

Mental Health Care and Intimate Partner Violence: Unasked Questions

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MENTAL HEALTH CARE AND INTIMATE PARTNER VIOLENCE: UNASKED QUESTIONS

DELANEY E. ANDERSON* AND RICHARD C. BOLDT**

There is significant overlap between the group of people who experience trauma, including domestic or intimate partner violence, and those who are hospitalized for severe mental illness. In recent years there has been a growing awareness in the mental health treatment community of the prevalence of trauma among individuals with behavioral health problems. Despite the strong evidence of elevated rates of exposure to domestic or intimate partner violence among individuals experiencing mental illness (including depression, anxiety, and post-traumatic stress disorder), mental health professionals often do not effectively address this co-occurring factor in assessing and treating their clients or patients. The failure of these clinicians to screen for domestic or intimate partner violence is even more troubling because of the presence of mental health coercion in some abusive relationships. Research suggests that individuals with co-occurring abuse histories and mental illness may be coerced by intimate partners, other family members, or by official agencies, to receive unwanted behavioral health treatment. This coercion may be the product of emergency detention and/or civil commitment procedures initiated by partners and other family members seeking to leverage those legal mechanisms in order to exert unwarranted control.

Paradoxically, an additional group subject to domestic or intimate partner violence experiences coercion that prevents them from accessing behavioral health services. This group includes some individuals who wish to receive mental health treatment (which may or may not relate to abuse) but who are prevented from doing so by their abusers. The group also includes some individuals whose abusers inhibit or discourage medication, treatment, or hospitalization, as well as those whose abusers pressure substance use or interfere in substance abuse treatment.

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This article addresses the overlap of trauma and mental disability, the failure of behavioral health services systemically to screen for domestic or intimate partner violence, the risk that abusive partners may manipulate the civil commitment system, and the likelihood that people with mental illness who experience domestic or intimate partner violence fail to receive sufficient trauma-informed treatment for their mental illness or other behavioral health needs. The article calls for more research, screening, and service integration to meet the needs of persons who experience both mental illness or disability and domestic or intimate partner violence, as well as adjustments to the legal rules governing emergency detention and civil commitment. In particular, it explores systematic screening procedures to assess for trauma, abuse, and coercion at the emergency petition and evaluation stages as well as at involuntary commitment hearings, and analyzes the need for greater system integration of mental health treatment with the existing structure of shelters and other supportive services for domestic or intimate partner violence.

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I. INTRODUCTION

There is significant overlap between the group of people who experience trauma, including domestic or intimate partner violence,¹ and those who are

1. While this article refers to “domestic violence” and “intimate partner violence” as related problems that fall within the broader set of traumatic harms that arise within close relationships, there are

hospitalized for severe mental illness.² One study, for example, found that the majority of patients in a hospital day program had experienced trauma at some point in their lives.³ The average lifetime prevalence rate of domestic or intimate partner violence among women⁴ accessing mental health services is almost 30% for those in inpatient facilities and 33% for those in outpatient treatment.⁵ Many studies also show that individuals with chronic or pre-existing mental illnesses are more often subject to domestic or intimate partner violence than individuals without mental illness.⁶

In recent years, there has been a growing awareness in the mental health treatment community of the prevalence of trauma among individuals with behavioral health problems. The National Council for Mental Wellbeing has

important differences. Domestic violence can occur between any persons who live together, including adult couples, parents, children, and siblings. The abuse can involve physical harms, but also includes emotional harms as well. Intimate partner violence need not take place within a family or between persons who live together, but generally refers to abusive conduct between individuals in a romantic or intimate relationship. *See generally, Intimate Partner Violence vs. Domestic Violence*, YWCA SPOKANE (Jan. 5, 2021), <https://ywcaspokane.org/what-is-intimate-partner-domestic-violence/> (expanding upon the differences between intimate partner violence and domestic violence).

2. *See generally*, Silje K. Floen & Ask Elklit, *Psychiatric Diagnoses, Trauma, and Suicidality*, 6 *Annals of General Psychiatry*, no. 12, April 20, 2007 (examining the associations of trauma and psychiatric diagnoses).

3. B. Christopher Frueh et al., *Patients' Reports of Traumatic or Harmful Experiences Within the Psychiatric Setting*, 56 *PSYCH. SERV.* 1123, 1127 (2005). Almost half reported histories of physical assault and multiple traumas, and 33% reported experiencing sexual assault. *Id.* The patients who had sexual assault histories reported more traumatic experiences while receiving psychiatric care than other patients without their histories. *Id.* They reported higher rates of medication coercion, unwanted sexual advances, sexual assault by hospital staff, and inadequate privacy, as well as a higher likelihood of feeling unsafe, fearful, distressed, and helpless. *Id.*

4. This Article uses both gendered and non-gendered terms to refer to victims. While the majority of victims of intimate partner violence are women, intimate partner violence is also directed against men, trans individuals, and those who identify as non-binary. *See NAT'L CTR. FOR INJ. PREVENTION & CONTROL, National Intimate Partner and Sexual Violence Study*, CTRS. FOR DISEASE CONTROL & PREVENTION (2011), https://www.cdc.gov/violenceprevention/pdf/nisvs_report2010-a.pdf (summarizing types of violence, "including types of sexual violence other than rape; expressive psychological aggression and coercive control, and control of reproductive or sexual health."). The gendered component of intimate partner violence is relevant here as much of the research focuses on the experiences of women and various examples reflect the impacts of sex stereotyping.

5. Sian Oram et al., *Prevalence of Experiences of Domestic Violence Among Psychiatric Patients: Systematic Review*, 202 *BRIT. J. PSYCH.* 94, 94 (2013).

6. *See, e.g.*, Hind Khalifeh et al., *Recent Physical and Sexual Violence Against Adults with Severe Mental Illness: A Systematic Review and Meta-Analysis*, 28 *INT'L REV. PSYCH.* 433, 445 (2016) (comparing people with and without severe mental illness and finding increased odds of domestic violence for those with severe mental illness across all studies); Hind Khalifeh et al., *Recent Intimate Partner Violence Among People with Chronic Mental Illness: Findings from a National Cross-Sectional Survey*, 207 *BRIT. J. PSYCH.* 207, 209 (2015) (finding individuals with chronic mental illness to have increased risk of intimate partner violence); Kylee Trevillion et al., *Experiences of Domestic Violence and Mental Disorders: A Systematic Review and Meta-Analysis*, 7 *PLOS ONE* 1, 9 (2012) [hereinafter Trevillion et al., *Experiences of Domestic Violence and Mental Disorders*] (finding consistent evidence that people with mental disorders experience increased odds of domestic violence relative to people without mental disorders).

observed that “[a]ddressing trauma is now the expectation, not the exception, in behavioral health systems. Every day, behavioral health organizations are asking the National Council how they can be better prepared to offer trauma-informed care.”⁷ The notion of “trauma-informed care” is now well established as an element of effective evidence-based treatment within the public mental health system.⁸ Nevertheless, the primary focus of these recent efforts to screen for and offer effective, trauma-informed interventions has been on survivors of childhood trauma.⁹ Less attention has been given to individuals with co-occurring mental health problems and ongoing experiences of intimate partner abuse. The insights and best practices that have been developed for those whose exposure to trauma impacts their behavioral health can usefully be applied to the group of individuals who experience intimate partner violence.¹⁰

Despite the strong evidence of elevated rates of exposure to domestic or intimate partner violence among individuals experiencing mental illness (including depression, anxiety, and post-traumatic stress disorder),¹¹ mental health professionals often do not effectively address this co-occurring factor in

7. *Trauma-Informed Care*, NAT'L COUNCIL FOR MENTAL WELLBEING, <https://www.thenationalcouncil.org/areas-of-expertise/trauma-informed-behavioral-healthcare/> (last visited Feb. 7, 2022).

8. See John Carney, *Governor Carney Announces Trauma Awareness Month Starts May 1, 2021*, DEL. NEWS (Apr. 26, 2021), <https://news.delaware.gov/2021/04/26/governor-carney-announces-trauma-awareness-month-starts-may-1-2021/> (recognizing trauma-informed care as a standard approach in mental health services). See also SAMHSA's *Concept of Trauma and Guidance for a Trauma-Informed Approach*, SAMHSA'S TRAUMA & JUST. STRATEGIC INITIATIVE, July 2014, at 9 (outlining SAMHSA's understanding and principles of trauma-informed care).

9. See, e.g., *Trauma-Informed Care*, *supra* note 7 (stating that “[t]rauma is a near universal experience of individuals with behavioral health problems.”). The National Council goes on to state that “[a]ccording to the U.S. Department of Health and Human Services' Office on Women's Health, 55%–99% of women in substance use treatment and 85%–95% of women in the public mental health system report a history of trauma, with the abuse most commonly having occurred in childhood.” *Id.*

10. One writer has offered the following account of how a concern for the effects of trauma has come into this field.

“Long before anyone used the term “trauma-informed,” caring professionals and committed volunteers were instinctively acting in a trauma-informed manner. Much of this was influenced by the emergence of the feminist movement and the increasingly influential voice of survivors of interpersonal trauma, as seen in the rape crisis centers and the domestic violence movements of the 1970s and the dramatic growth of child-advocacy centers and multidisciplinary teams in child abuse in the 1980s. These natural incubators for trauma-informed innovation and practice were “married” in the 1990s with the growing body of science and trauma-specific empirical research into how human beings respond in the aftermath of traumatic events, and how professionals and concerned activists could help them move toward recovery. That stream of research began with interest in combat-related post-traumatic stress after the Vietnam War. By the mid-1980s, the focus had expanded and was adopted by the wider mental health community as a relevant construct for understanding the cascade of symptoms often noted after rapes, shootings, and other major traumatic life events.” (citation omitted).

Charles Wilson et al., *Trauma-Informed Care*, ENCYC. SOC. WORK (Nov. 4, 2013), <https://oxfordre.com/socialwork/view/10.1093/acrefore/9780199975839.001.0001/acrefore-9780199975839-e-1063> (citation omitted).

11. Trevillion et al., *Experiences of Domestic Violence and Mental Disorders*, *supra* note 6, at 9.

assessing and treating their clients or patients.¹² For instance, one study revealed that mental health clinicians often failed to screen for and respond effectively to disclosures of abuse.¹³ The results showed that only 15% of mental health clinicians screened for domestic or intimate partner violence.¹⁴ Of those 15% that screened, only 27% provided the patient with referrals to support services.¹⁵

The failure of these clinicians to screen for domestic or intimate partner violence is even more troubling because of the presence of mental health coercion in some abusive relationships. Research suggests that individuals with co-occurring abuse histories and mental illness may be coerced by intimate partners, family members, or official agencies to receive unwanted behavioral health treatment.¹⁶ This coercion may be the product of emergency detention and/or civil commitment procedures initiated by partners and other family members seeking to leverage those legal mechanisms to exert unwarranted control.¹⁷ On occasion, the tactic is even more impactful when targeting these women's fear of losing custody of their children through the child protection system.¹⁸

Paradoxically, an additional group of people who are similarly subject to domestic or intimate partner violence experience coercion that *prevents* them from accessing behavioral health services.¹⁹ This group includes some

12. See Sarah Nyame et al., *A Survey of Mental Health Professionals' Knowledge, Attitudes, and Preparedness to Respond to Domestic Violence*, 22 J. MENTAL HEALTH 536, 541 (2013) (“Only 20 (15%) professionals routinely asked all service users about domestic violence and just 36 (27%) provided information to service users following disclosure.”).

13. *Id.* at 539.

14. *Id.* at 541. See also Kylee Trevillion et al., *The Response of Mental Health Services to Domestic Violence: A Qualitative Study of Service Users' and Professionals' Experiences*, 18 J. AM. PSYCHIATRIC NURSES ASS'N 326, 326–27 (2012) [hereinafter Trevillion et al., *The Response of Mental Health Services to Domestic Violence*] (similarly assessing documentation of domestic violence in case files, rates of domestic violence screenings, and inadequate support responses).

15. Nyame et al., *supra* note 12, at 541. In particular, one study found that, though psychiatrists likely have greater knowledge about domestic violence than other mental health professionals, they were less willing to discuss the topic than other responders, such as nurses. Kylee Trevillion et al., *Disclosure of Domestic Violence in Mental Health Settings: A Qualitative Meta-Synthesis*, 26 INT'L REV. PSYCH. 430, 441 (2014) [hereinafter Trevillion et al., *Disclosure of Domestic Violence in Mental Health Settings*].

16. See *infra* Section III.B.

17. See, e.g., *In the Int. of J.P.*, 574 N.W.2d 340, 344 (Iowa 1998) (noting that a woman removing herself and her children from an abusive home to a domestic violence shelter should not be considered as a source of “emotional trauma” to her children in a civil commitment hearing).

18. See Colleen Clark et al., *The Role of Coercion in the Treatment of Women with Co-Occurring Disorders and Histories of Abuse*, 32 J. BEHAV. HEALTH SERVS. & RSCH. 167, 170 (2005) (explaining that professionals' “dual duty” to the mother and her children leads to increased coercion on mothers to undergo psychiatric treatment). See also Carole Warshaw et al., *Mental Health and Substance Use Coercion Surveys*, NAT'L CTR ON DOMESTIC VIOLENCE, TRAUMA & MENTAL HEALTH, Mar. 2014, at 19 [hereinafter Warshaw et al., *Mental Health and Substance Use Coercion Surveys*] (noting that “abusers may accuse their partners of being unable to parent due to their mental health diagnosis . . . Because of the stigma and fear attached to mental illness . . . this can be a powerful accusation”).

