Volk v. DeMeerleer Study
Appendices

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APPENDIX A
Appendix A-- Volk Study Appropriation

Senate Bill 5883, Operating Budget, Section 606 for the University of Washington...
(25)(a) $140,000 of the general fund —
state appropriation for fiscal year 2018 is provided solely for the
University of Washington school of law to convene a study on the
Washington state supreme court decision Volk v. DeMeerleer, 386
P.3d 254 (Wash. 2016), and whether or not it substantially changed
the law on the duty of care for mental health providers and whether it
has had an impact on access to mental health care services in the
state.
The study shall include:
(i) Comprehensive review of duty to warn and duty to protect case law
and laws in the United States, including a description of how
Washington state's law compares to other states and to what extent,
if any, the Volk decision changed the law in this state;
(ii) 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;
(iii) An analysis of lawsuits brought in the state as a result of the Volk
decision, including the outcome of any such cases and any harm
alleged in each lawsuit;
(iv) An analysis of lawsuits brought in the state prior to the issuance of
the Volk decision, and since the issuance of the decision in Petersen
v. State, against outpatient mental health providers
alleged to have breached either the duty to warn or the duty to take
reasonable precautions established in Petersen, including the
outcome of any such cases and the harm alleged in each lawsuit;
(v) 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;
(vi) Whether insurance policy provisions and rates have been affected
due to the Volk decision;
(vii) 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;
(viii) Assessment of whether mental health service providers may be changing practice to limit exposure to the potential risks created by the Volk decision;
(ix) Assessment of legal and practice implications state legal standards regarding duty to warn and duty to protect in the voluntary and involuntary treatment context; and
(x) Comprehensive review of practices where the practice has been consistently shown to have achieved the results it seeks to achieve and that those results are superior to those achieved by other means.

(b) When performing the study under this subsection, the University of Washington school of law shall consult with subject-matter experts including, but not limited to, individuals representing the following organizations:
(i) Attorneys with experience representing defendants in personal injury cases or wrongful death cases related to the issues raised by duty to warn cases;
(ii) 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;
(iii) Department of social and health services;
(iv) Washington academy of family physicians;
(v) Washington association for mental health treatment protection;
(vi) Office of the insurance commissioner;
(vii) Washington council for behavioral health;
(viii) Washington state hospital association;
(ix) Washington state medical association;
(x) Washington state psychiatric association;
(xi) Washington state psychological association; (xii) Washington state society for clinical social work;
(xiii) Washington association of police chiefs and sheriffs;
(xiv) Victim support services;
(xv) NW health law advocates;
(xvi) National alliance on mental illness; 
(xvii) American civil liberties union; and 
(xviii) A sample of families who testified or presented evidence of their cases to the legislature.

(c) The University of Washington school of law shall consult each listed organization separately. Following collection and analysis of relevant data, they shall hold at least one meeting of all listed organizations to discuss the data, analysis, and recommendations.

The University of Washington school of law must submit the final report to the appropriate committees of the legislature by December 1, 2017.
APPENDIX B
Adherence to Antipsychotic Medication in Bipolar Disorder and Schizophrenic Patients

A Systematic Review

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Saioa López-Zurbano, MD,* † Añaki Zorrilla, PhD, MD,* ‡ § Purificación López, PhD, MD, * ‡ §
Eduard Vieta, PhD, MD, ‡|| and Ana González-Pinto, PhD, MD* ‡ ||

Abstract: Antipsychotics are the drugs prescribed to treat psychotic disorders; however, patients often fail to adhere to their treatment, and this has a severe negative effect on prognosis in these kinds of illnesses. Among the wide range of risk factors for treatment nonadherence, this systematic review covers those that are most important from the point of view of clinicians and patients and proposes guidelines for addressing them. Analyzing 38 studies conducted in a total of 51,796 patients, including patients with schizophrenia spectrum disorders and bipolar disorder, we found that younger age, substance abuse, poor insight, cognitive impairments, low level of education, minority ethnicity, poor therapeutic alliance, experience of barriers to care, high intensity of delusional symptoms and suspiciousness, and low socioeconomic status are the main risk factors for medication nonadherence in both types of disorder. In the future, prospective studies should be conducted on the use of personalized patient-tailored treatments, taking into account risk factors that may affect each individual, to assess the ability of such approaches to improve adherence and hence prognosis in these patients.

Key Words: adherence, antipsychotic, schizophrenia, bipolar disorder

One of the greatest problems clinicians face when dealing with chronic illnesses is the effectiveness of treatment. This is determined by various different factors such as patient tolerance of the drug, the appropriateness of the regimen, and, above all, adherence to the treatment prescribed. The best medication at the best dose can never be effective if the patient does not take it.

Medication adherence, previously known as compliance, has been defined as “the extent to which a person's behavior coincides with the medical advice given.” This may include refusing to attend medical appointments or to start a treatment program or early discontinuation, as well as incomplete implementation of the doctor's instructions. Such behavior has a negative effect on the outcome of the illness and leads to higher rates of recurrence and hospitalization, worsening of signs and symptoms, and increases in hospital costs.

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At least half of patients who are prescribed long-term medication do not finish the course, this phenomenon representing a particularly serious problem in chronic psychiatric illnesses, in which treatment adherence rates are even lower than in other conditions. Specifically, considering 2 serious psychiatric disorders, bipolar disorder, and schizophrenia, mean rates of treatment adherence are approximately 42% in schizophrenia and 41% in bipolar disorder, with considerable variation between studies. This variation is mainly attributable to a lack of consensus on the best methodology for assessing adherence (qualitative vs quantitative research, patient self-reporting vs reports of clinicians, direct measurement of blood or urine parameters vs indirect measurements), the period of observation (from a week to several months), and the criteria for defining lack of adherence. Furthermore, medication adherence is a dynamic dichotomous behavior, influenced by multiple factors that may be related to patients (adverse effects of medication), their social relationships (family support and therapeutic alliance), cognitive problems such as impaired memory or attention, and the system for providing health services. Analysis of these factors has become a critical issue for clinicians and researchers, given that identification of specific risk factors will make it possible to carry out patient-targeted interventions. This is particularly important in early stages of severe mental illness, where it has been seen that treatment nonadherence is most critical for patient outcome. It has been reported that nonadherence to antipsychotic drugs in patients diagnosed with schizophrenia or schizophrenia-like psychosis is associated with a lower probability of a good response to treatment and significantly less improvement than in those who adhere to treatment, a higher rate of positive and negative psychotic symptoms, and a greater risk of hospital readmission. Similarly, it has been found that patients with bipolar disorder with good treatment adherence had less severe signs and symptoms, lower scores in the Clinical Global Impressions bipolar mania and hallucinations/delusions scales, and a lower risk of suicide. Martinez-Aran et al demonstrated that a history of nonadherence in adults with bipolar disorder was significantly associated with cognitive impairment.

The objectives of this systematic review are to provide a detailed and comprehensive description of the most important factors associated with lack of adherence to antipsychotic medication in patients with schizophrenia spectrum disorder and bipolar disorder and thereby to contribute to clarify our understanding of the factors underlying nonadherence.

MATERIALS AND METHODS

Literature Search

This systematic review was conducted and is reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) statement. We performed
an electronic search in the PubMed (1990–2015) database, using the following MeSH terms: medication adherence, antipsychotic agents, mood disorder, psychotic disorder, and bipolar disorder. We selected 1990 as the start date for the search because of the reintroduction of clozapine in the following decade and the approval of risperidone by the Food and Drug Administration in the same period (1993).

In addition, we used the following filters: randomized controlled trial, meta-analysis, clinical trial, systematic review, controlled clinical trial, observational study, and humans. We reviewed all the articles published in English and Spanish. Subsequently, reference lists from the studies included in our systematic review were hand searched for additional relevant publications.

**Inclusion Criteria**

We included all the systematic reviews, meta-analyses, clinical trials, randomized clinical trials, and observational studies in which the study population was patients diagnosed with bipolar disorder, schizophrenia, schizoaffective disorder, or schizophreniform disorder who were being treated with antipsychotics and in whom factors associated with treatment adherence were assessed. Articles were excluded if patients had a diagnosis other than those mentioned previously or medical treatment with agents other than antipsychotics (eg, lithium or mood stabilizers), as well as if there was no assessment of factors associated with adherence to treatment with antipsychotics.

**Data Collection and Extraction**

From the set of articles selected in the systematic review, we excluded those that did not meet all the inclusion criteria or met any of the exclusion criteria. After reading the titles and the abstracts, we selected articles related to the objective of our study. These were then summarized and assessed by 2 independent reviewers using the “Critical Reading Sheets” tool developed by the Basque Office for Health Technology Assessment, and the most relevant data were retrieved. In the event of disagreement, a third researcher analyzed the article independently. The Basque Office for Health Technology Assessment tool facilitated the assessment of the methodological quality of the research described, classifying it as low, moderate, or high. In this review, we only included high-quality studies.

**RESULTS**

From the PubMed and manual backward searches, we identified a total of 96 articles. After screening and selection processes, we included 38 articles in this systematic review (Fig. 1). These corresponded to 22 cohort studies, 8 clinical trials, 6 reviews, 1 clinical guideline, and 1 meta-analysis. The characteristics of each study are summarized in Table 1.

A total of 51,796 patients were included, of whom 40,298 had been diagnosed with bipolar disorder, 10,385 with schizophrenia, 544 with schizoaffective disorder, 516 with schizophreniform disorders, and 53 with psychosis not otherwise specified.

Adherence to drug treatment can be measured by subjective methods, such as self-report and physician report, or objective methods, such as pill counting, blood or urine analysis, electronic monitoring, and electronic refill records. Of the 38 studies included in our review, 66% of the studies used subjective measures to assess adherence, 16% also used objective measures, 2% used only objective measures, and 16% of studies did not specify the measures used. The study by Lindenmayer et al was the only one in which adherence was measured with objective measures only and patients had a mean adherence of 65.5%. In studies in which objective and subjective measures...
were combined, adherence ranged from 60% to 81%, whereas in studies in which only subjective methods were used, adherence ranged from 34% to approximately 80%. Note that the reviews, meta-analysis, and guideline are not included in this description, because they are based on multiple studies using different methods and hence could have introduced bias into the analysis.

According to our findings, factors that influence treatment nonadherence are associated with patients themselves, the drug treatment, social issues, and the health system provider.

**Patient-Related Factors**

This category includes attitudes and behaviors, comorbidities and the severity of signs and symptoms, demographic and environmental factors, and the cognitive functioning of patients, as well as their relationship with their medication.

As part of the EMBLEM Project, González-Pinto et al analyzed 1831 patients with bipolar disorder and found that the following factors were significantly positively associated with good adherence: good illness awareness (good adherence from the start of treatment) and a short duration of episodes. On the other hand, factors related to poor adherence were high scores in the Clinical Global Impressions hallucinations/delusions scale at baseline and depressive symptoms during mania. Regarding symptoms, a study including 128 patients diagnosed with schizophrenia observed that the time to discontinuation was significantly longer in those with an early nondysphoric response (7.3 months) than those with an early dysphoric response. In patients with schizophrenia and affective disorders, Verdoux et al found that the intensity of delusional symptoms predicted poor treatment adherence ($P = 0.03$). In contrast, Patel et al did not find symptom to be predictive of adherence.

Analyzing 469 patients with bipolar disorders, Johnson et al found differences in adherence related to demographic characteristics; these included ethnic differences, with white patients having better treatment adherence than patients from other ethnic groups. These findings are in agreement with those of Zeber et al and Fleck et al. The authors found that Afro-American patients reported significantly more missed medication days and greater barriers to adherence than white patients. They also found a higher prevalence of patient-related factors influencing adherence (fear of becoming addicted and feeling that medication is a symbol of illness) in Afro-American patients than white patients, whereas the rates of treatment- or illness-related factors were similar in the 2 ethnic groups. Perkins et al confirmed these findings, with black ethnicity again being associated with lower medication adherence in patients with schizophrenia. Among white patients, Perlis et al observed in a cohort of 3460 patients with bipolar disorder that being Hispanic was associated with poor adherence, and, moreover, this association was not confounded by differences in other predictors such as household income or education. A similar pattern was observed in the study of Sajatovic et al, in which patients with bipolar disorder from minority races had poorer adherence than other individuals with the same diagnosis. Education was another demographic characteristic related to adherence in the study of Johnson et al in bipolar disorder (adherence decreased with level of education).

Young age has also been identified as a predictor of poor adherence in many studies, both in patients with schizophrenia and those with bipolar disorder. For the latter diagnosis, this association was found in the studies of González-Pinto et al, Sajatovic et al, Johnson et al, who reported that adherence decreased to a mean age of 41 years and thereafter increased with age, and Baldessarini et al, in which youth was a predictor of poor adherence, behind alcohol dependence and ahead of symptoms and adverse effects. In schizophrenia, Maeda et al noted that the age of patients was associated with increased awareness of disease prevention, older patients having more experience in the course of the disease, and possible relapses and hospital readmissions, and this led them to be more compliant with medication.

In addition to younger age, age at onset has also been cited as a risk factor for nonadherence to treatment, both in schizophrenia and bipolar disorder. Coldham et al found that non-adherent schizophrenic patients had an earlier age of onset, as well as being younger, and having poorer quality of life and premorbid functioning. Similarly, in a prospective study in 2010, Perlis et al observed that 874 of 3640 patients with bipolar disorder (24%) reported nonadherence on 20% or more study visits and the clinical features that were significantly associated with this included earlier onset of illness, as well as suicide attempts and alcohol abuse.

Nevertheless, the association of age at onset and nonadherence might be related to younger age (ie, in first-episode studies, younger age, and age at onset are equivalent), and this has not been well investigated. Furthermore, there is no consensus on this association between age and adherence within the set of studies included in the review, some authors having observed no significant differences between patients in different age groups.

In the study carried out by Lindenmayer et al, in 599 patients with schizophrenia, no baseline characteristics of patients, including demographic characteristics, initial body weight, and history of substance abuse, seem to be good predictors of adherence, whereas the severity of the depressive symptoms at baseline and a high level of hostility during the study were risk factors for nonadherence. In contrast to the aforementioned findings of Lindenmayer et al, alcohol and cannabis use and abuse have been found to be significantly associated with nonadherence to medication in several studies. In the 2015 meta-analysis of Czobor et al, in which they combined 2 studies, the European First-Episode Schizophrenia Trial (EUFEST) and the Clinical Antipsychotic Trials of Intervention Effectiveness, yielding a cohort of 1154 patients diagnosed with schizophrenia, they found that nonadherence to treatment was associated with substance abuse and hostility. This was consistent with earlier studies in schizophrenia, namely, those of van Nimwegen-Campailla et al, who found that patients who did not consume cannabis during treatment had a significantly longer treatment period (mean, 6.4 months) than cannabis users (mean, 4.3 months), and those of Miller et al, who found that the use of cannabis was associated with a 2.4-fold lower rate of adherence, independent of age, socioeconomic status, sex, and the medication prescribed. Similarly, in patients with bipolar disorder, Gonzalez-Pinto et al observed that the use and abuse of cannabis were key factors for nonadherence. Furthermore, Coldham et al found that schizophrenic patients who were nonadherent (73 of 186 patients) consumed significantly more cannabis and alcohol than an adherent group, and Verdoux et al described lower adherence in patients with schizophrenia and bipolar disorder who had alcohol abuse problems. Notably, in a clinical trial with 400 schizophrenic patients, ongoing substance abuse significantly predicted poor adherence, and Sajatovic et al found similar results in their study with veterans with bipolar disorder.

Regarding cognitive factors, Martínez-Aran et al found that nonadherent bipolar patients showed greater cognitive impairment in verbal learning tasks and some executive functions, as well as greater deterioration in spatial memory and in their ability to inhibit interference than adherent patients. Also in patients with bipolar disorder, Perlis et al found that cognitive
<table>
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<th>Study</th>
<th>Diagnosis</th>
<th>Definition of Adherence/Nonadherence</th>
<th>Classification of Adherence</th>
<th>Methodology</th>
<th>% Adherent/Nonadherent</th>
<th>Type of Antipsychotic</th>
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<tr>
<td>Adams and Scott (2000)²⁸</td>
<td>Clinical trial</td>
<td>SZ and affective disorders</td>
<td>Adherence: levels of adherence &gt;75%</td>
<td>Adherent, partially adherent (&lt;70%), uncertain adherence.</td>
<td>Adherent: 49% Partially adherent: 38% Not classified: 21%</td>
<td>NR</td>
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<tr>
<td>Baldessarini et al (2008)²⁹</td>
<td>Randomized, prospective, cross-sectional cohort study</td>
<td>BPD</td>
<td>Nonadherence: ≥21 doses missed in a period of 10 d</td>
<td>Adherent vs nonadherent</td>
<td>By self-report: 56.5% nonadherent By psychiatrists: 6% nonadherent</td>
<td>NR</td>
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<tr>
<td>Bond et al (2007)³⁰</td>
<td>Review</td>
<td>BPD</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>Depot FGA and SGA</td>
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<td>Czobor et al (2015)³³</td>
<td>Meta-analysis</td>
<td>SZ</td>
<td>NR</td>
<td>Adherence vs nonadherence</td>
<td>NR</td>
<td>NR</td>
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<td>Davis et al (1994)³⁴</td>
<td>Review</td>
<td>SZ</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>Depot FGA</td>
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<td>Day et al (2008)³⁷</td>
<td>Prospective, cross-sectional cohort study</td>
<td>SZ or schizoaffective disorder</td>
<td>NR</td>
<td>Adherence vs nonadherence</td>
<td>NR</td>
<td>NR</td>
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<td>Faries et al (2012)³⁵</td>
<td>Randomized double-blind clinical trial</td>
<td>SZ or schizoaffective disorders</td>
<td>NR</td>
<td>Adherence vs nonadherence</td>
<td>NR</td>
<td>NR</td>
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<td>Fleck et al (2005)³⁶</td>
<td>Cross-sectional cohort study</td>
<td>BPD</td>
<td>Highly adherent: those who had taken the pharmacological treatment ≥ 75% of the time</td>
<td>Adherent, partially adherent, nonadherent</td>
<td>Subjective: Structured questionnaire administered by the clinician</td>
<td>Highly adherent: 40% Partially adherent: 12% Nonadherent: 48%</td>
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<tr>
<td>Study</td>
<td>Design</td>
<td>Group</td>
<td>Adherence vs nonadherence</td>
<td>Subjective</td>
<td>Objective</td>
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<tr>
<td>González-Pinto et al (2010)</td>
<td>Prospective, observational cohort study</td>
<td>BPD</td>
<td>Nonadherence: answering “adheres about half of the time” or “almost never adheres” at ≥1 completed observations during the maintenance phase (3–24 mo)</td>
<td>Adherent: 76.6%</td>
<td>Oral FGA and SGA</td>
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<tr>
<td>Jeste et al (2003)</td>
<td>Cohort study</td>
<td>SZ or schizoaffective disorders</td>
<td>NR</td>
<td>Adherent: 76.6%</td>
<td>Oral</td>
<td></td>
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<tr>
<td>Jónsdóttir et al (2013)</td>
<td>Cross-sectional cohort study</td>
<td>BPD and SZ</td>
<td>Adherence (“full adherence”): taking all the medication the previous week and having a serum drug concentration within the reference range and a correct concentration-to-dose ratio</td>
<td>Full adherence, partial adherence, nonadherence</td>
<td>Schizophrenia: Full adherence: 55%</td>
<td>FGA and SGA</td>
</tr>
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<tr>
<th>Study</th>
<th>Diagnosis</th>
<th>Definition of Adherence/ Nonadherence</th>
<th>Classification of Adherence</th>
<th>Methodology</th>
<th>% Adherent/ Nonadherent</th>
<th>Type of Antipsychotic</th>
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<tbody>
<tr>
<td>Kahn et al (2008)(^3)</td>
<td>Open randomized controlled trial, 12-mo follow-up.</td>
<td>SZ, schizophreniform disorder or schizoaffective disorder</td>
<td>Nonadherence was defined as: 1. The use of a dose below the predefined range including complete discontinuation; 2. The use of a dose greater than the predefined range; 3. The use of another antipsychotic drug each for &gt; 14 days for 6 mo; 4. The use of any parenteral antipsychotic drug when the drug was active for &gt; 14 d for 6 mo.</td>
<td>Adherence vs nonadherence</td>
<td>Subjective: Treatment discontinuation was defined as occurring on the 15th day as soon as 1 of the 4 criteria for discontinuation was met.</td>
<td>Nonadherence: Haloperidol: 72% A amisulpride: 40% Olanzapine: 33% Quetiapine: 53% Ziprasidone: 53%</td>
</tr>
<tr>
<td>Karow et al (2007)(^9)</td>
<td>Multicenter, observational cohort study</td>
<td>SZ</td>
<td>Adherence (&quot;the patient almost always takes medication&quot;); patients and clinician report that the patient has taken almost always the medication, in an assessment after 12 mo</td>
<td>Patient takes the medication: almost always, sometimes, hardly ever, classified at 12 mo</td>
<td>Subjective: independently rated by patients and by physicians</td>
<td>Adherence by physicians: 82.9% Adherence by themselves: 88.3%</td>
</tr>
<tr>
<td>Kemp and David (1996)(^1)</td>
<td>Randomized, double-blind, placebo-controlled trial</td>
<td>SZ and BPD</td>
<td>NR</td>
<td>Complete refusal, partial refusal, reluctant acceptance, occasional reluctance about treatment, passive acceptance, moderate participation, active participation</td>
<td>Subjective: 1. Schedule for Assessment of Insight, a semistructured interview; Drug Attitude Inventory, a self-report measure; Attitudes to Medication Questionnaire, a semistructured interview 2. Adherence was measured using an observer-rated scale</td>
<td>NR</td>
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<tr>
<td>Lacro et al (2002)(^6)</td>
<td>Review</td>
<td>SZ</td>
<td>Adherence definition by: Strict criteria: &quot;regularly taking medications as prescribed.&quot; &quot;Stricter&quot; criteria: &quot;taking medications as prescribed at least 75% of the time.&quot;</td>
<td>NR</td>
<td>Subjective: Likert-type assessment scale</td>
<td>For the strict criteria: 58.8% adherence For the stricter criteria: 49.5% adherence</td>
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<tr>
<td>Study</td>
<td>Design</td>
<td>Population</td>
<td>Measures of Nonadherence</td>
<td>Objective</td>
<td>Measures of Adherence</td>
<td>Adherence Rate</td>
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<tr>
<td>Lieberman (2007)</td>
<td>Randomized, controlled trial, 18-mo follow-up.</td>
<td>SZ</td>
<td>NR</td>
<td>Objective: monthly pill counts</td>
<td>Adherence vs nonadherence</td>
<td>74% of patients discontinued the medication (nonadherent)</td>
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<td></td>
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<td>Subjective: 1. Direct interview with patients</td>
<td></td>
<td>64% of those assigned to olanzapine</td>
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<td>2. Reports by their families, and clinicians</td>
<td></td>
<td>75% of those assigned to perphenazine</td>
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<td>3. Plasma concentrations of mood stabilizers measured during the previous 2 y.</td>
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<td>82% of those assigned to quetiapine</td>
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<td>4. Plasma therapeutic drug monitoring</td>
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<td>74% of those assigned to risperidone</td>
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<td>5. Oral FGA and SGA</td>
<td></td>
<td>79% of those assigned to ziprasidone</td>
</tr>
<tr>
<td>Lindenmayer et al (2009)</td>
<td>Randomized prospective double-blind clinical trial</td>
<td>SZ or schizoaffective disorders</td>
<td>Nonadherence: not taking the complete dose of the prescribed medication</td>
<td>Objective: 1. Daily pill counts for each patient</td>
<td>Adherent: 65.5%</td>
<td>Oral SGA</td>
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<td>2. Measurement of olanzapine concentration in plasma (1/2 of the study patients)</td>
<td>Nonadherent: 24.5%</td>
<td></td>
</tr>
<tr>
<td>Maeda et al (2006)</td>
<td>Cross-sectional cohort study</td>
<td>SZ</td>
<td>Nonadherence: not taking the medication for at least 1 wk in the last month</td>
<td>Adherence vs nonadherence</td>
<td>Subjective: Rating of Medication Influences scale</td>
<td>NR</td>
</tr>
<tr>
<td>Martinez-Aran et al (2009)</td>
<td>Prospective, cross-sectional cohort study</td>
<td>BPD</td>
<td>Nonadherence: if at least 1 of the 3 assessments suggested nonadherence.</td>
<td>Adherent vs nonadherent</td>
<td>Adherent: 60%</td>
<td>NR</td>
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<td></td>
<td>Nonadherent: 40%</td>
<td></td>
</tr>
<tr>
<td>Menzin et al (2003)</td>
<td>Retrospective cohort study</td>
<td>SZ</td>
<td>Nonadherence: patients who were identified on the basis of having no record of a prescription refill for the medication in the last 6 mo of the 1-y follow-up period.</td>
<td>Adherence vs nonadherence</td>
<td>Subjective: records from paid medical and pharmacy claims for a random sample of California Medicaid (“Medi-Cal”) recipients</td>
<td>Discontinuation in patients who initiated the therapy with FGA: 58%</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Discontinuation in patients who initiated the therapy with SGA: 33%</td>
</tr>
<tr>
<td>Study</td>
<td>Diagnosis</td>
<td>Definition of Adherence/Nonadherence</td>
<td>Methodology</td>
<td>% Adherent/Nonadherent</td>
<td>Type of Antipsychotic</td>
<td></td>
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<tr>
<td>Miller et al (2009)</td>
<td>Longitudinal prospective cohort study</td>
<td>Adherence: average of weekly adherence for 1 mo was ≥50% of adherence</td>
<td>Three adherence assessments: Objective: 1. Plasma levels of antipsychotics after 16, 24, 36, and 52 wk. 2. Additional blood tests Subjective: 3. Reports by patients and their families, as well as clinicians</td>
<td>Adherent: 81% Nonadherent: 19%</td>
<td>Oral SGA</td>
<td></td>
</tr>
<tr>
<td>Mutsatsa et al (2003)</td>
<td>Prospective, cross-sectional cohort study</td>
<td>Schizophreniform disorder</td>
<td>Good vs poor adherence</td>
<td>Good adherence: 56% Poor adherence: 44%</td>
<td>Oral FGA and SGA</td>
<td></td>
</tr>
<tr>
<td>Study</td>
<td>Design</td>
<td>Disorder(s)</td>
<td>Adherence criteria</td>
<td>Adherence periods</td>
<td>Methods</td>
<td>Results</td>
</tr>
<tr>
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<tr>
<td>Perlis et al (2010)</td>
<td>Multicenter, observational prospective cohort study</td>
<td>BPD</td>
<td>Nonadherence: missing at least 25% of total doses of any 1 medication.</td>
<td>Adherent vs nonadherent</td>
<td>Subjective: Clinical Monitoring Form: patients were asked to report the total no. missed doses of each medication that they were prescribed in the preceding week and this was recorded by the clinician as mg per wk missed.</td>
<td>Adherent at all visits: 46.40% Nonadherent &lt; 10% of visits: 13.8% Nonadherent between 10% and 20% of visits: 15.8% Nonadherent ≥ 20% visits: 23.9%</td>
</tr>
<tr>
<td>Sajatovic et al (2006)</td>
<td>Retrospective cohort study</td>
<td>BPD</td>
<td>(Fully) adherence: patient has received all medication needed to take their AP as prescribed.</td>
<td>Fully adherent, partially adherent, nonadherent</td>
<td>Subjective: MPR for patients receiving any antipsychotic medication. Fully adherent: 51.9% Partially adherent: 21.2% Nonadherent: 26.9%</td>
<td></td>
</tr>
<tr>
<td>Sendt et al (2015)</td>
<td>Systematic review</td>
<td>SZ</td>
<td>NR</td>
<td>NR</td>
<td>No consensus: the definition varying between studies reviewed The method varied between studies, no mean rate reported</td>
<td>Rates varied between studies, no mean rate reported Oral and depot FGA and SGA</td>
</tr>
<tr>
<td>Velligan et al (2009)</td>
<td>Guidelines</td>
<td>SZ and BPD</td>
<td>Adherence (most broadly used definition): ≥80% of the medication taken, both for SZ and BPD</td>
<td>NR</td>
<td>Subjective: 77% of the studies (eg, self-reports) Objective: &lt;23% of the studies (eg, blood tests).</td>
<td></td>
</tr>
<tr>
<td>Verdoux et al (2000)</td>
<td>Prospective longitudinal cohort study</td>
<td>SZ and affective disorders</td>
<td>Poor adherence: medication discontinuation for at least 2 wk in a period of 6 mo</td>
<td>Good vs poor adherence</td>
<td>Subjective: interviews with patients themselves, their relatives and clinicians, and data collection from hospitals every 6 mo for 2 y. Interrupted their medication at least once for the 2-y follow-up: 53.1% Poor medication adherence: 33%-44%.</td>
<td></td>
</tr>
</tbody>
</table>
TABLE 1. (Continued)

<table>
<thead>
<tr>
<th>Classification of Adherence</th>
<th>Methodology</th>
<th>Study</th>
<th>Diagnosis</th>
<th>Type of Antipsychotic</th>
<th>% Adherent/Nonadherent</th>
<th>Type of Study</th>
<th>Type of Classification</th>
<th>Study Diagnosis</th>
<th>Nonadherence of Adherence Methodology</th>
<th>% Nonadherent</th>
<th>Nonadherence: any antipsychotic medication</th>
<th>Adherence vs nonadherence</th>
<th>Type of Study</th>
<th>Type of Classification</th>
<th>Study Diagnosis</th>
<th>Nonadherence of Adherence Methodology</th>
<th>% Nonadherent</th>
<th>Nonadherence: any antipsychotic medication</th>
<th>Adherence vs nonadherence</th>
<th>Type of Study</th>
<th>Type of Classification</th>
<th>Study Diagnosis</th>
<th>Nonadherence of Adherence Methodology</th>
<th>% Nonadherent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adherence vs nonadherence</td>
<td>Subjective: self-reports</td>
<td>Weiden et al (2004)</td>
<td>SZ</td>
<td>Oral FGA and SGA</td>
<td>Adherence: 63%</td>
<td>Cohort study</td>
<td>Adherence</td>
<td>Good adherence: 50.9%</td>
<td>1. No missed doses:</td>
<td>Good adherence:</td>
<td>50.9%</td>
<td>Missing the medication at least once:</td>
<td>Poor adherence:</td>
<td>49.2%</td>
<td>Missing the medication at least once:</td>
<td>Good adherence:</td>
<td>51.2%</td>
<td>Poor adherence:</td>
<td>48.7%</td>
<td>Missing the medication at least once:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adherence vs nonadherence</td>
<td>Subjective: self-reports</td>
<td>Zeber et al (2008)</td>
<td>BPD</td>
<td>Oral FGA and SGA</td>
<td>Adherence: 50%</td>
<td>Cross-sectional</td>
<td>Adherence</td>
<td>Good adherence: 51.2%</td>
<td>1. Missed medication days (no. days in the last 4 on which the patient forgot to take the medication at least once):</td>
<td>Good adherence:</td>
<td>51.2%</td>
<td>Missing the medication at least once:</td>
<td>Poor adherence:</td>
<td>48.7%</td>
<td>Missing the medication at least once:</td>
<td>Good adherence:</td>
<td>51.2%</td>
<td>Poor adherence:</td>
<td>48.7%</td>
<td>Missing the medication at least once:</td>
<td></td>
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</tbody>
</table>

BPD indicates bipolar disorder; MPR, medication possession ratio; NR, not reported; SZ, schizophrenia.

