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Guidelines for Handling Domestic Violence Cases in Community Mental Health Centers

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Community mental health centers are becoming increasingly involved in the delivery of services to victims and perpetrators of domestic violence. To help centers plan a domestic violence program and address the risk of liability in treating clients who may be dangerous, the authors suggest principles to guide clinical decisions, standards for service delivery, and standards for staff development. Domestic violence is clearly defined as criminal behavior. In treatment, cessation of violence takes priority over family reunification and resolution of issues between victim and perpetrator. Decisions about accepting a perpetrator in treatment should be made by the treatment provider, even if treatment is mandated by the court. Suggestions for reducing the burden of domestic violence cases on individual clinicians include using treatment teams, establishing guidelines for maximum caseloads, and encouraging mixed caseloads. CMHCs have an important role in a comprehensive approach to domestic violence that includes a wide array of services and careful coordination among agencies that provide them.

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Historically, few community mental health centers (CMHCs) have developed specialized clinical programs for victims and perpetrators of domestic violence. Administrators and clinicians have been reluctant to become involved in what they saw as a criminal justice problem or to expand services to perpetrators who are resistant to treatment.

In the past ten years, however, research, clinical experience, and advocacy by experts on domestic violence have stimulated CMHCs to address the effects of these crimes. Justification for increased involvement of CMHCs includes documentation of the psychological impact of victimization and a growing understanding of the psychological variables associated with perpetrators' behavior.

The serious psychological impact of domestic violence has been amply documented in the literature. Walker (1) reported that battered women have a rate of depression twice that of the general population of women. Stark (2) estimated that 26 percent of women who attempt suicide and 30 percent of female alcoholics are battered women. Carmen and associates (3) found that 43 percent of inpatients had confirmed histories of physical or sexual abuse or both. Of these patients, 51 percent were victimized by a spouse or former spouse.

Rose and colleagues (4) reported that 67 percent of intensive case management clients had a history of both physical and sexual abuse. In a study of psychiatric inpatients, Post and associates (5) found that 48 percent of the patients reported a history of relationships in which battering occurred and 27 percent reported having inflicted violence on a domestic partner.

Studies of perpetrators have found small percentages of major mental illness, although affective, cognitive, and interpersonal dysfunction is prominent (6,7). Perpetrators of domestic violence are likely to have childhood histories of physical and sexual abuse (8) and to have witnessed violence between parents (1, 9); to have a history of substance abuse (10–12), suicidality (10), and depression (13); and to show evidence of personality disorders (14).

Although research has documented that victims and perpetrators of abuse are present in clinical populations, client records reveal that a history of abuse is rarely detected. In a study of mental health intake procedures, twice the number of clients disclosed abuse in response to a structured interview that included questions about victimization than in response to a standard intake interview (15). A study of outpatients found that 68 percent had experienced major physical or sexual assaults or both, but that 71 percent of those patients had never before disclosed the experience of abuse to a clinician (16).

Lack of detection of patients' history of abuse may have significant implications for CMHC staff, who run the risk of treating symptoms without addressing one of the major causes of the individual's emotional problems. Saunders and associates (15) suggested that early knowledge of a client's history of criminal victimization allows clinicians to conduct a thorough assessment of the patient's victimization in addition to other forms of evaluation, place presenting problems in the context of a history of victimization, make a more accurate diagnosis, and deliver appropriate treatment more rapidly.

Given the current constraints on the size of caseloads at many CMHCs, early identification of an appropriate course of treatment for patients with a history of domestic violence is not only ethically sound but efficient.

This paper discusses community mental health centers' role in a comprehensive approach to domestic violence cases and suggests guidelines for establishing values on which to base clinical decisions, standards for program policies and treatment modalities, and standards for staff development.

Liability issues

Clinicians are increasingly raising concerns about their liability in providing services to dangerous persons. Data released by the Bureau of Justice Statistics make clear the dangerousness of domestic violence. A total of 16.5 percent of murders occur within the family, and three of four women who are killed are murdered by domestic partners (17). Fifty-eight percent of spousal assaults result in visible physical injury to the victim (18). Seventy-five percent of spousal assaults occur at the point of separation or divorce (18), a time when family members often seek assistance from mental health care providers or are mandated by a court to participate in treatment. Clinicians must be alert to the possibility that the person in treatment at this time of crisis may be in danger or may present a danger to other family members.

