their respective agencies. For a variety of practical reasons, they were not always able to do so. The demands of their respective positions, the need to maintain the existing services, and the turnover and absenteeism discussed above often precluded direct and continuous supervision of the screening and referral procedures. The staff resistance, barriers, and misunderstandings, therefore, were not fully realized and addressed at times. We also observed at the batterer program signs of “training decay” as the referral project progressed. Administrators and staff began to forget, misrepresent, or misunderstand some of the referral procedures as they were initially taught.

We identified an additional issue that reflects a central problem noted in the multisite Judicial Oversight Demonstration (JOD) project funded by the National Institute of Justice to enhance community coordination in domestic violence cases (Visher et al., 2006). The increased coordination, referral, and accountability tend to further overload the collaborating agencies. More cases or clients are to receive services, monitoring, and management and staff are consequently required to do additional tasks and assume more responsibilities. Even with supplemental funding, the overload often persists and contributes to poor implementation. The batterer program in our referral project initially obtained outside funding for a case manager and system coordinator. Similar to some agencies in the JOD project, those funds were diverted to other needs within the agency, and the manager and coordinator responsibilities were absorbed by existing office staff. Existing staff also assumed

the responsibilities of the proposed positions in previous projects at this site (see Gondolf, 2008b).

Another aspect of overload is the demands of the usual client or caseload. The courts, clinic, and batterer program in our study were all operating beyond capacity prior to the referral project, and each had experienced recent funding cutbacks. They were insufficiently staffed, supported, and equipped (e.g., inadequate computers or data systems). The mental health clinic, for instance, received approximately 100 phone calls per day, and clinicians were evaluating as many as 15 clients per day in individual sessions. The occasional difficulties in contacting the clinic or obtaining verification were understandable in this light. Similarly, the batterer program had intakes for 80 to 100 men a month and 20 ongoing groups to manage. The program's need to collect fees, record attendance, track compliance, and coordinate with the court and probation precluded attention to mental health referrals.

Last, the agencies involved in our research project differed in orientation and priorities. There was no outright conflict or competition, but there was sometimes a clash of purposes, assumptions, or expectations. Probably the most obvious in this regard was the difference in the punitive orientation of the court and the accommodating approach of the clinic. The court expected and required the men to obtain a mental health evaluation and assumed that coercion from possible sanctions was sufficient to have them complete that task. As the clinic administrator explained to us, the clinicians tended to rely on their clients' wanting help or treatment. Their clients are typically motivated to present and discuss their mental health problems and needs. The clinicians, moreover, reported a reluctance to be involved in court-mandated cases because of the time, persuasion, and documentation they require.

## **Recommended Remedies**

The underlying issues expose the need not only for further staff support and supervision but also for some structural changes or reorganization. Our immediate response to the identified problems was for the research team to take a more active role in the implementation of the referral system. We discussed our observations among our research staff and advisory committee members and initiated intermediate corrections. During what became a transitional referral stage between voluntary and mandatory referral, we recommended or reinforced closing one of the four intake sites, contacted the intake staff by phone or e-mail to confirm referral notification, adjusted the intake schedule to ensure the proper sequence of sessions, and redirected clinic verification to the research office via e-mail. The clinic administrator began to check referral compliance through the clinic's database, designated experienced clinicians to conduct the evaluations, and encouraged motivational interviewing with resistant referrals. The referred men were also advised to make sure they identified themselves by the batterer program name, so the clinic would know to promptly schedule an appointment.

One more extensive remedy would have been additional ongoing staff training and supervision. We retrained the intake staff at the batterer program once during the research project and needed to do that every few months, perhaps in briefer meetings, to sustain interest and consistency. Part of the reason why this did not happen was because of the additional cost of paying the contracted staff for their participation in training and the difficulty in scheduling all the staff for a joint training time. Most of them had other jobs and families to consider along with leading two batterer groups a week. The principal investigator or research assistant did observe the program intake every 2 to 3 months and the domestic violence court occasionally. When we did, we were usually able to assist the intake staff or court liaison in completing their tasks as well as question or reinforce referral procedures. More regular supervision and oversight no doubt would have been beneficial.