Some adverse effects, such as secondary extrapyramidal symptoms (akathisia, pseudoparkinsonism, dyskinesia, and acute dystonic reactions), neuroleptic dysphoria, sexual dysfunction, and weight gain are associated with nonadherence in schizophrenic patients.46 Subjective distress, weight gain, and body mass index (BMI) were found to be predictive of therapeutic nonadherence, specifically, obese individuals being twice as likely to report nonadherence as patients with a normal BMI.53 Weight gain was also a fear in patients with bipolar disorder and a better predictor of nonadherence than adverse effects such as excessive sedation and tremors.29

In both types of disorders, illness awareness and trust in the medication have been found to be predictive factors for good adherence.2,19,31,33,46,51 In schizophrenia, according to patients, the most important reasons for continuing with their medication are the beneficial effects in terms of control of positive symptoms, a perception of improvement,35,37 a reduction in the rate of hospital readmissions, and the prevention of relapses.25 With regard to the reasons for discontinuing treatment, patients have cited insufficient improvement or actual worsening of symptoms, adverse effects of the medication,9,35,37 denial of the illness, and not considering medication to be necessary.9,45 In the clinical trial carried out by Adams and Scott,28 including 39 patients with schizophrenia, it was found that perception of illness severity and benefits of the treatment explained 43% of the variance in adherence.

Administering structured interviews about concerns and expectations regarding medication to 90 patients with bipolar disorder, Sajatovic et al50 found that 39% of patients were not concerned about their medication; 29% had specific concerns (worrying about developing more health problems); 6% feared becoming addicted; and 5% were worried about the economic costs. Patients’ expectations ranged from hoping that the medication would be able to decrease their symptoms and stabilize their mood (23%) to expecting it to help them to become “normal” (20%) and even curing them (20%), individuals reporting a feeling of disappointment when this did not happen.

**Drug Treatment-Related Factors**

**First- Versus Second-Generation Antipsychotic Drugs**

The Clinical Antipsychotic Trials of Intervention Effectiveness compared effectiveness of first-generation antipsychotic (FGA) and second-generation antipsychotic (SGA) drugs in patients with chronic schizophrenia. Differences in time to discontinuation of treatment due to ineffectiveness were lower with olanzapine, although there were no differences between the FGA perphenazine and SGA drugs such as risperidone or quetiapine.40 The EUFEST study also found that the risk of discontinuation was lower with olanzapine than with haloperidol (33% vs 72%). In fact, the risk of discontinuation due to any cause was higher with haloperidol than with all SGAs. With respect to discontinuation due to nonadherence, there were also no differences between first- and second-generation drugs.38
Another study compared 298 schizophrenic patients starting antipsychotic treatment with FGAs (n = 93) or SGAs (n = 205), the SGAs being associated with significantly less treatment switching and less use of concomitant medications than FGAs. On the other hand, in the 1-year follow-up, it was observed that both groups of patients took the drugs on 60% of days.42 In line with these findings, in a review of the risks of nonadherence, Lacro et al16 reported that there was inconclusive evidence of a relationship between nonadherence and the type of treatment.

In a recent systematic review, that only included studies in schizophrenia, Send et al51 found no significant differences in rates of adherence between the 2 types of antipsychotics. On the other hand, in bipolar disorder, Sajatovic et al49 observed that patients who take FGAs were more adherent than those taking SGAs.

To sum up, it seems that some SGAs give some advantages in relation to adherence versus FGA. Nevertheless, the rates of nonadherence are high, and new therapeutic approaches are required.

**Depot Versus Oral**

Formulation type has been found not to be a consistent predictor of nonadherence.45,51 The main reasons for changing from an oral to an intramuscular or depot antipsychotic30,34,44 are usually nonadherence and resistance to oral antipsychotics.34,44,45 Prescription of a depot medication must, however, be accompanied by discussion with the patient about personal benefits, because beliefs and attitudes have an important influence on adherence to depot medication.45

**Factors Associated With Social Relationships**

A good therapeutic alliance between the patient and the physician17,54 and the level of family support31,46 have been found to be significantly associated with good treatment adherence in both pathologies.19 In the multivariate analysis carried out by Zeber et al,54 with patients with bipolar disorder, the overall score on the Health Care Climate Questionnaire (a measure of therapeutic alliance) was found to be significantly positively associated with the number of days on which medication was not missed. Furthermore, in schizophrenic patients, Coldham et al31 found a higher level of family involvement in the adherent group (80%) than the nonadherent group (51%).

**Factors Associated With the Health Service Provider**

Barriers to or difficulties accessing treatment (lack of economic resources for buying medication or lack of transport to reach health service providers) were found to be predictive of nonadherence in schizophrenic and bipolar patients in the reviews conducted by Perkins46 and Velligan et al,19 respectively. Patient experience with the health system was also found to be associated with subsequent adherence to drug treatments in both types of disorder.17,19

To summarize the findings in a clear way, Table 2 lists all factors associated with nonadherence rates found in literature by diagnosis. We can observe that a number of factors are common to both types of disorders, whereas other factors are more closely related to the clinical symptoms of each diagnosis.

### TABLE 2. Factors Common to Both Pathologies and Specific Factors by Diagnosis

<table>
<thead>
<tr>
<th>Factors Commonly Involved in Nonadherence</th>
<th>Factors Potentially Involved in Nonadherence in Bipolar Disorder</th>
<th>Factors Potentially Involved in Nonadherence in Schizophrenia</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low level of education</td>
<td>Positive symptoms</td>
<td>High severity of depression at baseline</td>
</tr>
<tr>
<td>Young age</td>
<td>High severity of depressive episodes</td>
<td>Early dysphoric response</td>
</tr>
<tr>
<td>Cognitive impairment</td>
<td>Rapid cycling</td>
<td>Short illness duration</td>
</tr>
<tr>
<td>High intensity of delusional symptoms and suspiciousness</td>
<td>High affective morbidity</td>
<td>Adverse effects: extrapyramidal symptoms, neuroleptic dysphoria, akathisia, sexual dysfunction, and weight gain.</td>
</tr>
<tr>
<td>Substance abuse/dependence</td>
<td>Comorbidity with other conditions</td>
<td>Poor response to or tolerance of treatment</td>
</tr>
<tr>
<td>Minority ethnicity</td>
<td>(anxiety, obsessive compulsive disorder)</td>
<td>Early treatment discontinuation rate</td>
</tr>
<tr>
<td>Poor insight</td>
<td>Comorbidities by other conditions</td>
<td>Hostility to treatment</td>
</tr>
<tr>
<td>Poor therapeutic alliance</td>
<td>Hostility to treatment</td>
<td></td>
</tr>
<tr>
<td>Low socioeconomic status</td>
<td>Barriers to treatment, bad patient experience of admission</td>
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</tbody>
</table>

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studies, as we have said previously, we found this association in most cases.31 In particular, adolescents may be less tolerant to the adverse effects of antipsychotics (sexual dysfunction, sedation), more concerned about the stigma of the illness, or more impulsive and impatient if treatment is complex or does not improve symptoms sufficiently fast, and these attitudes can lead to treatment discontinuation.32,35 Furthermore, ethnicity is associated with significant differences in adherence, antipsychotic adherence rates tending to be lower in black than white patients.36,37,38 On the other hand, level of education and quality of life also have an impact on adherence; patients with a low level of education or poor quality of life are more prone to nonadherence.39

Regarding modifiable factors, a psychological model has been proposed, the Health Belief Model, which aims to explain and predict health behaviors, focusing on attitudes and beliefs of individuals that may have an influence on adherence.16 This model indicates 2 behaviors that play a very important role in medication acceptance: (1) patients must be aware of their own condition (they must perceive their vulnerability and the seriousness of the illness) and (2) they must know and interiorize the benefits of treatment adherence.24,31,46 These 2 requisites are of particular importance in patients with first psychotic episodes, given that they tend to occur during adolescence,56 a critical period of development at biological, personal, and social levels.35,37 For this reason, a specialized early intervention program is needed at this stage of the illness in young patients,38,39 to attempt to minimize the consequences of the psychosis.60 A study on adolescents, all treated with antipsychotics, assessed their subjective experience with medication with the “Drug Attitude Inventory” and found that a change to more positive medication attitudes was associated with significantly greater medication adherence, decreases in psychopathology, and improvement in functioning.61 To achieve this change in patient attitude, it is essential to include psychoeducation in the treatment program, to teach patients about their illness, medication and adverse effects, and relapse prevention.19

Cognitive Behavioral Therapy is a model of psychotherapy intervention focused on understanding patient’s perception of their problems and treatment. Cognitive Behavioral Therapy therapists help patients identify and modify negative automatic thoughts about medications and strengthen their belief that taking their medication is a step toward recovery and improving their well-being. This type of therapy has been found to improve adherence and symptom management and to enhance insight in patients with schizophrenia.19

In addition, psychoeducation may be extended to include the patient’s family, as seen in previous studies,31,46 and then treatment becomes more effective in reducing relapse rates and the symptoms of the illness than if psychoeducation is given only to the patient.22 As long as the patient consents, involvement of a family member would help improve the management of the patient’s treatment program, providing support through the course of the disease and reminding the patient take medications, attend health appointments, etc., and improving the patient environment. Therapeutic alliance has also been identified as a relevant factor for improving adherence to antipsychotics.17,54,63 A study on patients with bipolar disorder found that patient collaboration was significantly associated with good adherence, that is, patients being involved as a comanager of their own illness, with the psychiatrist considering their opinions and comments during the intervention process, helped improve the management of the illness, and hence led to better treatment adherence.64 These 2 factors, therapeutic alliance and patient collaboration, together with social support and a positive environment11,46 are also predictive of good adherence during treatment.

Therefore, the first contact between the patient and the health system is a key factor because it influences patient perception. The following factors help patients develop a more positive perception of their illness and drug treatment: approachable clinicians, who discuss the beliefs, fears, and needs of patients regarding their illness and treatment; continuity of care provided by a single health care team; more frequent and/or longer visits17; and easy access to their health center.19 Regarding the last of these factors, physical or economic barriers, such as a lack of public transport to reach the health center or difficulties meeting the costs of new antipsychotics, clearly hinder patients’ capacity to adhere to medication.19,46 Health centers should explore ways to facilitate access, and clinicians should provide support and advice as part of the treatment, being proactive in the breaking down of barriers, for example, offering free samples of drugs to start the treatment,46 or informing patients and families about the drugs, and helping them obtain grants to cover the cost of drugs, especially in the case of people with low economic resources. These gestures could also contribute to improve patient-clinician relationships.

In line with these ideas for improvement, new strategies for therapeutic interventions include offering economic rewards to patients with a psychotic disorder to investigate whether financial incentives would affect their adherence to antipsychotic medication. A study with 73 patients with schizophrenia and bipolar disorder demonstrated the effectiveness of this type of intervention, showing benefits in adherence, contact, monitoring, and patient trust in 77% of cases.67 Further research is needed into this type of intervention; however, benefits were only found in the short-term, intrinsic demotivation being observed in the long term.83

Other important modifiable risk factors are alcohol and drug abuse, which can be said to have an almost direct relationship with nonadherence to antipsychotic drugs.23,33,43,47,52 Notably, in a study with patients with bipolar disorder, alcohol dependence was the factor most strongly associated with nonadherence, above and beyond being young, and even the potential adverse effects of treatment.29 The findings of Barbeito et al58 in the first psychotic episodes support the view that there is a link between nonadherence and cannabis use, and interestingly, they found not only that patients who had never used cannabis had better adherence but also that patients who were nonusers with a history of dependence were also good adherers to treatment. These results are in line with those of the 2006 study of Sajatovic et al,69 in which past substance use disorder did not differ between adherent and nonadherent patients. Hence, we conclude that cannabis abuse does not cause irreversible damage in patients and that the aim of interventions should be to create a targeted and personalized treatment, not only to increase medication adherence but also to encourage the cessation of substance abuse.

Among the adverse effects of antipsychotics, weight gain is probably the health problem that is most likely to result in nonadherence.19 In fact, there is an association between adherence and patient BMI, adherence being lower among those with higher BMIs, and more subjective distress was related to weight gain.53 Extrapyramidal adverse effects such as pseudoparkinsonism, akathisia, dyskinesias, and sexual dysfunction were also found to be of great importance in nonadherence.56 One way to address this type of factor would be to create strategies for offering specific treatments depending on patients’ characteristics, carefully considering the risk-benefit ratio of each drug and selecting those least likely to have relevant adverse effects in given patients.70–74 Type of antipsychotic may be a factor underlying loss of adherence in some patients, related to low efficacy or severe adverse effects, but results were mixed across the articles reviewed. Specifically, not all studies found significant differences in adherence between FGA and SGA drugs that would be able to guide our
choice, and more importantly, loss of adherence was observed with both types of antipsychotic.

Regarding the route of administration, depot formulations are the type most widely chosen for patients with severe lack of adherence, although again data are mixed, results differing by trial design.75 Despite the use of depot medication, patient lack of insight or poor therapeutic alliance over time and among others factors mean that patients tend to become nonadherent again.

We conclude that neither lack of medication effectiveness nor the choice of route of administration is the real factor that prevents patients from continuing treatment. If possible, it is important to accompany treatment with an informative and explanatory discussion about the benefits thereof and to reduce polypharmacy (which increases the risk of adverse events and pharmacokinetic interactions, thereby increasing the likelihood of nonadherence). In addition, reducing the number of pills, when possible, is a good way to increase adherence, making the treatment easier for patients to remember and follow.66

Regarding adverse events, there are innovations in personalized medicine, with growth in the area of pharmacogenetics. Numerous studies have found polymorphism in genes that are involved in the metabolism of antipsychotics. Moreover, in relation to adherence, there is a direct relationship between some polymorphisms and the development of adverse events. For example, it has been found that genetic polymorphisms in the genes encoding cytochrome P450 enzymes CYP2D6 and CYP2C19 provide an explanation as to why some patients do not respond to drugs as expected, whereas others show an exaggerated response or serious adverse effects after receiving a standard dose that should have been safe for them. These differential responses to treatment are related to 2 phenotypes in the population, the extensive metabolizer and the poor metabolizer. The gene coding for CYP2D6 is highly polymorphic, and several mutations have been identified in poor metabolizers, all leading to the absence of functional CYP2D6. It is relatively common that poor metabolizers of CYP2D6 and CYP2C19 show an exaggerated drug response and adverse effects when they receive standard doses, whereas at the other extreme, so-called ultrarapid metabolizers do not respond to standard doses. Recently, the molecular basis of ultrarapid metabolism has been identified as the CYP2D6 gene amplification.76,77 Given this, new personalized medicine has the potential to reduce adverse events and indirectly increase adherence.78

Another new area of knowledge has emerged, namely, pharmacovigilance.79 The most common adverse effects of drug therapy are observed before approval for clinical use. The less common adverse effects may not be observed, however, until after regulatory approval in clinical practice; in some cases, serious effects may be discovered many decades after a drug receives regulatory approval.80 The aim of pharmacovigilance is to monitor drug safety and effectiveness after approval and understand the epidemiology and mechanisms of vast heterogeneity in drug-related outcomes, at individual and population levels. This area together with pharmacogenomics, seeking to explain the genomic basis of interindividual differences in efficacy and safety of drugs, creates the new term “pharmacovigilance.” This union enables a more mechanical approach, allowing extrapolation of early signs of drug-related events from 1 population to another, when the worldwide distribution of pharmacogenomics biomarkers linked to a given drug safety or efficacy event is known.79 It also helps us understand the pharmacokinetic and pharmacodynamic performance of drugs in population extremes, such as poor and ultrarapid metabolizers, mentioned previously and thus prompts a population-scale overview during postmarketing surveillance.81

A third new area of knowledge is pharmamicrobiomics. In relation to the Human Microbiome Project, it has been observed that drug-microbiome interactions may shed light on the influence that individual microbiota can have on the effects and adverse events of therapies in individuals. Gut microbiota can vary from 1 person to other because of differences in diet, health, use of medicines, place of residence, or age. Some drugs are particularly affected by gut microbes, and this is a little explored area that may help us understand patterns of adherence.78 For instance, it has been demonstrated that the gut microbiota has a role in the metabolic dysfunction associated with olanzapine in an animal model.82 In the future, the microbiome will be taken into account along with other factors, in personalized medicine. It is likely that considering the microbiome in the development of personalized medicine will initially be too expensive. Nevertheless, the use of this new tool may be justified and provide benefits in some patients with serious adverse events.

On the other hand, it has been observed that long hospital stays favor medication adherence. In particular, they allow pharmacotherapy to be optimized and to be more effective, given that patients’ beliefs and attitudes regarding their illness and medication can slowly change during admission, enabling a therapeutic alliance to develop, and this subsequently helps maintain treatment adherence.83 In relation to this, psychoeducation therapies mentioned previously play a very important role in the preparation of patients for the type of response they should expect, how their symptoms will improve, the management of adverse effects, and how to adjust their medication dosage.

Another very important area in which there is margin for improving practice relates to cognitive impairment in patients with psychiatric illnesses. In recent years, several studies have been conducted in an attempt to clarify the relationship between cognitive dysfunction and nonadherence. Jeste et al87 indicated that memory and conceptualization dysfunction were very good predictors of poor medication management. However, the results regarding predictive factors are mixed. On the one hand, Martinez-Aran et al18 analyzed cognitive dysfunction in a sample of patients with bipolar disorder and found that patients with the lowest levels of adherence had greater cognitive impairments. In this type of patients, adherence can be improved with the use of electronic pill boxes or alerts, to remind them to take their medication and hence adhere to their treatment.84 Furthermore, Perlis et al48 observed that memory impairment was the only significant predictor of nonadherence in 3460 patients with bipolar disorder, which might suggest that nonadherence is likely to result, at least in part, from the cognitive deficits that are increasingly recognized in these patients.85

In line with this, a study by Torrent et al86 in patients with bipolar disorder and moderate to severe cognitive disability showed functional improvement after a functional remediation program compared with usual care and psychoeducation. In this new type of intervention, patients perform exercises to improve memory, attention, problem solving and reasoning, multitasking, and organization, to strengthen their cognitive and general functioning. With the same objective, Velligan et al87 developed a program called cognitive adaptation training, which seems to be a promising strategy to improve adherence. Cognitive adaptation training focused on medication adherence uses individually tailored environmental supports (eg, signs, checklists, electronic cuing devices, organization of belongings) to cue adaptive behavior in the patient’s home environment and help compensate for cognitive deficits. It also addresses logistic issues related to obtaining medication (eg, picking up prescriptions) and getting to appointments. In a study published in 2008 involving patients with schizophrenia, Velligan et al87 found that a full cognitive
adaptation training program, focused on many aspects of community adaptation, and a cognitive adaptation training program, focused only on adherence to medication and appointments, were both better than treatment as usual in improving adherence, reducing relapse rates, and increasing time to relapse or exacerbation of symptoms. The full program produced greater improvements in functional outcome than the other 2 interventions.

On the other hand, unlike the aforementioned studies, Perkins et al.17 and Maeda et al.41 found that patients with the poorest adherence had better cognitive performance. Such contradictions between studies make it necessary to conduct further research in this area and, in turn, identify techniques that are useful for patients.

In several studies, symptom at baseline was found to be a relevant factor. In particular, the duration of episodes was observed to be a key factor in patients with bipolar disorder, adherence being better in patients with short episodes than those with longer ones.24 In patients with schizophrenia, Lindemmayer et al.1 found that the time to medication discontinuation was significantly longer in patients with high levels of hostility toward the study and those with poor insight.33,88 Taking into account these results, characterizing the symptom, monitoring symptom response on an ongoing basis (eg, using a daily checklist or mood chart),19 and reducing patient hostility may contribute to preventing future nonadherence.

Table 3 summarizes factors that it might be feasible to modify through interventions to improve patient adherence. A psychoeducational intervention in which patients are provided with a global overview of all these factors, with emphasis on aspects that are most relevant to their own profiles, may help encourage them to take a proactive role in the management of their illness.

Limitations

The findings of the review are limited by the wide range of rates of adherence found in the scientific literature (from 10 to 76% in schizophrenia14 and 20 to 66% in bipolar disorder),15 this being attributable to the different measures and definitions of adherence used. The percentages of studies included in our review that used subjective (66%), objective (2%), or both (16%) kinds of measures are consistent with figures in other studies described in the clinical guidelines developed by Velligan et al.19 These authors19 evaluated 161 studies on adherence, and 77% used only subjective measures. Nosé et al.2 also found that only 1% of studies used objective measures (urine tests).

As we explained previously, the rate of adherence differs markedly between studies that use subjective measures (34%52–80%99). Errors associated with this approach can be seen in the study of Baldessarini et al.29: adherence measured by self-report resulted in more than half (56%) of patients being classified as nonadherent, whereas in assessments carried by psychiatrists, only 6% of patients were classified as nonadherent.

There are also sources of error when using objective measures. Plasma or urine measures only determine whether the patient is taking the medication at the time but cannot be considered proof of their usual behavior.43 If the patient only took the medication before the test, adherence would be overestimated.13 In particular, it is essential to use objective measures for testing adherence, when nonadherence is denied by the patient and ignored by the family.18

Pill counting can also overestimate adherence, because patients can throw away pills without ingesting them.1 In brief, by describing these results, we want to underline the wide range of measurements in the literature and the need for agreeing on an appropriate methodology, to enable more accurate research in this field and comparisons between studies.

In terms of our methodology, another limitation is that the assessment of the quality of each article using critical reading sheets is open to a degree of subjective interpretation, although we have attempted to compensate for this to some extent by 2 different researchers reviewing each article independently.

Despite these limitations, in this systematic review, we have been able to classify the multiple factors associated with adherence to antipsychotics, in patients from the 38 selected studies, into 4 groups related to patients themselves, the drug treatment, their environment (social issues), and the health system provider. Finally, all factors were grouped by diagnosis to clarify the results.

---

**TABLE 3. Potential Areas for Intervention to Improve Adherence**

<table>
<thead>
<tr>
<th>Factors associated with patients</th>
<th>Consider patient ethnicity as a potential risk factor for nonadherence.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pay special attention to young patients for early intervention programs.</td>
<td>Accompany treatment with an informative and explanatory discussion about the benefits of treatment.</td>
</tr>
<tr>
<td>Tackle dependence on alcohol and other drugs, encouraging cessation.</td>
<td>Reduce polypharmacy, making the treatment easier for patients to remember and follow.</td>
</tr>
<tr>
<td>Increase awareness of the illness and of the benefits of antipsychotic treatment (eg, through psychoeducation and psychotherapy interventions).</td>
<td>Factors associated with social relationships</td>
</tr>
<tr>
<td>Prevent or minimize adverse effects of antipsychotics, implementing personalized treatment.</td>
<td>Improve the patient-physician relationship (strengthening the therapeutic alliance).</td>
</tr>
<tr>
<td>In cases of cognitive dysfunction, use programs and/or technical devices to support treatment adherence.</td>
<td>Involve the family in the illness of the patient.</td>
</tr>
<tr>
<td>Assess patient education and quality of life and take the results into account in planning treatment.</td>
<td>Factors associated with the service provision system</td>
</tr>
<tr>
<td>Characterize the symptom at onset and during the course of the illness.</td>
<td>Avoid patients’ first contact with the health system being a traumatic experience.</td>
</tr>
<tr>
<td>Consider patient ethnicity as a potential risk factor for nonadherence.</td>
<td>Reduce access barriers to treatment and health centers (eg, offering free samples of medications to start the treatment or inform patients of grants available to cover the medication costs).</td>
</tr>
</tbody>
</table>
allowing us to produce a summary of all the key factors that may affect patients in the management of their medication.

We can conclude that great efforts must be made to enhance adherence in patients with schizophrenia and bipolar disorder. Among the most important factors influencing this behavior, there are nonmodifiable factors, such as young age (adolescents having lower levels of adherence) and ethnicity but also many potentially modifiable factors, and these include the following: symptom at baseline, alcohol and drug abuse, illness awareness, therapeutic alliance and family support, adverse effects (weight gain and extrapyramidal adverse effects being the most important for patients), quality of life, level of education, previous experience with health services, and level of cognitive impairment.

Improvements in patient symptoms and quality of life are dependent on good adherence to drug treatment. In the era of precision psychiatry, the choice of the right treatment for the right patient may be an affordable unmet need, and this may be particularly relevant when trying to predict poor treatment adherence. Hence, early interventions focused on adherence enhancement may be particularly relevant. Accordingly, this systematic review seeks to facilitate efforts to improve patient behavior, by identifying factors associated with adherence in specific diagnoses and proposing potential strategies to address modifiable factors.

AUTHOR DISCLOSURE INFORMATION

This study was supported by health research funds from the Spanish Government, cofunding FEDER (PI12/02077, PI11/01977, PI14/01900); the Basque Foundation for Health Innovation and Research (BIOEF); Networking Center for Biomedical Research in Mental Health (CIBERSAM); and the University of the Basque Country (GIC12/84). The psychiatric research department in University Hospital Araba is supported by the Stanley Research Foundation (03-RC-003). Dr. González-Pinto has received grants and served as consultant, advisor, or CME speaker for the following entities: Almirall, AstraZeneca, Bristol-Myers Squibb, Cephalon, Eli Lilly, Glaxo-Smith-Kline, Janssen-Cilag, Jazz, Johnson & Johnson, Lundbeck, Merck, Otsuka, Pfizer, Sanofi-Aventis, Servier, Shering-Plough, Solvay, the Spanish Ministry of Science and Innovation (CIBERSAM), the Ministry of Science (Carlos III Institute), the Basque Government, the Stanley Medical Research Institute, and Wyeth. Dr. Víeta has received grants and served as consultant, advisor, or CME speaker for the following entities: AB-Biotics, Actavis, Allergen, AstraZeneca, Bristol-Myers Squibb, Ferrer, Forest Research Institute, Gedeon Richter, Glaxo-Smith-Kline, Janssen, Lundbeck, Otsuka, Pfizer, Roche, Sanofi-Aventis, Servier, Shire, Sunovion, Takeda, Telefonica, the Brain and Behaviour Foundation, the Spanish Ministry of Economy and Competitiveness (CIBERSAM and PI 12/00910), the Seventh European Framework Programme (ENBREC), the Stanley Medical Research Institute, and the Comissionat per a Universitats i recerca del DIUE de la Generalitat de Catalunya (2014 SGR 398), Aequas, Adamed, Alexza, Bial, Dainippon Sumitomo Pharma, Eli Lilly, Gedeon Richter, Janssen-Cilag, Jazz, Johnson & Johnson, Merck, Novartis, Organon, Pierre-Fabre, Qualigen, Shering-Plough, Solvay, Sumitomo Dainippon, Telenófica, Teva, the Spanish Ministry of Science and Innovation (CIBERSAM), United Biosource Corporation, and Wyeth. The other authors declare no conflicts of interest.

REFERENCES


APPENDIX C
Hi Terry,

Alice forwarded me your request. Please see my question in red below. Here is the data for state hospital bed capacity and occupancy rates.

Will send you E&T beds when I have it.

Can

---

From: Terry J. Price [mailto:torice@uw.edu]
Sent: Thursday, November 2, 2017 3:31 PM
To: Huber, Alice (DSHS/RDA) <hubera@dshs.wa.gov>
Subject: Data on psych beds and freestanding residential evaluation and treatment facilities in WA

Hello Alice—

Zosia Stanley at the Washington Hospital Association gave me your name as someone who may have data that we are looking for to complete a report to the Legislature about mental health capacity in the state. “SCQISH”—I’m not sure what this acronym is—may have collected data that would be useful to us. We are looking for:

1. The number of inpatient psych beds in the state, and it would be great to have the average census (i.e., generally full 95% of the time, or something like that) —
2. The number of outpatient beds or spots at the freestanding residential evaluation and treatment facilities in the state.

Any data you have along these lines would be very helpful. It would be great to have it within a week, if possible. (Sorry for the rush.)

Please let me know if you need more description of the data.

Thanks!

Terry Price

Terry J. Price, MSW, JD
Executive Director, Center for Law, Science and Global Health
University of Washington School of Law
William H. Gates Hall, Rm. 438
### Funded Bed Capacity

*SFY2000 - SFY2016*

Data Sources: ESH: Mark Kettner; WSH: Cache database provided by Julie Klingbell; CSTC: Cache database provided by CSTC

Date Run: 1/12/2017 and 1/13/2017

Report Compiled By: DSHS BHA Office of Decision Support and Evaluation: Theresa M. Becker

<table>
<thead>
<tr>
<th>SFY</th>
<th>Western State Hospital</th>
<th>Eastern State Hospital</th>
<th>CSTC</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Civil $^2$</td>
<td>Forensic</td>
<td>Civil $^2$</td>
</tr>
<tr>
<td>2000</td>
<td>639</td>
<td>253</td>
<td>219</td>
</tr>
<tr>
<td>2001</td>
<td>637</td>
<td>223</td>
<td>219</td>
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<tr>
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<td>614</td>
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<td>219</td>
</tr>
<tr>
<td>2003</td>
<td>550</td>
<td>241</td>
<td>191</td>
</tr>
<tr>
<td>2004</td>
<td>539</td>
<td>241</td>
<td>191</td>
</tr>
<tr>
<td>2005</td>
<td>535</td>
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<td>191</td>
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<td>2006</td>
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<td>627</td>
<td>270</td>
<td>222</td>
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<td>657</td>
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<tr>
<td>2009</td>
<td>597</td>
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<td>567</td>
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<td>192</td>
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<td>557</td>
<td>285</td>
<td>192</td>
</tr>
<tr>
<td>2016</td>
<td>557</td>
<td>285</td>
<td>192</td>
</tr>
</tbody>
</table>

**Data Notes: 2017**

$^1$Funded capacity as of June 30th of each fiscal year. This may or may not be the same as what's in the legislative bills.