The *Tarasoff* decision of 1976 set the precedent that clinicians have a duty to protect identifiable victims when clients make specific threats to harm those persons (19–21). Clinicians are also exposed to liability if they fail to ask clients questions about the existence of violence (20). Thus CMHC staff can reduce their risk of liability by identifying patients who are victims or perpetrators of domestic violence among the persons they treat and by making an accurate assessment of lethality or dangerousness presented by each case. Based on this assessment, appropriate treatment strategies, as outlined in this paper, may be used and strategies that increase dangerousness may be avoided.

The proposals outlined in this paper in one sense constitute a plan for reducing liability because they recommend thorough diagnosis and relevant, appropriate treatment that differs somewhat from traditional clinical practice. To provide treatment that more effectively attends to issues affecting clients and to reduce risk of liability, CMHCs are encouraged to establish formal protocols and programs for addressing the needs of victims rather than to rely on the judgment of individual clinicians.

A multiagency approach

Battered women's shelters, historically working in isolation from other community services, provided intervention and a broad range of services in cases of domestic violence and laid the foundation for future program development. In the past decade, service delivery has evolved from the isolated efforts of shelters to reflect responses by many different types of professionals.

The key to an effective community response to domestic violence is a comprehensive approach integrating the services of a wide range of agencies. Close cooperation between these agencies is essential. Some services, such as legal intervention, are provided by only one agency, such as local law enforcement. Other services, such as crisis counseling, may be available from several sources, including CMHCs, private mental health practitioners, shelters for abused spouses, and the state department of social services.

Five kinds of services are needed in the community to address cases of domestic violence. They are consultation, education, and preventive services; crisis care; counseling and clinical services; support services; and residential services. First, activities in the area of consultation, education, and prevention include staff training and development, community-based and school-based education and prevention programs, interagency coordination and planning, and organization of a network of community volunteers. Second, crisis care services include 24-hour hotlines, crisis counseling, evaluation and screening of victims and perpetrators, psychiatric hospitalization, detoxification, medical services, transportation, police intervention, protective services, and short-term protective shelter.

The third type of services needed —counseling and clinical services— includes diagnosis and evaluation; treatment planning; individual, couples, and family counseling; and separate group counseling for victims and perpetrators. Support services, the fourth type, include in-home crisis intervention and family stabilization; legal intervention through the police, courts, and correctional system; and medical and legal advocacy. Additional support services include respite care, case management, follow-up services, self-help groups, and separate support groups for victims and perpetrators.

Fifth, residential services include protective shelter for victims, residential treatment for perpetrators, therapeutic foster care, group homes, drop-in shelters for children, transitional living arrangements, halfway houses for paroled offenders, psychiatric facilities, and halfway houses and 30-day residential treatment settings for substance abusers.

Developing services in mental health centers

CMHCs should address the issue of domestic violence in two ways. First, specialized services targeted for victims or perpetrators of domestic violence should be developed. Second, the capacity to address domestic violence through existing services should be enhanced. For example, CMHCs may not need to develop a specialized crisis hotline for domestic violence because this service is routinely offered by spouse abuse shelters. However, clinicians who staff 24-hour mental health crisis hotlines in CMHCs should be trained to intervene appropriately in cases of domestic violence.

Before creating specialized services for domestic violence, the CMHC should develop standards of care to guide clinical practice. Standards guide staff in developing clinical programming, help emphasize the need for high-quality care, and address risk of liability. Three types

of standards are needed. The first type is value standards, which delineate principles that consistently underlie clinicians' work with violent families. Program standards, the second type, direct the mode of treatment and intervention. Human resources standards, the third type, guide recruitment, training, and retention of staff.

Value standards. Value standards provide the basis for clinical decisions. Given the significance of values as an organizing influence in daily practice, it is important for staff to articulate and routinely re-examine their value base and that of the CMHC's program for addressing domestic violence. We suggest that CMHCs' value standards should incorporate the following principles:

- Domestic violence is clearly criminal behavior.
- The primary goal of treatment for perpetrators of domestic violence is the cessation of physical, sexual, and psychological violence and the safety of victims and other family members who may have witnessed violence against the victim. This goal takes priority over reunification of the family or resolution of issues in relationships among family members.
- Perpetrators of domestic violence are accountable for their violent behavior.
- The underlying theme of treatment services for victims is empowerment and a progression to "survivorship." This process involves recovery from abuse-driven self-blame, learned helplessness, and other effects of domestic violence. Empowerment includes clarifying that victims cannot control and are not responsible for the violent behavior of perpetrators.
- The safety of clinicians who provide services in cases of domestic violence is a high priority throughout assessment and treatment.
- Services to victims and perpetrators are less effective if the agencies providing the services work in isolation from each other. A community response rather than a single-agency response is essential.
- Because domestic violence cases include dangerous and traumatic content, these cases should be handled by a treatment team rather than a single clinician. The case discussion and support offered by the treatment team protect clinicians from the emotional impact of providing trauma-related care and help ensure that lethality issues are constantly addressed by the primary clinician.

