

CASE MANAGEMENT FOR AFRICAN AMERICAN MEN IN A BATTERER COUNSELING PROGRAM

Final Report of a Demonstration Project Evaluation

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IN A BATTERER COUNSELING PROGRAM:
FINAL REPORT OF A DEMONSTRATION PROJECT EVALUATION**

EXECUTIVE SUMMARY

Introduction: One of the principal questions facing domestic violence intervention is how to improve the outcomes of so-called batterer counseling. Among the recommendations for improvements are specialized counseling and extended services for African-American men who are more likely to drop out of counseling and be re-arrested. In a recent experimental evaluation of specialized counseling, specialized counseling failed to improve outcomes over conventional racially-mixed counseling. A next logical step is to test the effect of extended services through case management with African-American men arrested for domestic violence.

This study examined case management through a demonstration project at the Domestic Abuse Counseling Center (DACC) in Pittsburgh during March 2003 to May 2004. African-American men court-mandated to batterer counseling were individually assessed at program intake, referred to appropriate services in addition to batterer counseling, asked to report on their referral contacts the following week, and then called periodically to monitor their individual needs and referral compliance. A computerized tracking and record system helped to coordinate the case management and oversee the men's individual needs and referral contacts.

Our expectation was that the men who received case management in addition to batterer counseling would have better outcomes than those men who attended only batterer counseling. The underlying assumption is that more service contact improves batterer program outcomes, especially given the compounding issues and problems of many batterer program participants.

Method: The study used a quasi-experimental design of 202 African-American men who received case management and a comparison group of 482 African-American men who previously completed batterer counseling without case management. (The comparison group was established in a previous evaluation of specialized batterer counseling conducted at DACC.) This outcome evaluation focused on program dropout based on clinical records, re-assaults reported by the men's female partners, and re-arrests based on police records. Both samples completed a social history questionnaire, an alcohol screening test, and a racial identity scale at program intake. The men's female partners were interviewed about the men's behavior at program intake and every three months over a 12-month follow-up period. The outcomes of the current case management sample were cross-tabulated with those of the previous sample, and multivariate analyses were computed to control for possible differences in the sample characteristics that may have influenced the bivariate results. The impact of social service contact, as reported by the men's partners during the follow-up, was also examined.

A formative evaluation was also conducted to help qualify and interpret the outcomes. It used three steps to assess the implementation of the case management and the extent of its intended service delivery. One, the implementation of the project was

evaluated through direct observations of the case management assessment process and through semi-structured interviews with program staff. Two, service delivery was determined using computerized client records of the initial referrals and case management follow-up calls. Three, the men's impressions of and recommendations for the case management were collected through follow-up phone interviews with a subsample of men (n=72) 4-5 months after program intake. These three steps provide a means to determine project integrity—that is, the extent to which the intended case management was implemented and whether the outcomes are attributable to that case management. They also help to expose additional considerations and implications for the development of case management in batterer programs.

Results: The case management project was not implemented as initially designed primarily because of time constraints at program intake and staff shortcomings during the project. As a result, it resembled more a “systematic referral” than conventional case management. That is, the assessment was more superficial than initially intended, the case management phone calls were fewer and less frequent, and portions of the computerized record-keeping were not completed. However, the streamlined case management did improve over time after two experienced staff replaced the initial project staff. The essence of the project was maintained, and basic needs and referrals were identified for over 200 men, the number of men specified for the project.

Our formative evaluation exposed some lapses in the computerized record keeping, as well. Records were missing for nearly half of the assessed men. According to the available records, most of the men were referred for job or financial assistance, and only a small portion received referrals for substance abuse or mental health problems. Barely half of the referred men were contacted as part of the case management phone follow-up. The service delivery did appear to improve over time: The average number of referrals increased as did the referral contacts. The outcome of the case management calls is unclear, however, because of incomplete or insufficient records, but an encouraging portion of the men did report that “things were going well.”

The interviews with the men suggest that the referral system had little usage or impact. Over half of the men claimed that they did not receive any referral at program intake. Only two-thirds of these men said they contacted a referral. Half of the men who contacted a referral said it was of little assistance, and few believed it helped them reduce their domestic abuse. Very few men recalled receiving case management phone calls, and most of the men thought the calls were not particularly helpful. However, the responding men generally thought the referral system should be continued. They felt the referral information was useful to know even if they did not act on it.

Only a small portion of men received job assistance, drug and alcohol treatment, or other counseling, according to the women's reports during the outcome follow-up. The men receiving case management were, however, significantly more likely to have obtained some assistance beyond the batterer program, specifically church attendance and “getting a job” on one's own. There was little evidence that the principal referrals to job placement and employment services led to increased contact with those services.

The systematic referrals of the case management project did not appear to improve program outcomes. Rates for dropout from batterer counseling, re-assault reported by female partners, and domestic violence re-arrests over a 12-month follow-up are nearly

identical for the case management sample and comparison sample receiving no case management. The men's threats toward women and women's perceptions of safety are also equivalent across the two samples. (Potential differences in sample characteristics do not appear to account for the "no effect," according to multivariate analyses predicting re-assault and re-arrest outcomes.) The outcomes do, however, appear to improve later in the project after enhancing the project implementation.

The fundamental assumption that additional service contact would improve the batterer program outcomes was also not supported. According to analyses of the women's reports of their partner's service contact, the men who *did* receive any additional assistance, drug treatment, other counseling, or other forms of help were no less likely to re-assault their partners, or be re-arrested for violent crimes. The men receiving some form of drug and alcohol treatment and other help did have slightly lower rates of any re-assault, severe re-assault, or any arrest, but these tendencies were not statistically significant.

Conclusion: Our study of the case management project of the Domestic Abuse Counseling Center shows little benefit from case management overall. This result may be related to the difficulties in implementing the case management, getting men to comply with the referrals, and the limitations of the referrals themselves. There is some indication that improving the implementation of the referral system improved the outcomes. A fully implemented case management might, therefore, have a more positive effect on outcomes with African-American men. To achieve such an implementation would cost much more in terms of staffing, supervision, and administration than was available for the current project. In sum, the outcomes of the case management project were compromised by poor project implementation and lack of program resources.

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OVERVIEW

One of the tangential findings in the program evaluations of counseling for domestic violence offenders, or “batterer counseling,” has been the higher dropout and re-arrest rates among African-American men. These outcomes are especially a concern in urban areas where African-American men may account for half the counseling participants, as they do in Pittsburgh (Gondolf, 1999). Researchers and clinicians have argued for specialized counseling and more comprehensive intervention to improve batterer counseling outcomes (e.g., Blake & Darling, 1994; Hampton, Carrillo & Kim, 1998; Oliver, 1994; Williams, 1994, 1998). In a recent experimental evaluation of specialized batterer counseling for African-American men in Pittsburgh, the program dropout, re-assault, and re-arrest rates were similar for both African-American men randomly assigned to culturally-focused counseling in an all African-American group and those receiving conventional counseling in a racially mixed group (Gondolf, 2005)

While the culturally-focused counseling identified individual and social issues facing the African-American men, it did not offer additional services to effectively address them (see Williams, 1993, 2000). All of these issues tend to contribute to dropout and re-arrest, and could be eased by providing additional services. A substantial portion of the African-American men do have financial problems, lower education, alcohol or drug misuse, psychological problems, and parenting difficulties associated with poverty and discrimination (Gondolf, 1999, 2005). All these problems have been established as risk factors for program dropout and re-assault—and recidivism in general (e.g., Hotelling & Sugarman, 1986, Jones & Gondolf, 2001). Case management would assess these factors, provide referral services and reinforcement for contacting them, and periodically review the men’s needs and progress—and as a result improve the outcomes of batterer counseling.

Moreover, state standards for batterer programs pose the need for assessment and referral of program participants in general. Our review of the batterer program standards available on-line (www.biscmi.org) showed that 89% of the 36 states currently with standards recommend attention to psychological problems and alcohol abuse. A small portion of the standards also indicate a need to identify other risk factors, particularly unemployment, illiteracy, and parenting deficiencies. The means to do this are, however, vague and inconsistent. A range from screening to case management is suggested but without procedural detail.

A more comprehensive intervention to batterer program participants is more generally recommended in the move toward a coordinated community response and judicial oversight of domestic violence perpetrators (see Pence & Shepard, 1999). Assessment, referral, and supervision are urged as a means to address the men’s compounding problems and known risk factors. This might be accomplished through court-mandated assessment or evaluation, routine evaluations by probation officers, or as part of batterer program intake. The effectiveness of such approaches has not, however, been researched.

Case management has also been an implicit goal of domestic violence coordinating councils that advocate a coordinated community response to domestic violence cases (Pence & Shepard, 1999). One state survey indicated that at least 76% of the councils (N=41) sought to further develop batterer intervention with additional services and supervision of batterers (Allen, 2006). A shared mission and cross-training, as well as leadership and decision-making, were associated with the council members perceiving the

councils to be effective (Allen, 2005). Studies of other human service collaborations show that such councils can enhance communication among service agencies and improve service delivery (Foster-Fishman et al., 2001). However, the internal and external barriers to achieving coordinated services loom large, and collaborative efforts too often fail at achieving their goals (Roussos & Fawcett, 2000). Staff knowledge, agendas, perspectives, and priorities may counter the goals of the collaboration and coordinated services (Sink, 1996). Sufficient incentives, resources, and supervision may be necessary for collaborations to succeed (Klein & Sorra, 1996). This uncertain context raises the question whether case management based in a batterer program can be effectively implemented.

A demonstration project of case management was implemented at the Domestic Abuse Counseling Center (DACC) in Pittsburgh to examine this assumption. The Mid-Atlantic Addiction Training Institute, based at Indiana University of Pennsylvania, studied this project to determine whether case management improved the outcomes of batterer counseling for African-American men. The heart of the study is an outcome evaluation comparing program dropout, re-assault, and re-arrests for a sample of African-American men who received case management versus a previous sample of African-American men who received only batterer counseling. Clinical records were assessed for program attendance and dropout. The men's female partners were interviewed every 3 months over a 12-month period for reports of further abuse and assault, and police records were obtained to determine re-arrests over the 12-month follow-up period. This comparison sought to identify any improvement in outcomes attributable to the case management project.

To interpret and explain the outcome results, a formative evaluation was also conducted—that is, a descriptive study of the project's implementation and operation. Case management observations and program staff interviews were conducted to assess project implementation, and a subsample of program participants was interviewed to obtain the men's impressions of and recommendations for case management. Additionally, information on service contact was drawn from the follow-up outcome interviews to test the assumptions of the systematic referral within case management—specifically, that referral would increase service contact, and service contact would improve outcomes.

This document represents the final report on the evaluation of the case management demonstration project. The report is divided into two main parts. Part I summarizes the formative evaluation of case management implementation and operation. It includes three main sections with each section presenting one of the components of the formative evaluation: project implementation, service delivery, and the men's impressions and recommendations. Part II reports on the outcome evaluation of the case management and service contact. The following sections are included in this part: the program outcomes for referral versus no referral, the extent of service contact for the referral and no referral samples, and the impact of service contact on batterer program outcomes. Each section presents the methods and findings of a study component and a summary of that component. A concluding section briefly summarizes the major findings and poses recommendations regarding case management with domestic violence offenders.

PART I: FORMATIVE EVALUATION

Introduction

Batterer Counseling and Case Management: The case management project consists of two main interventions: the batterer counseling and the case management administered to 202 African-American men appearing during program intake at DACC from March 2003 to May 2004. The batterer counseling used in our study follows the parameters common to most state guidelines for batterer programs and the gender-based cognitive-behavioral treatment outlined in published manuals (e.g., Pence & Paymar, 1993; Russell, 1995; Stordeur & Stille, 1989). The format is weekly sessions (1½ hours long) for groups of 13-18 men over a required duration of 16 weeks. The curriculum principally addresses abusive behavior and thought patterns associated with abuse. It considers 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. Each topic is presented with handouts, exercises, role-plays, or demonstrations. (For more details see "Description of Case Management Demonstration Project" in the Appendix.) The counseling is monitored by a program supervisor who periodically observes sessions and reinforces procedures, curriculum, and format by debriefing the group counselor after the sessions.

The innovation being studied is the addition of case management to the counseling. The case management includes conventional case management procedures. The case managers are to meet individually with each man as part of program intake. At this intake meeting, the case managers conduct a formalized needs assessment considering prior abuse, other criminal activity, alcohol and drug use, psychological and physical health, employment history and job status, social service contact, and social support. The man's background questionnaire, completed at program intake, serves as a guide in this assessment. The case managers also make bi-weekly follow-up calls to the men to monitor the referral contacts and offer additional support. A computerized tracking and contact form indicates the number, nature, and result of calls to the batterer program participants, and any new problems or needs along with the new referrals and recommendations for those problems. The case management is intended not only to make and monitor referrals, but also to educate men to the formal and informal supports in their community and motivate them to access and use these supports.

Implementation Monitoring: An important step in evaluation research is monitoring the implementation and integrity of the project to be evaluated. This monitoring can help identify the degree to which the outcome is attributable to the intended project as opposed to some other circumstances. In our case management evaluation, we drew on three sources of information to assess conformity to the project procedures:

One, the evaluator participated in five meetings devoted to organizing the project and establishing its procedures. He summarized the agreements made in the meetings and submitted them to the batterer program administrators for their confirmation and implementation.

Two, the evaluator directly observed three intake assessment sessions and conferred with project staff 4-5 times about the case management follow-up phone calls. He focused on the procedures being used, response of the men, and the setting of the assessment, and wrote a summary of these observations following each observation and conference.

Third, the evaluator conducted semi-structured interviews with the three staff responsible for the case management. He asked the staff about the procedures used, changes in the project, problems and difficulties with the project, contributions and accomplishments of the project, and recommendations for improving the project.

The principal findings from this qualitative information are summarized below in three sections. The sections follow the main topics of the staff interviews: procedures, problems, contributions, and recommendations. The findings offer what is sometimes referred to as a “formative evaluation” of the project (i.e., a description of how the project was “formed” or implemented). They also provide information to be used in interpreting and qualifying the results of the more quantitative outcome evaluation.

