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BRIDGING HEALTHCARE, POLICE, AND COURT RESPONSES TO INTIMATE PARTNER VIOLENCE PERPETRATED BY INDIVIDUALS WITH SEVERE AND PERSISTENT MENTAL ILLNESS

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A subgroup of individuals with severe and presistent mental illness (SPMI) commit acts of intimate partner violence (IPV). State and federal legislators have enacted statutes altering police response to IPV. Proarrest laws have curbed police discretion to a degree, and resulted in more IPV arrests. Unaware of alternative options, such as family court, mental health professionals may refer families with IPV to the police. However, perpetrators with SPMI may be inappropriate for adjudication in the criminal justice system. A singular legal response to IPV may miss the opportunity for detection and assertive treatment of SPMI, that could promote safety and reduce the likelihood of violence.

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Offenders with SPMI may also have difficulty comprehending court procedures. This article discusses the potential for a more flexible approach to IPV through interdisciplinary coordination and training of police, judges, attorneys, legal advocates, mental health professionals and substance abuse providers.

KEY WORDS: mental illness; domestic violence; police response.

CASE SCENARIO

> Wanda came to the attention of the prosecutor's office. Her husband had assaulted her and been arrested for a misdemeanor Assault in the Third Degree. They shared three children in common. The police responded to the home, yet Wanda did not want the case to proceed in criminal court. She explained that her husband was under a great deal of stress and didn't mean to hit her. After meeting with Wanda, it became apparent that her husband had violent propensities, had been physically and mentally abusive in the past, and that her children may be at risk as well. Wanda wanted to "drop the charges." She attended a victim information session at the prosecutor's office, which included information on the dynamics of domestic violence, a video of the local shelter and a list of referrals for community agencies. After participating in the session, Wanda did not self-identify as a "battered woman" and the case was reduced to a lower level crime—a violation, called "Harassment." Despite the charges being reduced, the interaction with the police resulted in a referral to Child Protective Services, an agency also working with the family. Shortly after the case was resolved, Wanda returned to the prosecutor's office to speak with the Assistant District Attorney who had run the information session. Her husband had set one of their children on fire for reasons unknown to anyone else. Her husband was severely mentally ill. None of the criminal justice practitioners had screened nor identified that this perpetrator was in need of acute psychiatric care. A tragic outcome resulted despite the involvement of a specialized police and prosecutor unit.

INTRODUCTION

Intimate partner violence (IPV) perpetrators are a heterogeneous population that varies widely in the breadth and severity of their violence

as well as factors related to personality and psychopathology that are likely to contribute to their violence (1). Data support that individuals treated for mental illness are more likely to engage in violent behavior than non-treated individuals residing in the same community (2). Although epidemiologic data on IPV among individuals with severe and persistent mental illness (SPMI) per se are unavailable, it may be that a subgroup of individuals with SPMI are at elevated risk for IPV perpetration given that SPMI have elevated rates of co-occurring substance use disorders and disorders of conduct (3) that are strongly linked to IPV. Difficulties with forming stable partner-relationships may also confer increased risk for IPV in this population given the association of IPV with informal, short-term relationships compared to stable marriages (1).

POLICE RESPONSE TO IPV

State and federal legislators have been passing mandatory and pro-arrest legislation in an effort to curb police discretion for IPV. Although well intended, mandatory arrest policies may not meet the needs of IPV perpetrators with a SPMI, and more importantly, may not meet their partners' needs. Prior to the legislative trend towards mandatory arrest, police utilized a mediation/counseling response, and therefore may have been more likely to refer for medical or psychological care, or to consult with partners in terms of a preferred response. Under the new mandatory arrest laws, police officers may use less discretion, even if they are aware that the perpetrator is severely mentally ill.

The shift from a mediation/counseling approach that predominated in the 1970s to mandatory arrest was influenced by social science mandatory arrest studies. Particularly influential was the Minneapolis Domestic Violence Experiment (4) that concluded that arrests are associated with lower domestic violence recidivism. These policy changes also took place in the wake of successful civil law suits filed against police departments, most notably *Thurman v. Torrington*.[1] In that case, the plaintiff claimed that her constitutional rights were violated due to police officers' nonperformance or malperformance in responding to her calls for help against an abusive, threatening husband. The plaintiff claimed the police responded differently to her calls for assistance than they would have a case involving two strangers. The plaintiff ultimately secured a civil judgment of $2.3 million against the City of

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[1] 595 F. Supp. 1521 (D. Conn. 1984).

Torrington Police following an incident in which she was stabbed and kicked resulting in permanent disabilities.

