Volk v. DeMeerleer Study

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Center for Law, Science and Global Health
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Research Team

Tanya E. Karwaki, JD, LLM, PhD
Research Associate, Center for Law, Science and Global Health

Jaclyn Greenberg, JD, LLM (candidate)

Annemarie Weiss, LLM

Gavin Keene, JD (candidate)

Faculty Supervisors

Patricia C. Kuszler, MD, JD
Charles I. Stone Professor of Law
Faculty Director, Center for Law, Science, and Global Health

Terry J. Price, MSW, JD
Executive Director, Center for Law, Science, and Global Health

VOLK V. DEMEERLEER STUDY

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I. EXECUTIVE SUMMARY

In December, 2016, the Washington Supreme Court decided the *Volk v. DeMeerleer* case. This case dealt with the duty of outpatient mental health providers towards third parties who might be endangered by a patient. In this tragic case, a patient with a long history of mental illness, who had been treated periodically by a psychiatrist, murdered his former girlfriend and her son and then killed himself. Notably, the patient had not voiced a threat or homicidal ideation toward the victims. The question before the Court was which of two standards to apply with respect to liability: a common law standard derived from prior case law or a later statutory standard that arguably applied only to harm committed by recently released inpatients.

The former common law standard was derived from a 1983 case, *Petersen v. State of Washington*, which held that a mental health provider has a duty to protect any foreseeable victim who might be harmed by a patient. In that case, a recently released inpatient injured a stranger in a car accident. Western State Hospital was judged to have been liable for the harm to the third party. Following *Petersen*, the Washington State Legislature narrowed the duty with its amendment to RCW 71.05.120(3), limiting it to taking reasonable precautions to provide protection from violent behavior where the patient has communicated an actual threat of physical violence against a reasonably identifiable victim or victims.

The Court in *Volk* adopted the broad common law standard of the *Petersen* case, applying it in the outpatient context. As a result, outpatient mental health providers now have a more capacious duty to protect third parties than do inpatient providers caring for committed patients. This incongruity led the legislature to commission the University of Washington School of Law to conduct a study of how Washington's duty to third parties in the mental health context compares to other states, the evolution of Washington law, the concerns and views of a variety of stakeholders engaged in mental health care and services, and the likely impact on Washington state's mental health care resources.

Our research team reviewed the statutory and case law across the nation. Our research revealed that although states frame the duty to third parties variably as a duty to protect, duty to warn, or duty to protect and duty to warn, the content of the duty was remarkably similar. Thirty-four (34) states have an affirmative provider duty to protect and/or warn third parties when they are endangered by a patient. All but two of these states characterize the threat triggering a duty to third parties as one which is a serious, imminent, and explicit threat of physical harm or death. Virtually all (33) define the third parties who are due protection or warning as reasonably or clearly identifiable, specific, or in a defined zone of risk; only one state, Wisconsin, extends the duty beyond the reasonably identifiable to the anyone foreseeable. Generally the duty is extinguished and exhausted when the provider warns the readily identifiable victim, notifies law enforcement, or commits the threatening patient. Many states have provisions and cases linking the duty to protect/warn to the duty and capacity to control the potentially dangerous patient.

Most states base their statutory and case law on the *Restatement (Second) of Torts* in which Section 315 provides an exception to the general rule that no one owes a duty to protect a third party from harming another. Under Section 315, a person has a duty to control the conduct of a third person and thereby to prevent physical harm to another if a special relationship exists between the

actor and the third person which imposes a duty upon the actor to control the third person's conduct, or a special relationship exists between the actor and the other which give to the other a right of protection. Section 315 has been interpreted as requiring a relationship to be "definite, established, and continuing," and as containing some degree of control by the defendant over a third party.

Nine (9) states provide providers with the discretion to disclose confidential information to warn or protect a third party, but do not frame it as a duty. Eight (8) states do not recognized any third party duty to warn or protect in the mental health care context.

The Legislature also requested an in-depth review of the Washington case law from the 1983 *Petersen* case to the present. During this time period, there were a series of duty to protect and/or warn cases involving mental health providers, law enforcement, or both. Those emerging from outpatient therapy scenarios have all found that either the "special relationship" requirement was not met or the outpatient setting did not provide sufficient opportunity to control the patient. Cases finding an affirmative duty to protect more broadly were confined to those in which law enforcement (e.g. parole and probation officers) was supervising the perpetrator and had the capacity to control perpetrator and prevent harm to third parties. Most recently, *Binschus v. State* (2016) had both corrections and mental health personnel involved. In that case, the Court held that once a patient was released and *out of the control* of the county, there was no duty to protect third parties against foreseeable dangers.

The broad duty imposed by *Volk* is clearly of concern to a wide variety of stakeholders. Our researchers contacted, interviewed, and in some cases surveyed 18 separate groups/organizations designated by the legislature, as well as four additional stakeholders. Most mental health providers (89%) were aware of *Volk*; seventy percent (70%) are considering changes to their practice to forestall liability, even though our inquiry of medical malpractice carriers indicates that they have not experienced increased claims, nor instituted any changes to the premium structure. Half of surveyed providers had already instituted changes in their practices. These changes included: increased screening to screen out patients deemed high risk, more assiduous questioning regarding violent intent; more frequent resort to law enforcement assistance, increased referrals for more intensive care and commitment; and more detailed documentation. Many were concerned that protection of third parties would derail their focus on the patient's needs. Many of these themes were echoed in the Stakeholders Meeting held on November, 18, 2017.

A few providers indicated an intention to retire early or severely limit their practices. This concern resonates with our study and review of mental health resources in Washington state. While the number of outpatient providers has increased marginally over the last decade, the majority (60-75%, depending on category) practice in metropolitan NW Washington. Stakeholders noted that inpatient resources are limited. Our major inpatient psychiatric hospitals (Western, Eastern, Child Study and Treatment) have maintained a very high occupancy over the last several years. Indeed, the absence of inpatient capacity has led to increased usage of single bed certifications for psychiatric care in general hospitals. There is precious little capacity to absorb an increased number of patients referred for inpatient mental health care.

In summary, the mental health provider duty toward third parties under *Volk* is substantially broader than previously inferred from Washington legislation and case law. Moreover, outpatient

providers now have a far more expansive duty to third parties than do inpatient providers who have greater capacity to control a patient. Indeed, Washington is now an outlier compared to other jurisdictions. The practical implications are meaningful, particularly for the patients who are labile, engage in therapy irregularly and/or do not comply with their medication regimen—and also those who may not actually utter threats. Stakeholder providers evince considerable concerns, notably seeking to utilize inpatient and law enforcement resources more readily than in the past and being less likely to accept high risk patients into their practices.

II. COMPREHENSIVE REVIEW OF THE "DUTY TO WARN" AND THE "DUTY TO PROTECT"

The University of Washington School of Law Center for Law, Science and Global Health was asked to "convene a study on the Washington State Supreme Court decision *Volk v. DeMeerleer*, 386 P.3d 254 (Wash. 2016)." The *Volk* case (explained in detail below) elaborated on the duty of mental health providers to protect foreseeable victims of a dangerous patient. The goal of the study was to evaluate whether or not this case "substantially changed the law [in Washington] on the duty of care owed to third parties by mental health providers and whether it has had an impact on access to mental health services in the state." *See* Appendix A, *Volk* Appropriation, §(25)(a). This portion of our report details the results of the nationwide comprehensive survey of law and how Washington's current law compares to other jurisdictions.

The legislative appropriation for a comprehensive review of "duty to warn" and "duty to protect" law required three major subsets of legal research. First, it required an in-depth 50 state survey of legislative and case law related to the duty to warn and duty to protect. In the interest of being complete, we also included the District of Columbia. *See* Appendix A, *Volk* Appropriation, §(25(a)(i). Second, it included a detailed historical review and analysis of "duty to protect" lawsuits brought in Washington against outpatient mental health care providers since the decision in *Petersen v. State*, 671 P.2d 230 (Wash. 1983), the preeminent case in Washington prior to *Volk*. *See* Appendix A, *Volk* Appropriation, §(25(a)(iii). Finally, it included an analysis of how the *Volk* decision changed the law in Washington and how "Washington State's law compares to other states." *See* Appendix A, *Volk* Appropriation, §(25(a)(i).

NOTE: All cases and statutes referred to in this text are available in the Appendix I, the complete summary of the fifty states and District of Columbia, and in the Supplementary Materials (each state's statute and cases) available on the submitted USB drives or archived with the House Judiciary Committee.

A. Background: The *Tarasoff* Case and the Duties to Endangered Third Parties

The concept of a duty owed to third parties from a mental health patient was initially recognized by the California Supreme Court in *Tarasoff v. Regents of the University of California.* In that case, a student, while in therapy with a University psychologist, threatened to kill his former girlfriend. The psychologist was so concerned about this threat that he took steps to have the student committed, including consulting with his supervising psychiatrist and approaching University police to initiate proceedings. The police briefly took the patient into custody, but determined that the patient was rational and released him on his promise to stay away from his former girlfriend, Tatiana Tarasoff. The psychiatrist and psychologist concurred and concluded that commitment was not necessary. Subsequently, the patient murdered his former girlfriend. Ms.

Tarasoff's family sued the University of California arguing that the therapist, among others involved, including the police, had a duty to warn the victim of impending danger.

The California Supreme Court ruled on the case twice. In the first case, the Court found therapists owed a duty to warn their patient's foreseeable victims of danger. 529 P.2d 533 (Cal. 1974). In the second case, the Court phrased the duty as a duty to protect: when a patient threatens serious danger of violence to another, the therapist is obliged to use reasonable care to protect the foreseeable victim against such danger. *See* 551 P.2d 334 (Cal. 1976).

Considerable confusion with respect to terminology emerges from this first seminal case, largely because the California Supreme Court first used the term "duty to warn" and then later the term "duty to protect." The confusion and conflation of this terminology issue are discussed in detail in Section II.B of this report, *infra*.

The Court rested the duty to warn or protect on the "special relationship" between the therapist and patient, as well as the "foreseeability" of the victim. Generally, no one owes a duty to protect a third party from being harmed by another person. The final *Tarasoff* opinion relied on an exception to the rule, Section 315 of the *Restatement (Second) of Torts*, to support its ruling. It states:

> A person has a duty to control the conduct of a third person and thereby to prevent physical harm to another if:
> (a) A special relation exists between the actor and the third person which imposes a duty upon the actor to control the third person's conduct, or
> (b) A special relation exists between the actor and the other which gives to the other a right of protection.

The Court held:

> When the avoidance of foreseeable harm requires a defendant to control the conduct of another person, or to warn of such conduct, the common law has traditionally imposed liability only if the defendant bears some special relationship to the dangerous person.... Since the relationship between a therapist and his patient satisfies this requirement, we need not here decide whether foreseeability alone is sufficient to create a duty to exercise reasonable care to protect a potential victim of another's conduct.

551 P.2d at 342-43. Of note, Section 315 has been interpreted as requiring the special relationship to be "definite, established, and continuing" and evidencing some degree of control by the defendant over a third party. *See* Jaclyn Greenberg, 92 Wash. L. Rev. Online 13, 23-24 (2017) (*quoting Binschus v. State*, 186 Wn.2d 573, 579 (2016)) , https://www.law.uw.edu/wlr/online-edition/greenberg/.

The *Tarasoff* case rang alarm bells nationally across the mental health provider community. Key among the concerns was the potential impact on patients who, in the wake of *Tarasoff*, would not be honest and unfettered in revealing their thoughts and feelings in the course of therapy. Therapists argued that they would be crippled in providing much-needed care and counseling if

patients fear their confidential thoughts and fears could be disclosed. There was also much concern about the difficulty in ascertaining what constituted a "foreseeable" victim. Mental health providers argued that they are not omniscient and stressed patients often vent thoughts that are fleeting. Yet another concern was how to discharge the duty, especially if the only resort is to engage law enforcement. Despite these concerns, the *Tarasoff* standard became the national common law standard.

After *Tarasoff*, the courts and legislatures in California and beyond grappled with its dimensions. In *Thomson v. Alameda*, 27 Cal.3d 746 (1980), the California Supreme Court dealt with a case in which a juvenile offender was released from a county institution on a temporary leave. The offender had known propensities for violence, particularly towards young children. Within 24 hours of his release, he murdered a neighbor's child. Noting that *Tarasoff* "required that warnings be given directly to the identifiable potential victim or to those who, in turn, would advise such individuals of potential danger," the Court in *Thomson* found that county authorities had no duty to protect or warn:

> Despite the tragic events underlying the present complaint, plaintiffs' decedent was not a known, identifiable victim, but rather a member of a large amorphous public group of potential targets. Under these circumstances we hold that the County had no affirmative duty to warn plaintiffs, the police, the mother of the juvenile offender, or other local parents.

27 Cal.3d at 758. *Thomson* thus narrowed the class of victims to whom a duty is owed.

Subsequently, in 1985, the California legislature refined the duty to protect and narrowed *Tarasoff* even more. It clarified that psychotherapists have a duty to protect and duty to warn only "reasonably identifiable" victims. Nearly 30 years later, in 2013, the California legislature excised "duty to warn" and left in the statute solely a "duty to protect," but explicitly added this was not to be interpreted as a substantive change. See Cal. Civ. Code §43.92.

These cases provide both background and a snapshot of the confusing issue of terminology that is amplified in our national review of legislative and case law.

B. Review of Case Law and Legislative Provisions Across the United States

Using multiple electronic databases, our team retrieved and reviewed statutes and cases from all fifty states and the District of Columbia that address mental health care providers' duty to protect and/or duty to warn endangered third parties. *See* Appendix I and Supplementary Materials. In conducting the research, we sought to discover the legal nuances with respect to the statutory and common law duties ascribed to mental health providers and to parse through some of the complexities in terminology. This will provide a national context for the in-depth review of Washington's case law, *infra* in Section III.

1. Terminology with Respect to the "Duty to Protect" and the "Duty to Warn"

In conducting the legislative and case law survey, it became clear that there are a number of variations in terminology. We have sought to reconcile these when possible and to understand the

nuances of the terms different states have employed in addressing the duty to third parties in the context of mental health care.

As stated above, going back to *Tarasoff*, the prevailing terms are "duty to warn" and "duty to protect." These terms are often employed separately, sometimes applied variably to different classes of mental and other health care providers, and sometimes treated synonymously or in a linked fashion, although as discussed below, the basis for each is distinct. Thirty-four (34) states use one or both of these terms to describe the duty of variable categories of providers with respect to potential third party victims.

The "duty to protect" arguably implicates a broader range of activities than the "duty to warn." For example, the "duty to protect" may be satisfied not only by warning the victim or class of victims and/or law enforcement, but also by requiring other actions and reasonable steps to forestall harm to potential third parties and others. These may include, but are not limited to, utilizing capacity to control the dangerous patient through commitment to an inpatient setting, imposing or referring for an enforceable, more aggressive treatment regimen, or engaging an additional provider to evaluate the patient.

2. Summary of the National 50-State (plus District of Columbia) Legislative and Case Survey

In our survey of legislation and case law, we focused on: (i) the description, content and terminology defining the duty owed to third parties; (ii) which mental health care providers have duties to third parties; (iii) who qualifies as a potential third-party victim; (iv) how the threat is qualified with respect to triggering the duty; and (v) how the duty may be discharged or extinguished.

a) Description of the Duty to Third Parties

In addition to the duty to protect and the duty to warn (discussed above), some states also use discretion to disclose and the duty to control. While our mandate in this study was to focus on the duty to warn/protect, the capacity and duty to control is actually a fundamental part of the case and statutory law. Similarly a number of states stop short of duties to warn, protect or control and instead have adopted a more permissive discretion to disclose. Complicating the matter is that a number of states employ several of these duties in the case or statutory law. There are eight states that neither recognize a duty to warn or protect nor provide for discretion to disclose risks to others.

Nineteen states use both the duty to protect and the duty to warn terminology, often not distinguishing between them in terms of what the duty entails. The following table (Table 1) summarizes the approach taken by these states. For full citation, see the states' summary in Appendix I. Note: Because Washington is not a hybrid due to the *Volk* decision, as described in detail below, it has been added here as well.

