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UNLOCKING FAMILY COURT'S POTENTIAL FOR PUBLIC HEALTH PROMOTION

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INTRODUCTION

Beginning in 1999, a movement has been taking place in Upstate New York—an effort to unlock the potential of Family Courts to promote public health. For fifteen years, through a partnership between SUNY Buffalo Law School's Women, Children & Social Justice Clinic, the University of Rochester School of Medicine and Dentistry's Department of Psychiatry's Laboratory of Interpersonal Violence and Victimization (LIVV), and the Seventh and Eighth Judicial Districts for the New York State Office of Court Administration (the Team), a new way of doing business in Family Courts has been unfolding. Changes resulting from these collaborative efforts, which promote health and wellness through multidisciplinary collaboration, may be applicable to many communities. While the partnership formed over a decade ago, the Team didn't know they were a part of a recognized method of research. The term, Community-Based Participatory Research (CBPR), has since evolved to a central role in public health research.

1 The authors would like to thank Eileen Whitney, Director, Monroe County Family Court Children's Center; Taryn Johnson, Lead Teacher, Monroe County Family Court Children's Center; and Michelle LaRussa-Trott, MSW for their involvement in court-improvement projects. No funding was provided for this study. The corresponding author is Dr. Catherine Cerulli. She can be reached at the University of Rochester Medical Center, 300 Crittenden Boulevard, Box PSYCH, Rochester, New York 14642; by e-mail at Catherine_Cerulli@urmc.rochester.edu; or by phone at (585) 275-5269.
concept in translational public health research. It is now a well-recognized means for academics to partner with their communities to provide benefits to all and enhance the social justice promoting aspect of research. Its applicability to Family Court is important to consider given the number of people who interface with Family Court everyday for a myriad of needs: custody, visitation, financial support, protection orders, mental health, etc.

Co-authors Dr. Catherine Cerulli and Dr. Ann Marie White met in 2003, and upon hearing Dr. White speak, Dr. Cerulli shared with her colleagues that it appeared they had been using CBPR methods since establishing their partnership. Although the Team had not given their mutual actions a precise name, the Team was actually engaged in CBPR. The term CBPR provided a framework, voice, and context to describe the collaborative research that the Team had been using in a field that had yet to adopt these principles for engaged research.

Other reports have introduced court-centric CBPR to public health audiences since the Team began their work (e.g., suicide prevention). However, this article will be among the first to provide an overview of CBPR and the underlying principles for attorneys by specifically addressing Family Court as a potential venue for this work. This article presents three topic areas related to CBPR emerging from this Team: 1) an overview of therapeutic justice; 2) an overview of CBPR; and 3) detailed descriptions of two court improvement projects: the operation of an on-site daycare and the creation of the first known mental health clinic at court. The ultimate goal of this article is to stimulate further dialogue about how universities and courts can partner to initiate and sustain therapeutic justice in a meaningful way. Overall, the purpose of this goal is to improve litigants' physical and mental health, thereby excelling in an explicit mission of courts and law enforcement to protect community quality of life and well-being. While

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2 See generally Barbara A. Israel et al., Review of Community-Based Research: Assessing Partnership Approaches to Improve Public Health, 19 ANN. REV. PUB. HEALTH 173 (1998) ("Community-based research in public health focuses on . . . inequities through active involvement of community members, organizational representatives, and researchers in all aspects of the research process."); Nina B. Wallerstein & Bonnie Duran, Using Community-Based Participatory Research to Address Health Disparities, 7 HEALTH PROMOTION PRAC. 312 (2006) (describing the challenges amongst the partnering relationships and suggests that academia culture should transform to "strengthen collaborative research relationships").

3 See Israel et al., supra note 2, at 177-78; Wallerstein & Duran, supra note 2, at 312-13.

many projects have been conducted, the Team selected two specific court improvement projects for this article: a court-based daycare that meets the health needs of underserved urban minority children and the creation of a mental health clinic for victims. Given the high volume of families that utilize both services, these provide great examples with high public health promotion potential.

I. THERAPEUTIC JUSTICE: ADDRESSING COURT-CLIENTS’ NEEDS

Reinforcing traditions from court-reform, Professor Bruce Winick, an early advocate of therapeutic justice, an idea he researched with Professor David Wexler, believed “[t]herapeutic jurisprudence should be defined to include anything that enhances the psychological or physical wellbeing of the individual.”6 In part a legal reform movement, therapeutic justice asks lawyers and judges to consider the mental and emotional consequences of the legal system on litigants and to recognize the effect of their own ethical, personal, and spiritual values on their behavior and decisions in the courtroom.7 Employing these values, practitioners should seek to achieve a just outcome for all parties and to minimize conflict where possible. The rise of therapeutic justice in recent decades in some measure influenced the expansion of specialty courts for drugs, domestic violence, and many other issues.8 Regardless of the national movement, therapeutic justice is implemented at a state or even local levels of government.