CASE MANAGEMENT IMPLEMENTATION

Changes in Procedure

This section summarizes observations of the case management procedures and interviews with project staff about the implementation of the case management project. The main finding is that the case management was not implemented as designed (see “Case management Design and Procedures” in the Appendix). As a result, the project was more of a “systematic referral” rather than conventional case management. While each man was briefly assessed and received a referral, the extent and thoroughness of the initial assessment was reduced to self-reported needs, and referrals that matched those needs. A portion of the men did not attend the orientation session the following week and were discharged from the program or went directly to their group session. The staff did not check the referral contacts of these men, offer alternatives or additional possibilities, or provide encouragement to continue with the referrals. The follow-up phone calls for additional assessment and referral recommendations were decreased to a single call to the small portion of men who could be easily reached, and to informal contact in group sessions or during a man's call to the program office about attendance or payment problems. Also, documentation for a substantial portion of the assessments and follow-up calls was not entered in the computerized database until a much later time. This documentation was to be used for confirming referral contact and in advising men in the follow-up phone calls.

These shortcomings were attributed to the initial staff who did not consistently follow the established procedures, and later to staff cutbacks that limited the implementation. (The initial staff person conducted the assessments and follow-up for the first 5 months of the project, and two more qualified staff replaced her for the remaining 9 months.) The project implementation also proved to be more time consuming than expected and needed to be streamlined as a result. Even with the streamlined assessment and follow-up calls, staff considered the referral system to be time consuming and not particularly worthwhile.

There was some variation in the implementation over the course of the project as a result of the staffing change. The initial project staff superficially administered the assessment and only informally made follow-up contacts. She misled the administrators about the extent of her case management work. Structured clinical supervision might have prevented this from happening. The two replacement staff were more experienced at assessment; one was a trained social worker with low-income African-American clients, and the other had worked as a batterer counselor and intake staff for approximately five years. These staff were directly familiar with many of the referral sources and therefore able to make more appropriate and extensive referrals and to promote those referrals with the men. The number of referrals increased to two or three per person in the last 6 months of the project rather than one during the first 6 months.

The replacement staff also made improvements in the assessment procedures. For instance, instead of an open-ended list of topics, they referred to the close-ended inventories on the background questionnaires administered at program intake as part of the outcome study. This procedure reduced assessment time while deepening assessment information. The staff began, furthermore, to write the referrals on the men's attendance sheets to ensure that the men would not forget or misplace them. The staff's approach was noticeably more engaging, as well. They made clear instructions about the intake, promoted

the opportunity represented by the program, and responded positively to men's questions and objections. The observed sessions were very orderly and positive in tone.

Problems and Barriers

The staff elaborated on several instructive problems and barriers to implementing the case management. The first problem area relates to the circumstances of the intake sessions. The replacement staff indicated that the assessments were too superficial because of time limitations. The assessment was conducted as part of a three-hour intake session that included an introduction to the batterer counseling program, determination of fees and attendance, and completion of background questionnaires. Moreover, it was only possible to spend about 5 minutes individually with each man amidst intake groups that often numbered as many as 15. Moreover, the men frequently became restless and frustrated with the length of the intake session and hurried to respond to the assessment and leave.

The staff felt they needed more time to break through defensiveness and resistance and to sort through the men's apparent and latent needs. For instance, the small number of referrals for drug and alcohol treatment may have been due to the men's denial of drinking and drug problems. More time to build rapport and to probe, or to use screening instruments, may have helped to identify more of these problems. The staff also pointed out that the small meeting rooms did not allow for sufficient privacy to establish rapport. The rooms had small desks that put the men close enough to be overheard by "strangers."

A second set of problems focuses on the men's attitudes and resources. According to the staff, the men need to be motivated for the case management to be successful. It takes some effort to seek referral information, make referral contacts, and act on the referral services. This may be a lot to expect given resistance to the court-mandate to the batterer program, the demands of the weekly batterer counseling, and suspicion towards the referral process in general. The staff believe that some of the men are simply not able or not prepared to make the required effort.

The staff were also concerned that, for some men, assessment and referrals in themselves may have raised resistance to the counseling program. Asking questions about problems and shortcomings may have reinforced the stigma and deficiencies that the men already felt in being mandated to the court for special treatment. A few men also complained that being singled out for case management because they were African-American was racially biased and even insulting. The case management project was administered at program intake sessions composed primarily of African American men, because the case management, in this particular project, was intended for African-American men.

A more practical issue is the difficulty of meeting the men's financial needs. The vast majority of the men needed money to pay for the counseling program, fines to the court, and possibly child support. However, the employment and job referral agencies had very limited success in helping the men earn additional income. The referral agencies were themselves facing staff reductions and therefore could not sufficiently help the men. Furthermore, job opportunities were decreasing because of cutbacks in services throughout the city and a declining employment base in the region. The staff saw these as the most pressing issue facing the men's compliance and success in the batterer program and a detriment to the program budget based largely on user fees.

Contributions of the Project

Despite the apparent problems with the case management project, the project inherently made some contributions. It obviously provided many men with service referrals which proved helpful to some of the men. Some men did openly and eagerly talk about their personal problems and needs, despite the setting and time constraints. For instance, one man openly disclosed his mental health problems to a staff while the project evaluator sat nearby observing the session. There were also men who did contact the referrals and were very much helped by them, according to their comments to staff and in our follow-up interviews (discussed in a following section). As our evaluation interviews with men indicated, some of the men appreciated getting the referral information regardless of whether they acted on it at that point.

The staff observed an indirect contribution as well. Many men appeared to appreciate the individual attention in the assessment process. It helped them get better acquainted with staff and air their own problems and needs. The one-on-one assessment, according to the staff, thus helped to "break the ice" for the group interaction that was to follow in the batterer counseling sessions. The assessment and follow-up calls may have demonstrated some concern for the men and helped to ease their defensiveness.

Summary

The case management project was not implemented as initially designed primarily because of time constraints at intake and staff shortcomings during the project. As a result, it was more systematic referral than conventional case management. The assessment was less thorough than initially intended, the follow-up calls were fewer and less frequent, and portions of the computerized record-keeping were not completed. However, the streamlined referral did improve over time after two experienced staff replaced the initial project staff.

Some of the men were openly resistant or unmotivated to seek and contact referral sources. They may have benefited from coerced compliance--namely, court-mandate to referrals with sanctions for non-compliance. This sort of mandate is currently being tested in a more elaborate screening process for mental health and alcohol problems followed by mandated referrals for those men who screen positive for these problems.

The essence of the project was maintained, nonetheless, and basic needs and referrals were identified for over 200 men as intended. Some of these men did readily disclose personal problems, appreciated the referrals, and made helpful contacts, despite the limitations of the implementation. Men may also have been more responsive to the batterer counseling as a result of the personal attention and show of concern. The extent of the referrals and their impact is examined further in the record analysis and follow-up interviews discussed in the following sections.

SERVICE DELIVERY

Computerized Client Records

Another way to evaluate project implementation is through the documentation of service delivery. This service delivery represents the actual “input” that is contributing to the “output” represented in the program outcome portion of this study. Did the clients actually contact the referral services, and, if so, to what extent? To assess the service delivery, we tabulated the information in the computerized client records maintained by DACC for each program participant. DACC established a data entry system for identified needs, referrals made, referrals contacted, case management follow-up calls, additional client needs, and further referrals. The case management staff were instructed to enter the appropriate referral information following the assessment and orientation sessions that comprised the program intake. This information was to be used not only to document service delivery, but also as reference for case management follow-up calls to the men.

There were 114 records available for the 202 men assessed at program intake for case management. According to the staff, the 88 missing records had not been entered into the database because of time constraints and staff cutbacks. Over one-third (36%; n=32) of the missing records were from the last three months of the project (March 2003-May 2004) when staff cutbacks precluded the data entry, and nearly one-fifth (17%; n=15) of the missing cases were mistakenly omitted from the first two months of subject recruitment because the men were discharged for absences shortly after the first session. The rest of the missing cases (47%; n=41) were randomly distributed over the course of the project. The characteristics of the missing cases did not differ significantly or substantially (at most by a few percentage points) from the characteristics of the case management sample as a whole. (Twenty-three demographic, behavioral, and abuse variables were used in the comparison.) Therefore, we might assume that the 114 cases with computerized records are representative of the 202 men receiving case management. (See Table 2 in the section on “Project Outcomes” in Part II for sample characteristics.)

Initial Referrals

We first considered the nature of the referrals and, not surprisingly given the portion of unemployed men, they were mostly for unemployment or financial problems. According to the computerized records, over half of the referred men (56%; n=64 of 114) were directed to an employment-related agency, specifically employment search, job training, and financial assistance services. A fifth of the men received referrals for education (20%; n=23), and nearly one-fourth for substance abuse, mental health, or family counseling (23%; n=26). About a third of these latter cases, or only 8 men, were identified as needing substance abuse treatment, and about half, or 14 men, needed mental health treatment. A small portion of the total number of men (7%; n=8 of 114) did not need any further referrals according to the staff assessments. (See Table 1.)

We also considered the number of referrals that the men received. The majority of men (60%) were given one referral, but the number of referrals per man increased over time. About 40% of the men received two or more referrals, 16% three or more, and 4% received four referrals (the maximum number given to any one man). The average number of referrals increased from 1.5 per man (n=44, March 2003-September 2003) to 2.0 per man (n=70, October 2003-March 2004) after the first few months when replacement staff took

over the project. Initially, only a third of the men received two or more referrals, and later nearly one-half received two or more referrals.

At the orientation session during the week following assessment, the men were to report on their referral contact, but less than half of the men had contacted their referrals. A third of the men (30%) visited the referral, another 13% had made an appointment, and a quarter (26%) had taken no action at that point. Nearly a third of the assessed men (31%; n=35) did not attend this session, according to the computerized records. Some of these men began attending group counseling the following week without reporting on their referral contact (56%), and others were discharged for failing to attend any further sessions (44%).

TABLE 1: REFERRAL TYPE AND CONTACT (percentages)

Referral Action	Percentage
REFERRAL TYPE	
None needed	7
Employment related	56
Education	20
Additional counseling	23
REFERRAL CONTACT	
Visited agency	30
Made appointment	13
Taken no action	26
Absent from session	31

n=114

Case management Follow-up

According to the computerized records, a substantial portion of the referred men were not contacted for case management follow-up (50%; n=57 of 114). The staff indicated that some men were informally contacted at their counseling groups, and some others were phoned but the information about the call was not entered into the records. No documentation is available to determine the extent or nature of the informal contacts and unrecorded calls. The records indicate that staff attempted to contact 63 men (55% of the referred men) with an average of 3 attempts per man (SD=1.9), and reached 49 men at least once (43% of 114 referred men or 78% of the called men). Two thirds of the contacted men (67%; n=33 of 49) were reached more than once.

There is some evidence, however, that the case management follow-up contact increased over time. Only 36% (n=16 of 44; August-October 2003) of the referred men were contacted by phone in the beginning months of the project as opposed to 65% later in the project (n=50 of 77; November 2003-March 2004). This increase coincides with the improved project implementation, and particularly the change of staff, noted in the summary of assessment observations and staff interviews appearing in the previous section.

The nature or outcome of the case management follow-up calls is not completely clear. Not all the calls were specifically to follow-up on the initial referrals. Some were about counseling absences or fees due. For instance, three-fourths of the attempted calls

(76%; n=48 of 63) were directly related to referrals. The records show a response for only about half (n=25) of the contacted men, and most of these men (64%; n=16 of 25) reported “things were going well”; that is, they were working or continuing job training. The rest indicated employment problems, continued job search, or unhelpful referrals (36%; n=9 of 25). There is very little in the records about new or revised referrals during the case management follow-up.

Summary

Our assessment of service delivery exposed some lapses in the computerized record keeping. Records were missing for nearly half of the assessed men (44%; n=88 of 202), but the men with available records appear representative of the overall sample. According to the available records, most of the men were referred for job or financial assistance, and only a small portion received referrals for substance abuse or mental health problems. Less than half of the men (40%) were given more than one referral, but the average number of referrals increased over time. The portion of men who actually contacted a referral agency was less than half (43%) of those originally referred, but it did increase over time as the implementation improved.

The computerized records suggest that only a portion (43%) of the referred men were contacted as part of the case management follow-up, and the contacts with many of these men were made for attendance and fee issues rather than referral follow-up. The portion of men contacted in the case management follow-up did, however, increase later in the project. Finally, the outcome of these follow-up calls is unclear because of incomplete or insufficient records, but an encouraging portion of the men did report that “things were going well.”

In sum, the referrals were primarily to address employment issues, and the case management follow-up fell short of the original design. The referrals might have been more comprehensive in response to the substance abuse and mental health problems generally associated with batterer program participants, and the follow-up needed to be more extensive considering the portion of men who did not initially contact a referral agency and the nature of their problems.

MEN'S IMPRESSIONS AND RECOMMENDATIONS

Direct Observation and Staff Interviews

To further explore the usage and impact of the referral system, we conducted a 5-month follow-up interview with a subsample of men over the telephone. The object was to obtain the men's impressions of, experience with, and recommendations for the project. This follow-up was conducted separately and with a different intent from the case management follow-up calls made earlier by the project staff. In these calls, research assistants attempted to contact each man 5 months after his DACC program intake. The man would have just finished the required 16 weekly group sessions of domestic abuse counseling. A maximum of 6 calls at different times of the day were attempted over a three-week period.

The research assistants attempted to call the last 156 men recruited out of the total sample of 202. (The 46 men recruited during the first two months of the project were omitted since they were likely to be influenced by the shortcomings of the project start-up discussed above.) A total of 72 were interviewed at a 46% response rate. Most of the un-interviewed men (n=84) had disconnected phones (37%), did not respond to messages (39%), or did not answer repeated calls (19%). The research assistants interviewed the men who were reached with a structured questionnaire of closed- and open-ended items. The questionnaire asked about the specific referrals and follow-up calls the men received, the helpfulness and impact of the referrals, and general suggestions and recommendations.

A comparison of background characteristics shows that the current subsample is similar to the entire sample in demographic characteristics (e.g., age, education, employment), but significantly less likely to show violent tendencies (i.e., monthly drunkenness, other prior arrests, prior severe domestic violence, re-assault in follow-up, and program dropout). Our subsample does have similar economic and educational needs, but it appears to be biased in favor of men who have less severe alcohol problems and are more compliant to referrals. (See section on "Project Outcomes" in Part II for sample characteristics.)