Some subsequent studies have indicated that arrest policies might unintentionally escalate violence in family relationships (5,6) or were no more effective than mediation (7). However, more recently, analyses of 4,032 incidents based on data combined across five sites showed an association with arrest and less repeat offending based on crime reports and victim interviews (8), supporting that mandatory arrest policies are appropriate. However, data are unavailable to determine whether such policies should also be applied uniformly to the subgroup of IPV perpetrators with a SPMI. In this article, it is suggested that uniform mandatory arrest policies for IPV may have deleterious effects on SPMI offenders as well as their partners, and that these questions require research.

Despite the proliferation of policies and statutes across the United States, myths still abound that officers assigned to IPV calls for service are like "empty holsters" providing a social work role (9). However, the officer at the scene, and even the dispatcher, still retain great discretion when responding to an IPV call. Dispatchers screen these cases and prioritize the calls for the responding officer's response time. Officers ultimately evaluate the case on the scene (9). Hence, there is still great variability in response even in the context of mandatory arrest laws. It is argued that dispatchers and particularly police officers should also consider the presence of a SPMI in their decision-making.

Although improved, police academy training on IPV is minimal considering the frequency with which police officers make IPV calls. Indeed, in one study of 91 police calls for service to homes with children, 85 cases were devoted to domestic violence calls (10). More recently, there has been competition for issues related to homeland security that may reduce domestic violence training further. Police officers are also likely to receive minimal training in mental illness, and mental health difficulties may be particularly difficult to discern in the context of an acute IPV incident.

TREATMENT RESPONSE TO IPV

Equally important is the training of mental health providers to respond to IPV. To underscore the importance of training, some (although not most) domestic abuse incidents may be primarily caused by mental illness (11). Nonetheless, training of mental health providers in domestic violence may be minimal, and competence is likely to vary

considerably by area, setting, and provider. Potential barriers to training may contribute to such variability. Providers treating a SPMI population often focus on the hierarchy of needs including food and shelter and primary medical concerns. IPV may not be perceived as a priority. Time dedicated towards hospital in-services, grand rounds and medical school curriculums is also consumed by myriad competing salient issues.

Clinicians may also perceive that IPV is the province of the legal system, particularly given increases in mandatory arrests and protection orders. However, interventions demonstrated to be effective in treating alcoholism also are associated with marked decreases in domestic violence offending (12). These data support that treatment of underlying disorders that contribute to IPV, for example alcoholism, may also be effective in curbing IPV, even though they were not designed for that purpose explicitly. Although data on IPV per se are not available, successful treatment of thought disorder, perceptual disturbance, and other symptoms of SPMI may also affect domestic violence perpetration. The effective treatment of disorders that frequently co-occur with SPMI closely linked with aggression, particularly substance use disorders, may have an even greater impact. In summary, the effectiveness of police and clinicians when confronted with IPV among individuals with SPMI is likely to be enhanced by more training in assessment and intervention. Acceleration of research in this area including program evaluation studies in order to create an empirical basis for such training is also needed.

There is momentum for enhanced training focused on domestic violence among clinicians that treat persons with SPMI. Due to the increasing concerns relative to community-based violence, a heightened awareness exists for clinicians who work with at-risk individuals. This concern has led to programs targeting the training of assessment and management of violence. Within the mental health treatment system these trainings target persons with substance use disorders, child and adolescent conduct disorders and individuals with severe mental disorders with histories of violent behaviors. Over the past few decades this issue has received increased attention due in part to the transition of individuals with severe mental disorders from institutions into the community. With continuing trends towards reduced inpatient stays in psychiatric facilities, at-risk patients are increasingly fending for themselves in the community with limited resources and supports. As a result, community mental health service providers require new skills with which to manage a potentially higher-risk patient. This issue takes on further import, as public-sector mental health systems

face mandates to provide more cost-effective services in less restrictive environments (13).

Training for providers working with persons with severe mental disorders may include a review of risk factors for IPV perpetration along with crisis intervention and other techniques to reduce the likelihood of aggression. Barriers to obtaining such violence prevention training may include the gathering of large groups of staff, limited financial resources to support training, and increased productivity pressures of agencies employing mental health providers. Furthermore, agency leaders and mental health clinicians may feel unprepared or incompetent to deliver such training. Barriers to effective assessment of IPV identified in studies of primary care have included fear of opening a "Pandora's box," time constraints, concerns about offending patients, and provider confidence (14). These concerns may also apply to providers treating the SPMI. Although there are several potential barriers, studies indicate that lack of education is the major barrier to primary care screening of IPV, and that routine IPV screening will increase following brief, focused training (15). It seems likely that the importance of education in assessing IPV generalizes to other treatment professionals as well.