Program standards. Program standards guide delivery of services to victims and perpetrators. We recommend developing a specialized domestic violence program within the CMHC that most appropriately falls under the auspices of mental health or forensic services. In agencies without a specialized program, these standards may be implemented by generalist mental health clinicians. The program standards suggested below address policies, assessment and treatment modalities, and a structure for court-mandated services for perpetrators.

- The program should develop written procedures for reporting child abuse as specified by state law and for warning intended victims of violence when threats are made by program clients.
- The needs of child witnesses of domestic violence should be addressed through direct services or formal referral agreements with other agencies.
- Clients' rates of program dropout, dismissal, and program completion should be measured. Ganley (22) strongly supports evaluation of treatment programs for perpetrators of domestic violence.
- The program should adopt guidelines for maximum caseloads for clinicians. Both victims and perpetrators should be included in caseloads to help clinicians maintain a balanced clinical perspective, but a victim and a perpetrator who have a relationship should not be treated by the same clinician.
- Couples and family therapy should not be started until the perpetrator, through participation in a treatment program, acknowledges responsibility for the violence and takes steps to control violent behavior that are verified by the victim. Services for families and couples should not begin until at least six or eight months after the perpetrator's violent behavior has stopped.
- Although services for perpetrators should be mandated by the court, services for victims should be voluntary. The only exception to this principle is that services may be mandated for a victim who suffers from a mental illness and is a danger to self or others or for a victim who is unable to provide self-care.
- Services for victims should begin with an assessment of the client's safety, the safety of children in the home, and the immediate medical needs of both the client and the children. Factors affecting the client's safety should be reviewed periodically throughout treatment.
- Services for perpetrators should begin with an evaluation of mental status and an assessment of the risk and dangerousness of the perpetrator's behavior. The clinician should take a complete psychosocial and psychiatric history and a history of violence in current and past relationships and should include in the record information about the perpetrator's criminal history, including the police report associated with the most recent episode of violence. The clinician should determine if the perpetrator has a history of chemical abuse or dependence and should assess the perpetrator's amenability to treatment. Each of these factors have been associated with dangerousness in perpetrators (22). Thorough assessments such as these have been recommended by several authors (8,10). Victims who are willing to be interviewed should be asked for collateral information to verify the disclosures of the perpetrator.
- Services provided to perpetrators should be specifically aimed at addressing the problem of violence and should address cognitive, behavioral, and emotional processes.
- Treatment modalities used with perpetrators should include individual and group therapy and psychoeducational groups. The effectiveness of the group modality with this population has been documented (7,22). If groups are provided, concurrent groups for partners of the perpetrators should be offered by

the program or coordinated with other agencies providing services to victims.

- The program should document evidence of significant increases in the perpetrator's lethality or dangerousness. The need for continuing assessment of risk is supported by the life-threatening nature of some battering behavior (22). The program should establish procedures for alerting the victim and law enforcement officials when threats are made by the perpetrator or when the safety of the victim is a concern.
- Perpetrators entering treatment should sign a contract that requires their attendance, participation, and payment for services and should sign a statement that they will cease violence. Contracts should include permission for a broad release of information to allow clinicians to contact the victim and others who would provide essential information or who have a legitimate need to be informed of the perpetrator's progress in treatment.
- A perpetrator's entry into court-mandated treatment should be predicated on a guilty plea or follow an adjudication of guilt.
- The treatment provider should evaluate a perpetrator who is referred for court-mandated treatment before deciding to accept the perpetrator into treatment. The final authority to admit or reject any perpetrator should remain with the agency that provides treatment. Some criteria for ineligibility include a history of violent felony offenses, alcohol or drug dependency, active psychosis or significant organic mental impairment, continued unwillingness to accept responsibility for violence, and previous dismissal from the program.
- Programs that provide court-mandated treatment should send regular reports of the perpetrator's course of treatment to the court and the prosecutor.
- Programs providing court-mandated treatment should designate a minimum number of sessions for program completion. A treatment course of one two-hour session per week for 16 weeks or its equivalent is recommended. Guidelines for dismissal from the treatment program include serious recidivism into violence or any recidivism into violence that is not self-reported; failure to attend scheduled appointments, participate actively in groups, or complete assignments; and failure to pay for treatment services in accordance with the fee schedule of the agency.
- The court-mandated program must operationally define completion of the program to include objective measures of acquired knowledge related to issues discussed in treatment.