Grounded in this reform movement, the Team started to wonder: “What about the victim’s side of the fence?” and “What about the kids coming to court?” At the end of the day, they’re people and their lives have context. The socio-ecological model suggests there are societal factors, community factors, relationship factors, and individual factors that all affect

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7 Wexler & Winick, supra note 5, at 981; see BLACK’S LAW DICTIONARY 933 (9th ed. 2009) (defining therapeutic jurisprudence as “[t]he study of the effects of law and the legal system on the behavior, emotions, and mental health of people; especially a multidisciplinary examination of how law and mental health interact”).

Figure 1 Ecological model showing shared risk factors for sub-types of interpersonal violence

people’s lives and well-being—via decisions, actions, and outcomes in and beyond their control. Figure 1 depicts the socio-ecological model and how

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these factors influence each other in relation to risk for interpersonal violence.

The diagram also details the specific risk factor in the context of the ecological model: individual, relationship, community, and societal. The Team has observed that court-based studies often fall short of considering the multiple factors described in such a socio-ecological model.\textsuperscript{11} Without taking these factors into consideration, court-based researchers may focus on the individuals, only examining risk factors for behavior. While certainly fruitful approaches, the predominance of these analytic perspectives can inadvertently reinforce a paradigm that can lead to courts re-victimizing and re-traumatizing those desperate for refuge from such experiences (e.g., priming court professionals to mentally ask of their clients: "What is wrong with you?" versus "What happened to you?" – the latter being the trauma-informed approach).\textsuperscript{12} Traditional court practices, focusing only on the legal issues and punishment, miss out on an opportunity to serve community members in a more meaningful way, as individuals that have the potential to contribute positively to the community if only their needs were being addressed.\textsuperscript{13}

\textit{A. Numbers Don't Tell the Truth, the Whole Truth, and Nothing but the Truth}

Researchers might examine quantitative court data, explore conviction rates, and conclude, "This prosecutor's office is doing a bad job because they have a low conviction rate." However, if researchers interviewed the victims embroiled in that system, or the perpetrators prosecuted, those litigants might reply:

\begin{quote}
\textit{I was treated with dignity.}
\textit{I was treated with respect.}
\end{quote}


\textsuperscript{12} Denise E. Elliot et al., \textit{Trauma-Informed or Trauma-Denied: Principles and Implementation of Trauma-Informed Services for Women}, 33 J. COMMUNITY PSYCHOL. 461 (2005) (exploring principals of trauma informed services, benefits of the approach, and characteristics of trauma informed services).

\textsuperscript{13} See Wexler \& Winick, \textit{supra} note 5, at 1004.
I received the resolution I wanted, even if I chose to drop the charges.

By implementing socio-ecological models or frameworks alongside CBPR principals, researcher-practitioner partnerships seeking to advance therapeutic justice will be better able to evaluate and improve court processes and illuminate a client-centeredness approach. For instance, the ability to better understand the potential chaos in litigants lives will make the court experience not only easier, but also an opportunity for health improvement. Recent studies demonstrated the high levels of health burden experienced by court-involved victims and perpetrators.¹⁴ Many victims indicated symptoms of depression, post-traumatic stress disorder, suicidal thoughts, and other mental health disparities.¹⁵ Researchers felt there was a direct link between court involvement of victims or perpetrators and subsequent poor health and continued abuse.¹⁶

II. COMMUNITY-BASED PARTICIPATORY RESEARCH

The first principle of CBPR is to consider the "community as a unit of identity."¹⁷ The community might be construed from the identities of families, groups of individuals, or agency workers.¹⁸ This vantage point is critical for identifying potential risks and benefits of research or court

¹⁵ See, e.g., Cerulli et al., supra note 14, at 94; You et al., supra note 14, at 240; Conner, Cerulli & Caine, supra note 14, at 115.
¹⁶ See generally Cerulli et al., supra note 14; You et al., supra note 14; Conner, Cerulli & Caine, supra note 14.
¹⁷ Israel, et al., supra note 2, at 178-80; see also Barbara A. Israel et al., Community-Based Participatory Research: Policy Recommendations for Promoting a Partnership Approach in Health Research, 14 EDUC. FOR HEALTH, 182, 184 (2001) [hereinafter Community-Based Participatory Research] (utilizing the principles of community-based participatory research to recommend policy changes).
¹⁸ See Israel et al., supra note 2, at 178.
involvement that go beyond the ethics frameworks and reviews focused solely on the individual.