$^2$Civil capacity includes HMH capacity

Prepared by WSH REDA Office

July 2015
# ESH Occupancy Rate by State Fiscal Year

**Data Source:** Yaro Trusevich  
**Date:** 10/23/2017

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Patient Days</th>
<th>Capacity</th>
<th>Percent Occupancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>101755</td>
<td>115705</td>
<td>88%</td>
</tr>
<tr>
<td>2008</td>
<td>104982</td>
<td>116022</td>
<td>90%</td>
</tr>
<tr>
<td>2009</td>
<td>103946</td>
<td>110275</td>
<td>94%</td>
</tr>
<tr>
<td>2010</td>
<td>101801</td>
<td>104755</td>
<td>97%</td>
</tr>
<tr>
<td>2011</td>
<td>100630</td>
<td>104755</td>
<td>96%</td>
</tr>
<tr>
<td>2012</td>
<td>100194</td>
<td>105042</td>
<td>95%</td>
</tr>
<tr>
<td>2013</td>
<td>98364</td>
<td>104755</td>
<td>94%</td>
</tr>
<tr>
<td>2014</td>
<td>97736</td>
<td>104755</td>
<td>93%</td>
</tr>
<tr>
<td>2015</td>
<td>89597</td>
<td>104755</td>
<td>86%</td>
</tr>
<tr>
<td>2016</td>
<td>94515</td>
<td>110502</td>
<td>86%</td>
</tr>
<tr>
<td>2017</td>
<td>103258</td>
<td>115705</td>
<td>89%</td>
</tr>
</tbody>
</table>
Western State Hospital Occupancy Rate (SFY) On Last Day of Fiscal Year, June 30th

Data Source: Julie Klingbeil
Date: October 24, 2017

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Capacity on Last Day of FY</th>
<th>Percent Occupancy on Last Day of FY</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>897</td>
<td>94</td>
</tr>
<tr>
<td>2008</td>
<td>927</td>
<td>96</td>
</tr>
<tr>
<td>2009</td>
<td>867</td>
<td>90</td>
</tr>
<tr>
<td>2010</td>
<td>837</td>
<td>93</td>
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<tr>
<td>2011</td>
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<td>2012</td>
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<td>93</td>
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<td>2013</td>
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<td>95</td>
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<tr>
<td>2014</td>
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<td>99</td>
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<tr>
<td>2015</td>
<td>842</td>
<td>99</td>
</tr>
<tr>
<td>2016</td>
<td>842</td>
<td>94</td>
</tr>
<tr>
<td>2017</td>
<td>842</td>
<td>96</td>
</tr>
</tbody>
</table>

**Note:** Occupancy rate based on the last day of the SFY
## CSTC Occupancy rate data

Provided by CSTC, Rick Mehlman

Date: 10/23/2017

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Patient Days</th>
<th>Capacity</th>
<th>Percent Occupancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>16769</td>
<td>17155</td>
<td>98%</td>
</tr>
<tr>
<td>2008</td>
<td>16901</td>
<td>17202</td>
<td>98%</td>
</tr>
<tr>
<td>2009</td>
<td>16767</td>
<td>17155</td>
<td>98%</td>
</tr>
<tr>
<td>2010</td>
<td>16817</td>
<td>17155</td>
<td>98%</td>
</tr>
<tr>
<td>2011</td>
<td>16114</td>
<td>17155</td>
<td>94%</td>
</tr>
<tr>
<td>2012</td>
<td>16122</td>
<td>17202</td>
<td>94%</td>
</tr>
<tr>
<td>2013</td>
<td>16822</td>
<td>17155</td>
<td>98%</td>
</tr>
<tr>
<td>2014</td>
<td>16570</td>
<td>17155</td>
<td>97%</td>
</tr>
<tr>
<td>2015</td>
<td>16406</td>
<td>17155</td>
<td>96%</td>
</tr>
<tr>
<td>2016</td>
<td>16660</td>
<td>17202</td>
<td>97%</td>
</tr>
<tr>
<td>2017</td>
<td>16239</td>
<td>17155</td>
<td>95%</td>
</tr>
</tbody>
</table>

**Note:** Occupancy rate based on the last day of the SFY
Hi Terry,

They are not double counted. Here are the 300 beds:

<table>
<thead>
<tr>
<th>Facility</th>
<th>TXMY</th>
<th>BHO</th>
<th>City</th>
<th>County</th>
<th>E&amp;T Program Beds</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yakima Valley Memorial Hospital</td>
<td>3R</td>
<td>GCBHO</td>
<td>Yakima</td>
<td>Yakima</td>
<td>12</td>
</tr>
<tr>
<td>PeaceHealth - St. John Medical Center</td>
<td>3R</td>
<td>Great Rivers</td>
<td>Longview</td>
<td>Cowlitz</td>
<td>22</td>
</tr>
<tr>
<td>Multicare Behavioral Health Inpatient Services - Auburn</td>
<td>3R</td>
<td>King</td>
<td>Auburn</td>
<td>King</td>
<td>20</td>
</tr>
<tr>
<td>UW Medicine Harborview Medical Center</td>
<td>3R</td>
<td>King</td>
<td>Seattle</td>
<td>King</td>
<td>66</td>
</tr>
<tr>
<td>UW Medicine Northwest hospital (Geriatric)</td>
<td>3R</td>
<td>King</td>
<td>Seattle</td>
<td>King</td>
<td>27</td>
</tr>
<tr>
<td>Swedish Medical Center Ballard</td>
<td>3R</td>
<td>King</td>
<td>Ballard</td>
<td>King</td>
<td>18</td>
</tr>
<tr>
<td>St. Joseph Medical Center</td>
<td>3R</td>
<td>NSBHO</td>
<td>Bellingham</td>
<td>Whatcom</td>
<td>10</td>
</tr>
<tr>
<td>Skagit Valley Psychiatric Services</td>
<td>3R</td>
<td>NSBHO</td>
<td>Mount Vernon</td>
<td>Skagit</td>
<td>15</td>
</tr>
<tr>
<td>Swedish Medical Center Edmonds</td>
<td>3R</td>
<td>NSBHO</td>
<td>Edmonds</td>
<td>Snohomish</td>
<td>24</td>
</tr>
<tr>
<td>Mary Bridge Adolescent Behavioral Health Unit</td>
<td>3R</td>
<td></td>
<td></td>
<td></td>
<td>8</td>
</tr>
<tr>
<td>Sacred Heart Adolescent Beds</td>
<td>3R</td>
<td>Spokane</td>
<td>Spokane</td>
<td>Spokane</td>
<td>24</td>
</tr>
<tr>
<td>Sacred Heart Adult &amp; takes geriatric beds</td>
<td>3R</td>
<td>Spokane</td>
<td>Spokane</td>
<td>Spokane</td>
<td>28</td>
</tr>
<tr>
<td>Sacred Heart ACU Adult (critical care unit)</td>
<td>3R</td>
<td>Spokane</td>
<td>Spokane</td>
<td>Spokane</td>
<td>14</td>
</tr>
<tr>
<td>(PeaceHealth) Southwest Washington Medical Center</td>
<td>3R</td>
<td>SWBH</td>
<td>Vancouver</td>
<td>Clark</td>
<td>12</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td><strong>300</strong></td>
</tr>
</tbody>
</table>
Single Bed Certification Quarterly Update

July 2017

A Single Bed Certification (SBC) allows a person to be detained under the Involuntary Treatment Act when there are no available certified Evaluation and Treatment (E & T) facility beds. The detained person is able to temporarily receive involuntary inpatient mental health treatment services from a licensed facility that is not currently certified as an Evaluation and Treatment facility, under WAC 388-865-0500. The Behavioral Health Organization (BHO) or its designee (Designated Mental Health Professional) must submit a written request for the SBC to the local State Hospital. The SBC requires the facility named in the SBC be willing and able to provide timely and appropriate mental health treatment in order to not be considered boarding; which was found to be a violation of a person’s civil liberties in the Supreme Court decision, In re detention DW.

Source DSE report and graph ran 7/20/17
Single Bed Certification Quarterly Update

July 2017

This quarter has seen a relatively large jump in Single Bed Certification use. As reflected in previous reports, the greatest use of Single Bed Certifications continues to occur in the most populous BHOs, King County BHO, North Sound BHO and Spokane County Regional BHO.

King County BHO has shown a 34.5% increase in use of SBC during this quarter. This is due in part to the ITA court defense bar’s motion to dismiss based on the gap in time from detention to admission at an E&T facility. The solution for this challenge by King County DMHPs has been to put everyone who is detained on a SBC, so they can show that every detained person is receiving mental health treatment from the time they are detained.

Source DSE report ran 7/20/17 Graph by Robby Pellett
Single Bed Certification Quarterly Update

July 2017

<table>
<thead>
<tr>
<th>Monthly SBC by Age Group and BHO</th>
<th>APR2017</th>
<th>MAY2017</th>
<th>JUN2017</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adult</td>
<td>Youth</td>
<td>Adult</td>
</tr>
<tr>
<td>FACILITY</td>
<td>100</td>
<td>12</td>
<td>115</td>
</tr>
<tr>
<td>GC BHO</td>
<td>0</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>GRBHO</td>
<td>9</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>KCBHO</td>
<td>239</td>
<td>3</td>
<td>351</td>
</tr>
<tr>
<td>NC BHO</td>
<td>4</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>NSBHO</td>
<td>58</td>
<td>1</td>
<td>80</td>
</tr>
<tr>
<td>OPBHO</td>
<td>21</td>
<td>2</td>
<td>44</td>
</tr>
<tr>
<td>SABHO</td>
<td>19</td>
<td>1</td>
<td>30</td>
</tr>
<tr>
<td>SC BHO</td>
<td>99</td>
<td>3</td>
<td>129</td>
</tr>
<tr>
<td>SWWASO</td>
<td>6</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>TMBHO</td>
<td>31</td>
<td>4</td>
<td>37</td>
</tr>
<tr>
<td>Statewide Total</td>
<td>586</td>
<td>27</td>
<td>805</td>
</tr>
</tbody>
</table>

Source DSE report ran 7/24/17

On average approximately 4% of the total Single Bed Certifications are for minors.
Overall there is a general increase in Single Bed Certifications for most of the legal categories, except 72-Hour Detentions and 14-Day Commitments.
Single Bed Certification Quarterly Update

July 2017

Unavailable Detention Facilities Reports (No Bed Available Reports)

When a Designated Mental Health Professional determines a person meets criteria for involuntary inpatient treatment, but is unable to detain the person at risk due to the lack of an available bed at an Evaluation and Treatment facility, or the person cannot be served by the use of a Single Bed Certification, the Designated Mental Health Professional is required to make a report to the Department within 24 hours stating they were unable to detain the person due to the lack of a certified E&T bed.

Source DSE report ran 7/25/17 Line Graph by Robby Pellett
Single Bed Certification Quarterly Update

July 2017

The divergence of individuals versus reports decreased this quarter, which indicates that generally Evaluation and Treatment beds were found sooner for these individuals.

<table>
<thead>
<tr>
<th>BHO</th>
<th>17-Apr</th>
<th>17-May</th>
<th>17-Jun</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N Rpts</td>
<td>N Indiv</td>
<td>N Rpts</td>
</tr>
<tr>
<td>GCBHO</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Great Rivers</td>
<td>4</td>
<td>4</td>
<td>7</td>
</tr>
<tr>
<td>King</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>North Central</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>NSBHO</td>
<td>5</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Optum-Pierce</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>SWWASO</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Salish</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Spokane</td>
<td>6</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Thurston-Mason</td>
<td>1</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong>*</td>
<td>17</td>
<td>12</td>
<td>25</td>
</tr>
</tbody>
</table>

Source: DSE report ran 7/25/17

During the past quarter, Greater Columbia BHO submitted 9 reports, Great Rivers BHO submitted 14 reports, North Central BHO submitted 13 reports, North Sound BHO submitted 7 reports, SWWA submitted 2 reports, Thurston Mason BHO submitted 3 reports, and Spokane County Regional BHO submitted the most reports with 16 No Bed Reports. King County BHO, Optum Pierce BHO, and Salish BHO were able to detain all the individuals they found detainable in the past quarter which is due in large part to the fact that DMHPs in those regions have access to hospitals that accept Single Bed Certifications.

For information regarding this report, contact David Reed, reeddl@dshs.wa.gov
Hello Terry!

Attached is the requested information. My data analyst tells me there are exceptions, these are:

2017 data was not added as we do not have complete data for the year.
We do not differentiate Psychiatrists or Psychiatric Nurses from their parent professions.
The Behavioral Analyst licenses started issuance on July, 1 2017, and thus, we currently do not have data on this profession.

I have asked others, we are coming up with nothing on religious counselors.

I hope this helps!

Denise Wilmovsky
Office Manager
Office of Health Professions
Department of Health
PO Box 47852
Olympia, WA 98504-7852

The Department of Health works with others to protect and improve the health of all people in Washington State.

---

From: Terry J. Price [mailto:tprice@uw.edu]
Sent: Tuesday, July 11, 2017 2:23 PM
To: DOH HSQA PDRC External Requests <PDRC@DOH.WA.GOV>
Subject: Inquiry about mental health professionals licensed in WA State

Hello—

I am with the University of Washington School of Law, and in its recent budget, the Washington State Legislature has asked us to gather information for a study of licensed mental health professionals in the state. I am interested in receiving information about the total number of mental health professionals licensed in Washington State for the last five years. I would like annual figures, if possible, for 2013, 2014, 2015, 2016 and 2017 for the following professions:

Agency affiliated counselors
Certified Counselors
Counselors
Certified advisor
Chemical Dependency professionals
Hypnotherapist
Licensed behavioral analyst
Marriage and Family Therapists
Mental Health counselors
Psychologist (Ph.D)
Psychiatrist (MD)
Sex Offender Treatment providers
Social Worker (MSW)
Social worker associate independent clinical
Social worker associate advanced
Licensed clinical social workers
Psychiatric nurses

And any other category of mental health professional that your office keeps track of. Does your office track religious counselors at all? If not, do you know how to obtain that information?

Thank you very much.

Terry Price

Terry J. Price, MSW, JD
Executive Director, Center for Law, Science and Global Health
University of Washington School of Law
William H. Gates Hall, Rm. 438
P.O. Box 353020
Seattle, WA  98195-3020
Direct: (206) 221-6030
Fax: (206) 543-5671
tprice@uw.edu  www.law.washington.edu
<table>
<thead>
<tr>
<th>Profession</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chemical Dependency Professional</td>
<td>2869</td>
<td>2868</td>
<td>2874</td>
<td>2878</td>
</tr>
<tr>
<td>Chemical Dependency Professional Trainee</td>
<td>1492</td>
<td>1542</td>
<td>1454</td>
<td>1546</td>
</tr>
<tr>
<td>Agency Affiliated Counselor</td>
<td>6529</td>
<td>7059</td>
<td>7990</td>
<td>8884</td>
</tr>
<tr>
<td>Certified Counselor</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Certified Advisor</td>
<td>691</td>
<td>675</td>
<td>598</td>
<td>560</td>
</tr>
<tr>
<td>Hypnotherapist</td>
<td>710</td>
<td>736</td>
<td>764</td>
<td>747</td>
</tr>
<tr>
<td>Marriage and Family Therapist Associate</td>
<td>423</td>
<td>454</td>
<td>504</td>
<td>556</td>
</tr>
<tr>
<td>Marriage and Family Therapist</td>
<td>1336</td>
<td>1408</td>
<td>1473</td>
<td>1572</td>
</tr>
<tr>
<td>Mental Health Counselor Associate</td>
<td>1628</td>
<td>1717</td>
<td>1763</td>
<td>1890</td>
</tr>
<tr>
<td>Mental Health Counselor</td>
<td>5653</td>
<td>5912</td>
<td>6211</td>
<td>6577</td>
</tr>
<tr>
<td>Psychologist</td>
<td>2596</td>
<td>2707</td>
<td>2831</td>
<td>2925</td>
</tr>
<tr>
<td>Sex Offender Treatment Provider Affiliate</td>
<td>34</td>
<td>32</td>
<td>27</td>
<td>24</td>
</tr>
<tr>
<td>Sex Offender Treatment Provider</td>
<td>102</td>
<td>99</td>
<td>101</td>
<td>98</td>
</tr>
<tr>
<td>Advanced Social Worker (MSW)</td>
<td>110</td>
<td>120</td>
<td>117</td>
<td>133</td>
</tr>
<tr>
<td>Associate Advanced Social Worker</td>
<td>212</td>
<td>202</td>
<td>221</td>
<td>232</td>
</tr>
<tr>
<td>Associate Independent Clinical Social Worker</td>
<td>1084</td>
<td>1274</td>
<td>1483</td>
<td>1623</td>
</tr>
<tr>
<td>Independent Clinical Social Worker</td>
<td>3659</td>
<td>3787</td>
<td>3966</td>
<td>4106</td>
</tr>
</tbody>
</table>

**Notes:**

The Behavioral Analyst licenses started issuance on July 1, 2017, and thus, we currently do not have data on this profession.

We do not differentiate Psychiatrists or Psychiatric nurses from their parent professions.

2017 data was not added as we do not have complete data for the year.
From: Wilmovsky, Denice D (DOH) [mailto:Denice.Wilmovsky@DOH.WA.GOV]
Sent: Tuesday, November 28, 2017 12:04 PM
To: Terry J. Price <tprice@uw.edu>
Subject: FW: Inquiry about mental health professionals licensed in WA State

Hello, I have passed on your questions, here is the response:

I have attached a table of the locations of our mental health professionals by group with a couple of caveats

1) Due to the way our data system works, we are only able to pull exact location numbers for credentials if we pull certain reports on the exact day in question. As the report was not pulled on the exact day needed, we are unable to get exact location counts for last year. However, we are able to approximate these numbers and this is what I have attached above.

2) The location provided in the above data is based on the address provided by the practitioner at time of application/renewal/update. We cannot make assumptions as to whether the address provided represents their place of practice, their home location, etc.

Is it safe to assume you would like the 2017 numbers(locations as soon as they become available (aka Jan 1, 2018)? If I know in advance, I can make sure to requestl the report needed to determine exact locations

Thank you,

Denice Wilmovsky
Office Manager
Office of Health Professions
Department of Health
PO Box 47852
Olympia, WA 98504-7852
The Department of Health works with others to protect and improve the health of all people in Washington State

---

From: Terry J. Price <mailto:tprice@uw.edu>
Sent: Saturday, November 25, 2017 12:43 PM
To: Wilmovsky, Denice D (DOH) <Denice.Wilmovsky@DOH.WA.GOV>
Subject: RE: Inquiry about mental health professionals licensed in WA State

Hi Denice—One other question for you—Do you also sort by geographic location of provider? If you do, I’d be very interested in where the 2016 providers were located. I don’t need each license category if it would be easier to review as a group.

Thanks very much! Terry

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

Attached is the requested information.
My data analyst tells me there are exceptions, these are:

- 2017 data was not added as we do not have complete data for the year.
- We do not differentiate Psychiatrists or Psychiatric Nurses from their parent professions.
- The Behavioral Analyst licenses started issuance on July, 1 2017, and thus, we currently do not have data on this profession.

I have asked others, we are coming up with nothing on religious counselors.

I hope this helps!
### Location of Mental Health Professionals Licensed in WA State (Approximate)

<table>
<thead>
<tr>
<th>USA Practitioner Location</th>
<th>Washington State Practitioner Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>By State</td>
<td>By County</td>
</tr>
<tr>
<td>Alaska</td>
<td>Adams 17</td>
</tr>
<tr>
<td>Alaska</td>
<td>Asotin 32</td>
</tr>
<tr>
<td>Alabama</td>
<td>Benton 600</td>
</tr>
<tr>
<td>Arkansas</td>
<td>Chelan 264</td>
</tr>
<tr>
<td>Arizona</td>
<td>Clallam 306</td>
</tr>
<tr>
<td>California</td>
<td>Clark 1264</td>
</tr>
<tr>
<td>Colorado</td>
<td>Columbia 17</td>
</tr>
<tr>
<td>Connecticut</td>
<td>Cowiitza 350</td>
</tr>
<tr>
<td>DC</td>
<td>Douglas 108</td>
</tr>
<tr>
<td>Delaware</td>
<td>Ferry 20</td>
</tr>
<tr>
<td>Florida</td>
<td>Franklin 190</td>
</tr>
<tr>
<td>Guam</td>
<td>Garfield 4</td>
</tr>
<tr>
<td>Hawaii</td>
<td>Grant 170</td>
</tr>
<tr>
<td>Idaho</td>
<td>Grays Harbor 228</td>
</tr>
<tr>
<td>Idaho</td>
<td>Island 335</td>
</tr>
<tr>
<td>Illinois</td>
<td>Jefferson 166</td>
</tr>
<tr>
<td>Indiana</td>
<td>King 11743</td>
</tr>
<tr>
<td>Kansas</td>
<td>Kitsap 1204</td>
</tr>
<tr>
<td>Kentucky</td>
<td>Kittitas 139</td>
</tr>
<tr>
<td>Louisiana</td>
<td>Klickitat 48</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>Lewis 263</td>
</tr>
<tr>
<td>Maryland</td>
<td>Lincoln 21</td>
</tr>
<tr>
<td>Maine</td>
<td>Mason 163</td>
</tr>
<tr>
<td>Michigan</td>
<td>Okanogan 106</td>
</tr>
<tr>
<td>Minnesota</td>
<td>Pacific 117</td>
</tr>
<tr>
<td>Missouri</td>
<td>Pend Oreille 35</td>
</tr>
<tr>
<td>Missouri</td>
<td>Pierce 3888</td>
</tr>
<tr>
<td>Mississippi</td>
<td>San Juan 83</td>
</tr>
<tr>
<td>Montana</td>
<td>Skagit 479</td>
</tr>
<tr>
<td>North Carolina</td>
<td>Skamania 26</td>
</tr>
<tr>
<td>Nebraska</td>
<td>Snohomish 2673</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>Spokane 2643</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>Stevens 101</td>
</tr>
<tr>
<td>New Mexico</td>
<td>Thurston 1643</td>
</tr>
<tr>
<td>Nevada</td>
<td>Wahkiakum 26</td>
</tr>
<tr>
<td>New York</td>
<td>Walla Walla 270</td>
</tr>
<tr>
<td>Ohio</td>
<td>Whatcom 1076</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>Whitman 112</td>
</tr>
<tr>
<td>Oregon</td>
<td>Yakima 760</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>TOTAL for WA 31,689</td>
</tr>
<tr>
<td>Rhode Island</td>
<td></td>
</tr>
<tr>
<td>South Carolina</td>
<td></td>
</tr>
<tr>
<td>South Dakota</td>
<td></td>
</tr>
<tr>
<td>Tennessee</td>
<td></td>
</tr>
<tr>
<td>Texas</td>
<td></td>
</tr>
<tr>
<td>Utah</td>
<td></td>
</tr>
<tr>
<td>Virginia</td>
<td></td>
</tr>
<tr>
<td>Virgin Islands</td>
<td></td>
</tr>
<tr>
<td>Vermont</td>
<td></td>
</tr>
<tr>
<td>Washington</td>
<td>31689</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>12</td>
</tr>
<tr>
<td>West Virginia</td>
<td>2</td>
</tr>
<tr>
<td>Wyoming</td>
<td>1</td>
</tr>
<tr>
<td>TOTAL for USA</td>
<td>34,263</td>
</tr>
</tbody>
</table>
Hello all:

Thank you all for the phone call recently to discuss the Volk study.

As requested during that discussion, I have looked into finding more information on the number of psychiatrists practicing in our state. I think the most helpful resources would likely be the demographic information collected by the state Medical Quality Assurance Commission (attached). According to the reported data, there are 1,038 physicians in the state that report psychiatry as their primary practice. The information can be more specific, however – it also tracks, for example, the number of self-reported child psychiatrists in the state.

I hope this information is helpful. The Commission is, in my experience, very helpful in answering questions and may be an additional resource to the study in the future.

Please let me know if I can answer other questions or provide additional information.

Thank you so much,
~Tierney

Tierney Edwards, JD
Associate Director of Legal and Federal Affairs
Washington State Medical Association
2001 Sixth Avenue, Suite 2700
Seattle, Washington 98121
(206) 956-3657 (office)
(206) 441-5863 (fax)
tee@wsma.org (email)
Physician Demographic Census Aggregate Report

I - PHYSICIAN INFORMATION

Census start date: October 1, 2015
Census end date: September 30, 2017
Created on: October 16, 2017
Total Returns: 21,287

Sex

<table>
<thead>
<tr>
<th></th>
<th>Active</th>
<th>Retired</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>64%</td>
<td>74%</td>
</tr>
<tr>
<td>Female</td>
<td>36%</td>
<td>26%</td>
</tr>
</tbody>
</table>

Credential Status

<table>
<thead>
<tr>
<th>Status</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Retired</td>
<td>0%</td>
</tr>
<tr>
<td>Retired Active</td>
<td>3%</td>
</tr>
</tbody>
</table>

Age group and breakdown by sex

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Total</th>
<th>Percentage</th>
<th>Male</th>
<th>Male %</th>
<th>Female</th>
<th>Female %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1900 - 1945</td>
<td>1,452</td>
<td>7%</td>
<td>1,321</td>
<td>6%</td>
<td>131</td>
<td>1%</td>
</tr>
<tr>
<td>1946 - 1964</td>
<td>9,030</td>
<td>42%</td>
<td>6,516</td>
<td>31%</td>
<td>2,514</td>
<td>12%</td>
</tr>
<tr>
<td>1965 - 1982</td>
<td>9,553</td>
<td>45%</td>
<td>5,373</td>
<td>25%</td>
<td>4,180</td>
<td>20%</td>
</tr>
<tr>
<td>1983+</td>
<td>1,252</td>
<td>6%</td>
<td>569</td>
<td>3%</td>
<td>683</td>
<td>3%</td>
</tr>
<tr>
<td>Total</td>
<td>21,287</td>
<td>100%</td>
<td>13,779</td>
<td>65%</td>
<td>7,508</td>
<td>35%</td>
</tr>
</tbody>
</table>

Practitioners by sex and year of birth:
How would you classify your race/ethnicity?

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Active</th>
<th>Retired</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>65%</td>
<td>82%</td>
</tr>
<tr>
<td>Black/African American</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>Asian</td>
<td>18%</td>
<td>7%</td>
</tr>
<tr>
<td>Native Hawaiian/other Pacific Islander</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>3%</td>
<td>1%</td>
</tr>
<tr>
<td>Other</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>Multiple</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>Prefer not to answer</td>
<td>7%</td>
<td>5%</td>
</tr>
</tbody>
</table>

Do You have a DEA number?

<table>
<thead>
<tr>
<th></th>
<th>Active</th>
<th>Retired</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>96%</td>
<td>71%</td>
</tr>
<tr>
<td>No</td>
<td>4%</td>
<td>29%</td>
</tr>
</tbody>
</table>

Do you currently reside in Washington State?

<table>
<thead>
<tr>
<th></th>
<th>Active</th>
<th>Retired</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>73%</td>
<td>83%</td>
</tr>
<tr>
<td>No</td>
<td>27%</td>
<td>17%</td>
</tr>
</tbody>
</table>

Where did you obtain your Medical Degree?

<table>
<thead>
<tr>
<th>Location</th>
<th>Active</th>
<th>Retired</th>
</tr>
</thead>
<tbody>
<tr>
<td>Washington State</td>
<td>15%</td>
<td></td>
</tr>
<tr>
<td>Other US State/Territory</td>
<td>68%</td>
<td></td>
</tr>
<tr>
<td>Unknown US</td>
<td>1%</td>
<td></td>
</tr>
<tr>
<td>Foreign Country</td>
<td>16%</td>
<td></td>
</tr>
<tr>
<td>Unknown</td>
<td>0%</td>
<td></td>
</tr>
</tbody>
</table>
Are you ABMS Board Certified?

<table>
<thead>
<tr>
<th></th>
<th>Active</th>
<th>Retired</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>11%</td>
<td>19%</td>
</tr>
<tr>
<td>Yes</td>
<td>89%</td>
<td>81%</td>
</tr>
</tbody>
</table>

What are your ABMS Board Certifications (Some practitioners have multiple certifications)

**General Medicine**
- Allergy and Immunology: 94
- Anesthesiology: 1,183
- Dermatology: 287
- Emergency Medicine: 983
- Family Medicine: 2,981
- Internal Medicine: 4,351
- Pediatrics: 1,638
- Physical Med and Rehab: 255

**Preventive Medicine**
- Aerospace Medicine: 22
- Occupational Medicine: 120

**Medical Genetics**
- Clinical Biochemical Genetics: 3
- Clinical Cytogenetics: 2
- Clinical Genetics: 38
- Clinical Molecular Genetics: 2

**Radiology**
- Diagnostic Radiology: 1,368
- Interventional Radiology: 29
- Medical Physics: 0
- Nuclear Medicine: 101
- Radiation Oncology: 154

**Neurology and Psychiatry**
- Neurology: 397
- Neurology/Child Neurology: 35
- Psychiatry: 971

**Pathology**
- Pathology - Anatomic: 81
- Pathology - Clinical: 41
- Pathology-Anatomic/Clinical: 391

**Surgical**
- Colon and Rectal Surgery: 36
- Neurological Surgery: 145
- Obstetrics and Gynecology: 852
- Ophthalmology: 407
- Orthopaedic Surgery: 631
- Otolaryngology: 249
- Plastic Surgery: 137
- Surgery: 707
- Thoracic and Cardiac Surgery: 114
- Urology: 236
- Vascular Surgery: 102

Total Board Certifications: 19,261
Have you retired from clinical practice?
- No: 92%
- Yes: 8%

<table>
<thead>
<tr>
<th>DOB</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1900-1945</td>
<td>55%</td>
<td>45%</td>
</tr>
<tr>
<td>1946-1964</td>
<td>89%</td>
<td>11%</td>
</tr>
<tr>
<td>1965-1982</td>
<td>99%</td>
<td>1%</td>
</tr>
<tr>
<td>1983+</td>
<td>100%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Do you plan on retiring from clinical practice in the next 12 months?
- No: 97%
- Yes: 3%

Upon retirement from clinical practice, will you convert your license to "retired active"
- No: 41%
- Yes: 59%

II - PRACTICE INFORMATION

Do you currently practice in Washington?
- Yes: 77%
- No: 23%

At how many locations do you provide patient care?
- 0 or unknown: 7%
- 1: 58%
- 2: 21%
- 3 or more: 14%

Approximately, how much time do you spend at each site in a given month?