CMHC administrative officers and medical directors should attain the same level of expertise about domestic violence issues as they have in other areas of community mental health.

Human resource standards

Human resource standards should address staffing requirements at all levels of the CMHC's domestic violence program. Domestic violence services constitute a program specialty comparable to other major specialties in mental health and should be recognized as a major priority by the highest levels of management. Chief administrative officers and medical directors should attain the same level of expertise about domestic violence issues as they have in other areas of community mental health. Additional recommendations in the areas of management, recruitment and retention of staff; training; and clinical supervision are as follows:

Management. The board of directors of the CMHC should endorse the agency's commitment to providing domestic violence services. Sound risk management calls for approval of program design and policies at the board level. The medical director's training about domestic violence should be updated regularly so that he or she is prepared to exert a meaningful influence on treatment, as recommended in the American Psychiatric Association' guidelines for practice in CMHCs (23).

The domestic violence program should be managed by a well-trained, experienced clinician with an advanced degree. The breadth of clinical disorders encountered in these programs, as well as the stresses experienced by staff, tax the skill of even well-qualified clinical leaders. The director's primary assignment and interest should be in the domestic violence program. A director who must divide time between several unrelated programs may neglect vital aspects of design and management for the domestic violence program.

Recruitment. Staff of the program should have at least a master's degree in a mental health field. Some research has shown that professionals who have a family systems perspective may be less likely to identify abuse and less accurate in assessing the level of dangerousness that the abuse presented to the client (24). Programs that experience difficulty recruiting staff with existing specialized training should screen for applicants who have philosophical biases congruent with those of the agency.

Retention. Staff turnover can be detrimental to the content and process of programs for perpetrators that have a limited duration. Services for victims are also affected and may be terminated prematurely if the relationship with the treating clinician is interrupted. Steps should be taken to minimize staff turnover whenever possible. Staff of domestic violence programs are routinely exposed to stories of trauma and may experience vicarious traumatization, with its attendant manifestations of depression and a grim attitude (25). Model programs for debriefing staff members who have experienced a critical incident or who have been assaulted may be useful in addressing traumatization (26).

Managers can help clinicians reduce burnout by encouraging them

to vary caseloads to include clients from more benign environments. Except in extreme circumstances, this option should be presented as a choice for clinicians rather than an obligation. Program administrators should maintain open communication with staff of domestic violence programs as part of risk management and support for the difficult decisions that must be made.

Training. All new clinical staff in the program should receive training that specifically addresses issues in domestic violence. The staff should receive continuing education at least once a year because research in this area is constantly modifying the understanding of abuse. Staff should also receive training in related fields, including substance abuse.

Clinical supervision. Because domestic violence cases often involve a wide spectrum of disorders, case-oriented supervision is vital to sound program management. Both routine and crisis-oriented supervision must be provided. Cross-disciplinary supervision helps further treatment team building (27). Arranging supervision from outside the program hierarchy may facilitate input from other specialties and help correct the tendency toward stagnation.

The CMHC's psychiatrists should be trained in domestic violence issues and should be available for psychiatric evaluations and psychopharmacology consults. Having a psychiatrist involved in a domestic violence case helps reduce risk of liability in most centers.

Conclusions

CMHCs are increasingly becoming involved in the delivery of services to victims and perpetrators of domestic violence. Whether the increased focus results from recognition of the psychological impact of the crime, understanding of the increased vulnerability of mentally ill persons to victimization, concerns about liability associated with treating dangerous persons, or a commitment to respond to community needs, program planning in this area must attend to the challenge of developing services that are sensitive to individual clients while underscoring to the community an intolerance of the crime itself.

CMHCs have an important role in providing some of the many services needed to address domestic violence and in carefully coordinating these services with those offered by other community agencies. To fulfill this role, CMHCs must have human resource development plans that are sensitive to the responsibilities assumed by clinical staff in domestic violence programs.

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