Referrals and Service Contact

Over half the men contacted (54%, n=39) said that they did not receive any referrals to other services at the DACC intake session, and only a quarter (28%, n=20) reported contacting a referral service. That is, about two-thirds of the men who recalled receiving a referral contacted a service. Those who did not (n=8) claimed that they got help on their own, had no transportation, thought costs would be too high, or had a felony record. Only 4 of the 20 men (20%) who attempted to contact a referral service had problems contacting or visiting it (i.e., no transportation, call not returned, needed service not available). Most of the men who contacted a service obtained employment information, job training, or resume-writing instruction; a few received help with parenting; and over half of these men (55%; n=11 of 20) indicated that the contact was helpful to some extent (20%, n=4) or a great extent (35%, n=7).

However, the services did not appear to substantially improve DACC program participation or reduce abuse, according to the responding men. Only 4 of the 20 men who contacted a referral service (20%) said their participation or abuse reduction was improved by the referral. In these cases, the referral service contributed to better listening,

relationship building, and self-control. The majority of men (66%; n=41 of 72) did see the exercises and information about domestic violence at the orientation (e.g., handouts on 'time outs') as "very helpful" in reducing their abusive behavior. (Over a quarter [27%] answered to "some extent"; 10 men [14% of 72] did not answer because they did not attend the orientation.) Typically, men said that the 'time outs' helped them control their anger or deal better with arguments and disagreements—both of which were also addressed in the group counseling sessions. The most helpful things about the program were the "timeouts" and self-talk (e.g., "think instead of react"), group communication and support, and self-reflection and understanding.

Case Management Follow-up and Recommendations

The clinical records indicate that nearly half the men were later contacted by phone as part of DACC's case management follow-up. However, only 13% of the respondents (n=9 of 72) indicated that they were called. These men reported being invited to return to the DACC counseling. One man said he received an additional employment referral. Most of the men pointed out that what they most needed was more help getting a job. Over half the sample (61%; n=44 of 72) responded to a final question on whether the referral system should be continued, and nearly three-quarters said "yes" (73%; n=32). The overwhelming reason for the positive response was that the additional information about available services was useful to know. The men added, however, that several things could be improved: more specific help with finances, more information about employment, and advance notice of referral expectations. The men's general comments fell into three categories: praise for the domestic abuse counseling, criticism of the program's costs, and accusations about their female partners (e.g., the women need counseling or had them falsely arrested).

Summary

The most striking finding of this exploratory follow-up with the men is that most of them claimed they did not recall receiving a referral. This could reflect the large number who failed to contact a referral, according to the clinical records, or the men's failure to remember or resistance to questioning. Moreover, only two thirds of the men who recalled receiving a referral said they contacted a referral service. About a half of these thought the referral was of little help, and few believed it helped them reduce their domestic abuse. Very few men recalled receiving a case management follow-up call and most of these men found that call of little or no help. However a majority of responding men thought the referral system should be continued mainly because the additional information was useful to know—even if not acted on. They especially wanted more concrete help with finances and employment. From the men's reports, the referral system appears overall to have had little usage and impact.

PART II: OUTCOME EVALUATION

Introduction

The culminating part of the project evaluation is an outcome study based on a one-year follow-up with the men's female partners or identified new partners. The object here was to test whether the case management project improved the outcomes of the batterer programs as expected. In this part of the evaluation, the outcomes of the African-American men subject to the systematic referral (i.e., the abbreviated "case management" described in Part I) were compared to previous batterer program participants who did not receive referrals. The latter were men from a study of specialized batterer counseling for African-American men that immediately preceded the current one on case management. The outcomes are those commonly used in previous evaluations of batterer programs: batterer program dropout according to program records, further threats and re-assault according to the men's female partners, and re-arrest based on statewide arrest records. These women's reports and arrest records were collected over a 12-month follow-up period following program intake. A previous evaluation with a four-year follow-up showed that a 12-month follow-up is sufficient to detect differences in outcomes, since the vast majority of men who re-assault their partners or are re-arrested do so within 12 months (Gondolf, 2002).

Follow-up data about service contact beyond the batterer program is also analyzed to test two underlying assumptions of the case management and its systematic referrals: one, that systematic referrals will increase service contact, and, two, that service contact will improve batterer program outcomes. In this case, the percentages of service contact are compared for the two case management samples. The re-assault rate is then compared for men with additional service contact and those men without service contact. Four main categories of service contact are tested in this manner: any additional service, drug and alcohol treatment, other counseling in addition to batterer counseling, and other forms of help (e.g., job training or church involvement). These analyses not only examine underlying assumptions of assessment and referral, but also serve to confirm the project implementation explored in the formative evaluation (Part I) which is more qualitative in nature and is beset by missing cases.

As in Part I, each component of the outcome evaluation is addressed separately below with its own summary:

PROGRAM OUTCOMES FOR REFERRAL VERSUS NO REFERRAL

Method

Follow-up Procedures: Research assistants called the men's partners within two weeks of the man's program intake and every three months thereafter for one year. The repeated interviews at 3-month intervals are preferred over one retrospective interview at the end of the follow-up, because they reduce the span of recall and thus improve accuracy and also increase contact and thus raise response rates. The repeated interviews, furthermore, allow for examination of a variety of follow-up timeframes, rather than just one cumulative period of 12 months, that might help to expose outcome trends over time.

During each interview, the woman was asked about the status of her relationship and contact with her partner, the man's behavior toward her, the man's alcohol and drug use and any other violent behavior, and additional assistance or intervention the man received. The women were also asked to rate their perceptions of safety, the likelihood of re-assault, and the extent of the men's change overall. The research assistants used contact information obtained from the man at program intake and systematic calling to reach as many women as possible. (These procedures were established in a previous program evaluation with a relatively high response rate. See Gondolf & Deemer, 2004, for a full discussion of the tracking, calling, and interviewing procedures.)

We obtained our target response rate of at least 60% for the full 12-month follow-up period. It is generally assumed that at least 60% of the subjects must be interviewed during such a follow-up in order to approach a representative group of respondents. In our follow-up, information was collected from the partners of 79% of the men at program intake, 72% at the 3-month follow-up, 65% at the 6-month follow-up, and 62% at the 12-month follow-up. The full sample included 705 men with 202 of these men receiving referrals (i.e., in the "case management project") and 482 in the comparison group of "no-referral" men. The response rates were equivalent for the referral and no-referral samples. A new partner was contacted for 7% of the total sample ($n=50$ of 705), or 10% of the men with an interviewed woman ($n=50$ of 506). Half of the new partners overlapped with the initial partner ($n=25$ of 50); that is, two women were interviewed for some men.

Comparison Sample: The comparison sample of no-referral ($N=482$) is drawn from the previous evaluation completed immediately prior to the case management project. In this study, 503 African-American men court-mandated to the Domestic Abuse Counseling Center were randomly assigned to one of three counseling options: 1) culturally focused counseling with only African-American men, 2) conventional batterer counseling with only African-American men, and 3) conventional batterer counseling in a racially mixed group of men. The expectation was that the culturally-focused option would produce the best program outcomes for the African-American men. That is, the culturally-focused option would produce lower dropout, re-assault, and re-arrest rates than the other two options. A variety of analyses show, however, similar outcomes across the three options. (See the Appendix for a summary of the "Culturally-Focused Batterer Counseling" clinical trial.) Twenty one men of the 503 men in this study were deleted from the comparison sample of no-referral because these 21 men received case management and are therefore included in the referral sample. This occurred due to a brief overlap of the current and previous studies. The remaining "no-referral" sample is, consequently, a total of 482 men.

Because of the similar outcomes across the three options in the previous study, the three counseling options are collapsed into one comparison group (N=482) and contrasted to the referral sample (N=203). Demographic and behavioral characteristics of the referral sample and comparison sample were compared to assess the equivalence of the two samples and expose extraneous factors (e.g., income level) that may have contributed to differences in the outcomes (see Table 2 on page 22). The group receiving referrals had a significantly greater income, was more likely to be married, was less likely to be using drugs or getting drunk, and was less likely to make threats and cause bruises. The samples were, in other words, slightly biased in favor of the referral group (i.e., the men in the case management project). We might expect, therefore, this group to have a better outcome than the comparison group simply because of these characteristics.

Outcomes: The principal outcome measure was *re-assault* as defined by items on the Conflict Tactics Scale (Straus, 1979). More specifically, re-assault was physical abuse of the subject's female partner reported by that partner during follow-up interviews. It was assessed through a series of questions that included an open-ended question about "how is the relationship going," descriptions of any conflicts and their circumstances, and an inventory using the categories of the Conflict Tactics Scale (CTS). A re-assault was considered any mention during the interview of tactics on the physical aggression subscale of the Conflict Tactics Scale (i.e., push, shove, grab; slap; hit with a fist, bit, kick; hit with something, attempt to hit with something; choke or burn; threatened with a knife or gun; used a knife or gun; forced sex against will). *Severe re-assault* was also identified as the use of any of the so-called "severe" tactics of the Conflict Tactics Scale (i.e., hit with a fist, bit, kick; hit with something, attempt to hit with something; choke or burn; threatened with a knife or gun; used a knife or gun; forced sex against one's will).

Four additional outcome variables were considered: batterer program dropout, threats, women's perceptions, and re-arrest for domestic violence. *Program dropout* was assessed as a man's completing less than the court-required 16 weekly sessions according to the program's computerized attendance records. *Threats* were based on an inventory of non-physical violence from the Maltreatment of Women Scale (Tolman, 1989) (i.e., threat to hit, attack, or harm; to kill; to take away children or harm them; to kill or seriously harm other people; to kill or hurt himself). The women's indication of any of these items over the course of the follow-up interviews at 3, 6, 9, and 12 months was counted as a "threat."

Women's perceptions of their safety and likelihood of re-assault were collected in order to supplement the re-assault findings, as we and others have done in previous batterer program evaluations (Dobash et al., 2000; Gondolf, 2002). These variables offer some indication of the subjective experience of the women beyond the behavioral acts (e.g., re-assaults) of the man, and an indication of whether their quality of life is improving along with cessation of the violence. The women were asked to estimate how safe they felt at each follow-up interview, and how likely it is that their partners would hit them in the next three months (using a 5-level Likert scale). The women were also asked to rate how much the man had changed since entering the program (using a 5-level Likert scale ranging from "no extent" to a "great extent"). The rating at each follow-up interval is used in the analysis rather than a cumulative measure over the course of the full 12-month follow-up period.

Re-arrests were determined by reviewing the arrest records provided by the Pennsylvania Commission on Crime and Delinquency (PCCD). The records include all arrests in the state and arrests where the charges were dropped. Records were requested

for a subsample of 100 subjects randomly drawn from men in the referral sample and 100 randomly drawn from the comparison sample of previous batterer program participants who did not receive referrals. The subsample of 200 total subjects was used to reduce the time and cost of obtaining the records. Records were available for 183 of the 200 subjects (17 or 9% were missing); the PCCD staff speculate that those men without records either do not have any arrests, had their record expunged, or used aliases that prevented locating their actual record. The characteristics of the men with missing records were not significantly different than those of the men with records, suggesting that the missing records were not likely to bias the results.

The records were coded for offenses involving domestic violence, other violence (i.e., violence toward non-family members or acquaintances), drug and alcohol-related crimes (including drunk driving and drug possession,) and any crime (i.e., any of the previous categories) that occurred during the 12-month follow-up period. If the charges associated with a particular arrest included more than one category of crimes, the arrest was categorized as the highest priority crime indicated by the above order of crime categories (e.g., charges for disorderly conduct *and* domestic violence were coded as domestic violence).

Analysis: To address the question of whether the systematic referral improves program outcomes, the outcomes for the referral sample were compared to the outcomes of our prior evaluation of specialized counseling for African-American men conducted at the same site. In a series of bivariate analyses, the various outcomes were cross-tabulated by the referral and no-referral samples. Fisher's Exact Test was computed for each cross-tabulation to gauge statistical significance at less than the .05 level. (Fisher's Exact Test is prescribed for two-way cross-tabulations like those used in our analyses.)

Multivariate analyses were also computed to control for possible differences in characteristics across the two samples that may have contributed to the results of the initial bivariate comparison. These analyses are, therefore, intended to confirm the bivariate results rather than replace them—that is, they are confirmatory analyses. First, a logistic regression was constructed for the dichotomous outcome of re-assault versus no-re-assault during the 12-month follow-up. The equation was also computed for other follow-up time frames (0-6 months and 3-12 months). Variables for demographics, relationship status, previous behavior, prior intervention, and perceptions were entered into the equation. (See Table 2 for a listing of the variables.) Each category of variables was entered as a "block" using a forward stepwise procedure. The variable for case management (referral vs. no referral) was then entered (i.e., direct entry with no stepwise removal) to examine its contribution to the re-assault outcome. We were specifically looking for a statistically significant odds ratio for the case management. This would indicate that the case management project did improve the outcome measure of the batterer program.

Second, logistic regressions were computed for the outcome variable indicating a domestic violence arrest during the follow-up, and then for arrest for any violence and for any crime during the follow-up. The variables for prior domestic violence arrests, any violence arrests, and any crime arrests were respectively entered as controls into the equations in place of the subjects' report of arrests and prior violence used in the previous analyses.