The second CBPR principle is to build up and upon the strengths and resources of both community and academic partners. Many organizations say, "I don’t have the money to do the research project." or "I really want to do research, but I don’t have the resources." With CBPR, each partner contributes the resources available to them, as well as bringing their unique insight to help co-create the research questions, design, methodology, and dissemination. While a law school, medical school, or court may not have the individual resources to conduct a project as described in Part III—with an estimated budget of $180,000—together they may be able to implement a scientifically rigorous study that resulted in positive change.

Another CBPR principle involves integrating knowledge and action. Once knowledge is gained, it is imperative that the information be shared with the community and immediately used to improve health. This can only occur with a commitment to co-learning. The learning can’t stop after the data is collected. Contrary to CBPR principles, however, many academic partners come into a community to do research, collect data, and return to their academic institutions providing little or no feedback to the community in which the research took place. It is important that once the researcher has collected that data, even if the data cannot be published, the researcher will make sure the information gets back to the community.

CBPR is a process that includes feedback loops and collaborative exchanges. The research Team goes back and forth between the research and professionals practicing in the field in which the research is based. Once the research yields results, the Team continues to implement an improve processes and continues to evaluate the new measures or procedures.

One of the few tensions with CBPR is that new ideas and processes don’t always work. People can lose steam and become disengaged. Another

19 Id.
20 See id.
21 See infra Part III (describing the projects the Team researched and implemented using the principles of CBPR).
22 See Israel et al., supra note 2, at 179.
23 Id. at 180.
24 See id. at 179.
25 Id. at 180 (stressing the importance of “ongoing feedback of data and use of results to inform action” in CBPR relationships).
26 Id. at 177, 180.
27 See id. at 180.
28 See Community-Based Participatory Research, supra note 17, at 184 (noting that CBPR “involves a long-term commitment by all partners”).
challenge to CBPR implementation is tight timelines; junior faculty, eligible for tenure, experience publish-or-perish pressures. CBPR relationships take time to develop, as it takes time to foster and build trust between parties. So, as a CBPR partner, one must consider the competing demands of academia and the community. However, CBPR can provide junior faculty, post-doctorate students, and community leaders with a different perspective of research, with a way to begin to understand research that can’t be taught in, or turned off by, a textbook. It can also help provide research opportunities in the face of limited resources.

Part III describes two different projects, conducted in New York State, which provide examples of how the Team utilized the CBPR principles. Over the past fifteen years, the Team has used millions of federal grant dollars to provide services to court litigants, resources otherwise unavailable to any one entity absent the partnership.

III. MAKING COURT A BETTER PLACE: COURT-IMPROVEMENT PROJECTS

A. Family Court Children’s Center

Last week, seven-year old Peter sat at a desk next to a guardian ad litem, ready to testify in a Family Court proceeding. Peter’s parents were both in the courtroom, on opposite sides, fighting for custody. Before the proceeding began, the presiding Judge told Peter he might be happier if he left the courtroom. “It’s going to be really boring,” the Judge told him. Peter agreed to go, and followed a court officer down the hall. In a situation like this, sparing Peter about 30 minutes of boredom is only a superficial benefit. Much more importantly, he was not forced to watch his parents argue with each other about who should have the right to see him, hear a litany of past sins involving alcohol, drug abuse, and infidelity. Nor would Peter have to witness the laundry list of offenses his father had committed against him, which a social services attorney was about to present. On this long day at court, Peter’s safe haven was the local Hall of Justice Children’s

29 See Israel et al., supra note 2, at 190-91.
30 See id. at 183.
31 See id at 192-93 (explaining how CBPR works best when there is support “top down and bottom up”).
32 See infra Part III.
The New York State Family Courts are courts of original jurisdiction within the state’s Unified Court System, annually handling thousands of cases. In 1994, the New York State Permanent Judicial Commission on Justice for Children (PJCJC) established a Court Improvement Program supporting Children’s Centers throughout the state. Out of sixty-two counties in New York State, the PJCJC provided space and funding for a Children’s Center in twenty-four counties. Independent, not-for-profit agencies operate each of the centers, such as the Hall of Justice Children’s Center run by URSMD in Monroe County. The need for the centers was in one part logistical. Current chair of PJCJC and former Chief Judge Judith S. Kaye, who was instrumental in the centers’ creation, felt that the well-being of families and children in the court setting was paramount to serving court clients and mitigating disruptions in the courtroom. Specialty courts exist as a means to create therapeutic results that take parties’ needs into consideration. While the court system has an obligation to provide just results for every user, Family Court has a particular responsibility to protect children. Like adults, children may play different roles in the system based on the circumstances that brought them to court. In the juvenile system, children are defendants. In other branches of the Family Court system, they may be the objects of custody disputes or, in extreme cases, forced to

