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ARTICLE

OVERMEDICALIZATION OF DOMESTIC VIOLENCE IN THE NONCARCERAL STATE

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ABSTRACT

Scholars have recently cast doubt on the justifications for the criminalization of domestic violence, arguing that the criminal legal system proves inadequate in preventing future battering. Domestic violence, the argument continues, is largely a public health problem, which requires implementing noncarceral measures to effectively address it. Decriminalizing domestic violence aligns with broader reforms to defund police and decrease prosecution of many other crimes. A noncarceral alternative to criminalization requires divesting resources from police, prosecutors, and prisons while investing resources in nonpunitive institutions, including healthcare systems.

Health-based reforms to curb domestic violence underscore the central role that mental health measures play under a noncarceral regime. Rejecting the reliance on criminal measures to prevent domestic violence would make mental health professionals responsible for treating batterers who pose a risk to their intimate partners. Yet, conceptualizing domestic violence through a public health framework raises a host of

^{*} *In loving memory of A.B., 1945–2020, who experienced forced mental treatment worse than criminal sanctions.*

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concerns because medicalized interventions incorporate noncriminal but inherently coercive measures. These include mandatory treatment programs, surveillance, monitoring, reporting, and involuntary civil commitment. The emerging trend to adopt mental health interventions in lieu of criminal sanctions highlights the perils of overmedicalization of domestic violence, including depriving batterers of their liberties without robust adversarial proceedings and other due process protections.

In examining the interrelationship between criminal law and public health's mandatory measures, this Article makes two novel contributions. First, it argues that overmedicalization of domestic violence is yet another facet of the general medicalization phenomenon, defined as unjustifiably applying medical solutions to social problems. Second, this Article uses the treatment of domestic violence as a case study to demonstrate that alternatives to criminalization, often touted as "progressive" reforms, carry their own risks. The implications of this argument extend far beyond the domestic violence context; a myriad of medicalized substitutes to carceral tools exert substantial social control over people by managing and disciplining vulnerable communities, especially people of color and other historically disadvantaged groups. Thus, overmedicalization may result in replacing states' problematic "governing through crime" strategy with the equally troublesome "governing through medicine" model, which perpetuates similar harms that the criminal legal system has created.

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INTRODUCTION

A.B. is a seventy-year-old man who has been suffering for fifteen years from early onset Parkinson's disease.¹ Parkinson's patients often experience a host of psychiatric symptoms, ranging from depression and anxiety to hallucinations.² Some patients, like A.B., also exhibit reactive violent behaviors (including sudden anger outbursts) as well as incidents of physical aggression targeted toward their caregivers, such as pushing, kicking, and hitting.³ As A.B.'s psychiatric symptoms gradually worsened, he became more aggressive toward his wife, M.B., who was his primary caregiver. One day, A.B. retrieved a carving knife and moved toward M.B. Distressed and concerned, M.B. called A.B.'s primary care physician, asking him to increase the dose of the antidepressants that he had prescribed A.B. Upon hearing M.B.'s description of the aggressive incident, the doctor reported the case to the county's mental health services. Within an hour, a psychiatrist issued an order mandating A.B.'s psychiatric hospitalization for an initial evaluation to determine whether a longer term of civil commitment was necessary. The involuntary psychiatric hospitalization order was issued pursuant to the psychiatrist's determination that A.B. posed a significant risk to his wife and himself. A.B. and M.B., as well as their three adult daughters, vehemently objected to the involuntary hospitalization, but their wishes were ignored. Two nurses arrived at his home and against his will—and his family's expressed wishes—forcefully restrained A.B. and admitted him to a psychiatric hospital.⁴

A.B.'s story offers a cautionary tale on the perils of using mental health measures to address complex problems of intimate partner violence. It illustrates the risks of vesting mental health professionals with the power to deprive individuals of their liberty with fewer protections compared to those of criminal proceedings. While the civil commitment order did not implicate the criminal legal system, it was as coercive as a criminal arrest because it involved the use of physical force to subdue A.B.'s resistance.

More broadly, this case demonstrates the extent to which reliance on nonpunitive institutions to curb domestic violence might result in adopting civil, yet inherently coercive, tools that raise similar concerns as criminal responses. Until recently, domestic violence has been unanimously conceptualized as a criminal law problem that called for robust punitive responses.⁵ The legal system's principal intervention has heavily relied

1. The facts described above relay my personal observations of the coercive interventions used against A.B. by mental health professionals while addressing the incident. To respect the family's request for privacy, I redacted all additional identifying information about the case.

2. See Daniel Weintraub, *Management of Psychiatric Disorders in Parkinson's Disease*, 17 *NEUROTHERAPEUTICS* 1511, 1512–14 (2020); Sandeep Grover, Mansi Somaiya, Santhosh Kumar & Ajit Avasthi, *Psychiatric Aspects of Parkinson's Disease*, 6 *J. NEUROSCIENCES IN RURAL PRAC.* 65, 67–68 (2015)

3. See Zachary A. Macchi, Janis Miyasaki, Maya Katz, Nicholas Galifianakis, Stefan Sillau & Benzi M. Kluger, *Prevalence and Cumulative Incidence of Caregiver-Reported Aggression in Advanced Parkinson Disease and Related Disorders*, 11 *NEUROLOGY CLINICAL PRAC.* 826, 826 (2021) (describing a study that found that 18.2% of caregivers reported physical aggression by Parkinson's patients, and that physical aggression cumulative incidence was associated with, among others, patient depression).

4. A.B. was ultimately released from the psychiatric hospital after his attorney persuaded the psychiatrists that a court-ordered commitment was unnecessary.

5. See MICHELLE MADDEN DEMPSEY, *PROSECUTING DOMESTIC VIOLENCE: A PHILOSOPHICAL ANALYSIS* 206–08 (2009).

on criminal enforcement mechanisms, including prosecuting assaults of intimate partners and criminally enforcing civil protection orders that have been violated.⁶

In recent years, scholars have questioned the effectiveness of the criminal legal system in preventing harm to victims and the justifications for continued criminalization of domestic violence.⁷ Ample studies suggest that the criminal legal system proves unhelpful in decreasing the prevalence of domestic violence and the enormous physical, mental, and emotional harm it inflicts.⁸ Moreover, many victims—especially those who are Black, Indigenous, or People of Color (BIPOC)—are reluctant to engage the criminal legal system, which often manifests in refusing to testify at their intimate partners' trials given concerns that the system is racist and unjust.⁹

Proceeding from the assumption that the criminal legal system either does not “work”—or when it does, its costs and harms far exceed its benefits—commentators have called to decriminalize domestic violence and replace carceral responses with alternative interventions.¹⁰ Domestic violence reforms align with increasing demands to divest from carceral institutions by defunding the police and reducing criminal prosecutions.¹¹ Reformers urge investing resources in alternative institutions that are more suitable to address social problems like harmful behaviors committed by people suffering from mental illness.¹²

In this Article, I consciously choose not to engage in the preliminary policy debate over decriminalizing domestic violence. Instead, I assume that reforms to decriminalize at least some forms of domestic violence will ultimately be implemented.¹³ The purpose behind this deliberate choice to bypass the initial question of *whether* domestic violence *should* be decriminalized is to shift the focus to the *how* and *what* questions by critically evaluating health-based alternatives to criminalization.

6. For some literature on enforcement of domestic violence statutes, see, for example, Deborah Tuerkheimer, *Recognizing and Remediating the Harm of Battering: A Call To Criminalize Domestic Violence*, 94 J. CRIM. L. & CRIMINOLOGY 959 (2004), and Jane K. Stoeber, *Freedom from Violence: Using the Stages of Change Model To Realize the Promise of Civil Protective Orders*, 72 OHIO ST. L.J. 303, 313–17 (2011). For a discussion of laws to remove firearms from people with civil protection orders against them, see Carolyn B. Ramsey, *Firearms in the Family*, 78 OHIO ST. L. J. 1257 (2017). In this Article, I use the terms “domestic violence” and “intimate partner violence” interchangeably.

7. See LEIGH GOODMARK, *DECRIMINALIZING DOMESTIC VIOLENCE* 1–6 (2018); Leigh Goodmark, *Should Domestic Violence Be Decriminalized?*, 40 HARV. J.L. & GENDER 53, 67–75 (2017).

8. See GOODMARK, *supra* note 7, at 6, 34–41, 52–53.

9. *Id.* at 18–19; see also DEMPSEY, *supra* note 5, at 204–10.

10. GOODMARK, *supra* note 7, at 32–33.

11. See, e.g., Jocelyn Simonson, *Police Reform Through a Power Lens*, 130 YALE L. J. 778, 791–92 (2021) (observing that abolitionists contend that the state should provide safety and security not through “policing and prosecutions and prisons” but through “support of communities and responding to harm in other ways”); Monica C. Bell, Katherine Beckett & Forrest Stuart, *Investing in Alternatives: Three Logics of Criminal System Replacement*, 11 U.C. IRVINE L. REV. 1291, 1293–94 (2021) (proposing alternatives to the criminal legal system, including investment in the welfare state, safety production, and racial reparations).

12. See Darcy Covert, *Transforming the Progressive Prosecutor Movement*, 2021 WIS. L. REV. 187, 222 (2021).

13. This prediction is consistent with reforms to decriminalize other crimes by adopting alternative measures. See generally I. Bennett Capers, *Afrofuturism, Critical Race Theory, and Policing in the Year 2044*, 94 N.Y.U. L. REV. 1 (2019) (reimagining a future legal regime informed by critical race theory).

This Article examines the implications of implementing a public health approach to domestic violence prevention. One of the key features characterizing existing legal treatment of domestic violence is the failure to prevent it. The criminal legal system is largely backward looking, seeking to punish batterers for past harm. Yet, it proves inadequate for preventing future harm. Reformers have recently advocated for conceptualizing domestic violence through an alternative lens that prioritizes prevention.¹⁴ Domestic violence, they argue, is a multifaceted phenomenon that ought to be conceptualized largely as a public health problem.¹⁵ To better address domestic violence, the argument continues, the noncarceral state should adopt interventions that rely on a forward-looking public health approach.¹⁶

Substituting a public health approach for criminalization, however, has its own drawbacks. One of the consequences of implementing a public health approach to curb domestic violence is that alternative civil measures are also capable of depriving people's liberties, thus perpetuating similar concerns that criminalization has raised. By employing a public health approach, the healthcare system—and particularly mental health institutions—would presumably be strengthened.¹⁷ Mental health professionals, including psychiatrists, psychologists, and social workers, would play a major role in the noncarceral state; entrusted with the responsibility for identifying batterers who pose significant risk to their intimate partners, these institutional actors would be vested with the power to employ preventive measures to avert future battering.¹⁸

The reason for substituting mental health interventions for punitive tools in the noncarceral state lies with the medicalization phenomenon, which has become prevalent in recent years.¹⁹ Extensive literature addresses medicalization, which is defined as implementing medical solutions to a host of social problems, such as homelessness and substance abuse.²⁰ But to date, scholars have neither recognized nor studied the treatment of domestic violence perpetration as yet another manifestation of medicalization.²¹ Yet, as this Article demonstrates, the medicalization of domestic violence perpetrators has already begun to take hold in many jurisdictions across the nation.²² This Article contributes to existing literature on the general medicalization phenomenon by identifying the medicalization of domestic violence—namely, the use of mental health measures to prevent future battering—and by highlighting the ways in which it reproduces the criminal legal system's punitive approaches and its carceral institutions.

14. See GOODMARK, *supra* note 7, at 9–10.

15. See *id.* at 34, 52, 75, 100.

16. *Id.* at 53–56.

17. See *infra* Part II.A.

18. See *infra* Part II.B.

19. See *infra* Part II.A.

20. See, e.g., Craig Konnoth, *Medicalization and the New Civil Rights*, 72 STAN. L. REV. 1165, 1170–71 (2020). For further discussion of medicalization, see *infra* Part II.A.

21. Commentators have critiqued the medicalization of domestic violence survivors who use reactive force against those who batter them. In contrast, this Article focuses on the implications of medicalization on batterers, a phenomenon that commentators have yet to address. For examples of literature on medicalization of domestic violence survivors, see Alafair S. Burke, *Rational Actors, Self-Defense, and Duress: Making Sense, Not Syndromes, Out of the Battered Woman*, 81 N.C. L. REV. 211, 350 (2002); Anne M. Coughlin, *Excusing Women*, 82 CALIF. L. REV. 1, 71–76 (1994).

22. See *infra* Part II.B.

Furthermore, reforms to replace carceral measures with a public health approach to address other social ills—like drug addiction, poverty, homelessness, and child abuse and neglect—demonstrate their heavy reliance on a therapeutic approach that integrates mental health interventions.²³ Analogizing between domestic violence and comparable areas suggests that the medicalization of domestic violence is an inevitable feature of implementing a public health approach in the noncarceral state.

This Article argues that adopting a therapeutic mental health approach to domestic violence prevention might result in overmedicalization, namely overdiagnosis and overtreatment of batterers that is not medically justified. Drawing on interdisciplinary studies, it suggests that medicalization of domestic violence is unwarranted because the perceived connection between mental illness and domestic violence is overstated as domestic violence is largely *not caused* by mental illness.²⁴ Some psychiatric studies have found a modest association between mental illness and domestic violence, suggesting that people with a host of mental problems have an increased likelihood of committing violence against their intimate partners.²⁵ The implications of these findings, however, must be carefully scrutinized. First, only a small subset of people who batter their intimate partners do so *because* of their mental illness.²⁶ Even if there is some modest correlation between mental illness and domestic violence, it does not prove causation.²⁷ Second, these medical studies stress that the increased risk is mediated by other significant risk factors, especially alcohol and other substance abuse.²⁸

Furthermore, the medicalization of domestic violence is not only medically unwarranted but also troublesome from constitutional and policy perspectives. Shifting the responsibility to address domestic violence to mental health institutions raises significant concerns because these institutions suffer from similar problems that characterize the criminal legal system. Civil alternatives to incarceration, often touted as “progressive” reforms, also implement mandatory measures that deprive individuals of their rights and liberties, particularly within the mental health system.²⁹ Mental health institutions impose social control strategies that are similarly coercive to policing. These strategies include mandatory treatment programs, electronic surveillance, behavioral observation, and reporting requirements.³⁰

One particularly disconcerting consequence of reliance on a therapeutic approach to domestic violence involves involuntary civil commitment of batterers who endanger the safety of their intimate partners.³¹ The vast majority of states have broadly worded

23. See *infra* Part II.B.1.

24. See *infra* Part II.C.

25. See *infra* Part II.C.

26. See E. Lea Johnston, *Reconceptualizing Criminal Justice Reform for Offenders with Serious Mental Illness*, 71 FLA. L. REV. 515, 533–34 (2019).

27. See *infra* Part II.C.

28. See *infra* Part II.C.

29. For an excellent account of the unintended consequences of alternatives to prisons, see MAYA SCHENWAR & VICTORIA LAW, *PRISON BY ANY OTHER NAME: THE HARMFUL CONSEQUENCES OF POPULAR REFORMS* (2020).

30. See *id.* at 51–85.

31. See Laura I. Appleman, *Deviancy, Dependency, and Disability: The Forgotten History of Eugenics and Mass Incarceration*, 68 DUKE L.J. 417, 422, 458–60 (2018).

civil commitment statutes that authorize involuntary psychiatric hospitalization of people deemed dangerous to others.³² Involuntary commitment proceedings, however, are not robustly adversarial and courts are highly deferential to psychiatric experts' discretion, which results in affording batterers with fewer constitutional protections than criminal defendants.³³

Taken together, a public health approach to domestic violence carries potential risks for misapplication, abuse of discretion, and overinclusiveness. Like carceral measures, health-based social control mechanisms disproportionately affect vulnerable populations, including BIPOC.³⁴ Therefore, the perils of overmedicalization of domestic violence are exacerbated based on race, class, and gender disparities.

While the arguments made in this Article focus mostly on domestic violence, they carry broader implications beyond that specific context. This Article uses the emerging phenomenon of substituting noncarceral mental health alternatives for punitive measures in the area of domestic violence as a case study for highlighting general concerns about reliance on health-based measures in other criminal law domains.

Most discourse on reforming the flawed criminal legal system emphasizes the need to dismantle existing carceral institutions.³⁵ Yet, much less attention is devoted to the nature of alternative measures that would be adopted in the noncarceral regime, which this Article seeks to do. The paradigm shift from carceral to health measures requires not only abolishing and defunding existing systems but also building alternative noncarceral institutions. It also calls for cautiously evaluating those systems' implications by highlighting some of their unintended consequences.

Assessing the nature of medicalized alternatives to criminalization through a critical lens calls attention to the insidious interrelationship between carceral measures and other tools of social control and population management reliant on medicalization. The increasing trend to view many social problems as public health issues might result in replacing states' infamous "governing through crime" approach with a "governing through medicine" model, which is equally problematic.³⁶

One clarification is warranted before proceeding: highlighting the potential risks stemming from substituting noncarceral for carceral institutions nowhere implies that continued criminalization is warranted. This Article concedes that domestic violence should be treated as a public health problem and supports the adoption of alternatives to carceral measures that foster harm prevention. Yet, the Article's goal is to call attention to the potential adverse consequences of adopting mental health alternatives to criminalization. Critically assessing the specific details of these alternatives aims to ensure that noncarceral institutions do not perpetuate the problems that currently characterize the criminal legal system's treatment of domestic violence.

This Article proceeds in four Sections. Section I describes evolving scholarly accounts of domestic violence conceptualization and typology. It briefly outlines

32. See *infra* Part III.B.

33. See *infra* Part III.B.

34. See *infra* Part III.C.

35. See, e.g., Amna A. Akbar, *An Abolitionist Horizon for (Police) Reform*, 108 CALIF. L. REV. 1781 (2020).

36. See *infra* Part III.A.

proposals to decriminalize domestic violence, divest from policing and prosecution, and conceptualize domestic violence through a public health lens. Section II situates the medicalization of domestic violence within the broader medicalization phenomenon by considering analogous areas of law that draw on a public health approach to address various social ills. After demonstrating how recent reforms have already begun implementing therapeutic approaches to domestic violence, Section II posits that the noncarceral state will largely rely on mental health interventions as its principal tool to prevent domestic violence. Scrutinizing psychiatric studies on the weak association between mental illness and domestic violence, it argues that mental health interventions are largely unjustified.

Section III juxtaposes the overmedicalization of domestic violence with the overcriminalization phenomenon by elaborating on the risks of adopting mental health alternatives to criminalization. It examines the concerns stemming from states' use of noncarceral measures to exercise social control over vulnerable populations, highlighting their socially constructed racialized, gendered, and class-based effects. Section IV considers potential control mechanisms to alleviate these concerns. Rejecting a "one-size-fits-all" solution to domestic violence, it calls for carefully tailoring the chosen measures to domestic violence typology. Section IV concludes with stressing the need for providing equitable treatment to domestic batterers who genuinely suffer from mental illness.

I. REJECTING CARCERAL MEASURES

Following the advocacy of feminist reformers in the 1980s and 1990s, domestic violence has been conceptualized as not only a criminal but a gendered problem where men use physical violence to exert power and control over their female intimate partners.³⁷ Domestic violence was defined as a pattern of *intentional* behavior, which includes physical, sexual, financial, emotional, and psychological tactics that are used instrumentally by batterers to restrict the liberties of their intimate partners.³⁸ Under this account, battering is motivated by a desire to preserve patriarchal dominance and superiority, which is threatened when women seek independence by ending a relationship.³⁹

Conceptualizing domestic violence through this gendered power-and-control lens has not only gained legal traction but has also received significant support in social science research. Sociologist Evan Stark's seminal book on coercive control validated the feminist account.⁴⁰ Stark argued that the legal system's emphasis on individual incidents of physical violence obscures other manifestations of coercive control.⁴¹ These

37. See AYA GRUBER, *THE FEMINIST WAR ON CRIME: THE UNEXPECTED ROLE OF WOMEN'S LIBERATION IN MASS INCARCERATION* 42–45 (2020).

38. See Donna K. Coker, *Heat of Passion and Wife Killing: Men Who Batter/Men Who Kill*, 2 S. CAL. REV. L. & WOMEN'S STUD. 71, 85 (1992).

39. See Martha R. Mahoney, *Legal Images of Battered Women: Redefining the Issue of Separation*, 90 MICH. L. REV. 1, 65–66 (1991).

40. See EVAN STARK, *COERCIVE CONTROL: THE ENTRAPMENT OF WOMEN IN PERSONAL LIFE* (2007).

41. *Id.* at 11, 13–14.

also include a host of nonphysical behaviors intended to maintain power and control over women.⁴²

This prevalent power-and-control paradigm has resulted in placing a premium on the criminal legal system as the main tool to address domestic violence. Criminal statutes against domestic violence combined with criminal enforcement of civil-order violations have produced a legal system that heavily relies on the criminal law in the effort to end gender-based violence.⁴³

Yet, despite vigorous criminal enforcement of domestic violence laws in the past thirty years, the problem persists, as statistics show that the rates of domestic violence today remain staggering.⁴⁴ Data show that reliance on the criminal legal system to curb domestic violence has failed; rates of reporting battering to police are low, the number of cases that prosecutors drop due to victims' refusal to testify against their intimate partners is high, and batterers' recidivism and future violence remain disconcerting.⁴⁵ The chasm between states' investment in criminal enforcement and the continuous harm inflicted on victims suggests that criminalization *alone* is incapable of preventing the problem. This is because punitive measures fail to address the root causes of battering, including the risk factors that contribute to it.⁴⁶ The Parts below describe recent developments in the conceptualization of domestic violence and proposals to adopt alternative approaches to tackle the problem.

A. Domestic Violence Typology

Until recently, battering motivated by coercive control was largely conceived as the only form of domestic violence. In recent years, this power-and-control conceptualization of domestic violence has begun to shift toward evolving understandings of the phenomenon. Following a lively debate among researchers about the different types of domestic violence, sociologist Michael Johnson argues that domestic violence is not a "unitary phenomenon" that consists solely of men assaulting women to maintain patriarchal control.⁴⁷

42. *Id.* at 5 (stressing the patriarchal nature of coercive control which is established through the "microregulation of everyday behaviors associated with stereotypic female roles, such as how women dress, cook, clean, socialize, care for their children, or perform sexually").

43. See GOODMARK, *supra* note 7, at 12–33.

44. See NAT'L COAL. AGAINST DOMESTIC VIOLENCE (NCADV), DOMESTIC VIOLENCE (2020), http://assets.speakcdn.com/assets/2497/domestic_violence-2020080709350855.pdf?1596828650457 [<http://perma.cc/T89J-9VK8>] (stating one in four women and one in ten men experience one or overlapping forms of domestic violence, including physical violence, sexual violence, or stalking by an intimate partner throughout their lifetimes).

45. See RACHEL E. MORGAN & JENNIFER L. TRUMAN, U.S. DEP'T OF JUST., BUREAU OF JUST. STAT., CRIMINAL VICTIMIZATION, 2019, at 5 tbl.3 (2020), <http://bjs.ojp.gov/content/pub/pdf/cv19.pdf> [<http://perma.cc/FT94-89BY>] (reporting that the number of instances of intimate partner violence in 2019 was 695,060—which equals a rate of 2.5% per 1,000 persons age 12 or older).