Table 1: Description of Duties to Warn and Protect

States	Description of Duties
Alabama, Colorado, Illinois, Indiana**, Kentucky* Louisiana, Maryland, Nebraska, New Hampshire**, New Jersey, Oklahoma, Tennessee, Washington	Statutory duty to warn and protect; no distinction between terms made * duty limited to inpatient context ** statute uses both terms, case law refers only to duty to warn
Idaho, Massachusetts, Minnesota, New York, South Dakota, Utah	Statutory and/ or common law duty to warn and protect tied to duty or capacity to control

In most of these states, the concepts of "duty to warn" and "duty to protect" appear to be a distinction without a discernable difference. Moreover, several states also integrate "duty to control" provisions into their statutory or common law framework by which the duty to warn or protect requires a capacity for provider control of the patient. Washington uses "duty to protect" language in case law (*Petersen*, *Volk*) and references "duty to warn" in its Involuntary Treatment Act (inpatient commitment) statute, Wash. Rev. Code §71.05.120. It requires warning of the victim and/or notification of law enforcement.

Nine states employ the "duty to warn" language alone. These states include Arizona, Arkansas, Georgia, Michigan, Mississippi, Missouri, Montana, South Carolina, and Wisconsin. The content of the duty to warn generally includes warning the foreseeable victim and/or notifying law enforcement. Arkansas and Michigan mention utilizing commitment in fulfilling the duty to warn. Georgia and Wisconsin provide no guidance on what constitutes a warning.

Six states have embraced the terminology of "duty to protect." These include California, Delaware, Ohio, Pennsylvania, Vermont, and Virginia. The content of the "duty to protect" varies from state to state. Ohio has the most fulsome description, incorporating warning of the clearly identifiable victim, notifying law enforcement, seeking a second risk assessment, implementing a responsive treatment plan, and pursuing involuntary commitment of the patient. Vermont employs a non-specific description of "whatever steps are reasonably necessary to protect the foreseeable victim of that danger."

In summary, in the states with a duty to protect, a duty to warn, or a duty to protect and to warn, the quality and description of the duty to warn and the duty to protect are not significantly differentiated in the majority of case and statutory law. One could argue that the duty to protect is marginally more prescriptive and provides for a larger array of provider actions to protect.

Separate from the duty to warn or protect, nine states give providers, or some classes of providers, discretion to disclose with the aim of protecting third parties. The latter approach allows

mental health providers to breach confidentiality with the aim of preventing harm to third parties, but does not require them to do so. The policy purpose underlying this discretionary approach is for providers to maintain confidentiality when possible, but protect them from liability when they act in the interest of protecting third parties from harm. In this sense, the approach echoes public health reporting which provides for mandatory reporting of some public health threats (certain contagious diseases, gunshot wounds, child abuse), but may also provide for permissive reporting of other health issues or by other classes of reporters.

In Oregon, where there is a broad discretion to disclose, *see* Or. Rev. Stat. § 179.505(12), there is no affirmative duty to warn or to protect unless the provider has a duty to control. Providers susceptible to this duty are those who accept patients on conditional release under the purview of the state's Psychiatric Security Board (PSB). The relevant Oregon case is *Cain v. Rijkin*, 300 Or. 706 (1986), in which a psychiatric patient on conditional release after commitment and actively engaged in a day treatment program ran a red light, hitting another car and killing one of its occupants. The Oregon Supreme Court held that, because the patient was under "control" of the PSB, there was a duty of reasonable care to persons foreseeably endangered.

As in the Oregon case, the "duty to control" is generally imposed on mental health providers who have a "take charge" relationship with the patient. For example, in *Tamsen v. Weber*, 802 P.2d 1063 (Ariz. 1990), a patient who had been involuntary committed was allowed grounds privileges, escaped and assaulted a woman. The court held that the facility had a capacity to control the patient and had not prudently exercised its duty to do so. This concept is refined in *Lundgren v. Fultz*, 354 N.W.2d 25 (Minn. 1984), a Minnesota case, in which a woman was shot and killed by a paranoid schizophrenic. The patient had a long history of commitment and ongoing outpatient care where he frequently enunciated thoughts of killing others and himself. After a period of relative quiescence, the psychiatrist affirmed that the patient could recover his gun collection. Five months later the patient admitted he had stopped taking his medication, stopped coming to his appointments and a few weeks later killed the victim. The Court noted the fact that the provider-patient relationship had been ongoing from the time of involuntary commitment, through subsequent admissions, and ongoing outpatient treatment. The Court held that the psychiatrist had a longstanding "special relationship" with the patient and had the capacity and duty to control the patient.

Eight states have not addressed or not recognized a duty to protect and/or duty to warn, or even the discretion to disclose to third parties a danger presented by a mental health patient. For example, Iowa has explicitly declined to recognize a duty to warn or a duty to protect. In *In re Estate of Votteler*, 327 N.W.2d 759 (Iowa 1982), Iowa's Supreme Court declined to find a duty to warn in a case with facts very similar to those in the *Petersen* case here in Washington. Subsequently, *in Estate of Long ex rel. Smith v. Broadlawns Medical Center*, 656 N.W.2d 71 (2002), a case involving a readily identifiable victim, the Iowa Supreme Court reaffirmed that it has not adopted the duty principles flowing from *Tarasoff*.

Similarly in Maine, the Supreme Court addressed the issue in two cases and found that an expanding liability for psychiatrists for third-party harm to be "socially undesirable." In addition, Kansas, Nevada, New Mexico, North Carolina, and North Dakota have not recognized a duty to take reasonable care to protect a third party or the discretion to disclose in the mental health context. Notably, although Nevada has not recognized a duty to warn a potential victim of a mental health

patient, it has recognized the presence of a special relationship between a cab driver and patron with respect to risk of harm. See *Mangeris v. Gordon*, 580 P.2d 481 (Nev. 1978).

b) Who Has a Duty to Third Parties in the Context of Mental Health Care

Most states confine duties to third parties in the context of mental health care to specific classes of providers, rather than the entire universe of health care providers. Mental health professionals are defined with variable specificity from state to state, ranging from the generic "mental health providers" to specific licensure categories of mental health providers, such as psychologist, licensed clinical social workers, licensed professional counselors, marriage and family counselors, and advanced practice registered nurses (APRN) trained in psychiatric care. Although physicians are generically licensed, many statutes apply the duty to psychiatrists. California applies the duty to protect to "psychotherapists" or to persons who the patient reasonably believes is a "psychotherapist," including a long list of potential providers. Colorado also lists many potential "mental health providers" that are covered by the duty to warn and protect, some clearly licensed providers, others not. See Appendix I.

While some states limit the class of affected providers to "licensed" providers, some are less specific with respect to licensure status. For example, Utah applies the duty to "therapists" and Arizona speaks generically of "mental health providers." South Carolina does not specify which providers have a duty to warn. The summary chart in Appendix I provides state-by-state detail on who is required to warn, protect and control. Some of the mental health provider "duty to warn or protect" states also provide a broader class of providers with the discretion to disclose or warn.

c) Who Qualifies as a Potential Third-Party Victim

States generally define the third-party beneficiary as one who is reasonably identifiable by the covered provider. Some use terminology such as "clearly identifiable", "specific person" or person within a zone of risk such as parents. This is the case in 33 of the 34 states that have a duty to warn and/or a duty to protect.

Wisconsin imposes a duty to warn foreseeable third parties with no requirement that the target victim be readily identifiable. The governing (and only) case is *Schuster v. Altenberg*, 144 Wis.2d 223 (1988), in which a psychotic patient was the driver in a car accident that killed her and severely injured her mother, who was a passenger in the vehicle. There the Wisconsin Supreme Court explicitly extended the duty to warn beyond those who are readily identifiable to the public at large. This scenario mimics the facts in *Petersen*, the seminal Washington case discussed below, although *Petersen* frames the duty as a duty to protect. There is no statutory provision in Wisconsin. Notably, Delaware also had a broad duty to protect the public at large, but the Delaware legislature narrowed the scope of the duty to readily identifiable victims. *See* Del. Code Ann.16 §5402.

The states which provide for a discretion to disclose often speak to protection of a broader class of third parties. For example, Alaska cites "other individuals or society." *See* Alaska Stat. § 08-29.200. Connecticut uses the "patient himself or other individuals." *See* Conn. Gen. Stat. §52.146(c). Other states with a discretion to disclose use more circumscribed language. For

example, Rhode Island provides for disclosure only to the patient's family. *See* R.I. Gen. Laws §5-373-4.

The variation in terms described above is displayed in Table 2 below:

Table 2: Characterization of Potential Third Parties

States Note: *Italicized States are "discretion to disclose" states*	**Description of Third Party**
Alabama, Arkansas, California, Delaware, Georgia, Idaho, Illinois, Indiana, Kentucky, Louisiana, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, Ohio, Oklahoma, Pennsylvania, South Dakota, Utah, Vermont, Virginia,	Reasonably Identifiable Victim or Victims; Clearly Identifiable Victims
Arizona	Persons within a "zone of risk" – i.e., parents or others in foreseeable area of danger
Colorado, Maryland, Minnesota, New York, South Carolina, Tennessee,	Specific person or persons; specific clearly identified or identifiable potential victim, endangered person,
District of Columbia, Alaska, Connecticut, Florida, Hawaii, Oregon, Rhode Island, Texas, West Virginia, Wisconsin.	Others, Society, Third party without requirement of identifiability; Another individual, or not specified

Some states cast different universes of victims as beneficiaries of discretion to disclose, duty to warn, duty to protect and duty to control. For example, Georgia requires psychiatrists to warn foreseeable or readily identifiable targets of "not generalizable threats" made by their patients. *See Jacobs v. Taylor*, 379 S.E.2d 563 (Ga. Ct. App. 1989). Georgia also has a duty to control and protect a wider universe of potential victims from harm when mental health providers have a control capacity over the potentially dangerous patient via voluntary or involuntary commitment procedures. *See Bradley Ctr. Inc. v. Wessner*, 296 S.E.2d 693 (1982). Arizona, Kansas, Massachusetts, Minnesota, North Carolina, Nebraska, Oklahoma, and Oregon impose a duty to control upon mental health providers with respect to patients presenting more generalized or amorphous danger. This duty is consistent with having a "special relationship with the patient and the capacity to control through commitment to an in-patient mental health facility." *See Rodriguez v. Catholic Health Institute,* 297 Neb. 1 (2017).

d) What Qualifies as a Sufficient Threat to Trigger a Duty to Third Parties

Regardless of how the duty to third parties is described (duty to protect, duty to warn, discretion to disclose, duty to control,), the majority of states characterize the level of threat that triggers the duty as one that presents a serious, imminent and explicit threat of physical harm. As

reflected in the summary chart at Appendix I, this is the case in all but two states. In Georgia, there is a duty to warn foreseeable or readily identifiable targets of 'generalized threats." As noted above, Wisconsin has a broad common law duty to warn that result when there is foreseeability of "harm" to a third party. *See* discussion of *Schuster v. Altenberg, supra.*

e) How Is the Duty Discharged or Extinguished

Yet another complex issue is determining how a mental health provider extinguishes or discharges the duty to protect or duty to warn. The general rule is that the duty is extinguished upon reasonable efforts to warn the intended victim and/or informing law enforcement. This, of course, links closely to whether the victim(s) is readily identifiable. In states where the duty to control is integrated into the duty to warn and/or duty to protect, discharge of duty is frequently tied to commitment or hospitalization of the patient.

A few states differentiate and add language relevant to protection. For example, Alabama requires "reasonable steps" to protect third parties who are identified. Indiana includes taking steps to prevent patients from using violence until law enforcement takes charge of the patient and communicating the threat to other providers that have the capacity to warn. New York has a duty to warn that is somewhat ambiguous in that it is linked to a duty to report under state law; this law does not address third parties, but does provide providers the discretion to disclose. New York also has a duty to protect only when the mental health provider has a special relationship with the patient that includes the ability to control and commit the patient. *See Oddo v. Queens Village Committee for Mental Health*, 71 N.E.3d 946 (2017).

In the states which have adopted solely a duty to protect, Pennsylvania's is the most limited. Pennsylvania confines protection of the third party to warning of the specific, readily identifiable victim. *See Emerich v. Philadelphia Ctr. For Human Dev. Inc*., 720 A.2d 1032 (1998). In that case, the Court noted that while other actions are available, the least expansive means should be employed commensurate with the circumstances. California considers the duty to protect discharged upon reasonable efforts to communicate the threat to the victim(s) and to a law enforcement agency. *See* Cal. Civil Code §43.92. Delaware adds the criteria of arranging for the patient's commitment. *See* Del Code. Ann. 16 §5402. Virginia includes the following as a means to satisfy the duty to protect: involuntary commitment of the patient, notifying the victim, notifying law enforcement and providing therapy. *See* Va. Code Ann §54.1-2400.1. Ohio has an even more fulsome approach in that it includes commitment of the patient, notification to both law enforcement and the victim, creation of a treatment plan to thwart the threat, and a second risk assessment. These provisions apply in the "duty to protect" context with respect to clearly identifiable potential victims who are threatened with serious physical harm, including causing death. *See* Ohio Rev. Code Ann. § 2305.51. Notably, Ohio has been cited as a model by some of the Washington stakeholders we consulted and surveyed. *See* discussion *infra*, at V.J.

From our research, it seems clear that the duty of the provider is extinguished once a warning has been delivered or a patient committed. Obviously, if the patient resumes a relationship with their provider after commitment or third party warning, the duty to warn or protect may be refreshed anew.

III. WASHINGTON STATE CASE LAW: AN IN-DEPTH REVIEW

Our research team did an extensive review of Washington law, particularly the case law that arose after the 1983 *Petersen v. State of Washington* case to the present day. Notably, there were virtually no cases directly on point between *Petersen* and *Volk.* However, there are eleven related "duty to protect" and "duty to warn" cases. Of the eleven cases, seven dealt primarily with a duty to control in the context of law enforcement and probation officers, which is beyond the scope of the *Volk* facts, but demonstrate the interplay between duties to others and the capacity to control. Indeed in at least 3 of these, there are both law enforcement and mental health dimensions. Four cases arose in the context of mental health treatment, and none found liability for failure to protect third parties.

At the end of this section are four additional cases. The first is an unreported case, *Lennox v. Lourdes Health Network*, 195 Wash. App. 1003 (2016), that moved through the court system at roughly the same time as *Volk.* Supreme Court review of *Lennox* was denied in early 2017, shortly after the *Volk* decision in December, 2016. The second is a federal district court case, *Jackson v. City of Montlake Terrace*, which was decided in 2017 and drew upon Washington case law in its decision. Two cases filed subsequently to the *Volk* decision are at very early stages but are included as well. They are discussed in Section E, below.

A. *Petersen v. State of Washington*, 100 Wn.2d 421, 671 P.2d 230 (1983)

Washington's current debate on duty to third-party victims is rooted in the *Petersen v. State of Washington* case. The *Petersen* case involved a patient who had been involuntarily committed for a month at Western Washington State Hospital for psychosis due to drug ingestion. The day prior to his release, the patient was found driving recklessly in the parking lot of the hospital. He was released anyway. Five days after his release, the patient ran a red light, hitting another car and injuring its driver. Ms. Petersen, the driver of the other car, sued arguing that the State psychiatric hospital had failed to protect the universe of victims and was grossly negligent by failing to petition for continued commitment of a patient who presented a danger to others.

The *Petersen* case relied heavily on *Tarasoff* and a case from Nebraska, *Lipari v. Sears Roebuck & Co.*, 497 F.Supp. 185 (Neb. 1980). In that case, a patient had been committed for psychiatric care at the Veteran's Hospital and was discharged to an outpatient program. The patient did not comply with his therapy regimen at the VA and one month after ceasing therapy, he bought a gun from Sears, entered a nightclub and shot several of the patrons. The Nebraska Court held that both Sears and the VA hospital owed a duty to any foreseeable victims, including the injured parties in the nightclub.

Petersen raised many questions with respect to the duty to protect third parties, primary among these was the huge potential universe of third parties. Essentially, mental health providers would never be able to adequately warn the public at large or ensure that someone discharged from inpatient care would not present a danger to the public at some future time. In *Petersen*, as in *Lipari*, the patient had been involuntarily committed for a period of time, but deemed sufficiently recovered to be released from a "controlled" setting. Taken to the extreme, both *Petersen* and *Lipari* would mitigate against ever releasing a patient who had been involuntarily committed for uttering a threat against another or the world at large.