The staff retraining and supervision would help to alleviate two other issues: the consequences of administrative turnover and the administrator-staff gap. In a sense, additional training and supervision would augment the administrative oversight when it was interrupted and incomplete as well as stimulate communication within the agency ranks. Our involvement in the implementation did this to a degree at least enough to establish consistency through all but the court response to noncompliance. When this level of consistency was obtained, we considered the referral to be in a mandated rather than transitional stage. (The court inconsistencies were never fully resolved. The issues raised by the new judges and their discretion, as well as the district attorneys' need to close some cases, were beyond our resources and timing.)

The major remedy is an organizational one. The remedies discussed above ultimately need to be sustained and routinized through a structural modification; otherwise they are likely to be undone through the recurrence of the problems we initially encountered such as administrative turnover. We established an independent case manager and system coordinator for this purpose and, as is evident in the improved compliance, this organizational addition had a substantial impact. This person was one of our research assistants with previous program experience, administrative training, and familiarity with our research project. She attempted to call each referred man within a few weeks of batterer program intake to reinforce his compliance, help negotiate referral problems, and collect information about referral experience. She also was to maintain systematic contact with the agencies and facilitate the communications between them. For instance, she sought and received a list of the men notified about referral at the program orientation session and the names of men who complied with the mental health referral. She also met periodically with administrators to discuss any issues or concerns as well as to convey the perspectives of the other collaborating agencies.

The case manager being under the direction of the principal investigator, rather than a particular agency, helped in two ways. One, she was privy to information coming from the outcome research and various agencies to identify problems and ways to address them, and two, she was not consumed by other agency demands, biases, or

directives. She had the freedom to talk with the batterer program participants in her case manager role and also converse with administrators and staff in her system coordinator role. Consequently, she had a fuller picture and more leverage.

This remedy was perhaps an exceptional one in that the case manager and system coordinator position was part of the outcome evaluation and under the supervision of the principal investigator. The question beyond the outcome evaluation is where such a position would best be situated to maintain relative independence and yet have the support and authority to affect cooperation and correction. Also, identifying a person with the necessary combination of skills and experience seems essential. Most available people are likely to have background in one agency or another and the orientation and biases to go with that. Perhaps an advisory committee of some kind could help offer the checks-and-balances that the principal investigator and research team were able to provide in our project.

There is at least one community operating with this approach. Spokane, Washington maintains a coordination office for domestic violence intervention. Local services pay annual dues to fund the office and its staff. The coordinator operates independently of the separate agencies while conducting many of the tasks discussed above. These tasks include training meetings and conferences, system monitoring and auditing, and negotiating with administrators for procedural changes and adjustments. This structure goes beyond the domestic violence councils in many communities that often encounter the embedded problems we did and need either strong leadership or outside initiatives to solve them (Allen, 2006).

An additional structure remedy may be integrating batterer programming and mental health treatment within the same agency. Integration would reduce the complexity of the referral process and reduce the communication breakdowns. Consolidating staff and services would also likely improve consistency and accountability. We are aware of at least two batterer programs that are embedded in so-called behavioral health units of hospitals. At the one in Calgary, Canada, men are initially evaluated at the batterer program attached to a women's center. Men warranting mental health treatment are sent to the behavioral health unit for combined domestic violence education and mental health treatment instead of attending the conventional batterer program. A hospital-based batterer program in Fond du Lac, Wisconsin, conducts an extensive evaluation of court-referred batterers and provides supplemental treatments within the hospital setting along with the batterer education sessions. Conversely, the AMEND batterer program in Denver offers men individual mental health treatment in addition to the batterer program as well as special attention in the batterer group sessions. The main objection to such integration is the extra layer of staffing and cost it requires in comparison to referring to existing agencies and services. There is some concern, too, that the integration may diffuse the needed focus on stopping domestic violence and convey the impression that the violence is really a mental health problem.