TABLE 2: CHARACTERISTICS OF BATTERER PROGRAM PARTICIPANTS RECEIVING REFERRAL VERSUS NO-REFERRAL (percentages)

Characteristics	Sample	
	Intake Referrals n=202	No Referral n=482
DEMOGRAPHICS		
Less than 30 years old	40	44
Some college	29	26
Income >\$13,000	57	45**
Unemployed (other)	53	60
RELATIONSHIP STATUS		
Married	46*	35
Living with partner	40	44
See Partner Daily	46	50
Children Living with	48	44
PAST BEHAVIOR		
Parent hit parent	22	29
Used drugs (past year)	32*	41
Possible Alcoholism (MAST>0)	50	48
Drunk monthly or more (past year)	28*	37
DOMESTIC VIOLENCE		
Threats (past 3 mos.)	16**	28
Severe Assaults (ever)	19	22
Bruised (current incident)	30*	42
Partner also arrested (current incident)	8	13
PAST INTERVENTION		
Protection Order (ever)	25	23
DV arrest (ever)	26	28
Batterer Counseling (ever)	21	16
Non-DV arrest (ever)	42	43
Probation/parole (current)	33	32
PERCEPTIONS		
Very unlikely to hit again	70	75
Partner feels very safe	65	60
Racial Discrimination (in arrest or court)	45	42
High cultural identity (according to RIAS)	24	30

*p≤.05; **p≤.01

Results

Program Dropout: The direct comparison of our two samples indicates no “project effect” on the outcomes. For one, the case management project did not appear to improve the program dropout rates of the African-American men in batterer counseling (see Table 3 below). The overall dropout rate for the referral sample (n=202), according to the computerized clinical records of the batterer program, is 48%. That is, over half of the African-American men who received assessment and referral completed the required 4-months of weekly batterer counseling. The dropout rate of the comparison group of men *without* referral is nearly identical at 45%. (The slight difference is not statistically significant according to the Fisher’s Exact Test at $p < .05$)

Re-assault and Threats: Our main outcome of concern was the re-assault reported by the men’s female partners during the follow-up. The re-assault rate from program intake to 12 months following intake was 25% overall: 26% for the referral sample and 24% for the comparison no-referral sample. As shown in Table 3, the re-assault rates remain the same or nearly the same for the 3-month follow-up (Referral: 12% vs. No-Referral: 12%; n.s.) and for the cumulative 6-month follow-up (Referral: 18% vs. No-Referral: 17%; n.s.). There was also no significant difference for the post-program follow-up period from 3 months after intake through 12 months (Referral: 16% vs. No-Referral: 19%; n.s.). The rate of severe re-assault was nearly identical across the two samples for each of the follow-up periods. However, there was a tendency towards a lower rate of threats in the referral sample, but the difference was not statistically significant.

Women’s Perceptions: The women’s experience of the abuse and potential abuse, moreover, did not substantially differ across the samples (see Table 3 below). The portion of women who reported feeling “very safe” at the 3-month follow-up (73% for both samples), 6-month follow-up (Referral: 80% vs. No-Referral: 76%, n.s.), and 12-month follow-up (Referral: 77% vs. No-Referral: 79%) was nearly the same for both samples. The portion of women who said it was “very unlikely” that their partners would assault them again in the next three months tended to be higher for the referral sample, but this tendency was statistically significant only at the 6-month follow-up. This finding does not carry much weight given the overall results showing little or no difference between the samples across the variety of other outcome differences. The women’s rating of the men’s change overall also showed no significant differences in the portion of men who changed “some or a great extent.” It was encouraging to note, nevertheless, that over half of the women noted a change in the men through the 12-month follow-up.

Re-arrests: Our second main outcome was re-arrest for domestic violence during the 12-month follow-up (see Table 4 below). The cumulative arrest rates for that period show no statistically significant differences between the men receiving the intake referrals (or case management) and those who did not (9% overall for domestic violence). The “referral” subjects do have a slightly higher re-arrest rate in all categories, which is most pronounced for “any crime” arrests (i.e., domestic violence, other violence, alcohol/drug related, or other crime). The referral subjects were nearly 30% more likely to have been arrested for some crime during the follow-up (Referral: 36% vs. No-referral: 28%; n.s.). This tendency favoring no-referral reflects in part the prior arrests: the referral cases also tend to have higher prior arrest rates in all categories and especially in the category for “other crimes” (i.e., not including violence or alcohol/drug related). The referral cases were nearly 50% more likely to have committed other crimes (Referral: 75% vs. No-referral: 55%; $p < .05$).

When we control for the prior arrests in a three-way cross-tabulation, the follow-up arrest rates become nearly identical across the referrals and no-referrals for the cases with no prior arrests, but still favor the no-referrals for the men with prior arrests in the specific crime categories. In other words, the difference in prior arrest rates accounts, at least in part, for the slight difference in follow-up arrest rates across the referral and no-referral samples. Interestingly, the characteristics of the two samples (shown in Table 2) suggest a higher risk for re-arrest among the no-referral cases given their slightly lower levels of unemployment, drug use, and prior abuse; intensified police action during the case management project may account for higher arrest rates in the lower risk referral sample. As explained below under “Confirmatory Analyses,” multivariate analyses controlling for prior arrests *and* other batterer characteristics show that referral and no-referral do not significantly effect the follow-up domestic violence arrest or any arrest categories.

One additional observation from the prior arrest information: the prior arrest rates are very high with nearly 90% of the men having been previously arrested for some crime and over two-thirds having been arrested 3 or more times. Moreover, approximately two-thirds of the men in either sample have been arrested for domestic violence or other violence, and over one-fifth have been previously arrested for domestic violence 2 or more times. The level of prior arrests raises concern, given that prior arrests substantially increase the risk of re-assault against one’s partner (0-2 prior arrests for any crime: 20% re-assault reported by partner in 12-mo. follow-up vs. 3-10 prior arrests: 29% re-assault; n.s.; n=143). On these grounds, a substantial portion of the African-American men are not good candidates for batterer counseling, and apparently not very responsive to case management, represented in this study through the program intake and referral to other services.

TABLE 3: DROPOUT, THREATS, RE-ASSAULT, AND WOMEN’S PERCEPTIONS FOR REFERRAL VERSUS NO-REFERRAL (percentages)

Program Outcome	Sample	
	Intake Referrals	No Referral
PROGRAM DROPOUT (less than 16 weeks)	48	45
THREATS		
0-3 months (n=505)	15	20
0-6 months (n=455)	22	26
0-12 months (n=431)	29	37
3-12 months (n=431)	25	31
ANY RE-ASSAULT		
0-3 months (n=505)	12	12
0-6 months (n=455)	18	17
0-12 months (n=431)	26	24
3-12 months (n=431)	16	19
SEVERE RE-ASSAULT		
0-3 months (n=505)	9	9
0-6 months (n=455)	13	12
0-12 months (n=431)	17	18
FEEL “VERY SAFE”		
3 months (n=505)	73	73
6 months (n=455)	80	76
12 months (n=431)	77	79
HIT AGAIN “VERY UNLIKELY”		
3 months (n=505)	68	63
6 months (n=455)	76	65*
12 months (n=431)	78	72
MAN CHANGED (Some/great extent)		
3 months (n=505)	53	58
6 months (n=455)	53	62
12 months (n=431)	52	53

*p<.05 (Fisher’s Exact Test)

Note: No statistically significant differences between “intake referral” (case management sample) “and no referral” (previous specialized counseling sample) for all outcomes except “Very Safe” 0-6 months.

TABLE 4: PRIOR AND FOLLOW-UP ARRESTS FOR REFERRAL VERSUS NO-REFERRAL (percentages)

Crime of Arrest	Sample	
	Intake Referrals n=94	No Referral n=89
PRIOR ARRESTS		
Domestic Violence	52	46
Other Violence	61	54
Alcohol/Drug Related	60	60
Other Crime	75	55*
Any Crime	93	84
PRIOR MULTIPLE CRIMES		
Domestic Violence OR Other Violence	73	64
2 or more Domestic Violence Arrests	19	25
2 or more Violence Arrests	50	49
3 or more Arrests (Any Crime)	70	64
11 or more Arrests (Any Crime)	20	16
FOLLOW-UP		
Domestic Violence	10	8
Other Violence	10	9
Alcohol/Drug Related	13	8
Other Crime	13	10
Any Crime	36	28

*p<.05 (Fisher's Exact Test)

Note: The total number of subjects in each sample above is based on a systematic random sample drawn from the available 202 "referral" subjects and 482 "no referral" subjects.

Implementation Effect: There is some indication, however, that the implementation of the project influenced the outcomes. As discussed in the previous section on “project implementation,” the initial staff did not fully follow the established procedures. Also, it often takes time to refine and establish a new project in these sorts of demonstration projects. To test for an “implementation effect,” we compared the outcomes of the first 60 men recruited for the study to the last 142 men of the 202 case management or referral sample. (The first 60 men, or a third of the sample, were recruited under the initial staff who more loosely followed the procedures.) There was again little difference in the program dropout rates (50% for the early group and 47% for the later group). However, the re-assault rates were substantially lower for the later group. At the 3-month follow-up, the re-assault rate for the early group was 9% (n=42) versus 17% for the later group (n=102; not statistically significant). At the 6-month follow-up, the re-assault rate for the early group was 32% (n=38) and 11% for the later group (n=63; $p < .05$). The men in the later group were, in other words, 50% to 33% less likely to re-assault their partners. These results must be considered tentative because of the small size of the subsamples (the early and later groupings) and need to be controlled for subsample characteristics, but the tendency is impressive and appears to correspond to the improved implementation of the project.

Confirmatory Analyses: As mentioned in the “Analysis” section above, logistic regressions controlling for batterer characteristics were computed to confirm the bivariate analyses (e.g., the cross-tabulations of re-assault by case management referral). After entering the characteristics in a forward stepwise procedure, case management (i.e., systematic referral) was not a significant predictor of re-assault during the 0-12 month follow-up (OR=.25; $p = .35$). The characteristics that were significant predictors included the man’s parents’ hitting one another (OR=.70; $p = .02$) and the man’s perception that his partner felt “very safe” (OR=-.47; $p = .01$). The equation was statistically significant (Model $X^2 = 15.93$; $df = 3$; $p = .001$; $n = 444$), but it accounted for only a small portion of the variance (Cox & Snell R Square=.03).

Similarly, the logistic regression for domestic violence re-arrest showed that being in the case management project was not a significant predictor for that outcome (OR=-.12; $p = .83$). A different set of characteristics appeared, however, as significant predictors: drug use during past year (OR=4.77; $p = .02$); previous mandate to a batterer program (OR=3.172; $p = .05$). This equation was statistically significant (Model $X^2 = 9.07$; $df = 3$; $p = .03$; $n = 155$), but again accounted for little of the variance (Cox & Snell R Square=.06). The logistic regressions predicting any violence and any crime also showed no significant effect for case management, but different characteristics as significant predictors (predictors for any violence: the man drunk on a monthly basis; the woman also arrested at recent incident, the woman feeling “very safe”; predictors for any crime: the woman also arrested, protection order against the man, the woman feeling “very safe”).

Summary

The principal question facing the case management project was whether case management for the African-American men would improve batterer program outcomes. The comparison of the outcomes for the sample of men receiving case management and a comparison sample of men who did not indicates no “project effect” on the program outcomes. That is, the outcomes of batterer program dropout, re-assault and threats, women’s perceptions, and re-arrests were not significantly different for the men receiving

case management compared to men receiving only batterer counseling. Any variation in the characteristics of the two samples does not appear to account for the results—that is, the sample characteristics do not explain the “no effect.”

The apparent failure of the case management may in part be attributable to the shortcomings of the project’s implementation, described in Part I. This possibility is suggested in the significant difference in outcomes over the duration of the project. The outcomes were less positive at the beginning of the project during the staff’s inconsistency and breach of procedures. The outcomes improved, however, under new staff and their conformance to procedures. This finding at least raises the possibility that a fuller implementation of the case management might produce even more positive outcomes compared to no case management. As suggested in Part I, several barriers such as staff costs and time, and effective referral sources, however, make full implementation difficult and perhaps impractical.

SERVICE CONTACT FOR REFERRAL AND NO REFERRAL

Method

The intent of the DACC referrals was firstly to increase the men's contact with other social services. An increase in social service contact should therefore be evident following the DACC program intake when the case management was conducted. To test further the success of this intent, we examined the men's service contact reported by their female partners at three months after program intake, and compared the nature and rate of that contact against the prior sample of DACC participants who did not receive the case management referral.

As part of each 3-month follow-up interview, the women were asked to report on their partner's service contact in three areas: any assistance or support other than the program, and then more specifically, any treatment for alcohol and drug abuse (detox, inpatient, outpatient, 12-Step), counseling other than the domestic violence program (individual family or couples, group, clergy or church group, mental health clinic), and any other assistance (i.e., church, recreation, parenting, support groups, job training, self-help materials, medical care). If a woman indicated that she "didn't know" or was "uncertain," then that case was omitted from the analysis (16% of the 501 responding women from the case management and non-case management samples together).

We also considered the service contact at further points during the one-year follow-up to see if the service contact increased beyond the initial three-month follow-up. Based on the intent of the systematic referrals, we would expect that the men who received the case management assessment and referrals would have higher levels of service contact compared to the men in the previous sample who did not receive this service. Cross-tabulations of the different categories of service contact by case management (i.e., referral versus no referral samples) were used to test this expectation (Fisher's Exact Test, $p < .05$).

Results

The overall extent of social service contact among the batterer program participants, according to their female partners, is somewhat encouraging but not necessarily attributable to case management. As indicated in Table 5, over a third (34%) of the men from both samples received formal assistance of some kind (in addition to batterer counseling) within the first three months after batterer program intake. However, only a small portion of the men received other counseling (14%) or drug and alcohol treatment (11%). (About 6% of the total sample received both alcohol/drug treatment and other counseling.) Nearly a third of the men (30%) reportedly obtained other kinds of help. This category includes informal help-sources such as self-help materials, recreational activities, special clubs, and church attendance, as well as more formal services such as job training and placement services, parenting programs, and medical care.

The men who received systematic referrals were more likely to have obtained more of this additional formal help or assistance, but it was not in the areas targeted by the referrals. As shown in Table 5, the referred men were 50% more likely to receive additional "formal" help or assistance (44% vs. 29%; $p < .01$) than the men in the no-referral sample. However, there was no significant difference between the two groups (i.e., referral vs. no-referral) for other counseling (15% vs. 13%, n.s.) or drug and alcohol treatment (13% vs. 10%, n.s.). The major difference was for "other kinds of assistance" (49% vs. 26%, $p < .01$).

According to Table 6, the men with referrals and the men without referrals had similarly low rates of contact with job training or placement services (7% vs. 5%), and with parenting classes (4% vs. 3%), despite referrals specifically in these areas. The main difference was in church attendance with the referral men twice as likely to attend church (22% vs. 11%; $p < .01$). They were also much more likely to have contacted “other” services or activities not mentioned in our item list (13% vs. 4%, $p < .01$). These included getting a job, talking to friends, attending GED classes, and Bible class or study. “Getting a job” (not through referral) accounted for the significant difference between referred and non-referred men: ten of the thirteen men who got a job were from the referral (i.e., case management) sample.