Four years later, in 1987, the Washington Legislature addressed therapist liability in RCW 71.05.120(2) (now codified in RCW 71.05.120(3)):

> (1) No officer of a public or private agency, nor the superintendent, professional person in charge, his or her professional designee, or attending staff of any such agency, nor any public official performing functions necessary to the administration of this chapter, nor peace officer responsible for detaining a person pursuant to this chapter, nor any county designated mental health professional, nor the state, a unit of local government, or an evaluation and treatment facility shall be civilly or criminally liable for performing duties pursuant to this chapter with regard to the decision of whether to admit, release, or detain a person for evaluation and treatment: PROVIDED, That such duties were performed in good faith and without gross negligence.
>
> (2) This section does not relieve a person from giving the required notices under RCW 71.05.330(2) or 71.05.340(1)(b), or the duty to warn or to take reasonable precautions to provide protection from violent behavior where the patient has communicated an *actual threat of physical violence against a reasonably identifiable victim or victims*. The duty to warn or to take reasonable precautions to provide protection from violent behavior is discharged if reasonable efforts are made to communicate the threat to the victim or victims and to law enforcement personnel.

1987 c 212 § 301 (emphasis added).

Note that in the current statutory provision, the duty to warn as well as a duty to protect are referenced. *See* discussion *supra* re terminology.

The statute also elaborated upon how and when the provider duty is satisfied or extinguished. It states that the duty to warn is discharged once the provider has engaged in reasonable efforts to communicate the threat to the reasonably identifiable victim or victims or to law enforcement personnel. In the wake of this legislation, the duty to protect and warn in Washington were narrowed from the expansive approach taken in *Petersen.* Important for later developments, the liability immunity provision was inserted in the Involuntary Treatment Act, which pertains to inpatient commitments.

As noted above, eleven cases have been decided in Washington courts between *Petersen* and *Volk*. This line of cases is chronicled below and demonstrates the intermingling of duty to protect, to warn and to control in Washington case law.

B. Washington's Case Law on Duty to Third Parties in the Context of Mental Health

The first case with respect to duties to third parties in the wake of *Petersen* was *Noonan v. State*, 53 Wn.App. 558 (1989). In this case, a parolee was released on the condition that he enter and complete an alcohol treatment program. He was a non-compliant patient who ultimately absconded from the facility and a few days later kidnapped and raped a young girl. The parents of the victim sued, and citing *Petersen*, argued that the alcohol treatment facility knew or should have known that the perpetrator was likely to cause bodily harm to others if not properly controlled.

Citing the *Restatement (Second) of Torts* Section 315 (explained above), the Court noted that for liability to attach, a duty must first be established. The Court stated, "[O]ne who takes charge of a third person whom he knows or should know to be likely to cause bodily harm to others if not controlled is under a duty to exercise reasonable care to control the third person to prevent him from doing such harm." See 53 Wn.App. at 566 (*quoting* §315 of the *Restatement*). The Court found no special relationship between the alcohol treatment facility and the defendant.

Just one year later, the same alcohol rehabilitation facility was once again sued by the family of a patient. Here, an alcoholic was required to attend weekly group therapy sessions at the facility as part of a deferred prosecution program following a DUI offense. While complying with the weekly therapy regimen, the patient drove while drunk and caused a motor vehicle accident that killed two people in the other car. The Court determined that *Petersen* was distinguishable and not controlling. It noted that the treatment center did not have custodial control of the patient, thus, there was no special relationship under §315 of the *Restatement* and the psychiatrist had no legal duty to warn persons who might foreseeably be endangered by the patient. *See Metlow v. Spokane Alcohol Rehab. Center,* 55 Wn.App. 845 (1990).

In *Walker v. State*, decided in 1991, two police officers were murdered by a mentally-disturbed defendant who had been judged incompetent to stand trial and referred for mental health evaluation and treatment. After treatment, the defendant was deemed competent to stand trial and subsequently pled guilty. Following his plea, the defendant was released on his own recognizance by the court. The plaintiffs argued, that unlike the *Metlow* scenario, the patient had been in the custody and control of the psychiatric hospital and thus there was a duty to protect foreseeable victims. The Court, however, found that once the patient was discharged from the hospital, there was no longer any capacity for control and thus no duty to protect third parties. See *Walker v. State*, 60 Wn.App. 624 (1991).

The first case after *Petersen* to find a duty to third parties was *Taggart v. State*, 118 Wn.2d 195 (1992). This case arose in the context of a parole officer/parolee relationship. In this case, two parolees being supervised by parole officers violated their paroles and committed violent crimes. Here the Court essentially expanded the duty to warn to non-mental health contexts when there is a similar relationship with capacity to control. The Court held that this parole officer/parolee relationship qualified as a "special relationship" under §315, noting that it is a definite, established and continuing relationship and one that gives rise to the duty to control. The Court also cited §319 of the Restatement as relevant noting that a parole officer in the position to "take charge of a third person whom he knows or should know to be likely to cause bodily harm to others if not controlled is under a duty to exercise reasonable care to control the third person to prevent him from doing such harm." 118 Wn.2d at 220.

Bishop v. Miche, 137 Wn.2d 518 (1999), decided seven years later involved a probationer who, while driving drunk, killed a child. In this complex case, the Court of Appeals and Supreme Court found that, while the county probation officer had the capacity to exercise control over the probationer, proximate cause was lacking for other reasons. A second case involving probationers decided the same year had a different outcome. In *Hertog v. State*, 138 Wn.2d 265 (1999), a probationer with a history of substance abuse and sexual deviancy raped a young girl while on pre-trial release. Here the court held that probation counselors have a duty to control municipal court

probationers and to protect others from reasonably foreseeable harm resulting from the probationer's dangerous propensities. Similarly in *Stevenson v. State*, 100 Wash. App. 1021 (2000) (unpublished opinion), the Court found the State liable for a claim of third party harm when a man with a history of both mental illness and multiple parole violations was mistakenly released due to lost paperwork.

Between 2000 and 2005, there are no cases involving a duty to protect or a duty to warn. But in 2005, two cases arose, one involving a duty to third parties by community corrections officers and the other involving mental health providers. In *Joyce v. State*, 155 Wn.2d 306 (2005), a convicted felon under community supervision stole a car and was responsible for a fatal car accident. The court found that the community corrections officer did have a "special relationship" that gave rise to duties toward third parties. Quoting *Taggart*, the court found "the State has a duty to take reasonable precautions to protect against reasonably foreseeable dangers posed by the dangerous propensities of parolees." 155 Wn.2d at 310. In *Estate of Davis v. State*, 127 Wn.App. 833 (2005), a Washington Court of Appeals case addressed third-party duty in the context of mental health. Here a patient was evaluated by a mental health counselor to determine if further treatment was indicated. The counselor evaluated the patient, determined that there were no grounds for involuntary commitment and referred the patient to an outpatient clinic. Subsequently the patient committed murder. The Court of Appeals determined that this one interaction, essentially serving a triage function, was not sufficient to establish the necessary definite, established, and continuing relationship that would trigger a legal duty to third parties. In short, there was no "special relationship."

In 2015, *Husted v, State*, 187 Wn.App. 579 (2015**)**, involved a criminal offender who had absconded from supervision and indeed was subject to an arrest warrant at the time he injured third parties. Here the Court reasoned that there was no ongoing relationship, supervision or control capacity on the part of the department of corrections or the parole officer. Husted had, in effect, left the sphere of both the "special relationship" and the "take charge" capacity.

Most recently in *Binschus v. State*, 186 Wn.2d 573 (2016), there was a similar lack of duty to third parties. This case, which had both corrections and mental health provider involvement, involved a recently released jail inmate, who subsequently killed and injured several people in a psychotic shooting spree. The released inmate, Zamora, had a long history of psychiatric problems dating back over a decade to his teenage years. While serving a six-month sentence for malicious mischief and possession of controlled substances, he and his family made several requests that he be evaluated and treated for ongoing mental health issues. Zamora had a variety of run-ins with the police after release and ultimately murdered five people. He was subsequently sentenced to life in prison. The family of his victims sued the state arguing that the county owed a duty to the victims. They argued that the county had a special relationship with Zamora that gave rise to a duty to protect the victims under the *Restatement (Second) of Torts* §§ 315 and 319. Citing the Restatement, the court tied together the duty to protect with the duty to control, holding that absent a duty to control, there can be no duty to protect. In *Binschus*, the Court reasoned that, without a "take charge" control capacity, there could not be a duty to protect against all foreseeable dangers. 186 Wn.2d at 580.

The foregoing legal landscape on the duty to third parties was in place when *Volk v. DeMeerleer* was decided in late 2016.

C. *Volk v. DeMeerleer,* 187 Wash. 2d 241 (2016)

In December 2016, a majority of the Supreme Court of Washington changed the legal landscape for the duty to protect in Washington with its ruling in *Volk v. DeMeerleer,* 187 Wash. 2d 241 (2016). The facts and the appellate decisions of the case are summarized and analyzed below.

1. Summary of the Facts in Volk v. DeMeerleer

On July 18, 2010, Jan DeMeerleer, entered the home of his ex-girlfriend and her three sons and killed her and one of her sons, and attempted to kill another but the boy fended him off. DeMeerleer later killed himself. In addition to a suit against DeMeerleer's estate, the victims' family sued Dr. Howard Ashby, who had treated DeMeerleer on and off for years for mental illness, as well as the clinic where Dr. Ashby worked, to recover damages for their losses, alleging among other things, a failure to warn.

DeMeerleer had a long history of mental illness. He was a college student when he was diagnosed with bipolar disorder and depression. In 1992, at the age of 21, he was hospitalized after he attempted suicide. His disorder was treated with medications, and he was discharged with a planned medication regimen. This was his only hospitalization in the record.

In late 2001, DeMeerleer first consulted Dr. Ashby. During the intake interview, DeMeerleer confessed to suicidal ideation in the past but denied current suicidal or homicidal ideation. Dr. Ashby prescribed medication and instituted a plan to monitor DeMeerleer's response during ongoing therapy. DeMeerleer periodically presented to Dr. Ashby, and his medications were periodically adjusted over the next few years. Between 2001 and 2004, his condition was generally stable, although it faltered around 2003 when his marriage ended. At that time, he confessed to fleeting homicidal/suicidal thoughts but he denied forming any plans to actuate them.

In 2005, DeMeerleer entered into a relationship with Rebecca Schiering, a woman with three sons. There was nothing in the record regarding DeMeerleer's treatment, if any, between summer 2006 through summer 2009. DeMeerleer and Ms. Schiering became estranged in December 2009 after DeMeerleer slapped one of her children. Shortly thereafter, in December 2009, DeMeerleer contacted the Spokane Psychiatric Clinic in distress about the breakup (and his unemployment), and seeking to return to counseling and reinstitute his medication regimen. He was referred to local community-based mental health clinics and told to call back if the referrals were unsuccessful. It is unclear whether he pursued any care from them.

On April 26, 2010, DeMeerleer met with Dr. Ashby at the Spokane Psychiatric Clinic. During that visit, DeMeerleer admitted to occasional fleeting suicidal ideation, but evidenced no serious intent. He expressed no homicidal thoughts. In fact, DeMeerleer reported that he was mending his relationship with Ms. Schiering. Dr. Ashby confirmed his medication regimen. This was the last appointment between Dr. Ashby and DeMeerleer.

According to the record, between May and July 2010, DeMeerleer and Ms. Shiering spoke about reconciling, and DeMeerleer appeared stable. He expressed no suicidal or homicidal thoughts and engaged in normal activities with family and friends. On July 16, 2010, DeMeerleer reported to his sister that he and Ms. Shiering were "over for good." He had dinner with his family that night, and although initially appearing depressed, was laughing and appeared normal by the time he left. Arguably due to a sudden event (the break-up) that the therapist could not have known about, on the night of July 17, 2010, DeMeerleer entered Ms. Schiering's home, where he attempted to kill one of her sons by slashing his throat, and then shot and killed her and another of her sons; the third son was unharmed. DeMeerleer then returned home and killed himself.

Ms. Schiering's family subsequently sued Dr. Ashby and the Spokane Psychiatric Clinic for professional malpractice, alleging that they had failed to adequately assess DeMeerleer's propensity for violence and provide treatment, and failed to warn Ms. Schiering and her sons with enough time for them to protect themselves. They also alleged a claim for lost chance of survival.

Dr. Ashby and the Spokane Psychiatric Clinic successfully moved for summary judgment to dismiss the claims, arguing in part that "they owed no third-party duty to anyone in general or the Schierings in particular." Dr. Ashby relied on the undisputed fact that DeMeerleer did not threaten Rebecca Shiering or her children in his presence. The trial court agreed, concluding that neither Dr. Ashby nor the Clinic could have reasonably identified the Schiering family as potential victims of DeMeerleer because he had not communicated any threats to harm them.

2. The Washington State Court of Appeals Opinion

On appeal, the Washington State Court of Appeals identified two issues: the broad issue was what duty is owed by a mental health professional to protect a third party from the violent behavior of the professional's patient or client; and the narrow issue was whether those professionals hold a duty to protect a third person, "when an outpatient who occasionally expresses homicidal ideas, does not identify a target." 184 Wn.App. 139 (2014). The Court noted that under "*Tarasoff* and its offspring," Dr. Ashby should be granted summary judgment since DeMeerleer never voiced homicidal intent towards Schiering or her children.

Nonetheless, the appellate court held that the circumscribed duty to protect identifiable victims under RCW 71.05.120 applied only in the inpatient context, and did not preclude a broader duty to protect "anyone foreseeable" identified in *Petersen* from applying in the outpatient context. From its vantage point, the appellate court ruled that the legislature saw fit to curtail the duty in the inpatient context, but not the outpatient context. It reversed the summary judgment granted to Dr. Ashby and the Clinic, and remanded the proceedings.

Associate Chief Judge Brown dissented, arguing that the development of RCW 71.05.120 definitively narrowed *Petersen* in full—outpatient context included. The Chief Judge reasoned that the language used in the subsection, namely the obligation to take "reasonable care to protect," which mirrored the *Petersen* decision, demonstrated the Washington Legislature's intention. In his view, the trial court correctly reasoned that Dr. Ashby could not reasonably have identified the Schierings as targets, because DeMeerleer had not communicated any threat of violence toward them, and therefore, he had no duty to protect them.

3. The Washington State Supreme Court Opinion

The Supreme Court upheld the Washington Court of Appeals' application of *Petersen*'s duty to protect "anyone foreseeable" in the outpatient context but its opinion did not address the seeming conflict between that decision and its narrowing by the Washington Legislature in RCW 71.05.120. Instead, the Court considered the common law duty in isolation from its subsequent legislative curtailment. In particular, the Court concentrated on the significance of the presence of a "special relationship" between professional and patient, which gives rise to a duty to protect "anyone foreseeable." As noted above, Section 315 of the *Restatement (Second) of Torts* creates an exception to the general rule against liability for the acts of third parties if there is a "special relationship" between the actor and the other party. The Court noted several times that Dr. Ashby conceded that he and DeMeerleer had such a relationship.

The Supreme Court adopted *Petersen* in full, referring to it as "the most relevant analog," notwithstanding the different treatment contexts of the two cases, but it also went further. The Court hooked the duty to protect to the mere presence of a special relationship, regardless of the mental health professional's ability to control the patient. The Court further distinguished a number of duty to control or "take charge" cases, discussed above, including *Taggart* and *Joyce*, *supra*, tracing them back to a different provision of the *Restatement (Second) of Torts* (section 319), noting that outpatient mental health professionals do not have the same degree of control over their patients as law enforcement has with parolees. The Court denied that an ability to control the patient was intrinsic to the duty to protect third parties; it denied that the presence of control factored in the analysis whatsoever, saying, "[T]he amount of control or the nature of control Ashby had over DeMeerleer is not determinative of whether Ashby was under a duty to act for the benefit of DeMeerleer's victims." 187 Wn.2d at 262.

The Court reasoned that the California Supreme Court in *Tarasoff*:

> relied *solely* on an expansive reading of §§315 et seq. under which affirmative duties to act are imposed whenever the nature of the relationship warrants social recognition as a special relation, not based on any hypothetical ability to control the patient [emphasis in original].

Later on, the Court summed up its position stating that the "nature of the relationship in *Petersen* gave the doctor unique insight into the potential dangerousness of his patient as well as the identity of the potential victim." Thus, where such a relationship is present, so too is a duty to protect the foreseeable victims of the patient. The Court held:

> that after a special relationship is formed between a mental health professional and his or her outpatient satisfying *Restatement Sec. 315*, the mental health professional is under a duty of reasonable care to act consistent with the standards of the mental health profession, in order to protect the foreseeable victims of his or her patient.