<table>
<thead>
<tr>
<th></th>
<th>Site 1</th>
<th>Site 2</th>
<th>Site 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Over 250 hours</td>
<td>4%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>200 - 250 hours</td>
<td>12%</td>
<td>1%</td>
<td>0%</td>
</tr>
<tr>
<td>100 - 200 hours</td>
<td>47%</td>
<td>8%</td>
<td>3%</td>
</tr>
<tr>
<td>Under 100 hours</td>
<td>38%</td>
<td>91%</td>
<td>96%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Counties</td>
<td>Site 1</td>
<td>Site 2</td>
<td>Site 3</td>
</tr>
<tr>
<td>----------</td>
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<tr>
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<td>4,219</td>
<td>15,861</td>
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Please indicate your current area of practice and area of residency accredited by ACGME you have received*

<table>
<thead>
<tr>
<th>Area of Practice</th>
<th>Principal Practice</th>
<th>Principal Percentage</th>
<th>Secondary Practice</th>
<th>Secondary Percentage</th>
<th>ACGME Residency</th>
<th>ACGME Percentage</th>
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<td>0%</td>
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<td>44</td>
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<tr>
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<td>514</td>
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<tr>
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<td>187</td>
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<td>767</td>
<td>4%</td>
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<td>0%</td>
<td>109</td>
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<td>Other (e.g. Hospitalist)</td>
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<td>4%</td>
<td>716</td>
<td>5%</td>
<td>105</td>
<td>0%</td>
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<tr>
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<td>554</td>
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<td>7,698</td>
<td>59%</td>
<td>1,102</td>
<td>5%</td>
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<tr>
<td><strong>Total</strong></td>
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<td><strong>100%</strong></td>
<td><strong>13,046</strong></td>
<td><strong>100%</strong></td>
<td><strong>23,763</strong></td>
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*Some Physicians completed their ACGME residency in more than one field*
For patient related activities, indicate your practice arrangement and size of group.

- Single Specialty Group: 24%
- Multi-Specialty Group: 21%
- Solo Practitioner: 8%
- Employee of a Hospital or Clinic: 29%
- State or Federal Employer: 9%
- Other: 10%

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<th>Group size</th>
<th>Single</th>
<th>Single %</th>
<th>Multi</th>
<th>Multi %</th>
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<td>501 +</td>
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<td>0%</td>
<td>902</td>
<td>20%</td>
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<tr>
<td>101 - 500</td>
<td>146</td>
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<td>1,158</td>
<td>26%</td>
</tr>
<tr>
<td>51 - 100</td>
<td>424</td>
<td>8%</td>
<td>460</td>
<td>10%</td>
</tr>
<tr>
<td>21 - 50</td>
<td>1,010</td>
<td>20%</td>
<td>388</td>
<td>9%</td>
</tr>
<tr>
<td>1 - 20</td>
<td>2,999</td>
<td>59%</td>
<td>679</td>
<td>15%</td>
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<tr>
<td>Unknown</td>
<td>480</td>
<td>9%</td>
<td>829</td>
<td>19%</td>
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<tr>
<td>Total</td>
<td>5,073</td>
<td>100%</td>
<td>4,416</td>
<td>100%</td>
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</table>

Is your primary clinical practice:
- Office based: 45%
- Hospital based: 33%
- Neither: 22%

How many Physician Assistants do you sponsor?
- 0: 80%
- 1: 10%
- 2: 4%
- 3 or more: 6%

Do you have hospital clinical privileges in Washington State?

- All active licensees
  - Yes: 61%
  - No: 39%
- Practices in Washington
  - Yes: 75%
  - No: 25%
- Doesn't practice in Washington
  - Yes: 10%
  - No: 90%
Are interpretation services offered at your practice?

- Yes: 79%
- No: 21%

If yes, what languages are offered for interpretation?

- English: 59%
- Korean: 57%
- French: 55%
- Spanish: 73%
- Russian: 61%
- Mandarin Chinese: 58%
- Other: 14%
- Do not know: 21%

Do you speak any languages other than English well enough to communicate with your patients?

- Korean: 1%
- French: 3%
- Spanish: 15%
- Russian: 1%
- Mandarin Chinese: 3%
- Other: 14%

Are you currently accepting patients covered by Medicare, Medicaid, Tricare?

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<th>Medicaid</th>
<th>Tricare</th>
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<td></td>
<td>Accepting</td>
<td>% of pts.</td>
<td>Accepting</td>
</tr>
<tr>
<td></td>
<td>Total</td>
<td></td>
<td>Total</td>
</tr>
<tr>
<td>Yes</td>
<td>100%</td>
<td></td>
<td>100%</td>
</tr>
<tr>
<td>No</td>
<td>17%</td>
<td>4%</td>
<td>19%</td>
</tr>
<tr>
<td>Don’t know</td>
<td>23%</td>
<td>1%</td>
<td>25%</td>
</tr>
<tr>
<td></td>
<td>100%</td>
<td>3%</td>
<td>100%</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th></th>
<th>Medicare</th>
<th>Medicaid</th>
<th>Tricare</th>
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</thead>
<tbody>
<tr>
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<td>Don’t know</td>
</tr>
<tr>
<td>Accepting</td>
<td>61%</td>
<td>17%</td>
<td>23%</td>
</tr>
<tr>
<td>% of pts.</td>
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<td></td>
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<tr>
<td>67 - 100%</td>
<td>4%</td>
<td>2%</td>
<td>1%</td>
</tr>
<tr>
<td>34 - 66%</td>
<td>17%</td>
<td>4%</td>
<td>3%</td>
</tr>
<tr>
<td>1 - 33%</td>
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<td>9%</td>
<td>5%</td>
</tr>
<tr>
<td>0 or unk</td>
<td>54%</td>
<td>85%</td>
<td>90%</td>
</tr>
<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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</table>
In the past 12 months, how many weeks did you work or volunteer in a clinical setting?

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<th>Retired</th>
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<tr>
<td>40 - 47 weeks</td>
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<tr>
<td>31 - 39 weeks</td>
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<td>1%</td>
</tr>
<tr>
<td>1 - 30 weeks</td>
<td>10%</td>
<td>25%</td>
</tr>
<tr>
<td>0 or unknown</td>
<td>20%</td>
<td>67%</td>
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</tbody>
</table>

In a typical work week, indicate the average number of hours dedicated to the following professional activities

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<th>Research</th>
<th>Admin</th>
<th>Education</th>
<th>Volunteer</th>
<th>Other</th>
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</thead>
<tbody>
<tr>
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<td>Act</td>
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<td>1%</td>
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<td>31-40 hrs</td>
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<td>1%</td>
<td>1%</td>
<td>1%</td>
<td>4%</td>
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<tr>
<td>30 or less</td>
<td>28%</td>
<td>5%</td>
<td>17%</td>
<td>8%</td>
<td>54%</td>
<td>17%</td>
</tr>
<tr>
<td>0 or unk</td>
<td>8%</td>
<td>92%</td>
<td>81%</td>
<td>90%</td>
<td>44%</td>
<td>77%</td>
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<tr>
<td>Total</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
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Do you provide telehealth/telemedicine services?

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</tr>
<tr>
<td>Yes</td>
<td>14%</td>
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If yes, how many hours per week do you practice telehealth/telemedicine?

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<td>Over 40 hrs</td>
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<tr>
<td>31 - 40 hrs</td>
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</tr>
<tr>
<td>10 - 30 hrs</td>
<td>12%</td>
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</tr>
<tr>
<td>Under 10 hrs</td>
<td>52%</td>
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<tr>
<td>0 or unknown</td>
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What percentage of your telehealth/telemedicine population is provided to patients in Washington?

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<tr>
<td>67 - 100%</td>
<td>24%</td>
<td>16%</td>
</tr>
<tr>
<td>34 - 66%</td>
<td>4%</td>
<td>16%</td>
</tr>
<tr>
<td>1 - 33%</td>
<td>24%</td>
<td>11%</td>
</tr>
<tr>
<td>0 or unknown</td>
<td>48%</td>
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Do you prescribe opioids for patients with chronic noncancer pain?

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<td>72%</td>
<td>97%</td>
</tr>
<tr>
<td>Yes</td>
<td>28%</td>
<td>3%</td>
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</table>

If yes, Please estimate the number of opioid patients in the last month

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<td>Over 100</td>
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<tr>
<td>11 - 100</td>
<td>29%</td>
<td>9%</td>
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<tr>
<td>1 -10</td>
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<td>47%</td>
</tr>
<tr>
<td>0 or Unk</td>
<td>10%</td>
<td>41%</td>
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Are you a certified pain management specialist?

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<td>99%</td>
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<td>Yes</td>
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Under what section of WAC 246-919-863 are you qualified as a pain management specialist*

<table>
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<td>A</td>
<td>66%</td>
<td>27%</td>
</tr>
<tr>
<td>B</td>
<td>11%</td>
<td>18%</td>
</tr>
<tr>
<td>D</td>
<td>17%</td>
<td>36%</td>
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<tr>
<td>I do not Qualify</td>
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<td>18%</td>
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<tr>
<td>No answer</td>
<td>0%</td>
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Do you have colleague(s) to whom you can refer pain patients?

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<tbody>
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<td>No, I can treat w/o referrals</td>
<td>5%</td>
<td>9%</td>
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<tr>
<td>No colleagues to refer</td>
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<td>58%</td>
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<tr>
<td>Yes</td>
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<td>33%</td>
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If yes, How many colleagues are available?

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<td>3</td>
<td>12%</td>
<td>13%</td>
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<tr>
<td>4+</td>
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Do you treat patients through nontraditional therapies?

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<td>98%</td>
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<tr>
<td>Yes</td>
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Have you completed this census on behalf of another person?

<table>
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</thead>
<tbody>
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<td>4%</td>
<td>1%</td>
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<tr>
<td>No</td>
<td>96%</td>
<td>99%</td>
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*Physician may select more than one section*
## Physician principal area of practice and counties with practice sites - Northwest Washington

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Island</th>
<th>King</th>
<th>Pierce</th>
<th>San Juan</th>
<th>Skagit</th>
<th>Snohomish</th>
<th>Whatcom</th>
<th>Total</th>
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<td>Allergy and Immunology</td>
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## Physician principal area of practice and counties with practice sites - Southwest Washington

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<th>Clallam</th>
<th>Clark</th>
<th>Cowlitz</th>
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<th>Jefferson</th>
<th>Kitsap</th>
<th>Lewis</th>
<th>Mason</th>
<th>Pacific</th>
<th>Skamania</th>
<th>Thurston</th>
<th>Wahkiakum</th>
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### Physician principal area of practice and counties with practice sites - Eastern Washington

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III - SECONDARY CONTACTS

MDs who did not return a census form were emailed with a PDF copy of the census attached. Those without a valid email address were sent a hard copy. The secondary contact was made approximately three to four weeks after license renewal. The three most recent months are shown.

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<th>Month</th>
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<td>123</td>
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<td>August</td>
<td>349</td>
<td>120</td>
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<tr>
<td>September</td>
<td>153</td>
<td>49</td>
<td>32%</td>
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</table>
Hello Terry and all –

We were able to identify the miscommunication between data coding which resulted in our original underestimation, and our new numbers are below. Thereafter follows a question back to you all.

In April 2017, there were 670 ARNPs who held an active Washington state license with a psychiatric subcategory designation, of which 79.1% had addresses in Washington (Table X). Psychiatric ARNPs were approximately 8.6% of all ARNPs (including certified nurse midwives, certified nurse specialists, certified registered nurse anesthetists and certified nurse practitioners) and 10.7% of certified nurse practitioners with active Washington licenses in 2017. (Mary Sue Gorski, Nursing Consultant Advisor, Washington, State Nursing Care Quality Assurance Commission, personal communication, October 30, 2017) The mean age of the Washington psychiatric ARNPs was 53 years old, and 87.2% were female. Nearly all (96.0%) had urban addresses.

Table: Psychiatric ARNPs with Washington State Licenses, 2017.

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<th>With address in</th>
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<tr>
<td>Washington</td>
<td>530 (79.1%)</td>
</tr>
<tr>
<td>Oregon</td>
<td>37 (5.5%)</td>
</tr>
<tr>
<td>Idaho</td>
<td>8 (1.2%)</td>
</tr>
<tr>
<td>Other</td>
<td>95 (14.2%)</td>
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</table>

Data source: Washington State Department of Health, 2017 Health Professions Licensing Data System.

Table: Distribution, Age, and Sex of Psychiatric ARNPs in Washington by Accountable Community of Health, 2017.

<table>
<thead>
<tr>
<th>Accountable Community of Health (ACH)</th>
<th>N</th>
<th>Population</th>
<th>Rate per 100,000</th>
<th>Mean age</th>
<th>% (N) &gt;55 years</th>
<th>% (N) female</th>
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<td>Washington State*</td>
<td>530</td>
<td>7,183,700</td>
<td>7.4</td>
<td>53</td>
<td>51.9% (275)</td>
<td>87.2% (462)</td>
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<td>60</td>
<td>844,490</td>
<td>7.1</td>
<td>53</td>
<td>58.3% (35)</td>
<td>86.7% (52)</td>
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<td>North Sound</td>
<td>61</td>
<td>1,206,900</td>
<td>5.1</td>
<td>57</td>
<td>67.2% (41)</td>
<td>90.2% (55)</td>
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<td>89.7% (192)</td>
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<td>53.7% (22)</td>
<td>87.8% (36)</td>
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<td>710,850</td>
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<td>41.2% (7)</td>
<td>64.7% (11)</td>
</tr>
</tbody>
</table>

Data source: Washington State Department of Health, 2017 Health Professions Licensing Data System.

* ARNPs with Washington State license address only.
† Counties in multi-county ACHs are Whatcom, Skagit, Snohomish, San Juan, Island (North Sound), Ferry, Stevens, Pend Oreille, Lincoln, Spokane, Adams (Better Health Together), Grays Harbor, Mason, Thurston, Pacific Lewis, Wahkiakum, Cowlitz (Cascade Pacific Action Alliance), Whitman, Asotin, Garfield, Columbia, Walla Walla, Franklin, Benton, Kittitas, Yakima (Greater Columbia), Clark, Skamania, Klickitat (Southwest Washington Regional Health Alliance), Clallam, Jefferson, Kitsap (Olympic Community of Health), Okanogan, Chelan, Douglas, Grant (North Central).
Hello Professor Kuszler:

You asked:

I am looking for some help in tracking down national practice guidelines with respect to third party duty to warn -- the Tarasoff doctrine. This is where a health care provider has an affirmative duty to warn third parties, usually those that are readily identifiable, when one of the provider’s patient has enunciated a threat. I checked a few org but found not so much – It looks like the American Psychiatric Association has one but it is not open on their site – I figure they published it at some point – no luck with other orgs but I am hoping you can search through the medical and legal literature and find more than I did --Thanks for any help you can give.

I reviewed/searched the websites for the following organizations:

- 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

I also conducted searches in Google, GoogleScholar, the library catalog, Ebsco’s PsychARTICLES and PubMed using the search terms (“duty to warn” AND guidelines) or (“duty to protect” AND guidelines) or (tarasoff AND guidelines).

I wasn’t able to find anything concrete in the way of practice guidelines from any major national organizations dedicated to mental health/health care. As you noted in your initial email, the APA has locked documents on their website that appear to address the duty to protect, but those documents not part of their freely available practice guidelines and I am unable to access elsewhere.

Below are the items I was able to dig up that might be useful to you:

Box 353025, William H. Gates Hall, Seattle, WA 98195-3025
206.543.4089 fax 206.685.2185 lib.law.washington.edu
• An article titled The Duty to Protect from the Harvard Mental Health Letter (January 2006) (copy is attached to my response email and also can be accessed here) includes the following guidance:

The principles for managing a threat of violence are generally the same as those for dealing with a suicide threat. Therapists should find out whether a patient has ever seriously injured or thought about seriously injuring another person. Especially with new patients or any patients whose symptoms are becoming worse, it is important to know whether they are dangerous to others and whether the danger is due to mental illness. Is the patient losing the capacity to control violent impulses? Has he or she been violent in the past? Does he or she have an alcohol or drug problem? Are there factors that raise the risk of violence? Is the danger imminent, and can potential victims be identified? How serious is the intention, how well developed is the plan, and how soon could the threat be carried out? Has he or she taken any action to further the plan?

Except in an emergency, warning a potential victim is likely to be helpful chiefly when it is arranged with the patient’s permission and cooperation. Both legally and therapeutically, the risk of a bad outcome is greatest when the therapist discloses confidential information to warn a third person without notice to the person being treated.

In practice, such an outcome is rare. Patients usually announce intention to commit a violent act because they want the therapist’s help, so the information can be used therapeutically. If they are distressed by their impulses, as they usually are, patients tend to agree to hospitalization. And treatment often brings the thoughts and impulses under control. The potential victim is usually someone in the patient’s family or social circle, and this person can be included in the treatment, for example, through discussion of the problem in family meetings. The patient himself or herself may be able to warn the potential victim.

Before issuing a warning, the clinician should treat the underlying psychiatric illness. That usually includes prescribing appropriate medication or changing the therapeutic approach. Treatment often reduces the risk enough so that a warning ceases to be necessary or even advisable.

Therapists treating a potentially violent patient should also consult medical records and other professionals when in doubt, and they should record in writing what they have done and why. What makes sense therapeutically is also usually correct from the point of view of tort law. Given normal prudent practice, the Tarasoff decision and the duty to protect should not present an extraordinary burden to mental health professionals today.

• The Practice Guidelines for Forensic Assessment from the American Academy of Psychiatry and the Law (copy available here) includes the following:

[From p. 5 – emphasis added] Other limits of confidentiality may include an evaluator’s duty to report child or elder abuse or neglect, a duty of disclosure related to serious threat of harm to the evaluatee or to third parties (the duty to warn), and other duties
related to a specific jurisdiction. If any of these duties arises, the expert should consult with supervisors, peers, or an attorney and discuss the potential release of information with the referring agent before making the disclosure. Collateral sources interviewed should also be given notice of the limits of confidentiality, the purpose of the assessment, and the likely uses of the assessment.

Results.

- A webpage devoted to Privacy Rights from Mental Health America (available here) gives the following guidance to Healthcare Providers:

  **What do I do when I feel there is a serious threat of injury to my client or someone else?**

  If you feel your client is a serious and imminent threat to the health and safety of him or herself or to others, you may report to individuals who you believe could help address the threat, including family members and law enforcement. Depending on your state, you may be required or allowed to share an individual’s health information if a serious and imminent threat of physical violence has been communicated. These “Duty to Protect/Warn” laws exist in 45 states.

- We have a book published by the APA titled *Duty to Protect: Ethical, Legal, and Professional Considerations for Mental Health Professionals* (2009) available in the library. Catalog entry here. Please let me know if you are interested in having a copy of this book checked out and delivered to you.

- You have probably are already very aware of this, but I thought I’d pass along the National Conference of State Legislatures’ state-by-state breakdown on duty to warn legislation: [http://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx](http://www.ncsl.org/research/health/mental-health-professionals-duty-to-warn.aspx).

- As part of your work with the *Volk v. DeMeerleer* case, you are also probably also aware that the Washington State Medical Association, Physicians Insurance and the Washington State Hospital Association recently issued (May 2017) new guidance and guidelines on Washington State’s Duty to Warn or Protect Standard. A copy can be accessed here.

- Although not exactly on point, a few national health care organizations have promulgated guidelines related to the duty to warn family members of potentially harmful genetic information. If you are interested, these standards are described in an article from the American Journal of Bioethics titled *What does the Duty to Warn Require?* I’d be happy to pull these guidelines for you if you like.
APPENDIX E
To: Tanya Karwaki, J.D., L.L.M., Ph.D.
From: Northwest Health Law Advocates
Re: Volk decision and its potential impact on patients
Date: 11/13/2017

Thank you for offering Northwest Health Law Advocates (NoHLA) the opportunity to provide feedback on this timely issue. NoHLA advocates for improved access to quality health care, particularly for low-income individuals, and to secure the health care rights of all Washington State residents.

NoHLA appreciates the protective purposes of the Volk Court’s decision, in which it clarified that outpatient mental health providers can have a duty to warn third parties when it is reasonably foreseeable that a provider’s patient will harm a third party, even when that party is not readily identifiable. We are concerned, however, that the standard articulated by the Court may have an unintended negative impact on patients and providers alike, because:

a) its language explaining the preconditions for triggering the duty, as well as the means a provider should use to carry it out are confusing, creating a serious risk that it will be interpreted and applied in arbitrarily varying ways;
b) it seems likely to create (even unconscious) pressure on mental health providers to make unjustified disclosures of otherwise confidential patient information and needless involuntary commitment referrals; and,
c) its consequences will likely undermine provider-patient relationships.

Taken together, these factors create a significant risk of degrading the effectiveness of the mental health treatment received by many patients and dissuading patients from obtaining the treatment that they need. Unfortunately, these potential effects are more likely to be realized and magnified due to societal attitudes about mental illness and limitations on access to mental health treatment. Having a mental illness still carries with it significant stigma to many in our society. And, many persons with a mental health diagnosis do not receive treatment to address their condition(s). For a considerable number of these individuals, fear of the stigma associated with mental illness and treatment prevents them from accessing the care they need. In this context, it is important to examine the unintended harm that policies like the Volk rule may have on persons with mental health conditions, their families and the people around them. Equally, if not more important, we must consider and work on reducing the prejudices that continue to be linked to having a mental health condition and receiving treatment for it (including inaccurate and discriminatory views about the asserted dangerousness of people with mental illness) and seek to ensure that all who would benefit from receiving mental health treatment have access to affordable and high-quality care.
May 2017: The Washington Supreme Court decision in Volk v. DeMeerleer, 386 P.3d 254, 187 Wn.2d 241 (2016), alters the scope of the “duty to warn or protect” in at least three critical ways:

1. It brings into question the groups of health care professionals who are subject to the duty to warn or protect in the voluntary inpatient and outpatient setting.
2. The duty now clearly applies in the voluntary inpatient and outpatient setting.
3. Most importantly, outside of the context of an involuntary commitment proceeding, the scope of persons to warn or protect now includes those that are “foreseeable” victims, not reasonably identifiable victims subject to an actual threat.

Facts of the case: The Volk decision involved circumstances in which a psychiatrist was treating a patient who had expressed suicidal and homicidal thoughts in the past. Many years later, and about four months after being last seen by the psychiatrist, the patient killed two individuals known to the patient. The patient had not voiced any thoughts to harm them. Representatives of the deceased filed a lawsuit against the psychiatrist for failing to protect them from the patient’s violent actions. That lawsuit is still pending at the trial court, but the Supreme Court’s decision established a new standard that is now binding on treatment providers.

In Volk, the Supreme Court held that, in the outpatient and voluntary inpatient treatment setting, the duty of health care providers to warn or protect potential victims of violence extends to all individuals who may be “foreseeably” endangered by a patient, even if no specific target was identified.

The WSMA, Physicians Insurance, and the Washington State Hospital Association recommend that physicians and providers who treat patients with violent tendencies or ideations consider implementing the following guidelines (these guidelines are intended to be general guidance and not legal advice):

- Continue to use reasonable care to act consistent with the standards of your profession.
- Complete and update suicide and violence risk assessments with findings documented in the patient’s medical record.
- Develop a policy and procedure to assess whether a patient has dangerous propensities, and use it consistently.
- Document in the patient’s medical record why you reached your clinical decision and measures you have recommended to mitigate potential risk, even when you are assessing a patient who has violent tendencies or ideations and do not believe the patient will harm others.
- In all cases, carefully consider and document in the patient’s medical record the measures taken to mitigate risk. Measures will fall into two categories: measures to treat the patient and measures to warn potential victims. Measures to treat the patient may include, but are not limited to: seeking to hospitalize the patient; seeking to initiate involuntary commitment proceedings;

WSMA, Physicians Insurance and the Washington State Hospital Association will continue to pursue legislative, regulatory and judicial options to address the results of the Volk decision. Currently, legislative efforts to fund a study of the decision on the state’s mental health treatment system are underway. Additional details on those options will be forthcoming.
scheduling more frequent visits or contacts with the clinic; starting injectable medication, etc. Measures to warn potential victims may include notifying law enforcement and notifying “foreseeable” victims.

✓ When you decide to issue a warning, notify law enforcement before contacting potential victims. Document in the patient’s medical record your notification efforts and the individuals or groups notified.

✓ In Volk, the Supreme Court held that it is a jury’s responsibility to determine who may be a foreseeable victim. We cannot, therefore, provide firm guidance on how to identify a foreseeable victim. In assessing the scope of foreseeable victims, consider people close to the patient, such as family members, work colleagues and others within the person’s social circle. Depending on your assessment, notification to a broader group could be required. In that case, coordination with law enforcement may be necessary. You must assess every case individually.

✓ For any action taken, document in the patient’s medical record the reasons the action is necessary to warn or protect foreseeable victims, and, if applicable, to prevent or lessen a serious and imminent threat to a person or the public’s health or safety, as described above.

Finally, we recommend that you consider these points in a clinical context, act in good faith and document in the patient’s medical record your thought process in sufficient detail to justify any course of action you decide to take, even if you feel that a patient has not triggered the duty to warn or protect potential victims.

Questions?

**Washington State Medical Association**: Tierney Edwards, JD, 206-956-3657, tee@wsma.org
**Physicians Insurance**: Risk Management, 800-962-1399, risk@phyins.com
**Washington State Hospital Association**: Taya Briley, 206.216.2554, tayab@wsha.org
APPENDIX G
All Survey Responses to: If you HAVE CHANGED your practice, briefly describe these changes

November 7, 2017

**Limit who I consider being available to treat**

I will not take on new patients in my practice if they have a history of explicit (as opposed to fantasies of violence without external action) violence against others (e.g. domestic violence, child abuse) and/or a history of litigation for threats of violence against others. I will not work with someone who owns firearms used for personal protection (as opposed to for hunting) unless they agree to have weapons removed from their home or secured in a locked location.

*added attention to potential risk factors. Also, however, perhaps bit more cautious about screening potentially high risk patients*

**Limited acceptance of any patient who has any history of aggression or violence, even persistent ideation**

**Not taking antisocial clients anymore**

**Referring on patients who seem particularly unstable.**

*more documentation, less likely to take on more severely distressed patients*

*Screening out people with suicide risk factors which is unfortunately a large list*

*More reluctant to accept people who have history of violence. I have asked the agencies where I am a contractor to give assurance that patients are connected with another clinician should I retire or leave the agency.*

*I no longer accept referrals for patients with anger issues*

*I am not taking patients with a history of violence or suicide attempt.*

*Initial Interview over the phone with direct questioning of potential client on thoughts of harming others. If affirmative, I refer the to someone else.*

*Decided not to see higher risk patients, i.e. lower functioning borderline individuals with a propensity to act out.*

*Increased screening of patients to avoid patients who I perceive as having a higher risk of violence.*

*I exercise more caution in taking clients.*

*Intake includes a higher awareness of the risk that a potential client poses. I cannot accept the liability of potential violence and need to refer these cases on to public mental health.*

*I have stopped taking patients who I believe may require me to protect or warn others who may be endangered by the patient in the future.*

*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 may retire sooner than anticipated given the combination of decreasing insurance reimbursements plus higher liability risks due to Volk.*

**Documenting hi risk. Turning down potentially high risk patients**

*I spend more needless time on documentation- not for patient care!*  

*In the context of my primarily inpatient psychiatry and consult psychiatry work, I have a lower threshold to alert police (in the case of non-specific violent threats) and individuals (in the case of specifically targeted but vaguely imminent threats). This has clearly led to a loss of therapeutic engagement with some paranoid and very psychosocially isolated people. I don't think it has made anyone safer.*
All Survey Responses to: If you HAVE CHANGED your practice, briefly describe these changes

November 7, 2017

<table>
<thead>
<tr>
<th>Referring more patients to substance avoids programs even though I could manage them myself and it would be easier for the patient. My hospital is telling me to call the police on all my patients that have voiced some violent thoughts even if they have no intent to harm anyone. Some of my colleagues are doing this as instructed. This is not ethical and will not protect people in the long run.</th>
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| Ask about and document additional specific questions of clients. |
| I have stopped taking high risk clients. |

| Screening for anger |
| I don't accept patients with a history of violence - or who even seem rageful. While it is really impossible, if 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 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. I have considered whether to close my practice altogether. |

| N/A |

| Reviewing even lower-risk clients with supervisor, increased personal anxiety about clients at risk for harm to others. Would be less likely to see clients at-risk in private practice part of my work (screen out.) |
| I state this in my disclosure and bring this to client attention at first session |
| Modified my disclosure statement - added Volk language to list of mandated reporting requirements. Since I don't have any special certification or training that might protect liability, I don't take clients that indicate any possibility of aggressive behavior toward others. |

| More cautious about who to treat. |
| I have asked more questions to assess for risk of violence. I have asked about particular targets of violence. 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. Screening for violence, not treating patients at risk for violence, calling law enforcement even when I don't think a patient is an immediate threat so that I can document that I did so in screening patients, and considering potentially violent ones, I am more conservative in balancing wanting to help but mitigating risks to my private practice. |
| I have referred a few existing patients to other providers (or just terminated care). I am more selective on incoming referrals, and do not accept patients with any history of aggression toward others. I no longer accept any patients that have previously been committed (forensically or civilly) for treatment. |
| I screen and document with this ruling in mind. |
| I recently discharged a patient from my practice who had engaged in domestic violence. I have begun screening potential patients for violence risk and declining to accept potentially violent patients; I have terminated relationships with potentially violent patients; I plan to increase calls to law enforcement; I anticipate making more referrals for involuntary commitment; I have heard of psychiatrists deciding not to move to Washington due to this. |
| I do a much more thorough duty to warn/protect than previously, and document in my notes that I have considered this on just about every patient. |
Increased referrals for involuntary detainment and increased frequency of notifying law enforcement

Less likely to take on patients with potential for physical violence. assessing for risk of violence

Not accepting patients who are actively suicidal, physically aggressive or have a history thereof. Consider a broader range of potential victims and broader arrange 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.

1) Spend more time on documentation. 2) Think more about the legal requirements; this can be distraction from thinking about patients and their care needs. 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. 4) I have reached out to Dr. Piel at the Seattle VA and she helped me think through a complex case. 5) If I have a lot of complex cases, I might start limiting the patients that I see and screen more. They are too time consuming and my time is not spent helping patients. In turn, this is not protecting the public.

I am avoiding taking new patients who could be at increased risk for committing a violent crime. I don’t see patients anymore

Pre-screen and decline any new prospective request for treatment if any aggressive behavior or recent run-ins with police.

standardized assessment of risk for violence

Thinking more about “possible” third parties and “possible” harm. This compromises attention on the patient which could help actually manage current and probable symptoms, including causes of one’s aggression/violent thoughts etc.

Increased discussion with colleagues about duty to warn. Increased calls to law enforcement

Increased the likelihood of calling law enforcement around potentially violent patients (which destroys the treatment relationship, making me unable to be their clinician), and declined to serve patients with violent history because of unending/unrestricted liability for any future actions that they may commit after treating them.

More detailed questions about thoughts of violence

I moved in 2015 from MD (where I had an outpatient practice for 20 years) to WA, anticipating I would open a private practice or seek outpatient work at a clinic. Because of the Volk decision, I have been unwilling to treat psychiatric outpatients in Washington. I am working on a very reduced part-time schedule treating some of my old MD patients by telemedicine and covering weekends at Cascade Hospital, where the inpatients are already on ITA so I don’t have to worry that they’ll harm anyone and I’ll be held liable.

Do not accept patients who will potentially put me at legal risk when I am not able to predict their chances of being violent. How accurate are judges at predicting violence in the people they evaluate?