46. See GOODMARK, *supra* note 7, at 53–54.

47. See Michael P. Johnson, *Conflict and Control: Gender Symmetry and Asymmetry in Domestic Violence*, 12 VIOLENCE AGAINST WOMEN 1003, 1005, 1010–12 (2006).

Johnson's typology distinguishes between two main behaviors that are considered domestic abuse.⁴⁸ The first type aligns with the familiar power-and-control paradigm and includes behaviors that Johnson refers to as "intimate terrorism" or "coercive controlling violence," involving a cycle of abuse through which mental, emotional, physical, and sexual abuse, as well as economic and social isolation, are used to exercise control over another person.⁴⁹ Johnson also identifies a second category, which he coins "common" or "situational couple violence," that refers to gender-neutral violence, including isolated incidents of abuse that occur in the heat of an argument where both men and women could resort to violence.⁵⁰ Situational couple violence includes violent behaviors that cannot be explained by the familiar intentional pattern of patriarchal domination and control.⁵¹

Johnson's typology has opened the door to expanding the understanding of the reasons behind domestic violence. This revised conceptualization has resulted in a growing realization that the power-and-control account obfuscates the role that other factors play in the dynamics of domestic battering.⁵² The multifaceted account highlights distinct types of domestic violence that are driven by various root causes, including economic marginality and other life stressors.⁵³ The root causes that lead people to commit violence against their intimate partners include substance abuse, financial strain, poverty, unemployment, past abuse, low class status, and race.⁵⁴ Stressors that are correlated with domestic violence are the batterers' mental illnesses and their psychological makeup; individuals who struggle with addiction, poverty, and unemployment often develop mental disorders that contribute to battering.⁵⁵

The significant role that life stressors play in contributing to domestic violence incidents was recently illustrated by the troubling increase in the number of domestic violence incidents during the COVID-19 pandemic. Dubbed "a pandemic within a pandemic," the combined effect of quarantine mandates, long periods of social isolation, growing unemployment, and financial insecurity exacerbated domestic strife, accounting for the rise in domestic violence.⁵⁶

48. See MICHAEL P. JOHNSON, A TYPOLOGY OF DOMESTIC VIOLENCE: INTIMATE TERRORISM, VIOLENT RESISTANCE, AND SITUATIONAL COUPLE VIOLENCE 25 (2008). Johnson's typology includes a third category, which is irrelevant to the discussion here, dubbed "violent resistance," which is the use of self-defense by women who have been abused by intimate partners. *Id.* at 72.

49. See *id.* at 25–47.

50. Johnson explained that only those suffering from coercive controlling behaviors ask for state intervention because they feel most endangered, whereas situational couple violence typically does not lead to reports to the police, and the information about situational couple violence stems from people's responses to surveys. *Id.* at 60–71, 93, 115; see also Johnson, *supra* note 47, at 1005.

51. See Michael P. Johnson & Janel M. Leone, *The Differential Effects of Intimate Terrorism and Situational Couple Violence: Findings from the National Violence Against Women Survey*, 26 J. FAM. ISSUES 322, 322–23 (2005).

52. See Carolyn B. Ramsey, *The Stereotyped Offender: Domestic Violence and the Failure of Intervention*, 120 PENN ST. L. REV. 337, 338 (2015).

53. See JOHNSON, *supra* note 48, at 64.

54. See Ramsey, *supra* note 52, at 382.

55. *Id.* at 387–88.

56. See, e.g., N. van Gelder, A. Peterman, A. Potts, M. O'Donnell, K. Thompson, N. Shah & S. Oertelt-Prigione, Commentary, *Covid-19: Reducing the Risk of Infection Might Increase the Risk of Intimate*

The main takeaway of the aforementioned typology is that different forms of domestic violence should be treated differently according to the specific reasons that contribute to their occurrence.

Critics of existing legal responses to domestic violence call for abandoning the single-dimensional framework that conceptualizes all domestic violence cases as criminal behaviors that are explained solely by the “power-and-control” account. The next Part describes reforms to replace criminal responses with noncarceral interventions that incorporate other accounts of domestic violence.

B. Decriminalizing Domestic Violence

Until recently, physical assaults occurring within the family were considered the paradigm example of criminal behavior that justified criminal interventions.⁵⁷ Yet, commentators began to cast doubt on whether the criminal legal system was an adequate tool to address domestic violence and called for revising the existing treatment of this problem. Reformers’ positions regarding the role for criminal enforcement significantly vary. Some argue that the criminal legal system, standing alone, is insufficient to prevent domestic violence, thus calling for revamping civil measures (mostly protection orders).⁵⁸ Others argue that the criminal legal system must be supplemented with additional strategies, such as economically supporting victims.⁵⁹ Still others call for a fully abolitionist position to domestic violence treatment, given the intrinsically punitive nature of the criminal legal system and the systemic racism that characterizes it.⁶⁰

In a groundbreaking book titled *Decriminalizing Domestic Violence*, Professor Leigh Goodmark rejects the view of domestic violence as mostly a criminal law problem, arguing that existing research does not justify the continued reliance on criminalization as the primary response to curb the harms of domestic violence.⁶¹ She stresses that the criminal legal system’s efforts to curb domestic violence are insufficient in preventing future violence, and even when the system does “work,” the costs to affected families, as well as to society at large, are too high and unjustified.⁶²

Likewise, Professor Aya Gruber’s book *The Feminist War on Crime* advances an anticarceral position, denouncing feminist reformers’ role in advancing punitive measures that arguably contributed to mass incarceration.⁶³ Criticizing prosecutorial policies, such as mandatory arrest and no-drop prosecution for domestic violence, Gruber calls on reformers to abandon their continued reliance on criminal law as the principal

Partner Violence, 21 *ECLINICALMEDICINE* 1, 1–2 (2020); Megan L. Evans, Margo Lindauer & Maureen E. Farrell, *A Pandemic Within a Pandemic—Intimate Partner Violence During Covid-19*, 383 *NEW ENG. J. MED.* 2302, 2302–03 (2020).

57. See Dempsey, *supra* note 5, at 4 & n.4.

58. See Jane K. Stoever, *Enjoining Abuse: The Case for Indefinite Domestic Violence Protection Orders*, 67 *VAND. L. REV.* 1015, 1069 (2014).

59. See Deborah M. Weissman, *In Pursuit of Economic Justice: The Political Economy of Domestic Violence Laws*, 2020 *UTAH L. REV.* 1, 5–6 (2020).

60. See Dorothy E. Roberts, *Democratizing Criminal Law as an Abolitionist Project*, 111 *NW. U. L. REV.* 1597, 1605–06 (2017).

61. See GOODMARK, *supra* note 7, at 26–32.

62. *Id.* at 26.

63. See GRUBER, *supra* note 37, at 43–45.

tool to resolve the problem of domestic violence and to reimagine alternative tools to address gender-based violence.⁶⁴

The multiple concerns underlying the criminal legal system's treatment of domestic violence have led some reformers to urge replacing criminal interventions with nonpunitive alternatives that would better address victims' specific needs in order to end domestic abuse without partaking in states' carceral regimes.⁶⁵

C. A Public Health Approach to Domestic Violence

A public health approach has emerged as a dominant framework for addressing domestic violence under an alternative legal regime. In recent years, reformers have considered a public health approach to resolve different social problems, including homelessness, drug and alcohol abuse, child abuse and neglect, human trafficking, and sexual offenses.⁶⁶ Likewise, calls for reforming society's response to domestic violence rest on reconceptualizing domestic violence as a public health issue. For example, Professor Goodmark explains that domestic violence is a multifaceted problem that implicates public health issues, among others.⁶⁷ Goodmark further finds that a public health approach to domestic violence rests on the premise that violence is preventable; thus, efforts to revamp prevention measures include investigating the causes and correlations of the problem and implementing interventions that are based on that evidence.⁶⁸

Policymakers agree that domestic violence is indeed a public health problem, given its pervasive effects on victims' physical and mental health.⁶⁹ Likewise, healthcare systems embrace an integrated approach to the treatment of domestic violence within the

64. *Id.* at 17–18.

65. See, e.g., Deborah M. Weissman, *The Community Politics of Domestic Violence*, 82 BROOK. L. REV. 1479, 1492–93 (2017); Donna Coker, Leigh Goodmark & Marcia Olivo, *Introduction: CONVERGE! Reimagining the Movement To End Gender Violence*, 5 U. MIAMI RACE & SOC. JUST. L. REV. 249, 249–50, 255 (2015).

66. See, e.g., V. Noah Gimbel & Craig Muhammad, *Are Police Obsolete? Breaking Cycles of Violence Through Abolition Democracy*, 40 CARDOZO L. REV. 1453, 1506–19 (2019); Katharine Silbaugh, *Reactive to Proactive: Title IX's Unrealized Capacity To Prevent Campus Sexual Assault*, 95 B.U. L. REV. 1049, 1068–71 (2015); Jonathan Todres, *Moving Upstream: The Merits of a Public Health Law Approach to Human Trafficking*, 89 N.C. L. REV. 447, 469–93 (2011).

67. See GOODMARK, *supra* note 7, at 10.

68. See *id.* at 53–74.

69. The Centers for Disease Control and Prevention describes intimate partner violence as a “serious public health problem” that affects millions of Americans. *Intimate Partner Violence*, CTRS. FOR DISEASE CONTROL & PREVENTION: VIOLENCE PREVENTION, <http://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html> [http://perma.cc/RH9Y-HL5X] (last visited May 1, 2022). Similarly, the American Medical Association policy statement on family and intimate partner violence declares that the “all forms of family and intimate partner violence (IPV) are major public health issues and urges the profession, both individually and collectively, to work with other interested parties to prevent such violence and to address the needs of survivors.” *Violence and Abuse: Family and Intimate Partner Violence* H-515.965, AMA POLICYFINDER, <http://policysearch.ama-assn.org/policyfinder/detail/Violence%20and%20Abuse?uri=%2FAMADoc%2FHOD.xml-0-4664.xml> [http://perma.cc/BRF9-EVJQ] (last visited May 1, 2022).

medical community, urging healthcare providers to screen patients suspected to be domestic violence victims.⁷⁰

Pitted against criminal law's punitive goal, public health's main aim is harm prevention.⁷¹ One of the key shortcomings in relying on criminal law interventions to address domestic violence is their inability to prevent incidents of domestic violence or their escalation.⁷² In contrast, a noncarceral regime would prioritize prevention of future harm to victims over punishment of batterers, therefore making a public health approach a more suitable response to domestic violence.

While a growing body of scholarship emphasizes the need for adopting a public health approach to address many social problems (including domestic violence), the very notion of "public health" is far from being agreed upon.⁷³ It is a fluid concept that is subject to different understandings among public health scholars and may be used in a narrow or broad sense.⁷⁴ Before further pondering the implications of implementing a public health approach to domestic violence, it is necessary to define what I mean in this Article by using this terminology.

Broadly conceived, a public health approach focuses on prevention of harm to the health and well-being of populations by adopting preventive measures at three separate levels: primary, secondary, and tertiary prevention.⁷⁵ Primary prevention focuses on systemic preliminary interventions that are aimed at preventing potential harm from ever occurring.⁷⁶ Applied to the domestic violence context, the goal of primary prevention is to prevent violence before its first manifestation. Primary prevention emphasizes policy reforms to decrease batterers' access to guns and alcohol as well as the centrality of education programs.⁷⁷ As such, primary prevention is mostly aimed at populations at large rather than treating specific affected individuals.⁷⁸

Secondary prevention also focuses on early intervention, but its main goal is to detect initial manifestation of harm and prevent the escalation and spread of harm that has already occurred.⁷⁹ Secondary prevention also incorporates principles of harm reduction, which are strategies seeking to minimize existing injuries.⁸⁰ Since the goal of

70. See Karen Oehme, Nat Stern, Elizabeth Donnelly & Rebecca Melvin, *Improving the Emergency Medical Services System's Response to Domestic Violence*, 26 HEALTH MATRIX 173, 178–79 (2016).

71. James A. Mercy, Mark L. Rosenberg, Kenneth E. Powell, Claire V. Broome & William L. Roper, *Public Health Policy for Preventing Violence*, 12 HEALTH AFFS. 7, 9, 11 (1993).

72. See GOODMARK *supra* note 7, at 53.

73. See, e.g., Josh Gupta-Kagan, *Toward a Public Health Legal Structure for Child Welfare*, 92 NEB. L. REV. 897, 920–24 (2014); Melissa McPheeters & Mary K. Bratton, *The Right Hammer for the Right Nail: Public Health Tools in the Struggle Between Pain and Addiction*, 48 U. MEM. L. REV. 1299, 1301–03 (2018).

74. See Wendy K. Mariner, *Public Health and Law: Past and Future Visions*, 28 J. HEALTH POL., POL'Y & L. 525, 525–29 (2003).

75. See Gupta-Kagan, *supra* note 73, at 920–23.

76. See David Dante Troutt, *Trapped in Tragedies: Childhood Trauma, Spatial Inequality, and Law*, 101 MARQ. L. REV. 601, 619 (2018).

77. See GOODMARK, *supra* note 7, at 56–73.

78. See *id.* at 53–54.

79. See McPheeters & Bratton, *supra* note 73, at 1303.

80. Harm reduction strategies are increasingly used in the context of substance abuse. See generally Aila Hoss, *Legalizing Harm Reduction*, 80 OHIO ST. L.J. 825, 829 (2019) (justifying harm reduction strategies as part of both public health and human rights models).

secondary prevention is to minimize the prevalence, duration, and severity of harm once it has manifested, it targets those viewed as “at risk,” meaning those who have already harmed others.

Tertiary prevention addresses harm once it has already occurred, focusing on preventing the continued occurrence of violence and the reduction of its negative consequences on victims.⁸¹ The paradigmatic example of tertiary measures is criminalization, which rests on a backward-looking approach that seeks to punish wrongdoing after harm had already been inflicted.⁸²

While primary prevention is mostly an uncontested part of any domestic violence reform, there is a more difficult (and largely disputed) question: What would secondary and tertiary prevention measures encompass in a noncarceral state that discards punitive tools to curb violence? Professor Goodmark, for example, largely rejects the use of tertiary prevention in addressing domestic violence.⁸³ She uses the term “public health” in a narrow sense that encompasses mostly primary prevention. Goodmark’s approach prioritizes population-level interventions over interventions that are aimed at treating specific individuals responsible for battering.⁸⁴ Intervention programs, argues Goodmark, should only be used to target the correlates of intimate partner violence, such as alcohol abuse.⁸⁵ This approach, however, excludes any therapeutic mental health intervention targeted at treating individual batterers from the scope of “public health.”

The problem with a narrow understanding of public law’s contours is that primary prevention standing alone is insufficient to prevent specific incidents of violence once harm has already been inflicted and might further escalate. Moreover, the rejection of any role for tertiary prevention is by no means an integral tenet of a public health approach.

In contrast, I argue that a broader understanding of what implementing a public health approach entails is necessary under an alternative noncriminal legal regime. The discipline of public health is sufficiently capacious to encompass concerted efforts that incorporate primary, secondary, and tertiary prevention of domestic violence.⁸⁶ A comprehensive vision of a public health approach to domestic violence must view the three types of prevention as complementing, rather than contrasting with, one another.

Moreover, developing alternative nonpunitive responses to domestic violence prevention requires adopting what public health scholars refer to as the social-ecological

81. See *id.*; McPheeters & Bratton, *supra* note 73, at 1303; GOODMARK, *supra* note 7, at 53–54.

82. See GOODMARK, *supra* note 7, 54

83. *Id.* at 53–54.

84. *Id.* at 53–56.

85. See *id.* at 70–71.

86. See Camille M. Davidson, *What’s Love Got To Do With It? Examining Domestic Violence as a Public Health Issue Using Their Eyes Were Watching God*, 81 UMKC L. REV. 867, 893–97 (2013); see also McPheeters & Bratton, *supra* note 73, at 1301–02; Linda Chamberlain & Julie Ann Rivers-Cochran, *A Prevention Primer for Domestic Violence: Terminology, Tools, and the Public Health Approach*, VAWNET (Mar. 2008), <http://vawnet.org/material/prevention-primer-domestic-violence-terminology-tools-and-public-health-approach> [http://perma.cc/48XH-NS3R]; cf. Nancy Chi Cantalupo & William C. Kidder, *Systemic Prevention of a Serial Problem: Sexual Harassment and Bridging Core Concepts of Bakke in the #MeToo Era*, 52 U.C. DAVIS L. REV. 2349, 2361 (2019) (integrating primary, secondary, and tertiary prevention in the context of sexual harassment).

model of public health.⁸⁷ This model advocates for integrating multilayered intervention at the interpersonal, community, and societal levels.⁸⁸ Implementing a social-ecological model to domestic violence prevention includes the following four levels: (1) the individual within the context of relationship, (2) relationships within the context of community, (3) community within the context of society, and (4) the broader societal environmental factors.⁸⁹ This model is contrasted with the behavioral model of public health which relies exclusively on efforts to change individual behaviors, which often proves ineffective.⁹⁰

Rejecting criminal responses to domestic violence as the main tertiary prevention tools does not mean that alternative tertiary prevention measures will not be adopted in their stead. Tertiary prevention remains vital in the noncarceral state as it is a necessary strategy to protect victims from further harm. Currently, the question of what tertiary prevention of domestic violence will look like once police responsibilities are transferred to alternative institutions remains an open one. One of the challenges for policymakers in the noncarceral state would be developing tertiary preventive measures that replace policing and prosecution in addressing domestic violence.

Pondering the precise nature of alternative tertiary prevention of domestic violence calls for recognizing the interrelationship between the notions of public health and health-based measures. The extent to which medicalized interventions—particularly mental health measures—should be incorporated into crafting public health responses for domestic violence remains understudied. Commentators have yet to address the relationship between a public health approach and medicalized interventions to domestic violence.

Critics of my position might argue that a public health approach and medicalized interventions are distinct notions, and implementing a public health approach to domestic violence does not entail implementing any health-based (including mental health-based) interventions.⁹¹ Furthermore, critics might disagree with my claim that medicalized interventions (particularly ones focused in mental health) would play a central role under a public health approach that prioritizes alternative tertiary prevention in lieu of

87. See Lindsay F. Wiley, *Health Law as Social Justice*, 24 CORNELL J.L. & PUB. POL'Y 47, 79–80 (2014); LAWRENCE O. GOSTIN & LINDSAY F. WILEY, PUBLIC HEALTH LAW: POWER, DUTY, RESTRAINT 381 (3d ed. 2016); Niyi Awofeso, Commentary, *What's New About the "New Public Health"?*, 94 AM. J. PUB. HEALTH 705, 708 (2004).

88. See Heather Howard & Wendy F. Guastafarro, *Mothers and Opioid Use Disorder: Moving Toward Justice, Wellness, and Engagement*, 32 J. AM. ACAD. MATRIM. L. 29, 32 (2019) (observing that the social-ecological model of public health requires interventions at the individual, interpersonal, community, and societal levels).

89. The Centers for Disease Control prioritizes the social-ecological model for violence prevention. See *The Social-Ecological Model: A Framework for Violence Prevention*, No. CS221239A, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/violenceprevention/pdf/sem_framework-a.pdf [<http://perma.cc/LD79-CSSJ>] (last visited May 1, 2022). For scholarly discussions of the social-ecological model, see, for example, Wiley, *supra* note 87, at 79–80; Todres, *supra* note 66, at 482, 487; Kimberly S.G. Chang, Hamida Yusufzai & Anna Marjavi, *Medical-Legal Collaboration and Community Partnerships: Prioritizing Prevention of Human Trafficking in Federally Qualified Health Centers*, 36 GA. ST. U. L. REV. 1075, 1077–79 (2020); Silbaugh, *supra* note 66, at 1068.

90. See GOSTIN & WILEY, *supra* note 87, at 23–26 (contrasting the behavioral and social-ecological models of public health).

91. I thank Professor Leigh Goodmark for directing my attention to this point.

criminalization.⁹² Instead, their argument might continue, a host of other non-medicalized interventions could be adopted as part of a comprehensive tertiary prevention strategy.⁹³

Concededly, a public health approach to domestic violence and medicalized interventions to the problem are not synonymous notions. Tertiary prevention of domestic violence could and should incorporate multi-level prevention strategies aimed at preventing further harm to survivors of domestic violence. These strategies include a host of evidence-based, non-medicalized interventions that extend beyond mental-health responses, such as the effective use of civil protection orders, as well as providing financial compensation and housing protections to survivors of domestic violence.⁹⁴

Indeed, a civil protection order is a commonly used tertiary prevention measure that is often sought by domestic violence survivors, especially those who would like to stop abuse but prefer to avoid reliance on the criminal legal system.⁹⁵ Such an order, which is now available in all U.S. jurisdictions, bars an individual who has committed an act of domestic violence from further abusing a victim by incorporating various conditions, including provisions that prohibit all contact with the victim, abusive intimidation, or harassment.⁹⁶ If children are involved, orders can also set conditions on visitation.⁹⁷

Civil protection orders offer an important tertiary prevention tool, yet their implementation is characterized by a host of problems that significantly impede their effective enforcement.⁹⁸ Enforcement of these orders is significantly lacking and remains inconsistent; high rates of noncompliance are attributed to the failure to properly enforce these orders.⁹⁹ In fact, in many cases, civil protection orders are violated,¹⁰⁰ and filing for orders exacerbates physical violence, sometimes even resulting in intimate partner homicide.¹⁰¹ Moreover, the current enforcement of civil protection orders heavily relies on the criminal legal system, as violations of protection orders amount to either a separate misdemeanor or felony offense, or to either criminal or civil contempt of court

92. I thank Professors Debora Pogrund Stark and Sean Bland for highlighting these counterarguments.

93. I thank Professors Debora Pogrund Stark and Sean Bland for highlighting these counterarguments.

94. See Debra Pogrund Stark, *What's Law Got To Do with It? Confronting Judicial Nullification of Domestic Violence Remedies*, 10 NW. J.L. & SOC. POL'Y 130, 140–47 (2015) (elaborating on additional remedies available for domestic violence survivors with orders of protection). It should be stressed, however, that under existing laws, violations of civil protection orders result in criminal prosecution, either under criminal contempt statutes or under a separate offense. For discussion of evidence-based interventions in the context of human trafficking, see Todres, *supra* note 66, at 469.

95. See Elizabeth L. MacDowell, *From Victims to Litigants*, 67 HASTINGS L.J. 1299, 1311 (2016) (observing that protection orders were intended to provide survivors with an alternative to the criminal legal system).

96. *Id.*; Emily J. Sack, *Battered Women and the State: The Struggle for the Future of Domestic Violence Policy*, 2004 WIS. L. REV. 1657, 1667 (2004).

97. See Sack, *supra* note 96.

98. See Stoever, *supra* note 6, at 375–76.

99. See Sally F. Goldfarb, *Reconceiving Civil Protection Orders for Domestic Violence: Can Law Help End the Abuse Without Ending the Relationship?*, 29 CARDOZO L. REV. 1487, 1516–18 (2008).

100. See Jane K. Stoever, *Access to Safety and Justice: Service of Process in Domestic Violence Cases*, 94 WASH. L. REV. 333, 355 (2019) (noting that approximately one-half of protective orders are violated by abusive partners).

101. See Leslye Orloff, *Lifesaving Welfare Safety Net Access for Battered Immigrant Women and Children: Accomplishments and Next Steps*, 7 WM. & MARY J. WOMEN & L. 597, 617 (2001).

proceedings; violations may also lead to the batterer's mandatory arrest.¹⁰² Consequently, although protection orders are civil measures, ensuring compliance is inevitably intertwined with states' criminal enforcement mechanisms.