## Discussion

### Summary

The overriding finding from our formative evaluation was the difficulty in fully implementing mandatory referral to mental health treatment across the collaborating agencies—the courts, mental health clinics, and batterer program. Despite extensive planning, training, protocols, and support, inconsistencies in the screening and referral emerged and undercut the implementation of the supplemental mental health evaluation and treatment. The addition of an experienced case manager and system coordinator substantially improved implementation and with it referral compliance. This person worked directly under the supervision of the principal investigator and was therefore relatively independent of the individual agencies. She was able to monitor the “big picture” through the ongoing data collection of an outcome evaluation and remain relatively free of the demands and pressures within the agencies. Notably, the court response to the men’s noncompliance continued to be inconsistent according to our observations and the men’s reports. The leverage of the mandatory referrals was therefore diminished and a fuller compliance hampered. The main reasons for the court inconsistencies were reportedly the increased number of judges circulating through the domestic violence court and the tendency to move cases through the system to avoid a backlog.

The other major issue is the different missions of each of the agencies. They don’t necessarily clash, but they do pose different priorities, orientations, and emphases. One example lies in a third of the referred men being diagnosed with adjustment disorders and not being recommended for treatment (Gondolf, 2007a). As staff from the mental health clinic explained, the clinicians are accustomed to voluntary clients and individuals who present psychiatric symptoms. Many of our referred men tended to introduce their relationship problems and to refuse to elaborate on their mental health issues. The practical demands in the clinic as well preclude special accommodations and outreach to the batterer referrals. The intake unit of the clinic, for instance, received up to 100 calls a day and each clinician saw as many as 15 clients in various states of need.

### Implications

The difficulties with mandatory implementation raise further questions about so-called “coordinated community response” and the efforts to develop agency collaboration for domestic violence cases. A series of studies suggest that increased coordination and collaboration tend to increase service delivery, referral compliance, and positive outcomes for batterer programs (e.g., Bennett, Stoops, Call, & Flett, 2007; Gamache, Edleson, & Schock, 1988; Gondolf, 2000; Murphy, Musser, & Maton, 1998). However, another set of recent studies exposes the shortfalls of coordination efforts and

questions their effectiveness (California State Auditor, 2006; Labriola et al., 2007; Visher et al., 2006). These studies include a national survey of agencies involved in batterer intervention, a state review of agency compliance to batterer intervention guidelines, and a demonstration project of enhanced coordination in domestic violence cases. They note many of the same difficulties encountered in our research project: training decay, staff turnover, diverted funds, competing priorities, and system overload.

The interpretation of these shortfalls is unclear however. Is “community coordinated response” an illusive ideal undercut by intractable “real world” circumstances? Or, has it not been fully realized because of a lack of adequate resources, organizational restructuring, and commanding leadership? The improved implementation under our case manager and system coordinator, amid several unexpected challenges, suggests that coordination and collaboration can be improved with a modest investment. Although the referral compliance and ultimately service delivery increased, it still fell far short of the goal. Moreover, the overall effectiveness of increased “services” in reducing domestic violence—that is, supplemental mental health treatment—was negligible in our research project (Gondolf, 2007a) as was the case in the demonstration project of enhanced coordination in domestic violence cases (Visher et al., 2006). It is, of course, very difficult to tease out the impacts of a coordinated community response and ultimately determine the outcome of its full implementation.

In this regard, the formative evaluation proves to be of vital importance in interpreting and discussing the results of any outcome evaluation—that is, the effectiveness of supplemental mental health treatment in improving batterer program outcomes. As critics of narrowly focused outcome evaluations have argued, context of a program or treatment can substantially influence outcomes (see Dobash & Dobash, 2000; Guba & Lincoln, 1989; Pawson & Tilly, 1997). For example, our formative evaluation of an experimental clinical trial of culturally focused batterer counseling suggested that the outcomes of the experimental group may have been neutralized by the batterer program’s close relationship to the courts (Gondolf, 2007b). The outcomes of the current mental health treatment for batterer program participants are likely to be the result of the shortcomings of referral implementation rather than the effectiveness or ineffectiveness of the treatment. More attention clearly needs to be devoted to improving the collaborations within coordinated community responses.

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**Edward W. Gondolf**, EdD, MPH, is research director for the Mid-Atlantic Addiction Research and Training Institute (MARTI) based at Indiana University of Pennsylvania. He conducts research on the response of the courts, mental health practitioners, alcohol treatment clinicians, and batterer treatment programs to domestic violence. His two most recent books are *Assessing Woman Battering in Mental Health Services* and *Batterer Intervention Systems: Issues, Outcomes, and Recommendations*. He is also professor of sociology at Indiana University of Pennsylvania.