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33 This is a fictitious example based on real scenarios encountered at the Children’s Center. This example was created to explain the need and function of childcare centers.
40 See id. at 11-48.
testify. In each case, the court employs protections to lessen the likelihood of emotional damage to the young participant.41

Five days a week, centers provide a serene respite for children from the often-contentious environment of Family Court.42 There are many reasons a child may come to court: the child may be a necessary party to the case or required to testify. In many cases, a parent may simply lack the resources or connections to access childcare. The Children's Centers are guided by the philosophy that no child should have to unnecessarily endure the potential emotional harm from witnessing an argumentative day in court.43

The very idea of a Family Court, including court Children's Centers, fits neatly under the umbrella of therapeutic justice.44 Many researchers have described this approach in regard to the mission of the juvenile court system in the United States.45 Though the system far outdates the use of the term, juvenile courts were viewed as therapeutic rather than a source of retribution.46 This is because they sought to avoid the harms of formal punishment and displayed optimism toward rehabilitation.47 In this sense, therapeutic justice has focused quite closely on the needs of young defendants.

In addition, therapeutic justice has a strong applicability in the field of family law. Professor Barbara Babb wrote, "Therapeutic justice should strive to protect families and children from present and future harms, to reduce emotional turmoil, to promote family harmony or preservation, and to provide individualized and efficient, effective justice."48 To that end, Family Courts are designed to address a family's legal issues quickly, creating fewer traumas for children and families than a traditional trial court.

41 See id. at 1.
42 Children's Centers in the Courts, supra note 37.
43 Id.
46 McCoy, supra note 8, at 1515-16.
While this may be the purpose of many Family Courts nationally, there is little empirical evidence that such a result is achieved.

Family Courts employing therapeutic justice recognize parties to the case as consumers. Yet the reach of therapeutic justice in the Family Courts has largely excluded non-party children. What becomes of the child forced to watch as his parents argue with each other in the courtroom, either about a previous traumatic incident, or, in severe cases, an abusive incident involving the child himself? The rapid expansion of specialty courts in recent decades suggests the court system is ready to address the needs of litigants in a more empathetic fashion. Recognizing the negative impact of family law proceedings on children, some courts have implemented programs for mandatory mediation or education of parents in conflict over parenting or custody issues. While these measures have certainly been positive, children are largely not yet afforded the protection they need. The Children's Centers represent an effort by the New York State Unified Court System to provide a safe space for children not parties to the legal proceeding yet who are adversely affected by it and without agency to seek help.

i. Ensuring Equal Access to Justice for Parents

Beyond providing quality care to the children themselves, the Children's Centers are of great value to the parents who use them. The ability to bring a child to court and leave them in a carefully mediated environment may break down some important barriers to justice for parents. Unfortunately, funding for Children's Centers statewide has been cut because, on some level, their services are not seen as essential. Perhaps to some, the Children's Centers solve a problem that should not need to be solved by the state—some may question, why do people need to bring their kids to court at all? But for many, access to reliable, safe childcare is not a reality. Often, users of the Family Court system have recently experienced

50 See William J. Howe & Hugh Mcissac, Finding the Balance: Ethical Challenges and Best Practices for Lawyers Representing Parents when the Interests of Children are at Stake, 46 Fam. Ct. Rev. 78, 78-79 (2008) ("Virtually every jurisdiction . . . seeks to achieve the best interests of the child when resolving divorce, custody, or parenting disputes.").
51 Id. at 83-85.
or remain in a traumatic moment in their lives. Perhaps whatever family resources they may have had available are no longer feasible options for childcare.\footnote{See Children's Centers in the Courts, supra note 37 (noting that the centers also “facilitate connections between families and services such as Head Start, WIC, food stamps, literacy and other community services”).} The Federal Government has made legislative judgment not to discriminate against parents. For example, under Title VIII of the Civil Rights Act of 1968, commonly referred to as the Fair Housing Act, potential tenants with children are a protected class.\footnote{See 42 U.S.C. §§ 3601-06 (2013).} It follows that, as a matter of policy, one should not be denied their day in court because of financial strain and inability to afford childcare.