The service contact for the referred men did increase over time for all service categories (i.e., any help, other counseling, drug and alcohol treatment, other assistance). As shown in Table 7, the portion of referred men who had service contact nearly doubled from the 0-3 month follow-up period to the 0-12 month follow-up period. A significant difference between the service contact of the referred and non-referred men continued through the 0-6 month follow-up for the “any help” category, but was gone by the 12 month follow-up (0-12 mos.). Those men indicating “any help” were nearly equivalent by then. The significant difference for the “other assistance” category remained throughout the follow-up periods. The service contact with “other counseling” and “drug and alcohol treatment” was nearly the same for the referred and non-referred men throughout the follow-up.

TABLE 5: SERVICE CONTACT FOR NO-REFERRAL vs. REFERRAL AT 3-MONTH FOLLOW-UP (percentage)

Service Contact	Sample		Total n=419
	Referral n=122	No-Referral n=297	
Any assistance	44	29	34*
Other counseling	15	13	14
D&A treatment	13	10	11
Other help	49	26	30*

*p<.01; D&A=drug and alcohol

TABLE 6: ITEMS FOR “OTHER ASSISTANCE” (percentage)

“Other help” Item	Sample		Total n=419
	Referral n=122	No-Referral n=287	
Church attendance	22	11	15*
Recreational activity	2	4	4
Parenting classes	4	3	3
Special clubs	0	1	1
Job placement	7	5	6
Self-help materials	1	2	2
Medical care	3	1	2
Other items	13	4	7*

*p<.01

TABLE 7: SERVICE CONTACT FOR REFERRALS OVER TIME (percentage)

Service Contact	Time Period			
	0-3 mos. n=122	0-6 mos. n=105	0-12 mos. n=83	3-12 mos. n=83
Any assistance	44*	60*	75	68
Other counseling	15	24	28	21
D&A treatment	13	18	24	16
Other help	40*	60*	79*	72*

*p<.01; D&A=drug and alcohol

Summary

In sum, the intention to increase service contact with systematic referral was not fulfilled, according to the women's reports about the men. The referred men were significantly more likely to have obtained some assistance beyond the batterer program, but not in terms of other counseling or drug and alcohol treatment. The main difference was other forms of assistance, specifically church attendance and "getting a job" on one's own. Job placement and employment service was one of the main referrals, along with education, parenting classes, and drug and alcohol treatment. The portion of those contacting job placement services was, however, relatively small. The difference in the portion of men attending church is difficult to explain. There was no explicit referral to churches or church programs. Church attendance may indicate more motivation to reach out or change that was spurred by the extra attention of assessment and referral.

The obvious limitation of these findings is that the service contact was reported by the women. The women may have not had sufficient contact or communication with the men to accurately assess his service contact. They did have the option, however, to indicate that they did not know. Those cases were deleted from the analyses, as indicated in the method section. The extent and impact of the service contact is also not assessed, nor is the reason or means of the contact. We do not know for sure whether the service contact was directly related to referral or not. In any case, the evidence for an increase in service contact associated with systematic referral remains weak.

SERVICE CONTACT AND PROGRAM OUTCOMES

Method

The main assumption underlying the referrals is that additional services help to reduce further the men's abuse; re-assault, and re-arrests. We examined this assumption with bivariate and multivariate analyses with men who had contacted various services beyond the batterer counseling versus those who had not (in both the referral sample or previous no-referral sample). In the bivariate analyses, we first cross-tabulated the cumulative re-assault (for 0-6 months, 0-12 months, and 3-12 months) by the categories of service contact (i.e., any additional assistance, other counseling, drug or alcohol treatment, and other help). Related outcomes, such as threats, severe re-assault, feeling safe, and the extent that the man changed were also examined as "outcomes," along with re-arrests. Our multivariate analyses used logistic regressions to control for possible differences in characteristics between the men with service contact and those without any. Different characteristics of the men with and without service contact could account for the results in the bivariate analyses, especially considering that the men with service contact are likely to have more problems that might contribute to re-assault (e.g., drug or alcohol abuse, psychological problems).

As in the previous confirmatory analyses for case management, variables for demographics, relationship status, previous behavior, prior intervention, and perceptions were entered into the equation predicting any re-assault during the follow-up, and also for re-arrests. Each category of variables was entered as a "block" using a forward stepwise procedure. The variables for service contact were then alternately entered (i.e., direct entry with no stepwise removal) to examine their contribution to the re-assault or re-arrest outcome. The service contact categories for 0-3 months were used since these are most likely to represent contacts associated with the referrals made at batterer program intake. We were specifically looking for any statistically significant odds ratio for the variables indicating any assistance, other counseling, drug and alcohol treatment, and other help.

Results

Re-assault: According to both bivariate and multivariate analyses, additional service contact did not significantly improve the batterer program outcomes (i.e., reduce re-assault or re-arrests) (see Tables 8 and 9), but there are some encouraging tendencies in the expected direction. A direct comparison across the categories of service contact (i.e., bivariate analyses) shows no statistically significant differences in the cumulative re-assault or re-arrest rates between the men with various kinds of service contact and those men with no such contact (i.e., any additional assistance, drug and alcohol treatment, and other counseling, and other help.) There is a tendency in the expected direction for drug and alcohol treatment (0-3 mos.) and re-assault (0-12 mos.: Treatment 21% vs. No-treatment 29%; $p=.34$, $n=337$); and also for "other help" (0-3 mos.) and re-assault (0-12 mos.: Other help 22% vs. No-other 30%; $p=.15$; $n=337$). These tendencies are not, however, statistically significant, according to the Fisher's Exact Test at $p<.05$. The tendencies were similar for the 3-12 month follow-up period after program intake and referral, except for "other help" which showed no influence in this outcome period. This 3-12 month period allowed for the acquisition and impact of the extra service.

Additionally, drug and alcohol treatment was associated with a lower rate of “severe re-assault.” The treated men were half as likely to severely re-assault their partners during the 0-12 month follow-up (Treatment: 9% vs. No-treatment 22%, $p=.07$, $n=337$). This difference approached statistical significance ($p=.05$). The rates for severe re-assault (0-12 months) were also lower for men indicating “other help” (16% vs. 22%, n.s.), but not significantly so.

The bivariate analyses show a similar tendency for the three main crime categories of interest, but must be viewed with caution given the small sample size ($n=113$) resulting from the random sampling of the two referral and no-referral samples to select arrest records, and the attrition of service contact reports during follow-up (see Table 9). As with re-assault, the men making contact with drug and alcohol treatment were a third less likely to be arrested for any crime during the 0-12 month follow-up (Treatment: 20% vs. No treatment: 29%; n.s.). Interestingly, men with other counseling, other help, or any assistance were almost twice as likely to be re-arrested for domestic violence—the opposite of our expectation (e.g., Any assistance: 15% vs. No assistance: 7%; n.s.).

TABLE 8: RE-ASSAULT BY SERVICE CONTACT (percentage)

Re-assault	D&A Treatment			Other Counseling			Other Help			Any Assistance		
	Yes	No	Sig	Yes	No	Sig	Yes	No	Sig	Yes	No	Sig
Any during 0-12 mos.	21	29	.34	26	28	.96	22	30	.15	27	27	1.0
Any during 3-12 mos.	15	22	.41	23	21	.70	20	22	.66	25	19	.26
Severe during 0-12 mos.	8	22	.07	20	19	1.0	16	22	.77	21	20	.77

$n=337$; Significance (Sig.) based on Fisher’s Exact Test (two tailed).

TABLE 9: RE-ARREST BY SERVICE CONTACT (percentage)

Re-arrest during 0-12 mos.	D&A Treatment			Other Counseling			Other Help			Any Assistance		
	Yes	No	Sig	Yes	No	Sig	Yes	No	Sig	Yes	No	Sig
Domestic Violence	7	9	1.0*	16	8	.21*	14	8	.33	15	7	.18
Any Violence (domestic violence or other assault)	13	14	1.0*	17	14	.68*	14	16	1.0	15	15	1.0
Any Crime	20	29	.76*	33	27	.73*	29	30	1.0	28	28	1.0

$n=113$; Significance (Sig.) based on Fisher’s Exact Test (two tailed): * includes one cell with less than 5 cases.

The multivariate analyses produced appear to confirm these results. The categories for service contact were not significant predictors of the re-assault or re-arrest outcomes, after controlling for the men’s characteristics. According to the odds ratios, drug and alcohol treatment did, however, appear to lower the chances for re-assault during the 0-12 month follow-up period ($OR=-.46$; $p=.33$), as did “other help” ($OR=-.60$; $p=.07$). The inclusive variable, asking if there was *any* help or assistance, also suggested a decrease in the

likelihood of re-assault and was approaching statistical significance (OR=.74; p=.10). Only one of the control variables significantly influenced the likelihood of re-assault: the man perceiving that his partner felt “very safe” (OR=-.49; p=.01). The equation overall was weak both in terms of the measured variance (Cox & Snell R Square=.03) and in its statistical power (Model $X^2=10.39$; df=5; p=.07; n=302). These results were similar for the follow-up period 3-12 months after program intake and service referral (Cox & Snell R Square=.039; Model $X^2=9.52$; df=5; p=.09; n=259).

We also tested for the effect of continuing each service category through the 6-month follow-up—that is, did continued service contact improve the re-assault outcome? To do so, we entered the service contact variables for 0-6 months into the equations, and also interaction terms for service contact at 0-3 months and 0-6 months (e.g., alcohol treatment *and* other counseling). None of these variables or interactions significantly influenced the re-assault outcome.

Logistic regressions using the service categories to predict re-arrest produced similar results. None of the service categories were statistically significant predictors in separate equations with re-arrests for domestic violence, any violence, and any crime as outcomes. The odds ratio for drug and alcohol treatment did suggest a reduction in domestic violence re-arrest for those men who contacted this kind of service (OR=-.75; p=.26), while the odds ratios for the other service categories suggested an increase similar to those in the bivariate cross-tabulations.

As in the previous logistic regressions with case management, the re-arrest outcomes produced different sets of predictors. The significant predictors for domestic violence re-arrest were drunkenness on a monthly basis (OR=4.44; p=.05) and being on probation (OR=6.45; p=.03). The predictors for any violence re-arrests were the woman also being arrested at recent incident, the man being on probation, and the man claiming racial discrimination in the arrest or court action; the predictors for any crime re-arrest were unemployment, the woman also arrested, and the woman feeling “very safe.” All three equations for re-arrests are significant but account for a relatively small portion of the variance (e.g., the equation statistics for domestic violence re-arrests are: Model $X^2=16.91$; df=8; p=.03; n=115 and Cox & Snell R Square=.14).

Other Abuse and Women’s Perceptions: Interestingly, the portion of men who threatened their partners was significantly higher for the men who obtained drug and alcohol treatment and for men who had other counseling (0-3 months after intake). For instance, 46% of the treated men threatened their partners during the 3-12 month follow-up period versus 30% of the men who did not receive treatment (p<.05; n=311). Similarly, approximately half of men with additional counseling (52%) threatened their partners versus a quarter (27%) of the non-counseled men (p<.01, n=311). These differences persist for the 0-3 month, 0-6 month, and 0-12 month follow-up periods, as well.

In terms of the women’s perceptions, the women whose partners sought “other help” were more likely to report “feeling very safe” at the 3 month follow-up (82% vs. 67%; p<.01, n=391). However, this difference was not significant at later follow-ups or for other categories of service. The men with “any assistance” or “other assistance” were more likely to have changed some or a great extent, according to their female partner. For example, 65% of the men with “any assistance” had reportedly changed to some/great extent, whereas 52% of the non-treated men had changed to this extent at the 12-month follow-up (p<.05, n=333). The men with alcohol treatment or other counseling were also more likely

to have changed, but the difference was not statistically significant (e.g., alcohol treatment: 67% some/great change vs. no-treatment: 55% some/great change; $p=.21$, $n=333$).

Summary

The expectation that additional service contact would improve the batterer program outcomes was not supported, according to analyses of the women's reports of their partner's service contact and re-assault, and also re-arrests. In both bivariate and multivariate analyses, the men who received any additional assistance, drug treatment, other counseling, or other help were no less likely to re-assault their partners. The men receiving some form of drug and alcohol treatment and other help did have slightly lower rates of any re-assault and severe re-assault, but this tendency was not statistically significant. Interestingly, the men with drug and alcohol treatment or other counseling were significantly more likely to have threatened their female partners during the follow-up. It is possible that these men blamed their partners for having to contact the extra services, were more distressed and threatening and therefore warranted the services, or were stirred by the additional issues exposed in the services. One positive sign emerged from the women's perceptions: the women were significantly more likely to identify some or a great change in their male partner if he had assistance of some kind.

As mentioned in the previous section, the precision of the service contact measure is questionable. The various categories of service contact do not account for the extent or nature of the various services, nor do they consider the combination of services that some men might have received. The tendencies toward lower re-assault for those men with drug treatment or other help, therefore, warrants further investigation with more refined measures. Also, the attempt in logistic regressions to control for this possibility of different characteristics across the men with service contact and those without is not likely to be sufficient. This is especially the case given the extent of the problems that are likely to contribute to men making service contact in the first place. An experimental study that randomly assigns men assessed with influential alcohol or psychological problems to additional treatments would be the ideal, but it is unlikely to be practical or easy to implement.

PART III: CONCLUSION

Summary

Our evaluation of the case management project at the Domestic Abuse Counseling Center shows little benefit from the case management overall. This result may be related to the difficulties in implementing the case management, getting men to comply with the referrals, and the limitations of the referrals themselves. There is some indication that improving the implementation of the referral system improves the outcomes. It would logically follow that implementing case management as designed might have the expected positive effect on outcomes with African-American men. The “systematic referral” that was implemented in this project was, however, not sufficient in itself.

Formative Evaluation: Our formative evaluation of case management with batterer program participants exposed the problems and limitations of the case management demonstration project, and the difficulties of implementing case management in general. The case management project was not implemented as initially designed primarily because of time constraints at intake and staff shortcomings during the project. As a result, the case management might more accurately be characterized as “systematic referral” than conventional case management. The men’s intake assessments were less thorough than initially intended, the case management follow-up calls were fewer and less frequent, and portions of the computerized record-keeping were not completed. However, the streamlined referral did improve over time after two experienced staff replaced the initial project staff.