187 Wn.2d at 263.

The majority opinion weighed the policy reasons for recognizing an exception to the general common law rule of nonliability to third parties. In particular, it borrowed the competing policy

concerns identified by an outpatient case from the Ohio Supreme Court, *Estates of Morgan v. Fairfield Counseling Ctr.*, 77 Ohio St. 3d 284 (1997). In that case, a young schizophrenic man who had been under continuous outpatient counseling for one year murdered his parents and injured his sister. The Ohio Supreme Court set out five competing policy concerns for weighing liability or immunity, including (1) the psychotherapist's ability to control the patient; (2) the public's interest in safety from violent assault; (3) the difficulty inherent in attempting to forecast whether a patient represents a substantial risk of physical harm to others; (4) the goal of placing the mental patient in the least restrictive environment and safeguarding the patient's right to be free from unnecessary confinement; and (5) the social importance of maintaining the confidential nature of psychotherapeutic communications.

Regarding factor (1), the psychotherapist's ability to control outpatients, the Court stated there must be "some ability to 'control' the third person's conduct, or else the duty contemplated in *Petersen* would essentially be one of strict liability." 187 Wn.2d at 264. The Court echoed the *Estates of Morgan* opinion, writing that "courts that have failed to recognize a duty in the outpatient setting take an overly narrow view of the level of control necessary." *Id.* Ultimately, the Court concluded, without specifying details:

> Even bearing in mind the lesser amount of control available to mental health professionals in the outpatient setting, sufficient control nevertheless exists to recognize the duty. There are a number of preventative measures mental health professionals can undertake in the outpatient setting, even without taking actual custodial control, which we reiterate is not required by §319, in order to mitigate or prevent their patients' foreseeable violent actions.

187 Wn.2d at 268. The Washington Supreme Court majority then found that all factors weighed in favor of imposing the duty.

Notably for this report, though not mentioned anywhere in the Supreme Court's *Volk* opinion, the Ohio Legislature scaled back the *Estates of Morgan* duty by statute enacted two years after that decision in 1999. The statutory intent states clearly the General Assembly's position "to respectfully disagree with and supersede the statutory construction holding of the Ohio Supreme Court in" *Estates of Morgan.* They then enacted Ohio Rev. Code Ann. §2305.51, which provided for a duty to predict, warn of or take precautions to provide protection from a patient's violent behaviors when an explicit threat of imminent and serious physical harm or death is enunciated against a clearly identifiable potential victim and the provider believes that the patient will carry out the threat.

The dissenting opinion challenged the majority's relationship-driven, control-free analysis as being an unprincipled and unprecedented interpretation of the existing law. It notes the majority's construction would "broaden the special relationship exception to encompass any mental health professional, and by its reasoning any ongoing relationship of influence, regardless of that person's ability or inability to exercise the control required." Further, the special relationship analysis articulated by the majority was not tied to Section 315 of the *Restatement (Second) of Torts*, but rather Section 41 of the *Restatement (Third) of Torts*—which has yet to be accepted by courts. Under the former, existing law, one cannot fully disengage the presence of a special relationship from the capacity to control and the duty to do so. In making that point, the dissent

pointed out that in *Petersen*, the third-party duty was not uncoupled from the capacity to control. Moreover, the majority opinion is at odds with the Supreme Court's decision in *Binschus*, which was decided earlier in 2016, and which explicitly tied the duty to protect with a capacity to control. See *Binschus v. State*, 186 Wn.2d 468 (2016), discussed *supra*.

The dissent also challenged the policy rationale advanced by the majority. The benefit to society of broadening mental health provider liability so significantly was dubious, considering the potential problems in imposing the broad duty. Specifically, the rate of involuntary commitment would be likely to increase, inviting greater harm to those unnecessarily confined; law enforcement would be burdened to address a threat that is neither specific nor imminent; and, the threat of unnecessary confinement on the one hand or unjustified breach of confidentiality on the other would discourage patients from seeking care in the first place. *See* Greenberg, 92 Wash. L. Rev. Online at 47. The dissent would have affirmed the summary judgment in favor of Dr. Ashby and the Clinic.

4. Analysis of Volk v. DeMeerleer in the Context of National Law

In considering *Volk* in the larger context of both national norms and policy, there are a number of issues that beg for greater clarity. These include:

- what constitutes—and what does not constitute—a special relationship (as that term has been interpreted by the courts)
- what role does control of the patient play
- what constitutes a sufficient threat or danger that would trigger a duty to protect and/or warn
- how broadly should the class of potential third-party victims be defined, and
- how can the duty be satisfied

a) Special Relationship

One of the questions the Court of Appeals noted, but did not address, was the question of what qualifies as a "special relationship." In the facts of this case, Dr. Ashby conceded that point, so there was no inquiry. Yet, the opinion notes that DeMeerleer did not maintain a regular, ongoing relationship with Dr. Ashby, but rather engaged in therapy on a "hit or miss" basis. DeMeerleer was a peripatetic patient at best.

Moreover, given that virtually every analysis of the "special relationship" defines it as "definite, established, and continuing," this question should have been explored and answered. In *Volk*¸ the patient's relationship with Dr. Ashby had been essentially non-existent from 2006 through 2010. The facts note that DeMeerleer presented to the Spokane Clinic in late 2009 and was referred for outpatient therapy at a community mental health center. This indicates he had no ongoing outpatient relationship with Dr. Ashby at that point. When does the special relationship end? Surely, once established, it cannot be eternal. There is a real question of fact, not resolved in the case, as to whether the "special relationship" between Dr. Ashby and DeMeerleer existed after 2006, since there was only one contact after that period between provider and patient.

Arguably, the special relationship was resuscitated by the one visit with Dr. Ashby in April 2010, but one could argue that after such a long period of no contact, the relationship is starting anew. As such, it could be deemed a new encounter, similar to the triage interview in the *Estate of Davis* case, *supra*. There is a question as to whether Dr. Ashby's relationship was durable and continuous over a period of time such that it is sufficient to be classed a "special relationship" under §315 of the *Restatement* or under case law.

b) Duty to Control

The *Volk* opinion states that control is not necessary for a duty to warn to apply. However, the lack of control was recognized in two Washington cases addressing the duty to warn in the context of outpatient alcohol treatment. In *Binschus, Noonan* and *Metlow*, discussed above, the courts found no duty to warn and/or duty to protect third parties because of the general lack of control over the patient and the absence of capacity to "take charge." Virtually all jurisdictions do link the duty to warn and/or duty to protect with the capacity to exercise some sort of control, most commonly an ability to commit the patient or, in some cases, to refer the situation to law enforcement. As the dissent in *Volk* notes, absent a capacity or justification to control, the "special relationship" responsibilities cannot be justified: "without the *ability* to control, the §315 requirement to *exercise* control would be to no effect; one cannot use what one does not have." 386 P. 2d at 284.

In the opinion relied on by the Washington Supreme Court, *Estates of Morgan*, the Ohio Supreme Court focused heavily on the intersection between the capacity to control and the duty to warn. It noted that since *Tarasoff*, a majority of courts that have considered the issue and that "collectively, they recognize that there are various levels of being in "control" pursuant to Section 315, and being in "charge" pursuant to Section 319, with corresponding degrees of responsibility for the patient's violent actions. The Court acknowledged that the two Sections essentially are interrelated. Thus, although psychotherapists may have less ability to control the patient in the outpatient setting than in the hospital setting, the lesser degree of control is not held to justify a blanket negation of the duty to control. The Court noted that there are several tools of control that can be used by outpatient mental health providers, such as "prescribing medications, fashioning a program for treatment, using whatever ability she has to control access to weapons or to persuade patient to voluntarily enter the hospital, issuing warnings or notifying authorities, and if appropriate, initiating involuntary commitment." *Id.* at 296.

The *Morgan* Court concluded that the special relationship must embody a sufficient element of control to warrant a corresponding duty to warn. When the therapist knows or should know that the patient presents a risk of substantial harm to others, the therapist is under a duty to exercise his or her professional judgement to prevent that harm.

In contrast, the Supreme Court's majority opinion in *Volk* divorces the duty to protect from any part of the duty to control:

> "Instead, *Petersen* and subsequent interpretations of §315, implies that regardless of the setting in which the special relationship is formed, as soon as it exists, the mental health professional may be liable to the reasonably foreseeable victims of his or her patient based

solely on that relationship rather than any hypothetical ability to confine or control the patient."

386 P.3d at 270-71. The Court further cited *Taggart v. State*, 118 Wn. 2d 195 (1992), discussed *supra*, which was primarily a duty to control case. This essentially undercuts the Court's overall view that the duty to control and the duty to warn are divorced from each other.

The outpatient treatment setting provides very few methods of control. Much of the outpatient treatment relationship depends on the compliance of the patient with respect to the medication and the therapy schedule. However, the health care provider has no capacity to ensure that a patient takes his medications. Similarly, maintenance of an ongoing therapy schedule depends on the patient presenting for his appointments as prescribed. It is clear that DeMeerleer was not compliant on either front.

The lack of control in the outpatient setting is one of the reasons that across the nation the duty to warn and/or protect third parties, even the justification to disclose to third parties, is narrow. Absent logical parameters, a broad duty would not only be impossible to implement, it would be antithetical to the treatment relationship. The fact that virtually all states that have addressed the duty to protect in the outpatient setting have limited this duty to warning readily identifiable victims of imminent danger reflects both attention to reality and public policy aims. It also allows for mental health care providers to sensibly comply with the duty. Once a patient has voiced a threat to do imminent and serious harm to a readily identifiable third party, it is possible for the provider to commit the patient for inpatient care and to warn the victim and law enforcement. If the patient is violent and likely a danger to others, the patient is still committable. If the patient enunciates what amounts to a serious threat to a readily identifiable person, confidentially may be breached to warn the potential victim. However, in the *Volk* case, none of these applied.

c) What Constitutes a Sufficient Threat/Danger

During that one visit in April, 2010, DeMeerleer did not express any homicidal thoughts; he admitted to occasional suicidal ideation but no desire to actuate these thoughts. In fact, he was characterized as relatively stable. There was no danger evident to justify a warning during this visit. Not only did DeMeerleer not express any homicidal thoughts during this visit, he never uttered threats directed at Ms. Schiering or her children. DeMeerleer's attack on Ms. Schiering occurred three months after his last visit with Dr. Ashby. During those three months, if anything, DeMeerleer appeared less troubled and more "normal" in his interactions with family and friends.

Moreover, during DeMeerleer's long history of psychiatric care, he had not pursued or acted out on any suicidal or homicidal thoughts expressed over his many years of therapy. If we consider DeMeerleer's relationship with Dr. Ashby intact from his first visit in 2001, the indicia for a duty to protect are, if anything, much less pronounced in 2010. Moreover, at no point in DeMeerleer's long history was he deemed committable on the basis of being a danger to himself or others, or being gravely disabled. This was not, of course, the case in *Petersen v. State*, where the patient had been involuntarily committed as a result of self-directed violence; treated as an inpatient; showed signs of reckless, if not dangerous, behavior the night before he was released; and visited harm on an unidentifiable third party only five days after his release.

Were we to consider non-compliance with medication regimens and all voiced homicidal or suicidal thoughts as indicia for danger to others, the duty to protect the entire universe of potential victims would be incalculably large. In terms of bipolar disease alone, such as what DeMeerleer struggled with, only 41% of patients take their medications as prescribed. *See* Sainza Garcia *et al.*, "Adherence to Antipsychotic Medication in Bipolar Disorder and Schizophrenic Patients: A Systematic Review, 36 J. Clinical Psychopharmacology 355 (2016), included in Appendix B. This percentage decreases over time. Similarly, patients frequently express suicidal thoughts and vent anger and threats toward others while in therapy sessions. Were mental health providers to act on and seek to protect every potential victim mentioned without analyzing the seriousness and reality-basis associated with the assertion, it is likely that the warning and protection process would overtake and exceed the time devoted to actual treatment. *Volk v. DeMeerleer* would require providers to warn a much broader realm of potential victims, including family members and literally everyone mentioned during therapy.

The *Volk* approach to who is in the universe of potential victims in terms of a duty to protect is distinctly out of step with respect to a duty to warn and/or protect parameters across the nation. As detailed in our national summary, *supra,* 33 of the 34 states that recognize a mental health provider duty to protect or to warn third parties limit the sphere of beneficiaries to those who are readily and/or clearly identifiable and/or specific.

The one state that has applied the duty to warn or to protect to a broader class of victims, beyond those readily identifiable, did so in the context of cases very similar to *Petersen*. In the Wisconsin case, the patient had been engaged in treatment for a psychotic condition at the time of her car accident. See *Schuster v. Altenberg,* 144 Wis. 2d 223 (1988) *discussed supra*. In that case, there was the specter of control; the patient was in active day treatment at the same facility where he had been involuntarily committed.

Such was not the case with DeMeerleer. While he was far from a model patient, he had a twenty-plus year history of functioning in society and had not required involuntary commitment. While he had frequently admitted to suicidal thoughts, he had not acted on them, save for the distant alleged suicidal attempt as a college student more than twenty years earlier. His homicidal ideation several years previously had been directed towards his wife and her lover at the time of their divorce and not acted upon. Thereafter, he expressed no homicidal thoughts during his therapy sessions. Moreover, after the divorce, DeMeerleer established a functional relationship with his former wife and shared custody of their child. In his therapy sessions with Dr. Ashby, DeMeerleer did not enunciate any homicidal threats directed at the Schierings or anyone else. Notably, when he resumed therapy in April 2010, after an apparent four-year hiatus from care, he was relatively stable. There were no readily identifiable victims and no imminent threat uncovered during the single therapy session in April, 2010; nor did DeMeerleer exhibit any symptoms or signs that would have justified commitment.

5. Cases Simultaneous, or Subsequent, to Volk

Four cases are summarized in this section. One was contemporaneous to *Volk* and resulted in an unpublished (not-citable) opinion that was denied review by the Washington Supreme Court.

There is also one federal district court case that relied upon Washington case law in coming to its decision. The other two cases are just at the filing stage. See Appendix I/Washington.

The completed case is *Lennox v. Lourdes Health Network*, 195 Wash. App. 1003 (2016) (unpublished), rev'd denied by 187 Wash. 2d 1013 (2017). It was decided in the Washington Court of Appeals mid-2016. In this case, a longtime psychiatric patient who had been treated for some time as an inpatient was released on a least restrictive alternative status. The mental health care providers continued to treat the patient on an outpatient basis, but despite being in treatment, the patient murdered his grandmother. The court relied on a different section of RCW 71.05.120, which pertains to decisions to admit or discharge a patient, not a duty to warn or protect as in *Volk.* The Court held that the appropriate standard for determining liability was gross negligence and found that providers' decisions in caring for the patient did not evidence gross negligence. Thus they had limited immunity under RCW 71.05.120(1) for failure to reinstitute involuntary commitment.

The federal district court case from the Western District Washington was decided after *Volk.* In *Jackson v. City of Mountlake Terrace,* 2017 WL 841751 (W.D. WA), police brought a man to Swedish Hospital for a mental health evaluation and potential involuntary commitment. He was evaluated at Swedish and released after they determined that he did not meet the criteria for an involuntary commitment. Within a few hours, the released patient committed a murder. The court noted that, unlike the scenario in *Petersen,* there was no ongoing "special relationship" between Swedish Hospital and the patient, thus there was no duty to foreseeable victims. Thus the court reasoned that this case was similar to *Estate of Davis v. State, Dept. of Corrections,* 127 Wash. App. 833 (2005), *supra*, at page 17, rather than *Petersen:*

> However, Washington courts have recognized an exception to this rule and "a duty to act for the potential victim of a psychiatric patient when 'a special relation exists between the actor and the third person which imposes a duty upon the actor to control the third person's conduct.'" *Volk v. DeMeerleer*, 386 P.3d 254, 260 n.2 (Wash. 2016) (quoting *Peterson*, 671 P.2d at 236 and Restatement (Second) of Torts § 315 (1965)). "Stated another way,... once a special relation exists between the mental health professional and his [or her] patient, the mental health professional owes a duty of reasonable care to any foreseeable victim of the patient. *Id*. However, such "a duty to a particular person will be imposed only upon a showing of a definite, established and continuing relationship between the defendant and the third party." *Honcoop v. State*, 759 P.2d 1188, 1195 (Wash. 1988); *Volk*, 386 P.3d at 263; *Hertog, ex rel. S.A.H. v. City of Seattle*, 979 P.2d 400, 407 (Wash. 1999).

See Jackson v. City of Mountlake Terrace et, al, slip copy at *6.