Civil protection orders without a robust enforcement mechanism are toothless and fail to provide domestic violence survivors with necessary protection from further abuse. Invigorating the use of civil protection orders in a noncarceral legal regime therefore requires developing robust enforcement mechanisms that do not rely solely on criminal enforcement. While I support the development and implementation of various enforcement mechanisms that would increase the effectiveness of civil protection orders, fully elaborating on them exceeds the scope of this Article, which largely does not center on the problems associated with civil protection orders.

Instead, this Article focuses mostly on health-based responses, including mental health interventions, as one of various forms of potential alternative responses to existing criminalization of domestic violence. Several reasons underlie this specific choice. First, reformers seeking to defund the police by recalibrating some police responsibilities explicitly call for increasing the funding for mental health services to replace the police's roles.¹⁰³ Invigorating the responsibilities and powers of mental health professionals thus inevitably implicates a significant expansion in mental health interventions. Second, expanding the scope of medicalized interventions to domestic violence is a predicted direction because it is consistent with existing reliance on such interventions in a host of other comparable areas.¹⁰⁴ Third, medicalized alternatives to criminalization are the most problematic interventions compared to other alternatives, as they carry ample unintended consequences affecting batterers' liberties, and therefore warrant especially close scrutiny.¹⁰⁵ Finally, while the social-ecological approach to public health is now the favored model among public health law scholars,¹⁰⁶ legislatures and policymakers may not fully adopt it and may instead gravitate towards behavioral or therapeutic approaches that focus on treatment of individual batterers.¹⁰⁷ Moreover, multilevel interventions under the broader social-ecological model also include some intervention at the interpersonal level, namely, addressing the individual batterer within the context of relationship *in addition to* societal, community, and environmental levels.¹⁰⁸

This Article highlights the inevitable interconnectedness of implementing a public health approach to domestic violence and the role for mental health interventions under this approach. Health-based interventions aimed at treating affected batterers are necessarily an integral component of implementing a public health approach; some batterers pose serious physical risks to the lives of their intimate partners, and this unique

102. See generally David M. Zlotnick, *Empowering the Battered Woman: The Use of Criminal Contempt Sanctions To Enforce Civil Protection Orders*, 56 OHIO ST. L.J. 1153, 1194–96, 1215 (1995) (observing that violations of civil protection orders have evolved to involve more criminal sanctions).

103. See Jessica M. Eaglin, *To “Defund” the Police*, 73 STAN. L. REV. ONLINE 120, 128–29 (2021).

104. See *infra* Part II.A.

105. See *infra* Parts III.A and III.B.

106. See Lindsay F. Wiley, *Teaching Health Law From a Social-Ecological Perspective*, 61 ST. LOUIS U. L.J. 381, 388 (2017) (contrasting the social-ecological model with the “outmoded behavioral model”).

107. See *infra* Part II.B for an explanation of how some jurisdictions already incorporate a more therapeutic approach.

108. See Howard & Guastaferrro, *supra* note 88, at 32.

dangerousness requires some form of monitoring (sometimes incapacitation) to prevent lethal consequences.¹⁰⁹ Embracing mental health measures in lieu of imprisonment of domestic batterers is therefore an inevitable feature of a holistic understanding of a public health approach. The next Section demonstrates how tertiary prevention in the noncarceral state inescapably incorporates a therapeutic approach that implements mental health interventions. It shows how this direction is largely attributed to the medicalization phenomenon in general and to the medicalization of domestic violence in particular.

II. THE MEDICALIZATION OF DOMESTIC VIOLENCE

Assuming that adopting a broad understanding of a public health approach to domestic violence is warranted raises the question: What alternative institutions would step in to fill the void left by the decriminalization of domestic violence? To avoid a regulatory gap, noncarceral institutions would become responsible for curbing domestic violence by facilitating preventive measures to decrease its incidence. Mental health professionals—including psychiatrists, psychologists, and social workers—will become the central institutional actors tasked with protecting domestic violence victims' safety in the noncarceral state.

The prospect of turning to mental health institutions as an alternative to criminalization is consistent with a general trend in other areas of law to increasingly rely on health-based measures to resolve a host of social problems, a phenomenon that scholars refer to as medicalization. The Parts below elaborate how the treatment of domestic violence in the noncarceral state is situated within the broader context of medicalization.

A. *The Medicalization Phenomenon*

Medicalization has recently become a prevalent conceptual framework that underlies the contemporary treatment of many societal ills ranging from substance abuse to poverty and homelessness.¹¹⁰ I do not attempt to provide a comprehensive discussion of the various manifestations of medicalization. Instead, I offer a brief overview of medicalization, highlighting its main tenets as a backdrop for understanding the unique concerns that arise in the specific context of medicalizing domestic violence.

109. See *Illinois Eyes GPS Use in Tracking Restraining Orders*, NPR (Apr. 2, 2008, 4:00 PM), <http://www.npr.org/templates/story/story.php?storyId=89318803> [<http://perma.cc/PP7M-5WCL>] (discussing the murder of Cindy Bischof, who was shot and killed by her ex-boyfriend, which prompted legislatures to propose GPS monitoring to track dangerous batterers' movements). For further discussion of GPS monitoring, see *infra* Part III.A.

110. See Konnoth, *supra* note 20, at 1170–71. Professor Konnoth calls for strengthening a medical civil rights approach and highlights the advantages of such an approach to advance people's civil rights. See *id.* Konnoth's support for medicalization of civil rights has been subject to fierce criticism. Critics argue that medicalization does not provide a clear civil rights cure and caution that this solution risks overinvestment in medical rights seeking and other issues related to disability. See, e.g., Rabia Belt & Doron Dorfman, Response, *Reweighting Medical Civil Rights*, 72 STAN. L. REV. ONLINE, 176, 179–85 (2020); Allison K. Hoffman, Response, *How Medicalization of Civil Rights Could Disappoint*, 72 STAN. L. REV. ONLINE 165, 166–76 (2020).

The medicalization phenomenon is well documented in the literature.¹¹¹ Over the past four decades, scholars have devoted significant attention to medicalization and its implications—largely emphasizing its dangers.¹¹² Even though the phenomenon has long been identified, medicalization lacks a single, unified definition as scholars from different fields embrace different understandings of the term.¹¹³

In general, medicalization is defined as the use of medical frameworks and language to identify, understand, and treat a host of social issues.¹¹⁴ Peter Conrad, a leading medicalization scholar, coined the term medicalization as follows:

defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem or using a medical intervention to “treat” it. This is a sociocultural process that may or may not involve the medical profession, lead to medical social control or medical treatment, or be the result of intentional expansion by the medical profession.¹¹⁵

Conrad’s account criticizes the use of medicine as a tool of social control because he views medicalization as a process through which nonmedical problems are *unjustifiably* defined and treated as medical problems, usually as illnesses or disorders.¹¹⁶

Following this line of critique, scholars from different legal fields have leveled fierce criticism of medicalization. Ample scholarship describes how many social problems have been medicalized (including disability, maternal care, poverty, housing, homelessness, and unemployment) and stresses the harmful implications for individuals placed under specific medical labels.¹¹⁷

For example, disability scholars criticize the medical model of disability, which frames disability as an individual medical problem rather than through the lens of a social model.¹¹⁸ Carceral measures, they continue, affect not only criminal law but also

111. For some notable works on medicalization, see, for example, KHIARA M. BRIDGES, *THE POVERTY OF PRIVACY RIGHTS* 109, 111–13 (2017); Russell K. Robinson & David M. Frost, *The Afterlife of Homophobia*, 60 ARIZ. L. REV. 213, 234–36, 253 (2018); Dean Spade, Commentary, *Resisting Medicine, Re/modeling Gender*, 18 BERKELEY WOMEN’S L.J. 15, 23, 28–29 (2003). Some commentators also observe medicalization’s potential benefits. See, e.g., Konnoth, *supra* note 20; B. Cameron Webb & Dayna Bowen Matthew, *Housing: A Case for the Medicalization of Poverty*, 46 J.L. MED. & ETHICS 588 (2018).

112. See Konnoth, *supra* note 20, at 1174.

113. See Dayna Bowen Matthew, *Health and Housing: Altruistic Medicalization of America’s Affordability Crisis*, 81 LAW & CONTEMP. PROBS. 161, 162 (2018); Konnoth, *supra* note 20, at 1184.

114. See, e.g., Konnoth, *supra* note 20, at 1175–76.

115. Peter Conrad, *Medicalization and Social Control*, 18 ANN. REV. SOCIO. 209, 211, 223–24 (1992).

116. See Peter Conrad & Cheryl Stults, *Contestation and Medicalization*, in *CONTESTING ILLNESS: PROCESSES AND PRACTICES* 323, 324 (Pamela Moss & Kathy Teghtsoonian eds., 2008).

117. See Konnoth, *supra* note 20, at 1175, 1181–84.

118. See Jamelia N. Morgan, *Policing Under Disability Law*, 73 STAN. L. REV. 1401, 1406–09, 1457–58 (2021) (rejecting the medical model of disability and advocating for a social model of disability which views disability as a social construction); Elizabeth F. Emens, *Framing Disability*, 2012 U. ILL. L. REV. 1383, 1401 (2012) (viewing disability as an individual medical problem); Rabia Belt & Doron Dorfman, *Disability, Law, and the Humanities: The Rise of Disability Legal Studies*, in *THE OXFORD HANDBOOK OF LAW AND HUMANITIES* 145, 147 (2019) (distinguishing between an impairment (which is a biological condition) and disability (which is the social meaning given to the impairment)); Doron Dorfman, *Re-Claiming Disability: Identity, Procedural Justice, and the Disability Determination Process*, 42 LAW & SOC. INQUIRY 195, 197 (2017) (discussing the social model of disability).

healthcare systems because they function as a mechanism of social control of disabled people. Healthcare systems may also create inequities and disparities on the basis of poverty, race, gender, citizenship status, and sexuality.¹¹⁹

Feminist and reproductive rights scholars criticize medicalization as exerting control over poor pregnant women and controlling women's reproductive rights.¹²⁰ Still others emphasize the harmful implications of medicalization on the rights of LGBTQ+ individuals, arguing that medicalization pathologizes homosexuality and transgender individuals.¹²¹ Taken together, commentators argue that converting normal human behaviors into medical problems carries negative implications because it results in diverting resources away from efforts to change problematic social constructs.¹²²

Moreover, medicalization has long been interwoven into carceral institutions, as it has played a key role in exerting social control over people. Professor Jonathan Simon has written extensively on how the medical model has dominated the American correctional system as the central rehabilitative-oriented penology until the 1970s.¹²³ Commentators further observe that criticism of mass incarceration obfuscates the fact that, throughout history, asylums served as carceral institutions used to manage and control the disabled, poor, and mentally ill.¹²⁴

One of the disconcerting aspects of medicalization is the disparate effect it has on minorities, especially people of color. Commentators describe how medical discourse continuously oppresses vulnerable communities.¹²⁵ For example, Professor Dorothy Roberts has lamented that reproductive health has been a key institution for oppression of Black women.¹²⁶ Professor Michele Goodwin's recent work, *Policing the Womb*, describes how the state criminalizes reproduction, pregnancy, abortion, birth, and motherhood.¹²⁷ Goodwin's account poignantly illustrates how medical professionals have become complicit in an oppressive system that disproportionately impacts poor women of color as they voluntarily step into the shoes of law enforcement in the name of fetal protection.¹²⁸

119. See Lisa C. Ikemoto, *In the Shadow of Race: Women of Color in Health Disparities Policy*, 39 U.C. DAVIS L. REV. 1023, 1026, 1029–31 (2006); Medha D. Makhoul, *Laboratories of Exclusion: Medicaid, Federalism & Immigrants*, 95 N.Y.U. L. REV. 1680, 1683 (2020).

120. See Khiara M. Bridges, *Race, Pregnancy, and the Opioid Epidemic: White Privilege and the Criminalization of Opioid Use During Pregnancy*, 133 HARV. L. REV. 770, 823 (2020).

121. See Spade, *supra* note 111, at 24–26.

122. See Konnoth, *supra* note 20, at 1177–78.

123. See Jonathan Simon, *The Return of the Medical Model: Disease and the Meaning of Imprisonment from John Howard to Brown v. Plata*, 48 HARV. C.R.-C.L. L. REV. 217, 229–33 (2013).

124. See Appleman, *supra* note 31, at 428–30; see also Jonathan Simon & Stephen A. Rosenbaum, *Defying Madness: Rethinking Commitment Law in an Age of Mass Incarceration*, 70 U. MIAMI L. REV. 1, 4 (2015).

125. See, e.g., Craig Konnoth, *Race and Medical Double-Binds*, 121 COLUM. L. REV. F. 135, 141–42 (2021); Morgan, *supra* note 118, at 1418; BRIDGES, *supra* note 111, at 109, 111.

126. See DOROTHY ROBERTS, *KILLING THE BLACK BODY: RACE, REPRODUCTION, AND THE MEANING OF LIBERTY* 6, 22–55 (1997).

127. See MICHELE GOODWIN, *POLICING THE WOMB: INVISIBLE WOMEN AND THE CRIMINALIZATION OF MOTHERHOOD* 189–98 (Cambridge University Press 2020).

128. *Id.* at 80, 195.

Despite concerns underlying the medicalization phenomenon, many commentators advocate for the adoption of a public health approach that integrates medical intervention measures in a variety of legal fields.¹²⁹ Drug treatment courts are the paradigmatic example of specialized, problem-solving courts that incorporate a medicalized approach to treating drug addicts.¹³⁰ These courts follow a therapeutic jurisprudential philosophy, and their main goal is treatment.¹³¹ They are premised on the idea that drug addiction is a disease; therefore, treating the afflicted addict is a more effective way to address drug-related criminal behavior than incarceration.¹³² The operation of drug treatment courts varies by jurisdiction, but one of their unifying features is courts' discretion to create individualized treatment plans for defendants that mandate their participation in rehabilitation programs.¹³³

The increasing support for adopting a therapeutic approach to drug addiction is illustrated by the Biden administration's growing enthusiasm for adopting mandated treatment programs and expanding drug treatment courts as alternatives to incarceration.¹³⁴ Likewise, the response to the opioid epidemic is the prime example for incorporating medical intervention measures as part of reliance on a public health approach.¹³⁵

But advocates of criminal-legal-system reform argue that drug addiction calls for harm reduction measures and community-based treatment rather than drug treatment courts, which rely on punitive measures to address noncompliance with mandated treatment.¹³⁶ Commentators extensively critique the operation of drug treatment courts,

129. See Gupta-Kagan, *supra* note 73, at 922.

130. See Erin R. Collins, *Status Courts*, 105 GEO. L.J. 1481, 1488–89, 1518 (2017). Professor Collins compares and contrasts problem-solving courts, like drug or domestic violence courts, with status courts like veterans courts, which are criminal courts that specifically target criminal offenders who have served in the U.S. military and provide them with intensive supervision, coordinated services, and treatment as an alternative to incarceration. *Id.* at 1492. Collins argues that while there are concerns underlying the privileged treatment of certain groups and the underlying notions embedded in these courts, they also offer a basis for future reform because they advance the notion that some individuals commit criminal offenses because of the influence of external factors beyond their control. *Id.* at 1525.

Since veterans courts also provide treatment to participants, there are overlapping concerns between veterans courts and domestic violence courts. I thank Professor Colin Miller for directing my attention to an open question concerning whether veterans courts should also handle domestic violence cases. For further discussion of this issue, see Note, Pamela Kravetz, *Way Off Base: An Argument Against Intimate Partner Violence in Veterans Treatment Courts*, 4 VETERANS L. REV. 162, 166 (2012).

131. While drug treatment courts rest on a therapeutic approach to substance abuse, they currently operate within the criminal legal system rather than within a public health framework or a civil system. See Josh Bowers, *Contraindicated Drug Courts*, 55 UCLA L. REV. 783, 787–88 (2008).

132. See Eric J. Miller, *Embracing Addiction: Drug Courts and the False Promise of Judicial Interventionism*, 65 OHIO ST. L.J. 1479, 1488–89 (2004).

133. *Id.* at 1537–39.

134. See Miriam Krinsky & Leo Beletsky, *Why It's Time To Abandon Drug Courts*, CTR. ON MEDIA CRIME & JUST. AT JOHN JAY COLL.: CRIME REP. (Mar. 5, 2021), <http://thecrimereport.org/2021/03/05/why-its-time-to-abandon-drug-courts> [http://perma.cc/AC8U-XXST].

135. See Leo Beletsky, *America's Favorite Antidote: Drug-Induced Homicide in the Age of the Overdose Crisis*, 2019 UTAH L. REV. 833, 867 (2019).

136. See Erin R. Collins, *The Problem of Problem-Solving Courts*, 54 U.C. DAVIS L. REV. 1573, 1607, 1618, 1621–22 (2021).

arguing that their treatment-oriented approach incorporates the criminal justice system's tools into the lives of many citizens, expanding the overall reach of the legal system.¹³⁷

Another example illustrating the extent to which medicalized intervention is unavoidably integrated into a public health approach concerns the maltreatment of children, which is another form of domestic abuse. Child abuse and neglect statutes enable expansive state intervention through child protective services following a caseworker's determination that a parent endangers their child's health and well-being.¹³⁸ Among the risk factors allowing for such intervention are parental depression, other mental health issues, and parental substance abuse.¹³⁹

Commentators lament that the current child welfare system is punitive and adversarial—mostly focusing on finding parental fault—yet miserably failing to prevent harm to children and protect them against serious maltreatment.¹⁴⁰ To remedy the broken child protective services system, Professor Josh Gupta-Kagan calls for implementing a public health approach in the area of child welfare.¹⁴¹ But applying primary prevention alone, he argues, is insufficient to protect children, therefore a public health approach must also integrate secondary and tertiary prevention.¹⁴² His recommendations for reform focus on strengthening medical institutions and expanding the power of medical health professionals to implement medical solutions. Among others, Gupta-Kagan advocates for a public health approach that involves the medical profession universally screening pregnant and postpartum women for substance abuse problems using evidence-based screening tools.¹⁴³

Similarly, Professor Maxine Eichner identifies a medicalization problem in child abuse cases, wherein doctors adopt a vague and unreliable theory of parents who allegedly seek unnecessary medical treatment for their children.¹⁴⁴ She warns against the risks stemming from courts' reliance on the broad notion of medical child abuse as broadly conceptualized by doctors, which puts all decisionmaking power in the hands of medical experts.¹⁴⁵

The treatment of homelessness is yet another example of medicalization. Conventional wisdom is that deinstitutionalization of patients from psychiatric care was largely responsible for the increase in homelessness.¹⁴⁶ Research suggests, however, that

137. See Jessica M. Eaglin, *The Drug Court Paradigm*, 53 AM. CRIM. L. REV. 595, 631–34 (2016); Miller, *supra* note 132, at 1542–47.

138. See Cynthia Godsoe, *Parsing Parenthood*, 17 LEWIS & CLARK L. REV. 113, 123–24 (2013).

139. *Risk and Protective Factors*, CTRS. FOR DISEASE CONTROL & PREVENTION, <http://www.cdc.gov/violenceprevention/childabuseandneglect/riskprotectivefactors.html> [<http://perma.cc/KZ42-XL8T>] (last visited May 1, 2022).

140. See, e.g., Marsha Garrison, *Reforming Child Protection: A Public Health Perspective*, 12 VA. J. SOC. POL'Y & L. 590, 621–30 (2005); Cynthia Godsoe, *Just Intervention: Differential Response in Child Protection*, 21 J.L. & POL'Y 73, 78 (2012); Godsoe, *supra* note 138, at 142.

141. See Gupta-Kagan, *supra* note 73, at 922.

142. See *id.* at 922–23.

143. *Id.* at 962–63.

144. See Maxine Eichner, *Bad Medicine: Parents, the State, and the Charge of "Medical Child Abuse"*, 50 U.C. DAVIS L. REV. 205, 210–12 (2016).

145. See *id.* at 239–306.

146. See Michael L. Perlin, *Competency, Deinstitutionalization, and Homelessness: A Story of Marginalization*, 28 HOUS. L. REV. 63, 67 (1991).

this is a misconceived notion because only about one-third of homeless people suffer from severe mental illness, and roughly one-fourth of homeless people have been released from inpatient care.¹⁴⁷ The vast majority of homeless people do not suffer from severe mental illnesses, even if becoming homeless might result in their developing such illness.¹⁴⁸ Thus, deinstitutionalization from mental institutions is *not* the sole cause of the increase in homelessness. Instead, the increase in homelessness is the result of economic policies, classism, and racism, whose effect is the continued marginalization of homeless people.¹⁴⁹ The purported connection between homelessness and mental illness is misleading because it obscures a host of policy failures including the failure to address fair housing and unemployment.¹⁵⁰ Furthermore, commentators caution that the trend of medicalization of poverty carries similar effects as the criminalization of poverty—including incapacitation, dependency, and racial and gender bias—urging policymakers to disconnect poverty from medical care.¹⁵¹

The literature on medicalization of a host of social problems, however, has yet to consider its implications for the domestic violence realm. To date, neither criminal law nor health law scholarship has identified domestic violence perpetration as one area which is also subject to medicalization. Yet, analogizing the treatment of domestic violence to the aforementioned legal areas in which a therapeutic approach has been implemented suggests that the medicalization of domestic violence is inevitable.

Concededly, there is a key difference between domestic violence and social problems like homelessness and drug abuse: the latter concern victimless behaviors that mostly cause harm to self, whereas the former inflicts harm on specific victims. Yet, the therapeutic approach (which has already been thoroughly implemented in other areas) will inescapably be adopted in the domestic violence realm because domestic violence, at its core, is a public health issue. The medicalization phenomenon, as manifested in the aforementioned areas that are analogous to domestic violence, illustrates that a public health and a therapeutic medical approach to social problems including domestic violence are not only inextricably intertwined but also inevitably inseparable.

One of the implications of this connection between public health and medicalization is manifested in many jurisdictions' increasing reliance on mental health measures in treating domestic violence. In particular, this emerging trend is illustrated in the domestic violence context through the adoption of therapeutic public health strategies to address battering. These include incorporating mental health interventions aimed at treating batterers to prevent escalation or increased frequency of domestic violence, as described below.

147. See Sidney D. Watson, *Discharges to the Streets: Hospitals and Homelessness*, 19 ST. LOUIS. U. PUB. L. REV. 357, 359–63 (2000) (noting that the prevalence of severe mental problems among homeless people ranges from twenty-five to fifty percent, though approximately thirty percent is an oft-cited number).

148. See Perlin, *supra* note 146, at 69.

149. See *id.* at 68.

150. *Id.* at 74–79.

151. See William M. Sage & Jennifer E. Laurin, *If You Would Not Criminalize Poverty, Do Not Medicalize It*, 46 J.L., MED. & ETHICS 573 (2018).