The essence of the case management project was maintained, nonetheless, and basic needs and referrals were identified for over 202 men as planned. In follow-up interviews with a subsample of men, some men did readily disclose personal problems, appreciated the referrals, and made helpful contacts, despite the limitations of the implementation. According to staff interviews and observations, men may also have been more responsive to the batterer counseling as a result of the personal attention and show of concern. The majority of men, however, were openly resistant or unmotivated to contact referral sources. They may have benefited from coerced compliance--namely, court-mandate to referrals with sanctions for non-compliance. This sort of mandate is currently being tested in a more elaborate screening process for mental health and alcohol problems followed by mandated referral for those men who screen positive for these problems (Gondolf, 2003).

According to the available clinical records, the referrals were not comprehensive and the compliance to referrals was low. Most of the men were referred for job or financial assistance, and only a small portion received referrals for substance abuse or mental health problems. Less than half of the men (40%) were given more than one referral, but the average number of referrals increased over time. The portion of men who actually contacted a referral agency was less than half (43%) of those originally referred, but it did increase over time as the implementation improved.

The computerized records also indicate that only a portion (43%) of the referred men were contacted as part of the case management follow-up calls, and the contacts with many of these men were made for attendance and fee issues rather than referral follow-up. The portion of men contacted in the case management follow-up did, however, increase later in the project. Finally, the outcome of these follow-up calls is unclear because of incomplete or

insufficient records, but an encouraging portion of the men did report that “things were going well.”

In sum, the referrals were primarily to address employment issues. More referrals might be expected to substance abuse and mental health treatment given that these problems are highly associated with batterer program participants. A previous study, for instance, showed that over half of the batterer program participants screened positive on the Michigan Alcohol Screening Test and over a fifth showed evidence of a major psychiatric disorder on the Millon Clinical Multi-Axial Inventory (Gondolf, 1999). Also, case management follow-up calls needed to be more extensive considering the portion of men who did not initially contact a referral agency and the nature of their problems.

The most striking finding of the follow-up interviews with the men is that most of them claimed they did not receive any referral. This could reflect the large number who failed to contact a referral, according to the clinical records; the men’s failure to remember the referrals; or their resistance to questioning about their compliance in the interviews. Moreover, only two-thirds of the men who recalled being referred reported that they actually contacted a referral. About half of these thought the referral was of little help, and few believed it helped them reduce their domestic abuse. Very few men recalled receiving a case management follow-up call, and most of these men found the call of little or no help. However, a majority of responding men thought the referral system should be continued mainly because the additional information was useful to know—even if not acted on. They especially wanted more concrete help with finances and employment. From the men’s reports, the referral system appears overall to have had little usage and impact.

Outcome Evaluation: Our outcome evaluation, comparing the outcomes for the sample of men receiving case management to those who did not, indicates no “project effect” on the program outcomes. That is, the outcomes of batterer program dropout, re-assault and threats, women’s perceptions, and re-arrests were not significantly different for the men receiving case management compared to men receiving only batterer counseling. Any variation in the characteristics of the two samples (i.e., referral/case-management and no-referral/no-case management) does not appear to account for the results—that is, the sample characteristics do not account for the “no effect.”

Moreover, the fundamental assumption that additional service contact would improve the batterer program outcomes was not supported, according to analyses of the women’s reports of their partner’s service contact and the outcomes of re-assault and re-arrest. In both bivariate and multivariate analyses, the men who received any additional assistance, drug treatment, other counseling, or other help were no less likely to re-assault their partners, or be re-arrested. The men receiving some form of drug and alcohol treatment and other help did have slightly lower rates of re-assault and re-arrest, but this tendency was not statistically significant. Interestingly, the men with drug and alcohol treatment or other counseling were significantly more likely to have threatened their female partners during the follow-up. It is possible that these men blamed their partners for having to contact the extra services, were more distressed and threatening and therefore warranted the services, or were stirred by the additional issues exposed in the services.

The outcome evaluation also substantiated the principal finding of the formative evaluation that case management was not fully or sufficiently implemented. For instance, the women’s reports during the follow-up showed the men receiving case management were significantly more likely to have obtained some assistance beyond the batterer

program, but not in terms of other counseling or drug and alcohol treatment. The main difference was in other forms of assistance, specifically church attendance and “getting a job” on one’s own, yet “job placement and employment service” was one of the main referrals, along with education, parenting classes, and drug and alcohol treatment. The portion of those contacting job placement services was relatively small across the samples.

The impact of the case management implementation is evident in the change of outcomes over the duration of the project. The outcomes were less positive at the beginning of the project during the staff’s inconsistency and breach of procedures. The outcomes improved, however, under new staff and their more thorough compliance with procedures. This finding reinforces the possibility that a full implementation of the case management might produce more positive outcomes compared to no case management.

Implications

Our study reveals implications for the implementation of case management in domestic violence counseling programs. One, additional and experienced staff are needed to conduct more extensive assessments at intake. Two, the referral agencies need to more effectively receive and assist the men. Three, the men’s compliance to the referrals needs to be increased through court-sanctions for non-compliance (i.e., make the referrals a mandatory part of their court-ordered counseling). Four, case management follow-up calls need to be made in order to monitor, support, revise, and extend the referrals. The problem with these sorts of recommendations is that they cost much more in terms of staffing, supervision, and administration than funding for the evaluated project allowed and that may be available to batterer programs in general.

A new project is currently testing a shorthand way to improve assessment and referral compliance (Gondolf, 2003). Screening tests for psychological disorders and alcohol abuse are being administered at batterer program intake, and men are being referred to a clinical evaluation and additional treatment on this basis. The referral agencies are prepared to respond to the special population of batterer program participants and are to report compliance directly to the batterer counseling program. Non-compliant cases, in turn, are reported to the court for sanctions. The main shortcoming of this new project is that it does not address the financial needs of many of the batterer program participants and especially the African-American men. Financial need was the main reason for referral in the case management project and remains a significant barrier to program completion and successful outcomes.

Other approaches to case management may make the implementation more complete as well. In some jurisdictions, case management is conducted through the probation department which may view non-compliance to referrals as a violation of probation and have more leverage over compliance. On the other hand, case management through a community-based umbrella agency may increase coordination of referral services and distinguish it from the criminal justice system. Additionally, there are a few batterer programs that incorporate case management within their program rather than as an adjunct to it. One option is to have the case management be included as part of the curriculum. That is, the supervision of referral compliance and referral to additional services could be conducted through the group counseling sessions. Another option is to have men receive job counseling, drug and alcohol treatment, or psychotherapy directly from supplemental batterer program staff.

As suggested in the introduction, coordination of service delivery through domestic violence services might improve case management. The case management in this study occurred with very little communication or preparation with the referral services. The capacity and activity of the services had, moreover, not been fully assessed. Discussion through a domestic violence council might lead referral services to adopt a tailored approach to the batterers and protocols that accommodate them. The councils help to develop a shared mission, knowledge, and concerns and to offer the leadership that enacts these. As mentioned in the introduction, the research on the success of these councils is limited, but according to the perceptions of their members, these councils are effective in improving service delivery in general (Allen, 2005, 2006).

Qualifications

It would be premature to dismiss outright the utility or effectiveness of case management in batterer programs. The current findings showing “no effect” may be compromised by several limitations and therefore warrant replication. The formative evaluation is, for instance, based on an analysis of incomplete records of the project implementation, although there was no substantial difference in characteristics between the subjects with records and without. The outcome evaluation used broad categories for service contact that did not consider the extent, nature, and combination of services. The impact of referral services is likely to be a much more complex process of service delivery and response. The service contact was, moreover, based on the women’s report of the men’s behavior that may have been incomplete or misinformed. An additional concern relates to lack of an experimental control or randomized comparison sample. Differences in batterer characteristics across the case management and non-case management samples may not be fully controlled in the multivariate analyses used to confirm the bivariate comparisons. The characteristics that were assessed, however, proved to be fairly similar across the two samples.

The DACC batterer program may, moreover, have unique features that make it less than representative. For example, the program is highly associated with a domestic violence court and may appear, especially to African-American men, as an extension of the criminal justice system bent on punishment rather than assistance. It is situated in an urban center with over half of its participants of African-American descent, in contrast to central and far west cities with a greater diversity of batterer program participants. The city of the evaluated program, moreover, faced several years of financial cutbacks that have affected the support of social services that might be referral sources for the batterer program case management.

The case management in this study, furthermore, focused on African-American men in response to the effort to improve the less favorable outcomes of batterer program participants who are African American. The question remains whether similar results would be achieved with Caucasian men who are less likely to be suspicious of the courts and batterer program, than African-American men who are more likely to see them as discriminatory and punitive. Also, Latino men may be even more reluctant to seek out referral services since the referrals may increase exposure of undocumented status. Their efforts to contact referrals may, moreover, prove fruitless given the movement in many states to deny services to migrants.

The ideal would be to have an evaluation of case management replicated in various

cities with a diversity of batterer program participants using an experimental design that randomly assigns batterers to different case management options. The case management would need to be more extensively funded to help ensure sufficient and expert staffing, and be more thoroughly supervised to ensure proper and full implementation. More details on the referral service contacts should be obtained, along with records from services to help verify women's and men's reports on their help-seeking in response to case management. The role of criminal justice oversight and sanctions for non-compliance, along with referral service responsiveness and effectiveness, needs further consideration, as well.

Conclusion

The outcome evaluation of the case management demonstration project indicates no significant improvement on batterer program dropout, re-assault, and re-arrests, as well as threats of violence and women's perceptions. There is also little evidence that contact with additional services in general improves outcomes. (Contact with drug and alcohol treatment appears to reduce substantially severe re-assault.) The formative evaluation of the project does, however, identify a variety of shortcomings in implementation of the project. It reveals instructive challenges in implementing case management within the demands of an on-going batterer program, the difficulty of ensuring compliance to referrals, and the minimal benefit from merely systematic referrals. Moreover, the outcome evaluation appears to confirm that superficial assessment, referral, and supervision are insufficient. The possibility of improving program outcomes will require a more consistent, intensive, and comprehensive implementation of case management—and the resources that these would entail.

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APPENDIX

Description of Case Management Demonstration Project

Case Management Design and Procedures

Culturally-Focused Batterer Counseling for African-American Men:
Summary of an Experimental Clinical Trial

DESCRIPTION OF CASE MANAGEMENT DEMONSTRATION PROJECT

Counseling Program: The setting for our proposed study of specialized case management will be the Domestic Abuse Counseling Center (DACC) in Pittsburgh, Pennsylvania. DACC offers weekly sessions of 1½ hours for groups of 13-18 men for a required duration of 16 weeks. A staff counselor follows a primarily instructional or didactic approach that conforms to a gender-based cognitive-behavioral curriculum set forth in the DACC facilitators' manual and monitored by a program director. The curriculum follows the fundamentals prevalent in the prominent manuals in the field (e.g., Pence & Paymar, 1993; Stordeur & Stille, 1989; Russell, 1995). In our previous multi-site evaluation, two complex statistical models show this approach to be appropriate therapeutically (White & Gondolf, 2000) and effective in reducing re-assault beyond arrest and court action without batterer counseling (Gondolf & Jones, 2001; Jones et al., in press).

The program begins with an initial group orientation meeting where program staff gather necessary information, present an overview of the program and its policies, introduce abuse and violence avoidance, assign men to a neighborhood meeting site, and set fees on a sliding scale. Two unexcused absences or an arrest for re-assault results in the man's dismissal from the program and return to court. The referrals come from a preliminary hearing in a specialized domestic violence court, which has been developed to ensure a "swift and certain" response to domestic violence arrests. The referred men must appear 30 days after court referral to demonstrate compliance to the referral and again at 90 days to demonstrate program completion. This "judicial oversight" is in contrast to the slow and uncertain response of the vast majority of probation offices to non-compliance (see Gondolf, 2000b). This procedure will help to minimize contamination from a variation in court delays and non-compliance response.

Site Features: The site offers several features that will facilitate the implementation of the proposed study. The volume of African-American court referrals will make subject recruitment possible in an acceptable duration of time. DACC receives approximately 1200 court referrals per year—95% of the court referrals. Half of these referrals are African-American men. We can comfortably estimate that 30-35 African-American men per month can be recruited for the study, or a total of at least 200 within 6-8 months. (This projection includes a refusal rate of 5%.) DACC also maintains neighborhood-based sites for group meetings, which helps to counter the dropout and non-compliance associated with long distances and unfamiliar settings (Humphreys & Woods, 1993).

The program length of DACC is four months as ordered by the court. Our previous multi-site evaluation showed three months to be a threshold for dropout in longer programs and a counter to the possible impact of a longer program length (Gondolf, 1997; 2000c). We found no significant difference in outcomes for the DACC program versus a 6-month and 9-month program, and there is no evidence as yet to demonstrate that the longer programs in themselves substantially improve outcomes (Gondolf, 1999a).

The current and previous research at DACC, moreover, provides a foundation for the proposed study. The current NIJ-funded evaluation of culturally-focused counseling offers two equivalent comparison groups and an established structure for subject recruitment, administering background questionnaires, and conducting a follow-up. These research procedures were established in our previous multi-site evaluation of batterer intervention systems (Pittsburgh, Houston, Dallas, and Denver) funded for six years by the Center for

Disease Control, US Department of Health and Human Services. They proved successful in obtaining subjects, protecting the men's partners, achieving high response rates, obtaining valid self-reports, and having statistically robust results (for a summary of the documentation, see Gondolf, 2001a).

Case management

The case management includes conventional case management procedures with additional cultural considerations. The two case managers are employed by and accountable to the counseling program, rather than a probation or corrections department. Their only job is to work with the program participants assigned to them. Both case managers will be African-Americans from the Pittsburgh community and will be trained by our consultant with expertise in working with African-American men arrested for domestic violence. This consultant is Oliver Williams, a professor of Social Work at University of Minnesota and Executive Director of the National Institute on Domestic Violence in the African-American Community. His two-day training will include procedures on identifying cultural and social issues, making referrals to resources and services, and developing and sustaining appropriate referral sources for African-American men.