The two other cases that have been referred to as post-*Volk* cases are *Toone v. Pioneer Human Services*, Spokane County Superior Court Cause No. 17-2-01996-2 (filed May 25, 2017), and *Douglass v. King County/DBA UW Medicine/Harborview Medical Center,* King County Superior Court Cause No. 17-2-20784-5 (filed August 7, 2017). In *Toone*, the mother of a long-time psychiatric patient who had heart surgery sued for wrongful death after her son committed suicide. The Complaint does not clearly allege a duty to warn, and there was no third-party assault victim of the son's actions. The *Douglass* case appears to be a classic *Petersen* case. The long-time

psychiatric patient was discharged from the hospital and five hours later stabbed a stranger. These cases are just in their infancy.

6. Conclusion

Our review of the Supreme Court's *Volk v. DeMeerLeer* case, in the context of both Washington's precedent and in relation to the other states, leads to the conclusion that the *Volk* decision is out-of-step with all other states (and the District of Columbia), with the single exception of Wisconsin. As noted above, eight states do not recognize any duty to protect or warn third parties of the danger presented by a mental health patient. Nine states (including D.C.) provide for provider discretion to disclose to prevent harm to others, but do not impose an affirmative duty to warn and/or protect. Of the remaining 34 states, 33 impose a duty to warn and/or protect readily or clearly identifiable, or specific third parties who may be in danger.

The *Volk* case substantially changed the duty to protect and the duty to warn in Washington in the outpatient context. Prior to *Volk*, outpatient providers believed that the breadth of their duty was that detailed in RCW 71.05.120(3). Post *Volk*, the duty is broader for outpatient mental health providers who have less control over the patient, and in the case of DeMeerleer, may not even have contact, let alone control. The result is an unworkable and counter-intuitive standard.

IV. FACTUAL DATA ON MENTAL HEALTH PROVIDER CAPACITY, INSURANCE CLAIMS AND NATIONAL PRACTICE GUIDELINES

The Legislature's appropriation also required investigation into several factual areas related to mental health services and insurance claims in Washington. First, the appropriation required a comprehensive review and assessment of the involuntary and voluntary treatment capacity available in the state, including information and data available from the select committee on quality improvement in state hospitals, related contractors, and other sources. Next, it required an assessment of the number of mental health service providers available to provide treatment to voluntary mental health patients in the state, whether that capacity has changed, and whether any such change is a result of the *Volk* decision, and a description of any changes as a result of the *Volk* decision. Additionally, the Legislature wanted an analysis of insurance claims filed as a result of the *Volk* decision, including the outcome of any such cases and any harm alleged in each claim filed, and whether insurance policy provisions and rates have been affected due to the *Volk* decision. And lastly, the Legislature wanted a survey of practice guidelines by mental health professionals related to the duty to warn or protect third parties.

A. Treatment Bed Capacity

According to the Washington Department of Social and Health Services (DSHS), since FY 2012, the inpatient treatment bed numbers have generally stayed the same.

Table 3: Inpatient Treatment Capacity

Western State Hospital	Civil Beds, 557	Forensic Beds, 285
Eastern State Hospital	Civil Beds, 192	Forensic Beds, 125 (since 2016), was 95 (until 2015)
Child Study and Treatment Center, serves 5-17 year olds	Civil Beds, 47	

The average percent occupancy for FY 2017 was 89% (Eastern State Hospital), 96% (Western State Hospital), and 95% (Child Study and Treatment Center). *See* Appendix C.

On the outpatient side, DSHS reports there are 937 evaluation and treatment beds, for initial holds and short-term commitments, which divides as follows:

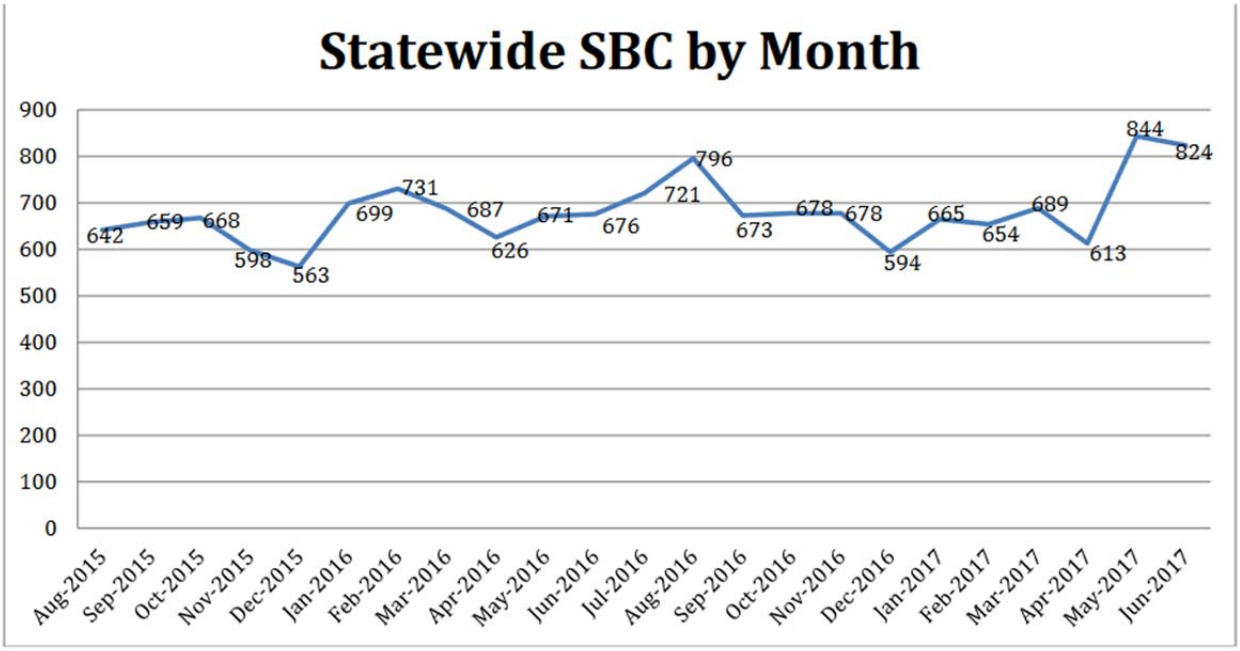
- 300 beds located in psychiatric units of inpatient acute care hospitals (inpatient)
- 361 beds located in freestanding psychiatric hospitals (inpatient)
- 276 beds located in freestanding evaluation and treatment centers licensed as residential treatment facilities

See Appendix C.

Of note, Washington providers continue to have difficulty finding available beds for forensic evaluations and civil commitments. Regarding forensic evaluations, Washington is still under a contempt order from Federal District Court Judge Marsha Pechman (W.D. WA), who found that the state still has unconstitutional delays in getting in-jail evaluations and inpatient restoration for alleged offenders. The contempt fines were more than $30 million at the end of October 2017. https://www.dshs.wa.gov/sesa/office-communications/media-release/dshs-statement-federal-district-court-contempt-ruling-trueblood-case-0

On the civil commitment side, Washington still relies on Single Bed Certifications (SBC), also known as "psychiatric boarding" to meet the need for civil commitment beds. The Washington Supreme Court rejected this practice in *In re: Detention of D.W.*, 181 Wn.2d 281 (2014) (psychiatric boarding not permitted to overcome overcrowding at evaluation and treatment centers). DSHS's chart for SBC use is as follows in Chart 1:

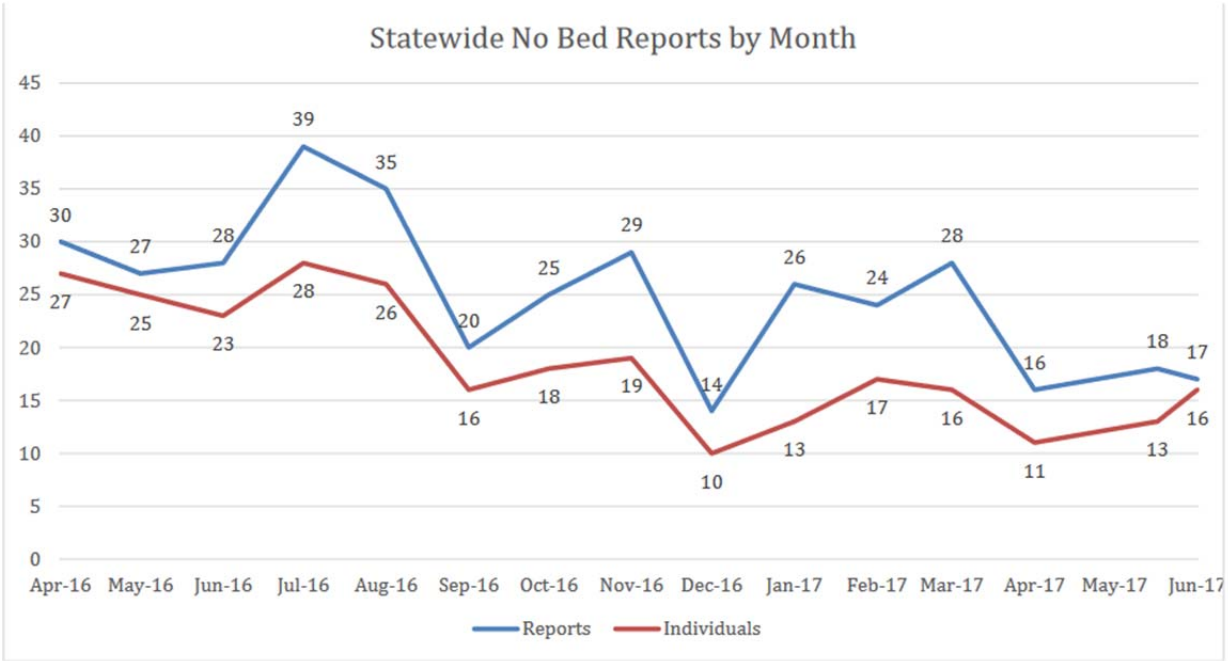
Chart 1



Source DSE report and graph ran 7/20/17

See Appendix C. Correspondingly, the Designated Mental Health professionals in the various counties who make the initial determination of commitment file "No Bed" reports if there is not space available for the person. Chart 2 displays the trend with respect to "No Bed" reports:

Chart 2



Source DSE report ran 7/25/17 Line Graph by Robby Pellett

With inpatient occupancy rates so high, and outpatient beds supplemented by SBCs or "No Bed" dismissals of evaluation and treatment holds, and with ongoing contempt fines for failures of timely forensic evaluations, the conclusion appears to be that Washington's mental health system's capacity is still insufficient. If the result from the *Volk* decision is to hospitalize more outpatients, that will certainly put additional strain on the existing resources.

B. Washington's Mental Health Providers

The Washington State Department of Health licenses this state's mental health professionals. The following table summarizes the information obtained from the department's licensed mental health practitioners:

Table 4: Licensed Mental Health Professionals in Washington

	2013	**2014**	**2015**	**2016**
Chemical Dependency Professional	2869	2868	2874	2878
Chemical Dependency Professional Trainee	1492	1542	1454	1546
Agency Affiliated Counselor	6529	7059	7990	8884
Certified Counselor	2	3	5	5
Certified Advisor	691	675	598	560
Hypnotherapist	710	736	764	747
Marriage and Family Therapist Associate	423	454	504	556
Marriage and Family Therapist	1336	1408	1473	1572
Mental Health Counselor Associate	1628	1717	1763	1890
Mental Health Counselor	5653	5912	6211	6577
Psychologist	2596	2707	2831	2925
Sex Offender Treatment Provider Affiliate	34	32	27	24
Sex Offender Treatment Provider	102	99	101	98
Advanced Social Worker (MSW)	110	120	117	133
Associate Advanced Social Worker	212	202	221	232
Associate Independent Clinical Social Worker	1084	1274	1483	1623
Independent Clinical Social Worker	3659	3787	3966	4106

There are several caveats with this information, as follows:

(a) The Department does not track whether the clinician works in an inpatient or outpatient setting.
(b) The Behavioral Analyst license just began being issued on July 1, 2017, and the Department had no information it could share at the time of the request.
(c) The Department did not share 2017 data because it was not a complete data set.
(d) The Department does not differentiate psychiatrists or psychiatric nurses from their parent professions.
(e) Neither the Department, nor any other central agency, licenses or registers religious counselors, so there is no way to quantify the number of those counselors in Washington.

Further to point (d), demographic information collected by the state Medical Quality Assurance Commission shows that there are 1,038 physicians in the state that report psychiatry as their primary practice. There are 530 psychiatric advanced registered nurse practitioners in Washington, with more than half in King and Pierce counties and the North Sound region. *See* Appendix C.[1]

It is much too soon to determine whether the number of providers has changed as a result of the *Volk* decision. In 2015, DOH licensed mental health providers totaled 32,382; the following year in 2016, the total was 34,356. This represents an increase of 1,974 professionals, or 6% increase. This will have to be compared to 2017 and 2018 data when released to see if there is a significant change in the number of providers. Of note, 58% of these providers are located in King, Pierce and Snohomish counties. *See* Appendix C. Even with a change in total providers, it would be hard to assess without more survey data whether the *Volk* decision played any role in that change, and that survey would have to target prospective mental health trainees who opted out of training because of the *Volk* requirements, an extremely difficult-to-identify population.

C. Insurance Claims, Policy Provisions, and Rates Related to *Volk*

For this part of the legislative mandate, our research team contacted Physicians Insurance, The Doctors Company, Professional Risk Management Services: The Psychiatrists' Program, and the Office of the Insurance Commissioner (OIC). We also consulted the provider stakeholders regarding their professional liability insurance rates. Given that *Volk* was decided in December 2016, the overwhelming response received was that it is simply too early to tell what possible effects the *Volk* decision may have on insurance claims, policy provisions, and rates.

1. There Have Been No Insurance Claims Filed as a Result of the Volk Decision

No insurance claims have been filed with the insurers we contacted. Insurers emphasized that it is too early to know if, or how many, claims will be filed as a result of *Volk*. Potential plaintiffs are still well within the statute of limitations for filing a lawsuit. As The Doctors Company stated, medical malpractice cases are distinct from other property and casualty cases as far as the time it takes from a new cause of action being created, to cases being filed under that new cause of action, to the final resolution of the claim. More specifically, they explained that it averages about 2.25 years between the event and the claim being reported, and another 2.25 years between the claim being reported and the claim being closed.

Moreover, as the OIC confirmed, it might be a few years before insurers can resolve any new open claims stemming from the *Volk* decision, close them, and report them to the OIC. The OIC does not collect data on the legal theory under which claims were filed. They do, however, collect data on the type of allegation. Two codes that may be relevant to a claim related to *Volk* are 718, Third Party Claimant, and 708, Failure to Protect a Third Party. Since 2009, 29 claims have been submitted to the OIC under these codes. Only four of them were for specialties that appear

[1] This is an increase from the total presented at the November 18, 2017 public meeting. The research team received updated information after that meeting from Mary Sue Gorski, Washington State Nursing Care Quality Assurance Commission, personal communication and the update is included in Appendix C.

mental-health related, and it is impossible to identify any third-party aspect at this point. It remains to be seen if there will be a spike in claims reported under these codes in a few years that may relate to *Volk*.

2. Insurance Policy Provisions and Rates Have Not Yet Been Affected Due to the Volk Decision

To date no insurer has made any changes to rates or policy provisions as a result of *Volk*. Physicians Insurance indicated that they often see a 3-5 year cycle for rate changes and causes of action. Professional Risk Management Services: The Psychiatrists' Program responded:

> The effect of the *Volk* ruling on the pricing of medical professional liability coverage will be ascertained once there have been covered claims paid by carriers in the aftermath of this opinion. While it would appear that *Volk* will have the effect of driving up verdict amounts and/or expanding the insurers' liability, insurance carriers will need to demonstrate actual increased losses (frequency and/or severity) to justify any rating increase. Any change in rate requires prior approval from the Washington Office of the Insurance Commissioner, and to obtain approval for any such increase in rate, an insurer must generally demonstrate actual and not hypothetical increased frequency and severity. To the extent that the *Volk* ruling results in such development, such losses may be utilized as a contributing factor to justify any rate increase in a rate submission to the Insurance Commissioner.

While some mental health professionals consulted in this study voiced concern that their insurance policy rates may increase in the future, none had experienced any rate increase yet. Additionally, related to the insurance policy issue, some defense attorneys suggested an unintended consequence of *Volk* might be that some mental health professionals, such as some in private practice, choose to forego carrying liability insurance so as to be less attractive to plaintiff's attorneys. Other defense attorneys thought that the high cost of defending such a lawsuit would encourage providers to maintain coverage since it includes defense costs. Moreover, malpractice carriers might leave the Washington market. Health care attorneys recalled that large insurance companies have exited the market when general malpractice verdicts set records. *Volk* liability could provoke a similar response in the future. Finally, one stakeholder queried what the long-term potential trickle-down effect on the health insurance market might be as a result of *Volk*. If there are ultimately increases in liability insurance rates for mental health professionals, this could create a significant risk for increases to health insurance premiums for Washington state residents.