19. Warshaw et al., *Mental Health and Substance Use Coercion Surveys*, *supra* note 18, at 2.

individuals who wish to receive mental health treatment (which may or may not relate to abuse) but who are prevented from doing so by their abusers.²⁰ It also includes some individuals whose abusers inhibit or discourage medication, treatment, or hospitalization, as well as those whose abusers pressure substance use or interfere in substance abuse treatment.²¹

This article addresses the overlap of trauma and mental disability, the systematic failure of behavioral health services to screen for domestic or intimate partner violence, the risk that abusive partners may manipulate the civil commitment system, and the likelihood that people with mental illness who experience domestic or intimate partner violence fail to receive sufficient trauma-informed treatment for their mental illness or other behavioral health needs. The article calls for more research, screening, and service integration to meet the needs of persons who experience both mental illness or disability and domestic or intimate partner violence, as well as adjustments to the legal rules governing emergency detention and civil commitment. In particular, it explores systematic screening procedures to assess for trauma, abuse, and coercion at the emergency petition and evaluation stages as well as at involuntary commitment hearings, and analyzes the need for greater system integration of mental health treatment with the existing structure of shelters and other supportive services for survivors of domestic or intimate partner violence.

Before turning to these topics, however, Section II explores the nature of mental illness and its relationship to the social structures that mediate psychic distress (and that shape the relationships out of which domestic abuse and intimate partner violence spring). This conceptual framing is essential in addressing the co-occurrence of mental disability and exposure to domestic and intimate partner violence.²² Section III then examines research on behavioral health screening practices for domestic and intimate partner violence and looks at the barriers that prevent behavioral health professionals from more consistently identifying clients who have experienced domestic or intimate partner abuse.²³ Section III also describes mental health coercion as an abuse tactic often utilized by abusers.²⁴ Given the evidence of inadequate screening and the potential for abuse of the emergency detention and involuntary hospitalization mechanisms, Section IV identifies practices to improve the civil commitment process to ensure that it is more responsive to individuals who experience mental health coercion.²⁵

20. *Id.*

21. *Id.* at 16–17.

22. *See infra* Section II.

23. *See infra* Section III.

24. *See infra* Section III.

25. *See infra* Section IV.

II. TWO CONCEPTIONS OF MENTAL ILLNESS: THE BIOLOGICAL MODEL AND THE STRESS PROCESS FRAMEWORK

From one perspective, mental illness is the manifestation of biological and genetic factors, perhaps interacting with environmental triggers, to produce psychic disfunction or distress. One of the most prominent advocates of this biological model of mental disability has been Eric Kandel. Kandel provided a basic framework of five principles to describe this model.²⁶ The first principle is that “[a]ll mental processes, even the most complex psychological processes, derive from operations of the brain.”²⁷ The second and third principles are that genes impact neural structure and that social or developmental factors contribute importantly to “modify the expression of genes and thus the function of nerve cells.”²⁸ Fourth, Kandel asserted that “[a]lterations in gene expression induced by learning give rise to changes in patterns of neuronal connections” and are likely “responsible for initiating and maintaining abnormalities of behavior that are induced by social contingencies.”²⁹ Finally, Kandel explained that psychotherapy, as a form of learning, can be effective “by producing changes in gene expression that alter the strength of synaptic connections,” thus changing psychological and behavioral outcomes.³⁰

While still accepting that biological and genetic factors contribute to psychopathology, an alternative perspective focuses instead on how social structures affect the onset and course of emotional, cognitive, or behavioral problems.³¹ This sociological model emphasizes that the experiences of people with mental illness are embedded within a social context.³² One particularly insightful version of this model has been developed by Leonard Pearlin, whose stress process framework has significantly influenced research within the field.³³ The domains of this framework consist of stressors (the chronic “strains” to which individuals are exposed), stress mediators, stress modifiers, and stress

26. Eric R. Kandel, *A New Intellectual Framework for Psychiatry*, 155 AM. J. PSYCH. 457, 460 (1998).

27. *Id.*

28. *Id.*

29. *Id.*

30. *Id.*

31. Carol S. Aneshensel et al., *The Sociology of Mental Health: Surveying the Field*, in HANDBOOK OF THE SOCIO. OF MENTAL HEALTH 1, 1–2 (Carol S. Aneshensel et al. eds., 2d ed. 2013).

32. *Id.*

33. See generally Leonard I. Pearlin, *The Sociological Study of Stress*, 30 J. HEALTH & SOC. BEHAV. 241 (1989) [hereinafter Pearlin, *The Sociological Study of Stress*] (describing how “basic information about people’s social and institutional affiliations and statuses” should be treated “not simply as data that need to be controlled statistically,” but to “examine the bearing of these data on each domain of the stress process: the exposure to and meaning of stressors, access to stress mediators, and the psychological, physical, and behavioral manifestations of stress).

outcomes or manifestations.³⁴ Taken together, these domains make up a framework for assessing the structural arrangements in which individuals are embedded that largely determine, in the view of Pearlin and his colleagues, how individuals experience the effects of stressful events.³⁵

As applied to the question of behavioral health generally and mental illness particularly, the stress process framework emphasizes the social conditions that influence individual experience:

[W]hen we look at the etiology of mental health, we are able to see a convincing example of how personal problems may often have their beginnings in social problems. This message needs to be underscored and repeated, for when the political climate of society shifts to the right, a contrary message tends to arise, namely, that social problems start as personal problems. We can assert that what has been learned and what will be learned in the future will continue to go directly against the grain of such a claim. Personal problems can be and often are reflections of structures and contexts in which people lead their lives.³⁶

In emphasizing social structures and people's locations within them as a means of understanding the stress process and its relation to mental illness, Pearlin's work focuses on two particular kinds of structures. The first set of structures are the "various systems of stratification"—including those based on social and economic class, race, ethnicity, gender, and age—that produce an "unequal distribution of resources, opportunities, and self-regard," thus producing "stressful life conditions" for low-status individuals.³⁷ The second structural context "is found in social institutions and their arrangements of statuses and roles."³⁸ In particular, "incumbency" in a fixed role derived from the organization of a social institution (i.e., the role assigned to individuals in a traditional Western nuclear family system) can play a meaningful part in originating and mediating experiences associated with problematic stress and the manifestations of that stress that sometimes include psychic disfunction or distress.³⁹

The stress process framework identifies two principal sources of stress, "life events" and "chronic strains" (stressors that produce enduring problems),

34. *Id.* at 241–42. Pearlin notes that most research into individual stress begins with an exigency (typically a discrete event) that people experience as problematic. *Id.* By contrast, he argues, many stressful experiences "don't spring out of a vacuum but typically can be traced back to surrounding social structures and people's locations within them." *Id.* at 242.

35. *Id.*

36. Leonard I. Pearlin & Alex Bierman, *Current Issues and Future Directions in Research into the Stress Process*, in *HANDBOOK OF THE SOCIO. OF MENTAL HEALTH* 325, 337 (Carol S. Aneshensel et al. eds., 2d ed. 2013).

37. Pearlin, *The Sociological Study of Stress*, *supra* note 33, at 242.

38. *Id.*

39. *Id.*

both of which arise out of people's social circumstances.⁴⁰ While it is tempting to focus on highly salient life events, including discrete traumatic encounters involving violence or abuse, Pearlin's model redirects our attention to the continuing circumstances within which life events, including powerful experiences, are embedded.⁴¹ "Thus, in interpreting events-health relationships we are susceptible to exaggerating the importance of eventful change and to minimizing—or overlooking altogether—the problematic continuities of people's lives. The confusion between an event and a more chronic life strain impedes a clear understanding of the social etiology of ill health and emotional distress."⁴²

Returning to the general problem of how to address more effectively the constellation of treatment and other human service needs of individuals with mental illness or behavioral health disorders who have experienced domestic or intimate partner violence, the insights provided by the sociological model supplement the biological model, which assumes that the source of emotional distress and disfunction lies primarily within the physical body.⁴³ In addition, the sociological model pushes the analysis beyond a simple focus on "life events" to include the chronic, structural, and role-based features of an individual's situation that, when compounded, produce psychic strain and impact the efficacy of therapeutic interventions.⁴⁴

The stress process literature contains an extensive discussion of the variety of chronic strains that serve as stressors and that can contribute to problematic outcomes, including mental illness or disfunction.⁴⁵ Many strains are "role-based" in nature and can be traced to the institutional characteristics that surround individuals in distress and the demands that those institutional or social organizations place on their incumbents.⁴⁶ Others chronic strains are "ambient" in nature and include living in poverty, being exposed to violence, or living in circumstances in which one regularly fears violence.⁴⁷

Whether they are role-based or ambient, problematic strains often occur in clusters. "[I]mportant life problems," explains Pearlin, "do not exist in isolation from other problems. The very integration of individuals' activities and relationships means that disruptions in one area of their lives serve to create other disruptions."⁴⁸ This tendency of stressors to occur in clusters means that people

40. *Id.* at 244–46.

41. *Id.*

42. *Id.* at 244.

43. See Kandel, *supra* note 26, at 460.

44. Pearlin, *The Sociological Study of Stress*, *supra* note 33, at 245.

45. *Id.*

46. *Id.*

47. *Id.* at 246.

48. *Id.* at 248.

who may be alike in terms of their exposure to any one stressor may experience significantly different outcomes based on variation in the range of other problematic strains they face.⁴⁹ Taken seriously, this insight should have a meaningful effect on the way that behavioral health assessments, intervention planning, and service delivery are organized. Particularly for clients or patients with co-occurring histories of trauma and mental illness, the careful gathering of clinical, social, and family histories and the thoughtful integration of services is crucial to making meaningful progress in ameliorating the distress and disfunction that these individuals are likely to experience.

The way in which individuals experience difficult life events and chronic, structural strains can be impacted significantly by mediating features that are either internal or external in nature. Internal mediators are “aspects of self” that “represent personal resources and appear to serve as appreciable barriers to the stressful effects of difficult life conditions.”⁵⁰ But external mediators are perhaps even more crucial in driving outcomes. In this respect, both coping and social support are key concepts in understanding stress outcomes. The function of coping is “either to change the situation from which the stressors arise, to manage the meaning of the situation in a manner that reduces its threat, or to keep the symptoms of stress within manageable bounds.”⁵¹ Behavioral health services that are attentive to these capacities are likely to be more productive, especially for those clients or patients who face both acute and chronic stressors.

Individuals’ social support “is associated with their integration into various social institutions and contexts” and is “inherently interactional.”⁵² Supportive relationships can be located within formal and informal social structures and institutions, including families, local communities, voluntary associations, and even the health care system. At this point, the stress process framework comes full circle. The foundational premise that “personal problems may often have their beginnings in social problems”⁵³ and the associated idea that the experience of mental illness is embedded within a social context inform the observation that the institutional and social context within which support is given and received crucially determines the efficacy of that support. Thus, the institutional structures

49. *Id.* at 248–49. This observation about the tendency of stressors to occur in clusters is connected to the related notion, often associated with intersectionality theory, that individuals experience systems of power and exclusion based on the multiple social positions they occupy. *See generally*, Kimberle Crenshaw, *Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics*, 1989 U. CHI. L. F. 139 (1989). *See also* Peggy McIntosh, *Reflections and Future Directions for Privilege Studies*, 68 J. SOC. ISSUES 194, 194 (2012) (noting the various effects that multiple group identities and overlapping social structures have in individual lives).

50. Pearlman, *The Sociological Study of Stress*, *supra* note 33, at 250.

51. *Id.*

52. *Id.* at 251.

53. Pearlman & Bierman, *supra* note 36, at 338.

that are in place to deal with mental disorder and with the effects of trauma, and the legal processes that govern the operation of those structures, must be attentive to the ways in which individuals can both be coerced into unwanted care and prevented from receiving needed treatment and other services.

Just as mediators can be understood as mechanisms that help individuals manage exposure to stressors, other circumstances, which Pearlin terms moderators, serve to modify the relationship between exposure and outcomes, often by intensifying problematic manifestations of chronic and/or acute stressful conditions.⁵⁴ One important moderator of particular relevance to persons who have experienced trauma is involuntary civil commitment. Involuntary commitment deprives a person of liberty, which can have a consequential impact on her emotional wellbeing.⁵⁵ The mere fact of physical confinement, the likelihood of being subjected to unwanted treatment, the loss of privacy, and the isolation and stigma are all potentially significant harms, especially for those who may already be psychologically vulnerable.⁵⁶ Indeed, researchers have found that people who are involuntarily hospitalized report decreased feelings of self-worth and increased concerns about stigma.⁵⁷

Viewed through the lens provided by the stress process framework, the involuntary confinement, loss of control, and stigma associated with emergency detention or longer-term civil commitment can function as moderating factors, intensifying the negative effects of chronic strains and other discrete stressors that individuals may experience, particularly when they have gone through traumatic encounters with family members or other intimate partners and are manifesting emotional distress or psychic dysfunction. In addition, emergency detention and civil commitment shifts our understanding of the source of an individual's psychiatric distress from the chronic, often ambient, strains that structure his or her family and community environment to a much narrower focus on the patient's individual pathology. Being subject to coercive, state-enforced interventions under the laws governing emergency detention and civil commitment has the effect of transforming the psychic distress and dysfunction of these individuals, whose experience is embedded in a social context, into a highly individualized problem of mental illness.