While it may be assumed that mental health professionals would be better prepared than primary care physicians to handle IPV cases, mental health professionals may face similar issues including time constraints, clinician discomfort, and lack of familiarity with trauma. Lack of specific training on identification of situations involving IPV for mental health professionals has led to an underassessment of cases in psychiatric emergency settings. According to a review of psychiatric residents at four U.S. medical schools, only 28% received training in recognizing domestic violence and providing referrals and treatment, although the large majority have seen at least one case of IPV in the past year. Of the residents responding, half reported inquiring about domestic violence in less than 25% of their cases involving female patients and that slightly more than half did so, "only when a problem was suspected" (16).

It is likely that the benefits of IPV training for primary care physicians will also be evident in IPV training for providers treating SPMI. Although limited, mental health professionals with training in recognizing IPV have been shown to identify significantly more cases than their counterparts who had not (16). In a follow up study (17), a trauma orientation lecture to clinicians yielded significantly higher rates of trauma detection for both sexual and physical violence. Importantly, the improvement was seen with only a small amount of training time.

COURT RESPONSE TO IPV

Judges routinely issue protection orders in both the family court and criminal court settings at arraignment or initial appearances, frequently without consulting the petitioner/victim. Some states have mandated stiffer penalties for IPV perpetrators who violate court orders for protection. For example, in New York State, a perpetrator who violates a court order under certain circumstances now faces a mandatory arrest situation resulting in a felony charge. However, given the potential impact of symptoms of thought disorder and perceptual disturbance on judgment, decision-making, and other mediators of behavioral restraint, the effectiveness of a protection order may be reduced with SPMI offenders, particularly those receiving inadequate treatment (due to gaps in the system or noncompliance). Alternative responses to violations of protection orders, including an assessment of comprehension of the order, referrals for psychiatric care for those not in treatment (or enriched care for those that are), and innovations that serve to coordinate and formalize the efforts of psychiatric/social and legal systems should also be considered. Some of these similar concerns lead to the development of drug courts to address substance abusers with certain legal difficulties. The ability of SPMI offenders to comprehend and respond as required to protection orders requires investigation. An offender's SPMI may also affect a partner's decision to seek an order of protection. For example, the proarrest climate may cause some partners to hesitate in obtaining an order to protect their partners from future arrests. Alternatively, there may be increased potential by nonviolent partners for exploitation of perpetrators with an SPMI through a threat of arrest for IPV. These issues have not been examined systematically.

Intimate partner violence victims face an array of barriers to leaving an abusive partner, including the potential risk of greater harm, the courts awarding custody to the perpetrator, financial hardship, family and societal pressure to stay, guilt, and a potential bond formed with the perpetrator. However, for the partner of a perpetrator with SPMI, there may be additional complications. Although data are meager, the victim may assume, either erroneously or correctly, that if the perpetrator's mental health was stabilized via prescription medication coupled with therapy, the violence would stop. Also making difficult the victim's decision on whether to leave may be the stigma attached to mental illness and feeling the responsibility to remain with and look after the abusive partner.

Fortunately, the options available to IPV victims exceed calling the police. Caregivers can provide the victim with an array of options and

provide general safety-planning information making the security of the nonviolent partner and children the priority in the response to the identification of IPV. By teaming with a domestic violence shelter advocate, civil legal services and community-based children's programs, health-care providers can provide a safety net leaving the family members more in control of the violence and better able to cope with future violent incidents.

As an example, in New York State, as in many states, court options for families are also varied. Rather than calling the police and initiating a criminal action, the family can seek assistance in a family court setting whose mission dictated by the legislature includes making the violence stop (18). In the family court setting, the petitioner/victim exerts control over the direction of the case as evidenced by the caption that reads "Jane Doe, Petitioner v. John Doe, the Respondent." The family court judge can provide the petitioner/victim with relief including a referral to agencies, court ordered mental health or drug and alcohol evaluations, and treatment as needed.