The case management will proceed as follows. The case managers will meet individually with each man within two weeks of the court order to batterer counseling. They will track and locate men who do not respond to the court liaison's instructions to contact the case managers for an appointment and appear at an assigned program intake session. They will make three attempts to contact the men who did not comply with their appointment and attempt to resolve the problems causing their non-compliance. At the initial case management appointment, the case managers will conduct a formalized needs assessment considering prior abuse, other criminal activity, alcohol and drug use, psychological and physical health, social service contact, and social support. The man's background questionnaire, completed at program intake, will serve as a guide in this assessment.

Men identified as severely abusive toward their partners, arrested for prior violent assaults towards others, and heavy drinkers will receive intensive case management, which will include weekly contact with the case manager. All other cases will initially have bi-weekly contact unless the need for more contact arises. These procedures respond to the most prevalent risk markers for re-assault (Jones & Gondolf, 2001) and recommended procedures for on-going risk management (Borum, 1996; Heilbrun, 1997). The case management is intended not only to make and monitor referrals, but also to educate men to the formal and informal supports in their community and motivate them to access and use these.

At each contact, the case manager will monitor compliance to referrals, reinforce help-seeking, and consider additional needs. He will also discuss batterer program attendance and participation and ways to sustain these. Up to five calls will be made to track the man for each scheduled contact. The last contact will be at the end of the required four months of the batterer program and establish an "aftercare" plan.

The case manager will keep the following records. A tracking and contact form will indicate the number, nature, and result of calls to the batterer program participants, and a clinical-record form will indicate the man's compliance to previous referrals and recommendations, the case manager's response to non-compliance, any new problems or needs, and new referrals and recommendations. These records will be forwarded to the

researchers after the case is complete for tabulation of contacts and description of referrals. This information will be used to help assess the “dose” of the case management raised in the first secondary research question.

Source: PCCD grant proposal entitled “Case management for African-American men,” Edward Gondolf, Principal Investigator, Indiana University of Pennsylvania, January 2002. References are available in this document.

CASE MANAGEMENT DESIGN AND PROCEDURES

The design for the case management to be implemented at DACC was established through a series of staff meetings. The principal investigator participated in these as a facilitator, summarized the agreements and plans, and reviewed them with staff for revision and approval. The case management design outlined below represents the final agreement on what was to be implemented and how it was to be done. Some revisions were made to the original design indicated in the grant proposal in order to adapt to DACC protocols and many necessary details were added.

Case management Assignment

The orientation leader should indicate at the top of the background form the case management site (H1=East Liberty and H2= Mon Valley). The group assignment is to be made at the end of the second case management session and recorded in the DACC database. All the African American men are instructed to attend two case management sessions following the orientation. (White men at the Mon Valley site may be also assigned to case management based on need if there is room in the case management groups. The need may be determined during the fee assessment.)

The first case management session will convene immediately after the orientation. The men are held for another 60-90 minutes for assessment and referral. The second session convenes at the same site the following week at the usual orientation time. This way, the first session is on orientation week and the second is during the week when orientation is not being given at the site. If a man misses the second session, he will have to attend either the second case management session at the other site or wait until the next scheduled "second session" at the original site.

CASE MANAGEMENT (Life Skills Group)

Case management Sessions

Men recruited for case management were to attend two sessions of the Life Skills classes at one of two intake sites in African American neighborhoods. At the first session the group leader incorporates the determination of fees into the case management sessions. The assessment and referral recommendations will be recorded on the current DACC assessment form and entered into the DACC database.

At the second session, the group leader will assign a man to a group and instruct the man to attend the assigned batterer group starting the next week. The referral contacts and results – and any further recommendations -- must be recorded and entered into the DACC database.

Case management Follow-up

After the man completes the case management sessions, a case manager will call him every other week for four months. (The man's active phone number and best time for calling should be obtained in the case management sessions on the assessment form.) Three telephone attempts per week are sufficient. The calling should continue even if the man drops out of the program.

The case manager will ask about a) follow-through with previous referrals or recommendations, b) any problems with the program (e.g., attendance, payment, counselor), c) any new social needs or issues beyond the program, and d) pose additional problem-solving or referrals.

The results of these calls must be indicated in the Phone Log in the DACC Database.

Final Case management Check-up

At program completion/discharge, a case manager will meet the man in-person. The group leader will be notified with a comment on the roster to tell the man to stay after the session for the case management check-up (the man might be let out of the session early for this meeting). The case manager will meet any of the men due for a final case management session in some designated available space at the group meeting site.

The case manager will review a) additional service and referral contacts the man has had since the beginning of the program (including the kind and extent), b) any new or continuing needs or problems, c) and new referrals or recommendations that constitute an aftercare plan. This information will be recorded on a check sheet and entered by the case manager into the DACC database at a later time.

CASE MANAGEMENT SESSIONS

Procedures

The first 1½-hour sessions will begin with new men completing the current DACC case management assessment form. The main topics are education, employment, abuse as a child, parenting problems, criminality, mental health (new category), and alcohol (using the MAST short version instead of the full long version).

The case manager will review the completed form with each man, and/or in the group as a whole, and make recommendations for the main referrals (no more than two referrals for the most pressing issue should be made).

The man is assigned to make some form of contact with the referral and bring evidence of the contact to the next sessions. Encouragement and problem-solving are also offered.

The procedures for time-outs will also be reviewed using the handout men were given in the orientation, or examples of it being used will be sought from the men. The whole group can participate in this exercise.

In the second week of case management sessions, men will report on their referral contacts, discuss barriers or problems with the referral, and suggest continued or further action. This review can be done as a group and reinforced or clarified individually.

Men in the second week will also complete a written exercise about balancing their lives. This can be done and discussed among pairs of men while new men are completing the case management assessment forms.

The case manager will note the referral agencies, type, and outcome on the men's assessment forms and later enter them into the DACC database using the current data entry form.

Order of Sessions

1st week men

- 1) Attendance check and payment
- 2) Introduction to case management
- 3) Complete assessment forms
- 4) Referral recommendations
- 5) Listen to referral contact reports
- 6) Review and/or examples of time outs

2nd week men

- Attendance check and payment
- Assignment to batterer group
- Complete “balancing life” exercise

- Make referral contact reports
- Review or examples of time outs

Objectives of Case management

- Identify social and personal needs and problems
- Make appropriate referrals and confirm completed contacts
- Counter victim or helpless thinking
- Show individual care for men
- Help balance life and change lifestyle

CULTURALLY-FOCUSED BATTERER COUNSELING FOR AFRICAN-AMERICAN MEN: SUMMARY OF AN EXPERIMENTAL CLINICAL TRIAL

INTRODUCTION

In many major urban areas, African-American men comprise at least half of the men arrested for domestic violence and referred to “batterer” educational or counseling programs. The dropout and re-arrest rates of these men tend to be higher than those for white men in the same programs. African-American researchers and practitioners have argued that the conventional cognitive-behavioral counseling with African Americans needs to be revised in order to improve outcomes. “Culturally-focused counseling” has been endorsed as one way to do this. This approach explicitly identifies and addresses cultural issues that may reinforce violence or present barriers to stopping violence, such as prejudice in the criminal justice system. A set curriculum progressively leads men to and through cultural issues, and counselors are trained to acknowledge and elaborate cultural issues that emerge during group discussion.

Clinical Observations

Clinical explanations from social work and psychotherapy suggest that cultural differences contribute to African-American men dropping out of batterer counseling or re-assaulting if they do complete it. Many African-American men draw on a more personalistic culture that values reputation and familiarity over ascribed position or authority. Consequently, they may rely on kinship and friendship networks to talk about their problems rather than strangers in group counseling. Some African-American men are simply confused by the demands to change certain attitudes and behaviors that they see as normative and even essential to survival in their neighborhoods. This is especially the case with some of the anti-violence positions promoted in conventional batterer program curricula. Also, many African-American men may be suspicious of social services in general because they tend to be dominated by whites, who are often unfamiliar and unsympathetic to their social reality and experiences.

The literature on counseling African-American men uniformly prescribes greater social and cultural consideration to mitigate these issues and improve counseling participation and outcomes. It recommends several means to do so: cultural assessment as part of program intake, greater cultural awareness among group counselors, and a broader social focus and interaction in group counseling. These recommendations might be best integrated and implemented through culturally-focused batterer counseling with all African-American men in the group.

Outcome Research

Very little research examines the outcomes of culturally-oriented counseling in general, and the research that is available offers some contradictory results. A comprehensive review of the racial and ethnic outcome research concludes that culturally-oriented counseling produces more positive changes than counseling that does not explicitly consider cultural factors. However, the few outcome studies of conventional treatment groups provide only slight evidence that African-American men necessarily have poorer outcomes in such groups. The limited research on African-American-only groups and

racially-matched counselor-and-client has, moreover, produced inconclusive results. For instance, a few studies indicate similar mental health and alcohol use outcomes after conventional counseling in African-American-only groups or counselor-client matched treatment.

An additional line of research suggests that the lack of evidence supporting culturally-focused counseling is due in part to the cultural diversity within the African-American community. African-American students with a greater sense of racial identity are, for instance, more likely to prefer racially-matched counselors. It is not merely “race” that needs to be identified, but also the cultural attitudes that accompany one’s racial and ethnic background.

Batterer Counseling Evaluations

The research in the domestic violence field is limited to a few outcome studies of conventional batterer counseling and one preliminary study of culturally-focused counseling. A multi-site evaluation of batterer intervention systems offers support for a specialized response to African-American men arrested for domestic violence. In 1995, only half of the African-American men completed the Pittsburgh batterer program compared to 82% of the white men (n=210). Moreover, the African-American men were more than twice as likely to be re-arrested for domestic violence (13% vs. 5%).

A batterer program study in the Baltimore area confirms the role of race in dropout from a counseling approach similar to that used at the Pittsburgh program (N=101 including 40 African-American men). The strongest predictor for dropout was race with African-Americans being less likely to complete the program. Only one preliminary study of culturally-focused batterer counseling has been conducted to date (N=41). The African-American men in the culturally-focused counseling reported feeling more comfortable talking to other men in the group, and were more likely to develop friendships that carried outside of the group. They were more positive about the counselor as well.

Experimental clinical trials of culturally-focused batterer counseling for African-American men are ultimately needed to test the outcomes of this approach against conventional batterer counseling. African-American men would need to be randomly assigned to culturally-focused counseling, conventional counseling in a group of only African-Americans, and a conventional counseling in a racially-mixed group. The African-American-only conventional counseling would be necessary to help isolate the effect of culturally-focused counseling beyond the racial composition of the group. Additionally, the cultural attitudes of the men would be measured and tested as a possible moderating effect on the counseling outcomes. As the reviewed research suggests, individuals with stronger cultural attitudes tend to be more responsive to culturally-sensitive counseling or racially-matched counselors.

METHOD

Research Design

An experimental clinical trial was employed to test the expectation that culturally-focused counseling would improve batterer program outcomes, specifically program dropout, victim-reported re-assaults, and re-arrests during a 12-month follow-up period.

Approximately 500 African-American men, mandated by the domestic violence court in Pittsburgh to batterer counseling, were randomly assigned to one of three counseling options and their respective outcomes compared. The hypotheses were:

1) program dropout, re-assault, and re-arrest rates would be lowest for the culturally-focused counseling compared to conventional counseling in either the all-African-American groups or racially-mixed groups,

2) these outcomes would also be lower for the all-African-American groups with conventional batterer counseling than the conventional racially-mixed groups, and

3) men with high racial identification would have better outcomes in the culturally-focused counseling than in the other two counseling options (i.e., lower dropout, re-assault, and re-arrest rates).

We additionally examined the effect of overrides or reassignments to the randomization, the representativeness of the sample compared to previous samples and other sites, and the impact of program context, such as variations in dismissal policy, on the outcomes.

Counseling Implementation

The experimental group of culturally-focused counseling included a curriculum of cultural topics and discussion of emergent issues, along with basic anti-violence instruction, in a group of African-Americans. Two culturally focused counseling groups were added to the existing batterer program that has been the primary recipient of court referrals for the last 15 years in Pittsburgh. The program has multiple sites for group sessions throughout the city and a representative in the domestic violence court to receive referrals and assist with court supervision of compliance. The conventional group counseling followed a cognitive-behavioral curriculum, available on the internet, with “colorblind” implementation. The largely instructional format focuses on abusive behavior and thought patterns associated with abuse. Nearly all the contracted group counselors have a college degree and counseling experience of a year or more.

An external expert in culturally-focused curriculum helped to establish two groups of culturally-focused counseling beginning in the fall of 2001. He conducted a 3-day training with a group counselor recruited for the culturally-focused groups, and further instructed this counselor by observing and commenting on his performance in the groups on a monthly basis for 4 months. The counselor followed the manual for culturally-focused counseling mentioned above. The criteria for the culturally-focused counselor raised a difficult challenge: finding a man with strong ties to the African-American neighborhoods of the city and yet with group counseling skills sufficient to guide the discussion of the curriculum topics and issues. An African-American man initially recruited for the position developed conflicts with the administration and personal problems of his own. He consequently resigned after a few weeks of the in-service training. His replacement was less experienced in group skills and counseling in general.

All the groups were monitored for “treatment integrity” every six weeks through a combination of direct observation and audio tapes. A monitoring form was used to rate the group sessions on several aspects: curriculum presentation, group process, group leader, men’s participation, and overall impact. Additionally, 100 of the program participants were contacted by phone following the minimum requirement of 16-weeks of program attendance, and asked for their rating of these components and their impressions of the

program curriculum. The direct observation and subject interviews indicated that the counselors were adequately implementing the prescribed curriculum, but the observers later raised some suspicions that the culturally-focused counselor was inconsistent in his adherence to the curriculum and use of group skills.

The context of the batterer counseling, namely its linkage to the courts and enforcement of compliance, appears to contribute to program outcomes. Therefore, we also watched for variations in the program context during the course of the study and found two variations that warranted attention in the analysis. One, the dismissal policy was more strictly enforced in the second half of the study. Two, the probation department began to refer men to the program for 32 weeks instead of the 16 weeks from the domestic violence court (n=48 or 10% of the full sample).