D. National Practice Guidelines and Standards.

Our team and our research librarians searched extensively for published national practice guidelines and standards. None of the following organizations have published guidelines relevant to the issue of a duty to warn or protect:

- American Academy of Psychotherapists
- American Counseling Association
- American Psychological Association
- American Psychiatric Association
- American Mental Health Counselors Association

- American Psychotherapy Association
- Association of Practicing Psychologists
- Mental Health America
- American Medical Association
- American College of Physicians
- APA Practice Organization
- American Academy of Psychiatry and the Law

The American Psychiatric Association has two lengthy practice guidelines, one dedicated to Assessment and Treatment of Patients with Suicidal Behavior and one focused on Psychiatric Evaluation of Adults. Neither of these address the duty to warn or the duty to protect third parties. *See* Appendix D for research librarian summary.

V. QUALITATIVE DATA FROM CONSULTING WITH STAKEHOLDERS

The legislative appropriation for the *Volk* study specifically states that the University of Washington School of Law "consult with subject-matter experts." Appropriation, §25(b). In order to collect qualitative data for this study, our research team consulted representatives from the following organizations listed in the legislative mandate:

(1) Attorneys with experience representing defendants in personal injury cases or wrongful death cases related to the issues raised by duty to warn cases;
(2) Washington State Association for Justice, representing attorneys with experience representing plaintiffs in personal injury cases or wrongful death cases related to the issues raised by duty to warn cases;
(3) Department of Social and Health Services;
(4) Washington Academy of Family Physicians;
(5) Washington Association for Mental Health Treatment Protection;
(6) Office of the Insurance Commissioner;
(7) Washington Council for Behavioral Health;
(8) Washington State Hospital Association;
(9) Washington State Medical Association;
(10) Washington State Psychiatric Association;
(11) Washington State Psychological Association;
(12) Washington State Society for Clinical Social Work;
(13) Washington Association of Sheriffs and Police Chiefs;
(14) Victim Support Services;
(15) NW Health Law Advocates[2];
(16) National Alliance on Mental Illness;
(17) American Civil Liberties Union; and
(18) A sample of families who testified or presented evidence of their cases to the legislature.

As the above list was not exclusive, our research team also consulted with the following stakeholder representatives:

[2] See Appendix E for statement from NW Health Law Advocates.

(1) Washington Association of Designated Mental Health Professionals;
(2) Andrew Benjamin; Clinical Professor of Psychology, Affiliate Professor of Law, University of Washington;
(3) Association of Advanced Practice Psychiatric Nurses; and
(4) Washington Mental Health Counselors Association.

In addition to consulting with the above stakeholders, our research team also requested that the following organizations send a brief survey to their membership:

(1) National Association of Social Workers, Washington Chapter;
(2) Northwestern Psychoanalytic Society & Institute;
(3) Seattle Psychoanalytic Society & Institute;
(4) University of Washington Department of Psychiatry & Behavioral Sciences;
(5) Washington Mental Health Counselors Association;
(6) Washington State Coalition of Mental Health Providers & Consumers;
(7) Washington State Psychiatric Association;
(8) Washington State Psychological Association; and
(9) Washington State Society of Clinical Social Work.

The legislature requested that we assess: (1) whether mental health service providers may be changing practices to limit exposure to the potential risks created by the *Volk* decision; and, (2) the legal and practice implications of state law standards regarding the duty to warn and the duty to protect in the voluntary and involuntary treatment context.

A. Assessment of Whether Mental Health Service Providers May Be Changing Practices to Limit Exposure to the Potential Risks Created by the *Volk* Decision

In our consultations with, and surveys of, stakeholders it became apparent that there is a wide range of responses to *Volk*. Providers are: ignoring it for now, waiting for further clarity before deciding if any action is needed, waiting for another lawsuit to determine if any change in practice is necessary, developing changes to their practice, implementing changes to their practice, and considering leaving practice.

1. Data from Consulting with Stakeholders—Changes to Clinical Documentation and Policies and Procedures

Most stakeholders emphasize documentation efforts to attempt to limit potential liability under *Volk*. Much of the increased documentation is of the specific questions asked of the patient, the answers given by the patient, and any risk assessment tools used in the patient encounter. Appendix E contains an example of information disseminated to providers regarding *Volk* by the Washington State Medical Association, Physicians Insurance, and the Washington State Hospital Association, which advises, in part, careful documentation. The provider survey data also corroborates an increase in documentation efforts, as discussed below.

On the other hand, some providers reported that they think they are probably not asking patients for as many details of thoughts as they would have pre-*Volk*. This is because of fear that the answers given will be vague and then the provider will have to act on these vague thoughts even though they do not believe such action is warranted. These providers are attempting to walk a fine line between asking enough, but not too many questions.

Many health care entities are considering changing, are in the process of changing, or have already changed their policies and procedures to account for the *Volk* decision. For example, some health care entities are: clarifying the steps taken by a clinician, such as the assessment performed on a particular patient, whether law enforcement, potential victims, or parents, school personnel, government officials, or others were notified, or whether voluntary or involuntary commitment was warranted; and, creating a check list of possible clinical actions taken for each patient, such as evaluating or reviewing medications, intensifying treatment by scheduling more frequent appointments or monitoring medication compliance. Other facilities are requiring any potential *Volk*-like threat to be reported up through the supervisory chain of command. Some facilities that have changed their policies and procedures because of *Volk* stress that there are real financial costs associated with these changes. There are one-time legal fees for developing policies and procedures and there are continuing legal fees for more frequent consultations about a potential *Volk* situation. Added administration expenses are also incurred as it is often the most expensive leadership staff who are consulted as any potential *Volk* situation moves up the chain of command at a given facility.

2. Additional Changes to Practice

Providers also suggest that they are now more likely to consider the risk presented by the patient to the provider, rather than focusing on patient care. Some providers also report that they are now calling the Designated Mental Health Professionals (DMHPs) and requesting a patient evaluation for a vague patient statement. One provider organization reported about a 50% increase in calls to DMHPs and indicated that this is what is expected of them post-*Volk*. However, DMHPs (in different counties from the provider organization) have not yet experienced an increase in referrals to DMHPs.

B. Data from Surveys of Mental Health Service Providers

Surveys were sent to nine groups of mental health service providers. After providing a brief summary of the duty to warn/protect in Washington state, the survey asked 5 questions:

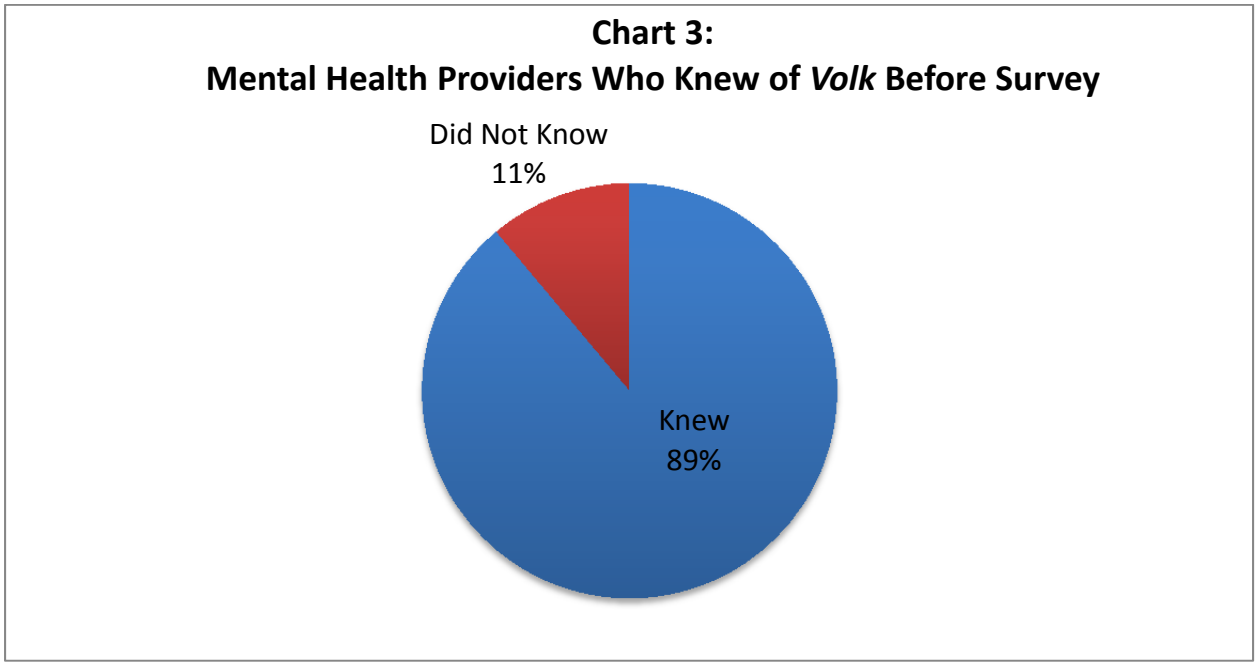
1) Before reading the overview, were you aware of the *Volk v. DeMeerleer* decision?
2) In response to *Volk* have you already changed your practice in an effort to limit exposure to risk?
3) If you have changed your practice, briefly describe these changes;
4) In response to *Volk* are you considering changing your practice in an effort to limit exposure to risk? and
5) Please briefly list any additional comments you have regarding *Volk* and your practice.

A total of 217 surveys were returned to our research team. The table below contains the number of completed surveys received for each group.

Table 5: Survey Response per Organization

Organization Surveyed	Number of Survey Responses Received
National Association of Social Workers, Washington Chapter	0
Northwestern Psychoanalytic Society & Institute	15
Seattle Psychoanalytic Society & Institute	28
University of Washington Department of Psychiatry & Behavioral Sciences	10
Washington Mental Health Counselors Association	52
Washington State Coalition of Mental Health Providers & Consumers	27
Washington State Psychiatric Association	50
Washington State Psychological Association	0
Washington State Society of Clinical Social Work	35

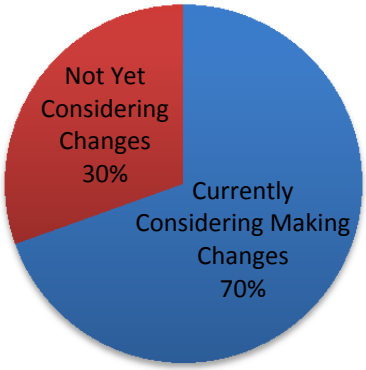
The survey results indicate that 89% of responding mental health service providers were already aware of the *Volk* decision prior to receiving the survey. See Chart 3 below.



Seventy percent of mental health providers reported that they are currently considering making changes to their practice to limit exposure to risk based on *Volk*. See Chart 4 below. The remaining thirty percent are not yet considering making practice changes. The large percentage of

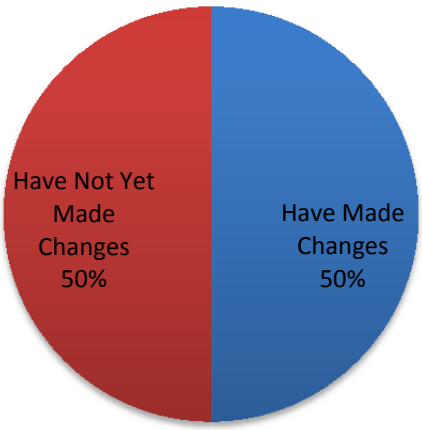
providers who are in the process of determining what changes they make to their practice to limit their liability may reflect the difficulties providers are having understanding the *Volk* decision's practice implications and how best to incorporate this court ruling into clinical practice.

Chart 4
Mental Health Providers Considering Practice Changes Based on *Volk*



Half of all responding providers report having already made changes to their practice in an effort to limit exposure to risk based on *Volk*. See Chart 5 below.

Chart 5: Mental Health Providers Reporting Changes Made to Practice Based on *Volk*



Ninety-two mental health providers described the changes they have already made to their practice in order to limit liability risk raised by *Volk*. See Appendix F for complete responses. Analysis of the described changes yielded nine themes that are described in Table 6 below.

Table 6: Changes Made to Practice

Theme	Percentage of Providers Making This Change[3]	Example Quotes
Increased screening/Less likely to accept high-risk patients	33	"I'm reluctant to take on new patients with a history or risk of violence, self-harm, anger problems and psychotic disorders. These are patients that are already very hard to find resources for outside of community mental health which is woefully underfunded and relies primarily on medications, with little to no talk therapy available. I worry that the most seriously mentally ill will have an even harder time accessing treatment." "I am much more careful in screening which patients I will accept for treatment. I am more reluctant to take on people who might have a major mental health illness than I was in the past."
Increased screening/Will not accept high-risk patients	28	"[I]f a potential client seems to be deeply depressed, has a history of suicide, or is particularly volatile, I will refuse to see them. In the past, I accepted such clients. (And I had no bad experiences doing so.)" "I have reduced my practice greatly and only treat non-violent clients to the best of my knowledge."
Increased documentation (separate from increased screening and modified disclosure forms)	9	"I spend more needless time on documentation – not for patient care!" "Ask about and document additional specific questions of clients."
Modified disclosure form	9	"Modified my disclosure statement – added Volk language to list of mandated reporting requirements." "Made my disclosure more clear in response to expression of anger with respect of threatening speech towards others."

[3] Percentages are given as a reference point; the results are not statistically significant.

Increased calls, or plans to increase calls, to law enforcement	8	"My hospital is telling me to call the police on all my patients that have voiced violent thoughts even if they have no intent to harm anyone. Some of my colleagues are doing this as instructed." "[C]alling law enforcement even when I don't think a patient is an immediate threat so that I can document that I did so."
Not practicing or considering not practicing	6	"I am quitting psychiatric practice in Washington due to the unreasonable level of risk this decision puts me under." "I may retire sooner than anticipated given the combination of decreasing insurance reimbursements plus higher liability risks due to Volk."
Focusing on potential victims/harms more than patient care	4	"I have spent more time documenting violence risk assessments and steps taken to address violence risk. My risk assessment questions are clearly driven by extra-therapeutic concerns about risks to third parties and feel intrusive to the therapeutic relationship." "Consider a broader range of potential victims and broader range of potential types of harm that a patient can inflict. Given vagueness of court ruling, forced to think about types of harm besides physical violence. Some of my patients have been very put off by my inquiry into these other areas, especially because they really aren't relevant to my work and there is no way that we can identify all the possible types of harms and then all of the possible victims. It is distracting from our meaningful work together, which for some patients, is focused on risk reduction for physical harm. I am just alienating them."
Increased referrals, or plans to increase referrals, for involuntary detainment	3	"Increased referrals for involuntary detainment." "Lower threshold for referring for hospitalization."
Peer consultations	3	"Feel like I need to consult more but this is not realistic for many patient encounters and I am doing this for liability reasons, not that my management would change." "Reviewing even lower-risk clients with supervisor."

While it is evident that some clinical practice changes have occurred, it is likely that more changes may follow as providers continue to grapple with their liability exposure post-*Volk*. Currently, much of the clinical community seems to be anxious and trying to better understand any potential liability and means of avoiding it. The *Volk* decision was recent and many clinicians

indicate that they do not yet have sufficient information to act appropriately. As one survey respondent stated, "I have anxiety about the *Volk* decision but have no client who has shown or expressed any evidence of aggressive tendencies so I would change my practice but haven't needed to yet. And, since *Volk* is so broad, it is hard to know how to change my practice effectively in any way but limiting my willingness to see people who may present a threat to my ability to foresee the future." *See* Appendix F.

C. Assessment of Legal and Practice Implications of State Law Standards Regarding Duty to Warn and Duty to Protect Pre- and Post-*Volk*

This assessment requires a closer look at the stakeholders' understanding of the duty owed after *Petersen* and the 1987 amendments to RCW 71.05.120 and before the *Volk* decision. This pre-*Volk* perspective is then compared with the post-*Volk* data.

1. Between Petersen and the 1987 Amendments to RCW 71.05.120 and Volk, Most Stakeholders Thought the Duty Owed Was Defined in RCW 71.05.120.