ii. Children's Centers as a Means of Protecting the Best Interests of the Child

The New York State Unified Family Court System employs a standard in custody disputes that requires the judge to always consider the best interests of the child.\footnote{See N.Y. SOC. SERV. LAW § 358-a(3)(c) (McKinney 2010) (“in determining reasonable efforts, the child’s health and safety shall be the paramount concern”).} This type of standard would not exist unless the court system was primarily concerned with the child’s well-being. In an attempt to “reduce emotional turmoil”\footnote{Babb, supra note 48, at 800.} generally, courts assume “direct responsibility for children’s well-being rather than serving as a passive arbiter of disputes between adult claimants.”\footnote{Richard Boldt & Jana Singer, Juristocracy in the Trenches: Problem-Solving Judges and Therapeutic Jurisprudence in Drug Treatment Courts and Unified Family Courts, 65 MD. L. REV. 82, 93 (2006).} Yet the child’s involvement in court proceedings, despite the ‘shield’ the court system has placed over him, may cause some degree of emotional discomfort. Effectively, we must ask whether the very nature of participating in a court proceeding that stems from a traumatic incident ‘revictimizes’ the child.

Courts certainly have at least some stake in the mental and medical well-being of participants. One example of this may be a protection order, where the court creates an enforceable document protecting one party’s health at the expense of the rights of another.\footnote{See N.Y. DOM. REL. LAW § 240 (McKinney 2014); Orders of Protection, WOMENSLAW.ORG, http://www.womenslaw.org/laws_state_type.php?id=5618&state_code=NY (last updated Oct. 29, 2012) (explaining the types of orders of protection available to women in New York as well as the process of obtaining and applicability of the orders).} If the goal of the court system is to reduce emotional turmoil generally, it must keep the best interest of the child at heart. This requires the court system to take a more
active role in promoting justice. Within the past few months, the harsh realities of New York State government budget cuts have hit the Children’s Centers hard. As part of a $170 million package of cuts to the court system, the Children’s Centers have seen their funding drop from $2.1 million to $1 million statewide.\(^\text{59}\) The Children’s Centers are operated by independent, not-for-profit agencies supported by state funding\(^\text{60}\) and have increasingly relied upon fundraising appeals, often to members of county government or county bar associations.\(^\text{61}\) For example, the Children’s Center in Monroe County remained open, in large part, due to resources provided by the University of Rochester. This can be attributed to the strong CBPR partnership between researchers at the University and the Monroe County Family Court leadership and staff.

New York is not alone in operating childcare facilities in the Family Courts. As part of a larger network, the Courthouse Drop-In Childcare Center at the Maleng Regional Justice Center in Kent, Washington, “serves children who are called to testify as victims or witnesses or whose parents or guardians have business in the court.”\(^\text{62}\) Similarly, the Superior Court of California, San Diego County, offers free childcare during mediation sessions.\(^\text{63}\) The importance of the centers both to the long-term health of children and in ensuring equal access to justice for primarily low-income parents, as part of the broader acceptance of therapeutic justice, has likely helped spread these types of resources to municipalities around the country.

The creation of the Monroe County Children’s Center has been a collaborative effort taken on by the Team. Approached by the Chief Clerk of Family Court, URSMD had to decide whether or not to accept the challenge of operating a court-based daycare facility.\(^\text{64}\) The Chair of the Department, Dr. Eric Caine, has always supported the vision that the Children’s Center could become a site for the promotion of public health initiatives. In a few short years, the center became a hub of activity. The

\(^{59}\) See Stashenko, *supra* note 52.

\(^{60}\) *Children’s Centers in the Courts, supra* note 37.

\(^{61}\) Interview with Eileen Whitney, Director, Monroe County Family Court Children’s Center, November 19, 2013.


Children’s Center boasts the first known telemedicine initiative, wherein parent-litigants can get their children’s medical conditions diagnosed through a web-portal at court. This allows them to leave court and pick up required medications and antibiotics rather than traveling to an emergency room or urgent care center due to the late hour of the day when many pediatrician offices are closed.

The Children’s Center is staffed by a professional team, including one provider who is masters prepared with a degree in counseling. When we examine the socioecological model (Figure 1), we realize that many of our court consumers are mothers and fathers who want their kids to be healthy and safe. In the case of consumers engaged in court due to domestic violence, if we want to break that intergenerational cycle of violence, we have to take advantage of the opportunity when the children are in court to provide beneficial services and give them hope for a healthy future.

A dedicated pediatrician designed a program called CAREing in Court, in which staff provides every parent that drops their child off a menu of services that they may need but may not be linked with yet. In the trial for this particular project, staff members were able to provide 217 referrals to 116 families, including those connected with asthma assistance, child care assistance, dental care, early intervention, emergency food stamps, family planning, Head Start, health insurance, heating assistance, housing support, medical care, parenting support, prenatal care, and a number of other programs. These are families that we had in our very midst, but who were not taking advantage of needed service linkage opportunities.