B. *How Domestic Violence Is Medicalized*

The concern that mental health interventions will gradually replace carceral responses to domestic violence is not merely theoretical. Various jurisdictions have already begun to medicalize domestic violence, thus demonstrating that a therapeutic approach is currently embedded within existing responses to battering.¹⁵² This emerging trend will likely continue in the noncarceral state; it is predicted a public health approach will substitute carceral interventions to address domestic violence by implementing therapeutic approaches that integrate mental health interventions for batterers.¹⁵³

Social scientists increasingly recognize that a therapeutic approach to domestic violence is superior to existing intervention models that largely rely on carceral measures.¹⁵⁴ Conceding that many domestic violence incidents are driven by stressors like substance abuse and mental illness has led to the emergence of an individualized approach to domestic violence that focuses on treating the specific batterer based on the root causes underlying their battering. Professor Linda Hamilton Krieger notes that adopting a public health approach “would reveal the complex web of individual and environmental determinants that contribute to intimate partner violence and refocus efforts on therapeutic interventions and harm reduction strategies.”¹⁵⁵

The emerging enthusiasm for therapeutic approaches to domestic violence aligns with legal scholarship’s increasing emphasis on evidence-based reforms to the criminal legal system.¹⁵⁶ In recent years, criminal law scholars broadly agree that reforming the criminal legal system should prioritize policies and practices that rest on a measurable

152. See Part II.B.1 for a discussion of batterer intervention programs implemented in Colorado and Florida. See also ANGELA R. GOVER, TARA N. RICHARDS & ELIZABETH A. TOMSICH, COLORADO’S INNOVATIVE RESPONSE TO DOMESTIC VIOLENCE OFFENDER TREATMENT: CURRENT ACHIEVEMENTS AND RECOMMENDATIONS FOR THE FUTURE 2–5 (2015), http://mdsoar.org/bitstream/handle/11603/5400/Final%20Crime%20Brief_2.10%20copy.pdf?sequence=1&isAllowed=y [<http://perma.cc/WRS6-3ST5>].

153. See generally Capers, *supra* note 13, at 56 (arguing that in a future noncarceral legal regime, individuals who engage in crimes of violence might be punished, but the core of that punishment will likely be treatment and therapy to work through anger issues). While this Article largely focuses on the implications of the medicalization of domestic violence for *batterers*, an additional facet of the medicalization of domestic violence under a public health approach concerns its implications on domestic violence *survivors*. The medicalization of survivors of domestic violence is also manifested in the reliance by psychiatrists, psychologists, and courts on the medicalized label “battered woman syndrome” to mitigate the punishment of women who killed their abusive intimate partners. Discussion of the problems stemming from the medicalization of domestic violence survivors who became criminal defendants exceeds the scope of this Article. In another article, titled *Survival Homicide*, I address the medicalization of domestic violence through survivors’ lens, and propose a designated homicide offense that incorporates defendants’ survival motive for killings that occur in the context of domestic battering. A draft is on file with the author.

154. See EDWARD W. GONDOLF, SUPPLEMENTAL MENTAL HEALTH TREATMENT FOR BATTERER PROGRAM PARTICIPANTS 1–2, 10 (2007), <http://www.ojp.gov/pdffiles1/nij/grants/223030.pdf> [<http://perma.cc/VZ8Y-6E4R>]; Donald G. Dutton & Kenneth Corvo, *Transforming a Flawed Policy: A Call To Revive Psychology and Science in Domestic Violence Research and Practice*, 11 AGGRESSION & VIOLENT BEHAV. 457, 459 (2006).

155. GOODMARK, *supra* note 7, at 74 (citing Professor Linda Hamilton Krieger).

156. See Brandon L. Garrett, *Evidence-Informed Criminal Justice*, 86 GEO. WASH. L. REV. 1490, 1496 (2018).

scientific empirical basis.¹⁵⁷ Drawing on insights from the scientific and medical fields, evidence-based decisionmaking uses quantitative analysis to evaluate the efficacy of reforms.¹⁵⁸

Similarly, employing a therapeutic approach to domestic violence relies on evidence-based reforms as underlying the treatment of domestic batterers. As the following discussion demonstrates, this position privileges quantitative scientific medical and psychological data, generated by the professional expertise of doctors and mental therapists instead of generalized, one-size-fits-all models.

1. Batterer Intervention Programs

Batterer intervention programs (BIPs) are extensively used in all states in an attempt to change batterers' behaviors.¹⁵⁹ These court-mandated programs are imposed as part of a pretrial diversion where a batterer agrees to obtain treatment in exchange for a nonprosecution agreement as part of a plea agreement or, alternatively, as one of the conditions of probation.¹⁶⁰

Social science literature identifies two competing approaches underlying the operation of BIPs: one embraces the feminist power-and-control model (discussed earlier in this Article in connection with domestic violence typology¹⁶¹) whereas the other rests on a gender-neutral therapeutic model.¹⁶² The power-and-control model emphasizes the need to protect female victims, as well as batterers' accountability, by encouraging men to take responsibility for their aggression.¹⁶³ In contrast, a primary goal of the therapeutic model is treating and rehabilitating the individual batterer by addressing the root causes leading to their abusive behavior, including substance abuse and mental illness.¹⁶⁴

Most state standards for BIPs have embraced the power-and-control approach under some variation of what is commonly known as the Duluth Model.¹⁶⁵ This model adopts a gender-based, cognitive-behavioral, and psychoeducational approach, which is aimed at changing men's attitudes—and, ultimately, behaviors—towards their female intimate partners.¹⁶⁶ Duluth-based programs are typically administered in group sessions, and as such, do not include any individualized treatment of batterers, including for mental disorders and substance abuse problems.¹⁶⁷

157. See RACHEL E. BARKOW, PRISONERS OF POLITICS: BREAKING THE CYCLE OF MASS INCARCERATION 15 (2019).

158. *Id.*; Garrett, *supra* note 156, at 1496.

159. See GOODMARK, *supra* note 7, at 58–62.

160. See Thomas L. Hafemeister, *If All You Have Is a Hammer: Society's Ineffective Response to Intimate Partner Violence*, 60 CATH. U. L. REV. 919, 995 (2011); Betsy Tsai, *The Trend Toward Specialized Domestic Violence Courts: Improvements on an Effective Innovation*, 68 FORDHAM L. REV. 1285, 1302–03 (2000).

161. See *supra* Part I.A.

162. See Ramsey, *supra* note 52, at 370.

163. See *id.* at 359–61.

164. *Id.* at 380–82.

165. See *supra* Part I.A.

166. See Ramsey, *supra* note 52, at 363.

167. See Julia Babcock, Nicholas Armenti, Clare Cannon, Katie Lauve-Moon, Fred Buttell, Regardt Ferreira, Arthur Cantos, John Hamel, Don Kelly, Cathleen Jordan, Peter Lehmann, Penny A. Leisring, Christopher Murphy, K. Daniel O'Leary, Sarah Bannon, Katie Lee Salis & Ingrid Solano, *Domestic Violence*

Recently, a growing number of social science studies have suggested that this prevalent approach to BIPs is only minimally effective at decreasing domestic violence.¹⁶⁸ Research has found that the main drawback in most existing BIPs is their reliance on a one-size-fits-all model that provides a single type of intervention to all batterers without regard to their underlying conditions or their specific treatment needs.¹⁶⁹ Studies further found that Duluth-based programs ignore the role of a myriad of risk factors and life stressors that correlate with domestic violence, including substance abuse, mental disorders, and child trauma.¹⁷⁰

In response to these findings, a therapeutic approach has emerged as an alternative model for treating batterers. Mental health specialists advocate for the adoption of an evidence-based approach to BIPs, which targets the specific root causes that drive the battering in particular cases and employs therapeutic measures to individual batterers.¹⁷¹ Treatment programs, they argue, should distinguish between different types of batterers based on specific treatment needs while considering risk factors, including mental health conditions and substance abuse.¹⁷² Moreover, the argument continues, since some batterers pose more danger to their intimate partners than others, BIPs should be designed according to batterers' specific risk level for future violence, dictating differences in treatment plans.¹⁷³

A major component of therapeutic approaches consists of using psychological screenings that integrate risk assessment instruments (RAIs) in evaluating batterers' risks of recidivism for future violence, and assigning differentiated interventions based on these tools. Multiple studies demonstrate that using structured RAIs increases the accuracy of predicting domestic batterers' risk of future violence.¹⁷⁴ A host of domestic violence RAIs have been developed to identify the risk of additional assault, the severity of the assault, and the potential risk of lethal violence.¹⁷⁵ For example, the Spousal

Perpetrator Programs: A Proposal for Evidence-Based Standards in the United States, 7 PARTNER ABUSE 355, 360–61 (2016), <http://escholarship.org/uc/item/20m2s2n8> [<http://perma.cc/RZ4G-U3FH>].

168. *See id.* at 364.

169. *Id.* at 367.

170. *See* Dutton & Corvo, *supra* note 154, at 459; Ken Corvo & Pamela J. Johnson, *Vilification of the "Batterer": How Blame Shapes Domestic Violence Policy and Interventions*, 8 AGGRESSION & VIOLENT BEHAV. 259, 260 (2003).

171. *See, e.g.*, George L. Lindenfeld, John T. Hummer & Katherine Billiot, *Anger and Aggression: A New Beginning?* 59 FAM. CT. REV. 161, 161–163 (2021); John Hamel, *Evidence-Based Domestic Violence Perpetrator Treatment*, DV TRAININGS, <http://domesticviolencetrainings.org/evidence-based-domestic-violence-perpetrator-treatment> [<http://perma.cc/NW8K-MHZW>] (last visited May 1, 2022).

172. Hamel, *supra* note 171.

173. *See* Babcock et al., *supra* note 167, at 379–80; *see also* Martin Rettenberger & Reinhard Eher, *Actuarial Risk Assessment in Sexually Motivated Intimate-Partner Violence*, 37 LAW & HUM. BEHAV. 75, 76 (2013).

174. *See* Sarah L. Desmarais & Samantha A. Zottola, *Violence Risk Assessment: Current Status and Contemporary Issues*, 103 MARQ. L. REV. 793, 794–99 (2020).

175. *See* Tonia L. Nicholls, Michelle M. Pritchard, Kim A. Reeves & Edward Hilterman, *Risk Assessment in Intimate Partner Violence: A Systemic Review of Contemporary Approaches*, 4 PARTNER ABUSE 76, 79 (2013). One commonly used risk assessment instrument is the Danger Assessment, developed by Dr. Jacquelyn Campbell, which is used to determine the level of danger an abused woman has of being killed by her intimate partner. It contains several risk factors which are associated with increased risk of homicide of people in violent

Assault Risk Assessment comprises twenty items including criminal history, psychological adjustment, spouse abuse history, current offence characteristics, and others.¹⁷⁶ Other RAIs specifically measure individual psychological history, psychopathology, and substance abuse.¹⁷⁷

The emerging understanding that treatment programs must be individually tailored to batterers' underlying conditions and their specific risk level has led some jurisdictions to reform their BIP by adopting a therapeutic approach that uses RAIs and mental health treatment.¹⁷⁸ Most state standards for BIP already include screening for mental illness at the intake stage; batterers with mental illness are referred to outside providers, rather than as part of the BIP.¹⁷⁹ But some states include individualized mental treatment in their BIP programs.¹⁸⁰

For example, Colorado and Florida have already adopted a therapeutic approach to battering. Colorado's standards for BIPs implement treatment plans that use a uniform RAI and differentiated treatment levels.¹⁸¹ Colorado's risk assessment tool is called the Domestic Violence Risk & Needs Assessment (DVRNA) and is designed to identify risk factors to be considered in determining the appropriate level of treatment intensity for an individual batterer.¹⁸² DVRNA is composed of fourteen domains of risk factors, which are measured along two dimensions: (1) criminogenic factors including substance abuse, psychopathy, and pro-offending activities; and (2) noncriminogenic factors including impulsivity, anxiety, and suicidal thoughts.¹⁸³ Based on their risk for future violence, batterers are placed into one of three categories (A through C) to delineate the intensity of treatment (low, moderate, or high).¹⁸⁴ Mental illness is designated as a significant risk factor that indicates initial treatment placement in level B at a minimum.¹⁸⁵ Moreover, depression and suicidal thoughts are designated as critical risk factors because of the increased association between these mental conditions and intimate partner homicide.¹⁸⁶

Domestic violence courts in Florida have developed programs that integrate therapeutic mental health interventions to individually treat batterers whose risk

relationships. For the contents of the Danger Assessment, see JACQUELYN C. CAMPBELL, DANGER ASSESSMENT, http://www.dangerassessment.org/uploads/DA_NewScoring_2019.pdf [<http://perma.cc/9XMH-CFPL>] (last visited May 1, 2022). I thank Professor Debra Poggrund Stark for directing my attention to the prevalent use of this risk assessment instrument.

176. See P. Randall Kropp & Stephen D. Hart, *The Spousal Assault Risk Assessment (SARA) Guide: Reliability and Validity in Adult Male Offenders*, 24 LAW & HUM. BEHAV. 101, 103 (2000).

177. One example of an RAI that incorporates mental illnesses is the Assessment Scale for Potential Violence (ASP-V). See LENORE E. A. WALKER, *THE BATTERED WOMAN SYNDROME* 327 (3d ed. 2009).

178. See Ramsey, *supra* note 52, at 387.

179. See *id.* at 378.

180. See *id.* at 387–88.

181. See GOVER ET AL., *supra* note 152, at 2–3.

182. See JESSE HANSEN, CHERYL DAVIS, JEANNE M. SMITH & STAN HILKEY, STANDARDS FOR TREATMENT WITH COURT ORDERED DOMESTIC VIOLENCE OFFENDERS: A PROCESS EVALUATION (2016), <http://cdpsdocs.state.co.us/dvomb/Research/Evaluation.pdf> [<http://perma.cc/LWZ4-EXLZ>].

183. See *id.* at 34.

184. *Id.* at 2.

185. *Id.* at 19.

186. *Id.* at 20.

assessment screening indicates that they suffer from serious mental illness.¹⁸⁷ For example, the Miami-Dade County Domestic Violence Court refers domestic violence offenders in civil protection orders and criminal cases to BIPs, which include mental health evaluation.¹⁸⁸ In criminal cases, defendants are transferred to a separate domestic violence mental health program, which provides additional resources to defendants with mental health issues.¹⁸⁹ Defendants are transported to a crisis stabilization unit and, upon stabilization, will return to court for case disposition, which frequently includes treatment and counseling.¹⁹⁰

2. Crisis Intervention Teams

The increasing popularity of crisis intervention teams (CITs) offers yet another example of the growing trend of relying on mental health interventions in lieu of policing when interacting with people suspected of suffering from mental illness, including in domestic violence incidents. Since mental healthcare in the United States is seriously underfunded, police often serve as first responders to most mental health crises.¹⁹¹ The dire shortage in mental health services disproportionately affects race- and class-marginalized populations who often lack access to adequate mental health care.¹⁹²

Initiatives to strengthen mental health interventions have emerged in recent years as a response to multiple incidents where police have fatally shot Black people experiencing crises associated with mental health.¹⁹³ Data show that at least ten percent of 911 calls to police involve some form of mental health crisis.¹⁹⁴ Data also demonstrate that about a quarter of people shot by police in the past five years have been people who suffer from mental illnesses.¹⁹⁵

The acknowledgement that police are not well suited to cope with people suffering from mental illness has increasingly led to calls to substitute mental health professionals for police in responding to potentially volatile encounters with people suffering mental health crises. Recent reforms calling for the defunding of police promote initiatives to

187. See CTR. FOR CT. INNOVATION, MIAMI-DADE COUNTY DOMESTIC VIOLENCE COURT 5 (2018), <http://www.courtinnovation.org/sites/default/files/media/documents/2018-07/miami-dade.pdf> [<http://perma.cc/8SNN-JQAX>].

188. *Id.*

189. *Id.*

190. *Id.*

191. See Stacey A. Tovino, *Psychiatric Restraint and Seclusion: Resisting Legislative Solution*, 47 SANTA CLARA L. REV. 511, 517 (2007).

192. See Morgan, *supra* note 118, at 1416–18. Relatedly, carceral institutions have turned into mental health facilities. See Samantha Michaels, *Chicago's Jail Is One of the Country's Biggest Mental Health Care Providers. Here's a Look Inside*, MOTHER JONES (Jan. 8, 2019), <http://www.motherjones.com/crime-justice/2019/01/chicagos-jail-is-the-one-of-the-countys-biggest-mental-health-care-providers-heres-a-look-inside> [<http://perma.cc/VR45-FMW2>].

193. See Eaglin, *supra* note 103, at 127–28.

194. Mike Maciag, *The Daily Crisis Cops Aren't Trained To Handle*, GOVERNING (Apr. 27, 2016), <http://www.governing.com/archive/gov-mental-health-crisis-training-police.html#:~:> [<http://perma.cc/6CKJ-H4ZX>].

195. Hasan T. Arslan, *Examining Police Interactions with the Mentally Ill in the United States*, in ENHANCING POLICE SERVICE DELIVERY: GLOBAL PERSPECTIVES AND CONTEMPORARY POLICY IMPLICATIONS 95, 98 (James F. Albrecht & Garth den Heyer eds., 2021).

strengthen mental health systems by increasing resources and access to mental healthcare.¹⁹⁶ These reforms seek to recalibrate public spending toward alternative institutions that could increase public safety more effectively and equitably, including mental health institutions.¹⁹⁷

An important component of these reforms consists of replacing police altogether with CITs that are comprised of mental health professionals. CITs are proliferating around the country in response to the lack of community-focused mental health resources and the recognition that mental health professionals are better suited than police to respond to the medical needs of populations suffering from mental illness. CITs also represent an attempt to reduce the dangers inherent in encounters between police and people in mental health crises.¹⁹⁸

The CIT model has significantly transformed in recent years. Originally, CITs consisted of specialized police-based programs where officers were trained to improve their skills in safely and effectively responding to mental health crises.¹⁹⁹ This model has evolved to comprise specially trained police officers collaborating with mental health professionals to de-escalate mental health situations.²⁰⁰ But in recent years, many jurisdictions have been experimenting with CIT models that substitute mental health professionals for police officers in encounters involving people experiencing mental health crises.²⁰¹

CITs are being increasingly employed in many jurisdictions nationwide. For example, Crisis Assistance Helping Out on the Streets (commonly known as CAHOOTS) operates in Eugene, Oregon.²⁰² CAHOOTS uses civilian teams, consisting of a medic and a behavioral specialist, to respond to emergencies involving people with mental health crises.²⁰³ In some cases, they accompany police in an attempt to offer emergency intervention in a safer manner than a typical police response.²⁰⁴ In others,

196. See Eaglin, *supra* note 103, at 127.

197. *Id.* at 128.

198. Katheryn Houghton, *In Montana, Crisis Support Teams Offer Alternatives to Policing Mental Health*, NPR (June 10, 2021, 5:00 AM), <http://www.npr.org/sections/health-shots/2021/06/10/1004744348/in-montana-crisis-support-teams-offer-alternatives-to-policing-mental-health> [<http://perma.cc/RJR7-E62T>].

199. See Amy C. Watson & Anjali J. Fulambarker, *The Crisis Intervention Team Model of Police Response to Mental Health Crises: A Primer for Mental Health Practitioners*, 8 BEST PRACTS. MENTAL HEALTH 71, 73–75 (2012).

200. See Taled El-Sabawi & Jennifer J. Carroll, *A Model for Defunding: An Evidence-Based Statute for Behavioral Health Crisis Response*, 94 TEMP. L. REV. 1, 11 (2021).

201. Stuart M. Butler & Nehath Sheriff, *Innovative Solutions To Address the Mental Health Crisis: Shifting Away from Police as First Responders*, BROOKINGS (Nov. 23, 2020), <http://www.brookings.edu/research/innovative-solutions-to-address-the-mental-health-crisis-shifting-away-from-police-as-first-responders> [<http://perma.cc/S6Y2-ZGPZ>].

202. See Morgan, *supra* note 118, at 1466–69 (discussing diversion programs); see also CAHOOTS: *Crisis Assistance Helping Out on the Streets*, WHITE BIRD CLINIC, <http://whitebirdclinic.org/cahoots> [<http://perma.cc/4HUE-BS9G>] (last visited May 1, 2022).

203. Morgan, *supra* note 118, at 1468. Similarly, the JustCARE program in Seattle, Washington, offers another example of CIT. JustCARE, COLEAD, <http://coleadteam.org/justcare> [<http://perma.cc/DVL7-9RTD>] (last visited May 1, 2022).

204. The Federal Substance Abuse and Mental Health Services Administration (SAMHSA) sets guidelines for teams (such as including a health care professional and connecting people to services) and

they independently respond to mental health crises without police intervention.²⁰⁵ Likewise, Law Enforcement Assisted Diversion/Let Everyone Advance with Dignity (commonly known as LEAD) is another community-based diversion program operating in Seattle, Washington, whose goal is improving public safety and public order while reducing unnecessary intervention from the criminal legal system.²⁰⁶ Another CIT has been operating in Anne Arundel County, Maryland, for several years.²⁰⁷ The model combines various techniques to respond to people's mental health crises, among them sending CITs in lieu of police.²⁰⁸ The CIT is composed of one highly trained police officer paired with an independently licensed clinician.²⁰⁹ CITs respond directly to 911 dispatches involving serious situations, including barricades, weapons in the home, extreme risk protection orders, and domestic violence.²¹⁰

Recent public health reforms in Chicago demonstrate the growing potential for mental health intervention to completely exclude police in emergency situations involving people with mental illness, and instead designate mental health professionals to respond to mental health-related crises. A recent legislative amendment proposed the expansion of the city's public mental health infrastructure by using funds taken from the Chicago Police Department budget.²¹¹ Housed within the Chicago Department of Public Health, a Chicago Crisis Response and Care System would provide twenty-four-hour crisis response teams.²¹² Another reform was recently adopted in Chicago that has mental health clinicians respond to 911 calls instead of police.²¹³ In August 2021, Chicago also

recommends that teams respond to calls without involving law enforcement. SAMHSA, NATIONAL GUIDELINES FOR BEHAVIORAL HEALTH CRISES CASE: BEST PRACTICE TOOLKIT (2020), <http://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf> [<http://perma.cc/38ZY-6D5Y>].

205. Scottie Andrew, *This Town of 170,000 Replaced Some Cops with Medics and Mental Health Workers. It's Worked for Over 30 Years*, CNN (July 6, 2020), <http://cnn.it/3jmQmrr> [<http://perma.cc/DTL9-2NRG>].

206. LEAD NAT'L SUPPORT BUREAU, <http://www.leadbureau.org> [<http://perma.cc/M9YY-RNMA>] (last visited May 1, 2022).

207. See *Crisis Response System*, ANNE ARUNDEL CNTY. MENTAL HEALTH AGENCY, INC., <http://www.aamentalhealth.org/crisisresponsesystem.cfm> [<http://perma.cc/9BM4-TYKH>] (last visited May 1, 2022).

208. *Id.*

209. *Id.*

210. *Id.*

211. *Order 2020-242*, CITY OF CHICAGO OFF. OF THE CITY CLERK (Sept. 9, 2020), <http://chicago.legistar.com/LegislationDetail.aspx?ID=4634468&GUID=14EFE224-617C-408B-A24E-C5D734EF96AA&Options=Advanced&Search=&FullText=1> [<http://perma.cc/3ZWK-3C72>].

212. Elizabeth Weill-Greenberg, *Chicago Lawmakers Push To Build Team of Emergency Responders Who Aren't Police*, APPEAL (Sept. 28, 2020), <http://theappeal.org/chicago-public-mental-healthcare-system-emergency-responder-program> [<http://perma.cc/V534-BQ7U>].