54. Leonard I. Pearlin, *The Stress Process Revisited: Reflections on Concepts and their Interrelationships*, in HANDBOOK OF THE SOC. OF MENTAL HEALTH 395 (Carol S. Aneshensel & Jo C. Phelan eds., 1999) [hereinafter Pearlin, *The Stress Process Revisited*].

55. Stephen J. Morse, *A Preference for Liberty: The Case Against Involuntary Commitment of the Mentally Disordered*, 70 CALIF. L. REV. 54, 58 (1982).

56. See Mathew Large & Christopher J. Ryan, *Disturbing Findings About the Risk of Suicide and Psychiatric Hospitals*, 49 SOC. PSYCHIATRY & PSYCHIATRIC EPIDEMIOLOGY 1353, 1353–55 (2014) (explaining that the stigma and trauma from primarily involuntary psychiatric treatment for vulnerable patients may contribute to suicides); SUSAN STEFAN, RATIONAL SUICIDE, IRRATIONAL LAWS: EXAMINING CURRENT APPROACHES TO SUICIDE IN POLICY AND LAW 120 (PATRICIA A. ZAPF ED. 1ST ED. 2016).

57. Syeda F. Akther, et al., *Patients' Experiences of Assessment and Detention Under Mental Health Legislation: Systematic Review and Qualitative Meta-Synthesis*, 5 BRIT. J. PSYCH. 1, 6 (2019).

III. THE NEED FOR MORE SYSTEMATIC SCREENING OF DOMESTIC AND INTIMATE PARTNER VIOLENCE BY BEHAVIORAL HEALTH PROFESSIONALS

Screening for experiences of domestic or intimate partner violence and responding effectively are both crucial facets of trauma-informed care. Evidence-based approaches to treatment require soliciting relevant information to shape a responsive treatment plan.⁵⁸ Using Pearlin's framework as a point of reference, domestic or intimate partner violence is likely a chronic and structural stressor in an individual's life that then affects her experience of mental illness and impacts the efficacy of therapeutic intervention. To shape a responsive treatment plan, behavioral health professionals must inquire about abuse experiences and respond effectively. If effective screening does not take place, the professionals are likely to adopt a *de facto* individualized approach, consistent with Kandel's biological model, that focuses on physical and biological indicia of illness, failing to consider abuse as a social and environmental factor that impacts an individual's mental health and treatment.

A. Screening Practices and Barriers

Despite evidence of a high prevalence of domestic and intimate partner violence among women who experience depression, anxiety, and post-traumatic stress disorders,⁵⁹ behavioral health professionals often screen for these histories less frequently than is recommended.⁶⁰ Many behavioral health professionals fail to screen for domestic or intimate partner violence, to respond effectively to disclosures of abuse, and, when screening does occur, to refer patients to support services.⁶¹

Behavioral health professionals have identified various factors that contribute to both the lack of screening and the ineffective response to domestic or intimate partner violence among their patients. They report difficulty screening due to lack of knowledge; they do not understand the dynamics of

58. See *Family and Intimate Partner Violence*, AM. MED. ASS'N, <https://policysearch.ama-assn.org/policyfinder/detail/family%20and%20intimate?uri=%2FAMADoc%2FHOD.xml-0-4664.xml> (2019) (encouraging American Medical Association physicians to screen and respond to domestic violence "to improve clinical services as well as the public health"). See also Daniel Dicola & Elizabeth Spaar, *Intimate Partner Violence*, 94 AM. FAMILY PHYSICIAN 646, 646 (2016) ("Patients who are being abused exhibit chronic physical and emotional symptoms in addition to injuries sustained as a result of physical and sexual violence. They are also at risk of death from homicide. IPV is largely underrecognized and under addressed as a health issue.").

59. See Trevillion et al., *Experiences of Domestic Violence and Mental Disorders*, *supra* note 6, at 9.

60. Nyame et al., *supra* note 12, at 541; see also Karen Oehme et. al., *Unheard Voices of Domestic Violence Victims: A Call to Remedy Physician Neglect*, 15 GEO. J. GENDER & L. 613, 620 (2014) (discussing screening by medical professionals more broadly).

61. See Nyame et al., *supra* note 12, at 537, 541. Additional studies have similarly assessed documentation of domestic violence in case files, rates of domestic violence screenings, and inadequate support responses. See Trevillion et al., *Disclosure of Domestic Violence in Mental Health Settings*, *supra* note 15, at 441.

domestic or intimate partner violence and therefore do not feel prepared to ask a patient about it.⁶² Such professionals also report failing to screen due to logistical factors that impact their ability and willingness to screen, including limited time, limited referral options, and the belief that domestic or intimate partner violence is outside the scope of their practice and therefore not germane to treatment.⁶³

Several factors further contribute to the failure of behavioral health professionals to effectively respond to their patients' disclosures of abuse. One factor, which mirrors the difficulty many have with screening, is a simple lack of knowledge about domestic or intimate partner violence and the available support resources.⁶⁴ A second factor is more deeply ingrained in the dynamics of the relationship between some patients and the behavioral health professionals who provide them with care. In one survey, a significant number of mental health patients or clients who disclosed abuse described negative responses by their behavioral health providers rooted in mental illness stigma; the patients believed that the professionals did not take their disclosures of abuse seriously because of their mental illness diagnoses.⁶⁵ These patients believed their experiences of abuse were not validated or acknowledged by the professional, despite the abuse having a significant impact on their mental health and treatment needs.⁶⁶

Finally, the dominance of the medical model may underlie both barriers to screening and the failure of treatment providers to respond effectively to disclosures of domestic or intimate partner violence.⁶⁷ The medical model approach to behavioral health is focused on diagnosing and treating symptoms and is grounded in a biological perspective, which in turn may lead physicians and behavioral health professionals to overlook the social determinants of mental illness, including abusive intimate or family relationships.⁶⁸ This approach pathologizes the patient's presenting mental health concerns instead of identifying the interconnectedness and impact of the patient's chronic stressors

62. Nyame, *supra* note 12, at 541; Galina A. Portnoy et al., *Patient and Provider Barriers, Facilitators, and Implementation Preferences of Intimate Partner Violence Perpetration Screening*, 20 BMC HEALTH SERVS. RSCH. 1, 6 (2020), <https://bmchealthservs.biomedcentral.com/articles/10.1186/s12913-020-05595-7>.

63. Portnoy et al., *supra* note 62, at 6–7. See also L. Kevin Hamberger et al., *Screening and Intervention for Intimate Partner Violence in Healthcare Settings: Creating Sustainable System-Level Programs*, 24 J. WOMEN'S HEALTH 86, 87 (2015) (explaining criticism of the medical model may also present a barrier to screening for domestic violence if providers are concerned about pathologizing experiences of intimate partner violence). For more information on critiques of the medical model, see Trevillion et al., *Disclosure of Domestic Violence in Mental Health Settings*, *supra* note 15, at 441.

64. Nyame, *supra* note 12, at 541.

65. Trevillion et al., *Disclosure of Domestic Violence in Mental Health Settings*, *supra* note 15, at 433.

66. *Id.* at 433. The patients' experiences of invalidation and lack of acknowledgement by the behavioral health professionals reflected a concern that such professionals questioned the patients' credibility because of their mental illness when disclosing abuse. *Id.* at 441.

67. *Id.* at 441.

68. *Id.*

and social circumstances, as described in the stress process framework.⁶⁹ Such a result is thus unlikely to address the underlying causes and impacts of domestic or intimate partner abuse by instead focusing on a psychiatric diagnosis and the medical management of symptoms.⁷⁰

When behavioral health professionals fail to consider domestic or intimate partner violence, the treatment of individuals experiencing such abuse will likely be less effective. The experience of being in an abusive relationship and the trauma associated with that abuse are often contributing stressors of the sort identified by Pearlin.⁷¹ Effective treatment cannot address those stressors if the treatment professionals are not aware that such stressors exist and impact their patients' symptoms and responses to medication or other therapies. Accordingly, "[g]ood clinical care" that responds to the needs of individuals experiencing domestic or intimate partner violence requires an assessment that screens for trauma and provides responsive referrals and treatments.⁷²

Additionally, this disconnect between prevalence and screening may impact an individual's behavioral health treatment through the emergency hospitalization and civil commitment processes. Mental health professionals play a key role in the civil commitment process; when they fail to adequately screen and respond to domestic or intimate partner violence, not only is their assessment of the individual incomplete for purposes of treatment planning, but courts also may lack relevant information to determine whether emergency detention and/or civil commitment is appropriate under the circumstances.

B. The Problem of Mental Health Coercion

The overlap of trauma stemming from domestic or intimate partner abuse and mental illness is complicated by mental health coercion, an emotional abuse tactic utilized by some perpetrators of intimate partner violence.⁷³ Mental health coercion may take various forms. A study from the National Center on Domestic Violence, Trauma, and Mental Health [NCDVTMH] highlights some important themes. The study—through reports by callers to the National Domestic Violence Hotline—collected data on incidents involving mental health

69. *Id.*

70. *Id.*

71. *Id.*

72. CAROLE WARSHAW & ERIN TINNON, NAT'L CTR. ON DOMESTIC VIOLENCE, TRAUMA, AND MENTAL HEALTH, COERCION RELATED TO MENTAL HEALTH AND SUBSTANCE USE IN THE CONTEXT OF INTIMATE PARTNER VIOLENCE: A TOOLKIT FOR SCREENING, ASSESSMENT, AND BRIEF COUNSELING IN PRIMARY CARE AND BEHAVIORAL HEALTH SETTINGS 9 (2018); *See generally* AM. PSYCHIATRIC ASS'N, *Treating Women Who Have Experienced Intimate Partner Violence*, 2019; U.S. DEP'T OF HEALTH & HUMAN SRVS., *A Treatment Improvement Protocol (TIP) 57: Trauma-Informed Care in Behavioral Health Services*, 2014 (explaining that trauma-informed services can promote better patient screening and assessment processes while decreasing the risk for re-traumatization).

73. *See* Warshaw et al., *Mental Health and Substance Use Coercion Surveys*, *supra* note 18, at 2.

coercion.⁷⁴ The callers surveyed were those who self-identified as victims and survivors of intimate partner violence.⁷⁵ The survey revealed that a substantial number of callers had experienced mental health coercion.⁷⁶ The forms of coercion that callers reported included abusive partners threatening to manipulate the civil commitment system, preventing some callers from receiving mental health treatment, and forcing others into substance use.⁷⁷

The frequency with which the civil commitment system is manipulated by abusive partners or family members is not clear from the survey data; however, the research does paint a concerning picture. In total, 89% of callers reported experiencing at least one of three forms of mental health coercion specifically asked about in the survey from an abusive partner.⁷⁸ Notably, 50.2% of callers reported that their abusive partners “threatened to report to authorities that the survivors [were] ‘crazy’ to keep the survivors from getting something they wanted or needed.”⁷⁹ The data also revealed an overlap in abusive tactics. For instance, 88% of callers reported both that the abusers made them feel as if they were going “crazy” and that their abusers threatened to report them as “crazy” to authorities.⁸⁰ The survey anecdotally captured specific tactics used by abusers, including telling family and friends that the victim is unstable, attempting to convince police or doctors that the victim is mentally ill, and threatening to report medication use and/or mental health treatment to the court to influence child custody determinations.⁸¹ Thus, the experiences captured by the survey reveal some of the ways in which abusers use mental health coercion to manipulate systems affecting survivors, like law enforcement and child custody.

Another study identified the prevalence of misuse of the civil commitment system by abusive partners. This study drew on focus groups of intimate partner violence survivors and survivor advocates to identify tactics that abusers used to manipulate the court system. Strategies identified included: “threatening to commit and/or committing their partners to psychiatric institutions; forcing their partners to take overdoses, which are then presented as suicide attempts; and withholding psychotropic medications.”⁸² This collection of survey data—in

74. *Id.* at 1.

75. *Id.* at 3.

76. *Id.* at 4.

77. *Id.* at 5.

78. *Id.* at 6.

79. *Id.* at 5. Further, 50% of responders also shared that their abusive partners would interfere in their mental health treatment. *Id.* at 6. Some individuals want help but are not free to access it while others want to leave but are forced into coercive treatment or threatened in order to stay. *Id.*

80. *Id.* at 8.

81. *Id.* at 9.

82. CAROLE WARSHAW ET AL., INTIMATE PARTNER VIOLENCE: A HEALTH-BASED PERSP., ch. 12 (Connie Mitchell & Deidre Anglin eds., 2009) [hereinafter WARSHAW ET AL., INTIMATE PARTNER VIOLENCE]. See generally, CAROLE WARSHAW ET AL., DOMESTIC VIOLENCE HEALTH POL’Y INITIATIVE, REPORT ON MENTAL HEALTH ISSUES & SERVICE NEEDS IN CHICAGO AREA DOMESTIC VIOLENCE

both a widescale national survey and a single community sample—reveals that abusers use the fear of the civil commitment system as a tactic of coercive control over survivors.⁸³

Perhaps one of the more compelling examples of abuse of the civil commitment system is detailed in *In the Interest of J.P.*, a 1998 decision from the Iowa Supreme Court.⁸⁴ The *JP* case concerns a woman, Jane, who fled to a domestic violence shelter to escape her husband's physical and emotional abuse.⁸⁵ Jane had previously sought treatment to cope with the abuse and was voluntarily hospitalized and diagnosed with depression before ultimately being referred to outpatient treatment.⁸⁶ After consulting with her doctor, Jane decided to stop her medication because of concerns about the possible side effects.⁸⁷ Eventually, Jane moved with her children to a domestic violence shelter.⁸⁸ After learning that Jane had fled to a domestic violence shelter, her husband petitioned the court to have her transported to the hospital for an emergency evaluation, claiming that she was non-compliant with her medication.⁸⁹ The court issued an order for Jane to be transported to the hospital for assessment, and, after a hearing, ordered outpatient commitment.⁹⁰ Notably, Jane's husband did not believe she posed a threat of physical harm to herself or others.⁹¹ The Iowa involuntary hospitalization standard required only a showing that someone was likely to inflict serious physical or emotional injury to another. "[S]erious emotional injury" was described as an injury, not necessarily physical, that could be diagnosed by a physician or mental health professional.⁹²

The Iowa Supreme Court reversed the trial court's commitment order and noted its concern with the lower court's reliance on Jane's escape to a domestic

ADVOCACY PROGRAMS (2003) [hereinafter WARSHAW ET AL., REPORT ON MENTAL HEALTH ISSUES & SERVICE NEEDS] (reporting findings related to domestic violence programs and the mental health system). Of course, an abusive intimate partner cannot "commit" an individual to psychiatric hospitalization on his own. This reference, presumably, refers to a decision by an abuser to initiate the emergency detention/civil commitment process by petition, report to the police, or by other measures designed to lead to involuntary hospitalization.