When looking at public health perspectives and interventions, work with universal approaches is available, like public messaging. Selected individuals can be targeted, people known to be at risk of developing health risks and the people already displaying the health issues identified as issues to be addressed. Daycares located in court settings provide the perfect place to grant access to services for these at-risk families.

By approaching families using a socioecological model, we are able to envelope them in care and offer them services to address many ongoing health-related needs – not merely the legal needs that caused them to cross

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66 Id.
68 Id.
69 Interview with Eileen Whitney, supra note 61.
the threshold of the courthouse. In addition to childcare, many petitioners suffer from mental health disparities.

B. Promoting Wellness at Court: Court-Based Mental Health Clinic

i. History of the Project

A hallway conversation led to a portfolio of research and the creation of victim mental health services located at court—again, the first such known service in the country. In 1999, an internationally known suicide researcher, Dr. Kenneth Conner, approached Dr. Cerulli and stated his interest in understanding intimate partner violence (IPV) perpetrators’ suicidal thoughts and behaviors. Dr. Cerulli had been working in IPV for many years and, in her professional capacity as a prosecutor, was very familiar with the threats perpetrators made to their victims, such as: “If you leave me, I’ll kill myself.” and “You will be sorry – if you leave, I’ll kill you, the kids, and then myself.” While these threats were always a frightening potential reality to the listener, they seemed to be a manipulative tactic employed by perpetrators to control their victims.

Dr. Conner explained that to keep victims safe, it was imperative to understand IPV perpetrators’ suicidal thoughts and behaviors. Dr. Cerulli took this notion one step further, focusing on very specific professions—attorneys and public health professionals also needed to know about the victim’s suicidal thoughts and behaviors. The Team conducted a study that inquired about victim’s court experiences, their physical and mental health, and their perpetrator’s mental health burden. We learned that perpetrators had a very high rate of suicidal ideating, much higher than the general population. More importantly, we discovered that they also attempted suicide at much higher rates, and that their suicide attempts were medically significant. Most significantly, men who were attempting suicide also had the highest ratings on the danger assessment scales and violence measures. We also learned that many victims felt suicidal, some as recent as the day they attended court. They would wake up every day facing numerous obstacles and feeling like they were fighting against all odds, just to be able to put their shoes on and get to work. Such painful personal experiences are signals these victims may suffer from with

70 See generally Conner, Cerulli & Caine, supra note 14.
71 See Cerulli et al., supra note 14.
72 See id.
73 See Conner, Cerulli & Caine, supra note 14, at 121.
74 See id. at 122.
depression, post-traumatic stress disorder (PTSD), and other mental health morbidities coupled with their victimization.\(^75\)

Beginning in 2004, we started to ask victims in more detail about their own depression.\(^76\) We also asked the victims from Family Court if they would use mental health services at court if offered, and overwhelmingly they replied yes.\(^77\) Because of the CBPR approach to these studies, providers (of both legal and social services) were able to express concerns about the stigmatization victims may experience by discussing and disclosing their mental health burdens. When we asked the survivors about their stigmatization, they said, they would much rather tell their bosses that they are home because they are depressed than because they are victims of domestic violence.\(^78\) A mental health stigmatization meant less to them than their IPV stigmatization did. For some reason, survivors believed mental health issues were more acceptable in our community than their violence experiences were. We didn’t make the mental illness “them,” and we didn’t tell survivors “they were their disease or illness.”\(^79\) Rather, we explained mental health burden is often a result of IPV. The Team, knowing there was a mental health burden among survivors using Family Court, and knowing that such individuals were not subsequently connected with services, had an obligation to answer the question, “What do we do?” In order to determine the answer, we conducted this project with a small grant from the SUNY Buffalo Law School ($2,000) and additional grant funding from a local mental health association ($3,000).

In 2007, the Team secured an $800,000 grant from the National Institute of Mental Health to embark on the first-known randomized control trial (RCT)\(^80\) in a Family Court setting.\(^81\) Based on a review of the

\(^{75}\) See Cerulli et al., supra note 14; Wilfred R. Pigeon et al., Sleep Disturbances and Their Association with Mental Health Among Women Exposed to Intimate Partner Violence, 20 J. WOMEN’S HEALTH 1923 (2011) (intimate partner violence victimization, depression, suicidality, and PTSD); Sharon M. Flicker et al., Depressive and Post-Traumatic Symptoms Among Women Seeking Protection Orders Against Intimate Partners: Relations to Coping Strategies and Perceived Responses to Abuse Disclosure, 18 VIOLENCE AGAINST WOMEN 420 (2012) (intimate partner violence victimization, depression, and PTSD).