213. *Mental Health Clinicians Will Start Answering Some 911 Calls in Chicago—Instead of Cops*, NBC 5 CHICAGO (July 14, 2021, 7:08 AM), <http://www.nbcchicago.com/news/local/mental-health-clinicians-will-start-answering-some-911-calls-in-chicago-instead-of-cops/2554199/#:~:text=For%20the%20first%20time%20in,for%20%E2%80%9Cbehavioral%20health%20calls.%E2%80%9D> [<http://perma.cc/9A9X-N9X4>].

launched a pilot program wherein a paramedic is dispatched with a mental health clinician for behavioral health calls.²¹⁴

The efficacy of CITs, however, remains unclear. For example, one study found that although CITs diverted more people out of the criminal legal system to psychiatric treatment, CITs did not significantly decrease the number of people killed or injured.²¹⁵ Moreover, the operation of a CIT proves especially effective in circumstances involving people who mostly engage in self-harming behaviors, such as substance addiction crises, psychotic episodes, incidents involving suicidal homeless people, and adolescent depression.²¹⁶ But responding to circumstances involving potential harm to third parties, including intimate partners, proves more challenging. One shortcoming of CITs is their inability to offer alternatives to policing in cases involving people suspected to pose danger to others.²¹⁷

While CITs are already being employed in domestic violence cases, reliance on mental health interventions will likely continue to increase in upcoming years for several reasons. First, there is a growing societal understanding that domestic violence is a public health issue that warrants implementing health-based measures. Second, a serious shortage in mental health services due to lack of funding results in prisons and jails serving as de facto mental health facilities.²¹⁸ In the noncarceral state, however, mental health institutions will be significantly funded, which will ultimately result in expanding their reach. Finally, studies suggest there is some association between mental illness and domestic violence perpetration, as elaborated below.

C. *Correlation Between Battering and Mental Illness*

The association between mental illness and domestic violence must be examined within the context of the general relationship between mental illness and criminal offending. Conventional wisdom holds that people with serious mental illness are disproportionately involved in criminality.²¹⁹ To better address sick people's needs in appropriate and humane ways, reformers call for substituting health-based measures for punitive interventions.²²⁰ Likewise, specialized mental health courts are premised on two assumptions: first, that defendants' underlying mental health conditions cause criminal

214. *Id.*

215. See Michael S. Rogers, Dale E. McNeil & Renée L. Binder, *Effectiveness of Police Crisis Intervention Training Programs*, 47 J. AM. ACAD. PSYCHIATRY & L. 414, 417–18 (2019).

216. See Andrew, *supra* note 205.

217. See Eric Westervet, *Mental Health and Police Violence: How Crisis Intervention Teams Are Failing*, NPR (Sept. 18, 2020, 5:00 AM), <http://www.npr.org/2020/09/18/913229469/mental-health-and-police-violence-how-crisis-intervention-teams-a-re-failing> [<http://perma.cc/S55N-FWKL>].

218. For example, Cook County Jail has become Chicago's largest mental health facility. See Lili Holzer-Glier, *Inside the Massive Jail that Doubles as Chicago's Largest Mental Health Facility*, HUM. TOLL OF JAIL, <http://humantollsofjail.vera.org/the-massive-jail-that-doubles-as-chicagos-largest-mental-health-facility> [<http://perma.cc/8YBM-97TE>] (last visited May 1, 2022).

219. See Johnston, *supra* note 26, at 518–19.

220. See *id.*

behavior; and second, that the primary goal of these courts is to reduce recidivism as treating mental conditions will prevent future criminal behavior.²²¹

Yet, the assumptions about the link between criminal wrongdoing and mental illness are unsupported by empirical evidence. A prevalent explanation for disproportionate representation of offenders with mental illnesses in the criminal legal system lies with the criminalization theory, which posits that the legal system has served as the primary tool of social control over people with serious mental illnesses.²²² Professor Lea Johnston critiques this account, arguing that it rests on intuitive, unverified, and false assumptions about causal links between mental illness and crime.²²³ She posits that studies show that only a small subset of crimes are *caused* by mental illness, and the vast majority of crimes are *not* motivated by any mental disorders.²²⁴ Instead, she continues, similar criminogenic risks that motivate criminality among people without any mental illnesses also account for criminal activity among people with mental illness, offering a more accurate account of the nuanced relationship between mental health and crime.²²⁵ Among the risk factors that predict recidivist violent behavior are antisocial personality patterns, substance abuse, employment instability, and marital and family problems.²²⁶ One implication of these studies is that treating mental illness alone will not prevent future criminal behavior since mental illness and criminal behavior are not causally linked.²²⁷ Also, there is no evidence that treating symptoms of mental illness reduces recidivism.²²⁸

These understandings similarly apply in the domestic violence context. Studies suggest that the connection between mental illness and domestic violence perpetration is not only overstated but also misperceived.²²⁹

The nature of the association between mental illness and domestic violence remains highly contested among the psychiatric community.²³⁰ A growing number of studies have recently found some correlation between domestic violence perpetration and mental illness.²³¹ For example, a 2014 British meta-analysis found an increased risk of violence

221. See E. Lea Johnston, *Theorizing Mental Health Courts*, 89 WASH. U. L. REV. 519, 521–22 (2012).

222. Johnston, *supra* note 26, at 519–20.

223. See *id.* at 521–22.

224. *Id.* at 533.

225. *Id.* at 533–34.

226. *Id.* at 522, 536–37.

227. See Collins, *supra* note 136, at 1617.

228. See Jennifer L. Skeem, Sarah Manchak & Jillian K. Peterson, *Correctional Policy for Offenders with Mental Illness: Creating a New Paradigm for Recidivism Reduction*, 35 LAW & HUM. BEHAV. 110, 118 (2011).

229. See *infra* notes 231, 237, and 241 for elaboration on psychiatric studies' findings.

230. Etiony Aldarondo & Fernando Mederos, *Common Practitioners' Concerns About Abusive Men*, in PROGRAMS FOR MEN WHO BATTER 2-1, 2-7 (Etiony Aldarondo & Fernando Mederos eds., 2002).

231. See, e.g., S. Oram, K. Trevillion, H. Khalifeh, G. Feder & L.M. Howard, *Systematic Review and Meta-Analysis of Psychiatric Disorder and the Perpetration of Partner Violence*, 23 EPIDEMIOLOGY & PSYCHIATRIC SCIS. 361, 370 (2014), <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC7192171> [<http://perma.cc/6T4K-3JRC>]; Vishal Bhavsar, Kyla Kirkpatrick, Marilia Calcia & Louise M. Howard, *Lockdown, Domestic Abuse Perpetration and Mental Health Care: Gaps in Training, Research, and Policy*, 8 LANCET PSYCHIATRY 172, 172 (2021), [http://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366\(20\)30397-7/fulltext](http://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(20)30397-7/fulltext) [<http://perma.cc/7C87-WR4P>].

toward an intimate partner among people with depression, generalized anxiety disorder, and panic disorder.²³² The authors of this study reached a two-pronged conclusion. First, psychiatric disorders are associated with a high prevalence of and increased odds for committing physical violence against an intimate partner, and a history of such violence is a predictor of current violence.²³³

Second, the authors stressed their inability to draw conclusions about whether a causal relationship exists between psychiatric disorders and perpetration of violence against intimate partners.²³⁴ While the purpose of the study was to try to establish that an increased risk of future violence against partners exists among people with diagnosed psychiatric disorders, the findings did not support such a hypothesis. Moreover, although people with psychiatric disorders are more likely to have a history of having been physically violent toward a partner compared with people with no psychiatric disorders, “there is little data on whether this is the case during episodes of illness or is entirely explained by substance misuse.”²³⁵

Some studies have found that psychiatric symptoms manifested in domestic violence cases that resulted in homicide, and particularly femicide—the killing of women by their intimate partners.²³⁶ For example, one study that examined 1,431 family homicide cases (1,180 involving homicide of an intimate partners and 251 involving homicide of another adult family member) found that twenty percent of those who killed their intimate partners had symptoms of mental illness at the time of the offense.²³⁷ Thirty percent of perpetrators with symptoms of mental illness at the time of the offense had been in contact with mental health services in the year before the homicide.²³⁸ In addition, one-third of perpetrators of intimate partner homicide had a lifelong diagnosis of mental illness.²³⁹

Yet, showing that a certain percentage of domestic violence offenders also had mental illness does not suggest that people with mental disorders are more likely to become domestic batterers. This study was also unable to conclude whether there was a causal relationship between psychiatric disorders and the perpetration of violence against intimate partners. The authors conceded that their results suggest that “policy makers are likely to face considerable challenges in identifying the risk of, or preventing, domestic homicide.”²⁴⁰

Similarly, the largest nationwide epidemiological study to date—published in 2019 following a collaboration between British, American, and Swedish

232. Oram et al., *supra* note 231, at 361, 373.

233. *Id.* at 370.

234. *Id.* at 373.

235. *Id.* at 372.

236. For a recent discussion of femicide as a continuing phenomenon that endangers the lives of many women and a distinct form of gender-based violence, see *Commonwealth v. Paige*, 177 N.E.3d 149, 157–61 (Mass. 2021) (Cypher, J., concurring).

237. See Siân Oram, Sandra Marie Flynn, Jenny Shaw, Louis Appleby & Louise Michele Howard, *Mental Illness and Domestic Homicide: A Population-Based Descriptive Study*, 64 PSYCHIATRIC SERVS. 1006, 1008 (2013).

238. *Id.*

239. *Id.*

240. *Id.* at 1010.

researchers—identified an association between the use of violence against intimate partners and documented mental disorders among men.²⁴¹ It found an increase in perpetration of intimate partner violence by people arrested for domestic violence after they had been diagnosed with mental disorders.²⁴² The study found that men diagnosed with depressive disorder, anxiety disorder, alcohol use disorder, drug use disorder, ADHD, or personality disorder were associated with a two- to eight-times higher risk of intimate partner violence against women compared with the general population, and a two- to four-times higher risk of intimate partner violence compared with unaffected siblings.²⁴³

The correlation between mental illness and domestic battering, however, is largely attributed to the “impact of substance misuse and familial influences on both domestic abuse perpetration and mental disorders, including childhood adversity.”²⁴⁴ The study’s authors stress that the risk of battering by people with mental disorders was especially increased with comorbid substance abuse and personality disorders. The association between mental illness and domestic violence was only attenuated when comorbidities were accounted for, namely the risk for intimate partner violence was much lower without the comorbidity of substance use disorders.²⁴⁵

Despite the growing number of studies that examined the connection between domestic violence and mental disorders, none of them supports the purported causal link between domestic violence perpetration and mental illness.²⁴⁶ Rather than establishing a *causal* relationship between domestic violence and mental illness, the studies merely point to some modest correlation between the two. The studies reinforce the understanding that while mental health professionals assess and treat a disproportionately large number of domestic batterers, mental disorders and perpetration of domestic violence are not causally linked.²⁴⁷

Moreover, these studies show that even if domestic batterers are largely more likely than nonviolent individuals to exhibit depression, psychopathy, or evidence of borderline or antisocial personality disorders, the reasons that account for their battering of intimate partners are varied and only rarely can be explained definitively by a single risk factor.²⁴⁸ Instead, domestic batterers tend to be driven by a combination of risk factors including

241. See Rongqin Yu, Alejo J. Nevado-Holgado, Yasmina Molero, Brian M. D’Onofrio, Henrik Larsson, Louise M. Howard & Seena Fazel, *Mental Disorders and Intimate Partner Violence Perpetrated by Men Towards Women: A Swedish Population-Based Longitudinal Study*, 16 PLOS MED. 1, 13 (2019), <http://doi.org/10.1371/journal.pmed.1002995> [<http://perma.cc/2H69-F6WB>].

242. *Id.* at 6, 13.

243. *Id.* at 1–2.

244. See Bhavsar et al., *supra* note 231, at 172–73.

245. *Id.*

246. Similarly, research examining the correlation between mass shootings and mental illness found some modest association between serious mental illness and mass shootings, but emphasized that it was rarely causal. See Jennifer Skeem & Edward Mulvey, *What Role Does Serious Mental Illness Play in Mass Shootings, and How Should We Address It?*, 19 CRIMINOLOGY & PUB. POL’Y 85–108 (2020). It concluded that serious mental illness plays only a limited role in mass shootings and is neither a necessary nor a sufficient condition for mass violence. *Id.* The authors stressed other major risk factors for violence shared by people with and without serious mental illness, including substance abuse, antisocial traits, anger, and a history of maltreatment. *Id.*

247. See Bhavsar et al., *supra* note 231, at 172–73.

248. See Aldarondo & Mederos, *supra* note 230, at 2–7.

substance abuse, entrenched grievances, personal setbacks, depression, rage, suicidal urges, and, only in some cases, serious behavioral disorders or mental illness.²⁴⁹

Carefully scrutinizing these studies is imperative because mischaracterizing the nature of the relationship between mental illness and domestic violence is not only flawed but also dangerous. First, overstating the modest correlation between domestic violence and mental illness risks further stigmatization of mental illness, which continues to permeate American society.²⁵⁰ Health law scholars have extensively documented the stigmatization of mental illness.²⁵¹ Erroneously conflating correlation with causation in domestic violence exacerbates this persistent stigma.²⁵²

Second, overstating the correlation between domestic violence and mental illness sustains common misunderstandings surrounding the conceptualization of domestic violence.²⁵³ It masks various underlying conditions—such as poverty and alcohol and drug abuse—that often drive domestic violence.²⁵⁴ Moreover, overemphasizing the role of mental illness in domestic battering contributes to the continued misunderstanding of the dynamics of domestic violence.²⁵⁵ Doing so obscures the fact that domestic violence is often a socially constructed behavior.²⁵⁶ Mental illness plays no role in coercive controlling, which accounts for a significant number of domestic violence incidents.²⁵⁷

Third, overstating the role of mental illness in domestic violence perpetration conceals the expressive message that battering is a wrongful and blameworthy behavior that warrants societal condemnation.²⁵⁸ Erroneously portraying domestic battering as motivated by mental illness thus impedes this message because batterers' agency is a prerequisite for placing blame. Finally, the aforementioned empirical evidence casts doubt on whether the medicalization of domestic violence is justified. Exaggerating the association between mental illness and domestic violence raises concerns about overmedicalization of this social problem, as the next Part demonstrates.

D. *Quaternary Prevention*

Conceding that the treatment of domestic violence is increasingly becoming medicalized raises the question of what could be wrong with mental health interventions. Critics are likely to be skeptical about my concerns regarding medicalization of domestic violence by arguing that medical treatment of batterers is preferable to criminalization. In response, I argue that mental treatment is a superior solution compared to carceral sanctions, but only if it is medically warranted. When medicalization is used excessively, concerns about overmedicalization arise.

249. See Bhavsar et al., *supra* note 231, at 172–73.

250. See STEPHEN P. HINSHAW, THE MARK OF SHAME: STIGMA OF MENTAL ILLNESS AND AN AGENDA FOR CHANGE 28–52, 93–114, 140 (2007).

251. See Michael E. Waterstone & Michael Ashley Stein, *Disabling Prejudice*, 102 NW. U. L. REV. 1351, 1363 (2008).

252. See Yu et al., *supra* note 241, at 12.

253. *Id.*

254. *Id.* at 12–13.

255. See Bhavsar et al., *supra* note 231, at 172–73.

256. See *supra* Part I.A.

257. See *supra* Part I.A.

258. See DEMPSEY, *supra* note 5, at 91–93.

Most scholarly critique of medicalized interventions in a variety of areas centers on resistance to and contestation of medicalization, highlighting risks of overmedicalization.²⁵⁹ Overmedicalization is largely defined as *unjustifiably* subjecting patients to overdiagnosis and overtreatment.²⁶⁰ Medicalization is wrong “when the institution of medicine oversteps its proper limits.”²⁶¹ This Article, which cautions against the adverse consequences of overmedicalization of domestic violence, joins existing literature that largely views medicalization in a negative light.²⁶²

Social scientists have expressed skepticism about the continual expansion of medical jurisdiction, highlighting the need to better distinguish between justified and unjustified medical intervention.²⁶³ Studies suggest a series of guiding questions to facilitate the distinction between medicalization and overmedicalization by asking whether medicine provides the most adequate method of understanding a problem and its causes, and whether it is the most effective and safest method to treat a problem.²⁶⁴ Moreover, illness categories and medical diagnoses are socially constructed, rather than automatically determined from medical diagnoses.²⁶⁵ The tools that medicine offers may not be adequate to address the complex social problem of domestic violence, which is at its core a social, economic, and cultural problem, rather than a medical one.

Medical literature has long proposed ways to ameliorate overmedicalization by suggesting that doctors consider quaternary prevention in deciding treatment options.²⁶⁶ Medical practitioners have coined the term quaternary prevention, often referred to as P4, to define actions taken to identify patients at risk of overmedicalization, protect them from medical invasion, and suggest interventions that are ethically acceptable.²⁶⁷ Quaternary prevention means prevention *from* medicine, namely methods to mitigate or avoid the results of unnecessary or excessive interventions by health systems, increase patients’ protection from unnecessary medical intervention, and consider ethical alternatives.²⁶⁸ These also include quaternary prevention in mental health.²⁶⁹

259. See Conrad & Stults, *supra* note 116, at 330.

260. See Armando Henrique Norman & Charles Dalcanale Tesser, *Quaternary Prevention: A Balanced Approach to Demedicalisation*, 69 BRIT. J. GEN. PRAC. 28, 28–29 (2019).

261. See Erik Parens, *On Good and Bad Forms of Medicalization*, 27 BIOETHICS 28, 30 (2013).

262. Some scholars identify positive implications of medicalization as a way to decrease health disparities and promote individuals’ civil rights, suggesting that its benefits outweigh its harms. See, e.g., Konnoth, *supra* note 20, at 1171; Dayna Bowen Matthew, *Health and Housing: Altruistic Medicalization of America’s Affordability Crisis*, 81 LAW & CONTEMP. PROBS. 161, 192–94 (2018); Kimberly D. Krawiec, Julia D. Mahoney & Sally L. Satel, *Foreword: Altruism, Community, and Markets*, 81 LAW & CONTEMP. PROBS. 1, 6–7 (2018).

263. See Conrad & Stults, *supra* note 116, at 333.

264. Emilia Kaczmarek, *How To Distinguish Medicalization from Over-Medicalization?*, 22 MED. HEALTH CARE & PHIL. 119, 123 (2019), <http://pubmed.ncbi.nlm.nih.gov/29951940> [<http://perma.cc/CW5L-4WRL>].

265. See Conrad & Stults, *supra* note 116, at 332.

266. See Marc Jamouille, *Quaternary Prevention, an Answer of Family Doctors to Overmedicalization*, 4 INT’L J. HEALTH POL’Y & MGMT. 61, 62 (2015).

267. See Carlos Martins, Maciek Godycki-Cwirko, Bruno Heleno & John Brodersen, *Quaternary Prevention: Reviewing the Concept*, 24 EUR. J. GEN. PRAC. 106, 106–11 (2018).

268. See Norman & Tesser, *supra* note 260, at 28.

269. K.L. Lazo Chavez, *On Purpose of Multiple Cases: Quaternary Prevention on Mental Health – “Primum Non-Nocere”*, 41 EUR. PSYCHIATRY S581, S581 (2017).

While medical researchers have long identified the need to incorporate quaternary prevention, this concept has yet to be recognized in legal literature.²⁷⁰ Integrating insights gained from medical studies into law by applying quaternary prevention in the domestic violence context is warranted because abandoning criminalization as the primary tool for addressing domestic violence will result in subjecting domestic batterers to overmedicalization. Quaternary prevention is necessary for protecting batterers from the harm resulting from overdiagnosis and overtreatment. Recent domestic violence research has underscored the drawbacks of applying disproportional interventions; over-intervening may encroach on the expression of an individual's own coping strategies, which may increase the likelihood of experiencing negative outcomes such as recidivism.²⁷¹ Providing unnecessarily intensive psychological services is not only wasteful of limited resources but also potentially harmful.²⁷²

The remainder of this Article proceeds from the assumption that an inevitable feature of overhauling carceral responses to domestic violence will be overmedicalization of this problem. Substituting mental health interventions for carceral ones should, therefore, take into account the risks embedded in the overmedicalization of domestic violence, which the next Section elaborates on.

III. THE RISKS OF OVERMEDICALIZATION

Adopting mental health interventions raises a myriad of concerns, as noncriminal preventive measures also pose significant risks to individual liberties.²⁷³ States' extensive reliance on the prevention paradigm in a wide variety of legal areas—ranging from preventive detention in the terrorism context to expansive understandings of the doctrines of attempt and conspiracy—often results in misuse, abuse, and overinclusiveness.²⁷⁴

A key tenet underlying any alternative to criminalization is that nonpunitive civil measures remain necessary for preventing harm to intimate partners.²⁷⁵ Abandoning the criminal legal system as the main vehicle responsible for prevention of domestic violence cannot leave an institutional vacuum because it would endanger victims' health and safety. A victim-centered approach to preventing the multiple harms of domestic

270. A Westlaw search that included the search term “quaternary prevention” yielded only three results. See WESTLAW EDGE, <http://1.next.westlaw.com/Search/Home.html?transitionType=Default&contextData=%28sc.Default%29> [http://perma.cc/9KHS-78LV] (last visited May 1, 2022) (search for “quaternary prevention”).

271. See Henrik Belfrage, Susanne Strand, Jennifer E. Storey, Andrea L. Gibas, P. Randall Kropp & Stephen D. Hart, *Assessment and Management of Risk for Intimate Partner Violence by Police Officers Using the Spousal Assault Risk Assessment Guide*, 36 LAW & HUM. BEHAV. 60, 66 (2012).

272. See Joel A. Dvoskin, Jennifer L. Skeem, Raymond W. Novaco & Kevin S. Douglas, *What If Psychology Redesigned the Criminal Justice System?*, in USING SOCIAL SCIENCE TO REDUCE VIOLENT OFFENDING 291, 297 (2011).

273. See, e.g., Christopher Slobogin, *A Jurisprudence of Dangerousness*, 98 NW. U. L. REV. 1, 1–3 (2003); DOUGLAS HUSAK, OVERCRIMINALIZATION: THE LIMITS OF THE CRIMINAL LAW 159–77 (2007).

274. See generally Michal Buchhandler-Raphael, *Overcriminalizing Speech*, 36 CARDOZO L. REV. 1667, 1678 (2015) (noting the expansion in endangerment crimes that rest on the preventive paradigm).

275. See NAT'L INST. OF CORR., A FRAMEWORK FOR EVIDENCE-BASED DECISION MAKING IN STATE AND LOCAL CRIMINAL JUSTICE SYSTEMS 10 (4th ed. 2017).

violence, as urged in this Article, requires states to adopt nonpunitive tertiary prevention measures that would prioritize promoting victims' health and safety.

States' power to protect the public's health and safety exceeds the criminal law's domain and extends into the realm of public health.²⁷⁶ The U.S. Supreme Court's jurisprudence has long recognized states' regulatory interest in the public's safety and health.²⁷⁷ Throughout American history, states have enacted expansive public health statutes to promote the public's general welfare.²⁷⁸ It is also broadly agreed that the government's interest in the community's health and safety may outweigh individuals' liberty interests in appropriate circumstances.²⁷⁹

While the protection of the public's health and safety has traditionally been entrusted to the police, states will retain this responsibility even after the police are defunded. States' police powers are conceptually and historically different from police as an institution and from the modern understanding of policing itself.²⁸⁰ Once the role for police is diminished, the power to protect the public's health and safety will be shifted to newly funded state institutions, which will step in to take on police's role. This power stems from the authority to exercise police powers and regulate various aspects affecting domestic victims' health and safety that all states will continue to exercise.²⁸¹

If alternatives to carceral measures included only voluntary treatments, mental health interventions would not be problematic. But if these alternatives incorporated involuntary, state-mandated interventions, significant concerns arise.