83. See Evan Stark, Re-presenting Battered Women: Coercive Control and the Defense of Liberty 3 (2012) (prepared for Violence Against Women: Complex Realities and New Issues in a Changing World) (on file with Les Presses de l'Université du Québec) (using the terminology of "coercive control" to describe survivors who "have been subjected to a pattern of domination that includes tactics to isolate, degrade, exploit and control them as well as to frighten them or hurt them physically").

84. *In the Int. of J.P.*, 574 N.W.2d 340 (Iowa 1998).

85. *Id.* at 342. Brief for Appellant at 5, *In the Int. of J.P.*, 574 N.W.2d 340 (Iowa 1998) (No. 97-1095), 1997 WL 34500627, at *7.

86. *J.P.*, 574 N.W.2d at 341–42.

87. *Id.*

88. *Id.*

89. *Id.* at 342.

90. *Id.*

91. Brief for Appellant, *supra* note 85, at 8.

92. *J.P.*, 574 N.W.2d at 344.

violence shelter to justify the harm element in the state's civil commitment requirements.⁹³ The court rejected the proposition that a woman leaving an abusive partner would satisfy such a requirement, stating:

A woman who removes herself to a shelter on the basis of an actual or perceived threat should not have to fear the action she took to protect herself will have negative repercussions. Any emotional trauma that resulted from Jane's avilment of the battered women's shelter should not have been considered in the decision of whether to order involuntary treatment.⁹⁴

The Iowa Supreme Court's decision was particularly important because the lower court failed to even consider domestic violence, instead stating that the "hospitalization hearing couldn't deal with all the problems that were brought up . . . like the domestic issues and stressors in the home and that those issues had to be dealt with separately because they were beyond the auspices of this proceeding."⁹⁵ Despite the court's disinterest, Jane's experience of domestic violence was a relevant consideration that was overlooked at the emergency evaluation stage of the civil commitment process.

Jane's experience illustrates several mental health coercion themes that arise in the context of domestic or intimate partner violence.⁹⁶ This first theme is the presence of a pre-existing mental illness that the abuser may then use as the basis for a petition for emergency evaluation. In Jane's case, her husband utilized her prior diagnosis and treatment for depression in support of his petition for her hospitalization.⁹⁷ The second theme is that an abuser may use the existing mental illness diagnosis to seek emergency hospitalization when a partner attempts to leave the abusive relationship or gain greater independence. Jane's husband filed the petition based on her depression and her choice to discontinue her medication use only after she had left him and fled to a domestic violence shelter.⁹⁸ These themes add context about mental health coercion to the survey data and further highlight the need for courts to take care as they respond to emergency hospitalization petitions and involuntary commitment proceedings.

While some abusers use the civil commitment system as a form of control, others assert control by alienating survivors from mental health supports.⁹⁹

93. *Id.* at 341, 344.

94. *Id.*

95. Brief for Appellant, *supra* note 85, at 13.

96. The authors conducted exploratory phone and email conversations with several legal practitioners working with clients who experienced domestic violence. These conversations identified individual experiences that mirrored the themes seen in *J.P.*

97. *J.P.*, 574 N.W.2d at 342.

98. *Id.*

99. See generally Warshaw et al., *Mental Health and Substance Use Coercion Surveys*, *supra* note 18, at 21–22 (highlighting abusers deliberately acting in ways to assert control by controlling a partner's access to mental health treatment, support, and recovery).

Survivors who experience this form of mental health coercion wish to seek treatment for their mental illness (which may or may not relate to their experience of abuse) but are prevented from doing so by abusive intimate partners or family members who inhibit, prevent, or discourage medication, treatment, or hospitalization and abusers who pressure substance use or interfere in substance abuse treatment.¹⁰⁰ The NCDVTMH survey frequently identified these abuse tactics among callers who shared experiences of mental health coercion. Almost 50% of callers who sought mental health treatment for their distress or depression reported that their partner had, at some point, attempted “to prevent or discourage [them] from getting that help or taking medication [they] were prescribed.”¹⁰¹ This percentage is especially significant given that 96.2% of callers who reported interference with medication and treatment also reported that their abusers called them “crazy” and told them that they were “losing their mind[s].”¹⁰² Callers shared that abusers controlled their medication usage by withholding or taking their medications, urging the survivor to take more than the prescribed dosage, or shaming the survivor for being dependent on the medication.¹⁰³

Manipulation and coercion relating to substance use may result in a substance use disorder that requires treatment, which the abuser may further utilize for control.¹⁰⁴ In the NCDVTMH survey, over a quarter of callers stated that their partners had pressured them or forced them to use alcohol or drugs or to take more of the substance than they wanted.¹⁰⁵ Over a quarter of callers also described using alcohol or drugs as a way to cope with abuse.¹⁰⁶ Finally, while only about 15% of callers sought help to deal with their alcohol or drug use, the majority of those who did were discouraged or prevented from accessing

100. *Id.*

101. *Id.* at 6.

102. *Id.* at 8–9.

103. *Id.* at 9.

104. Significant research links the experience of domestic violence with substance use disorders. See Katie M. Edwards et al., *Co-Occurrence and Recovery from Substance Abuse and Lifespan Victimization: A Qualitative Study of Female Residents in Trauma Informed Sober Living Homes*, 49 J. PSYCHOACTIVE DRUGS 1, 6 (2017) (noting that, for many women, the experience of domestic violence preceded their substance use disorder); Nicole Capezza et al., *Trends in Intimate Partner Violence Services Provided by Substance Abuse Treatment Facilities: Findings from a National Sample*, 30 J. FAM. VIOLENCE 85, 89 (2015) (noting the high comorbidity between intimate partner violence and substance use disorders, as well as the benefits of concurrent treatment approaches); Echo A. Rivera, *The Relationship between Intimate Partner Violence and Substance Use: An Applied Research Paper*, NAT'L CTR. ON DOMESTIC VIOLENCE, TRAUMA, AND MENTAL HEALTH, 2015 (identifying the minimal research beyond the NCDVTMH surveys on substance abuse and mental health coercion by abusers); Tracie Afifi et al., *Victimization and Perpetration of Intimate Partner Violence and Substance Use Disorders in a Nationally Representative Sample*, 200 J. NERVOUS & MENTAL DISEASE 684 (2012) (showing that intimate partner violence increased rates of substance use disorders).

105. Warsaw et al., *Mental Health and Substance Use Coercion Surveys*, *supra* note 18, at 11.

106. *Id.* at 12.

treatment by their abusers.¹⁰⁷ Callers identified a variety of tactics abusers utilized to prevent treatment, including not allowing the survivor to attend Alcoholics Anonymous meetings or to seek substance abuse treatment, withholding transportation and money needed for substance abuse treatment, or keeping substances present in the home while the survivor attempted sobriety and treatment.¹⁰⁸

The survey data identifying the frequency with which abusers make threats to abuse the civil commitment system and the anecdotal evidence illustrating the impact when those threats are effectuated suggest the need for more focused research into this problem. Additional studies could shed light on how often these threats are acted upon, and in what legal context. Further research is important not just for the purpose of better understanding mental health coercion, but also for helping to remediate its effects and minimize its frequency.

The available research on mental health coercion is limited to one national survey and a single focus group study done in a large city.¹⁰⁹ Similar research methods with a broader scope would provide greater understanding of the threat of mental health coercion in the civil commitment process. The establishment of focus groups whose attendees include individuals who experience these forms of abuse and survivor advocates would allow researchers an opportunity to learn how mental health coercion in the civil commitment system may occur in a specific jurisdiction. Multiple focus groups across jurisdictions would provide aggregate data to better understand the wide range of effects that coercion imposes on the lives of individuals who experience domestic or intimate partner abuse and who have behavioral health needs. Additional targeted nationwide survey data would also help to quantify the problem and allow jurisdictions to identify areas at risk for coercion; such data would provide information about the contexts in which abusers have threatened to abuse the civil commitment process, how often abusers followed through on such threats, and how often abusers have succeeded. This data would provide the ability for advocates and policy makers to better understand the issue and therefore help shape recommendations for legal protections against mental health coercion in the future.

IV. IMPROVING THE EMERGENCY DETENTION AND CIVIL COMMITMENT PROCESSES

The survey data highlights the realities of mental health coercion in domestic and intimate partner violence. Some abusers may use their partner's

107. *Id.*

108. *Id.* at 16.

109. See generally *id.*; WARSHAW ET AL., REPORT ON MENTAL HEALTH ISSUES & SERVICE NEEDS, *supra* note 82.

mental illness as a means of control by manipulating the emergency detention or civil commitment process. As a group, the individuals identified by the NCDVTMH survey data who suffer from some form of mental health coercion—those who are threatened with civil commitment, those whose access to mental health care is blocked, and those who are coerced into substance use—would benefit from a more responsive public mental health system that effectively screens their needs prior to hospitalization and links them to available and responsive resources. Some people within this group also would benefit from changes in the legal rules governing emergency detention and civil commitment to ensure that the process is not misused by abusive partners and to effectuate the requirement that mental health treatment be provided in the least restrictive setting available and appropriate to the individual's needs.¹¹⁰

When a person is transported to an emergency department or designated psychiatric facility for evaluation pursuant to an emergency detention order initiated by an abusive family member or intimate partner, this involuntary confinement may function as an additional source of psychiatric distress. States originally enacted emergency detention provisions in the early part of the 20th century to authorize police officers and physicians to hold individuals without the necessity of a court order.¹¹¹ In most states, medical and behavioral health professionals and law enforcement personnel retain the authority to arrange for designated persons to be detained and transported for psychiatric evaluation without prior judicial approval.¹¹² In addition, in a number of jurisdictions, interested persons, including family members, neighbors, teachers, and others, may also initiate a process leading to an emergency detention, although these lay petitions often require endorsement by a court according to specified statutory criteria.¹¹³ Even in places where judicial authorization is required for a lay petition, however, family members and others may effectively initiate an emergency detention without prior court review by calling 911 and relying on the authority of the responding police officials, or by bringing the individual directly to an emergency department or psychiatric facility.¹¹⁴

110. See *infra* text accompanying notes 225–232 (discussing the least restrictive alternative doctrine).

111. See generally PAUL S. APPELBAUM, *ALMOST A REVOLUTION: MENTAL HEALTH LAW AND THE LIMITS OF CHANGE* 21 (1994) (providing historical overview of emergency detention statutes).

112. See Leslie C. Hedman et al., *State Laws on Emergency Holds for Mental Health Stabilization*, 67 *PSYCHIATRIC SERVS.* 529, 530 (2016) (building and discussing a 50-state open-source data set of laws on psychiatric emergency holds); see also Richard C. Boldt, *Emergency Detention and Involuntary Hospitalization: Assessing the Front End of the Civil Commitment Process*, 10 *DREXEL L. REV.* 1, 10 (2017) (reviewing different forms of state statutes governing involuntary psychiatric admissions).

113. Hedman et al., *supra* note 112, at 530–31; Boldt, *supra* note 112 at 10.

114. See *Calling 911 and Talking to the Police*, NAT'L ALL. ON MENTAL HEALTH, <https://www.nami.org/Your-Journey/Family-Members-and-Caregivers/Calling-911-and-Talking-with-Police> (last visited Mar. 4, 2022) (noting that in some jurisdictions police officers responding to a 911 call “can force a person in crisis to go to the hospital involuntarily for a mental health evaluation”).