\(^{76}\) See Cerulli et al., supra note 14, at 97.

\(^{77}\) Id. at 96.

\(^{78}\) National Institute of Mental Health Research Grant Award, Grant #1K01MH75965-01 (Principal Investigator: Dr. Catherine Cerulli).

\(^{79}\) Cerulli et al., supra note 14, at 96.

\(^{80}\) Randomized control trials are research studies where participants are selected at random to be put in an assigned arm of the study. For example, participants in one arm might receive the treatment and the other arm could be the currently accepted treatment. After the data is collected results from the two arms would be compared.
literature, researchers rarely conduct RCTs with domestic violence survivors, let alone in court settings. The only reason we could launch an RCT was because we had the victim’s service agency, the survivors, and the court professionals at the table working together to co-create the design. This collaboration helped answer the most important question, “What’s going to work for this study in your setting?”

The study randomized survivors in to one of three modes of obtaining information at court: 1) a paper-pencil survey; 2) a paper-pencil survey coupled with a computer-generated public health survey which provided resources; or 3) later augmented by a brief patient engagement. Those who completed the computer survey were provided references and resources based on the issues they self-identified, which could be mental health care, childcare needs, food, pharmaceutical needs, psycho-social needs, and even information regarding smoke detectors, as we had had several cases of juveniles exposed to fire-starting violence in the home. By approaching mental health care with the socioecological model in mind (see Figure 1), survivors were shocked by the unique service provided at Family Court. Not only did we care about their safety and hand them a protective order, but we also cared about their physical and mental health and their hierarchy of needs: food, shelter, and clothing. It became a holistic approach.

While survivors were happy with the service they received, the Team was not happy with the results of the RCT. Although we invested energy in creating a model of care to test what is needed to link people with mental health help, based on results from the RCT only a small portion of survivors were utilizing these services. Petitioners with indicated mental health needs were still only connecting with services at a one-to-twenty ratio—of the twenty subjects who agreed they needed care and wanted it, only one actually connected with care. For the Team, that wasn’t good enough.

ii. The Implementation of the Clinic

Because we were not happy with our resulting one-to-twenty ratio, we started a mental health clinic right at court. The clinic was to provide a highly organized infrastructure to provide on-site, emergency mental health

81 National Institute of Mental Health Research Grant, supra note 78.
82 See id.
83 See Cerulli et al., supra note 14, at 95-97; Pigeon et al., supra note 75.
84 National Institute of Mental Health Research Grant Award, supra note 78.
help to court consumers. Anybody that was in the Family Court waiting room who screened for depression or PTSD based on symptomatology was able to get a clinical evaluation. We developed a new infrastructure to teach psychiatric residents how to work with mental health clients in the community setting. There was great enthusiasm. Why? Because we created a paradigm shift. To prepare the residents we had our IPV shelter staff come into our department for educational sessions and interdisciplinary trainings. In addition, every staff member newly hired, from post-doctoral psychiatric residents to social workers, complete a six-hour IPV training. We use an evidence-based curriculum that includes active learning and role-playing to address attitudes, knowledge, and behaviors. This approach is unprecedented in psychiatric departments.

The state provided funding for the initial clinic start-up through an education program to train residents in psychiatric medicine about community-based mental health. For three years, the state-university-court partnership yielded important lessons. First, psychiatric residents needed to learn about court processes. Many patients who suffer from mental health issues are embroiled in court-based processes: criminal proceedings, divorces, child custody cases, housing, and IPV protection order cases are but a few of the issues. Yet, very few residents receive any training about the legal system beyond forensic psychiatry; training in issues such as competency to stand trial.

Another lesson learned is that survivors are more likely to follow-up with care and engage with a provider if they build a therapeutic relationship while at the court. Based on clinical tracking records, over a six-month period the residents at the court-based clinic served 799 men and women. Currently, the court clinic is staffed by a part-time social worker and according to her tracking logs, in almost one year's time she had contact with over one thousand Family Court petitioners. The court-based social worker is available in the safe waiting room for protection order petitioners. Services can include immediate support of emotional needs, support navigating the court processes, linkage to mental health service through referrals, linkage to community resources, and other forms of