276. The Tenth Amendment to the U.S. Constitution grants states police powers. See Lawrence O. Gostin, *When Terrorism Threatens Health: How Far Are Limitations on Personal and Economic Liberties Justified?*, 55 FLA. L. REV. 1105, 1109 n.9 (2003).

277. See, e.g., *Jacobson v. Massachusetts*, 197 U.S. 11, 39 (1905) (upholding compulsory vaccination for smallpox outbreak).

278. See Lawrence O. Gostin, Scott Burris & Zita Lazzarini, *The Law and the Public's Health: A Study of Infectious Disease Law in the United States*, 99 COLUM. L. REV. 59, 128 (1999).

279. See Stephen J. Morse, *Uncontrollable Urges and Irrational People*, 88 VA. L. REV. 1025, 1052–53 (2002).

280. See James G. Hodge, Jr., *The Role of New Federalism and Public Health Law*, 12 J.L. & HEALTH 309, 309–11 (1998).

281. See George Bach, *Federalism and the State Police Power: Why Immigration and Customs Enforcement Must Stay Away from State Courthouses*, 54 WILLAMETTE L. REV. 323, 328 (2018). The U.S. Supreme Court addressed whether states have a duty under the Due Process Clause to protect their citizens against harms perpetrated by domestic batterers. In *Town of Castle Rock v. Gonzales*, 545 U.S. 748 (2005), the Court held that states are not required under the Due Process Clause to enforce protective orders in domestic violence cases. *Id.* at 760, 766. While the holding foreclosed the avenue for a constitutional remedy, it did not address other potential avenues that might provide redress to domestic violence victims, including a civil rights basis underlying states' duty to protect their citizens against gender-based violence. For critique of the *Castle Rock* decision, see, for example, Zanita E. Fenton, *State-Enabled Violence: The Story of Town of Castle Rock v. Gonzales*, in *WOMEN AND THE LAW STORIES* 379, 380, 404–08 (Elizabeth M. Schneider & Stephanie M. Wildman eds., 2011); Zanita E. Fenton, *Disarming State Action; Discharging State Responsibility*, 52 HARV. C.R.-C.L. L. REV. 47 (2017); G. Kristian Miccio, *The Death of the Fourteenth Amendment: Castle Rock and Its Progeny*, 17 WM. & MARY J. WOMEN & L. 277 (2011). Elaborating on the extent to which states have a duty to protect their citizens from the harms of gender-based violence exceeds the scope of this Article, and I plan to address it in future work. For the purposes of this Article, it suffices to stress that my argument rests on the premise that states have a legal duty to protect citizens from gender-based violence and that the responsibility for protecting their health and safety remains in the hands of states.

States' coercive power is by no means limited to criminal law and policing functions. Preventive measures may reproduce similar concerns to those created by the criminal legal system, even if they are nonpunitive in nature.²⁸² Critics of the expanding scope of public health express concerns about states' authority to coercively intervene under the banner of public health, warning that states' power of coercion must be carefully limited to prevent violations of individual rights.²⁸³ The Parts below elaborate on the risks of implementing health measures to reform the treatment of domestic violence. This analysis demonstrates that the risks of overmedicalization are analogous to the documented risks of overcriminalization, overenforcement, and mass incarceration.²⁸⁴

A. *Surveillance, Monitoring, and Reporting*

States' extensive reliance on imprisonment as a way of achieving social control over populations has been thoroughly documented. Professor Jonathan Simon has written extensively on the ways in which the legal system relied on prisons and jails as managerial tools to lock up people for long periods of time even when they did not pose any significant danger to the public.²⁸⁵ Implementing policies and practices that arguably promoted safety and security resulted in mass incarceration—a phenomenon that commentators have thoroughly criticized.²⁸⁶ Furthermore, states' use of carceral measures to exercise social control had a disproportionate effect on communities of color and other minorities, resulting in the marginalization of populations across race, class, and gender lines.²⁸⁷ American society, as Simon succinctly titles his book, “[g]overn[s] [t]hrough [c]rime.”²⁸⁸

Social control of marginalized populations, however, is not a distinct feature of the carceral state and may be similarly exercised by nonpunitive institutions. From World War II until the 1970s, a medicalized approach played a central role in the American penal system.²⁸⁹ Public mental health policy has been cyclical in nature and triggered by reform movements that had sought to transform social problems into mental health issues.²⁹⁰ Recent judicial directions mark the reemergence of the medical model under which prisoners are conceived as afflicted with a host of mental problems, which

282. See Ji Seon Song, *Policing the Emergency Room*, 134 HARV. L. REV. 2646, 2649 (2021); see also SCHENWAR & LAW, *supra* note 29, at 17–24.

283. See Lindsay F. Wiley, *Rethinking the New Public Health*, 69 WASH. & LEE L. REV. 207, 226–31 (2012).

284. For an excellent summary of problems of overcriminalization, overenforcement, and mass incarceration, see Benjamin Levin, *The Consensus Myth in Criminal Justice Reform*, 117 MICH. L. REV. 259, 265–302 (2018).

285. See JONATHAN SIMON, *GOVERNING THROUGH CRIME: HOW THE WAR ON CRIME TRANSFORMED AMERICAN DEMOCRACY AND CREATED A CULTURE OF FEAR* 82, 107–234 (2007) [hereinafter SIMON, *GOVERNING THROUGH CRIME*]; Jonathan Simon, *Racing Abnormality, Normalizing Race: The Origins of America's Peculiar Carceral State and Its Prospects for Democratic Transformation Today*, 111 NW. U. L. REV. 1625 (2017) [hereinafter Simon, *Racing Abnormality*].

286. See SIMON, *GOVERNING THROUGH CRIME*, *supra* note 285, at 131–32.

287. See Simon, *Racing Abnormality*, *supra* note 285, at 1639, 1642–43.

288. SIMON, *GOVERNING THROUGH CRIME*, *supra* note 285, at 73.

289. See Simon, *supra* note 123, at 217, 220.

290. Perlin, *supra* note 146, at 80.

suggests the return of the medicalization approach.²⁹¹ Similarly, commentators warn that the impact of the carceral state extends beyond the documented expansion of incarceration to encompass a range of control mechanisms, including probation, parole, and drug courts.²⁹² Taken together, noncarceral measures could also serve to control and manage populations and result in similar problems that the carceral state has created.

Furthermore, states' responses to the COVID-19 pandemic illustrate how the public health approach, which dominates in governments' interventions in containing the spread of disease, may result in the deprivation of individual rights as states rely on coercive measures deemed necessary for prevention.²⁹³ Involuntary preventive measures to control the harm to the public caused by diseases have long been utilized in American history, such as compulsory quarantine or isolation continuously authorized by state and federal laws.²⁹⁴ The U.S. Supreme Court has repeatedly upheld these measures, agreeing with state governors that the Constitution allows states to require involuntary preventive measures to protect the public.²⁹⁵

Moreover, these public health measures—lockdowns, stay-at-home directives, and quarantine orders—incorporated a variety of enforcement tools, ranging from civil enforcement to criminal punishment, where these measures have been violated.²⁹⁶ The

291. See Simon, *supra* note 123, at 217.

292. See, e.g., MARIE GOTTSCHALK, CAUGHT: THE PRISON STATE AND THE LOCKDOWN OF AMERICAN POLITICS 1–2 (2014).

293. See Jennifer Oliva, *Public Health Surveillance in the Context of Covid-19*, 18 IND. HEALTH L. REV. 107, 119–22 (2021); Jennifer D. Oliva, *Surveillance, Privacy and App Tracking*, in ASSESSING LEGAL RESPONSES TO COVID-19, at 40 (2020).

294. See JOHN FABIAN WITT, AMERICAN CONTAGIONS: EPIDEMICS AND THE LAW FROM SMALLPOX TO COVID-19, 8–10 (2020); Adam Klein & Benjamin Wittes, *The Long History of Coercive Health Responses in American Law*, LAWFARE (Apr. 13, 2020, 2:56 PM), <http://www.lawfareblog.com/long-history-coercive-health-responses-american-law> [<http://perma.cc/29ME-5TU7>].

295. See, e.g., *Friends of Danny DeVito v. Wolf*, 140 S. Ct. 2758 (2020) (denying application for stay of the governor's order to shut down non-life-sustaining businesses); *Jacobson v. Massachusetts*, 197 U.S. 11, 31 (1905) (upholding a vaccination statute enacted by Massachusetts to protect against smallpox, reasoning that a state or local law "enacted to protect the public health" will survive judicial scrutiny unless it bears "no real or substantial relation to [the public health], or is, beyond all question, a plain, palpable invasion of rights secured by the fundamental law"); cf. *Nat'l Fed'n of Indep. Bus. v. OSHA*, Nos. 21A244 & 21A247, slip op. at 13 (U.S. Jan. 13, 2022) (blocking the Biden administration's requirement that employees at large businesses be vaccinated).

296. For example, statistics on social distancing enforcement released by the Brooklyn District Attorney's Office show that, of forty people who were arrested between March and May 2020 for violating social distancing orders, thirty-five of them were Black. Ashley Southall, *Scrutiny of Social-Distance Policing as 35 of 40 Arrested Are Black*, N.Y. TIMES (Nov. 30, 2020) [hereinafter Southall, *Scrutiny*], <http://www.nytimes.com/2020/05/07/nyregion/nypd-social-distancing-race-coronavirus.html> [<http://perma.cc/77NZ-GG6K>]. Enforcement practices of public health orders in New York City raised similar concerns to aggressive stop and frisk practices, as enforcement disproportionately affected minority communities. See Ashley Southall, *N.Y.C. Commissioner Denies Racial Bias in Social Distancing Policing*, N.Y. TIMES (Nov. 5, 2020), <http://www.nytimes.com/2020/05/13/nyregion/nypd-social-distancing-race-coronavirus.html> [<http://perma.cc/7W49-KR3M>].

vigorous enforcement of COVID-19 public health orders raised ample concerns of overenforcement, especially among racial minorities in inner-city neighborhoods.²⁹⁷

Similar concerns animate the emerging turn to a public health approach in the realm of domestic violence prevention. Substituting noncarceral measures for policing requires grappling with the danger of mental health institutions being used as coercive prevention measures, ultimately resulting in managing populations suffering from mental illness.²⁹⁸ Medicalization of domestic violence poses genuine risks of deprivations of individuals' liberties because preventive, noncarceral measures that use mental health interventions carry great risks of overbroad implementation and misuse. The potential for abuse and overinclusiveness stemming from excessive use of these health-based tools reproduces the infamous dangers associated with carceral measures.

Reforms touted as “progressive,” which are aimed at replacing prisons with alternative noncarceral institutions, may suffer from similar problems that characterize the carceral state. Maya Schenwar and Victoria Law examine some key alternatives to incarceration that were recently proposed as part of a more cost-effective, humane response to crime.²⁹⁹ These include electronic monitoring at home, locking down people in substance abuse treatment centers, policing parenthood, community confinement, and others.³⁰⁰ Cautioning against these reforms' unintended consequences, Schenwar and Law argue that purportedly gentle alternatives to prison adopt coercive measures which are likely to exert substantial social control on many individuals.³⁰¹ These alternative measures not only risk transforming people's homes and communities into prisons but may also result in increasing the number of individuals under states' coercive control.³⁰²

While Schenwar and Law's work considers adopting gentler alternatives to carceral measures in a host of legal contexts, it does not touch on the implications of these reforms in the area of domestic violence. Moreover, to date, scholarly works have yet to address the risks stemming from implementing mental health measures in the realm of domestic violence.

Yet, ample concerns about the coercive nature of noncarceral measures animate proposals to substitute a public health approach for criminal interventions to address domestic violence. Social control and population management schemes operate within healthcare systems and are substantially shaped by carceral measures.³⁰³ These include extensive surveillance techniques, behavioral monitoring of people who are defined as dangerous to their intimate partners, and comprehensive state-imposed reporting requirements. One unifying theme characterizing these arguably therapeutic interventions is their involuntary nature—they are state mandated and their compliance is court enforced. When mental health measures become mandatory, rather than voluntary, they raise the same problems that the criminal legal system suffers from.

297. See Southall, *Scrutiny*, *supra* note 296.

298. See SCHENWAR & LAW, *supra* note 29, at 85.

299. *Id.*

300. *Id.* at 25–48, 51–85, 87–114, 141–72, 173–95.

301. *Id.* at 17–18.

302. See *id.* at 17–21; see also Goodmark, *supra* note 7, at 108 (noting that “[p]robation and other community-based services are viable alternatives to incarceration only to the extent that they don't serve to relocate state control from prisons to the community”).

303. See Morgan, *supra* note 118, at 1409, 1424.

Mandatory surveillance of domestic batterers characterizes not only carceral interventions but also a preventive medicalized approach to domestic violence. Electronic surveillance serves as a major instrument in efforts to prevent recidivism and violence, and it is extensively used to track people's movements.³⁰⁴ Commentators have long highlighted the potential dangers of states' reliance on tracking and monitoring technologies as alternatives to incapacitation of dangerous individuals, stressing that they allow the state to exert extensive control of individuals without necessary constitutional constraints.³⁰⁵

The use of electronic surveillance extends beyond criminal enforcement to cover a host of other areas, including the civil and public health realms.³⁰⁶ For example, civil protection orders are extensively used by courts to decrease the incidence of domestic abuse or its escalation.³⁰⁷ The main problem with these orders lies with enforcement challenges which impede their effectiveness.³⁰⁸ In response, several jurisdictions have started to implement electronic monitoring systems as a way to enforce compliance with civil protection orders.³⁰⁹ While such use of electronic monitoring is a civil enforcement mechanism rather than a carceral measure, it still exerts substantial social control on people by similarly managing populations in a manner that closely tracks methods used by the criminal legal system.³¹⁰ Substituting nonpunitive preventive tools for carceral measures raises significant concerns about increasing reliance on electronic surveillance and monitoring systems to track the whereabouts of domestic batterers.³¹¹

Furthermore, surveillance, monitoring, and reporting are also integral tenets of the therapeutic approach that underlies the operation of domestic violence courts.³¹² These exemplify a form of problem-solving courts that offer diversion programs as alternatives to traditional carceral measures by adopting a therapeutic approach to drug abuse, mental

304. See Kate Weisburd, *Sentenced to Surveillance: Fourth Amendment Limits on Electronic Monitoring*, 98 N.C. L. REV. 717, 730 (2020).

305. See Erin Murphy, *Paradigms of Restraint*, 57 DUKE L. J. 1321, 1345–46 (2008).

306. See Kate Weisburd, *Punitive Surveillance*, 108 VA. L. REV. (forthcoming 2022).

307. See Stoeber, *supra* note 58, at 1018–20.

308. See Emily J. Sack, *Domestic Violence Across State Lines: The Full Faith and Credit Clause, Congressional Power, and Interstate Enforcement of Protection Orders*, 98 NW. U. L. REV. 827, 830, 905 (2004).

309. See, e.g., 725 ILL. COMP. STAT. 5/110-5 (West 2021) (authorizing courts to order electronic monitoring of batterers); see also Pogrud Stark, *supra* note 94, at 146–47 (observing that domestic violence courts in Illinois assess risks of future violations of protection orders to order electronic surveillance of batterers as a condition of bond); EDNA EREZ, PETER R. IBARRA, WILLIAM D. BALES & OREN M. GUR, GPS MONITORING TECHNOLOGIES AND DOMESTIC VIOLENCE: AN EVALUATION STUDY (2012), <http://www.ojp.gov/pdffiles1/nij/grants/238910.pdf> [<http://perma.cc/4HKM-MS9N>]; Edna Erez & Peter Ibarra, *Making Your Home a Shelter: Electronic Monitoring and Victim Re-Entry in Domestic Violence Cases*, 47 BRIT. J. CRIM. 100, 102 (2007); Jaime Kay Dahlstedt, *Notification and Risk Management for Victims of Domestic Violence*, 28 WIS. J.L. GENDER & SOC'Y 1, 8, 10, 19–20 (2013).

310. See Hannah Brenner, *Transcending the Criminal Law's "One Size Fits All" Response to Domestic Violence*, 19 WM. & MARY J. WOMEN & L. 301, 341–44 (2013).

311. The use of electronic monitoring systems is common in other countries. See Rafael Espinosa, María Isabel Gutiérrez, Jorge Humberto Mena-Muñoz & Patricia Córdoba, *Domestic Violence Surveillance System: A Model*, 50 SALUD PUBLICA MEX. S12, S12–S18 (2008).

312. See Collins, *supra* note 130, at 1490–91, 1493–94.

illness, and domestic violence.³¹³ Diversion programs include a broad array of mostly therapeutic interventions that require individuals to complete a court-mandated program in exchange for dismissal or reduction of charges or no jail time.³¹⁴ Yet, despite their advantages compared to traditional criminal courts, domestic violence courts function in a way that reinforces the problems that characterize carceral measures.³¹⁵ This includes mandatory treatment programs, tight monitoring, surveillance, burdensome reporting requirements, and punishments for those who fail to follow prescribed programs.³¹⁶

Monitoring batterers plays an important role in the operation of domestic violence courts. While batterers remain in the community, courts place them under intense supervision, which includes long and invasive treatment that requires batterers to follow specified rules.³¹⁷ Courts engage in ongoing assessments of batterers throughout case processing and increase sanctions for noncompliance with court orders.³¹⁸ Compliance monitoring may also continue after discharge and involves either community supervision or probation.³¹⁹ Many domestic violence courts mandate batterers' court appearances for regularly scheduled status hearings to monitor compliance with protection orders and other requirements set by the court.³²⁰

The completion of batterers intervention programs is a key tenet of the operation of domestic violence courts.³²¹ As elaborated earlier, these programs, as well as participation in additional mental health treatment services identified by the court, are mandatory.³²² These involuntary treatment programs consist of either confinement to an inpatient treatment facility or outpatient treatment that includes confinement in the community under strict surveillance.³²³ Either way, their mandated nature makes them inherently coercive, which is why court-mandated treatment is in many respects similar to incarceration.

While domestic violence courts currently operate as criminal courts,³²⁴ the noncarceral state will likely repurpose them into civil courts. Yet, many of their key features will carry over, including mandatory treatment programs and extensive monitoring for compliance. Inherent problems stem from the involuntary nature of batterers' treatment programs, which will remain intact even if domestic violence courts transform into civil courts. The paradigmatic example of hugely problematic mandated

313. See MELISSA LABRIOLA, SARAH BRADLEY, CHRIS S. O'SULLIVAN, MICHAEL REMPEL & SAMANTHA MOORE, A NATIONAL PORTRAIT OF DOMESTIC VIOLENCE COURTS 56 (2010); Angela R. Gover, Denise Pasquette Boots & Shannon B. Harper, *Courting Justice: Tracing the Evolution and Future of Domestic Violence Courts*, 16 FEMINIST CRIMINOLOGY 366, 367–71 (2021).

314. See Miriam Krinsky & Liz Komar, "Victims' Rights" and Diversion: Furthering the Interests of Crime Survivors and the Community, 74 SMU L. REV. 527, 533–34 (2021).

315. See Gover et al., *supra* note 313, at 369–70.

316. See *id.*

317. See Collins, *supra* note 130, at 1494.

318. See Gover et al., *supra* note 313, at 369, 372.

319. *Id.* at 372.

320. See Collins, *supra* note 130, at 1491 n.45.

321. See *supra* Part II.B.1.

322. See Gover et al., *supra* note 313, at 369.

323. *Id.*

324. *Id.* at 369–72.

treatment programs rests with laws authorizing civil involuntary commitment of people with mental illness.

B. Involuntary Commitment

Adopting civil measures in lieu of carceral tools will increasingly result in states' turning to involuntary commitment of batterers, a prospect that raises multiple constitutional concerns, given the deprivation of liberty it entails. Almost all states currently authorize involuntary confinement of a mentally ill person upon a psychiatrist's certification that the individual poses a danger to themselves or others.³²⁵ While these statutes vary, most require a psychiatrist's determination that the person suffers from a mental illness for which immediate inpatient treatment in a hospital is appropriate and a *prediction* that, due to the mental illness, the individual is likely to engage in future behavior that causes serious harm to themselves or others.³²⁶ There are no separate statutes that are specifically designated to commit domestic batterers who suffer from mental illness and pose a risk to the safety of their intimate partners. But the statutory language of existing statutes is sufficiently capacious to cover situations where a psychiatrist predicts that a person endangers the safety of an intimate partner due to mental illness.³²⁷

Commentators have thoroughly critiqued the operation of civil commitment proceedings, highlighting concerns that such proceedings provide mentally ill people with fewer due process protections than criminal defendants.³²⁸ Elaborating on the many drawbacks of these proceedings exceeds the scope of this Article. Instead, I explain why the use of involuntary commitment proceedings to treat domestic batterers will increase once carceral responses are decreased and I highlight some of the problems that are especially pertinent to using civil commitment statutes in the domestic violence context.

Currently, states do not use civil involuntary commitment to address domestic violence cases because mandatory arrest policies initiate criminal proceedings as a way to incapacitate batterers.³²⁹ But abandoning carceral tools of confinement without replacing them with alternative measures to prevent future harm will create a regulatory vacuum that would leave victims underprotected. To fill this gap, civil involuntary

325. See William M. Brooks, *The Tail Still Wags the Dog: The Pervasive and Inappropriate Influence by the Psychiatric Profession on the Civil Commitment Process*, 86 N.D. L. REV. 259, 263 (2010).

326. See, e.g., N.Y. MENTAL HYG. LAW § 9.37(a) (Consol. 2021) ("likelihood of serious harm" means (a) a substantial risk of physical harm to the person as manifested by threats of or attempts at suicide or serious bodily harm or other conduct demonstrating that the person is dangerous to himself or herself, or (b) a substantial risk of physical harm to other persons as manifested by homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm).

327. See SAMHSA, CIVIL COMMITMENT AND THE MENTAL HEALTH CARE CONTINUUM: HISTORICAL TRENDS AND PRINCIPALS FOR LAW AND PRACTICE 11–12, 16 (2019), <http://www.samhsa.gov/sites/default/files/civil-commitment-continuum-of-care.pdf> [<http://perma.cc/42E8-ENK2>].

328. See, e.g., Alexander Tsesis, *Due Process in Civil Commitments*, 68 WASH. & LEE L. REV. 253, 298–300 (2011); Fred Vars, *Delineating Sexual Dangerousness*, 50 HOUSTON L. REV. 855, 859–60 (2013).

329. See Sack, *supra* note 96, at 1670–72.

commitment may serve as an alternative tool of temporary confinement of dangerous batterers in lieu of arrest.³³⁰

The turn to involuntary commitment statutes in the noncarceral state is compatible with adopting a public health approach to domestic violence and further aligns with the emerging medicalization trend discussed earlier.³³¹ The main tenets of the public health approach are prioritizing prevention of future harm over punitive measures and emphasizing the need to be proactive in contrast with traditional law enforcement's reactive nature.³³² Applied in the domestic violence context, preventing future harm by people who pose a danger to their intimate partners is the underlying rationale behind substituting involuntary commitment for carceral interventions.