Randomization and Sample

At the program intake, the men completed a structured background questionnaire, the Short Michigan Alcoholism Screening Test, the Racial Identity Attitudes Scale, a research consent notice, and a contact information form. They were then randomly assigned to one of the three counseling options and began attending group counseling the next week. The refusal rate to the assignment was a low 4%, in part because the men were required to attend a group at the program's discretion.

The total sample initially recruited was 501 men. This number includes all the African-American men ordered to the batterer counseling program in Pittsburgh between November 2001 and May 2003. However, some men were reassigned at program intake ("overrides") or during counseling because of scheduling or location conflicts. The total number of subjects randomly assigned with no initial or later reassignment, and also with the typical 16 required sessions, was 335, or 67% of the recruited sample.

One concern with deleting the reassigned non-random subjects was that the remaining sample would not likely be representative of the typical population eligible for program participation. We therefore retained the initial recruited sample of 501 and compared the outcome results for this full sample of 501 against the "pure" randomized sample. Using the total recruited sample also offered greater statistical power for the multivariate analyses employed in the study.

Variables

The three principal outcome variables for comparing the conventional and culturally-focused counseling were: program dropout, re-assault, and re-arrest for domestic violence. "Dropout" was assessed as completing less than the court-required 16 weekly sessions. "Re-assault" was defined as physical abuse of the subject's female partner reported by that partner during follow-up interviews. It was assessed using categories of the Conflict Tactics Scale. Additionally, the women's subjective appraisal of their own safety and well-being were considered. Domestic violence "re-arrests" were determined by reviewing the arrest records of each subject provided by the Pittsburgh police department.

To assess the hypothesized moderating variable of "cultural or racial identification," the Racial Identity Attitude Scale (RIAS) was administered at program intake. An average score of greater than 4 (for the 5-point Likert response) on the "internalization" subscale was used to indicate high racial identification.

Several other variables were assessed at program intake to help describe the sample, test for equivalent subsamples of counseling options, and offer controls for subsequent analyses: demographics, employment, relationship status, alcohol and drug use, past abuse and assault, prior social service and criminal justice contact. The Short Michigan Alcohol Screening Test was also administered at program intake to help identify alcoholic tendencies which are highly associated with program outcomes.

The victim reports of re-assault were obtained through follow-up interviews at 3, 6, 9, and 12 months after an initial interview at the time of the men's program intake. Two research assistants tracked the women using the contact forms of name and address information obtained from the male subjects at program intake and updated with each follow-up interview. The women were paid \$10 for each completed interview through a check mailed to an address they designated. The follow-up interviews were completed in July 2004 with a 66% response rate for the full 12-month period (0-12 months after intake; n=333), and 68% for the full 6 months after program intake (n=343).

Analysis

We first computed the percentages for the variables indicating the selected characteristics of the men in the sample, and compared these sample characteristics to other samples of African-American men and Caucasian men to help assess the representativeness of the current sample. To test for the effect of culturally-focused counseling on the program outcomes, we computed cross-tabulations using Chi Square statistics for each outcome variable with the counseling options, and Partial Eta Squared to help assess effect size. The tabulations were repeated with various samplings that accounted for the randomization implementation and program contingencies (e.g., no assignment change, stricter dismissal enforcement, 16-session mandates only, etc.). Three-way cross-tabulations were also computed using "high racial identification" as a control variable with the program outcomes and counseling options in order to test for a moderating effect of racial identification on the outcomes. Lastly, we conducted confirmatory multivariate analyses to control for the possible influence of the subsample characteristics, randomization implementation, and program context on the outcomes. Forward stepwise logistic regressions with the full recruited sample were computed for the outcome variables. Additionally, the time-to-re-assault was also examined using Kaplan-Meier Survival Analysis and Cox regressions controlling for sample characteristics.

RESULTS

Sample Characteristics

An inspection of characteristics across the three counseling options suggests nearly equivalent groups of men. Over half of the African-American men were over 30 years old (56%), not living with their partners (56%), not fully employed (60%), screened positive for alcoholism (57%), and had been previously arrested for violent crimes other than domestic violence (56%). Men in the racially-mixed option were, however, significantly less likely to have scored positive on the SMAST for alcoholism, but were more similar to the other counseling options in the proportion of men who reported being drunk at least once a month. This distribution of characteristics remains constant when the non-random cases are deleted.

The current sample of African-American men is, however, less likely to be employed than the 1995 sample of African-American men at the same site, and it is also almost twice as likely to be under-employed than African-Americans at other sites previously studied. For instance, the educational level and full-time employment rates of the current Pittsburgh African-American men were markedly lower than those of the Baltimore men in the attendance study mentioned in the introduction. These differences reflect the marked decline in Pittsburgh's economy during the past five years.

A comparison of the characteristics of the African-American men in the current sample to Caucasian men entering the program at the same period (N=71) confirm some expected differences but also expose some broad similarities across the racial groupings. The African-American men were less likely to be married and more likely to have children living with them. However, the two groupings of men had similar levels of partner contact. The African-American men were also more likely to report having used drugs in the past year, but less likely than the Caucasian men to report being drunk. Moreover, a greater portion of the African Americans had been threatened with guns/knives or witnessed shootings/stabbings, although they were similar to the Caucasians in exposure to other types of violence.

Program Dropout

The culturally-focused counseling did not appear to improve program dropout as expected. Approximately half of the men in each of the counseling options dropped out prior to completing the minimum required number of 16 sessions regardless of the sampling (i.e., full recruited sample or pure random sample). The overall completion rate for the current sample of African-American men is nearly the same as that of African-American men recruited at the same site in 1995 for our previous evaluation (n=105). The completion rates of the culturally-focused and conventional all-African-American groups were initially slightly higher than the racially-mixed option, but under stricter enforcement, the culturally-focused and conventional all-African-American options had slightly lower completion rates. Moreover, the men with "very high" racial identification were 30% more likely to complete the culturally-focused and all-African-American options ($p < .05$). Our multivariate analysis controlling for the potential differences in characteristics across the counseling options confirmed the "no effect" finding of the cross-tabulations.

Re-assault

There was no evident reduction in re-assault derived from assigning African-American men to culturally-focused counseling or conventional counseling in the all-African-American groups. The re-assault rate for the African-American men during the 12-month follow-up was 23% according to their partners' reports. This rate is less than the re-assault rate of 30% for a 1995 sample of African-American men at the same program site (n=105 with a response rate of 75%) for the same time period. This difference may be attributable to the increased length of the program (formerly 12 weeks instead of 16 weeks) and the lower partner contact during the follow-up period.

The cumulative re-assault rates were also not statistically different across the options at the 6-month, as well as the 12-month follow-up. There was, furthermore, no difference in the re-assault rates for the post-program period (i.e., the 9-month period following treatment) or when considering only program completers. Other victim-reported outcomes

(e.g., felt “very safe” at the 12-month follow-up) were overall very positive, but again showed no significant differences across the counseling options. While the men with high cultural identification were more likely to complete the culturally-focused and conventional all-African-American options, they were also more likely to re-assault their partners than their counterparts in the racially-mixed option.

Re-arrest

The re-arrest rate for domestic violence was overall relatively low—10% during the one-year follow-up. The re-arrest rate for any violent crime (i.e., domestic violence or other violence) rose to 18%. Nearly a third of the men were re-arrested for some crime. These re-arrest rates are comparable to those in our previous multi-site evaluation. However, the men in the culturally-focused option were twice as likely to be re-arrested for domestic violence as the men in the racially-mixed counseling—a difference that was also statistically significant. There is no significant difference in re-arrest for other crimes of violence or for any crime committed during the follow-up. The logistic regressions basically confirmed the results of the cross-tabulations of both the cumulative re-assault and re-arrest outcomes. Survival analyses also showed no significant difference across the three counseling options for the time-to-re-assault. Program completion significantly decreased the likelihood of both re-assault and re-arrest in all these multivariate equations.

DISCUSSION

Major Findings

The findings of our clinical trial show no apparent benefit from culturally-focused or conventional all-African-American counseling over conventional racially-mixed batterer counseling. There are some variations in the program outcomes, however, that warrant further consideration. One, the dropout rate increased in the culturally-focused and conventional counseling in all-African-American groups following stricter enforcement for absenteeism and delinquent payment. The all-African-American groups appeared more susceptible to the stricter enforcement. Two, although not a statistically significant difference, the conventional all-African-American option produced a slightly higher rate of re-assault than the other two options. Conventional all-African-American counseling, therefore, should be used as a comparison group in future studies to explore this tendency further.

Three, the lowest rates of domestic violence re-arrests were produced by the conventional racially-mixed option where there was likely to be a more direct and emphatic message about stopping violence and the consequences for it. The other groups might benefit from more explicitly establishing the consequences of violence and the means to avoid violence. Four, a moderating effect of high racial identification on program dropout may suggest that counseling in the all-African-American groups does at least more immediately engage the men in the counseling process.

The sample appeared to approximate the goal of randomization, as demonstrated by the similar distribution of characteristics across the counseling options and in the full and pure random samplings. The equivalent results in the cross-tabulations and logistic regressions with the different samplings, and the non-significant influence of the “random” variable in the regressions, further confirm this assumption. Therefore, we might also

assume that the results apply to all the African-American men enrolled in the Pittsburgh batterer program during the recruitment period and not just to an exceptional group that fully complied with the random assignment. The current sample of African-American men was however lower in socio-economic status than the previous batterer programs' samples of African-American men at the same site and at other sites, and than Caucasian men at the same site.

Possible Explanations

We examined several other explanations for the lack of any additive effect from culturally-focused counseling. One possibility is that batterer counseling in general has little or no effect, as a meta-analysis of batterer program evaluations suggests. We previously identified a moderate program effect in our multi-site evaluation using both instrumental variable analysis and propensity score analysis, and argue why this result might be more reliable than those of the available experimental studies. Moreover, the logistic regressions applied to the current data showed that program completion was a significant predictor of partner re-assault and domestic violence re-arrest.

Another explanation within clinical trials comparing alternative treatments is the “dodo bird” effect—that is, counseling approaches tend to produce similar outcomes because they include similar components, structures, or interactions. All of the counseling options in our study had, for instance, a clear message of change, directions on how to change, and group support for change. Furthermore, our options may have merely reflected the comparisons between process (i.e., discussion-oriented) and didactic (i.e., instructional) formats, or between dynamic and cognitive-behavioral modalities, that have shown similar outcomes in depression and alcohol treatment, as well as in batterer counseling.

Qualifications

We examined several other implementation issues of internal validity that could have influenced the results, in addition to violations of the random assignment. For one, our monitoring of “treatment integrity” found some evidence of treatment convergence. The debriefing interviews with the counseling participants reported similar amounts of discussion across the counseling options, but confirmed that the culturally-focused group was much more likely to address African-American issues. Two, the counselor leading the culturally-focused group may have been deficient in group skills and counseling experience. However, the observer consistently rated the counselor as adequate, and substantially more men in the culturally-focused groups rated their counselor as “very effective.” In our estimation, the internal validity of the clinical trial is, therefore, relatively strong.

The threats to external validity caused by the agency context of the culturally-focused groups are of greater concern. The culturally-focused counseling was an appendage to a social service agency that exclusively relied on more conventional counseling and may not have been as supportive of culturally-focused counseling as an agency with a different approach. The program's close relationship with the court and enforcement of compliance may also heighten the perception that the counseling, regardless of the approach, is an extension of the criminal justice system and to be viewed with suspicion. There is no direct evidence, however, that verifies these potential influences.

ADDITIONAL CONSIDERATIONS

There are several broader social and cultural considerations in interpreting the findings, as well. Our study exposed a diversity of racial identification and cultural attitudes that needs to be considered in culturally-focused counseling. Racial identification is obviously a complex and dynamic concept, and one that was only crudely measured by the instrument used in our study. The question remains as to whether men with high racial identification benefit from considering cultural issues in batterer counseling.

The broader social backdrop of racism, discrimination, and prejudice in society at large has been particularly visible in Pittsburgh. In the mid-1990s, a federal human rights commission investigated the police department in response to a highly publicized “police brutality” case. We might assume that this backdrop adds to resistance, resentments, and rationalizations that affect program outcomes, and therefore needs to be more explicitly addressed in culturally-focused counseling at this particular site.

Treatment Implications

A study of this sort does not produce decisive recommendations for treatment and intervention. On the one hand, culturally-focused counseling might not seem worth the extra resources required to recruit and train appropriate African-American counselors, maintain specialized groups along with conventional counseling groups, and negotiate the intra-agency tensions that we observed from introducing culturally-focused counseling. On the other hand, culturally-focused counseling was, for the most part, as effective as conventional batterer counseling. It might be offered at least as an option to which men might self-select rather than be assigned. Moreover, its effectiveness might be improved through some modifications suggested in our study.

For one, the identification, training, and support of appropriate African-American counselors warrants more attention and resources. Two, attendance and payment policies, that adversely affected program completion in the all-African-American groups, might be negotiated more liberally. Three, the culturally-focused counseling might be improved by linkages with resources and services in the African-American community, as the curriculum itself recommends. Also, embedding culturally-focused counseling in a community-based agency operated primarily by African-Americans might enhance program support and service referral.

A final treatment consideration is to approximate the benefits of culturally-focused counseling in racially-mixed groups through a culturally diverse staff and staff trained in cultural sensitivity. This approach alleviates the resource issue of establishing and supporting separate groups for men of different racial and ethnic backgrounds, and may better integrate the advantages of culturally-focused and conventional cognitive-behavioral counseling.

Research Implications

Our findings and qualifications have some obvious implications for further research. The most immediate need is for replication of our clinical trial at other sites and in different settings. The African-American men in our study are not necessarily representative of other cities especially in terms of socio-economic status. Evaluation of culturally-focused counseling might test the impact of linkages and associations with the neighborhood

services and programs, and of embedding the counseling in a community-based agency or organization, rather than as an appendage to an existing batterer program agency.

Culturally-focused counseling also needs to be tested with other racial and ethnic groupings and compared against the culturally-focused counseling with African-American men. If the culturally-focused counseling is more effective with other groupings or with other measures of racial and cultural identification, it would help reinforce the need to screen men for such counseling in order to make the specialized counseling more effective.

NOTE: The complete final report is available at

<http://www.iup.edu/maati/publications/Culturally-Focused%20Counseling--Final%20Report.doc>