There is considerable variation among states with respect to the essential legal requirements for initial detention and longer-term involuntary commitment. A fifty-state survey of emergency detention laws conducted in 2016 determined that the length of emergency detention ranges from twenty-three hours in North Dakota to ten days in New Hampshire and Rhode Island.¹¹⁵ The survey reported that police generally have the authority to detain a person for psychiatric evaluation, and that mental health practitioners in thirty-three states and other medical personnel in twenty-two states may request such a hold.¹¹⁶ Twenty-two jurisdictions permit “any interested person” to trigger the process.¹¹⁷ Judicial approval is required in twenty-two states; nine jurisdictions require judicial approval before admission, while thirteen others require it only after admission.¹¹⁸ There are additional variations among the states with respect to whether law enforcement officers are required to consult a mental health professional as part of the detention process, whether mental health professionals and law enforcement officers are required to obtain judicial authorization, and whether judicial decisions, if required, are based on *ex parte* submissions, medical certificates, or require direct testimony.¹¹⁹

As a baseline, consider the process in Maryland, where any “interested person” who has reason to believe that a person has a mental disorder and is a danger to herself or others may petition for emergency evaluation of that person.¹²⁰ The petitioner must base the petition on “examination or observation” and “other information obtained that is pertinent to the factors giving rise to the petition.”¹²¹ Medical and behavioral health professionals and peace officers may also file emergency petitions; however, both must have directly examined or personally observed the person’s behavior.¹²² An interested lay petitioner must submit the petition to a district or circuit court for review, and the court may endorse the petition upon finding probable cause.¹²³ A peace officer is then authorized to transport the person to an emergency facility where a physician must examine the person within six hours to assess the appropriateness of involuntary admission according to statutory standards.¹²⁴ If the person satisfies requirements for involuntary admission, the physician will then seek to transfer

115. Hedman et al., *supra* note 112, at 530.

116. *Id.* at 530–31.

117. *Id.* at 531.

118. *Id.*

119. *See id.* at 530–31 (identifying variations among states regarding interactions between law enforcement, mental health professionals, and courts throughout the emergency commitment).

120. MD. CODE ANN., HEALTH–GEN. § 10-622 (2020).

121. *Id.* § 10-624(b)(2).

122. *Id.* § 10-622(b)(1)(i)–(ii).

123. *Id.* § 10-623.

124. *Id.* § 10-624(a)(1)–(b)(2).

the person to a facility with a licensed inpatient psychiatric unit.¹²⁵ Within thirty hours of completing the involuntary admission paperwork, the emergency facility must notify the Public Defenders' Office, Mental Health Division.¹²⁶

The emergency evaluation process in Maryland can therefore be initiated by someone who has no mental health training and endorsed by a court without the testimony of a medical professional. Once detained and transported for evaluation, the decision whether to proceed with involuntary admission is made by professionals at the emergency assessment facility.¹²⁷ There must also be a determination that there is "no available less restrictive form of intervention that is consistent with the welfare and safety of the individual."¹²⁸ Importantly, a formal judicial proceeding at which the patient is represented by counsel need not take place for a full ten days after a person is taken into custody (with the possibility of an additional seven-day extension).¹²⁹ Most involuntary psychiatric stays in Maryland last less than ten days and thus most individuals who are detained involuntarily under these rules do not receive full judicial review.¹³⁰ Maryland, like many other states, does not require preliminary judicial involvement for emergency detentions initiated by the police or by health care professionals.¹³¹

While the approach to emergency detention and involuntary hospitalization in Maryland is similar to that followed in several other jurisdictions, there are important variations among states.¹³² Three features defining these varying legal regimes are of particular importance in governing how a jurisdiction's emergency detention and civil commitment system operates (or might operate) for individuals with co-occurring behavioral health problems and significant exposure to domestic or intimate partner violence. These features are: (1) the specific legal criteria required for initiation of the emergency detention

125. *Id.* § 10-625(a).

126. *Id.* § 10-625(c)(1).

127. *See id.* § 10-615(6) (mandating that an application for involuntary admission must include certification from two mental health professionals as identified in the statute).

128. *Id.* § 10-632(e)(2)(v).

129. *Id.* § 10-632(b)–(c).

130. Boldt, *supra* note 112, at 40–41.

131. *See* HEALTH–GEN. § 10-622(b)–(c) (establishing requirements for petitions for emergency evaluations). It is important to note that the Maryland Code, Health–General section 10-630 provides that "[a]ll court records relating to a petition for an emergency evaluation made under this subtitle are confidential and the contents may not be divulged, by subpoena or otherwise, except by order of the court on good cause shown." *Id.* § 10-630. This information might be considered by a court in a subsequent custody or protective order proceeding, however, pursuant to a good cause order. *Id.* § 10-630(a). In addition, because this confidentiality provision contains an exception for disclosure to a "law enforcement agency," police officers might have information about prior petitions when responding to a domestic violence call, which could drastically change the nature of the interaction police have with the person subjected to abuse. *Id.* § 10-630(b)(6).

132. *See* Hedman et al., *supra* note 112, at 530–32 (discussing variations in emergency detention between states).

process;¹³³ (2) the availability of legal counsel and judicial review either before or within the first hours or days of detention;¹³⁴ and (3) the availability and/or requirement of pre-detention screening at the county level, with the possibility of diversion to voluntary community-based alternatives to involuntary hospitalization.¹³⁵

A. Legal Criteria

The legal criteria that govern the decision making of police officers, health care professionals, and, where required, judges or magistrates—with respect to the initial decision to take an individual into custody for purposes of an emergency mental health evaluation—generally do not include express consideration of that person’s possible exposure to domestic or intimate partner abuse. In Maryland, for example, a “peace officer” must certify that he or she “personally has observed the individual or the individual’s behavior”¹³⁶ and that based on that observation and “other information obtained that is pertinent,”¹³⁷ which could be information reported by a family member or intimate partner, he or she has “reason to believe” that the evaluatee “[h]as a mental disorder” and “[p]resents a danger to the life or safety of the individual or of others.”¹³⁸ A health care professional can likewise trigger custody and emergency evaluation by certifying that, “[b]ased on examination or observation” and “other information,”¹³⁹ which again could come from family members and other intimates, the professional has “reason to believe that the individual has a mental disorder” and “presents a danger to the life or safety of the individual or others.”¹⁴⁰ In the alternative, a Maryland trial judge can entertain a petition from an interested layperson for the emergency evaluation of an individual.¹⁴¹ In these cases, the lay petitioner must use a form petition that asks for information about (1) past requests for emergency assessment of the evaluatee, (2) the evaluatee’s prior hospitalizations, (3) her history of psychiatric care and medications, and (4) the observed behavior that leads the petitioner to believe that the evaluatee presents a danger to herself or others.¹⁴² Whether the process is triggered by the unendorsed petition of a health care professional or peace officer or by an endorsed petition, none of these requirements can be expressly relied upon to elicit information

133. *See infra* Section IV.A.

134. *See infra* Section IV.B.

135. *See infra* Section IV.C.

136. HEALTH-GEN. § 10-622(b)(1)(ii).

137. *Id.* § 10-622(b)(2).

138. *Id.* § 10-622(a).

139. *Id.* § 10-622(b)(2).

140. *Id.* § 10-622(a).

141. *Id.* § 10-622(b)(1)(iii).

142. MARYLAND JUDICIARY, CC-DC-013 PETITION FOR EMERGENCY EVALUATION (2020), <https://www.courts.state.md.us/sites/default/files/court-forms/courtforms/joint/ccdc013.pdf/ccdc013.pdf>.

about the detained individual's exposure to abuse or to alert officials that the process could be tainted by the coercive demands of an abusive intimate partner or family relationship.

The information required for emergency detention in most other states is similarly unlikely to trigger an inquiry into these matters. In Massachusetts, for example, police officers, physicians, and other designated behavioral health professionals are authorized to apply for the emergency evaluation of an individual when they "ha[ve] reason to believe that failure to hospitalize such person would create a likelihood of serious harm by reason of mental illness."¹⁴³ This application for hospitalization must "state the reasons for the restraint of such person and any other relevant information which may assist the admitting physician or physicians," but no specific information is required that necessarily would disclose domestic or intimate partner abuse.¹⁴⁴

In addition, Massachusetts law permits "any person" to apply to a district court justice or a justice of the juvenile court for an emergency three-day commitment of a person when the applicant asserts simply that "the failure to confine would cause a likelihood of serious harm."¹⁴⁵ Upon receipt of this application, the court must conduct an evidentiary hearing, and after gathering "such evidence as he may consider sufficient," the court is authorized to issue a warrant for "the apprehension and appearance before him of the alleged mentally ill person, if in his judgment the condition or conduct of such person makes such action necessary or proper."¹⁴⁶ While a judge conducting these required hearings could inquire systematically into the nature of the relationship between the applicant seeking the restraint of another and the person subject to that application, and could even interview the restrained individual privately to determine if she has experienced control or abuse on the part of the applicant, nothing in the statute's procedural or substantive criteria guiding the court's decision-making ensures that such an investigation will take place.

The Massachusetts statute further provides that "[f]ollowing apprehension, the court shall have the person examined by a physician designated to have the authority to admit to a facility or examined by a qualified psychologist in accordance with the regulations of the department."¹⁴⁷ Of course, the designated physician or psychologist charged with conducting this admission evaluation could adopt a practice of systematically screening for domestic or intimate partner violence, and/or the department's regulations could require such a

143. MASS. GEN. LAWS ch. 123, § 12(a) (2021).

144. *Id.*

145. *Id.* § 12(e).

146. *Id.*

147. *Id.* If this physician or psychologist reports that "the failure to hospitalize the person would create a likelihood of serious harm by reason of mental illness," the court is permitted to order the individual detained for up to three days. *Id.*

screening. At present, however, there is no indication that this information is routinely sought, and the governing regulations do not require it.

In general, the statutes in other jurisdictions governing when an individual may be restrained for purposes of emergency psychiatric evaluation also do not delineate specific criteria that would reliably reveal abuse of the civil commitment system by intimate partners. The statutory process in some states does require a lay petitioner to appear in court and give sworn testimony in support of the request,¹⁴⁸ but most states permit an individual to be detained and transported for evaluation on the basis either of a written petition filed with the court or an affidavit or other sworn statement setting out general allegations with respect to the alleged impairment and potential danger to self or others that is the basis for this exercise of the state's police powers.¹⁴⁹

Experienced advocates who staff shelters and other community-based facilities for individuals who suffer domestic or intimate partner abuse have developed standardized questions designed to uncover the presence of problematic family or intimate relationships.¹⁵⁰ Those standardized inquiries could be adapted for use by courts and mental health professionals charged with making threshold psychiatric detention determinations and could be made part of the statutorily required process for involuntary commitment decision-making in jurisdictions that currently do not attend to the danger of mental health coercion. To be sure, there is a need to balance such an inquiry so that the legitimate concerns of family members or other intimates acting in good faith are

148. See, e.g., ARK. CODE ANN. § 20-47-210(a)(2) (2021) (requiring petitioner to appear before a circuit judge where the person sought to be immediately confined resides or is found); 405 ILL. COMP. STAT. 5/3-607 (2021) (entering a court order for temporary detention and examination is based on "personal observation and testimony in open court").

149. See, e.g., COLO. REV. STAT. § 27-65-105(1)(b) (2016) (requiring affidavit sworn to or affirmed before a judge that relates sufficient facts); GA. CODE ANN. § 37-3-41(b) (2010) (requiring a physician's certificate or the affidavits of at least two witnesses); KAN. STAT. ANN. § 59-2958(a) (2020) (specifying that a petitioner's request to the district court to issue an *ex parte* emergency order must be in writing); MO. REV. STAT. § 632.305(2) (1996) (specifying that an application may be filed by anyone with the court).

150. Significant social science research exists detailing effective measures to screen for experiences of domestic or intimate partner violence. An analysis of abuse screening measures identified five such measures that demonstrated a "high diagnostic accuracy" for identification of domestic violence, including the Hurt, Insult, Threaten, and Scream instrument, the Ongoing Violence Assessment Tool, the Humiliation, Afraid, Rape, Kick instrument, the Slapped, Threatened, and Throw instrument, and the Woman Abuse Screening tool. Heidi D. Nelson et al., *Screening Women for Intimate Partner Violence: A Systemic Review to Update the U.S. Preventive Services Task Force Recommendation*, ANNALS OF INTERNAL MED. (2012), <https://www.acpjournals.org/doi/10.7326/0003-4819-156-11-201206050-00447#t1-7>. A common feature of these tools is that they require specific inquiry into harmful behaviors. See CTRS. FOR DISEASE CONTROL & PREVENTION, INTIMATE PARTNER VIOLENCE AND SEXUAL VIOLENCE VICTIMIZATION ASSESSMENT INSTRUCTIONS FOR USE IN HEALTHCARE SETTINGS (Kathleen C. Basile et al. eds., 2007) (asking questions such as (1) "[a]t the present time does your partner threaten you with a weapon?" (2) "[d]o arguments ever result in hitting, kicking or pushing?" (3) "[d]o you ever feel frightened by what your partner says or does?").

not discounted when they seek to have a loved one brought to a designated facility for emergency evaluation. The goal should be the development of a standardized process of information gathering and the articulation of appropriate decision-making criteria that are sensitive to these competing interests and attentive to the relevant details of the relationships of all those involved.

B. Prompt Provision of Legal Counsel and Timely Judicial Review

With respect to the prompt provision of legal counsel and the timely availability of a judicial hearing, the statutory variation among states is even wider and the reliability of procedural protections far more mixed.¹⁵¹ Given research that raises significant concerns that behavioral health professionals—who either initiate the emergency detention process or are charged with assessing patients when they arrive at a hospital emergency department or specialized psychiatric unit for emergency evaluation—do not adequately screen for domestic or intimate partner violence,¹⁵² it becomes even more important to ensure the early involvement of advocates and judicial decision-makers who could be trained to be on the alert for abuse and coercion and obligated to attend to these issues. While emergency evaluators should be trained to screen for domestic and intimate partner violence, especially in the absence of any initial judicial review, the additional safeguards provided by vigilant counsel and by court involvement early in the process would likely add an additional layer of protection.