More time with violence screening (less with other MH concerns). Lower threshold for referring for hospitalization and calling law enforcement/potential victims.

I am quitting psychiatric practice in Washington due to the unreasonable level of risk this decision puts me under.
All Survey Responses to: If you HAVE CHANGED your practice, briefly describe these changes

November 7, 2017

I didn't realize this was limited to outpatient care. On the inpatient unit, if a patient has made threats about harming another person, I ask the social worker to contact this person and provide a brief statement of our concern at the time of patient discharge. In addition, if there is any lingering concern for imminent threat, I have the designated MHP evaluate the patient which helps engage the community mental health resources. We have also been notifying the police department at time of discharge. I have not had to address this in the outpatient setting yet, but I do ask about hx of violence toward others and homicidal ideation as a standard practice. The challenge I foresee is if the patient has a violent history, does that history in and of itself meet criteria to over-ride HIPPA to inform people the patient knows if no specific person is named?
We screen patients more carefully and consider reporting clients to authorities much more easily, even if there is no clear potential victim, which is troublesome because we also don't want to unnecessarily violate patient rights nor generate a list of mental health patients for the police.

More cautious about whom I will work with
different assessment, referring when risky patient
Have subsumed above into my understanding of the Tarasoff, etc. rulings, which I refer to in my Disclosure
I am more reluctant to take patients who have violent thoughts and/or have engaged in violent actions.
More carefully screen for violence and don't accept those patients
Disclosure statement and client screening
Cannot take high risk clients
Have implemented a new risk assessment procedure for cases that previously we would not have assessed. This means we are more likely to report a false positive.
Screening potential clients differently
Limit exposure to high risk clientele.
I am less willing to work with clients who have any history of violence or who seem impulsive.
Reducing number of clients I accept who report more serious struggles with suicidality or aggressive behavior.
In addition to informing clients before establishing a "special relationship" of duty to warn, systematically do the following: If a client presents with a threat towards another, obtain as much demographic data on this potential victim as possible - when indicated, contact emergency personnel immediately.
I am less open to working with people presenting with anger management issues.

We have tightened up our explanation of exceptions to confidentiality and we were now looking for these types of threats and are now including them in our scope of concern and reporting.
Assisting others to understand the implications of this decision.
Policy & Procedures; Notice of Disclosure
I was already familiar with the legal duty to warn.
I send termination letters to clients who I am no longer working with on a regular/frequent basis.
Add to disclosure, refer out more often
Additional documentation, increased risk assessment, additional attorney hours.
Made my disclosure more clear in response to expression of anger with respect of threatening speech towards others.
N/A
Questions and details about safety more comprehensive before first meeting (phone or email contact)
All Survey Responses to: If you HAVE CHANGED your practice, briefly describe these changes

November 7, 2017

The Volk decision influences my decision to further narrow the clients with whom I'm willing to work. This decision places an unreasonable burden on mental health professionals to anticipate violent acts. I have had clients in the past who had violent thoughts, and I believe my work with them was helpful to them. They did not act on those thoughts. Now, I would hesitate seriously before taking on such clients. The Tarasoff standard remains a reasonable and achievable standard to meet; I don't believe the Volk decision is reasonable at all.

I have reduced my practice greatly and only treat non-violent clients to best of my knowledge. I have stopped bringing in new clients who may be unpredictable or unstable.

Careful assessment of my relationship with a pt, as well as verbally stressing with my patient my responsibilities towards the safety of their associations with others.
This law places an unreasonable burden on the clinician and will result in less access to care for people who need help because of the untenable liability placed on clinicians.

This decision, which appears to allow a finding of liability where no responsibility for the event is in any reasonable way conceivable, is so bizarre that I cannot allow it to affect my thinking or clinical work lest it derail me from best practices.

Psychoanalytic treatment of severe mental illness (psychosis and borderline states of mind) is one of the ways society can be better protected from uncontained acts of violence. Putting the psychoanalyst in the position of being responsible for the present and future actions of their patients works against the very conditions needed to establish trust so that patients can feel free to share violent fantasies without fearing that the analyst will become a legal enforcer. These roles are mutually exclusive. Of course, if the patient reports a conscious intention to harm self or others, the analyst should evaluate with the patient what steps are needed to protect the treatment relationship and the patient. However, 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 will result in fewer individuals receiving treatment who desperately need our help.

This decision presents a significant obstacle to clinicians in terms of which patients they decide to take into their practice.

Committing a violent act is not predictable EVEN when I am seeing a patient regularly. I can warn when I feel the patient has a specific person in mind and a plan. I can warn when I suspect a plan and a group of possible targets. During over 35 years of practice, I have reported a potential danger only once. My patient laughed when I told him I had done so. He said you can't keep her safe if I really decide to kill her. She fled the country, wisely.

I would be less inclined to work with high-risk individuals. I believe this would put greater strain on public mental health institutions and reduce access to care those struggling with violent fantasies. I may be less willing to work with ill people who express anger if my misjudging their likelihood of acting results in liability for me. This feels like a slippery slope.

The best predictor of violence is previous violence. I routinely listen to patients ventilate their feelings about another person. These are people with no history of violence, who need a relationship that is totally confidential, where they can say anything that comes to their mind. If I were required to listen for potential victims of these nonviolent individuals, I could not do my work. I have treated judges, lawyers and all other professionals. All humans, in a free society, need confidential professional relationships where they can express their aggressive feelings. The Volk Decision was influenced by wrongheaded, misinformed, individuals who do not provide mental health services.

I think that for a private practitioner that there need to be specific and reasonable limitations outlined on the practitioner's duty to act and to protect.

This standard is unreasonable.

Volk decision not reasonable. Expectations of clinicians impossible to reach.

Many risk factors studied for suicide. It's our work to be there for people in spite of and because of these risks. But as a solo practitioner, I would be an idiot to risk a malpractice suit by, for example, accepting someone in my practice that has past history of attempt. I have helped people like this and kept them out of the hospital in the past but without reasonable protection by the law I can't reasonably do that job.

Same as above
Please Briefly List Any Additional Comments You Have Regarding Volk and Your Practice

November 7, 2017

The idea of responsibility after one is no longer practicing or for years after treatment has ended or been interrupted is unreasonable. We have no way of knowing what circumstances may arise that prompt patients we haven't seen recently to act violently.

It is often stressful to treat patients who are emotionally volatile. This legal decision increased the stress involved, and led me to decide that I was not willing to take on the amount of the stress and risk involved in treating patients who have difficulty managing their anger.

I do not think that it is reasonable or realistic to expect mental health providers to be responsible for a patient's violence or self-harm behavior after a treatment relationship is terminated.

It puts providers and patients in an untenable position in which the need of the provider to protect him/herself trumps a patient's needs for confidentiality and care.

Just feeling paranoid about impossible-to-predict legal exposure and looking forward to retirement.

The Volk decision

This decision is one more example of how we create a divide between people with resources and choice, and those who are relegated to public systems that already overwhelmed.

The Volk bill requires an assessment by the therapist that is not always possible. In general, potentially dangerous people cannot be charged until they commit a crime, yet Volk holds therapists liable for a patients' illegal actions.

I believe the public, and some judges, have little understanding of mental health problems and treatments so hold unrealistic expectations of what mental health professionals can predict or control. 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 (notwithstanding whatever jury instructions are given about foreseeability). And when faced with a sympathetic injured party or family member, they will want to award some damages or compensation for a terrible loss.

We conduct research trials where we routinely assess homicide risk. Based on Volk we are now seriously concerned about how to manage this risk within the context of a clinical trial with high risk populations (PTSD with substance use).

Hospitals are telling clinicians to warn and we are feeling a lot of pressure to do this. The hospital admin staff and legal system needs to understand the downsides of this. Warning should not be the first option. I think Dr. Piel has looked into the conflicts with HIPAA and ethics codes when making warnings because of the Volk ruling. Currently, we risk running afoul of the law no matter what we do. This is not the way to make mental health more available.

I am considering an attempt to limit my exposure to patients with high risk for violent behavior (prototypically young white men with DV/violent crime, impulse control and alcohol use problems) in order to limit my own risk for civil liability as a professional. Limiting my exposure could mean avoiding work in outpatient clinic settings wherein I might form such "special relationships" over time, or if working in clinic, to segregate out patients through various means, such as choice of practice location, screening out and referring high-risk patients elsewhere. Alternatively, I could enact treatment agreements with release-of-information expectations explaining my duties to foreseeable victims, probably screening out high-risk patients who would balk at such conditions. Increasing time to attend to risk notification and documentation of these conversations and their complexities and complications of clinical treatment relationships would certainly be a burden for those patients who would agree to such releases.

Feels like mental health is being asked to be the gatekeeper for society by the Volk ruling.
Your summary for this states that the court “considered the duty to warn in the outpatient setting.” Please note that this should be duty to protect! The case is complicated enough without having the law school stating this incorrectly. Dr. Piel gave a nice lecture about the history of these laws and distinction between warning and protecting. We want to make clear that clinicians should have options to determine what, in their CLINICAL JUDGMENT, should be done. The emphasis should be on the patient, not anyone in the public.

The law is too confusing! We have had risk management lawyers from harborview come try explain the ruling and they did not really understand it-- at least could not explain it to practicing clinicians. Luckily, Dr. Jennifer Piel has been able to help clarify and explain things in a way I can understand. But, how is the average clinician supposed to sort through all the legal standards and also provide good care in a 15 minute appointment? We will have to limit access to patients.

At my work, we got information from a lawyer on this today, and the lawyer was inconsistent in what the case means and what clinicians should do. The lawyer basically told us to ignore the law because we don't know what it means. They told us that you have to warn everyone, but then said that you can't breach HIPAA. If our lawyer consultants don't know what the case means and can't help us, then how is a busy practitioner supposed to meet the requirements!

Applying these laws can be challenging. Why don't lawmakers consult with experts who know both law and mental health like Dr. Piel? We need laws that support mental health, not hinder it. Lawmakers need to look at the science, not just gut reaction. If they want to prevent violence, there are a lot of other avenues they should be exploring, not preventing people from getting mental health treatment and dissuading clinicians from working with risky patients.

The Volk decision puts MH professionals in an extremely difficult position, both with regard to our ability to act as therapeutic agents for clients with harm thoughts/urges (the vast majority of whom will not act on these cognitions) and with regard to our ability to protect potential targets of violence. My clinical practice will likely change in so far as documentation and consultation is concerned.

As a practitioner, I can and do monitor closely any safety risks while working with clients including "duty to warn.” I worry with Volk I will be held responsible to monitor safety of former clients about whom I have no actual current knowledge. I also worry about breaching client confidentiality if I'm to act upon (i.e., report to possible intended targets) anything less than a clear and direct threat of harm from client to an individual or individuals.

This is a terrible decision which has made several practitioners I know consider retiring early rather than face increasing liability insurance costs or incurring extra risk.

The unintended consequence of this decision is to limit treatment availability, which might reduce future harm, because of liability placed on the therapist for actions unforeseen at the time. It is a little bit like holding liquor store owners responsible for future DUI accidents when the patron was sober at the time of purchase.

I just don't understand why people can't be rational. Counselors are not responsible for everything clients do.

I would avoid taking on clients w/ anger or violence issues

Retiring

I constantly struggle with clarity of a "foreseeable victim"

I want to be able to give my full attention and support to treating my clients with what I have control over. Years of impact, environment, substance, behavioral learnings, etc have shaped my clients. I devote my best self to supporting them, but also recognize that there are limitations to
my awareness of their outside lives in the one hour a week I see them and focus on specific issues they choose to present.

Although I have not made an actual step in anything to change my practice as of yet, Volk's decision and its impacts are something that I think of frequently in my practice. Its weight certainly prompts my unconscious expressions to show up in regards to my practice.

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.

This is a disastrous decision. It needs to be legislatively remedied if possible

The broad, generalized duty to protect "any foreseeable victims" in the face of a patient's "dangerous propensities" provides insufficient guidance for a clinician who actually sees patients and who must make actual clinical decisions in a prospective manner. The threshold for potentially being held liable for having failed to implement a counter-therapeutic intervention intended to protect a third party (rather than to help a patient) has shifted to the entirely undefined level of "dangerous propensities." Given the uncertainty of the level of risk needed to implement counter-therapeutic measures (such as issuing a warning, engaging law enforcement or initiating involuntary hospitalization) and the magnitude of the potential consequence (litigation), it is easily foreseeable that clinicians will screen patients with potential for violence away from entering their practice; end relationships with potentially violent patients (sometimes while the patient is involuntarily hospitalized); call law enforcement to intervene with potentially violent patients; and refer potentially violent patients for involuntary commitment. 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. The threat of litigation forces clinicians to conceptualize patients as potentially violent in a manner that is clearly counter-therapeutic and harmful to the physician-patient relationship.

limited practice with more seriously mentally ill patients, whether or not they have a history of violence.

Lower threshold for breaking confidentiality to discuss concerns for violent behavior.

Hard enough to recruit into psychiatry, now Volk makes it harder still.

It is hard for me to even wrap my mind around the implications of this, which is why I have not changed my practice. But, that being said, I could see myself being very hesitant to take patients with these issues.

I don't understand how a mental health professional can reasonably warn potential targets of violence when a patient does not identify specific individuals in our contacts. This decision and its implications seem unreasonable, asking mental health professionals to predict the future in an impossible and onerous way. This interpretation/decision seems unlikely to protect anyone, and more likely to undermine the patient-clinician relationship by reducing trust around confidentiality without a likely benefit to the patient, other individuals or society as a whole.

I plan on telling potential new patients that I cannot reduce the risk of violent acts and that if they have a history of violent behavior, they should seek treatment elsewhere.

This would harm patients immeasurably, profoundly, and permanently.

Improved screening to exclude violent/potentially violent patients from my practice

Opinion is that more persons who would benefit from mental health will not receive it secondary to Volk.
Having multiple standards in the state is not workable. It is too confusing and we are not serving patients or the community in trying to sort out legal obligations in contrast to working with patients. I really appreciate Dr. Piel and the guidance she has given through her recent educational program. It helps a lot. In the long run, though, we really need the legislature to step up.

The case does not make sense. How can an outpatient psychiatrist have so much more responsibility with less control than a psychiatrist who is seeing someone civilly committed? This type of law may pit doctor against doctor and actually shift patients in ways that are not helpful to anyone.

Not even the best psychiatrist is able to read minds and foresee danger to future victims that the patient has not discussed.

Volk just makes psychiatry more difficult. Nearly impossible.

We hear there is a shortage of psychiatrists, yet the courts and legislature defecate on us and put us in moral distress.

In response to Volk, I was initially thinking of patients at risk for homicide. I attended the WSPA CME and Dr. Piel's talk and realize that the case opens providers to potential liability for other types of dangerous acts by patients. I am worried about driving cases. I am worried about my patients with substance use and also those who have misused medications. I am considering limiting patients with history or current substance use. This is sad because we need more treatment for this, not less.

Have already modified new patient intake.

the summary above seems to understate the implications of the ruling. that patient would have scored low on a standardized violence risk assessment and - to our reading anyway - the victims weren't "foreseeable". the summary also doesn't speak to the conflict with privacy protection nor the gap between last appointment with psychiatrist and when the murders occurred

-Thank you to Dr. Piel and the WSPA for putting on the Fall CME on these issues: liability and assessing violence and approach to duty to protect/Volk/statute. -Strongly support a legislative response to create one uniform standard on duty to protect.

It is incumbent upon us in acting in the best interests of our patients to address their potential for violence just as we would address any other problems of a psychological nature.

The psychiatrist who testified for the plaintiff should be invited to a meeting to discuss his testimony

The courts must feel psychiatrists perform some form of magic with 100% positive outcomes for everyone they treat, to decide they should make us liable for any future acts of violence that any of our patients might commit in the future without the patient even having shared with their provider any specific threats of harm toward anyone in particular, even years after the conclusion of a treatment relationship. It frankly boggles the mind to think that this conclusion ever made sense to anyone. I wasn't aware that we had elected anti-mental healthcare judges to the State Supreme Court.

Considering declining to accept certain new Washington state patients

Putting psychiatrists at legal risk when they are not able to read the future is irrational. When judges can accurately predict violent behavior then they can demand that psychiatrist do the same. This has already changed how I accept patients. Let the judges treat violent patients, then perhaps they will see how impossible a position they have placed psychiatrists. I will no longer accept patients who have any detectable degree of violence rather than risk being sued for not reading minds.
I took a salaried position with a hospital 9 years ago because of being burned out in the private practice outpatient setting, a large part of that burnout was increasing incursions on the patient physician relationship by insurers demanding more and more clinical content in order to get paid and then of course Tarasoff came along expecting me to further breech confidentiality and then my out patient colleagues started refusing to see patients with low reimbursement insurance like Medicare and Medicaid - giving the neediest patients the worst access and I finally couldn't in good conscience join everyone in their flight from ethics to money. Now I do consultation work in a general in-patient community hospital where patient relationships are brief and medically focused and I have a huge hospital organization experiencing this risk with me. I would never go back to Outpatient psychiatry under these circumstances, though the need is great and the resources few. 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.

I would be less likely to treat patients who present with any additional risk

I work at an public institution and cannot turn individuals away due to liability concerns, but I do anticipate some larger institutional response along the lines of what I have listed above (more frequent warnings, more restrictions on where/how certain individuals can access care due to concerns about dangerous, and more referrals for hospitalization). I also think that a lot of psychiatrists/psychologists/social workers I know are concerned enough about volk that they may begin to make warnings or refer for hospitalization even in cases where it might not really be warranted.

It increases the sense of unavoidable jeopardy in practice of psychiatry and gives an additional incentive to retire earlier rather than later.

This decision will only cause psychiatrists to avoid the state of Washington, to "cherry-pick" patients, and to ask LESS about violence risk, while documenting simply "no SI/HI" in their notes, to avoid liability. As a result, the population (both patients and non-patients) will be at even higher risk. This is a decision that kills people.

If Dr.Volk is found at fault, we may attempt to limit our practice to 'lower risk' patients. We need a more clearly delineated protocol for outpatient mental health practice to protect patients and the public, that is both recognized by the state and is recognized in our profession as a good standard of care.

I do not work in a clinic. I have a "solo" practice

Adding more careful documentation

This ruling sets up a "Minority Report" type of mind-reading as an expectation for clinicians, as well as making clinicians fearful of treating patients to reduce the risk of violence in our communities, the real action of protecting. I believe that the standard should be the same as with suicide risk, and that a statement should be required from the patient about intent.

This decision represents a major misunderstanding of how mental health treatment works and will result in loss of access to mental health treatment.

If we hear something tangible, we can take steps to inform the police and/or intended victim. If it isn't tangible, and/or the patient hasn't been in our care for many months, we would have to be psychic to report anything. And we are not. I fear this opens things up to making it so that attorneys will target mental health providers and cause a lot of pain for everyone involved. Also, we can't do anything about things that patients don't tell us about. We can't control what they do. In order to minimize the risk of violence for some, treatment is helpful, but treatment can only be provided within a safe legal context for providers.
Please Briefly List Any Additional Comments You Have Regarding Volk and Your Practice

November 7, 2017

I do not understand how I could change my practice to limit my exposure to risk since it is impossible to predict the future and anyone could become a risk depending in circumstances that arose in their life.

Of particular concern is the expectation that a therapist has the duty to warn even though the client may not currently be in treatment or in fact hasn't been for quite some time. This puts all clinicians at risk for things completely out of their control.

My practice does not seem to attract many people who are at risk for committing violent Acts. I once had a client who called me on his way to his estranged Wife’s work and I did call her to warn her and I called the police. That is the only time this has happened to me in a career spanning 45 years. However, I am very concerned about the scope of this act. There are people who do not let you know it is completely unrealistic to think that a therapist knows everything about a person even if they have a special relationship and see each other an hour a week.

This is a large practice with 45 clinicians, the Volk decision has significantly changed the way we practice and has great potential to interfere with our ability to effectively treat patients beyond the Tarasoff requirements for outpatient mental health. It places an undue burden and liability on outpatient practitioners to be able to predict violence, something all professional suicide and homicide literature says is impossible to do.

I already do not accept patients with a history possible history where they perturbated abuse or violence against another person.

Volk may seriously impact clients ability to receive services when they may be part of population that need access to sound and clinically appropriate mental health services

I do not believe I can be responsible for the actions of former clients that I no longer work with in my practice.

How can I predict the future?

I am less likely to take on a new patient with a history of violence or aggression.

It seems like Volk is acting me to predict the future which I don't think I can do. working with entire clinic team to establish a protocol around duty to warn measures

I was already operating in a way that would be consistent with the Volk v DeMeerleer decision. Integrated Primary Care. So I am a consultant for the Primary Care Dr. This can create a gray area around the "special relationship"

I do not believe Volk was a fair decision. We simply do not have control over the actions of others to the degree that the decision seems to imply. It is absurd to hold therapists accountable in this manner. Are we to next be responsible for the actions of everyone in our patient’s lives, or the decisions and actions made by others? I already go to great lengths to “warn” and “protect”. We are simply not able to fulfill this, because individuals are ultimately responsible for themselves, and with whom they associate. The whole thing is outrageous and unlawful, in my view.

Already thoughtful about how to limit risk based on best practice

I am concerned that this will effect the client-therapist relationship especially where more significant mental illness is concerned (depression, anxiety, trauma included).

As a forensic specialist, I typically use a conservative approach that is informed by current legal standards. I am trying to help other clinicians without such background to understand how they can engage in due diligence while serving both their clients and public safety.

Making it clear to clients regarding "duty to warn"

I am currently unsure of how to change my practice to limit exposure to risk but it may look something close to the effect that I am screening for individuals with previous history or vulnerability factors that put them more at risk for engaging in violent behavior to protect myself
Please Briefly List Any Additional Comments You Have Regarding Volk and Your Practice

November 7, 2017

from the Volks decision which I feel puts an unattainable expectation on mental health professionals to for see the future (a common misconception of our roles in general).

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.

It seems a terribly unfortunate thing that has befallen the profession.

Has lead to increased caution in taking on higher risk clients

As a duty to warn, i would call the police. I am not a detective and would not know how to find contact information for a potential victim if they were not listed as a patients emergency contact, which is the only other contact I require of patients.

This decision is ridiculous and I fear will inhibit people from practicing, which will boomerang as more vulnerable under or un-served. How can anyone be expected to "foresee" victims? This is too high a standard for any professional and leaves great liability for those of us out here doing the tough work.

I understand the Volk decision and believe we as a profession have to come up with standards that go beyond the typical "duty to warn" we are trained to do. In situations such as in the Volk decision, I am unsure as a provider what my course of action would be and whether it would be considered as doing my due diligence.

I have a practice but am still growing it and have yet to read, though intend to read this decision. It seems like an unreasonable burden on clinicians. If you have concrete facts (i.e. a client makes statements about harming others) you can take action to protect others from harm. After hearing about this case, it really doesn't seem like the clinician had enough information to predict that the client would harm others. We can't predict the future! We can only work with what is communicated to us through words and body language.

I anticipate that I will need to carefully screen potential clients to avoid clients with criminal, violent pasts.

I have already considered that I have a duty to warn, but have not encountered this situation in my 40 years of practice. Thank you for the information.

I'm already very aware and cautious

I have already refused to accept individuals who have expressed undue angry behavior and out of control physical assaults against others. I believe this ruling puts undue stress on the counselor to "guess" what might happen and gives the trier the benefit of preknowledge of such dangerous action. No one is prescient yet we as counselors are now expected to know the future when we know expressly no one can truly guess the inner atmosphere of another.

The ruling endangers patients and providers alike because of the way it threatens the treatment relationship.

I may not take on high risk or violent clients.

I work in higher education, so my employment circumstances don't require me to change my practice.

Gathering more relevant information

It would be good for the entire professional community to have knowledge of this. Not just direct service professional, but also their administrations. Often, these are the people monitoring for quality, compliance, safety, etc. at least for agencies. It would be beneficial to for all to have a specific understanding of how this differs from the original Tarasoff ruling.
This has limited the type of clients and exposure to possible risk I am willing to take thus affecting every aspect of my work. That includes the relationship which research has shown is the key factor in success in therapy. It has affected every therapist I know and given many sleepless nights.

I continue to read what's available on this decision and its impacts on my field. It is often a topic of grave concern to my colleagues as well. We're all interested and willing to take appropriate steps to ensure the safety of our clients and to warn others when we have knowledge that they may be at risk because of our clients. The Volk decision seems to take this expectation much too far.

Depending on how cases brought to court relative to this law turn out, I may reduce it even more. Certainly I'm changing my intake documents and process. This law clearly implies mental providers must be/are mind readers. I'm not and I don't know any provider or even any everyday person who is. No one is a mind reader, nor can anyone be trained to be one. This law defies reason, but this is just one more example of the irrationality and ignorance of our state legislators regarding mental health and the treatment thereof.

I do not see any way I could truly limit my exposure to risk because I do not have a crystal ball to "foresee" future bad acts by a client unless it is in conjunction with the current duty to warn criteria of 1) "an actual threat," 2) "of physical harm" to a 3) "reasonably identifiable" person. Without these, there is no way for me to surmise /foresee threat in some way to the general public at some future point. Volk is a completely unreasonable decision and there is no way I can see to implement it. The only way to protect my practice from risk, or at least reduce it, from the Volk decision would be to screen out anyone seeking services who has anger issues or any history of altercations of any kind. If clinicians do that, the public is less safe because those people are not getting the help they need to have other tools for dealing with frustration, resentment and anger. And everyone was had those feelings before so I don't know even who a clinician could screen out!

Decision ill-conceived and dangerous. Legislation needs to be written and passed that will correct this situation.

I assume, being part of a health care system, that I do have some protections. However, I would appreciate ongoing education to understand the responsibilities between a private provider, and those who work outpatient within an agency or health care entity.

I need more information in order to take helpful measures.

I believe I act in a responsible manner with all of my clients. That does not mean that something might happen that doesn't raise a flag . . . but I sincerely hope if that should happen, that, perhaps with consult with trusted fellow professionals, the right thing will be done.
APPENDIX I
Invitees for Public Session
University of Washington School of Law
November 18, 2017, 10:00-11:30 AM

Physicians Insurance:
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Behavioral Health Resources
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## Volk v. DeMeerleer Legislative Study

**Stakeholder Meeting**

**November 18, 2017**

(*In-Person*)

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# Volk v. DeMeerleer Legislative Study

**Stakeholder Meeting**

**November 18, 2017**

**ONLINE**

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## South Dakota

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Alabama

Summary

- "Licensed marriage and family therapists" have a statutory duty to warn third parties about their patients' violent behavior only when the patient "has communicated to the marriage and family therapist a serious threat of physical violence against a reasonably identifiable victim or victims." Ala. Code § 34-8A-23. The duty is discharged when the therapist makes a reasonable effort to communicate the threat to the victim or victims and to a law enforcement agency. Id. The therapist cannot be liable for breach of confidentiality. Id.

- Alabama's statutory language for "licensed professional counselors" is a bit confusing: It seems that they have statutory immunity from civil liability for failing to warn or protect third parties from their patient's violent behavior, even if the patient communicates a serious threat of violence against a reasonably identifiable victim. Ala. Code § 34-8A-24. However, the statute goes on to say that if a duty does arise “under the limited circumstances outlined above,” it is discharged by making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency. Id. In making reasonable efforts, counselors cannot be liable for breach of confidentiality. Id.

- Psychotherapists have a common law duty to take reasonable steps to protect a targeted third party when the psychotherapist is aware that a patient poses a “significant, imminent threat of death or serious injury to an identified individual.” Morton v. Prescott.

- In the outpatient context, a psychiatrist typically does not have sufficient contact with outpatients to establish special relationship that confers liability for the outpatient’s criminal acts. King v. Smith.

Relevant legislation

_Ala. Code § 34-8A-24 (1975) (duty of counselors)_

There shall be no monetary liability on the part of, and no cause of action shall arise against a licensed professional counselor or associate licensed counselor in failing to warn of and protect from a client who has communicated to the licensed professional counselor or associate licensed counselor a serious threat of physical violence against a reasonably identifiable victim or victims. If there is a duty to warn and protect under the limited circumstances specified above, the duty shall be discharged by the licensed professional counselor or associate licensed counselor making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency. No monetary liability and no cause of action may arise against a licensed professional counselor or associate licensed counselor who breaches confidentiality or privileged communication in the discharge of their duty as specified in this chapter.

_Ala. Code § 34-17A-23 (1997) (duty of therapists)_
(a) There shall be no monetary liability on the part of, and no cause of action shall arise against, any person who is licensed marriage and family therapist in failing to predict and warn of and protect from a patient's violent behavior except where the patient has communicated to the marriage and family therapist a serious threat of physical violence against a reasonably identifiable victim or victims.

(b) The duty to warn of or to take reasonable precautions to provide protection from violent behavior arises only under the limited circumstance specified in subsection (a). The duty shall be discharged by the marriage and family therapist if reasonable efforts are made to communicate the threat to the victim or victims and to a law enforcement agency.

(c) No monetary liability and no cause of action may arise under this chapter against any person who is a licensed marriage and family therapist under this chapter for confidences disclosed to third parties in an effort to discharge duty arising pursuant to subsection (a) according to subsection (b).

Regulations and administrative guidance

*Ala. Admin. Code 750–X–6, App. II, § 4.05(b)(3)*

- The APA Code of Ethics as adopted in Alabama recognized that psychologists may disclose confidential information without the consent of the patient “as mandated by law, or where permitted by law for a valid purpose,” including specifically “to protect the patient or client or others from harm.”

Cases

*Morton v. Prescott, 564 So.2d 913 (Ala. 1990)*

- **Facts** – Plaintiff was assaulted by mental patient one day after the defendant, psychiatrist, released the patient from the hospital.
- **Held** – The psychiatrist had no duty of care to plaintiff because patient “made no specific threat of harm to the victim or to any identifiable group of which the victim might have been a member.” 916.
- **Significance** – Recognizes that when a psychotherapist is aware that a patient poses a significant, imminent threat of death or serious injury to an identified individual, the law imposes upon the therapist a duty to take reasonable steps to protect the targeted third party.
- **Key Language** – “Once [a patent verbalizes specific threats to inflict injury on another], then the possibility of harm to third persons becomes foreseeable and the psychiatrist’s duty arises.” Prescott, 564 So.2d at 916.

*Donohoo v. State, 479 So.2d 1188, 1191 (Ala. 1985)*

- Recognizing, in the context of the release of a parolee, “for policy reasons the duty to warn depends upon and arises from the existence of a prior threat to a specific identifiable victim. . . . In those instances in which the released offender poses a predictable threat of harm to a named or readily identifiable victim or group of victims
who can be effectively warned of the danger, a releasing agent may well be liable for failure to warn such persons.”

- Reasoning of this case applied to psychiatric context in Prescott (above)
- Reversed on other grounds, Ryan v. Hayes, 831 So.2d 21 (Ala. 2002).