The majority of stakeholders believed the duty owed by mental health providers during this time was defined in RCW 71.05.120. If an actual threat was made toward a readily identifiable victim, then the mental health provider would act on their duty. Typically, the provider would explore the context of the threat and whether the patient had the means to carry out the threat. If necessary, the provider would take action, including warning any victim and/or calling law enforcement. These stakeholders clarified that this was a clear duty for providers. There was a common understanding and agreement in the practice community as to how to operationalize this duty.

A small number of subject-matter experts did not specify the duty owed during this time period. One non-provider organization indicated that they were not familiar enough to fully comment regarding providers, but indicated that the legal community appeared to know the duty owed by providers. Another non-provider organization believed that *Petersen* specified the duty owed, but they were uncertain how that might affect the duty. Finally, one stakeholder contends that RCW 71.05.120 limits the duties to warn or take reasonable precautions to protect against a patient's violent behavior, to instances where the patient has communicated an actual threat of physical violence against a reasonably identifiable victim. In all other instances, the *Petersen* duty to protect anyone who might foreseeably be endangered applied.

2. Pre-Volk Most Clinicians Thought the Duty Owed Applied in Inpatient and Outpatient Settings

Most mental health clinicians considered the duty owed pre-*Volk* to apply to all treatment settings equally. Essentially, there was one duty that was not impacted by treatment setting

boundaries. This duty applied to a wide range of mental health providers, as listed in RCW 71.05.020.[4]

3. Clinical Judgment Was Part of Duty Pre-Volk

Depending on the individual patient history and context of any given situation where a duty to warn or to protect arose pre-*Volk*, a clinician used their professional judgment in deciding what, if any, action to take. The perceived bright-line rule pre-*Volk* meant that the emphasis was on clinical judgment, not risk of liability to the provider. As numerous mental health providers explained, it is important to determine whether a patient is venting emotions or actually threatening someone. Words alone may not be determinative, depending on the patient's history and the current context. Moreover, sometimes, as in the case of victims of crimes, making what could be perceived as threatening comments is part of the normal grieving process.

4. Pre-Volk, Warning Was Not the Only Possible Action

Stakeholders clarified that warning a potential victim or victims was one possible action, if necessary. This was generally understood in the provider community as arising when an actual threat against a reasonably identifiable victim was communicated. Moreover, a provider could also request an assessment for involuntary commitment and could contact law enforcement. Some providers specified that pre-*Volk*, there were some situations where no specific victim was identified but the threat appeared real and so the DMHP or law enforcement was called.

But, if a clinician did not consider a patient to be making an actual threat, that provider might take other actions such as: changing the patient's medications, recommending more frequent appointments with the patient, seeking voluntary hospitalization, and attempting to reduce any barriers to treatment.

5. After Volk, There Is Confusion Regarding the Duty Owed By Mental Health Professionals

Many stakeholders are unclear as to specifically what duty is owed, as well as to whom the duty applies. Many providers view *Volk* as an expansion of the existing duty to a broader duty owed to any foreseeable victim. Others suggest that it creates a new duty. Providers are uncertain how they will be judged retrospectively by a trier-of-fact. Risk assessments of patients can be subjective, and clinicians are concerned about putting questions of clinical judgment before a trier-of-fact. As one survey respondent replied: "It worries me that after a terrible injury or death has already occurred that the trier of fact (jury or judge) will be retrospectively deciding whether the injury or death was "foreseeable." They will likely conclude that if it happened it must have been foreseeable." *See* Appendix F.

[4] "Mental health professional" means a psychiatrist, psychologist, physician assistant working with a supervising psychiatrist, psychiatric advanced registered nurse practitioner, psychiatric nurse, or social worker, and such other mental health professionals as may be defined by rules adopted by the secretary pursuant to the provisions of this chapter." RCW 71.05.020.

In addition to being uncertain of the duty owed, there is also a lack of clarity as to whom the duty applies. Does it apply to voluntary commitments and emergency department providers? How far will the duty apply? Will it apply to any special relationship outside the mental health professionals, such as an attorney or a primary care provider such as an OB/GYN treating a patient with postpartum depression or DMHPs conducting an ITA assessment? Although some providers may view the *Volk/Petersen* cases as outpatient/inpatient cases, respectively, others do not and specifically note that now, providers might owe a higher duty to voluntary commitment patients than to involuntary commitment patients.

Some providers and attorneys note that pre-*Volk*, any decision to warn or take other protective measures greatly depended on the provider's clinical judgment of a given patient and situation. The post-*Volk* shift that they see is that the provider must report any threat to a potential victim or law enforcement, or call a DMHP and request an ITA assessment. This perspective essentially does away with the parsing of words over the duty to protect and the duty to warn; now the duty is one of taking action. But the action taken may be bounded by these three possibilities.

A few stakeholders indicated that the duty owed under *Volk* is clear because there was no substantive change in the law. The duty owed was described as: the duty to protect by exercising reasonable precautions, and the duty to warn. Prior to *Volk*, some attorneys suggested that providers may not have thought that a vague threat was actionable.

6. When the Volk Duty Begins Is Unclear

It is unclear to most stakeholders when, precisely, the *Volk* duty begins. According to many of the stakeholders, by definition it begins when a special relationship is formed, but that in itself is not clear. Stakeholder responses to when the *Volk* duty begins included: when a patient shares homicidal/suicidal thoughts; when a person becomes your patient; when a person acknowledges a risk on an intake form; and, the same as pre-*Volk*.

The *Volk* decision reiterates that a special relationship exists "on a showing that a definite, established, and continuing relationship exists between the defendant and the third party."[5] But many stakeholders expressed confusion as to the precise moment a duty under *Volk* begins.

7. Discharging the Duty Owed Under Volk

As explained by the stakeholders, the duty owed under *Volk* must be discharged when there is a credible threat to a foreseeable victim. Who to warn and what specific actions can be taken to discharge this duty may be hard to determine. Stakeholder responses to this query included: notifying law enforcement and/or a DMHP; changing medication, or taking other clinical measures such as requesting increased appointments with the patient. At one extreme, providers voiced concern that they can only speculate as to how to sufficiently discharge any duty owed under *Volk*. They worry that they will not know what they should have done until they go to trial in a given case. To some, discharging the duty seems to be a balancing act between treating the patient and protecting the public.

[5] *Volk* at 263 (citing *Honcoop*).

8. When the Volk Duty Ends

Most stakeholders cannot articulate when any duty under *Volk* might clearly end since a provider might be found to have a duty for a patient the provider did not consider currently being treated. Some think that it may depend on whether treatment ceased under a mutual agreement with a clear ending such as an understanding that the patient was better now and could return later for additional treatment if needed, or if a patient was terminated by the provider. Even if a provider or facility decides to terminate a patient, patients may not receive notification of such termination if they are transient, homeless, or otherwise difficult to contact. Moreover, as one stakeholder explained, a patient's acute episode of dangerousness may dissipate clinically, but a court may consider that acute episode to last indefinitely. One provider expert questioned whether, if a former patient moves out of state, will Washington providers have a heightened risk of being sued because of *Volk*? Another referred to Justice Wiggins' dissent that expanding liability beyond treatment is unsupportable. Several provider organizations and attorneys viewed the duty as never-ending. The exception to this is if the provider dies, and then his or her estate may be liable.

Formally terminating a patient from a given clinician may end any duty owed by the provider. However, as several stakeholders noted, many clinicians keep an open file with a patient even if the patient does not have frequent appointments. In many cases, the provider does this in order to keep the patient hooked into the health care system in case the patient increases treatment encounters. As these experts emphasized, these are often the people you do not want to formally cut off from care. Yet, it is plausible that providers will begin to increase their patient terminations because that may be a clean way to cut off liability. As one attorney hypothesized, a provider could theoretically terminate a patient one week, while notifying the patient that when they return for their next appointment in a week, it will be a new engagement. One mental health provider noted in the survey: "I think of my on-going work with clients over several years, in a small rural community, as work with more beginnings and endings, rather than being "available" to a client in a more indefinite/loosely structured way. I am taking the active position of writing the termination letter to end our relationship. They can choose to begin the relationship again but I don't want to be responsible for them if we are not working together in a regular/active pattern." *See* Appendix F.

One provider stakeholder organization stated that it was unrealistic in a busy outpatient setting to suggest that any duty owed to a patient would exceed the 24 hours immediately following the patient's appointment. They indicated that the duty would only be acted on within 24 hours.

D. Additional Clinical Practice Implications post-*Volk* and Potential Detrimental Impact on Clinical Judgment

There is some concern that under *Volk* a provider's actions will be mandated; once a patient is recognized as potentially dangerous, the provider must request involuntary commitment, call law enforcement, and/or notify a potential victim, if possible. Some providers dislike this approach because it does not permit the full use of their clinical judgment. Warning potential victims, itself, is not viewed by providers as necessarily the best option in a given situation. As providers noted, in some communities calling law enforcement can raise additional safety issues, and sometimes warning a potential victim can result in the potential victim's harming the patient. If providers do indeed increase these types of responses, there may be a chilling effect on patient care, depending

on patients' understanding of what is occurring. Patients may pick and choose more carefully what they say in a treatment environment because they do not want to be involuntarily committed, reported to law enforcement, or have a potential victim of a vague threat warned.

Because the *Volk* decision is so recent, it is too early to fully analyze any impact on mental health providers' clinical judgment. One provider organization reported that their providers have not yet changed how they use their clinical judgment post-*Volk*. These providers, however, are nervous and worried about being sued, and so may decide to change how they use their clinical judgment in the future. Another provider organization reported that their attention is diverted from thinking about the patient to thinking about a third party. Because the interests of the patient and the third party are often not aligned, clinical judgment changes to reflect that the provider has multiple duties, not simply a duty to the patient. Some think *Volk* causes providers to be more alarmist than pre-*Volk*, to stop using clinical judgment, and to act more as a detective or a fortune teller. Another provider organization suggested that it is likely to impact clinical judgment because providers are more likely to discuss threats made years ago with a patient, potentially skewing the patient-provider relationship. On one hand, increased attention to risk assessment and additional consultations regarding particular patients may strengthen clinical assessment skills. As one stakeholder stated, it woke them up to be more aware of the potential dangers presented by their patients. Stakeholders in other provider organizations reported that the need to consult and refer patients has increased solely for purposes of reducing risk, not for clinical reasons. And, many providers report that risk assessments are not foolproof. A good risk assessment may be completed and the patient may still leave the provider's office and harm himself or others shortly thereafter. Patients do not always tell the truth.

E. Mental Health Professionals' Workforce Concerns

Many stakeholders voiced concern about *Volk* impacting the ability to recruit out-of-state providers to Washington state. The looming fear of a protracted trial, potentially destroying a provider's career, may make recruitment to Washington state difficult. With shortages of providers in general, and specifically for mental health providers, there is concern over being a national outlier. While concern about potential recruitment impacts due to *Volk* were often raised by stakeholders, no one was able to provide evidence that it had begun to occur. This may be because it is difficult to ascertain exactly why an applicant does not accept a position. Others worried that the lack of clarity under *Volk* will cause premature burn-out among mental health practitioners.

F. Implications for Patient Access to Mental Health Services and Public Safety—Potential Impact on Patient Access to Mental Health Services

Providers repeatedly stated that because of *Volk*, they are likely to focus on foreseeability and liability concerns, to the detriment of patient care. Providers emphasize the likely harm to the therapeutic relationship resulting from *Volk*. One provider organization reported that patients have said that they do not want to talk about their thoughts anymore. Essentially, for these patients, there does not seem to be a safe place for them to discuss their thoughts and so they will not get care. Another organization indicated that they have not heard of any existing access issues but to the extent that professionals leave the field, such issues will then materialize.

The likely impact on patient access to mental health services may become further distinguished based on geography. Rural patients may have a harder time accessing treatment in their community with limited providers, particularly once any patient-provider relationship begins to deteriorate.

One stakeholder organization indicated that *Volk* will not create more barriers for patients to access care. Another suggested that, by holding providers accountable under *Volk*, this may lead to better care in the future as providers take additional steps to meet their standard of care.

G. Is the Public Safer After *Volk*?

The majority of stakeholders indicated that the public is not better protected under *Volk*. Many provider experts commented that one factor that contributes to the success of mental health therapy is the provider alliance with the patient. If the provider is overly focused on potential danger and harm presented by their patient, the provider will skew the alliance and the patient will feel investigated rather than understood and listened to. If patients have a weakened therapeutic relationship with providers, they may not seek or continue treatment. Having people in need of mental health treatment but not receiving it, does not serve the public's safety.

Many stakeholders stated that we do not currently have a perfect system and we will not be able to create one that prevents all tragedies. Protecting the public in general is too broad, only the public members that are specifically identified are protectable. The public would only be safer if providers could accurately predict dangerousness and violence, which providers cannot do. Some stakeholders queried: How long do you keep a patient locked up and how many patients do you lock up in order to keep one person safe? Other stakeholders stated that if everyone is locked up, then the public is protected. The goal, however, should be to balance individual rights with public safety.

A few subject-matter experts were still uncertain as to whether the public would be safer after *Volk*. These stakeholders suggested that it may depend on: how law enforcement responds to calls from providers; if providers stop taking certain patients, leaving them potentially untreated; and, if awareness is raised in the clinical community and providers focus more on risk factors.

One subject-matter expert thinks that public safety is better under *Volk*. Or, it would be if the law was strictly implemented and/or enforced.

H. Legal Implications

1. Perspectives that the Law Did Not Change with Volk

A few stakeholders clearly state that the *Volk* decision did not substantially change the law in Washington. The law is the same as it was following *Petersen*. There is a disjunctive duty: if there is a reasonably identifiable victim, then a provider has a duty to warn; if not, a provider has a duty to take reasonable precautions to protect. *Petersen* established the standard of care, but perhaps not all providers were abiding by this standard. Some of these stakeholders query whether the strong provider outcry against *Volk* was catalyzed by some professional organizations

encouraging their members to voice their opposition. Naturally, providers would like limitations on liability, and by raising concern over *Volk*, perhaps that is one way of achieving such limitations. Some attorneys that have been trying these cases since *Petersen* indicate that the issue has never been raised that *Petersen* did not apply to the outpatient setting. Another stakeholder likened the provider response to *Volk* to the original enactment of HIPAA, when a common recommendation was not to share personal health information with anyone.

2. Perspectives that the Law Did Change with Volk and Stakeholders' Suggestions for Corrections

A majority of subject-matter experts clearly state that the *Volk* decision substantially changed the law in Washington. Specifically, these experts thought the law changed: from a bright line rule to an unclear rule; from a reasonably identifiable victim to a foreseeable victim; by narrowing the application of the current statute to involuntary commitment settings; by creating a new duty; by changing the duty owed to a third party (not the duty owed to the patient); by requiring providers to do more than they can do legitimately or clinically; and that the decision fails to define control or mental health professional.

Many stakeholders would like to see enactment of a statute establishing a defined duty to warn when there is an actual threat towards a reasonably identifiable victim,[6] because it is a concrete duty that strikes an appropriate balance between duty to the patient and duty to the public. Others suggest: statutorily defining the circumstances triggering a *Volk* duty. Clarity and one uniform standard are what clinicians are seeking, as discussed more below.

3. Perceived Changes to Legal Practice

Some defense attorneys consider *Petersen* to be more of a sea change than *Volk* because *Petersen* created a duty that did not previously exist. Because *Volk* is viewed as affecting outpatient practice, it may not be a sea change because community providers are not perceived as treating the same level of mental health illness as inpatient providers. Community providers may see a difference in liability, but *Volk* may not open the floodgates of liability.

Defense attorneys suggest that there will never be a summary judgment granted for a mental health professional under any duty-to-protect claim. Prior to *Volk*, if there was no reasonably identifiable victim, there was no liability. Where there had been a good chance of having a case dismissed, now it is more likely that the provider will need to settle the case, or proceed to a trial. And, because there is no bright line rule, cases will be examined on a case-by-case basis.

Defense attorneys report that it is difficult to advise clients how to meet their duty under *Volk*. From their perspective, once a bad event occurs, plaintiff's attorneys will be able to find a "hired gun" to find something missing in the medical record, posit something that arguably should have been there, and opine that the provider did not comply with the standard of care. If the provider had done something differently, then the bad outcome would not have occurred. However,

[6] Interestingly, a subject-matter expert who believed *Volk* did not change the law also reported that more than a vague threat should be required before a provider calls law enforcement.

after the fact, it is hard to know that if a provider acted differently it would have made a difference in the harm caused by the patient. For instance, once you know the outcome, you can say that the provider should have called the DMHPs and requested the patient be involuntarily committed. But even in a hospital, a patient can harm herself or others.