As noted earlier, society has long relied on forced institutionalization to confine the mentally ill, as historical accounts of the infamous asylum demonstrate.³³³ Granted, involuntary commitment proceedings are not common in the carceral state due to significant underfunding of state psychiatric institutions.³³⁴ But a major component of reforms to defund police includes reallocating police funding and investing the freed-up resources in social services, including healthcare systems.³³⁵ Channeling budgets into mental health institutions is yet another reason why decriminalizing domestic violence will lead to revamping states' reliance on involuntary civil commitment.

The reemergence of the involuntary commitment institution is not merely a theoretical concern but already a major part of recent reforms to strengthen mental health treatment programs as an alternative to carceral measures.³³⁶ Several mental health advocates urge reinvigorating mandated psychiatric treatment as a more appropriate and compassionate form of care for the mentally ill.³³⁷ A modern-day iteration of psychiatric asylums, they argue, is essential for the safety of vulnerable people—without them, people with mental illness will continue to be relegated to incarceration.³³⁸ Instead, the argument continues, a new generation of flexible mental health institutions ought to be

330. See Donald H. Stone, *Confine Is Fine: Have The Non-Dangerous Mentally Ill Lost Their Right to Liberty? An Empirical Study To Unravel The Psychiatrist's Crystal Ball*, 20 VA. J. SOC. POL'Y & L. 323, 345 (2012).

331. See *supra* Part II.A.

332. See *supra* Part I.C.

333. See Appleman, *supra* note 31, at 422.

334. See Sara K. Rankin, *Hiding Homelessness: The Transcarceration of Homelessness*, 109 CALIF. L. REV. 559, 596–97 (2021) (discussing eighteenth century English asylums confinement of “those who suffered from depression or alcoholism, the homeless, and disobedient wives” and the abuses subjected on the confined).

335. See Eaglin, *supra* note 103, at 127–28.

336. See SCHENWAR & LAW, *supra* note 29, at 55–56, 64–74.

337. For example, a 2017 Treatment Advocacy Center Report proposes to increase the number of psychiatric beds to treat mentally ill defendants. See DORIS A. FULLER, ELIZABETH SINCLAIR, H. RICHARD LAMB, JAMES D. CAYCE & JOHN SNOOK, EMPTYING THE ‘NEW ASYLUMS’: A BEDS CAPACITY MODEL TO REDUCE MENTAL ILLNESS BEHIND BARS 2 (2017), <http://www.treatmentadvocacycenter.org/storage/documents/emptying-new-asylums.pdf> [<http://perma.cc/UH7W-J6WV>]. Similarly, health policy scholar Dominic Sisti wrote a *New York Times* op-ed, calling for invigorating mental health institutions to mandate involuntary treatment. See Dominic Sisti, *Psychiatric Institutions Are a Necessity*, N.Y. TIMES: ROOM FOR DEBATE (May 9, 2016, 11:01 PM), <http://www.nytimes.com/roomfordebate/2016/05/09/getting-the-mentally-ill-out-of-jail-and-off-the-streets/psychiatric-institutions-are-a-necessity> [<http://perma.cc/DK3R-LSAC>].

338. FULLER ET AL., *supra* note 337, at 2–3; Sisti, *supra* note 337.

further developed to help reduce the vast number of mentally ill people who are incarcerated.³³⁹ Furthermore, some states already have implemented psychiatric institutions as an alternative form of treating mentally ill defendants: states like Iowa, Texas, South Carolina, and Florida operate for-profit psychiatric prisons that arguably adopt a therapeutic approach in lieu of traditional prisons.³⁴⁰

Calls to strengthen mental health institutions are worrisome because involuntary civil commitment is a deeply problematic tool, perpetuating similar coercive practices that characterize carceral measures. Involuntary commitment proceedings are civil, rather than carceral, measures because they do not punish past crime but instead serve as a prophylactic tool to prevent future harm.³⁴¹ Yet, this nonpunitive measure is equally dangerous because it is, in essence, another form of incarceration given its involuntary nature and deprivation of liberties. While arguably legally justified under the prevention paradigm, individuals may be deprived of their liberties for indefinite time.³⁴²

The U.S. Supreme Court has long held that involuntary commitment proceedings must comport with substantive and procedural due process rights under state and federal law.³⁴³ But in practice, the constitutional protections afforded to patients in civil commitment proceedings are far less protective than those afforded to criminal defendants.³⁴⁴

Applying involuntary commitment statutes as a preventive measure to treat domestic batterers raises ample substantive and procedural due process concerns. From the perspective of substantive due process, the statutory definitions allowing for forced hospitalization are overbroad and overinclusive. The main prerequisite for involuntary commitment is that a person is diagnosed with a mental illness.³⁴⁵ Yet, the definitions employed by psychiatrists to determine mental illness are obscure and incoherent.³⁴⁶ Likewise, most states adopted the expansive standard of either “grave disability” or “need for treatment” as a condition of involuntary commitment, with only a few states still defining dangerousness solely as a “danger to self or others.”³⁴⁷ Civil commitment statutes define dangerousness in vague and overbroad terms, leading to psychiatrists’ recommendations of involuntary commitment decisions in circumstances falling short of

339. See Howard Husock & Carolyn D. Gorman, *The Case To Bring Back the Asylum*, WALL ST. J. (May 18, 2018, 11:44 AM), <http://www.wsj.com/articles/the-case-to-bring-back-the-asylum-1526658277> [<http://perma.cc/3VQ9-ENY8>].

340. See SCHENWAR & LAW, *supra* note 29, at 67.

341. See, e.g., *Beasley v. Molett*, 95 S.W.3d 590, 607 (Tex. App. 2002).

342. See Isaac D. Buck, *The Indefinite Quarantine: A Public Health Review of Chronic Inconsistencies in Sexually Violent Predator Statutes*, 87 ST. JOHN’S L. REV. 847, 850, 859–60 (2013) (discussing Sexually Violent Predator statutes, which permit commitment of sexually dangerous individuals as long as they are perceived to be a threat to society).

343. See *Addington v. Texas*, 441 U.S. 418, 425 (1979).

344. See Michael L. Perlin, *Who Will Judge the Many When the Game Is Through: Considering the Profound Differences Between Mental Health Courts and “Traditional” Involuntary Civil Commitment Courts*, 41 SEATTLE U. L. REV. 937, 939, 956 (2018).

345. See SAMHSA, *supra* note 327, at 11.

346. Stephen K. Morse, *Mental Disorder and Criminal Law*, 101 J. CRIM. L. & CRIMINOLOGY 885, 955 (2011).

347. See Stone, *supra* note 330, at 325.

an imminent danger requirement.³⁴⁸ Instead, involuntary commitment is based on a prediction that if not committed, future harm will likely ensue.³⁴⁹

Grounding involuntary hospitalizations on psychiatrists' predictions of domestic batterers' future dangerousness is hugely problematic because psychiatric diagnoses rely on professional judgments and intuitions to a greater degree than ordinary medical diagnoses.³⁵⁰ Yet, research suggests that an ongoing problem in the criminal legal system is that psychiatrists' clinical predictions of future violence are highly speculative, inaccurate, and unreliable.³⁵¹ Similarly, psychiatric diagnoses are often mistaken and result in false positives that can in turn lead to unnecessary treatment.³⁵² These concerns will likely exacerbate under civil alternatives to domestic violence treatment because a civil regime provides parties with less constitutional protections. In the absence of arrest as temporary confinement for domestic batterers in the noncarceral state, psychiatrists are likely to feel pressured to err on the side of caution and erroneously recommend involuntary commitment based on speculative predictions of future violence.

Another disconcerting feature of involuntary commitment concerns the authorization of use of physical force against patients for medical purposes. Psychiatric hospitals routinely use restraint measures and movement restrictions to manage psychiatric patients.³⁵³ These include drugs, mechanical devices, and physical restraints.³⁵⁴ Similar to police officers' use of force to subdue suspects who resist arrest, mental health professionals exercise significant physical force to subdue people who refuse to cooperate with psychiatric evaluation.³⁵⁵ Physical force is used throughout forced hospitalization to subdue resisting patients as well as to ensure compliance with medication.³⁵⁶ Data suggest that immobilization methods and physical restraint are frequently used in psychiatric facilities to manage behaviors of psychiatric patients.³⁵⁷ Mental health care is often being delivered in emergency contexts, where restraint and seclusion are used more often.³⁵⁸

Turning to civil commitment of domestic batterers as an alternative to carceral measures also poses procedural due process concerns given the deeply flawed proceedings leading to forced hospitalization. One major concern is the judicial deference to psychiatrists' expertise and professional discretion.

One of the adverse consequences of decriminalizing domestic violence is that the unregulated power that was once exclusively entrusted with prosecutors will be shifted

348. See Donald Stone, *Dangerous Minds: Myths and Realities Behind the Violent Behavior of the Mentally Ill, Public Perceptions, and the Judicial Response Through Involuntary Civil Commitment*, 42 *LAW & PSYCHOL. REV.* 59, 67 (2017).

349. Stone, *supra* note 330, at 326.

350. See Tsesis, *supra* note 328, at 293.

351. See Morse, *supra* note 346, at 957–58.

352. See Jerome C. Wakefield, *False Positives in Psychiatric Diagnosis: Implications for Human Freedom*, 31 *THEORETICAL MED. & BIOETHICS* 5, 9 (2010).

353. See Tovino, *supra* note 191, at 528.

354. *Id.*

355. *Id.* at 529.

356. *Id.* at 535.

357. *Id.* at 537.

358. *Id.* at 517.

to psychiatrists, creating similar dangers that the criminal legal system has created.³⁵⁹ Judges routinely defer to the discretion of mental health professionals, accepting without much scrutiny psychiatric assessments of people's dangerousness.³⁶⁰ Predictions of future violence determinations are made solely by expert opinions of psychiatrists whose professional expertise is unlikely to be questioned by judges.³⁶¹ Moreover, research suggests that only a minority of mental health professionals routinely employ structured risk assessments to predict an individual's dangerousness.³⁶² Instead, mental health professionals typically rely on unstructured risk assessments, which are predictive and based mostly on subjective expert opinions.³⁶³ Involuntary commitment hearings thus provide psychiatrists with the unregulated discretion to order commitments without meaningful judicial scrutiny.³⁶⁴

Critique of psychiatrists' use of subjective clinical predictions of future dangerousness in the process of deciding whether civil commitment is necessary have led to incorporating algorithmic RAIs that rely on standardized computational tests to predict future violence.³⁶⁵ While these RAIs are more objective and improve psychiatrists' ability to predict future violence, using algorithmic risk assessment to forecast future dangerousness poses its own problems.³⁶⁶

The absence of robust adversarial proceedings in involuntary commitment hearings is yet another disconcerting problem. Hearings in civil involuntary commitment courts are "short and perfunctory," or as Professor Michael Perlin has put it, "charades."³⁶⁷ Comparing traditional *civil* involuntary commitment courts with specialized *criminal* mental health courts, Perlin concluded that criminal offenders are provided more procedural rights and are treated with more dignity and respect by the criminal mental health court than by the civil court handling involuntary commitment.³⁶⁸ Most civil commitment hearings, continues Perlin, "are 'litigated' in pitch darkness," and "cases are disposed of in minutes behind closed courtroom doors."³⁶⁹ Civil involuntary commitment proceedings are largely *nonadversarial*, failing to employ rigorous

359. Ample literature addresses the unchecked, unregulated, and unstructured nature of prosecutorial discretion. See, e.g., ANGELA J. DAVIS, *ARBITRARY JUSTICE: THE POWER OF THE AMERICAN PROSECUTOR* 166 (2007); Rachel E. Barkow, *Institutional Design and the Policing of Prosecutors: Lessons from Administrative Law*, 61 *STAN. L. REV.* 869, 871 (2009).

360. See, e.g., Perlin, *supra* note 344, at 943–44; Sara Gordon, *The Danger Zone: How the Dangerousness Standard in Civil Commitment Proceedings Harms People with Serious Mental Illness*, 68 *CASE W. RES. L. REV.* 657, 677–84 (2016).

361. Perlin, *supra* note 344, at 943 n.32.

362. See John Monahan, *Tarasoff at Thirty: How Developments in Science and Policy Shape the Common Law*, 75 *U. CIN. L. REV.* 497, 511–12 (2006).

363. *Id.* at 498.

364. See Gordon, *supra* note 360, at 677–78.

365. *Id.* at 672.

366. See *infra* Part III.C for a discussion of the risks of algorithmic decisionmaking in the context of healthcare.

367. Perlin, *supra* note 344, at 937; Gordon, *supra* note 360, at 678.

368. See Michael L. Perlin, "The Judge, He Cast His Robe Aside": *Mental Health Courts, Dignity and Due Process*, 3 *MENTAL HEALTH L. & POL'Y J.* 1, 2–3 (2013).

369. *Id.* at 9 n.36.

advocacy on behalf of patients.³⁷⁰ Lawyers that represent patients too often fail to engage in the kind of vigorous advocacy needed to serve as a check on unfettered clinical discretion.³⁷¹ Public defenders appointed to represent individuals in civil involuntary commitment hearings often feel uncomfortable adopting an adversarial stance in these proceedings.³⁷² Such subpar representation arguably amounts to ineffective assistance of counsel.³⁷³

A related shortcoming concerns the timing of appointing legal representation to people subject to involuntary commitment proceedings. Courts recognize that mentally ill patients have “the right to effective assistance of counsel at all significant stages of the commitment process.”³⁷⁴ Some courts have found, however, that the right to counsel does not attach at “preliminary stages, such as psychiatric interview [sic] where custodial decisions are not involved.”³⁷⁵ Other courts held that the right to counsel extended to a prehearing psychiatric interview,³⁷⁶ but the right to counsel does not necessarily require physical presence of counsel if the interview could be preserved by other means such as a recording.³⁷⁷ The failure to appoint counsel in a prehearing psychiatric interview is problematic because the initial psychiatric evaluation is the first step that triggers the state’s initiation of involuntary commitment, which would eventually lead to depriving the patient’s liberty.

The evidentiary standard that is sufficient for authorizing civil involuntary commitment is yet another area demonstrating significant procedural due process concerns. Procedural due process requires that findings of a patient’s dangerousness and serious mental illness are established under the “clear and convincing” standard.³⁷⁸ The U.S. Supreme Court refused to adopt the more rigorous standard that is required for criminal convictions—that is, the evidentiary requirement of proof beyond a reasonable doubt.³⁷⁹ The constitutional protections that are afforded to criminal defendants under the Due Process Clause are thus deprived from patients diagnosed with mental illness because of the lower evidentiary standard.³⁸⁰

In sum, while involuntary commitment proceedings are civil rather than criminal measures, applying them to domestic batterers in the noncarceral state might result in batterers faring worse as compared to batterers in the carceral state.³⁸¹ Specifically,

370. See Michael L. Perlin, “*I Might Need a Good Lawyer, Could Be Your Funeral, My Trial*”: *Global Perspective on the Right to Counsel in Civil Commitment Cases*, 28 WASH. U. J.L. & POL’Y 241, 241 (2008).

371. See *id.*

372. See *id.* at 246–47.

373. *Id.*

374. See, e.g., *In re Beverly*, 342 So. 2d 481, 489 (Fla. 1977).

375. *Id.*

376. See, e.g., *Ughetto v. Acrish*, 494 N.Y.S.2d 943, 948 (Sup. Ct. 1985), *aff’d as modified*, 518 N.Y.S.2d 398 (App. Div. 1987); *Project Release v. Prevost*, 722 F.2d 960, 976 (2d Cir. 1983).

377. *Ughetto*, 494 N.Y.S.2d at 949.

378. *Addington v. Texas*, 441 U.S. 418, 424–25, 432 (1979).

379. *Id.* at 431–32.

380. See Tsesis, *supra* note 328, at 300–01.

381. See Perlin, *supra* note 344, at 956.

batterers would be afforded reduced procedural protections because commitment proceedings are far less adversarial in nature.³⁸²

C. *Algorithms and Systemic Racism in Healthcare*

The many shortcomings that plague the criminal legal system's treatment of domestic violence, including systemic racism, also characterize a public health approach to battering. The societal problem of discriminatory treatment of people of color is rampant not only in carceral contexts but also in nonpenal institutions. One of the perils of medicalizing domestic violence stems from health systems' use of risk prediction algorithms in making medical treatment decisions and its disproportionate effect on marginalized communities.³⁸³

Algorithmic risk assessment instruments are commonly perceived as a key component of prevalent evidence-based approaches to reforming the criminal legal system.³⁸⁴ Extensive literature addresses the concerns regarding the increasing reliance on algorithmic risk assessment in all aspects of the criminal legal system, including policing, sentencing, and parole decisions.³⁸⁵ Commentators demonstrate the various ways in which the purportedly objective data that motivate evidence-based reforms of the criminal legal system in fact perpetuate a host of racial biases.³⁸⁶

This criticism, however, obfuscates the reality that algorithmic decisionmaking is prevalent in many areas beyond the criminal law. Scholars stress that algorithmic decisionmaking is commonly employed in a variety of legal contexts, thus reinforcing and entrenching racial, class, and economic biases in these areas.³⁸⁷ Commentators further suggest that the source of racial inequality in algorithmic risk assessment instruments lies in the very nature of predictive assessments, rather than in particular

382. See Allegra McLeod, *Decarceration Courts: Possibilities and Perils of Shifting Criminal Law*, 100 GEO. L.J. 1587, 1665 (2012).

383. See Ziad Obermeyer, Brian Powers, Christine Vogeli & Sendhil Mullainathan, *Dissecting Racial Bias in an Algorithm Used To Manage the Health of Populations*, 366 SCI. 447–53 (2019), <http://www.science.org/doi/epdf/10.1126/science.aax2342> [<http://perma.cc/8N77-4Y7C>].

384. See, e.g., Sonja B. Starr, *Evidence-Based Sentencing and the Scientific Rationalization of Discrimination*, 66 STAN. L. REV. 803, 805–06, 809 (2014); Megan Stevenson, *Assessing Risk Assessment in Action*, 103 MINN. L. REV. 303, 313 (2018); Itay Ravid & Amit Haim, *Progressive Algorithms*, 12 U.C. IRVINE L. REV. 527, 535–38 (2022).

385. See, e.g., Andrew Guthrie Ferguson, *Predictive Prosecution*, 51 WAKE FOREST L. REV. 705, 705–06 (2016); Andrew Guthrie Ferguson, *Policing Predictive Policing*, 94 WASH. U. L. REV. 1109, 1117 (2017); Deborah Hellman, *Measuring Algorithmic Fairness*, 106 VA. L. REV. 811, 859 (2020); Sandra G. Mayson, *Bias In, Bias Out*, 128 YALE L. J. 2218, 2222 (2019).

386. See, e.g., Ngozi Okidegbe, *The Democratizing Potential of Algorithms?* 1–2 (Aug. 25, 2021) (unpublished manuscript), <http://ssrn.com/abstract=3835370> [<http://perma.cc/UG7F-Y9B9>]; Ngozi Okidegbe, *Discredited Data*, 107 CORNELL L. REV. (forthcoming 2022), <http://ssrn.com/abstract=3835414> [<http://perma.cc/9Q7D-EG7G>]; Sean Hill, *Bail Reform and the (False) Racial Promise of Algorithmic Risk Assessment*, 68 UCLA L. REV. 910, 910 (2021), <http://ssrn.com/abstract=3683790> [<http://perma.cc/9G94-P95J>].

387. See Ifeoma Ajunwa, *The Paradox of Automation as an Anti-Bias Intervention*, 41 CARDOZO L. REV. 1671, 1677 (2020).

algorithms.³⁸⁸ All methods of predictions, the argument goes, will project past inequalities into the future.³⁸⁹

Risk assessment tools are now commonly used in healthcare, including in forensic psychiatric facilities, general psychiatric hospitals, and treatment programs.³⁹⁰ These tools offer supportive responses to risk that include assistance in obtaining counseling, accessing social services, or pursuing medical, substance abuse, or mental health treatment.³⁹¹ Originally, these arguably objective algorithms were viewed as holding promise to ameliorate health disparities between patients of different race, ethnicity, gender, and sexual orientation.³⁹² But a growing body of studies shows that using medical computational models to make decisions related to healthcare exacerbates unfair and biased treatment of minority patients.³⁹³

Interdisciplinary studies demonstrate that racism and discrimination are deeply ingrained in healthcare systems.³⁹⁴ Health law scholar Professor Ziad Obermeyer has written extensively on the effects of predictive analytics in healthcare. In a 2019 study, Obermeyer argues that an algorithm widely used to allocate healthcare to patients in American health systems discriminates against Black people.³⁹⁵ The study demonstrates that healthcare algorithms are biased and prejudiced—faulty algorithms disproportionately affect patients of color because healthcare professionals operate in an inherently racist system, with implicit biases and subconscious prejudices affecting their decisions.³⁹⁶ Taken together, these studies raise concerns that using predictive analytics in healthcare serves to manage marginalized populations and disproportionately

388. See, e.g., Mayson, *supra* note 385, at 2224.

389. *Id.*

390. See Jodi L. Viljoen, Dana M. Cochrane & Melissa R. Jonnson, *Do Risk Assessment Tools Help Manage and Reduce Risk of Violence and Reoffending? A Systematic Review*, 42 LAW & HUM. BEHAV. 181, 181 (2018).

391. See Mayson, *supra* note 385, at 2289.

392. See, e.g., Ziad Obermeyer & Ezekiel J. Emanuel, *Predicting the Future--Big Data, Machine Learning, and Clinical Medicine*, 375 NEW ENG. J. MED. 1216, 1218 (2016).

393. See *id.*; W. Nicholson Price II, *Regulating Black-Box Medicine*, 116 MICH. L. REV. 421, 429, 432–34 (2017); W. Nicholson Price II, *Medical AI and Contextual Bias*, 33 HARV. J.L. & TECH. 65 (2019); Jessica K. Paulus & David M. Kent, *Predictably Unequal: Understanding and Addressing Concerns That Algorithmic Clinical Prediction May Increase Health Disparities*, NATURE: NPJ DIGITAL MED., July 30, 2020, <http://www.nature.com/articles/s41746-020-0304-9> [<http://perma.cc/VQ2T-7ZFX>]; Monique Tello, *Racism and Discrimination in Healthcare: Providers and Patients*, HARV. HEALTH PUBL'G: HARV. HEALTH BLOG (Jan. 16, 2017), <http://www.health.harvard.edu/blog/racism-discrimination-health-care-providers-patients-2017011611015> [<http://perma.cc/6SQK-6S3F>].

394. See Joe Feagin & Zinobia Bennfield, *Systemic Racism and U.S. Healthcare*, 103 SOC. SCI. & MED 7, 8 (2014), <http://reader.elsevier.com/reader/sd/pii/S0277953613005121?token=39D1253BB365526D222460C432AEC609025ADA9155798A595469AFEB60BE32CD5F5728838B5B03351F0A2E69E8F4BE02&originRegion=us-east-1&originCreation=20220426175600> [<http://perma.cc/UD6W-RXGT>].

