Tri-County Batterer Intervention Providers Network Meeting Minutes October 24, 2000

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Topic: Mental Health and Batterers

Washington County has had 5 DV related deaths in past month. In one case the offender showed up at his ex-wife's house, killed her boyfriend, the ex-wife, and himself. He had just completed deferred sentencing. High risk, depressed, dependent. Very compliant. Ex-wife was repeatedly given victim service referrals and restraining order information. Ex-wife contacted P.O. about safety concerns and his mental health. They did safety planning. Offender had a mental health assessment and nothing alarming was found. He was seeing an individual therapist the whole time.

Comments from the group were:
-Need to have better communication/ networking with other providers and courts. Mental helath providers need to be included in the coordinated community response.
-Should we even be working with severe mental health disorders? Such as severe depression, personality disorders, ADHD, delusional, paranoid schizophrenics. Duluth model recommends you screen out mental health issues and that they not be seen in DV groups. Characterological issues also require special attention, since they can be quite disruptive in group. The most common personality disorders are likely borderline, narcissistic, and psychopathic.
-Connection between depression and lethality. Especially with emotional dependency on victim (obsession). We should put big flags up when we see this. There is a piece missing in mental health assessment and risk assessment in catching this.
-Needs to be more cross training. Mental health professionals need to be more aware of and sensitive to DV issues in order to do adequate evaluations.
-Study done by CDC on DV and depression found that approximately one third of the abusive men scored high on a depression assessment.
-How do we work with men who can't function in groups? A current mental health crisis may prevent adequate use of the program and information being provided.
-How do we work with paranoid thought disorders and our own safety with these clients?
-Can we change anything at intake to detect some of these things? Should we be doing any sort of testing? Solutions has used the MCMI in the past, although primarily for research data. Should we be doing a mental health screen? Can discuss some of this next time during talk about Intakes.
-How do we work with men with childhood trauma? When empathy trainings spark feelings around their own victimization as children? Need to work on their own issues from childhood and stop victimization of others at the same time. They need to be given the strong message that they need to stop victimizing others in order to work on their own healing. There is no excuse for their abusive behavior, even if they were abused as children. Number one responsibility is to get across to batterers that they have to stop the violence.

-How do you prevent mental health clients from “poisoning” the direction of the group? These men can be quite needy, dominating of the group and can undermine the group accountability and focus. Suggestion: one on one work, try them out in group before you rule that out as an option, concurrent group and individual work. Financial limitations may make this difficult.
-Agency context makes a big difference in what we are able to do—money, time, laws, and capabilities.
-How do we deal with men who can’t get along with other group members? If they are scapegoated or abused by other members?
-Topic suggested for a later meeting: Methods of identifying mental health issues, referring, and networking. Possibly can develop a hand out or brief.

November 14th topic is Intakes.