On the other hand, plaintiffs' attorneys emphasize that these types of cases are difficult to bring successfully because the defense only has to show reasonable, possibly only slight, care.

I. Key Issues Raised by Stakeholders Beyond Those Addressed in the Appropriation

Although outside the scope of the study, the stakeholders raised concerns about the possible legislative response to *Volk*. A brief overview of stakeholder perspectives regarding ESB 5800 is useful in better understanding some of the issues raised by *Volk* that are concerning to stakeholders.

HB 1810 and SB 5800, relating to the obligations of mental health professionals, were introduced in the 2017 legislative session. As introduced, these bills added a new section to RCW 7.70, actions for injuries resulting from healthcare. While no action was taken on HB 1810 after a hearing in the Committee on Judiciary, the companion bill SB 5800 saw additional legislative action.

Specifically, a "mental health professional" was defined in this bill as a:

- Psychiatrist,
- Psychologist,
- Physician assistant working with a supervising psychiatrist,
- Psychiatric advanced registered nurse practitioner,
- Psychiatric nurse,
- Social worker,
- Chemical dependency professional; and
- Any person licensed by the department of health as a mental health counselor, mental health counselor associate, marriage and family therapist, or marriage and family therapist associate. (SB 5800(1)(a))

Mental health services meant outpatient and inpatient services provided to diagnose or treat mental disorders covered by the diagnostic categories listed in the most current version of the diagnostic and statistical manual of mental disorders. (SB 5800(1)(b)) The bill specified that mental health professionals and individual health care providers providing mental health services have a:

> *Duty to warn* or take reasonable precautions to *provide protection* from a patient's violent behavior only if the patient has communicated … an *actual threat* of physical violence against a *reasonably identifiable victim* or victims. (SB 5800 (2) emphasis added)

This duty could be discharged by reasonable efforts to communicate the threat to the victim(s) and to law enforcement personnel. (SB 5800 (3)) A mental health professional or individual health care provider is not liable for civil damages for failing to predict, warn of, or take reasonable precautions to provide protections unless the patient communicated an actual threat of physical violence against a reasonably identifiable victim and the provider failed to communicate the threat or take other reasonable measures, which might include reasonable attempts to hospitalize

the patient voluntarily. (SB 5800 (4)) The Oban striking amendment, which was adopted, made significant changes to SB 5800.

ESB 5800 made four key changes to SB 5800. First, ESB 5800 amended a different RCW chapter. Rather than amending RCW 7.70, it amended RCW 71.05, the chapter on mental illness. Second, ESB 5800 clarified that mental health services meant voluntary or involuntary outpatient and inpatient services. (ESB 5800 (1)(b)) Third, ESB 5800 limited the duty owed by a mental health professional or individual health care provider providing mental health services to a *duty to warn* only if the patient communicated an actual threat of physical violence that *poses a serious or imminent threat* to the health or safety of a reasonably identifiable person(s). (ESB 5800 (2)) Finally, under ESB 5800 providers are not liable for civil damages for discharging the duty to warn as provided in this bill, or having discharged the duty to warn, for failing to predict, warn of, or take reasonable precautions to provide protections as long as the provider acted in good faith and without gross negligence. (ESB 5800 (4))

During the course of our consultations with stakeholders, some raised the following concerns: (1) This would create a mandatory duty to warn rather than a duty to protect; (2) by requiring the threat to pose a serious *or* imminent threat, this bill would create conflict with federal law, HIPAA, requiring imminent *and* serious, as well as state law, RCW 70.02.050(1)(c); and (3) this bill protects egregious actors. As the stakeholders explained, a duty to protect permits mental health professionals to use their clinical judgment, possibly taking other actions rather than warning. Warnings can be problematic and may not always be the ideal response to a given situation. Possible negative consequences to warning include the warned victim becoming violent toward the patient. With respect to protecting egregious actors, providers should not be encouraged to refrain from asking a patient questions, so that the provider does not have to face the possibility of acting on a patient's responses. One stakeholder insisted that the legislation was not intended to be a blanket immunity for providers and that they were not seeking such immunity.

On the other hand, some stakeholders welcomed the clarity that this bill would provide. Specifically, by requiring an actual threat of physical violence, providers may have more clarity regarding when the duty is owed. And, since the threat has to be to a reasonably identifiable person(s), providers have more guidance and do not have to constantly consider non-identifiable, yet potentially foreseeable victims.

Additionally, stakeholders raised the following key issues during our meetings: certain patients are more dangerous than others and attention should be focused on these patients; mental health services are not sufficiently funded; providers want to use their clinical judgment; providers cannot accurately predict dangerousness; confidentiality and privacy; and, the need for one uniform standard in Washington state.

As one provider stated, patients who are dangerous are dangerous and *Volk* did not change that. There was general consensus among stakeholders that, within limited parameters, certain patients required some form of action on the part of the provider. Per attorneys on both sides of the issue, many of the lawsuits arise from patients who are already in the public mental health system. These patients have been discharged from an involuntary commitment, or they are on a less restrictive alternative and are now being treated in an outpatient setting. These are the patients who

should be focus of law and clinical practice, not patients who are venting their emotions and make a vague threat.

Stakeholders often raised the fact that mental health services are not sufficiently funded in Washington state. Many providers commented that the *Volk* decision put more responsibility on mental health providers without providing any additional financial support. Others commented that, as Washington has moved patients out of state hospitals, the state has not provided sufficient outpatient resources. For instance, outpatients need access to medications. If there were places where patients could go to access their medications, there may be fewer bad outcomes without an expansion of liability. Moreover, a person often cannot be detained without an available hospital bed. Some hospitals have the ability to do single bed certifications to meet a specific patient need, but not all hospitals. Depending on the county, a person may be found to be detainable but cannot be detained because there is no bed.

Providers generally want to use their clinical judgment and believe the law should facilitate this. Providers have many other tools available to them, besides calling the DMHP, calling law enforcement, or warning a potential victim. Depending on the situation and the patient, providers may change a patient's medication regime, may request more frequent appointments with the patient, and other clinical approaches to patient care.

Ohio is sometimes referred to by stakeholders in Washington as an example of a statutory approach that provides clarity and facilitates clinical judgment. Under Ohio Rev. Code Ann. § 2305.51(B) a mental health professional's duty to protect is triggered when there is an explicit threat of imminent and serious physical harm to a clearly identifiable person and there is reason to believe that the patient has the intent and ability to carry out the threat. This duty is discharged if the mental health professional: exercises authority to hospitalize the patient, establishes an appropriate treatment plan to thwart the threat and obtains a second risk assessment; or warns law enforcement and any potential victim. Ohio Rev. Code Ann. § 2305.51(C) provides that the mental health professional consider which course of action is appropriate and document the rationale for the clinical decision. For some Washington providers, this could be an appropriate approach in Washington state.

Predicting dangerousness and violence is not a science. A provider's ability to predict the dangerousness of a given person is a key point of contention in the response to *Volk*. Currently, while several assessment tools exist, there are no best practices or uniform screening of patients due to patient diversity. Many providers are emphatic that *Volk* requires them to predict how a patient is going to act and providers cannot do this accurately. As one provider explained, we can evaluate risk on a daily basis but we cannot predict what happens in the next hour. There is not sufficient science that mental health professionals can utilize to revamp practices. On the other hand, some stakeholders suggest that to some extent providers can predict dangerousness since that is what DMHPs do when they assess a patient for involuntary commitment.

Survey data reinforces the perception that clinicians must predict the future. For example, providers' comments included: "committing a violent act is not predictable EVEN when I am seeing a patient regularly;" "[w]e have no way of knowing what circumstances may arise that prompt patients we haven't seen recently to act violently;" "I worry with *Volk* I will be held

responsible to monitor safety of former clients about whom I have no actual current knowledge;" "[n]ot even the best psychiatrist is able to read minds and foresee danger to future victims that the patient has not discussed;" and, "it is impossible to predict the future and anyone could become a risk depending on circumstances that arose in their life." *See* Appendix G.

Providers' frustration with their understanding of the *Volk* decision is often evident: "The idea that we must abandon the only tool of any value—our trusting relationship with the patient based in the insane belief that we have the capacity to predict human behavior is more than I can tolerate." *See* Appendix G.

Moreover, there is concern on the part of clinicians that the *Volk* emphasis on potential violence of the mentally ill is disproportionate to the actual violence committed by the mentally ill. One survey response mirrors an often-heard refrain from stakeholders: "The effect of the Volk ruling in practice is to suggest that patients seeking mental health care are potentially violent at a level far out of proportion with the actual risk of violence while failing to recognize that these patients are far more likely to be victims of violence." *See* Appendix G.

Perhaps more troubling than the clinician as psychic is the perception that mental health providers are responsible for a patient's actions in the future. Providers state that: "to hold the analyst responsible for actions the patient takes in the future that may never have been discussed in the treatment is absurd;" and, "[i]n general, potentially dangerous people cannot be charged until they commit a crime, yet Volk holds therapists liable for a patients' illegal actions." *See* Appendix G. Providers, however, are only legally responsible for their actions, not those taken by their patients. A provider is not liable for a patient's harm to a third party, they are liable for any failure to fulfill their duty to warn and/or protect that third party.

While an analysis of HIPAA and Washington's Uniform Health Care Information Act is beyond the scope of this study, several stakeholders indicated concern about confidentiality and privacy in conjunction with *Volk*. Some providers are concerned that disclosing information under *Volk* might harm the patient-provider therapeutic relationship. Others are concerned that disclosing information under *Volk* might violate confidentiality and privacy laws. Not all providers join in this concern, as they believe that state law permits disclosure and, even if it did not, they would rather be at risk of a privacy lawsuit then a failure-to-protect lawsuit.

For those stakeholders that perceive *Volk* as significantly changing the law, there was often a desire voiced for the creation of one clearly defined legal standard applicable to all mental health professionals. Providers' confusion, or at the very least, providers' lack of clear understanding of what their duty is under *Volk*, when it begins, when it ends, and how they can satisfy their duty was echoed by many of the stakeholders. These stakeholders stated that they were looking for a legislative solution that is sensible and workable and that applies across treatment settings, such as outpatient and inpatient. Many stakeholders desired a return to the standard that they believed had applied pre-*Volk*—the duty to warn or to take reasonable precautions to provide protection from violent behavior where the patient has communicated an actual threat of physical violence against a reasonably identifiable victim or victims.

J. Stakeholder Meeting Held on November 18, 2017, at University of Washington School of Law

As required by the Legislature's appropriation, the research team held a meeting on November 18, 2017 at the University of Washington School of Law for interested stakeholders to hear the summary of the research and the conclusions. *See* Appendix H for list of invitees and attendees, both in-person and online. The USB drives disseminated to the House Judiciary Committee members and staff contain both the slides used for that presentation and a video of the presentation itself.

VI. STUDY CONCLUSIONS

The Washington State Legislature asked the University of Washington School of Law to conduct a comprehensive study of how Washington's duty to third parties in the mental health context has evolved. This study was commissioned in the wake of *Volk v. DeMeerleer* decided in late 2016—a case that arguably expanded the mental health care provider's duty to protect third parties.

In *Volk,* the Court determined that outpatient mental health providers have a duty to protect any foreseeable third party from a patient with a propensity for danger. The Court drew this broad standard from the 1983 *Petersen v. State of Washington* case in which a recently released inpatient injured another in a car accident. Western Washington State Hospital was judged to have been grossly negligent by releasing the patient and liable for the harm to the third party. The Court eschewed the statutory standard of RCW 71.05.120(3) enacted in 1987, that narrowed the duty, limiting it to taking reasonable precautions to provide protection from violent behavior where the patient has communicated an actual threat of physical violence against a reasonably identifiable victim or victims. The Court argued that this narrow standard applied only to the duty to protect third parties from recently released inpatients, not to outpatients.

As a result, the Legislature asked for a study of how Washington's duty to third parties in the mental health context compares to other states, an analysis of the evolution of Washington case law, documentation of the concerns and views of a variety of stakeholders engaged in mental health care and services, and an estimation of the likely impact of *Volk* on Washington state's mental health care resources.

Our in-depth study and review of statutory and case law across the nation revealed that Washington, in the wake of *Volk,* is clearly out of step with all but one state. In fact, eight states do not recognize any provider duty to protect or duty to warn in the context of mental health care. Nine states provide for provider discretion to disclose confidential information to warn or protect a third party, but do not impose a duty. The remaining 34 states do have provider duties to protect and/or warn third parties of potential danger presented by a patient. However 33 of these states limit the duty only to third parties who are readily identifiable, clearly identifiable, specific, or in the zone of risk. Wisconsin extends the duty to anyone foreseeable, but its law is founded on a single case which conforms quite closely to the fact pattern in Washington's *Petersen* case in that it dealt with harm inflicted by a recently released mental health in-patient.

In terms of what kind of threat triggers a duty to third parties, all states except Wisconsin and Georgia, characterize the threat as one which is a serious, imminent and explicit intent to cause physical harm or death. Wisconsin and Georgia have lower triggering thresholds: Georgia cites "generalized threats" and Wisconsin merely speak of "harm." Typically the duty to protect and/or warn is discharged once the third party is warned, law enforcement is notified, or the threatening patient is hospitalized or committed.

In analyzing the cases decided in Washington after the *Petersen* case, our research team found virtually no cases directly on point. Eleven cases dealt with the duty to protect or warn third parties. Four of these involved a mental health care provider's duty to protect or warn third parties. Three cases, all involving outpatient care, found that there was a lack of a sufficient "special relationship" between the provider and patient. One involved a former inpatient who had been discharged and subsequently murdered police officers; here the fact that the patient had been discharged from the hospital had terminated any special relationship.

The remaining seven cases dealt with the duty of probation, parole or corrections officers to protect potential victims of individuals under their supervision. Notably three of these cases involved individuals who had mental health issues. Of these seven cases, four of them found a duty to protect, noting that the probation/parole/ corrections officers all had ongoing special relationships with the perpetrators of harm, and, moreover, the officers had the capacity to exercise control over their charges. One case found that, although there was a duty, proximate causation was lacking. In the remaining two, one of which was a mixed law enforcement/mental health case, both found no duty due to lack of a sufficient special relationship and absence of a capacity to control.

Considering *Volk* in the context of Washington state case law, it seems to raise questions as to both the meaning of a "special relationship" and the role of control, both of which have been crucial and pivotal in Washington case law prior to *Volk.* Coupled with the increased breadth of the duty to protect any foreseeable victim, the *Volk* decision has left mental health providers perplexed and concerned.

Our study consulted with numerous providers and other stakeholder organizations and surveyed the membership of several of them. The majority knew of the *Volk* decision and were already considering or implementing changes in their practices to limit their exposure to liability. These changes included increasing patient screening to avoid accepting high-risk patients, enhanced and/or more detailed documentation including modified disclosure forms, increased referrals for involuntary commitment, and increased use of law enforcement assistance. Many providers voiced concerns about the impact of *Volk* on the quality of their relationships with their patients. Some noted that the necessary increased focus on risk to any foreseeable third party would detract from the time and concentration devoted to the patient's needs. Many of these issues were echoed in our Stakeholder Meeting on November 18, 2017.

Given that providers indicated that their knowledge of *Volk* may lead them to seek commitment and referral for commitment more frequently, insufficient inpatient beds may become a pressing issue in Washington. Our study and review of mental health resources in Washington, combined with changes in provider behavior, indicates that *Volk* may increase the strain on the state's existing inpatient mental health capacity. A few of our stakeholders spoke of the state

impact on the mental health system dating back many years to meet the aim of de-institutionalization of mental health services. Our research indicates that our major inpatient psychiatric hospitals (Western, Eastern, Child Study and Treatment) have operated at very high occupancy over the last several years. Indeed, the absence of inpatient capacity has led to increased usage of single bed certifications for psychiatric care in general hospitals. It is unlikely that there is capacity to absorb an increased number of patients referred for inpatient mental health care; and if an increase in patients occurs, it is likely that the single bed certification rate will increase.

In conclusion, the *Volk* case substantially changed the duty to protect and the duty to warn in Washington in the outpatient context. The duty is now broader for outpatient mental health providers who have less control over the patient, and in the case of DeMeerleer, for providers who may not even have recent contact, let alone control. Paradoxically, there is a more clearly defined, more workable standard for inpatient providers who do have control over patients. Providers fear that their relationships with their patients will be undermined by their duty to a broad universe of potential third-party victims. For many providers, *Volk* seems to impose an undue burden on outpatient providers; one that is rife with uncertainty and confers an unrealistic unsustainable duty upon them.

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