King v. Smith, 539 So.2d 262 (Ala. 1989).

- Facts: A psychiatric outpatient killed both of his daughters and himself while enrolled in an alcohol abuse treatment program administered by the defendant, a psychiatrist.
- Held: The defendant psychiatrist’s minimum personal contacts with outpatient were insufficient to show special relationship or circumstance necessary to make psychiatrist liable for outpatient’s criminal acts and subsequent suicide.

Alaska

Summary

- There is no affirmative duty for mental health professionals to warn or protect third parties. However, numerous statutes delineate exceptions to provider-patient confidentiality in situations where a patient threatens harm toward others.

- The exact standard triggering the exception varies from provider to provider: licensed professional counselors (Alaska Stat. § 08.29.200) (“a clear and immediate probability of physical harm to the client, other individuals, or society”), psychologists and associates (Alaska Stat. § 08.86.200) (“an immediate threat of serious physical harm to an identifiable victim”), licensed social workers (Alaska Stat. § 08.95.900) (“a threat of imminent serious physical harm to an identified victim”), marital/family therapists (Alaska Stat. § 08.63.200) (“a threat of imminent serious physical harm to an identified victim”), and welfare, social services, and related institutions (Alaska Stat. § 47.30.845) (“substantiated concern over imminent danger to the community”).

Relevant legislation

Alaska Stat. § 08.29.200 (2012)
  - (applies to: licensed professional counselors)
  - A licensed professional counselor may not reveal any communication revealed by their client when the client has employed the counselor in a professional capacity. Exceptions allow the counselor to communicate confidential information “to a potential victim, the family of a potential victim, law enforcement authorities, or other appropriate authorities concerning a clear and immediate probability of physical harm to the client, other individuals, or society.”

Alaska Stat. § 08.86.200 (1996)
  - (applies to: psychologist or psychological associates)
A psychologist or psychological associate may not reveal to another person a communication made to the psychologist or psychological associate by a client about a matter concerning which the client has employed the psychologist or psychological associate in a professional capacity. This section does not apply to cases “where an immediate threat of serious physical harm to an identifiable victim is communicated to a psychologist or psychological associate by a client.”

Alaska Stat. § 08.95.900 (1999)

- (applies to: licensed social workers and their employees)
- A licensed social worker and their employees may not reveal any communication revealed by their client when the client has employed the social worker in a professional capacity. Exceptions allow the social worker to communicate confidential information “to a potential victim or law enforcement concerning a threat of imminent serious physical harm to an identified victim made by the client.”

Alaska Stat. § 08.63.200

- (applies to: marital and family therapists)
- A licensed marital or family therapist may not reveal any communication revealed by their client when the client has employed the marital and family therapist in a professional capacity. Exceptions allow the therapist to communicate confidential information “to a potential victim or to law enforcement officers where a threat of imminent serious physical harm to an identified victim has been made by a client.”

Alaska Stat. § 47.30.845 (2001)

- (applies to: welfare, social services, and related institutions)
- Information and records obtained in the course of a screening investigation, evaluation, examination or treatment by welfare, social services and related institutions are confidential except to be disclosed “to a law enforcement agency when there is substantiated concern over imminent danger to the community by a presumed mentally ill person.”

Arizona

Summary

- Arizona has a common law duty to warn “third persons whose circumstances place them within the reasonably foreseeable area of danger where the violent conduct of the patient is a threat”, as established by the Arizona Supreme Court in Hamman v. County of Maricopa (relying on Tarasoff).
- Although the Arizona legislature enacted Ariz. Rev. Stat. Ann §36.517.02, in response to Hamman, in attempt to circumscribe the duty, to one involving “tak[ing] reasonable steps if a
patient communicates a threat against a third party” the Supreme Court found that the statute was unconstitutional in *Little v. All Phoenix South Community Mental Health Center Inc*, and reaffirmed the broader common law duty established by *Hamman*.

- *Hamman* appears to apply to physician-patient relationships in the outpatient context; the inpatient context offers a great degree of control that allows the physician to protect the patient from the patient’s dangerous propensities through the exercise of control, per *Tamsen v. Weber*

Relevant legislation


- Sub-section A. provides a mental health provider immunity from legal liability unless
  - [1] the patient has communication to the MHP “an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim or victims, and the patient has the apparent intent and ability to carry out such threat” and
  - [2] the MHP fails to take reasonable precautions
- Sub-section B. provides that “reasonable precautions” to prevent harm is discharged by a MHP if all of the following is done:
  - [1] communicate when possible the threat to all identifiable victims
  - [2] notify law enforcement in the vicinity where patient or any potential victims reside
  - [3] taking reasonable steps to initiate proceedings for voluntary or involuntary hospitalization, if appropriate
  - [4] any other precautions a reasonable and prudent MHP would take under the circumstances
- Sub-section C. provides immunity for disclosure of confidential information for the purpose of reducing the risk of harm when a patient has explicitly threatened to cause serious harm to a person

*Ariz. Rev. Stat. Ann §36-509 - Confidential of health care records unless disclosed to avert serious and imminent threat*

- Sub-section A requires health care entities to keep record confidential unless they are being disclosed to:
  - [6] governmental or law enforcement agencies if necessary to [c] avert a serious and imminent threat to an individual or the public
  - [7] persons, including family members, other relatives, closer personal friends or any other person identified by the patient, as otherwise authorized or required by state or federal law, or pursuant to ... [c] the health care entity believes the patient presents a serious and imminent threat to the health or safety of the patient or others, and the health care entity believes that family members, friends or others involved in the patient’s care, treatment or supervision can help to prevent the threat

- Sub-section A. established psychologist-client privilege but it “does not extend to cases in which the psychologist has a duty to report information as required by law”.


- Sub-section A. establishes behavioral health professional-client privilege but sub-section C. excludes it in “cases in which the [professional] has a duty to ... 1. Inform victims and appropriate authorities that a client’s condition indicates a clear and imminent danger to the client or others”


- Sub-section A. establishes psychologist-client privilege but clarifies that it does not extend to cases “in which the psychologist has a duty to report information as required by law”

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**Regulations and administrative guidance**


clarifies that notwithstanding Ariz. Rev. Stat. Ann §36-509, the provisions contained in Ariz. Rev. Stat. Ann. §36.517.02 permit health care entities to take certain steps to protect a victim, including (1) notifying a clearly identified or identifiable victim of explicit threats of imminent serious physical harm or death made by a patient (2) notifying law enforcement where patient resides (3) take other precautions under the circumstances, including providing such confidentiality information to the victim or law enforcement as may be reasonable and prudent

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**Cases**


- [early adoption of common law duty to warn, emphasis on ability to control patient in addition to the presence of a special relationship, although relationship ceased long before accident – not mental health case]
  - **Facts:** physician sued by victim of MVA because accident caused by patient who suffered seizure (epilepsy); issue on appeal was whether cause of action could be maintained against the physician, who had advised the driver to discontinue use of anti-convulsive drug 17 years prior to accident.
  - **Discussion:** Acknowledges generally no duty to control conduct of third person to prevent him from causing harm to another absent special relationship, relying on Restatement §315, and noting that relationships that give rise to a duty to control a third party’s conduct at set forth in §§316-319; identifies doctor-patient relationship as falling within §319, which provides that the doctor “took charge” of the patient. Id. 953
  - Appellant relies on Tarasoff. Id. 953. As well, decisions in which courts have imposed duties on doctors and medical or penal institutions who have physical custody or
dangerous individuals to protect third parties by taking reasonable measures to control their charges’ conduct. Id. 953

- “Some jurisdictions have limited the scope of the duty to warn to situations in which there is a specifically identifiable potential victim rather than the public at large”. Id. 953

- Re: duty to control patient conduct, some courts emphasized that absent a legal right or ability to control a patient, the fact of the presence of a “special relationship” will not by itself create a duty to protect third parties. Id. 953

- **Holding:** Any direct authority which Dr. M may arguably have had to control driver’s behavior ended in 1964 when Smith ceased to be his patient. Id. 954. However, “any injuries caused [to] third parties by such negligence within a reasonable period of time after the negligent act could give rise to liability”. Id. 954. “While it might be reasonable to find that Dr. M was able to control or at least affect [driver]’s behavior while he was his physician, his ability to do so after he ceased treating him diminished. Id. 954-955.

**Hamman v. County of Maricopa, 775 P.2d 1122 (Ariz. 1989)**

- **[common law duty to warn extends to third parties who are “within the zone of risk”, not necessarily the subject of a specific threat – outpatient case]** - Arizona Supreme Court held that therapists, in addition to their duty to protect their patients’ confidences, have an obligation to warn third persons whom their patients have threatened to harm

  - **Facts:** Son attacks father after being assessed by psychiatrist who had previously admitted the son to a psychiatric center. Psychiatrist provided parents medication to give to son, but did not warn them of his potential dangerousness (dispute). Psychiatrist sought summary judgment against various negligence claims on the basis that son never communicated any specific threat against his parents. Motion granted.

  - **Discussion:** Reviews Tarasoff in details, then discusses how Thompson, infra, distinguished from Tarasoff, and limited the duty to identifiable victims of a specific threat. Then discusses Petersen as being on the other side of the spectrum, in recognizing that a specific threat is not a prerequisite for liability but rather, applying a “foreseeably endangered” approach.

  - **Holding:** the duty extends to “third persons whose circumstances place them within the reasonably foreseeable area of danger where the violent conduct of the patient is a threat” (Id. 1129)

  - The “Brady Approach” is too narrow; Tarasoff envisioned a broader scope of a psychiatrist’s duty; follows the middle-of-the-road approach adopted in Jablonski by Pahl v. United States, 712 F.2d 391 (9th. Cir. 1983), in which the appellate court held that although no specific threats were made, the patient’s record of violence indicated that the victim (his girlfriend) was a more “sufficiently targeted” victim than were random members of the community Id. 398.

  - Psychiatrist in this case aware the schizophrenic-psychotic patients such as the son are prone to unexpected episodes of violence; that he was living with his
parents; and that they were the likely affected victims (“their constant physical proximity to Carter placed them in an obvious zone of danger. The [parents] were readily identifiable persons who might suffer harm if the psychiatrist was negligent in the diagnosis or treatment of the patient”)


- [applies a “duty to control”, rather than a duty to warn; distinguishes from Hamman, an outpatient case, and applies Restatement (Second) of Torts §319]

  - **Facts**: inpatient, involuntarily committed as a danger to himself, escapes from hospital, abducts a woman, beats her and leaves her for dead; woman sues doctor who granted the patient grounds privileges which led to him being unsupervised, allowing him to escape. Doctor argued that he had no duty of care because the patient made no specific threats towards the woman (she was a stranger) and therefore she was not a foreseeable, readily identifiable victim.

- **Discussion**:  
  - Discusses Restatement (Second) of Torts, particular §315 (special relationship exception to there being no duty to control the conduct of a third party), and §§316-319, as circumstances under which one is required to a control a third person’s conduct. (Id. 367)
  - *Hamman* does not control case because it did not involve a psychiatrist “in charge of” (language from §319) a committed patient.
  - “The scope of the duty imposed in such a case necessarily differs from that which applies to a psychiatrist whose patient has been involuntarily committed. An involuntarily committed patient is within the physician’s physical control. In contrast, a psychiatrist cannot monitor and control an outpatient’s interaction with the public. A psychiatrist’s duty to protect the public from an outpatient is therefore limited to identifiable potential victims whom he can warn” (Id. 368)

- **Holding**: “A psychiatrist can control the involuntarily committed patient, however, and can by the prudent exercise of such control protect the victim from the patient’s dangerous propensities. If [the doctor] knew or should have known of the [patient’s] dangerous propensities, then [he] had a duty to act with due care to protect others by controlling [the patient].” (Id. 368)


- [upholding *Hamman* and finding §36.517.02 unconstitutional – inpatient case (although not in hospital setting)]
  - **Facts**: wife sues hospital for injuries arising from when she stabbed by husband after he was not hospitalized despite expressions of suicidal and homicidal ideation
• **Discussion:** reviews *Hamman*, and how that case discussed the two major trends in the duty in other jurisdictions and how the court adopted the *Tarasoff* duty and specifically rejected as “too narrow” the Brady Approach (Id. 1372)
  - Three months after *Hamman* was decided, in direct response, the Arizona legislature enacted ARS §36.517.02, effective April 25, 1989 (Id. 1372)
  - The language of ARS §36.517.02 “removes any doubt that the statute was intended to be the exclusive means of establishing liability in this context” (Id. 1372) (refers also to the Minutes of the Senate hearing related to the proposed legislation)
• No threats by patient; therefore, no evidence to support a claim under §36.517.02 but there is evidence to support a *prima facie* claim of liability under *Hamman* – evidence indicated that defendants knew or should have known that patient posed a serious danger of violence to others, and that plaintiff was a foreseeable victim of patient’s violent tendencies and there was “within the zone of danger” (Id. 1374)
• Similar factual elements in this case to *Hamman* including, defendants’ failure to obtain and review prior medical records, awareness of “various incidents of stranger behavior [and] a few instances of violent conduct and refusal to admit the patient for hospitalization despite pleas to do so” (Id. 1374)
• §36.517.02 eliminates all claims which do not fit within the confines of the statute
• **Holding:**
  - §36.517.02 is unconstitutional – the state constitution protects the right to pursue common-law damage remedies – it does not simply regulate, but abrogates the general negligence cause of action recognized in *Hamman*. The statute effectively abolishes a cause of action for a foreseeable class of plaintiff i.e. those persons who are not clearly identified by a patient communicating an explicit threat of imminent series physical harm or death but who may nonetheless be a foreseeable victim subject to probably risk of the patient’s violent conduct (Id. 1376)


• [affirmed duty to warn in *Hamman*, but clarified that it was established as a matter of policy, not foreseeability, as foreseeability is no longer part of the legal analysis in negligence, following another case excluding foreseeability from the analysis - outpatient case]
• **Facts:** Patient shot and killed Graham and another person, both strangers to him. The Grahams sued the Regional Behavioral Health Authority (RHBA) contracted by the state who provided care to the patient for failing to have him involuntarily committed, and the state for vicarious liability.
• **Discussion:**
  - Considers the interplay between *Hamman* and *Gipson v. Kasey*, 214 Ariz. 141, 150 P.3d 228 (2007), in which the Arizona supreme court held that “foreseeability is not a factor
to be considered by courts when making determinations of duty” (Id. 231). Rather, foreseeability “is more properly applied to the factual determination of breach and causation than to the legal determinations of duty” (Id. 228)

- Refers to Hamman as consider between 3 choices in defining the scope of the duty
  - To the public at large
  - To those against whom specific threats are made
  - To foreseeable victims
- In choosing the latter, the Hamman court never said that the duty could never apply to strangers (i.e. “foreseeable victims who were previously unknown to the patient”)(Id. 3)
- Duty premised on policy, not foreseeability (Id. 3)
- Gipson did not undermine Hamman
- Held: “... while foreseeability remains an element of liability, it is not a consideration for the courts in its determination of the existence of the duty” (Id. 4)

Arkansas

Summary

- Statutory duty to warn that applies to mental health services providers, hospitals, facilities, community mental health centers, or clinics in cases where a “patient communicates an explicit and imminent threat to kill or seriously injure a clearly or reasonably identifiable potential victim or to commit a specific violent act or to destroy property under circumstances that could easily lead to serious personal injury or death and the patient has an apparent intent and ability to carry out the threat” (Ark. Stat. Ann. § 20-45-202 (a)).

- The established duty to warn entails either a notification of law enforcement in the county where patient or endangered person resides, a notification of the Department of Arkansas State Police, or an arrangement for the patients voluntary or involuntary hospitalization (Ark. Stat. Ann. § 20-45-202 (b)).

- If the health care provider disclosed confidential information in response to a patient’s credible threat of serious harm, the provider is exempted from liability for such disclosure (Ark. Stat. Ann. § 20-45-202 (d)).

- The decision in Fleming v. Vest implied the recognition of a cause of action based on state law against mental health providers for injury of third parties resulting from violent patient conduct
Relevant legislation


- Applies to mental health services providers, hospitals, facilities, community mental health centers, or clinics

- Subsection A. Exempts said providers and facilities from liability in cases when a patient communicates an explicit and imminent threat to kill or seriously injure a clearly or reasonably identifiable potential victim or to commit a specific violent act or to destroy property under circumstances that could easily lead to serious personal injury or death and the patient has an apparent intent and ability to carry out the threat if those providers and facilities have taken the precautions identified in Subsection B

- Subsection B. The duty owed by providers and facilities (MHP) is discharged, when
  [1] MHP notifies in a timely manner law enforcement in county where patient or endangered person resides,
  [2] MHP notifies Department of Arkansas State Police, or
  [3] MHP arranges for the patients voluntary or involuntary hospitalization.

- Subsection C. Requires notification of parent or parental guardian in cases where minor threatens harm or suicide against himself.

- Subsection D. Exempts MHP from liability for disclosure of confidential information if such disclosure was made where a patient has explicitly threatened to cause serious harm to an individual or property under circumstances that could easily lead to serious personal injury or death or if the provider has a reasonable belief that the patient poses a credible threat of serious harm to an individual or to property

- Subsection E. Requires a facility to evaluate a threat before discharging the patient, if a patient is already in the care of a mental health facility when such a threat is made. In such cases the facility may disclose the threat to the appropriate law enforcement agency and the potential victim.

Providers and facilities have a duty to warn and to take necessary precautions as outlined in the statute. If they take one of the prescribed precautions they are exempt from liability. Accordingly, the statute does not impose an explicit liability for failure to warn, but expands immunity from liability for those providers who take the prescribed precautions.

The statute does not create an express cause of action for failure to warn. However, by implication, a cause of action based on the failure of a mental health provider to warn of a credible threat is recognized.

- Applies to licensed counselors, including licensed associate counselors, licensed marriage and family therapist, and licensed associate marriage and family therapist
- Subsection A. places communications between mental health providers and their patients on the same basis as the attorney client privilege.
  - Attorney-client privilege in the state of Arkansas (Arkansas Rules of Professional Conduct Rule 1.6):
    - Subsection B (1). A lawyer might reveal confidential information to the extent the lawyer reasonably believes necessary to prevent the commission of a criminal act.
    - The commentary states that the overriding value of life and physical integrity permits disclosure reasonably necessary to prevent death or bodily harm. Other future harms as a result of a criminal act, such as fraud, damage to economic interests, or loss of property which are reasonably certain to occur, also permit disclosure if necessary to eliminate the threat.
- Subsection B. clarifies that nothing in the section construes a requirement to disclose any privileged communication


The privilege statute does not establish a duty to warn. Parallel to the attorney-client privilege disclosure is permitted where the counselor reasonably believes that injury or death of third parties are likely to occur.


- Applies to psychologists and psychological examiners
- Confidential relations and communications between respective mental health providers and clients are placed on same basis as attorney client privilege
- The statute prevents anything in this section to be construed as a requirement to disclose privileged information

Regulations and administrative guidance


[Regarding Extend of Privilege Statutes]
• **Facts:** Licensed mental health counselor employed by counseling center at state university was asked to provide school with list of student names, appointment times and whether students kept appointments.

• **Issue:** Recognizing that the university may have a valid interest in the utilization of counseling services provided by university staff, which takes precedence: the law establishing the confidentiality of the counseling relationship or the university policy?

• **Discussion:** university policy must yield to statute, but this depends on the facts involved and the ethical and professional guidelines
  o rules of professional conduct forbid attorneys from revealing “information relating to representation of a client” unless the client gives “informed consent” or the disclosure is “impliedly authorized” or otherwise falls within a specific exception under Rule 1.6(b).
  o According to statute this rule also applies to counselors
  o Opinion mentions exceptions for disclosure and implies the application to the mental health service provider context, thus implying possibly a permissive disclosure

**Cases**

*Fleming v. Vest, 475 S.W.3d 576 (Ark. App. 2015)*

• [Departure from privity doctrine, implying recognition of cause of action based on state law against mental health professionals for injuries sustained by third persons resulting from acts of violence committed by patients]

• Limits of Ruling: Court of Appeals decided on motion for summary judgement that revolved around statute of limitations, thus decision of issue is limited due to procedural and substantive context

• **Facts:** Deceased was killed by individual with bipolar disorder. Individual had previously been acquitted based on impaired mental state and had been in the care of Vest, a licensed psychiatrist. When Vest assumed responsibility of individual’s care, he began to withdraw level of pharmaceuticals administered to individual. Wife of deceased filed wrongful death action against patient’s treating psychiatrist and alleged that Dr. Vest was negligent in his treatment of Lands.

• **Discussion:** Core of appeal revolving around issue of statutory limitation is whether a treating physician might be liable to nonpatient for behavior of treated patient. And if so, does the Ark. Medical Malpractice Act or other tort law apply?
  o Court rejects argument that the Restatement of Torts §319 applies and favors application of the Medical Malpractice Act.
  o death of victim qualifies as a “medical injury” falls under the medical malpractice act. An “action for medical injury” is “any action against a medical care provider, whether based in tort, contract, or otherwise, to recover damages on account of medical injury.”
• The statute defines “medical injury” broadly. The court reads the term to include “any adverse consequences arising out of or sustained in the course of the professional services being rendered by a medical care provider to a patient or resident, whether resulting from negligence, error, or omission in the performance of such services” (Ark. Code Ann. § 16–114–201(3))

• Court of Appeals concludes that victim’s death occurred because of professional services rendered by patient’s psychiatrist and is thus a "medical injury" within the definition of the medical malpractice Act. Thus, a two-year statute of limitations must be applied.

California

Summary

• The duty to protect was born in California, under the common law, by the California Supreme Court in Tarasoff v. Regents of Univ. of California. Following its first 1974 ruling establishing a “duty to warn”, the Court in response to a motion for reconsideration, release its 1976 decision where it established that a therapist has a “duty to use reasonable care to protect the foreseeable victim from the threat of serious danger of violence of his patient”.

• The California Supreme Court subsequently narrowed the circumstances where the duty to protect arises, in Thompson v. County of Alemada, to where there was a predictable threat of harm to a named or readily identifiable victim, and not the general population.

• The duty to protect readily identifiable victims was later codified in the Cal. Civil Code § 43.92

• Under Cal. Civil Code § 43.92, sub-section (a) immunity for psychotherapists in failing to protect from a patient’s threatened violent behavior or failing to predict and protect from that violent behavior except no such immunity applies if the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims.

• The duty to protect is discharged, according to Cal. Civil Code § 43.92(b), by making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency.

• Cal. Civil Code § 43.92, applies only to psychotherapists as defined under Cal. Evid. Code § 1010, which covers a large range of mental health providers including psychiatrists, social workers, psychologists, and counselors in various settings

• California appeal courts have interpreted the duty under Cal. Civil Code § 43.92 narrowly, particularly:
  o There must be a concrete threat, per Calderone v. Glick
  o The patient’s conduct must amount to a serious threat of violence, not some trivial albeit inappropriate behavior, per Barry v. Turek
  o Though the threat may be communicated from someone other than the patient (i.e. a family member, as in Ewing v. Goldstein), the information must nevertheless have
actually been communicated to the therapist, per *Regents of the University of California v. Superior Court of Los Angeles County*

- Even if a threat of violence is communicated to a psychotherapist, the duty to warn arises only “if the information communicated to therapist leads the therapist to believe his or her patient poses a serious risk of grave bodily injury to another”, per *Ewing v. Goldstein*

Relevant legislation

*Cal. [Evid] Code § 1010 – Definition of “psychotherapist”*

- Provides the definition of the persons who qualify as a “psychotherapist” under *Cal. Civil Code § 43.92* or persons who the patient reasonably believes is a “psychotherapist”, including
  - a physician who practices, in whole or substantial part, psychiatry
  - a licensed psychologist
  - A licensed social worker
  - A school psychologist
  - a person licensed as a marriage and family therapist
  - a registered psychological assistant
  - a registered associate clinical social worker .... (among others, see entire list in folder)

*Cal. [Civil] Code § 43.92 – Duty to protect*

- Under sub-section (a), immunity for psychotherapists in failing to protect from a patient’s threatened violent behavior or failing to predict and protect from that violent behavior except no such immunity applies if the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims.

- Under sub-section (b), the duty established by sub-section (a) is discharged by making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency

Cases

*Tarasoff v. Regents of the University of California, 529 P.2d 553 (Cal. 1974) (en banc)*

- [Establishing the common law duty to warn “foreseeable victims”]

- **Facts:** a college student murdered a woman he had told his therapist he intended to do so. The student never identified the woman but the therapist could have learned her identity. The therapist reported the student to campus police and urged them to have him committed but they declined to do so after interviewing the student. No one warned the woman or her family.

*Tarasoff v. Regents of the University of California, 551 P.2d 334 (Cal. 1976) (Cal. 1976)*

- [Establishing the common law duty to protect foreseeable victims of the client. Id. at 340. The duty to protect requires whatever steps are reasonably necessary under the circumstances]

- **Discussion:**
• Basis for establishing the duty to protect rested on two factors: (1) the “special relationship” between the therapist and the patient and (2) foreseeability.

• The latter factor was deemed “the most important consideration in establishing the existence of the duty” (Id. 342).

• The former factor was based on the Restatement (Second) of Torts §315, which provides an exception to the general rule that no one owes a duty to protect a third party from harming another. (Id. 345)

• “Once a therapist does in fact determine or under applicable professional standards reasonably should have determined, that a patient poses a series danger of violence to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger (Id. 345)

  • **Holding:** “When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger.” Id.

  • The therapist can discharge this duty to protect by warning the intended victim or others likely to inform the victim of the threat, notifying the police, or taking “whatever other steps are reasonably necessary under the circumstances.” Id.

  • The policy behind this duty is the “public interest in safety from violent assault.” Id. at 346.

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**Thompson v. County of Alameda, 27 Cal.3d 741, 614 P.2d 728 (1980)**

• **[Limiting the scope of the duty to warn to situations involving specifically identifiable potential victims rather than the public at large]**

  o **Facts:** parents of young boy who was killed by a sexual offender within 24 hours of the man’s release from confinement. Man had said he would kill a child in the community at random but the county did not warn local police, the parents or the man’s mother (whose custody he was released into)

  o **Discussion:**

    ▪ Considered legislative policy and foreseeability. Police considerations included the risk to which each member of the public is necessarily exposed through parole and probation release. Statistics show that a significant number of released persons commit new violations, but the legislature nevertheless has made probation and parole an integral part of its rehabilitation effort (754). The court also believed imposition of a duty to warn in this context would be unwieldy and of little practical value. The requisite volume of generalized warnings probationary release offenders would dilute their effect, do little to increase safety measures, would stigmatize released offenders, and would be difficult to give (755-756).

    ▪ Further, warning the police without requiring the police to act on it would be ineffective. Police resources would be disproportionately diverted if action on
such warnings generally were required. Warnings to parents of neighborhood children was viewed as similarly impracticable. The court was concerned about the strain on resources and an inhibiting effect on rehabilitative efforts. Nor was the mother required to be warned she had no duty to act, when the identity of any potential victim was not known, and when the decision to release the offender to the mother’s custody was self-immunized (758-59)

- **Held:** California Supreme Court distinguished from *Tarasoff*, stating that it would not impose “blanket liability” (Id. 753), and that liability may be imposed only in those instances in which the released offender posed a predictable threat of harm to a named or readily identifiable victim. The man made a generalized threat to a segment of the population. Majority refused to impose a duty to protect such a large group. Id. 758.

*Barry v. Turek, 267 Cal.Rptr. 553 (App. 1 Dist. 1990)*

- [Considers a “reasonably identifiable victim” and “serious threat of physical violence”]
- **Facts:** patient sexually assaulted office worker in hospital. Prior to that, patient had acted inappropriately to various nurses, approaching them inappropriately or try to kiss and fondle them, but no verbal threats of violence were ever made to his treating therapist or his assistant and there is no evidence of the patient having any violent tendencies (553-554)

- **Discussion:**
  
  **Re: Reasonably identifiable victim**

  - Civil Code section 43.92 provides psychotherapists immunity from *Tarasoff* unless the plaintiff proves that the patient has communicated to his or her psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims (555)
  - Court satisfied that the appellant has established that she was part of a group of “reasonably identifiable victims” – based on the patient’s past pattern of conduct, any female working full-time on the seventh floor [of the hospital] was reasonably identifiable as a victim of the patient’s inappropriate sexual behavior. (555)
  - The plaintiff was within the group of women that the patient had daily access (555)
  - The patient’s persistence in pursuing the available women made it reasonable for one familiar with his actions to assume he might assault any accessible woman (555)

  **Re: patient presented serious threat of physical violence**

  - Prior to the assault, patient’s inappropriate conduct limited to incidence where he attempted to grab and kiss the nurses, and followed them in inappropriately close ways (555)
  - No physical violence was involved in these incidents and the nurses’ notes suggest they were not frightened by the patient’s conduct (555)

- **Held:** Exception under section 43.92 was not triggered for patient who committed serious sexual assault on female hospital employees because patient’s conduct prior to offense was limited to attempting to grab and kiss nurses, and did not constitute a “serious threat of physical violence”


- [Discusses the purpose of Cal. Civ. Code. §43.92 – to limit Tarasoff and another related case, Hedlund, and to strike the right balance between preserving patient confidentiality and protecting someone’s safety]
- [Information of a threat communicated by a family member constitutes “patient communication” under Cal. Civ. Code. §43.92]
- [Provides discussion of what rises to the level of “serious threat”]

**Facts:** patient depressed, related to former relationship and work issues. Expresses suicidal ideation. Therapist granted permission to speak to patient’s father, who later informs therapist that his son indicated a threat of harm to ex-girlfriend’s new boyfriend. Patient voluntarily hospitalized for suicidal ideation but released. Therapist attempts to persuade treating psychiatrist to keep him hospitalized to no avail. The day after his release, patient murders new boyfriend and kills himself (866-867)

**Discussion:**

*Historical context of enactment of 43.92*

- Section 43.92 enacted in response to Tarasoff and Hedlund v. Superior Court (1983), 34 Cal.3d 695, 194 Cal.Rptr. 805, 669 P.2d 41, in which the child of a woman shot by patient sued the therapist for failing to warn him of a known threat against his mother. The Supreme Court held that a therapist’s duty to warn potential victims of a patient’s threatened violence extends to “persons in close relationship to the object of a patient’s threat” (815)

- What would become Section 43.92 was intended to “limit the psychotherapists’ liability for failure to warn to those circumstances where the patient has communicated an ‘actual threat of violence against an identified victim’, and to ‘abolish the expansive rulings of Tarasoff and Hedlund’ ... that a therapist can be held liable for the mere failure to predict and warn of potential violence by his patient’, quoting the Assem. Com. On Judiciary, Analysis of Assem. Bill. No. 1133 (1985-1986 Reg. Sess), May 14, 1985)(816)

- Statute represents legislative effort to strike appropriate balance between the need to preserve patient confidentiality and recognition that under limited circumstances preserving confidences is less important than protecting safety of someone (816)

- Statute does not compel therapist to predict dangerousness of patient; rather, requires therapist to attempt to protect victim only after he or she determines that patient has made a credible threat of serious physical violence against a person (817)
RE: family member’s communication as protected under the patient-therapist privilege

- Communication from a patient’s family member to the patient’s therapist, made the purpose of advancing the patient’s therapy, is a patient communication within the meaning of Cal. Civ. Code §43.92. (817)

- The fact that the family member is not technically a patient is not crucial to the statute’s purpose (817)

- The construction “harmonizes” the competing principles discussed above and is consistent with the interpretation placed on the psychotherapist-patient evidentiary privilege (818) (noting that Tarasoff is itself rooted in the psychotherapist-patient privilege)

RE: The term “serious threat”

- Section 43.92 intended to eliminate immunity and to sanction an invasion into the psychotherapist-patient privilege only in the very narrow circumstance in which actual knowledge of potentially grave bodily injury is presented (821)

- The intent of the statute is clear – a therapist has a duty to warn if, and only if, the threat which the therapist has learned—whether from the patient or a family member—actually leads him or her to believe the patient poses a risk of grave bodily injury to another person – the duty arises in the face a threat to take a person’s life but also for acts short of murder, akin to mayhem or serious bodily injury (defined in the criminal code as disfiguring or disabling a person, breaking a bone, etc.) (821)

- Record contained sufficient facts from which jury could infer psychotherapist actually believed or predicted patient would fulfill his threat to kill victim

- **Held:** (1) communication from a patient’s family member to the patient’s therapist, made the purpose of advancing the patient’s therapy, is a patient communication within the meaning of Cal. Civ. Code §43.92. (2) A therapist’s duty to warn a victim arises if the information communicated leads the therapist to believe or predict that the patient poses a serious risk of grave bodily injury to another (811)

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*Calderon v. Glick, 131 Cal. App. 4th 224, 31 Cal. Rptr. 3d 707 (2d Dist. 2005)*

- **[Patient must communicate an actual threat]**

- **Facts:** patient denies any intention to harm former girlfriend or her family members when asked by psychotherapist only to later go on a shooting spree killing her and three members of her family, and wounding two more.