86 See id.
87 Elizabeth A. Edwardsen et al., Instructional Curriculum Improves Medical Staff Knowledge and Efficacy for Patients Experiencing Intimate Partner Violence, 176 Mil. Med. 1260, 1260-61 (2011).
88 See id. at 1260-64.
89 Interview with Michelle LaRussa-Trott, LMSW, in Rochester, N.Y. (Dec. 13, 2013).
supportive and collaborative assistance. \textsuperscript{90} Feedback from court clients and staff has been overwhelmingly supportive of the mental health services provided at court. \textsuperscript{91} It is difficult enough to engage litigants with court-based professionals after they may have already taken numerous buses and time from work. To then take additional resources of time and money to link with mental health care is a burden many survivors are not willing to bear. Our services were designed and implemented to alleviate these concerns.

iii. Unintended Consequences

Our community partners, especially IPV advocates, were concerned about the potential unintended results of court-based health care. They questioned: "What does this mean to survivors' court hearings?" and, "Will their medical and mental health records become the subject of fishing expeditions or opposing counsel?" They asked whether the University of Rochester Medical Center (URMC) counsel's office could insure that they will tamp down and actually fight subpoena requests. Because of this, the URMC staff did an unintended consequence study and tracked the number of subpoenas sought in the year following the implementation of the clinic. \textsuperscript{92} We learned the request for subpoenas actually went down in the year after we implemented the clinic. \textsuperscript{93}

\textbf{CONCLUSION}

Individuals often come to Family Court with broken hearts. They come because they need help. We are the guardians of their hope, whether it be for a day, a few weeks, a few months, or, sadly, for years. In order to fulfill our professional responsibilities we need to do better by partnering with researchers to use the scientific evidence at our disposal to improve the workings of the Family Court system.

A recent study completed by the Team revealed that judges are issuing protection orders without any correlation to the level of danger the

\textsuperscript{90} See Elizabeth L. Santos & Michelle LaRussa-Trott, Mental Health Services at the Hall of Justice (Nov. 17, 2010 unpublished PowerPoint), available at https://www.urmc.rochester.edu/psychiatry/documents/hall-justice.pdf.

\textsuperscript{91} Promoting Health and Wellness at Court, Grant from the Wilson Foundation (2012).

\textsuperscript{92} Personal conversation between Corey Nichols-Hadeed and Dr. Cerulli, in Rochester, N.Y. (Nov. 21, 2013).

\textsuperscript{93} Id.
victims are experiencing. In fact, survivors reporting the highest levels of danger (severe/extreme) are not receiving permanent protection orders at a higher rate than those who report lower levels of danger. We can do better by using evidence-based instruments in the court setting and making informed decisions. The Team has just secured funding to embark on study to examine whether evidence-based intake processes can improve protection order outcomes. Nationally, Family Court venues adjudicate a host of issues: custody, adoptions, visitation, juvenile cases, and criminal offenses. Family Courts, however, often lack the resources to address such issues. It is through partnering with universities that Family Courts can obtain the resources to reflect on their successes and improve upon services through evaluation.

The studies discussed in this article always employ mixed-methods, which is a model of research that embeds qualitative components, quantitative components, and CPBR principles into every project. The University of Rochester does not start a project without collaboration from the beginning. Each project has a Community Advisory Board (CAB) that is comprised of individuals that the project targets. The Team’s model is to run the scientific design, instruments, methods, and even the funding source through a vetting process. And why does that matter? The University shouldn’t be put in the situation of competing with community-based service agencies for dollars that will fund direct services. By collaborating during the planning phase of project development, projects can be designed to benefit both researchers and community partners while, at the same time, not depleting funds to conduct research that are actually earmarked for direct services.

In conclusion, the question remains, is the expansion of therapeutic justice through CBPR a step in the right direction? The very idea of therapeutic justice remains somewhat controversial. Some critics believe the practice may result in a loss of judicial independence. They argue, in a sense, the judge who seeks to impose the state’s chosen therapeutic remedy acts as an impartial arm of the state, ignoring the difference between the state’s and the defendant’s interests. For example, in the context of juvenile proceedings, some worry the court may be more likely to find against a parent if it “is the only way to obtain needed services for a child or family.” The adjudication may be less important to the court than

95 See id. at 154 tbl. 3.
connection with services. But does this balance of equities really weigh in the wrong direction?

It is best to think of therapeutic justice as a means of adding a tool to the practitioner's arsenal. Professor Wexler has noted, "Therapeutic jurisprudence in no way suggests that therapeutic considerations should trump other concerns; they represent but one category of important considerations which include autonomy, integrity of the fact-finding process, and community safety." By partnering with universities, and employing CBPR principles, courts can examine therapeutic outcomes while balancing the rights of the accused and victims within the context of their lives.

98 See id.