As noted, the involuntary confinement of an individual in Maryland need not be subject to judicial evaluation until well into the second week of the process.¹⁵³ By contrast, some jurisdictions have adopted statutory schemes in which court review is mandated within the first hours or days of the emergency detention process. Other states make preliminary judicial review of the detention decision available within the first few days of custody upon the request of the detained individual or her agent.¹⁵⁴

In Massachusetts, for example, counsel is appointed for persons who are admitted pursuant to emergency detention.¹⁵⁵ Counsel is permitted to request judicial review within a day of the detention decision, requiring the prompt filing

151. See Boldt, *supra* note 112, at 19 (explaining that some jurisdictions have statutory rules that reflect the “need for prompt judicial oversight” and others “maintain procedural timeliness that delay judicial hearings until well after many detained patients’ inpatient episodes have concluded”).

152. See *supra* Section III (detailing behavioral health professionals’ routine failure to screen for intimate partner violence).

153. See *supra* text accompanying note 111.

154. See Boldt, *supra* note 112, at 30 (describing this approach in California, New York, and Massachusetts).

155. *Id.* at 20.

of a civil commitment petition and a full judicial hearing.¹⁵⁶ In addition, Massachusetts's civil commitment law includes a provision that applies when a person subject to emergency detention "has reason to believe that such admission is the result of any abuse or misuse of the provisions" of the process.¹⁵⁷ In that event, the person may request an emergency hearing that must be held on the following business day, absent a request by the patient for a delay.¹⁵⁸ Similarly, in New York, specialized attorneys must be notified promptly of an involuntary psychiatric admission and either the assigned attorney or the patient can request a preliminary judicial hearing to review the decision.¹⁵⁹

Similarly, Virginia's statutes governing involuntary psychiatric detention interpose a judicial officer "as a required decision-maker early in the process, and often as a gatekeeper at the very front end of the process."¹⁶⁰ While some states, including New York and Massachusetts, make a preliminary judicial hearing available if requested by the patient, the Virginia approach instead provides for judicial review automatically.¹⁶¹ Initially, the detained person may be held for up to eight hours; during which time, she must be evaluated by a specially trained representative of a local "community behavioral health services board" to determine if she meets the criteria for a "temporary detention order" under Virginia law.¹⁶² The detained individual may be released during the initial eight hours of emergency custody or upon the expiration of that period.¹⁶³ In the

156. MASS. GEN. LAWS ch. 123, § 12(b) (2020) ("Any person admitted...who has reason to believe such admission is the result of an abuse or misuse...may request, or request through counsel an emergency hearing in the district court in whose jurisdiction the facility is located...the district court shall hold such hearing on the day the request is filed with the court or not later than the next business day.").

157. *Id.*

158. *Id.* The adoption of this abuse provision was likely in response to a Boston Globe article that highlighted the risk of abuse by medical professionals of the civil commitment system. See Marybeth Walsh, *Due Process Requirements for Emergency Civil Commitments: Safeguarding Patients' Liberty Without Jeopardizing Health and Safety*, 40 B.C. L. REV. 673, 688 (1999) (explaining that an article published in the Boston Globe in 1997, which described several cases of "improper emergency commitments under section 12," drew public attention to Section 12).

159. N.Y. MENTAL HYG. LAW § 9.39(a) (McKinney 2021) ("If at any time after admission, the patient...or the mental hygiene legal service gives notice to the director in writing of request for court hearing on the question of need for immediate observation...a hearing shall be held.").

160. Boldt, *supra* note 112, at 34. The Virginia code employs both magistrates and judges in this process. *Id.* at 35. The qualifications required to serve as a magistrate are set out in VA. CODE ANN. § 19.2-37. VA. CODE ANN. § 19.2-37 (2006). While formal legal training is not required for appointment as a magistrate, these officials are nonetheless judicial officers. Boldt, *supra* note 112, at 35.

161. See VA. CODE ANN. §§ 37.2-808, 809, 814 (2020) (outlining the procedures for emergency custody and preliminary judicial hearings in Virginia).

162. *Id.* § 37.2-808(B), 808(L).

163. *Id.* §37.2-808(K).

alternative, she may be detained for up to seventy-two hours if a magistrate issues a temporary detention order.¹⁶⁴

In a jurisdiction like Virginia that requires either front-end judicial review of emergency petitions and/or prompt judicial review shortly after detention, careful judicial screening to assess for the risk of abuse could be made a required element. Such screening at the pre-detention stage is currently difficult in most jurisdictions given the limited information required by most states' emergency petitions and the lack of access to the potential evaluatee. As noted below, instituting regular pre-petition screening would go a long way toward ameliorating these difficulties.¹⁶⁵ In any event, screening and assessment should be more productive at a formal involuntary commitment hearing, where the patient has legal representation and the opportunity to be present and to present evidence.¹⁶⁶

In Virginia, this formal judicial commitment hearing must be held at the conclusion of the seventy-two-hour temporary detention period.¹⁶⁷ The hearing, which is presided over by a district court judge or special justice, must include consideration of information provided by a psychiatrist or psychologist, and a "preadmission screening report" prepared by the local community services board.¹⁶⁸ These examinations provide an excellent opportunity to gather information about potential domestic abuse or intimate partner violence. By law, the psychiatrist/psychologist examination must contain a clinical assessment and substance abuse screening, a risk assessment, an assessment of the person's capacity to consent to treatment, a review of the treatment records from the temporary detention facility, a discussion of the individual's treatment preferences, an assessment of whether the individual meets criteria for discharge to "mandatory outpatient treatment" following a period of inpatient treatment, an assessment of the suitability of alternatives to inpatient treatment, and a recommendation for placement, care, and treatment.¹⁶⁹ Given the detailed requirements the law already imposes on the psychiatrist or psychologist charged with conducting this examination, it would be sensible to require as well that a standardized domestic or intimate partner abuse screening inquiry be included.

164. *See id.* (outlining the procedure for a magistrate issuing an emergency custody order); *id.* § 37.2-814(A) (requiring a commitment hearing for involuntary admission be held within seventy-two hours of the execution of the temporary detention order).

165. *See infra* note 173 (explaining that pre-petition screening provides an opportunity to actively investigate the petition, alleged facts, and whether there is an alternative, less coercive treatment option available).

166. *See generally*, CHRISTOPHER SLOBOGIN ET AL., LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS 930–65 (7th ed. 2020) (detailing formal procedure requirements for civil commitment hearings).

167. VA. CODE ANN. § 37.2-814(A).

168. *Id.* §§ 37.2-815(A), 816.

169. *Id.* § 37.2-815(B).

C. Pre-Detention Screening

The third feature of importance in governing how responsive a jurisdiction's emergency detention process might be for individuals with significant exposure to domestic or intimate partner violence concerns the availability of pre-detention screening. The National Task Force on Guidelines for Involuntary Civil Commitment—which was organized by the National Center for State Courts in the mid-1980s and charged with developing guidelines for the improvement of the civil commitment process—recommended that states create local screening agencies operated by community mental health centers or other county-based mental health officers to provide appropriate diversion from inpatient commitment to alternative forms of mental health and social services in the least restrictive setting at the earliest possible point in the process.¹⁷⁰ The Task Force urged jurisdictions to recruit and support “mental health screening officers,” who would be charged with performing pre-admission screening in the community to assess individuals in crisis, optimally before they were detained, in order to identify those who could safely and effectively be diverted to other mental health and social services as opposed to being involuntarily hospitalized.¹⁷¹ The Task Force noted that “screening should begin as early as possible in the involuntary civil commitment process in order to avoid unnecessary infringement of liberty, to ensure that persons are guided quickly and effectively toward the placement and treatment indicated by their presenting problems, and to minimize needless waste of limited resources.”¹⁷²

While the Task Force's report and recommendations did not discuss diversion to community-based services specifically geared to addressing the effects of domestic or intimate partner violence, the broad logic of their recommendations would certainly embrace the creation and funding of integrated community resources designed to systematically address the needs of identified persons with co-occurring behavioral health needs and exposure to domestic or intimate partner abuse. Effective pre-detention screening designed to identify individuals who might be the subject of coercion by abusive family members or intimate partners and to divert them into voluntary treatment and other appropriate services would therefore constitute an effective innovation to assist persons with behavioral health needs and experience with domestic abuse.¹⁷³

170. Joseph Schneider et al., Nat'l Ctr. for State Cts., *Guidelines for Involuntary Civil Commitment*, 10 MENTAL & PHYSICAL DISABILITY L. REP. 409, 429–30 (1986) (“Every locale should designate or establish an agency, program, or administrative unit charged with the responsibility for screening all candidates for involuntary civil commitment.”).

171. *Id.* at 429.

172. *Id.* at 428.

173. Even if professionals trained to identify domestic or intimate partner violence conduct the pre-petition screenings, there is reason to worry that the voices of those who seek to misuse the process for purposes of coercive control could predominate over those of the individuals in distress, who might not

The National Task Force report identified four states—Arizona, Minnesota, Ohio, and Washington state—that, at the time, performed pre-detention screening in the community.¹⁷⁴ Those states continue to maintain pre-detention screening practices. In Arizona, for example, a designated agency is charged with investigating applications for emergency detention within forty-eight hours of their filing.¹⁷⁵ The screening includes an investigation into the allegations set out in the application, as well as a voluntary interview and evaluation of the person at issue, when possible.¹⁷⁶ The Arizona approach has been an effective tool for implementing alternatives to involuntary treatment, with one study finding that 90% of cases brought to the screening agency were diverted in favor of voluntary care, a halfway house, or other mental health treatment.¹⁷⁷ While these data do not specifically identify whether cases of mental health coercion by intimate partners were among the 90% of diverted cases, it is likely that allegations of severe mental illness or danger to self or others that are manufactured or exaggerated to manipulate the civil commitment system would be vulnerable to exposure through this pre-detention investigation process.

In Minnesota, a screening team is used to investigate an individual's mental health status prior to hospitalization when a petition for civil commitment is filed by "an interested person."¹⁷⁸ The required investigation must include an exploration of less restrictive alternatives.¹⁷⁹ The screening team must interview

be as coherent in sharing their stories or might be afraid to disclose information about abuse altogether. *See infra* text accompanying notes 189–190. This concern can be ameliorated by adopting careful procedures to ensure that individuals subject to screening are interviewed in private, and by the careful use of structured instruments specifically designed to identify intimate partner or domestic abuse. *See infra* text accompanying notes 189–190. In addition, it is fair to question how "voluntary" alternative placements are when individuals subject to pre-petition evaluation face the prospect of emergency detention and possible involuntary hospitalization if they reject other community-based services. Janet A. Gilboy & John R. Schmidt, "Voluntary" Hospitalization of the Mentally Ill, 66 NW. U. L. REV. 429, 430 (1971). Given that the choice to agree to a voluntary placement often is made with the "threat of involuntary commitment as the principal means of persuasion," these decisions should be monitored carefully. *Id.* Of course, these concerns regarding coercion should be less pronounced if the decision is not with respect to hospitalization but instead involves outpatient community-located services that include specialized support for individuals who have experienced intimate partner or domestic violence and who have co-occurring behavioral health needs. *Id.*

174. Schneider et al., *supra* note 170, at 429–31 ("At least several states—Arizona, Minnesota, Ohio, and Washington, for example—have created screening agencies . . . in order to prove the delivery of mental health services at the community level.").

175. ARIZ. REV. STAT. ANN. § 36-520D (2021); Schneider et al., *supra* note 170, at 429–30.

176. ARIZ. REV. STAT. ANN. § 36-521(E) (2021); Schneider et al., *supra* note 170, at 430.

177. Schneider et al., *supra* note 170, at 430.

178. MINN. STAT. § 253B.23.1b (2021).

179. *Id.* § 253B.06.1; 1 MICHAEL L. PERLIN & HEATHER ELLIS CUCOLO, MENTAL DISABILITY LAW: CIVIL AND CRIMINAL § 4-2.3.3 (3d ed. 2016) ("In Minnesota, by way of example, courts have adhered fairly rigorously to the language of the revised statute, which demands a showing '[of] a substantial psychiatric disorder, [that the proposed patient] poses a substantial likelihood of physical harm to [self] or others, and that no less restrictive alternative to judicial commitment is available,' and findings by the

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the person at issue in the application, identify the conduct alleged in the petition, explore alternatives, and specify why alternatives are not appropriate.¹⁸⁰

In Ohio, the emergency detention and civil commitment processes can be initiated by the filing of an affidavit setting out allegations that the named individual requires hospitalization.¹⁸¹ Within two business days after receipt of this affidavit, the probate court must refer the affidavit to a designated state agency or a community mental health services provider authorized by that agency “to assist the court in determining whether the respondent is subject to court-ordered treatment and whether alternatives to hospitalization are available”¹⁸² The state agency or service provider must “review the allegations of the affidavit and other information relating to whether or not the person named in the affidavit or statement is a mentally ill person subject to court order, and the availability of appropriate treatment alternatives.”¹⁸³ While this referral is mandatory under Ohio law and may serve as the basis for a pre-detention investigation of the allegations made in the affidavit by an abusive intimate partner, the state’s statutes permit some individuals to be detained and transported to a facility before the requisite investigation has been completed.¹⁸⁴ Thus, a separate provision permits the court to immediately “issue a temporary order of detention ordering any health or police officer or sheriff to take into custody and transport the person to a hospital or other place designated [by statute].”¹⁸⁵ An additional section permits authorized health-care professionals and law enforcement officials to take individuals into custody and immediately transport them to a hospital for emergency evaluation even without judicial authorization.¹⁸⁶ In these instances, where immediate detention is permitted, the court or the health or safety official must determine that the individual’s mental illness poses an imminent danger. This required determination may prevent some loss of liberty due to manipulation of the process by an abusive intimate partner, but it is not as protective as a pre-detention screening would be.