Compared to family court, in the filing of a criminal action the victim has much less say as exemplified by the docket caption which reads "The People of the State of New York v. the Defendant." The criminal act is commenced because the perpetrator/patient has violated the laws of the state protecting citizens from acts of violence. Adjudication of a criminal court case has multiple stages and scores of criminal justice practitioners become involved in the handling of each case (see Lamberti and Weisman, this special section). In fact, the victim may not be aware of the professionals involved in the case or the nature of the information to which they have access. The judges and prosecutors may be unaware of the information that defense attorneys have been made aware. Also, the victim may have explained in some detail to the police officers his/her concerns, assuming this information is all relayed to the other parties. However, in some misdemeanor courts in New York, prosecutors are responsible for handling over 1000 cases during a month of "intake," when that attorney handles misdemeanor arraignments. These huge caseloads leave precious little time for thoroughly reading the files and conferring with all interested parties.

Given a fractured court system, many health care professionals are unaware of the legal options available to a family identified with IPV coupled with mental health issues. New York State provides a case example of such complexity. Figure 1 shows the multiple paths for referrals.

In addition to multiple court venues for IPV, each court has a specific "burden of proof, the level of evidence required for the parties to prove

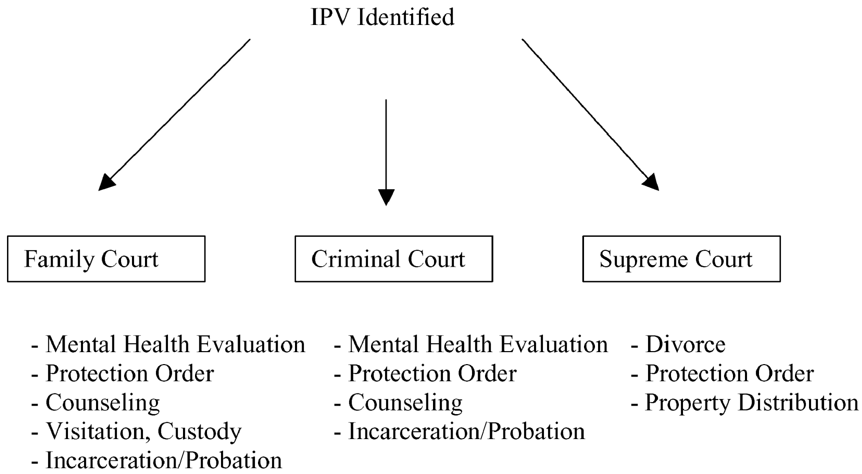

FIGURE 1. Court options.

the allegations. Family court has the lowest burden of proof; "a preponderance of the evidence" (19) while criminal court requires the facts proven "beyond a reasonable doubt" (20). In some states, including New York, the criminal courts maintain varied venues depending on the level of offense. There are misdemeanor courts, where the incarceration cannot be for greater than a year on a single offense, and felony level courts for more egregious offenses. Complicating this legal scheme, each court has a different party representing the litigants. In family court, there are civil attorneys assigned to the cases. The attorneys may be court appointed (free to the parties) or retained. In criminal court, there is a prosecutor representing New York State and a defense attorney for the mentally ill IPV perpetrator, who is either retained or paid for by the county or state, commonly called a "public defender." The complexity of training the family court and criminal justice discretionary decision-makers must also consider including the private attorneys involved in adjudicating these cases.

Health care professionals and victims are confused about the options available via the legal system. It is unclear as to the danger present for the SPMI perpetrator should the victim access relief in the legal system. Victims often feel they do not control the process and cases may be adjudicated based on the evidence without taking the families' wishes into consideration.

SUMMARY AND CONCLUSIONS

There are many challenges towards integration of the legal and mental health care systems for the care and welfare of individuals with severe mental disorders who may perpetrate acts of domestic violence, as well as their partners. Factors including difference in language, philosophies and endpoints for involvement with clients vary considerably. The criminal legal system is generally based on an adversarial and competitive process. The health care system is based on mutual trust, development of provider-patient alliance and the appreciation of chronic disabilities. However, despite the differences between the systems, recommendations that apply to both disciplines can be implemented to improve the handling of IPV perpetrated by individuals with a SPMI. Blanket responses such as mandatory arrest, the pursuit of orders of protection, and stiff legal sanctions when orders are violated, may not always serve to maximize victim safety, and potentially, can also have untoward effects on the IPV perpetrator's illness as well as the family. Alternative or additional responses may be required. These may include such an assessment of the comprehension of a protection order and remediation as needed, referral for treatment of SPMI as well as comorbid conditions particularly substance abuse and disorders of conduct. Additional goals should consider improving communication and coordination between legal and psychiatric/social provider systems utilizing innovative programs such as the development of specialty courts and intensive case management (21).