- **Discussion:**
  - a psychotherapist may be held liable for failure to warn [only] where the patient has communicated an ‘actual threat of violence against an identified victim’ (231)
plaintiff required to produce evidence that would “allow a reasonable trier of fact to find that [patient] had ‘communicated] to the [therapist] a “serious threat of physical violence against the victim” (232)

- **Held:** no statutory duty to warn individuals absent concrete threat expressly communicated by patient to therapist

Regents of the University of California v. Superior Court of Los Angeles County, 193 Cal. Rptr. 3d 447, 322 Ed. Law Rep. 995 (Cal. App. 2d Dist. 2015), review granted and opinion superseded by 364 P.3d 174

- **[Threat must be communicated to therapist; cannot infer the presence of a threat]**

- **Facts:** student with history of schizophrenic delusions and symptoms attacks another student in a chem lab with a kitchen nap, claiming he was provoked although the plaintiff stated she had been in the lab for hours and did not have any interaction with the student (454)

- Among the allegations is against the UCLA psychologist who treated the student, for failing to warn under Civil Code section 43.92

- **Discussion:**
  - Plaintiff provided no evidence that would allow a reasonable trier of fact to find that the student had communicated a serious threat of physical violence against her to the psychotherapist (468)
  - Record consistently indicates that the student told the therapist that he did not intend to harm anyone and never made any reference to the plaintiff (468)
  - Rejects the argument by plaintiff that total of information communicated by patient to UCLA staff amounts to an actual threat since it was never communicated to the therapist.

- **Held:** Relying on Ewing, the Court acknowledges the duties under section 43.92 may be triggered by information provided persons other than the patient, the information must nevertheless have been actually communicated to the therapist (468)

**Colorado**

**Summary**

- “Mental health providers” (“physician, social worker, psychiatric nurse, psychologist, or other mental health professional, or a mental health hospital, community mental health center or clinic, institution, or their staff”) have statutory immunity from civil liability for failing to warn or protect specific people against the violent behavior of a patient UNLESS “the patient has communicated to the mental health provider a serious threat of imminent physical violence against a specific person or persons.” Colo. Rev. Stat. Ann. § 13-21-117. The source of the imminent threat is not dispositive; what matters is that the provider is put on notice. *Halverson.*
• If the duty is activated, the provider must make reasonable and timely efforts to notify the specific person and law enforcement, and has discretion to involuntarily commit the patient. § 13-21-117.

• They cannot be held liable for satisfying their duty or subject to professional discipline for breaking privilege. Id. In fact, statements that trigger the duty to warn are by definition not privileged communications, and therefore providers can testify about statements. Kailey.

• The statutory immunity from civil liability for disclosing confidential information protects providers whether or not the patient is committed and whether or not the patient actually threatens anybody. McCarty.

• The statutory immunity from civil liability for failing to warn applies in the inpatient setting and protects providers even where they negligently answer a direct question. Marcellot.

**Relevant legislation**


  (1) As used in this section, unless the context otherwise requires:

  • “Mental health provider” means a physician, social worker, psychiatric nurse, psychologist, or other mental health professional, or a mental health hospital, community mental health center or clinic, institution, or their staff.

  ***

  (2)

  • A mental health provider is not liable for damages in any civil action for failure to warn or protect a specific person or persons, including those identifiable by their association with a specific location or entity, against the violent behavior of a person receiving treatment from the mental health provider, and any such mental health provider must not be held civilly liable for failure to predict such violent behavior except where the patient has communicated to the mental health provider a serious threat of imminent physical violence against a specific person or persons, including those identifiable by their association with a specific location or entity.

  • When there is a duty to warn and protect under the provisions of paragraph (a) of this subsection (2), the mental health provider shall make reasonable and timely efforts to notify the person or persons, or the person or persons responsible for a specific location or entity, that is specifically threatened, as well as to notify an appropriate law enforcement agency or to take other appropriate action, including but not limited to hospitalizing the patient. A mental health provider is not liable for damages in any civil action for warning a specific person or persons, or a person or persons responsible for a specific location or entity, against or predicting the violent behavior of a person receiving treatment from the mental health provider.
(c) A mental health provider must not be subject to professional discipline when there is a duty to warn and protect pursuant to this section.

(3) The provisions of this section do not apply to the negligent release of a patient from any mental health hospital or ward or to the negligent failure to initiate involuntary seventy-two-hour treatment and evaluation after a personal patient evaluation determining that the person appears to have a mental illness and, as a result of the mental illness, appears to be an imminent danger to others.

Cases


[Significance – Stands for the proposition that the source of the imminent threat is irrelevant—what matters is that the provider has been put on notice.]

Facts: Plaintiff, while an inpatient at defendant’s clinic, was sexually assaulted by another inpatient with a history of violent behavior. Plaintiff sued for negligence for, among other things, failing to protect her given that they were on notice of the attacker’s dangerous proclivities and his prior aggressive behavior toward plaintiff. Trial court ruled that the duty to warn or protect the plaintiff was only triggered if the plaintiff/victim (rather than the attacker) brought the attacker’s threats of physical violence to the clinic’s attention.


Holding: Trial court erred. § 13-21-117 applies whenever the threats have been communicated to the healthcare provider, no matter the source.

Discussion: Court engaged in a plain language statutory analysis


[Significance – Construes Colo. Rev. Stat. Ann. § 13-21-117 to protect providers who satisfy duty to warn, regardless of whether patient actually threatens anybody and regardless of whether patient was involuntarily committed.]

Facts: Patient called his psychologist at 1:30 a.m., described his strong negative feelings about his supervisors, and expressed concern that he might not be able to control his anger, and when discussing his supervisor, stated that he knew martial arts and, if provoked, could kill someone. Psychologist saw patient next day in hospital and determined he was potentially dangerous but released patient. Psychologist warned the patient’s supervisors and patient was fired. Patient sued for damages.


Holding: Psychologist had a duty to warn his patient’s supervisors because patient made serious threats of physical violence against them specifically. 1125.

Discussion:
Warning the supervisors discharges the psychologist’s duty, shielding him from civil liability, regardless of whether the patient actually threatened them. 1125 (“To hold that immunity is dependent on the outcome of such a factual dispute would thwart the purpose of the statute and would inhibit health care providers from providing warnings in a timely manner.”)

A decision by a psychologist to hospitalize a patient does not mean that psychologist has forfeited the immunity by also choosing to make a reasonable and timely effort to notify any person specifically threatened. 1125.

§ 13-21-117 trumps psychologist-patient privilege. 1126.


[Significance – Construes § 13-21-117 to apply beyond the outpatient setting, providing immunity to providers for failing to warn in the inpatient setting, even when they negligently answer a direct question about a patient’s dangerous proclivities.]

- Facts: Plaintiff, a psychiatric nursing educator, visited defendant’s facility with three of her students. Before entering the Psychiatric Intensive Care Unit of the hospital, she asked the nursing staff whether there were any patients who presented a special risk to her safety or that of her students. She received assurance that there were none. However, shortly after entering the unit, a patient assaulted her. Defendants knew that the patient presented a special risk.

- Holding: § 13-21-117’s immunity protects providers (1) even when they negligently answer a direct question about whether a patient is dangerous and (2) beyond the outpatient setting.

- Discussion:
  - § 13-21-117 applies even when providers negligently answer a direct question about a patient’s dangerous proclivities because statute “precludes liability not only for failure to warn, but also for failure to protect any person.” 1278.
  - § 13-21-117 is not confined to the physician-patient relationship; communications between providers are covered. 1278–79.
  - § 13-21-117 does not apply only to outpatients because the phrase “including, but not limited to, hospitalizing” makes clear that hospitalization was one, but not the only, possible responsive action, and thus, it follows that notifying the authorities or the person who had been threatened was an option for the hospitalized as well as the non-hospitalized patient. 1280.

People v. Kailey, 333 P.3d 89 (Colo. 2014) [Supreme Court of Colo.]

Facts: Defendant was convicted of two counts of aggravated incest. He met with DOC psychologist candidate for a private therapy session. He made statements about witnesses from his trial that the psychologist believed to constitute serious threats of violence. Psychologist reported statements in “incident report” to DOC. State filed additional charges of retaliation against a witness. Defendant moved to exclude psychologist’s statements as protected by psychologist-patient privilege.

Holding: Threats of imminent physical violence against a specific person are not confidential as a matter of law, and thus are not privileged.

Discussion:
- “[I]f a mental health treatment provider believes, using his or her professional judgment, that statements made by a patient during a therapy session threaten imminent physical violence against a specific person or persons—and accordingly trigger the provider’s “duty to warn”—the patient’s threatening statements are not protected by the psychologist-patient privilege.” 91.
- “[P]roviders have a duty to larger society to affirmatively violate patient confidentiality when an identified individual is at imminent risk of physical violence, and a breach of this duty to warn may lead to civil liability. . . .” 94.
- “[T]hreatening statements disclosed pursuant to that duty are not subject to the privilege because (1) such statements are not confidential as a matter of law, and (2) barring them would be inconsistent with legislative intent.” 94.

Fredericks v. Jonsson, 609 F.3d 1096 (10th Cir. 2010) [Federal, construing Colo. law]
- Significance – held that psychologist had no duty to warn neighbors of any potential danger posed by patient pursuant to Colo. Rev. Stat. Ann. § 13-21-117, even though patient had a history of stalking neighbors and told psychologist that he used to harbor violent fantasies involving them, because patient did not “communicate” any serious threat of physical violence because he never told psychologist that he presently intended to harm or threaten neighbors.

- Significance – Holds that psychiatrist had no duty to warn plaintiffs, who were all shot and seriously injured by psychiatrist’s former patient in patient’s assassination attempt on President Reagan, because it was not foreseeable that patient would attempt presidential assassination. Holds that touchstone for common law duty to warn (Restatement (2d) Torts § 315) is foreseeability.
Connecticut

Summary

- Per Conn. Gen. Stat. § 52-146c psychologists are permitted to disclose specific information without consent if they have a good faith belief that there is a risk of imminent injury to the patient or other individuals or their property.
- The scope of the duty to warn is permissive.
- Connecticut Supreme Court and lower courts have not explicitly recognized a Tarasoff duty to warn, but have implied that such a duty would be recognized pursuant to Restatement (Second) Torts § 315 should there be a special professional relationship allowing for a mechanism of control and a foreseeable, identifiable victim (either individually or as part of a class) (see Kaminski).

Relevant legislation

Conn. Gen. Stat. § 52-146c – Privileged Communications between psychologist and patient (Title 52 Civil Actions, Chapter 899 Evidence)

- Privileges all communications between a psychologist and patients. Communications shall not be disclosed without consent in any criminal or civil court actions or preliminary, legislative and administrative proceedings.
- Subsection C. Consent for disclosure shall not be required if
  - [3] the psychologist believes in good faith that there is risk of imminent personal injury to the person or to other individuals or risk of imminent injury to the property of other individuals; and if
  - [4] child abuse, abuse of an elderly individual or abuse of an individual who is disabled or incompetent is known or in good faith suspected.

Cases

Kaminski v. Town of Fairfield, 216 Conn. 29, 33–34, 578 A.2d 1048, 1051 (1990)

- [Absent a special relationship of custody or control, there is no duty to protect a third person from the conduct of another. Supreme Court implies that it would recognize a duty to warn on the part of a psychotherapist under the appropriate factual circumstances (existent professional relationship and readily identifiable victim)]

Facts: Schizophrenic was shot by police officer whom he had struck with an axe in an attempt to resist being removed from his parent’s home upon their request. Mother had previously contacted mental health clinic expressing concern that son might need to be rehospitalized. She informed them of son's aggressive and violent behavior. Officer escort accompanied nurse to
patient's home. Officer was attacked with an axe and shot patient. Parents brought action against police officer alleging damages for wrongful death.

- **Discussion:** Police Officer alleged that parents had failed to warn him of son's dangerous behavior and his possession of multiple axes. Defense relied on Tarasoff arguing that he was a foreseeable victim and that parents had a duty to warn him.
  - Court distinguished Tarasoff based on lacking professional relationship between parents and son – and their lack of control over him - and the fact that police officer was not a readily identifiable victim.
- **Holding:** Parents did not breach duty to warn about son’s dangerous propensities.

*Fraser v. United States, 236 Conn. 625, 674 A.2d 811 (2nd Cir. 1996)*

- [Relying on Kaminski. Following a certified question to the Conn. Supreme Court the 2nd Circuit Court of Appeals held that psychotherapist had no duty to control an outpatient not known to be dangerous from inflicting bodily harm on a victim who was neither identifiable nor within a foreseeable class of victims]
- **Facts:** Mental patient fatally stabbed his employer. Patient was first placed in psychiatric care under the US Marine Corps. Upon his release from service he received outpatient treatment at VMCA. In the years before the fatal incident patient received voluntary inpatient as well as outpatient care for schizophrenic episodes and delusions.
- **Discussion:** Issue of whether VMCA had a duty to control outpatient and warn his victim was certified to the Connecticut Supreme Court (236 Conn. 625, 674 A.2d 811 (1996))
  1. Does Connecticut recognize a general duty on the part of a psychotherapist to control a patient being treated on an outpatient basis in order to prevent harm to third persons?
     - Yes, depending on circumstances. Following Restatement (Second), Torts § 315 Connecticut precedents impose only a limited duty to take action to prevent injury of third person requiring special relationship of custody and control and existence of identifiable victim (either individually or as part of class)
  2. If so, do the allegations of the complaint in the pending case, as amplified by the submissions of the plaintiff in opposition to the defendant’s motion for summary judgment, present a triable jury issue?
     - No. Facts do not support existence of duty to control since VMCA neither knew nor had reason to know that patient would attack his employer because employer was not an identifiable victim, a member of a class of identifiable victims or within the zone of risk to an identifiable victim. Control mechanism between VMCA and voluntary patient was lacking.

- **Dissent** argues that the trier of fact should have decided whether victim was identifiable.
• **Holding:** VMCA did not have a duty to control owed to plaintiff's decedent (Fraser v. United States, 83 F.3d 591, 591–92 (2d Cir. 1996))


[Affirming elements of special relationship entailing mechanism of control and foreseeability]

• **Facts:** Plaintiff was sexually abused by defendant psychiatrist resident. During resident's education resident underwent required psychoanalysis sessions with instructor, in which resident disclosed that he was a pedophile. Instructor never disclosed this fact to the school. Plaintiff brought suit against resident instructor and school claiming duty to warn or control resident to prevent harm from children.

• **Discussion:** Court denies defendant's summary judgement as matter of law. The Court distinguishes the case from Fraser. 1. The relationship between resident and instructor included a control mechanism that does not exist in the usual analyst-voluntary patient relationship (instructor authorized to disclose information about resident which would have made him unsuitable candidate). 2. Jury could reasonably conclude that victim of abuse was within a foreseeable class of victims to whom instructor might owe a duty of care.

**Delaware**

**Summary**

• "Mental health services providers" have statutory immunity from legal liability for harm to third persons or property caused by a patient UNLESS the patient “has communicated to the mental health services provider an explicit and imminent threat to kill or seriously injure a clearly identified victim or victims, or to commit a specific violent act or to destroy property under circumstances which could easily lead to serious personal injury or death, and the patient has an apparent intent and ability to carry out the threat.” Del. Code Ann. 16 § 5402. Any duty owed is discharged if the provider, in a timely manner, notifies law enforcement and warns the potential victim, or arranges for the patient's commitment. *Id.*

• Mental health professionals have an affirmative common law duty to protect the public at large from their patients' harmful conduct. *Naidu v. Laird*, 539 A.2d 1064 (Del. 1988). This duty to protect can include warning potential victims, controlling the patient’s conduct (commitment), or referrals or treatment plans that provide oversight. *Id.*

**Relevant legislation**

*Del. Code Ann. 16 § 5402 (duty to protect)*

  o (a) Except as provided in subsection (d) of this section, no cause of action shall lie against a mental health services provider, nor shall legal liability be imposed, for inability to prevent harm to person or property caused by a patient unless:
▪ (1) The patient has communicated to the mental health services provider an explicit and imminent threat to kill or seriously injure a clearly identified victim or victims, or to commit a specific violent act or to destroy property under circumstances which could easily lead to serious personal injury or death, and the patient has an apparent intent and ability to carry out the threat; and

▪ (2) The mental health services provider fails to take the precautions specified in subsection (b) of this section in an attempt to prevent the threatened harm.

  o (b) Any duty owed by a mental health services provider to take reasonable precautions to prevent harm threatened by a patient is discharged, as a matter of law, if the mental health services provider, in a timely manner:

  ▪ (1) Notifies a law enforcement agency near where the potential victim resides, or notifies a law enforcement agency near where the patient resides, and communicates the threat of death or serious bodily injury to the clearly identified victim or victims; or

  ▪ (2) Arranges for the patient's immediate voluntary or involuntary hospitalization.

  o (c) Whenever a patient has explicitly threatened to cause serious harm to a person or property, or a mental health services provider otherwise concludes that the patient is likely to do so and the mental health services provider, for the purpose of reducing the risk of harm, discloses any confidential communication made by or relating to the patient, no cause of action, either criminal or civil, shall lie against the mental health services provider for making such disclosure.

  o (d) Whenever a patient within the custodial responsibility of a hospital or other facility has made or makes threats of the kind dealt with in subsection (a) of this section, the mental health services provider and institution, agency or hospital shall, prior to such patient’s discharge, consider and evaluate previously made threats made by such patient. Under such circumstances, the mental health services provider may consider it prudent to inform appropriate law enforcement agencies or the previously threatened party as a measure of precaution. Subsections (a) and (c) of this section shall also apply to the hospital or facility.

_Del. Code Ann. 16 § 5401. (definition of “mental health services provider”)_

Except where the context indicates otherwise, as used in this chapter:

***

4. “Mental health services provider” means any physician, registered professional nurse, licensed counselor working in the field of mental health, psychologists and licensed clinical social workers as defined in this chapter.
Cases


Significance – Prior to adoption of Del. Code Ann. § 5402 (above), Supreme Court of Delaware held that mental health professionals have an affirmative duty to protect the public at large from their patients’ harmful conduct, which can include warning victims, or controlling or monitoring their patients’ behavior, which trumps p-p privilege.

- **Facts:** A schizophrenic patient with an extensive history of voluntary and involuntary commitment, resistance to medication, and violent behavior, including multiple psychosis-induced automobile accidents, was released from a hospital by the defendant psychiatrist after surface level review of patient’s records. Five and a half months later, the patient crashed into plaintiff’s husband, killing him. Widow (plaintiff) brought wrongful death action against psychiatrist and the hospital.

- **Law:** Common law tort, Restatement § 315. 1072.

- **Judgment:** Psychiatrist was grossly negligent in releasing mental patient.

- **Held:** Established “duty of reasonable care for safety of third parties” – Mental health professionals have an affirmative common law duty to protect third parties from their patients’ harmful conduct. The duty to protect can include warning potential victims, controlling the patient’s conduct (commitment), or referrals or treatment plans that provide oversight.

- **Discussion:**
  - Psychiatrists can consider a patient’s past psychiatric history when assessing their level of “danger to themselves or others.” 1071.
  - “[B]ased on the special relationship that exists between a psychiatrist and a patient, a psychiatrist owes an affirmative duty to persons other than the patient to exercise reasonable care in the treatment and discharge of psychiatric patients. Reasonable care is that degree of care, skill, and diligence which a reasonably prudent psychiatrist engaged in a similar practice and in a similar community would ordinarily have exercised in like circumstances.” 1072.
  - The duty requires that mental health professionals initiate whatever precautions are reasonably necessary to protect potential victims, including warning potential victims or class of victims and/or to control actions of patient. 1073.
  - “This duty arises only when, in accordance with the standards of the profession, a psychiatrist knows or should know that his patient’s dangerous propensities present an unreasonable risk of harm to others.” 1073.
  - Whether time lapse since release (5.5 months) relieved defendant from liability was a question of fact for the jury.
Summary

- By statute, mental health professionals can disclose mental health information on an emergency basis to any of the ten individuals/entities listed below if he or she reasonably believes that such disclosure is necessary to protect “another individual” from “a substantial risk of imminent and serious physical injury.” D.C. Code § 7-1203.03.

Relevant legislation

D.C. Code § 7-1203.03 (2009)

(a) To the extent the disclosure of mental health information is not otherwise authorized by this chapter, mental health information may be disclosed, on an emergency basis, to one or more of the following if the mental health professional reasonably believes that such disclosure is necessary . . . to otherwise protect . . . another individual from a substantial risk of imminent and serious physical injury:

(1) The client's spouse, parent, or legal guardian;

(2) A duly accredited officer or agent of the District of Columbia in charge of public health;

(3) The Department of Mental Health;

(4) A provider as that term is defined in § 7-1131.02(27);

(5) The District of Columbia Pretrial Services Agency;

(6) The Court Services and Offender Supervision Agency;

(7) A court exercising jurisdiction over the client as a result of a pending criminal proceeding;

(8) Emergency medical personnel

(9) An officer authorized to make arrests in the District of Columbia; or

(10) An intended victim.

(a-1) Any disclosure of mental health information under this section shall be limited to the minimum necessary . . . to otherwise protect the client or another individual from a substantial risk of imminent and serious physical injury.
(b) Mental health information disclosed to the Metropolitan Police Department pursuant to this section shall be maintained separately and shall not be made a part of any permanent police record. Such mental health information shall not be further disclosed except as a court-related disclosure pursuant to subchapter IV of this chapter. If no judicial action relating to the disclosure under this section is pending at the expiration of the statute of limitations governing the nature of the judicial action, the mental health information shall be destroyed. If a judicial action relating to the disclosure under this section is pending at the expiration of the statute of limitations, the mental health information shall be destroyed at the termination of the judicial action.

Florida

Summary

• Several confidentiality statutes allow the disclosure of patient information where a patient has declared intention to harm other persons – release of information may be limited to person that patient intends to harm, to appropriate family members, to law enforcement or other authorities.

• Courts have repeatedly declined to extend these permissive disclosure statutes to create a mandatory duty to warn. (See eg. Boynton v. Burglass, Green v. Ross)
  o A duty to warn has been recognized only in very limited circumstances (See O’Keefe v. Orea, basing duty to warn on existing treatment relationship between provider and third party)
  o Courts are reluctant to apply Tarasoff doctrine arguing that psychiatrists lack sufficient control over voluntary outpatients necessary to trigger duty to warn. (See Boynton v. Burglass – rejecting Tarasoff in outpatient context)

Relevant legislation

Fla. Stat. § 394.4615 – Clinical Records, confidentiality (Title XXIX Public Health, Chapter 394 Mental Health)

• Applies to mental health professionals and administrators under the Mental Health Act.

• Confidential clinical patient records may not be disclosed without express and informed consent of the patient or his/her guardian.

• Subsection 3. Information from the clinical record may be released when
  o (a) a patient has declared an intention to harm other persons. When such declaration has been made, the administrator may authorize the release of sufficient information to provide adequate warning to the person threatened with harm by the patient. (Fla. Stat. Ann. § 394.4615 (West))
• Subsection 8. Any facility or private mental health practitioner who acts in good faith in releasing information pursuant to this section is not subject to civil or criminal liability for such release.

• Information from a clinical record may be released under the Mental Health Act when the patient has declared an intention to harm other persons. If such a declaration is made an administrator may authorize the release of sufficient information to provide adequate warning to the person threatened with harm by the patient. Any facility or private mental health practitioner who acts in good faith in releasing information under this section are not subject to criminal or civil liability.

Proposed Legislation 2017 Florida Senate Bill 1756 – Examination and Treatment of Individuals with Mental Illness (BILL DIED IN APPROPRIATIONS)

  o (3) Information from the clinical record may be released in the following circumstances:
    o (a) The individual has declared an intention to harm self or others. If the declaration has been made, the administrator may authorize the release of sufficient information to prevent harm.

Fla. Stat. Ann. § 456.059 (West) – Communications confidential, exceptions

• Applies to psychiatrists.

• A psychiatrist may disclose patient communications to the extent necessary to warn any potential victim or to communicate the threat to a law enforcement agency where:
  o [1] A patient is engaged in a treatment relationship with a psychiatrist;
  o [2] Such patient has made an actual threat to physically harm an identifiable victim or victims; and
  o [3] The treating psychiatrist makes a clinical judgment that the patient has the apparent capability to commit such an act and that it is more likely than not that in the near future the patient will carry out that threat,

• No civil or criminal action shall be instituted, and there shall be no liability on account of disclosure of otherwise confidential communications by a psychiatrist in disclosing a threat pursuant to this section.

Fla. Stat. Ann. § 491.0147 (West) – Confidentiality and Privileged Communications

• Applies to clinical social worker, family and marriage therapists, mental health counselors, and psychotherapists (Fla. Stat. Ann. § 491.003 (West)).

• Any communication between listed professionals and patient is confidential.
Subsection 3. Exception from confidentiality where there is a clear and immediate probability of physical harm to the patient or client (based on the judgement of the licensed professional), to other individuals, or to society.

- In such cases the licensed professional may only communicate the information to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.
- No liability or cause of action of any nature shall arise from the disclosure of such communications.

_ Fla. Stat. Ann. § 490.0147 (West) - Confidentiality and privileged communications_

- Applies to psychologists.
- Subsection 3. Privilege of confidential client-psychologist communications may be waived when there is a clear and immediate probability of physical harm to the patient or client, to other individuals or to society.
  - Psychologist may disclose information only to the potential victim, appropriate family member, or law enforcement or other appropriate authorities.

Cases


- [Psychiatrist had no duty to warn potential victim of danger posed by voluntary outpatient under Fla. Stat. Ann. § 456.059, statute merely permitted psychiatrist to make disclosure, but did not require it]
- Facts: Blaylock shot and killed Boynton. Blaylock was voluntary outpatient of psychiatrist Burglass. Parents of victim brought action against psychiatrist for failure to hospitalize voluntary outpatient who murdered their son and for failure to warn son, parents, or police that patient was violence-prone, and had threatened harm to son, and failure to prescribe proper medications for patient.
- Discussion: Court of Appeals declines to recognize Tarasoff duty and affirms the order of the trial court dismissing plaintiffs' complaint with prejudice for failure to state a cause of action based on the following reasons:
  - Psychiatry is an inexact science and Courts should be reluctant to impose liability (distinction from physician’s diagnosis of communicable disease where an accurate and reliable diagnosis is possible).
  - Per common law a special duty to control can be recognized where a special relationship exists. This relationship is based on the recognition that the person on whom the duty is to be imposed has the ability or the right to control the conduct of another. Following Hasenei (D. Md. 1982) the Court concludes that the relationship between a psychiatrist
and a voluntary outpatient is lacking sufficient elements of control. To impose a duty would require psychiatrist to foresee harm which may not be foreseeable.

- Imposing duty would have significant effects on patient-psychiatrist relationship as confidentiality is the cornerstone of such a relationship.
- Confidentiality statutes in Florida do not require a psychiatrist to warn, but are couched in permissive terms.

- **Holding:** Psychiatrist had no duty to control voluntary outpatient or to warn victim who patient killed or others about patient's behavior, and therefore psychiatrist was not liable for malpractice to victim's parents. Psychiatrist did not have statutory duty to warn victim that patient posed threat to him.


- Court parallels statute at issue here with F.S.A. § 456.059 and concludes that legislative waiver of confidentiality and permissive language does not equate to the legislative creation of a cause of action not previously recognized in Florida
- Court is reluctant to establish duty to warn per decision making authority, but reverts possibility of creation of cause of action for failure to warn to legislature


- [Court extended the reasoning in Boynton and Green to conclude that a case manager at a community mental health facility who has provided non-custodial mental health care for a client has no duty to warn the nursing staff at a psychiatric hospital that the client may be dangerous when the client is admitted to the hospital]
- Court concludes that outcome seems more obvious when the alleged tortfeasor is merely a case manager and not a licensed psychiatrist and when the entity to be warned is not an ordinary citizen, but a psychiatric hospital accepting a patient under the Baker Act


- [recognizing a cause of action for failure to warn where psychiatrist was treating a minor patient, and was treating patient's parents at the same time]
- **Facts:** Minor psychiatric patient attacked and killed his father four days after patient's release from emergency hospitalization. Psychiatrists who treated minor patient also treated his mother and father in connection with their inability to cope with patient's deteriorating condition. Minor had physically attacked three people; was then admitted to hospital. Psychiatrist determined minor was stable enough to be released. Upon release mother informed psychiatrist
that minor could not be cared for in their home since he was acting out of control. Psychiatrist prescribed different dosage of medication. Four days later minor attacked and killed father

- **Discussion**: Court concludes that psychiatrists had a duty to warn mother and father regarding son's deteriorating condition based on a cause of action for medical negligence pursuant to section F.S.A. 766.102(1). Court does not reach the Boynton/Tarasoff “duty to warn” analysis.
  
  o Per general rule a physician owes a duty only to persons within the patient/physician relationship, with the single exception being the contagious disease cases with readily identifiable third parties
  
  o Here, duty to warn is derived from psychiatrist's relationship with the parents of his minor patient (and the parent's right to be fully informed of child's condition and prognosis) and the physician-patient relationship between psychiatrist and mother directly.