In Washington state, a designated crisis responder is assigned to investigate petitions for involuntary hospitalization.¹⁸⁷ The evaluation must include an investigation into the facts of the application as well as the “reliability and credibility” of the people who are providing information and seeking to initiate

trial court that ‘specifically state the proposed patient’s conduct which is the basis for determining that each of the requisites for commitment is met.’”).

180. § 253B.07(1)(a)(1); PERLIN & CUCOLO, *supra* note 179, § 4-2.1.3.

181. See OHIO REV. CODE ANN. § 5122.111 (West 2021) (listing requirement for an affidavit of mental illness).

182. *Id.* § 5122.13.

183. *Id.*

184. *Id.* § 5122.11.

185. *Id.* § 5122.11.

186. *Id.* § 5122.10(A).

187. WASH. REV. CODE § 71.05.153(1) (2021).

hospitalization.¹⁸⁸ This requirement is an excellent foundation for building a systematic screening protocol designed to uncover cases in which individuals have been exposed to family or intimate partner abuse and may be subject to mental health coercion by their partners. The inquiry into the “reliability and credibility” of those providing information should include mandatory questions about the relationship between the petitioner and the individual who is potentially subject to involuntary commitment, as a means of exploring the ambient strains and other stressors bearing upon the allegations of mental illness and the need for care.

Several additional states, including California and Alabama, currently also provide for pre-petition or pre-admission community-based screening as part of their relevant statutory framework.¹⁸⁹ In California, the law permits any person to apply for a pre-petition screening to a designated screening agency.¹⁹⁰ This investigation goes beyond the “nominal consideration” of alternatives found in most state requirements in favor of an active investigation into the petition, the facts alleged in the petition, and whether there is an alternative, less coercive treatment option available.¹⁹¹ A mental health screening officer investigates by interviewing the person who is the subject of the proposed petition for emergency detention.¹⁹² The officer is charged with determining whether the person will agree voluntarily to receive crisis intervention services or an evaluation in her own home or a designated facility.¹⁹³ Based on these findings, a judge may order that the individual undergo a mandatory evaluation and may order a law

188. *Id.*

189. As noted above, some jurisdictions either require or permit a designated local official to conduct a screening investigation *prior* to the evaluatee’s detention. ARIZ. REV. STAT. ANN. § 36-521 (2017); MINN. STAT. § 253B.06.1 (2021); OHIO REV. CODE ANN. § 5122.13 (West 2014). By contrast, in other jurisdictions the law contemplates that the individual identified in a petition for involuntary hospitalization will be detained and transported for evaluation but that no “admission” to the facility is permitted until a preliminary screening evaluation is completed. *See, e.g.*, ARK. CODE ANN. § 20-47-210 (West 1989); D.C. CODE § 21-522(c) (2008); D.C. CODE § 21-523 (2003); IOWA CODE § 229.22.2a (2021); MASS. GEN. LAWS ch.123, § 12 (2020). The process in Alabama provides yet a third variation. ALA. CODE § 22-52-7 (1991). In Alabama, when a petition seeking civil commitment is filed, the probate judge must “order the sheriff of the county in which the respondent is located to serve a copy of the petition upon the respondent and . . . bring the respondent before the probate judge instanter.” *Id.* The judge then must “determine from an interview with the respondent and with other available persons what limitations, if any, shall be imposed upon the respondent’s liberty and what temporary treatment, if any, shall be imposed upon the respondent pending further hearings.” *Id.* If the judge does not order the respondent to be held pending a further hearing, the court may “order the respondent to appear at the times and places set for hearing the petition and may order the respondent to appear at designated times and places to be examined by licensed medical doctors or qualified mental health professionals.” *Id.* In effect, the Alabama provisions permit but do not require a pre-detention examination, depending upon the probate judge’s determination with respect to custody at the initial proceeding, which the individual has been required to attend. *Id.*

190. CAL. WELF. & INST. CODE § 5201 (West 1969).

191. Boldt, *supra* note 112, at 27.

192. CAL. WELF. & INST. CODE § 5202 (West 1969).

193. *Id.*

enforcement officer to take the individual into custody and transport her to a designated facility.¹⁹⁴ If, however, the screening officer determines that the individual does not meet the statutory requirements for involuntary admission, but determines that she would benefit from community-based services targeting the emotional and practical problems associated with exposure to domestic or intimate partner abuse, the screening agency could divert the person from the civil commitment system into alternative community-based care.¹⁹⁵

Interestingly, the statute governing this process recognizes the potential for its abuse by a party who in bad faith seeks the restraint of another.¹⁹⁶ California law thus provides that “[a]ny individual who seeks a petition for court-ordered evaluation knowing that the person for whom the petition is sought is not, as a result of mental disorder, a danger to himself, or to others, or gravely disabled is guilty of a misdemeanor, and may be held liable in civil damages by the person against whom the petition was sought.”¹⁹⁷ While the threat of criminal or civil liability may be a deterrent to mental health coercion in some cases, the development of a standardized protocol for eliciting information with respect to domestic or intimate partner abuse that is made a regular part of the pre-petition screening routine would supplement this after-the-fact remedy and provide additional protection to vulnerable individuals with both mental illness and exposure to unwarranted abuse or control by their intimate partner or family.

D. The Geriatric and Child Custody Analogies

In addition to building systematic screening protocols at the local level before an individual is detained or involuntarily admitted to a psychiatric facility, the adoption of rules requiring judicial screening *after* detention that systematically includes an inquiry into possible domestic or intimate partner violence would also be an appropriate response, especially in those jurisdictions requiring that a court conduct a preliminary review of emergency detentions within the first few days of custody. Similar judicial screening requirements are already in place in some jurisdictions when older adults are subject to involuntary hospitalization, and in child custody proceedings.

In some jurisdictions, older adults are protected by specific screening protocols as part of the process by which emergency hospitalization and

194. *See id.* § 5206 (providing that the judge shall order the evaluation when a person refuses or fails to accept evaluation voluntarily).

195. *See Schneider et al., supra* note 170, at 427 (discussing procedures to encourage diversion to less restrictive treatment alternatives).

196. *See CAL. WELF. & INST. CODE* § 5203 (West 1969) (providing penalty for false application for petition).

197. *Id.*

involuntary commitment decisions are made.¹⁹⁸ In Maryland, for example, in cases involving the involuntary hospitalization of an individual who is sixty-five years of age or older, an administrative law judge (ALJ) must make a finding that “there is no available, less restrictive form of care or treatment that is adequate for the needs of the individual.”¹⁹⁹ This finding must be based on a recommendation by the Adult Evaluation and Review Services—staff specifically identified to assess the appropriateness of admissions of older adults.²⁰⁰ Presumably, this geriatric evaluation and the consideration of less restrictive alternatives is well suited to uncovering cases in which family members or others seek to involuntarily hospitalize an elderly person for improper reasons.

The danger of mental health coercion by abusive intimate partners also plays out through the child custody process. One author noted:

Domestic violence (DV) advocates and survivors have consistently voiced concerns about the ways mental health issues are used against battered women, not only by abusers but also by the systems in which women seek help (e.g., batterers using mental health issues to control their partners, undermine them in custody battles, and discredit them with friends, family, child protective services, and the courts).²⁰¹

As with the civil commitment process, the NCDVTMH survey revealed that abusers frequently threaten to use mental illness as a coercive tool to manipulate the child custody system.²⁰² Critics have identified several concerns about the role of intimate partner violence within the child custody process. One such criticism is that judges’ decisions about intimate partner violence in child custody decisions may be influenced by the judges’ own background and personal experiences, including the judges’ gender, history of abuse, or connection to someone who has been abused.²⁰³ Another criticism is that the child custody

198. See Karen Blank et al., *Psychiatric Commitment of the Elderly*, 2 J. GERIATRIC PSYCHIATRY & NEUROLOGY 140, 144 (1989) (concluding that involuntary hospitalization should be reserved for elderly patients who are most likely to come to harm without hospitalization).

199. MD. CODE REGS. 10.21.01.09F(6) (2021).

200. MD. CODE ANN., HEALTH—GEN. § 10-603(c) (1983); See *Adult Evaluation and Review Services (AERS)*, MD. DEP’T OF HEALTH TALBOT CNTY., health.maryland.gov/talbotcounty/Pages/AERS.aspx (explaining how the Adult Evaluation and Review Services work in Maryland local health departments).

201. WARSHAW ET AL., INTIMATE PARTNER VIOLENCE, *supra* note 82, at 148.

202. Warshaw et al., *Mental Health and Substance Use Coercion Surveys*, *supra* note 18, at 16–17.

203. DANIEL G. SAUNDERS, STATE LAWS RELATED TO FAMILY JUDGES’ AND CUSTODY EVALUATORS’ RECOMMENDATIONS IN CASES OF INTIMATE PARTNER VIOLENCE: FINAL SUMMARY OVERVIEW 2 (2016); see Allison C. Morrill et al., *Child Custody and Visitation Decisions When the Father Has Perpetrated Violence Against the Mother*, 11 VIOLENCE AGAINST WOMEN 1076, 1078–79 (2005) (discussing how battered women may be disadvantaged by judges’ attitudes toward domestic violence); Mieko Yoshihama & Linda G. Mills, *When is the Personal Professional in the Public Child Welfare Practice? The Influence of Intimate Partner and Child Abuse Histories on Workers in Domestic Violence Cases*, 27 CHILD ABUSE & NEGLECT 319, 320–23 (2003) (discussing factors influencing professional attitudes and responses to domestic violence); see also Daniel G. Saunders & Phillips Kindy, Jr.,

evaluators—those charged with the responsibility of interviewing parents and making recommendations to the court—are not always trained or may fail to identify domestic or intimate partner violence.²⁰⁴ These evaluators hold significant power in the child custody process and courts accord great deference to their determinations.²⁰⁵ When the evaluators fail to properly identify intimate partner violence in a family unit, their failure may result in greater emotional and physical harm to the children and the parent subjected to that abuse.²⁰⁶

The criticisms and concerns over the impact of intimate partner violence on child custody determinations led to significant changes in the laws governing this process.²⁰⁷ Every state now requires that intimate partner violence be considered a factor in custody decisions, and in a minority of states, it is given special weight.²⁰⁸ A 2016 evaluation identified the various legal reforms states have adopted to govern how information about domestic violence impacts child custody determinations beyond simply being considered as one factor when determining the child’s best interest.²⁰⁹ Such reforms include: statutes containing a rebuttable presumption that it is not in a child’s best interest to be placed in sole or joint custody with an abuser parent; statutes exempting individuals who have experienced domestic violence from otherwise mandatory mediation with an abusive co-parent; and statutes that exempt individuals who experience domestic violence from “friendly parent” requirements, where one partner must facilitate the child’s relationship with the other partner.²¹⁰

Predictors of Physicians’ Responses to Woman Abuse: The Role of Gender, Background, and Brief Training, 8 J. GEN. INTERNAL MED. 606, 608 (1993) (discussing how factors such as gender and personal experience affect physicians’ response to abuse of women).

204. See MICHAEL S. DAVIS ET AL., CUSTODY EVALUATIONS WHEN THERE ARE ALLEGATIONS OF DOMESTIC VIOLENCE: PRACTICES, BELIEFS, AND RECOMMENDATIONS OF PROFESSIONAL EVALUATORS iii (2010) (evaluating “the relationship between the evaluators’ beliefs and practices and their recommendations for custody and visitation”). A study of New York legal service providers providing representation in civil legal proceedings to domestic violence survivors found a high correlation between parenting plans recommended by custody evaluator and judges adoption. *Id.* at iv. However, a survey of judges revealed that 34% believed the court should not defer to evaluators in their final determinations because it would be an “abdication of judicial authority.” *Id.* at 20.

205. *Id.*

206. See *id.* at 6–7 (discussing how long-term exposure to domestic violence between adults negatively impacts children’s behavior, comparable to the effects of child abuse).

207. See SAUNDERS, *supra* note 203, at 11–13 (DISCUSSING THE IMPLICATIONS OF INTIMATE PARTNER VIOLENCE FOR POLICY AND PRACTICE). Such advocacy led to various practices that formally integrated domestic violence consideration into child custody determinations. *Id.* Reformers continue, however, to challenge the inadequacies in the child custody system that have gone unaddressed or have been exacerbated by the reforms adopted. See Joan S. Meier, *Denial of Family Violence in Court: An Empirical Analysis and Path Forward for Family Law*, 1, 30–35, 47–52 (GW L. FAC. PUBL’N & OTHER WORKS, Working paper No. 1536, 2021) (discussing the evolution of custody law and the role of social recognition of domestic violence).

208. See SAUNDERS, *supra* note 203, at 12 (discussing the weight of “friendly parent” statutes in determining child custody outcomes among different states).

209. *Id.* app. at 1–3.

210. *Id.*

The civil commitment process and the process by which child custody decisions are made are decidedly different in standard and scope, most profoundly in their respective legal standards (dangerousness to self or others as opposed to the child's best interest) and with respect to the underlying relationship at the core of the proceeding.²¹¹ However, the ongoing effort to ensure the child custody system is responsive to the particular concerns of parents who themselves have been the target of domestic violence is a helpful point of reference and supports the conclusion that experiences of domestic or intimate partner violence are similarly relevant to judicial decision-making in other settings, namely emergency detention and civil commitment.²¹² Moreover, despite their differences, the research suggests that abusers strategically use information about mental health to gain leverage in both child custody and civil commitment proceedings.²¹³ Thus, the development of systematic screening protocols for intimate partner or domestic violence in civil commitment proceedings would be helpful in guarding against this form of abuse.