395. See Obermeyer et al., *supra* note 383.

396. *Id.* at 447.

disadvantage people of color, in a manner similar to the use of predictive algorithms in the criminal legal system.³⁹⁷

The concerns underlying the use of predictive algorithms in healthcare carry important implications for the medicalization of domestic violence phenomenon. In assessing whether an individual poses significant risk to their intimate partner, mental health professionals routinely rely on risk assessment predictions about future dangerousness.³⁹⁸ Arguably, the preferable approach to engaging in such predictions is using structured risk assessment, which is based on objective rules that specify in advance which risk factors are to be measured in predicting violence.³⁹⁹ As previously noted, the critique underlying psychiatrists' subjective predictions of the likelihood of future dangerousness have resulted in increased reliance on algorithmic risk assessment instruments, which are arguably more objective and accurate tools to predict future violence.⁴⁰⁰

But substituting algorithmic risk assessment for psychiatrists' subjective opinions creates its own problems. Considerable risks may stem from the predictive nature of these assessments of the risk of future violence. RAIs currently play a dominant role in addressing domestic violence under the criminal legal system.⁴⁰¹ Yet, predictive tools are subject to ongoing controversy regarding their ability to accurately measure the likelihood of future domestic battering and their use of past domestic violence as a predictive risk assessment factor.⁴⁰²

Research on the accuracy of risk assessment tools suggests that risk assessment approaches demonstrate only moderate predictive accuracy.⁴⁰³ Compounding the problem is the fact that an instrument's predictive validity depends on the independent predictive accuracy of its individual assessments.⁴⁰⁴ Assessments' accuracy depends on a multitude of factors, including "the accuracy and availability of information required to complete the assessments" and "the attitudes, training, and knowledge of individuals completing the assessments."⁴⁰⁵ Commentators stress that using RAIs to predict future violence may produce erroneous conclusions due to problems inherent in their implementation.⁴⁰⁶

Likewise, the problems that underlie the criminal legal system's reliance on risk assessment tools will also manifest under a health-based approach to domestic violence

397. See Sarah Valentine, *Impoverished Algorithms: Misguided Governments, Flawed Technologies, and Social Control*, 46 FORDHAM URB. L.J. 364, 411–13 (2019).

398. See Monahan, *supra* note 362, at 499–502.

399. *Id.* at 499.

400. See *supra* Part III.B. for a discussion of the difficulties stemming from justifying civil commitment decisions using psychiatrists' subjective expert opinions.

401. See Desmarais & Zottola, *supra* note 174, at 794.

402. See Rettenberger & Eher, *supra* note 173, at 76.

403. See R. KARL HANSON, LESLIE HELMUS & GUY BOURGON, THE VALIDITY OF RISK ASSESSMENTS FOR INTIMATE PARTNER VIOLENCE: A META-ANALYSIS 9 (2007), <http://www.publicsafety.gc.ca/cnt/rsrscs/pblctns/ntmt-prtnr-vlnce/ntmt-prtnr-vlnce-eng.pdf> [<http://perma.cc/P63J-FGXL>].

404. See Desmarais & Zottola, *supra* note 174, at 804.

405. See *id.*

406. *Id.* at 807.

because similar instruments will be used by mental health professionals. The growing reliance on algorithmic decisionmaking in healthcare raises similar concerns to those identified in the criminal law context.⁴⁰⁷ Similar to algorithmic prediction in the realm of criminal law, predictive health analytics can be inaccurate for a host of reasons.⁴⁰⁸ These erroneous predictions may also subject people to harmful treatment and result in ample adverse consequences.⁴⁰⁹

Health law scholars have juxtaposed the use of predictive medicine to predictive policing as health systems also rely on predictive algorithms to identify and treat patients and guide decisionmaking processes across healthcare systems.⁴¹⁰ For example, Professor Glenn Cohen has identified common problems in the use of predictive analytics in policing and healthcare decisionmaking.⁴¹¹ These problems include disadvantageous effects on racial minorities and disruption of the traditional role of physicians, whose professional judgment is being replaced by computational models.⁴¹² He further stresses the risks inherent in imperfect implementation of predictive analytics in healthcare and suggests that they should only be used to complement rather than supplant human judgment.⁴¹³

An additional manifestation of systemic racism that compounds the overmedicalization of domestic violence concerns the disparate allocation of treatment programs and its detrimental impact on marginalized communities, especially BIPOC. Renowned racial discrimination scholar Professor Joe Feagin applies systemic racism theory to healthcare and public health institutions.⁴¹⁴ Feagin found that institutionalized white socioeconomic resources, discrimination, racialized framing, and white oppression severely restrict the access of BIPOC to adequate socioeconomic resources, healthcare, and health outcomes.⁴¹⁵

Once again, the practices of drug treatment courts offer a useful analogy to the treatment of domestic violence.⁴¹⁶ The way problem-solving courts operate raises

407. See Sarah E. Malanga, Jonathan D. Loe, Christopher T. Robertson & Kenneth S. Ramos, *Who's Left Out of Big Data? How Big Data Collection, Analysis, and Use Neglects Populations Most in Need of Medical and Public Health Research and Interventions*, in *BIG DATA, HEALTH LAW, AND BIOETHICS* 145, 155–62 (I. Glenn Cohen ed. 2018); I. Glenn Cohen & Harry S. Graver, *Cops, Docs, and Code: A Dialogue Between Big Data in Health Care and Predictive Policing*, 51 U.C. DAVIS. L. REV. 437, 447–49 (2017).

408. See Sharona Hoffman, *What Genetic Testing Teaches About Predictive Health Analytics Regulation*, 98 N.C. L. REV. 123, 126–27, 151–54 (2019) (discussing the risks of erroneous predictions); Cohen & Graver, *supra* note 407.

409. Hoffman, *supra* note 408, at 129–30.

410. For scholarship documenting the concerns of algorithmic predictions in healthcare, see, for example, Cohen & Graver, *supra* note 407, at 445–47, and Hoffman, *supra* note 408, at 151–54.

411. See Cohen & Graver, *supra* note 407, at 448, 450–51, 455.

412. See *id.*

413. *Id.* at 455–58.

414. See Feagin & Bennefield, *supra* note 394, at 7–14.

415. See JOE R. FEAGIN, *THE WHITE RACIAL FRAME: CENTURIES OF RACIAL FRAMING AND COUNTER-FRAMING* 152–53 (3d ed. 2020); JOE R. FEAGIN & KIMBERLY DUCEY, *RACIST AMERICA, ROOTS, CURRENT REALITIES, AND FUTURE REPARATIONS* 173 (4th ed. 2018) (describing persisting racial barriers in healthcare).

416. See Collins, *supra* note 130, at 1490–91.

concerns about disproportionate effects across racial and class lines.⁴¹⁷ Likewise, drug treatment centers are more widely accessible to individuals with financial means than to the poor.⁴¹⁸

Intersectional feminist perspectives stress that race, ethnicity, class, sexual orientation, disability, immigration status, and other marginalized identities interact to compound BIPOC experiences.⁴¹⁹ Intersectional disadvantages, such as lack of access to resources and poverty, place minority victims at heightened risk of experiencing domestic abuse.⁴²⁰ The experiences of minority women are negatively affected by ingrained racism and discriminatory treatment among service providers, as well as structural deprivation of services.⁴²¹

Similarly, using health-based interventions to treat domestic violence raises concerns about their disparate effects on BIPOC—particularly, the risk of disparate allocation of preventive and treatment programs. Batterers who are white and privileged are more likely to benefit from mental health treatment than BIPOC.⁴²²

IV. REIMAGINING ALTERNATIVES

Having identified the perils of overmedicalization of domestic violence, this Section considers possible ways to alleviate these concerns and minimize the risks of misuse and overinclusiveness of mental health interventions. Fully developing the necessary measures to ameliorate the identified risks exceeds the scope of this Article; I leave that for future work. Here, I begin to sketch some key measures, painting in broad strokes some future directions by outlining the two-pronged strategy below.

A. Tailoring Solutions to Typology

One of the shortcomings of the existing carceral regime is the uniform solution it purports to offer to all cases labeled “domestic violence.” The sole reliance on criminal law as the main tool to address domestic violence does not call for distinguishing the different types of domestic violence as carceral responses adopted a unified solution to all cases.

Noncarceral solutions to address domestic violence should reject a one-size-fits-all intervention by tailoring the solution to the specific causes that trigger the battering. The noncarceral state must acknowledge that not all incidents labeled “domestic violence”

417. See Michael M. O’Hear, *Rethinking Drug Courts: Restorative Justice as a Response to Racial Injustice*, 20 STAN. L. & POL’Y REV. 463, 465–66 (2009).

418. See Hefei Wen, Janet R. Cummings, Jason M. Hockenberry, Laura M. Gaydos & Benjamin G. Druss, *State Parity Laws and Access to Treatment for Substance Use Disorder in the United States: Implications for Federal Parity Legislation*, 70 JAMA PSYCHIATRY 1355 (2013).

419. See BETH E. RICHIE, *ARRESTED JUSTICE: BLACK WOMEN, VIOLENCE, AND AMERICA’S PRISON NATION* 101–02, 106–07 (N.Y.U. Press 2012).

420. *Id.*

421. See Kimberle Crenshaw, *Mapping the Margins: Intersectionality, Identity, Politics, and Violence Against Women of Color*, 43 STAN. L. REV. 1241, 1251–52, 1262–65 (1991).

422. Cf. Angela P. Harris & Aysha Pamukcu, *The Civil Rights of Health: A New Approach to Challenging Structural Inequality*, 67 UCLA L. REV. 758, 770 (2020) (“[W]e argue that subordination on the basis of race, gender, class, citizenship, sexuality, and other power and privilege differentials is a central driver of health disparities.”).

are cut from the same cloth and the problem is more nuanced than the single dimensional account that dominated the criminal legal system.⁴²³ Instead, different domestic violence typologies dictate different interventions. While some cases are driven by batterers' intent to control intimate partners, others are explained by a combination of social stressors including substance abuse, mental illness, past abuse, and poverty, which necessitate treating these underlying conditions.

Alleviating the concerns associated with overmedicalization requires cautiously delineating the types of domestic violence that genuinely require a therapeutic approach. When the root cause of battering is mental illness, a therapeutic approach is normatively warranted. But when batterers are motivated by coercive controlling, mental health treatment is not only practically unhelpful but also unwarranted. Using medicalized solutions in the latter cases illustrates the paradigmatic example of overmedicalization.

Additionally, highlighting domestic violence typology underscores the important variation between batterers in terms of their respective blameworthiness. Being afflicted with mental illness is hardly a blameworthy behavior. Therefore, placing blame and holding mentally ill batterers criminally accountable cannot be justified. In contrast, batterers who are driven by a patriarchal intent to control their intimate partners are morally blameworthy, and therefore establishing accountability for their wrongdoing must remain a chief goal of any legal response.⁴²⁴

In addition, properly classifying the type of domestic violence at issue is necessary because of the tension between the goals of treatment and accountability. By focusing on treatment, society conveys a message that batterers are not to blame for the harm they inflicted while afflicted by medical conditions. The therapeutic approach thus undermines accountability as a core goal that underlies societal responses to domestic violence.⁴²⁵ But a therapeutic approach is an unjustified response to address battering that is driven by coercive control. Instead, in those situations, society ought to focus on batterers' accountability to ensure that they take full responsibility for their behavior.

Denouncing domestic violence as wrongful, morally blameworthy behavior ought to be a critical part of any reform adopted by the noncarceral state. Sending an expressive societal message that strongly condemns the wrongfulness of battering remains vital under nonpunitive alternatives.

B. *Equitable Treatment*

The critique of the medicalization phenomenon leveled in this Article does not reject mental health interventions where they are genuinely warranted from a medical perspective. The small subset of batterers that are diagnosed with serious mental illness may justifiably be subjected to mental health interventions to prevent future harm to intimate partners. In these cases, the problem lies not with mental health institutions as a harm prevention tool but with their operation, which currently fails to offer fair and just treatment of mental health patients.

423. *See infra* Part I.A.

424. *See* Dempsey, *supra* note 5, at 68, 97, 203, 212.

425. *Id.* at 203, 212.

To ensure that batterers who truly suffer from mental illness are treated in an equitable manner, noncarceral states must develop substantial control mechanisms to protect batterers from mental health professionals' overreaching powers. These mechanisms are necessary for ameliorating the medicalization of domestic violence concerns by ensuring that the mental health interventions that replace criminal responses do not replicate the harms that the criminal legal system created. The overarching goal of these control mechanisms is to ensure that states treat batterers who suffer from mental illness with dignity and respect.⁴²⁶

Equitable treatment of batterers requires shifting away from two key features that currently characterize the criminal legal system's operation: the use of coercive measures and liberty deprivations.⁴²⁷ First, mental treatment programs are problematic only if they are coercive in nature. Therapeutic interventions in the noncarceral state must privilege autonomous choices to receive treatment. This entails voluntarily enrolling batterers in mental treatment programs by obtaining their consent, rather than mandating it by coercive court orders.

Second, therapeutic interventions must use the least restrictive means to treat batterers in a manner that minimally intrudes on their freedoms. The vast majority of mental illness treatments may be done within the community rather than inpatient facilities.⁴²⁸ Mental health interventions should mostly rely on providing outpatient treatment services that avoid locking up batterers. Inpatient treatments in mental health institutions should be viewed as the last resort to be used only after outpatient treatment has been exhausted or is not feasible. Likewise, mental health professionals should not physically restrain patients unless the patient genuinely threatens serious physical violence. Force should neither be used to compel compliance with medication nor to force treatments such as electroconvulsive therapy.

In addition, equitable treatment of batterers requires offsetting the effect of having considerable discretionary power concentrated solely in the hands of mental health professionals, with very little judicial oversight. This necessitates bolstering adversarial proceedings as prerequisites for mental health interventions that interfere with batterers' liberties.

The criminal legal system is adversarial in nature, given the inherently conflicting interests of the government and the defendant. At first glance, health institutions might appear nonadversarial, as healthcare providers' interests in treatment are naturally more aligned with patients' needs.⁴²⁹ Yet, this "shared interest in treatment" account is inaccurate for at least two reasons.⁴³⁰ Today's cost-constrained health system creates an adversarial relationship between patients and healthcare providers who are often

426. See Jonathan Simon & Stephen A. Rosenbaum, *Dignifying Madness: Rethinking Commitment Law in an Age of Mass Incarceration*, 70 U. MIAMI L. REV. 1, 51 (2015); Bruce J. Winick, *Therapeutic Jurisprudence and the Civil Commitment Hearing*, 10 J. CONTEMP. LEGAL ISSUES 37, 44 (1999).

427. See SAMHSA, *supra* note 327, at 32–33.

428. See Ken Kress, *An Argument for Assisted Outpatient Treatment for Persons with Serious Mental Illness Illustrated with Reference to a Proposed Statute for Iowa*, 85 IOWA L. REV. 1269, 1291 (2000).

429. See Cohen & Graver, *supra* note 407, at 472.

430. *Id.*

government employees representing the government's financial interests.⁴³¹ More importantly, these healthcare providers are also entrusted with promoting the public's safety.⁴³² Their state interest in preventing future harm to domestic violence survivors may outweigh their concern for batterers' interests. Involuntary civil commitment is one example where the government and batterers' interests diverge; state-employed psychiatrists may support involuntary hospitalization of batterers to protect intimate partners while batterers' interest is to maintain their freedom. Vigorous adversarial proceedings in all domestic violence cases are thus necessary to account for these disparate interests.

A critical tool to bolster the adversarial nature of mental health interventions is the adoption of mandatory legal representation for batterers in all legal proceedings involving medicalized interventions. Mandating legal representation provides a system of checks and balances to ensure that decisionmaking authority does not rest exclusively with mental health professionals.

Equitable treatment of batterers must ensure batterers' rights comparable to those afforded to criminal defendants. This necessitates appointing counsel to batterers at the state's expense during all stages of domestic violence proceedings. Requiring states to appoint counsel for batterers would mirror their duty to appoint a defense attorney to indigent defendants in criminal proceedings, which the Court mandated in its seminal decision in *Gideon v. Wainwright*.⁴³³ Commentators have argued that *Gideon's* ambit should be expanded to guarantee legal representation to indigent litigants in all civil cases implicating fundamental interests.⁴³⁴ But the Court has yet to adopt a right to appointed counsel in civil proceedings which carry potential for deprivation of liberties.⁴³⁵

To date, no court has held that indigent civil litigants are entitled to court appointed attorneys when their freedoms might be curtailed as a result of noncarceral measures.⁴³⁶ Courts acknowledge that civil commitment proceedings are quasi-criminal actions and appoint counsel during the hearing itself.⁴³⁷ But the right to appointed counsel does not attach in the preliminary stages leading to that hearing, including the initial psychiatric examination.⁴³⁸ Notably, batterers do not currently have a right to appointed counsel in all other civil proceedings, including civil protection orders, even though these may also use coercive measures such as monitoring and reporting.⁴³⁹

Relatedly, an additional adversarial measure that should be adopted to offset mental health professionals' discretionary power consists of allowing batterers to introduce their

431. See William M. Sage, *Physicians as Advocates*, 35 Hous. L. Rev. 1529, 1533 (1999); see also Song, *supra* note 282, at 2646.

432. Sage, *supra* note 431; see also Song, *supra* note 282, at 2646.

433. 373 U.S. 335 (1963).

434. See, e.g., Laura K. Abel, *A Right to Counsel in Civil Cases: Lessons from Gideon v. Wainwright*, 15 Temp. Pol. & Civ. Rts. L. Rev. 527, 530 (2006).

435. The Court narrowly interpreted the right to counsel in civil cases in *Turner v. Rogers*, 564 U.S. 431 (2011).

436. *Cf. id.* at 442–43 (enumerating instances in which the Court has found a right to counsel in civil matters).

437. See, e.g., *Vitek v. Jones*, 445 U.S. 480, 496–97 (1980) (plurality opinion).

438. E.g., *In re Beverly*, 342 So.2d 481, 489 (Fla. 1977).

439. See *supra* Part III.A.

own expert testimony in all medical proceedings. Mandating legal representation to batterers is insufficient for protecting batterers' rights as attorneys lack the medical knowledge necessary to overcome the state's psychiatric expert opinion. In typical adversarial proceedings, trials' outcomes often hinge on a battle between the parties' expert opinions.⁴⁴⁰ The psychiatrist whose expert opinion supports the state's civil commitment order represents only the state's interests, which do not necessarily align with batterers' interests.⁴⁴¹ To ensure that batterers' interests are adequately represented, they must introduce their own psychiatrist expert opinion to counter the state's psychiatrist opinion.

Concededly, allowing batterers to introduce a contrasting expert opinion would be a viable solution only to those who could afford it. Since indigent batterers lack the means to introduce their own expert opinion, disparities between different batterers will be exacerbated. Like in the criminal legal system, these disparities will disproportionately impact racial minorities. To resolve this concern, whenever the government initiates civil commitment proceedings, batterers should be entitled to introduce a contrasting expert opinion at the state's expense.

Finally, implementing meaningful judicial oversight is necessary to offset the power wielded by mental health professionals. As previously noted, judges are deferential to psychiatrists given their perceived expertise.⁴⁴² For other experts, however, judges serve as gatekeepers by ensuring that juries do not place undue weight on their opinions.⁴⁴³ Similarly, judges should play a more robust role during civil commitment hearings by carefully scrutinizing psychiatric expert opinions.

CONCLUSION

"To destroy is easier than to create, and that is why so many people are ready to demonstrate against what they reject. But what would they say if one asked them what they wanted instead?"

- Ivan Klima, Love and Garbage

The treatment of domestic violence in the noncarceral state serves as a case study that highlights a variety of concerns in other legal contexts about the adverse consequences of substituting a public health approach for carceral measures. Criminal law scholarship largely centers around divesting from carceral institutions that have proved to malfunction and harm minority communities, aiming to dismantle the broad criminal legal system's apparatus.⁴⁴⁴

Endeavors to abolish or defund carceral institutions are merely the beginning, not the end, of a meaningful reform of the legal system. The next crucial step involves rebuilding alternative institutions that would fill the roles of the discarded ones. But it is much easier to criticize and destroy than to create anew. Reformers largely paint

440. See Lee Waldman Miller, *Cross-Examination of Expert Witnesses: Dispelling the Aura of Reliability*, 42 U. MIAMI L. REV. 1073, 1074 (1988).

441. *Id.*

442. See *supra* Part III.B.

443. *Daubert v. Merrell Dow Pharms., Inc.*, 509 U.S. 579, 594–97 (1993).

444. See, e.g., Anthony O'Rourke, Rick Su & Guyora Binder, *Disbanding Police Agencies*, 121 COLUM. L. REV. 1327, 1337–42 (2021); Simonson, *supra* note 11, at 783–87.

noncarceral alternatives in broad positive strokes, overlooking some of their potential negative implications.⁴⁴⁵

Genuine commitment to overhauling the carceral state requires grappling with the specific operation of noncarceral regulation. Divesting powers from carceral institutions inevitably vests powers in other institutions. Given the medicalization phenomenon, these alternatives consist mostly of healthcare systems. This results in an equilibrium where carceral institutions are weakened but health systems are strengthened.

A streamlined account of criminal legal system reforms portrays criminal law as inherently problematic, whereas public health is largely perceived as a favorable alternative. But a more nuanced account must acknowledge that a public health approach that relies on medicalized interventions has its own costs. Classifying coercive measures as civil merely removes the criminal label but does not necessarily change the substantive problems underlying their operation.

Health-based alternatives to carceral measures often rely on intrusive social control mechanisms, albeit therapeutic rather than outright punitive. Noncarceral states should adopt reforms that carefully probe the functions of health institutions and cabin the powers of their key institutional actors. Such scrutiny is necessary not only to ensure that these institutions do not replicate the problems created by the criminal legal system but also to safeguard against the possibility that the therapeutic dragnet ensnares even more vulnerable individuals.

An unintended consequence of substituting therapeutic for carceral frameworks is the potential for further expanding the reach of mandated mental health treatments to cover larger numbers of people compared with carceral responses. This results in states casting a broader net on those classified as “patients” rather than criminal defendants.⁴⁴⁶ While criminal measures are typically perceived as overbroad, in some respects they are narrower than therapeutic interventions. This is because the legal and medical communities have disparate goals: while criminal legal actors aim to place blame for past wrongdoing, medical actors aim to diagnose and treat to prevent future harm.⁴⁴⁷ Since medical actors are not concerned with criminal responsibility, the definitions they employ to diagnose and treat health conditions are inherently broader than those used under criminal law. Embracing the therapeutic paradigm may thus result in sweeping more people into state-mandated systems.

This Article does not purport to resolve all issues that might arise if health measures replace carceral tools. Rather, its goal is to amplify areas of concern that must be taken into account to alleviate the identified risks. In posing the challenging question of precisely what noncarceral regulation would look like, I aim to ignite a robust discussion about the tradeoffs of medicalized interventions in the noncarceral state, as the devil is in the details of their operation. I urge reformers to acknowledge that, while mental health

445. See, e.g., Mariame Kaba & John Duda, *Towards the Horizon of Abolition: A Conversation with Mariame Kaba*, NEXT SYS. PROJECT (Nov. 9, 2017), <http://thenextsystem.org/learn/stories/towards-horizon-abolition-conversation-mariame-kaba> [<http://perma.cc/MGD7-PVNN>].

446. See SCHENWAR & LAW, *supra* note 29, at 85.

447. See Rebecca Hollander-Blumoff, *Crime, Punishment and the Psychology of Self-Control*, 61 EMORY L.J. 501, 504–10 (2012).

measures are purportedly gentler and more humane, they are far from being problem free.