It is recognized that IPV warrants a rigorous response that may necessitate police and court involvement. Injuries, both physical and emotional, suffered at the hands of an individual with SPMI are no less harmful. Victim safety must remain first and foremost. It is argued that a more flexible and varied response, particularly when based on proper training of the police, legal and treatment professionals involved, may actually promote safety by ensuring that the SPMI is addressed. Training should start in the police academy, medical school, and law school, and continue throughout one's professional career. Such a training effort will require the prioritization of IPV education commensurate with its prominence in routine police work, medical care, and legal practice. Beyond "basic training," in light of data of an association of mental illness and violence (2) which seems likely to extend to IPV, issues related to recognition and intervention with SPMI offenders must become an integral part of routine IPV training. Ultimately, empirical data will be needed to inform policy and training of individuals with an SPMI who commit acts of IPV. Research activities should include epidemiological

investigations of the co-occurrence of SPMI and partner violence, intervention studies with this population that include rigorous evaluations of IPV outcomes, along with systematic evaluations of specialized programs and training efforts.

REFERENCES

1. Schumacher JA, Feldbau-Kohn S, Smith Slep AM, et al: Risk factors for male-to-female partner physical abuse. Aggression and Violent Behavior 6:281–352, 2001.
2. Steadman H, Mulvey E, Monahan J, et al: Violence by people discharged from acute psychiatric inpatient facilities and by others in the same neighborhoods. Archives of General Psychiatry 55:393–401, 1998.
3. Mueser KT, Rosenberg SD, Drake RE, et al: Conduct disorder, antisocial personality disorder and substance use disorders in schizophrenia and major affective disorders. Journal of Studies on Alcohol 60:278–284, 1999.
4. Sherman L, Berk R: Police response to domestic violence incidents. American Sociology Review 49:261–271, 1984.
5. Sherman LW, Schmidt JD, Rogan DP, et al: From initial deterrence to long-term escalation: Short-custody arrest for poverty ghetto domestic violence. Criminology 29:821–850, 1991.
6. Sherman LW, Schmidt JD, Rogan DP, et al: The variable effects of arrest on criminal careers: The Milwaukee Domestic Violence Experiment. Journal of Criminal Law and Criminology, 83:137–169, 1992.
7. Dunford F: The measurement of recidivism in cases of spousal assault. Criminal Law and Criminology 83:122–130, 1992.
8. Maxwell C, Garner J, Fagan J: The effects of arrest on intimate partner violence: New evidence from the spouse assault replication program. National Institute of Justice Research Brief, Washington, DC, 2001.
9. Buzawa ES, Buzawa CG: Domestic Violence: The Criminal Justice Response, 2nd ed. Thousand Oaks, CA, Sage, 1996.
10. Cerulli C, Tomkins S (editors): Monroe County Family Court Domestic Violence Intensive Intervention Court Evaluation. State University of New York at Buffalo School of Law Family Violence Clinic, University of Rochester Medical School Department of Psychiatry, 2000.
11. Gelles RJ: Through a sociological lens: Social structure and family violence, in Current Controversies on Family Violence. Edited by Gelles RJ, Loseke DR. Newbury Park, NJ, Sage, 1993.
12. Caetano R, Schafer J, Fals-Stewart W, O'Farrell T, Miller B: Intimate partner violence and drinking: New research on methodological issues, stability and change, and treatment. Alcoholism: Clinical and Experimental Research 27:292–300, 2003.
13. Swanson J, Swartz M, Estroff S, et al: Psychiatric impairment, social contact, and violent behavior: Evidence from a study of outpatient-committed persons with severe mental disorder. Social Psychiatry and Psychiatric Epidemiology 33(Suppl):S86–S94, 1998.
14. Sugg NK, Inui T: Primay care physicians' response to domestic violence. JAMA 267:3157–3160, 1992.

15. Berger RP, Bogen D, Dulani T, et al: Implementation of a program to teach pediatric residents and faculty about domestic violence. Archives of Pediatric and Adolescent Medicine 156(8):804–810, 2002.
16. Currier GW, Barthauer LM, Bruce ML: Training and experience of psychiatric residents in identifying domestic violence. Psychiatric Services 47:529–530, 1996.
17. Currier GW, Briere J: Trauma orientation and detection of violence histories in the psychiatric emergency service. Journal of Nervous and Mental Disease 188:622–624, 2000.
18. New York Family Court Act §812(2)(b)).
19. New York Family Court Act §832.
20. New York Penal Law §25.
21. Lamberti JS, Weisman RL, Schwarzkofp SB, et al: The mentally ill in jails and prisons: Towards an integrated model of prevention. Psychiatric Quarterly 72:63–77, 2001.