E. Greater System Integration and the Least Restrictive Alternative Doctrine

Improved screening for domestic or intimate partner violence should be linked to greater system integration of mental health treatment with domestic or intimate partner violence support services.²¹⁴ Linking existing domestic violence support and advocacy resources to assessments for mental health treatment would help to ensure individuals are treated in the least restrictive environment, particularly in cases where effective screening discloses that an individual's psychic distress or disfunction is the manifestation of stressors associated with domestic or intimate partner abuse and that effective mediators of those stressors are better deployed by community-based services that are tailored for those who experience family-based trauma.²¹⁵

The least restrictive alternative doctrine has two dimensions, one grounded in statutory and constitutional law principles and the other in "broad ethical principles that guide contemporary practice in community mental health

211. *See id.* (comparing state statutes' standards for child custody).

212. *See supra* note 207 and accompanying text.

213. *See supra* note 82–83 and accompanying text.

214. *See* Amrutha Ramaswamy et al., *Intimate Partner Violence (IPV) Screening and Counseling Services in Clinical Settings*, KAISER FAM. FOUND. (Dec. 2, 2019), <https://www.kff.org/womens-health-policy/issue-brief/intimate-partner-violence-ipv-screening-and-counseling-services-in-clinical-settings/> (recommending that intimate partner violence screenings should be included in wellness exams and that providers should refer individuals to ongoing mental health support services).

215. *See* Trevillion et al., *The Response of Mental Health Services to Domestic Violence*, *supra* note 14, at 334 (suggesting that improved screening processes in mental health settings would promote disclosure of domestic violence and professional awareness of services needed for individuals who experience violence and poor mental health).

settings.”²¹⁶ The concept of the least restrictive alternative received important attention from Judge David Bazelon, perhaps the most influential voice within mental health law in the second half of the 20th century. In his opinion in *Lake v. Cameron* in 1966, Judge Bazelon relied on statutory grounds to hold that “[d]eprivations of liberty solely because of dangers to the ill persons themselves should not go beyond what is necessary for their protection.”²¹⁷ It should be noted, however, that the U.S. Supreme Court has never expressly held that treatment in the least restrictive environment is a constitutionally enforceable right. The Court has deployed a “least restrictive means” analysis in other areas, particularly involving the First Amendment,²¹⁸ but because the Justices held in *Heller v. Doe*²¹⁹ that persons with mental disabilities are not members of a suspect class entitled to heightened judicial scrutiny, the formal requirement that the state demonstrate that its actions are “necessary” to accomplish an “important” government interest has not been applied in the civil commitment context.²²⁰ To be sure, the U.S. Court of Appeals for the Third Circuit, in its widely cited opinion in *Romeo v. Youngberg*,²²¹ did hold that the involuntarily hospitalized plaintiff in that case had a “right to treatment in the least intrusive manner.”²²² However, the U.S. Supreme Court declined to endorse this holding, suggesting instead that “the constitution only requires that the courts make certain that professional judgment in fact was exercised” in the state’s decision about where to place an individual requiring behavioral health treatment.²²³ In the final analysis, and notwithstanding some ambiguous language in *O’Connor v. Donaldson*²²⁴—where the Court suggested that involuntary psychiatric hospitalization should be limited to persons who are imminently dangerous²²⁵—the legal foundations of the least restrictive alternative doctrine rest primarily in state constitutional law decisions and state statutes. Indeed, an overwhelming majority of American jurisdictions now require, as a function of state law, that

216. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., CIVIL COMMITMENT AND THE MENTAL HEALTH CARE CONTINUUM: HISTORICAL TRENDS AND PRINCIPLES FOR LAW AND PRACTICE 23 (2019).

217. *Lake v. Cameron*, 364 F.2d 657, 660 (D.C. Cir. 1966).

218. *See, e.g., Shelton v. Tucker*, 364 U.S. 479, 488 (1960) (finding that even when the government has a compelling purpose to limit First Amendment freedoms, limits should not stifle broad liberties when less drastic means can achieve the same purpose).

219. 509 U.S. 312 (1993).

220. *See id.* at 330 (holding that Kentucky need not advance a compelling purpose when limiting personal freedoms; it need only promote a “reasonable and identifiable governmental objective”).

221. 644 F.2d 147 (3d Cir. 1980), *rev’d* 457 U.S. 307 (1982).

222. *See id.* at 164–70 (holding that when deciding between major alternative courses of treatment for an individual, analyzing which course of treatment is least intrusive to the individual is appropriate).

223. *Youngberg v. Romeo*, 457 U.S. 307, 321 (1982) (quoting *Romeo v. Youngberg*, 644 F.2d at 178 (J. Seitz, concurring)).

224. 422 U.S. 563 (1975).

225. *O’Connor v. Donaldson*, 422 U.S. 563, 575–76 (1975).

persons with mental disabilities be treated in the least restrictive setting that is reasonably available.²²⁶

The second dimension that grounds the least restrictive alternative doctrine derives from well-established ethical principles. A framework for applying those principles has been provided by James Childress and Thomas Beauchamp, who have suggested that health care policies and practices, including civil commitment and behavioral health practices, should be evaluated on the basis of: (1) respect for individual autonomy or self-determination; (2) capacity for non-maleficence, or the avoidance of unwarranted harm; (3) ability to foster beneficence, or the provision of benefits that outweigh associated risks; and (4) fairness, particularly in the distribution of burdens and benefits.²²⁷ Application of these principles supports the least restrictive alternative doctrine for a state's exercise of its civil commitment authority. Involuntary hospitalization is, by definition, coercive and thus inconsistent with patient self-determination.²²⁸ To the extent that it imposes significant costs in terms of loss of freedom of movement and privacy and carries the potential for significant stigma, civil commitment also may fail the requirement of non-maleficence.²²⁹ Beneficence turns on the relative balance of costs and benefits associated with involuntary detention and treatment and presumably will vary with the circumstances of individual cases. Fairness remains a concern, especially given data suggesting that some forms of commitment may be deployed more often with patients of color and those whose economic and social circumstances are marginal.²³⁰

226. CHRISTOPHER SLOBOGIN ET AL., *supra* note 166, at 901. In the context of involuntary commitment, the least restrictive alternative doctrine is designed to ensure that individuals are not hospitalized against their will if there is some less restrictive means available to ensure their care and safety. JOHN PARRY, 4 TREATISE ON HEALTH CARE LAW § 20.04 (2021).

227. See THOMAS BEAUCHAMP & JAMES CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 12 (5th ed. 2001) (listing autonomy, non-maleficence, beneficence, and justice as primary factors to be considered in developing care policies and practices).

228. Some critics argue that severely mentally ill patients whose decision-making capacity is impaired by their disease cannot exercise authentic choice with respect to hospitalization or treatment and thus their agency is not undermined by their civil commitment. See, e.g., Bruce J. Winick, *Outpatient Commitment: A Therapeutic Jurisprudence Analysis*, 9 PSYCH., PUB. POL'Y & L. 107 (2003) (arguing that preventive outpatient commitment can be implemented in a therapeutic manner and lead to patients accepting treatment voluntarily). From this point of view, involuntary hospitalization and/or treatment may even enhance autonomy if it restores the patient's ability to make an informed choice down the road. *Id.*

229. See *Humphrey v. Cady*, 405 U.S. 504, 509 (1972) (noting that civil commitment constitutes a "massive curtailment of liberty"); see also Note, *Developments in the Law – Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1193–201 (1974) (arguing that when an individual is committed, he loses autonomy and faces increased social stigma).

230. See David Doak, Note, *Theorizing Disability Discrimination in Civil Commitment*, 93 TEX. L. REV. 1589, 1606 (2015) (reporting that Black individuals are more often committed than white individuals); see also SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 216, at 29 (stating that African Americans are overrepresented in individuals receiving outpatient commitment and that increasing the rate of involuntarily committed individuals from minority populations could be interpreted as either coercive or beneficial).

With this framework in mind, it is clear that the autonomy principle is undermined when an individual who has experienced domestic or intimate partner abuse is subject to mental health coercion as a consequence of the manipulation by her abuser of the emergency detention/civil commitment system.²³¹ When this coercion results unnecessarily in involuntary hospitalization, the least restrictive alternative doctrine has been violated.²³² By contrast, a system that provides pre-detention screening for domestic or intimate partner violence and offers access to voluntary community-based supportive services, designed particularly for those who have experienced abuse, as an alternative to inpatient psychiatric hospitalization, is a system that supports self-determination and autonomous decision-making for those with co-occurring mental disabilities and domestic trauma who can safely be treated in outpatient settings.

Moreover, a revised emergency detention and civil commitment process, that is attentive to the dangers of mental health coercion by abusive intimate partners and that is linked effectively with specialized services for those who experience domestic or intimate partner abuse, advances non-maleficence by removing involuntary psychiatric treatment as a stress moderator that is harmful to those with co-occurring mental illness and exposure to trauma.²³³ The service integration element also ensures that more effective treatment and other resources are made available to this vulnerable population, thus promoting their interest in beneficence and in strengthening their access to stress mediators.

The systematic screening of emergency petitions for domestic violence, along with the integration of screening, referral, and service delivery in the community, would help to ensure that individuals with co-occurring mental illness and histories of trauma obtain needed services for their complex challenges. These measures are especially critical given the failure of behavioral health professionals in screening for and providing domestic violence-related referrals and resources.²³⁴

Domestic violence support resources are comprised of survivor advocates who uniquely focus on supporting survivors of domestic violence. Survivor advocates provide distinct and complementary services to mental health

231. See Leigh Goodmark, *Autonomy Feminism: An Anti-Essentialist Critique of Mandatory Interventions in Domestic Violence Cases*, 37 FLA. ST. U. L. REV. 1, 32–43 (2009) (analyzing restrictions to survivor autonomy effectuated by systems responding to abuse, most notably the criminal system).

232. Involuntary commitment should only be ordered when it is the least restrictive means of ensuring the person's safety: "either (i) that a person may not be committed if his or her needs can be met in a less restrictive setting, or (ii) that a person whose needs can be met in a less restrictive setting may be committed to services in that setting but may not be committed as an inpatient." SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 216, at 12.

233. See *id.* at 31 ("Trauma history [should be] taken into consideration as part of a thorough assessment while minimizing the risk of re-triggering trauma.").

234. See *supra* Section III.B.

counselors; they are not engaged in diagnosis and treatment, but rather provide crisis support to survivors and help navigate the different systems and resources that survivors may choose to engage.²³⁵ They also are trained to identify abuse patterns, help survivors create safety plans to leave abusive relationships, and access key community resources to provide comprehensive aid.²³⁶ Linking individuals who have experienced domestic or intimate partner violence with abuse-specific support resources helps them receive care that is responsive to their presenting needs. Survivor advocates and domestic or intimate partner violence service providers should be included on pre-screening taskforces and should be retained to train personnel in both the public mental health and legal systems on domestic and intimate partner abuse screening practices and warning signs of abuse. This sort of system integration would likely provide greater insight before an emergency evaluation decision is made.

V. CONCLUSION

This article focuses primarily on the impact of domestic or intimate partner violence on individuals who encounter the mental health care system; however, the connection between mental illness, involuntary hospitalization, and trauma extends beyond domestic abuse. Instituting a routine system of trauma-informed screening that assesses for the least restrictive environment would help to ensure that individuals who have experienced domestic or intimate partner violence, as well as those with other trauma histories, receive treatment that is responsive to their needs and delivered in a setting that is appropriate to their trauma histories. More informed screening and resource integration protocols would also work to guard against attempts made by abusers to manipulate the civil commitment system.

Both the premise that “personal problems may often have their beginnings in social problems,”²³⁷ and the related idea that mental disorders frequently reflect a stress process rooted in an individual’s social context, lend support to the call for more effective screening and service integration to meet the needs of those who experience both mental illness and domestic or intimate partner violence, as well as adjustments in the legal rules governing emergency detention and civil commitment. The institutional structures in place to deal with mental disorder and the effects of trauma, and the legal processes that govern the operation of those structures, must be attentive to the ways in which individuals

235. On the difference in this field between mental health professionals, whose focus is diagnosis and treatment, and survivor advocates, whose focus is on self-help and support, see Kathleen J. Ferraro, *Negotiating Trouble in a Battered Women’s Shelter*, 12 URBAN LIFE 287 (1983).

236. *Advocacy*, BATTERED WOMEN’S JUST. PROJ., <https://www.bwjp.org/our-work/topics/advocacy.html> (last visited Apr. 15, 2022).

237. Pearlman & Bierman, *supra* note 36, at 338.

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can both be coerced into unwanted care and prevented from receiving needed treatment and other services.

While stress mediators in the form of domestic violence support resources effectively linked to the public mental health system would likely help individuals manage exposure to the strains associated with domestic or intimate partner violence, involuntary detention and hospitalization is an important stress moderator that can intensify the problematic manifestation of psychic distress associated with domestic trauma. Civil commitment involves physical confinement, potentially unwanted treatment, the loss of control and privacy, isolation, and stigma, all of which may significantly harm those who are already psychologically vulnerable. Great care must be taken to ensure that individuals with co-occurring mental disorders and exposure to domestic or intimate partner violence receive a careful and thorough evaluation and are directed to appropriate forms of treatment and the other support services they may require.