**Georgia**

**Summary**

- Providers who act in good faith in compliance with the law are immune from civil and criminal liability for discharge decisions, so long as those decisions meet the applicable standard of care. *Ga. Code Ann*. § 37-3-4.

- There is no “blanket” duty to warn the general public about patients who make generalized threats; only a duty to warn “foreseeable or readily identifiably targets.” *Jacobs v. Taylor*. However, there is an exception in that “[t]here is no duty to warn of the obvious, or of that which the plaintiff already knew or should have known.” *Jacobs v. Taylor*.

- An independent “duty to control” to protect third parties arises “where the course of treatment of a mental patient involves an exercise of ‘control’ over him by a physician who knows or should know that the patient is likely to cause bodily harm to others,” *Bradley Ctr., Inc. v. Wessner*, or where a special relationship exists between the psychiatrist and a third party. *Bruscato v. Gwinnett*.

**Relevant legislation**

*Ga. Code Ann*. § 37-3-4. **Liability for violations.**

Any hospital or any physician, psychologist, peace officer, attorney, or health official, or any hospital official, agent, or other person employed by a private hospital or at a facility operated by the state, by a political subdivision of the state, or by a hospital authority created pursuant to Article 4 of Chapter 7 of Title 31, who acts in good faith in compliance with the admission and discharge provisions of this chapter shall be immune from civil or criminal liability for his or her actions in connection with the admission of a patient to a facility or the discharge of a patient from a facility; provided, however, that nothing in this Code section shall be construed to relieve any hospital or any physician, psychologist, peace officer, attorney, or health official, or any hospital official, agent, or other person employed by a private hospital or at a facility operated
by the state, by a political subdivision of the state, or by a hospital authority created pursuant to Article 4 of Chapter 7 of Title 31, from liability for failing to meet the applicable standard of care in the provision of treatment to a patient.

Cases

*Bradley Ctr., Inc. v. Wessner, 296 S.E.2d 693 (Ga. 1982).*

[Significance – Supreme Court of Georgia case that imposed a “duty to control” dangerous patients on providers who exercise control over their patient and who know or should know that the patient is likely to cause bodily harm to others]

- **Facts:** Plaintiff’s father became a “voluntary” patient in defendant’s private mental health hospital after experiencing long-term marital problems with plaintiff’s mother because of her extramarital affair. While the program was technically “voluntary,” the hospital had the authority to detain him for 48 hours if he sought discharge against medical advice. It became clear during his time in the hospital that he would likely cause bodily harm to his wife and her paramour if he had the opportunity. He expressed multiple times that he felt angry and planned to be violent. In spite of this, he was issued an unrestricted weekend pass privilege. While exercising his pass, he murdered plaintiff’s mother and her paramour. Plaintiff filed wrongful death action against hospital on theory of act was foreseeable and that defendant’s negligence caused deaths.

- **Law:** Common law negligence: “One 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.” Restatement, Torts 2d, § 319.

- **Held:** “where the course of treatment of a mental patient involves an exercise of ‘control’ over him by a physician who knows or should know that the patient is likely to cause bodily harm to others, an independent duty arises from that relationship and falls upon the physician to exercise that control with such reasonable care as to prevent harm to others at the hands of the patient.” 721.

- **Judgment:** Defendant was liable because it had taken “charge” of the patient, who was under its “control,” including on the day of the murder when, as a patient, he was outside of the facility only because he had been granted an unrestricted pass. 722. And the defendant failed to adhere to applicable psychiatric standards in diagnosing and treating patient.

- **Discussion:**
  - Third parties need not be privy to the underlying physician-patient relationship to be entitled to sue for the negligent breach of the duty to control, 723: “[W]e find meritless appellant’s attack on the verdict insofar as that attack is premised upon the lack of physician-patient privity between itself and appellees’ deceased. “[T]he therapist owes a legal duty not only to his patient, but also to his patient's would-be victim and is subject in both respects to scrutiny by judge

- In response to public policy concerns: We do not find that, under such circumstances, the imposition of liability for damages proximately resulting from the breach of the duty to exercise “control” hampers any public policy of this state with regard to the “open door” treatment of those mental patients who, in the exercise of due care by the treating physician, should be afforded such treatment. 725.


[Significance – Finding that the Bradley Center holding did not apply where hospital/physician did not have “control” over patient]

- **Facts:** Child filed wrongful death action against a physician and two hospitals for their alleged negligence in failing to foresee and prevent fatal shooting of his mother by his father following the father’s attempted suicide and release from hospital.

- **Held:** No duty arose to prevent the patient from causing bodily harm to others because none of the defendants ever had “control” over the patient in sense that they could have claimed legal authority to confine or restrain him against his will, notwithstanding his presence in hospital for medical treatment following suicide attempt.

- **Discussion:**
  - **Dictum:** Even if the hospital did have authority to involuntary commit the patient, the defendant hospitals were not equipped to hold him and treat him (they were not “emergency receiving facilities”) and therefore could not have committed him. 157.


[Significance – There is no “blanket” duty to warn the general public about patients who make generalized threats; only a duty to warn “foreseeable or readily identifiably targets.” However, there is an exception in that “[t]here is no duty to warn of the obvious, or of that which the plaintiff already knew or should have known.”]

- **Facts:** Children of victims who had been killed by released mental patient brought action against psychiatrists who had treated or had administrative contact with patient while he was hospitalized.

- **Judgment:** Psychiatrists did not have duty to warn because identifiable victim was cognizant of risks and other victims were not identifiable or foreseeable.

- **Held:**
  - “There is no duty to warn of the obvious, or of that which the plaintiff already knew or should have known.” 568.
  - There is no “blanket” duty to warn the general public about patients who make generalized threats. 568.
Discussion:

- “No evidence is present in the record that the [unacquainted victims] were foreseeable or readily identifiable targets of Murray's threats.” 568.


**[Significance – There is no duty to protect without duty to control or a special relationship between psychiatrist and third party; there is no duty to warn when danger is obvious]**

- **Facts:** Mentally ill patient murdered his mother, who supervised him daily. Father brought wrongful death action against son’s treating psychiatrist, alleging that psychiatrist breached duties to protect wife from harm and to warn her of son’s dangerousness after he altered son's medication regimen.

- **Law:**
  - Restatement, Torts 2d, § 315(b):
    - “[A] doctor, like any actor, generally has no duty to exercise control over third persons to prevent them from harming others. A narrow exception exists to this rule in situations where a physician has control over a patient who is known to be violent and causes harm to others.”
    - “There is no duty to warn of the obvious, or of that which the plaintiff already knew or should have known.” Jacobs v. Taylor, 190 Ga.App. 520, 527(2), 379 S.E.2d 563 (1989).” 445.

- **Held:**
  - Psychiatrist had no duty to protect mother from harm because he did not have “control” over patient (as required under Bradley Center) and had no special relationship with mother, who was not patient.
  - Psychiatrist had no duty to warn mother of potential risks of son's dangerousness following the withdrawal of son's anti-psychotic medications because she was aware of his dangerous proclivities.

- **Discussion:**
  - No special relationship existed between mother and patient's psychiatrist so as to impose duty upon psychiatrist to protect mother from harm; it was undisputed that psychiatrist provided psychiatric services to patient only and that mother did not receive any medical evaluation, care, or treatment from psychiatrist, and mother's presence as a caretaker during patient's therapy sessions did not confer upon her a “patient like” status.
  - Psychiatrist had no duty to warn mother of potential patient's dangerousness following the withdrawal of patient's anti-psychotic medications; evidence established that mother already knew of patient's violent tendencies based upon past incidents occurring before and after the medications were withdrawn, and mother's knowledge of patient's behavioral tendencies was superior to that of psychiatrist, in that mother had supervised patient daily for

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three years prior to the incident and she had readily observed patient's behavioral tendencies both before and after the medications were withdrawn.

- “Extending a physician's duty of care to third parties beyond the provisions of the Bradley Center test mandating that the physician exercise control over the patient could discourage outpatient care to the detriment of the state's express policy of providing the “least restrictive alternative,” “least restrictive environment,” or “least restrictive appropriate care and treatment” to mental patients. See OCGA § 37-3-161.”

### Hawaii

**Summary**

- Haw. Rev. Stat. Ann. § 626-1, Rule 504.1 exempts communications between psychologist and client from privilege where client expresses an intent to commit a criminal or tortious act and where psychologist believes that such act is likely to result in death or substantial bodily harm.
- A mandatory duty to warn/to protect has not been recognized per Hawaii common law.
- The decision in *Lee v. Corregedore* implied which elements would be necessary to find a “special relationship” between client and mental health provider: ability to foresee risk and take precautions against that risk.

**Relevant legislation**


- Subsection B. A client has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications made for the purpose of diagnosis or treatment among the client, the client's psychologist, and persons who are participating in the diagnosis or treatment.
- Subsection D (6). No privilege exists for communications reflecting the client’s intent to commit a criminal to tortious act that the psychologist reasonably believes is likely to result in death or substantial bodily harm.

**Cases**

*Lee v. Corregedore, 83 Haw. 154, 156, 925 P.2d 324, 326 (1996)*

- [Defining elements of what would constitute “special relationship” that triggers a duty, refusing to extend Tarasoff doctrine to suicide of outpatient]
- Facts: Veteran committed suicide. Previous to suicide he had been in the psychiatric care of a psychiatrist and social worker at the Veterans Administration Clinic, and in the care of a
Veteran’s Services Counselor. Veteran had threatened to commit suicide twice before his death. Parents of the veteran alleged that counselor had a duty arising from his professional relationship with veteran to prevent him from causing and/or exposing himself to any serious injury and/or harm which was reasonably foreseeable.

- **Discussion:**
  - Relying on *Seibel v. City and County of Honolulu*, court concludes that in order to establish a “special relationship” necessary for imposing a duty to prevent veteran from harm an ability to foresee the risk and to take precautions against that risk.
  - Court declines to follow and extend Tarasoff by referencing *Bellah v. Greenson*, and its limitations of Tarasoff, holding that courts should not extend Tarasoff to require psychiatrists to disclose the confidences of their patients when the patients are contemplating suicide.

- **Holding:** The relationship between counselors and their noncustodial clients is not sufficient to impose a duty upon counselors to prevent their clients’ suicides.

**Idaho**

**Summary**

- Idaho has a statutory duty to warn where “a patient has communicated an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim or victims, and the patient has the apparent intent and ability to carry out such a threat” under I.C. §6-1902

- The legislature specifies what is required to discharge the duty to warn in I.C. §6-1903, specifically MHPs must:
  - make a reasonable effort to communicate, in timely manner, the threat to the victim;
  - notify the law enforcement agency closest to the patient’s or victim’s residence; and
  - supply a requesting law enforcement agency with any information concerning the threat.
  - If the victim is a minor, a parent, noncustodial parent, or legal guardian must be informed

- Further, I.C. §6-1904(1) provides MHPs immunity from various liability (i.e. civil, criminal, regulatory) if the MHP failed to predict or take precautions to provide protection from a patient’s violent behavior and there was no specific threat (i.e. the circumstances of the duty to warn identified in §6-1902 don’t apply)
  - However, I.C. §6-1904(1) does not guard against negligence in those circumstances

- Note, however, that I.C. §6-1904(3) clarifies that the section does not “modify” any duty to protect arising from a take charge relationship (i.e. if the patient is within the custodial control
presumably referring to the common law duty to protect those foreseeably endangered by someone subject to a take charge relationship, per *Sterling v. Bloom*

Relevant legislation

*Idaho Code § 6-1901 – definition of an MHP*
- Physician, professional counsellor, psychologist, social worker, licensed professional nurse

*Idaho Code § 6-1902 – limitation on an MHP’s duty to warn*
- The duty to warn arises when a patient has communicated an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim or victims, and the patient has the apparent intent and ability to carry out such a threat.

*Idaho Code § 6-1903 – discharge of the duty to warn*
- Mental health professionals must make a reasonable effort to communicate, in timely manner, the threat to the victim and notify the law enforcement agency closest to the patient’s or victim’s residence and supply a requesting law enforcement agency with any information concerning the threat. If the victim is a minor then in addition the mental health professional must make an effort to notify the parent, noncustodial parent, or legal guardian of the minor.

*Idaho Code § 6-1904 – immunity from liability*
- Sub-section (1) protects a MHP from liability for failing to “predict or take precautions to provide protection from a patient’s violent behavior” – apart from the duty to warn in I.C. §6-1902, unless the MHP was negligent according to the standard of care exercised by members of their profession
- Sub-section (2) provides immunity for disclosing confidential information in furtherance of the duty to warn
- Sub-section (3) notes that this section does not modify “any duty to take precautions to prevent harm by a patient that may arise if the patient is within the custodial responsibility of a hospital or other facility or is being discharged therefrom”

Cases

*Sterling v. Bloom, 111 Idaho 211, 723 P.2d 755 (1986)*
- [established the common law duty to protect those foreseeably endangered by those who are “in charge of persons who are dangerous or who have dangerous propensities”]
  - **Facts:** man with history of DUIs caused MVA while DUI, resulting in extensive injuries to plaintiff while the man was on probation, and under legal custody and control of the state parole board (213).
  - **Discussion:**
    - Discusses the “duty to control a dangerous charge ‘and to guard other persons against his dangerous propensities’, with reference to Dean Prosser and §319 of the Restatement (Second) of Torts (225)
- Emphasizes relationship between the third party and the defendant: “The key to this duty is not the supervising individual’s direct relationship with the endangered person or persons, but rather is the relationship to the supervised individual. The duty extends to the protection and safety of “others” foreseeable endangered.” (225)
  - **Held:** Duty on the part of parole officers to control a dangerous person and guard other persons against his dangerous propensities, per §319 exists in Idaho (226)

*Caldwell v. Idaho Youth Ranch, Inc. 132 Idaho 120, 968 P.2d 215 (1998)*

- [discusses the *Sterling* duty and the duty to warn and its limitations for mental health professionals imposed by statute]

- **Facts:** three months after being released from a youth corrections facility, a juvenile offender committed a brutal murder of another youth. The offender ordered to be admitted to the Youth Ranch facility following various crimes tried in Juvenile Court, and was placed on probation for two years. During his stay at the ranch, the offender underwent psychological assessment; he also to be physically restrained 20 times in his last four months at the facility due to altercations with other residents and staff (122).
  - The offender was released into his father’s custody early, by joint decision of the state department overseeing the juvenile court and the facility. (122)

- **Discussion:**
  - Discusses *Sterling* as recognizing that those in charge of dangerous persons or person who have dangerous propensities owe a duty to control to prevent the person from causing harm (123)
  - Notes that there are two components of the *Sterling* duty: (1) determine whether the supervising body actually has control of the individual in question and (2) if so, determine whether the harm caused by the individual was foreseeable (123-124)
  - Court finds that the facility owed no duty to the plaintiffs because it no longer had custody or control of the juvenile at the time of the murder (124)
  - In *obiter,* Court addresses issue of foreseeability and finds that there was none here that the juvenile would “committed cold blooded murdered under the influence of illegal substances some three months after being released from the [facility]” (125)
  - The Court rejects the plaintiffs’ allegation that the facility “breached its duty by failing to properly warn the [parole] Department about the juvenile’s behavioral problems. ...” (125)
  - [notes that the concept of foreseeability must be narrowly drawn, citing authority omitted] and that “human behavior is difficult to predict with certainty, leading to the necessity for claimants to demonstrate that the harmful behavior should have been highly predictable based upon demonstrated past conduct” (125)
Court goes on to state: “in fact, in Idaho the legislature does not place liability on mental health professionals for failing to predict human behavior unless explicit threats are made by a patient regarding a specific intended victim, referencing I.C. §6—1902 (“A mental health professional has a duty to warn a victim if a patient has communicated to the mental health professional an explicit threat of imminent serious physical harm or death to a clearly identified or identifiable victim or victims, and the patient has the apparent intent and ability to carry out such a threat.”) (125-126)

Relying on and affirming the policy statement in the Utah Supreme Court decision Rollings v. Petersen (See below), Court states that in order for the facility to be liable for the acts of the juvenile the “behavior must have been highly predictable. Proof that [the offender] had anger management problems is not sufficient evidence to predict that [he] would commit cold-blooded murder…” (126)

Court notes that, unlike the situation in Tarasoff v. Petersen, the juvenile never made any statements to anyone at the facility indicated that he had intentions or plans of committing murder (126)

- **Held:** summary judgment in favor of Idaho Youth Ranch affirmed; the facility did not owe a duty of care to the plaintiff as the minor was not in the custody or control of the Youth Ranch at the time he committed the violent acts upon the third-party.

**Illinois**

**Summary**

- Illinois has different statutory duty to warn standards for different professions.
- [1] per 740 Ill. Comp. Stat. Ann. 110/11 psychiatrists, physicians, psychologists, social workers, or nurses providing mental health or developmental disabilities services may disclose confidential patient communications in order to protect a specific individual where a patient has made a specific threat of violence -> disclosure is permitted, but not mandatory
- [2] per 405 Ill. Comp. Stat. Ann. 5/6-103 physicians, clinical psychologists, clinical social workers, nurses with MA in psychiatric nursing, licensed clinical professional counselors and licensed marriage and family therapists are subject to liability where a patient has communicated a serious threat of physical violence against a reasonable identifiable victim or victims.
  - Providers can discharge of the duty to warn and protect by making a reasonable effort to communicate the threat to the victim and to a law enforcement, or by obtaining hospitalization of the patient -> mandatory duty to warn
  - Class of protected parties under this statute is limited. It applies only if the patient threatens to harm another person who also has a physician-patient relationship with that same clinician or who is intimately related to the patient.
- Illinois Courts have not recognized the Tarasoff reasoning but have established a very limited duty to warn and protect per decision in Eckhardt v. Kirts where (1) the patient made a specific threat of violence; (2) the threat was directed at a specific and identified victim; and (3) there is
a physician-patient relationship or a “special relationship” between the patient and the victim (eg. between mother and fetus (see Renslow v. Mennonite Hosp.)).

Relevant legislation


- Applies to psychiatrists, physicians, psychologists, social workers, or nurses providing mental health or developmental disabilities services or any other person not prohibited by law from providing such services or from holding himself out as a therapist if the recipient reasonably believes that such person is permitted to do so. (see 740 Ill. Comp. Stat. Ann. 110/2)

- Subsection viii. Records and communications may be disclosed to the extent, in the therapist's sole discretion, disclosure is necessary to warn or protect a specific individual against whom a recipient has made a specific threat of violence where there exists a therapist-recipient relationship or a special recipient-individual relationship.

- An individual or institution making a good faith disclosure under this Section is immune from any civil, criminal or other liability


- Applies to physicians, clinical psychologists, clinical social workers, nurses with MA in psychiatric nursing, licensed clinical professional counselors and licensed marriage and family therapists

- Subsection B. As a general rule there shall be no liability upon a provider’s failure to warn of and protect from a recipient’s threatened or actual violent behavior.
  - BUT: Statute imposes liability where the recipient has communicated to the provider a serious threat of physical violence against a reasonably identifiable victim or victims; and where
  - The threatened person also has a physician-patient relationship with that same clinician or is intimately related to the patient.

- Subsection C. A provider can discharge of this duty to warn of and protect by making a reasonable effort to communicate the threat to the victim and to a law enforcement agency, or by a reasonable effort to obtain the hospitalization of the recipient

- Subsection A. If the provider is acting in good faith and without negligence in connection with the preparation of documents (eg. applications, petitions) for the apprehension, transportation, examination, treatment, habilitation, detention or discharge of an individual under the provisions of this Act, he incurs no civil or criminal liability.
Cases


- [requiring existence of direct physician-patient relationship between phys. and plaintiff or between patient and plaintiff for viability of med. malpractice action]

- **Facts:** Automobile passenger injured when driver lost control of vehicle and hit tree, apparently because of side effects of prescription drugs, brought action against drug manufacturers, physicians, and administering hospital, alleging negligence and products liability claim.

- **Court** holds that a plaintiff cannot maintain a medical malpractice action absent a direct physician-patient relationship between the doctor and plaintiff or a special relationship between the patient and the plaintiff.


- [implying three factor test for determining existence of duty to warn, providing basis for majority of subsequent “duty to warn” cases]

- **Facts:** Decedent’s wife shot husband with his police service revolver. Estate of husband filed malpractice action alleging that wife’s treating psychiatrist’s negligence was cause of wrongful death of husband. Defendant filed for SJ based on lack of duty owed to the plaintiff.

- **Discussion:** Plaintiff urges Court to apply *Tarasoff* analysis. Court declines application.
  - Negligence complaint must set out the existence of a duty of the defendant towards the plaintiff. The primary elements for determining the existence of a duty owed are:
    - the patient must make specific threat(s) of violence,
    - the threat(s) must be directed at a specific and identified victim,
    - a direct physician-patient relationship between the doctor and the plaintiff or a special relationship between the patient and the plaintiff.
  - Court also stated that the limits of this duty are consistent with public policy. In particular:
    - The policy against expanding the liability of health professionals to an indeterminate class of potential plaintiffs;
    - The acknowledgement that behavior is unpredictable and the field of psychotherapy too inexact to require therapist responsibility for all patient acts; and
    - The policy against placing a severe burden on those who provide mental health care thereby reducing opportunities for needed care.

- **Holding:** Wife made no specific threats of violence against husband. Risk was not reasonably foreseeable. Thus, no duty was owed to the husband. Grant of SJ is confirmed.
**Doe v. McKay, 183 Ill. 2d 272, 700 N.E.2d 1018 (Ill. Supr. Court 1998)**

- [Supreme Court confirms application of Eckhardt and Kirk]
- **Facts:** Father of adult psychological patient sued therapist, based on actions of therapist in allegedly making false suggestions to patient that adult had sexually assaulted her during her childhood.
- **Discussion:** Specifying existence of duty test in Eckhardt. Elements for finding of duty to warn are: (1) the foreseeability of the plaintiff’s injury, (2) the likelihood of the occurrence, (3) the magnitude of the burden of guarding against it, and (4) the consequences of placing that burden on the defendant.
  - Supreme Court does not find a duty here arguing that if therapists could be subject to suit by nonpatient party, they might alter their course of treatment to their patient’s detriment and might be forced to divide their loyalties between competing interests. Further imposing such a duty could be inconsistent with the duty of confidentiality. Allowing a nonpatient action against therapist would intrude on relationship between therapist and patient.
- **Holding:** Relying on Kirk, no duty is extended to the plaintiff for psychic injuries allegedly arising from the therapist’s treatment of plaintiff’s daughter.


- [rejecting Tarasoff reasoning and confirming application of Eckhardt v. Kirts and Doe v. McKay]
- **Facts:** Wife was murdered by husband, a mental health patient, who had thoughts on killing wife and had threatened to kill her. Estate of wife brought wrongful death action against mental health care providers, alleging that 10 health care providers (physicians, psychologist, social workers et. al.) breached duties to protect wife from patient’s violent acts.
- **Discussion:** Defendants file to dismiss motion relying on Doe v. McKay, arguing that no duty was owed by them because the duty of care of a health-care professional runs only to the patient and not to non-patient third parties. Plaintiffs contend that the defendants owed a duty to warn and to protect wife against potential violent acts of her husband pursuant to section 324A of the Restatement (Second) of Torts.
  - Supreme Court confirms rejection of Tarasoff rationale, and follows the reasoning in Eckhardt v. Kirts and Doe v. McKay.

**Sherer v. Sarma, 2014 Ill App (5th) 130207, 18 N.E.3d 181**

- [holding that no duty can be established where there were no specific threats against an individual, even where the threatened plaintiff individual is in a physician patient relationship with the defendant]
• **Facts:** Wife and husband were both patients of same licensed psychiatrist. Husband, diagnosed with schizophrenia, stopped taking medications. He reported to psychiatrist that he was feeling irritable and could not be around patients. Husband did not make any specific threats. Husband later stabbed wife. Mother brought wrongful death and survival action on behalf of daughter against psychiatrist.

• **Discussion:** Plaintiff challenges the application of *Eckhardt* Test since victim in *Eckhardt* was not a patient of defendant doctor. Here, wife was patient of psychiatrists as well as husband.
  
  o Court disagrees with plaintiff and confirms application of *Eckhardt* in this case as the Supreme Court has not explicitly rejected or adopted the *Eckhardt* Test in such circumstances. In addition, *Eckhardt* was decided in February 1989, and in 1990, the General Assembly amended the Mental Health and Developmental Disabilities Confidentiality Act (740 ILCS 110/1) to allow for the disclosure of privileged communications, arguing that while *Eckhardt*'s specific-threat elements might have been dicta when the case was decided, they are now recognized public policy.

• **Holding:** Applying the Eckhardt test the Court finds that there was no legal duty to protect or to warn since there was no evidence that husband had ever made specific threat of violence against wife in provider-patient communications.

**Other sources**

Secondary sources summarizing or criticizing the Illinois approach can be accessed through the state materials.

**Indiana**

**Summary**

• Mental health service providers are subject to liability for failure to predict or warn/take precautions to protect. Liability is limited to instances where a patient has communicated an actual threat of physical violence or other harm against a reasonably identifiable victim or victims (Ind. Code Ann. § 34-30-16-1).

• Provider can discharge of this duty by taking one of the steps outlined in Ind. Code Ann. § 34-30-16-2
  
  o In *Davis v. Edgewater* the court has declined to interpret the language of “reasonable effort” to extend beyond the legislative intentions and to include a duty to follow up with police departments after a reasonable attempt of notification has been made.

• Provider is not liable for disclosing confidential patient information when attempting to comply with duty to warn/protect as established in statute.
Relevant legislation

**Ind. Code Ann. § 34-30-16-1 (West) – Predicting or Warning of Violent Behavior**
- Applies to mental health service providers
- Generally, a mental health services provider is immune from civil liability to third persons from failing to predict or warn/take precautions to protect from a patient’s violent behavior.
- Liability is only incurred if the patient has communicated “an actual threat of physical violence or other means of harm against a reasonably identifiable victim or victims, or evidences conduct or makes statements indicating an imminent danger that the patient will use physical violence or use other means to cause serious personal injury or death to others.”

**Ind. Code Ann. § 34-30-16-2 (West) – Duty to Warn or to Take Reasonable Precautions, Discharge**
- Duty arising under Section 1 is discharged when a provider takes one or more of the following actions:
  - (1) Makes reasonable attempts to communicate the threat to the victim or victims;
  - (2) Makes reasonable efforts to notify a police department or other law enforcement agency having jurisdiction in the patient's or victim's place of residence;
  - (3) Seeks civil commitment of the patient under IC 12-26;
  - (4) Takes steps reasonably available to the provider to prevent the patient from using physical violence or other means of harm to others until the appropriate law enforcement agency can be summoned and takes custody of the patient;
  - (5) Reports the threat of physical violence or other means of harm, within a reasonable period of time after receiving knowledge of the threat, to a physician or psychologist who is designated by the employer of a mental health service provider as an individual who has the responsibility to warn under this chapter.

**Ind. Code Ann. § 34-30-16-3 (West) – Disclosure of Information**
- If a provider discloses information in order to comply with Sections 1 or 2 the provider is exempt from civil or criminal liability imposed by Indiana statutes that protect patient privacy and confidentiality.

Cases

- [interpreting “reasonable effort” in Ind. Code Ann. § 34-30-16-2, declining to extend statutory language beyond legislative intent]
- Facts: Gore was in care of community mental health center. In May 2005 center requested an emergency detention of Gore which was supported by a licensed physician due to Gore’s non-
compliance with his medication and his confrontational, aggressive, paranoid behavior. Request was granted and sent to police, but detention was never executed. Gore killed Davis a few days later.

- **Discussion:** Plaintiff claims that mental health center failed to exercise ordinary due diligence or care to follow up on the detention order or secure or ensure its enforcements.
  
  - *Ind. Code Ann. § 34-30-16-2* provides that mental health provider can discharge of his duty by making reasonable efforts to notify police department or other law enforcement agency. Here, mental health center faxed the emergency order to the police department and noted receipt of that order.
  
  - Court declines to extend statutory language of “reasonable effort” to include following up on police action and to create extended duty on part of provider.
  
  - In addition, mental health center obtained civil commitment order, thus Edgewater had immunity from liability by fulfilling its obligations pursuant to *Ind. Code Ann. § 34-30-16-2*.

- **Holding:** Mental Health center was discharged from its duty pursuant to *Ind. Code Ann. § 34-30-16-2*.

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- [first impression interpretation of Ind. Code Ann. § 34-30-16-1, stating that when third parties were present when mental patient made violent threats towards them provider should be discharged of their duty]

- **Facts:** Patient brought to emergency department for psychosis and paranoid schizophrenia as well as suicidal ideations. His mother expressed that patient had threatened killing the family; she then signed application for emergency detention. A week later clinical therapist filed for involuntary commitment, stating that patient presented substantial risk of harm for himself and others. Prior to commitment hearing, mother decided to cancel commitment proceedings and to take patient home. Half a year later patient shot his sister, brother, mother and nephew.

- **Discussion:** Duty to warn under Ind. Code Ann. § 34-30-16-1 was triggered since patient communicated specific threats of actual violence against identifiable victims. Provider discharged of the duty since patient’s family members were present when patient communicated threats against them to care provider. Provider was aware that they had actual knowledge and did not need to add an explicit warning to that effect to satisfy the requirements of section 34–30–16–2(1)
Iowa

Summary

- According to the 2017 recent Supreme Court decision, Estate of Gottschalk v. Pomeroy
  Development, there is no common law duty to warn owed by mental health professionals to
  third parties, as first stated in Leonard v. State

- The Supreme Court has taken pains to emphasize that it is not considering the issue of the duty
  to warn and/or duty to protect – which it appears to distinguish as two separate duties (see
  Gottschalk) outside of the particular facts of a case.

- For instance, in Anthony v. State, the Court denied a duty to the general public and seemed to
  adopt the “Thompson standard” referring to the California case that narrowed Tarasoff to
  identifiable victims, Thompson v. Alameda County, which depends upon and arises from the
  existence of a prior threat to a specific identifiable victim. But it adopted that Thompson
  Standard only insofar as it clarified that no duty to warn arose in the instant case under it.

- The legislature does not appear to have taken up the issue.

Other notes

- In Gottschalk, the Supreme Court affirmed its earlier decision to apply the Restatement (Third)
  of Torts: Liability for Physical and Emotional Harm §41, which the Volk Supreme Court applied
  controversially. Section 41, at 64-65, provides in relevant part:
  
  o (a) An actor in a special relationship with another owes a duty of reasonable care to
    third parties with regard to risks posed by the other that arise within the scope of the
    relationship.
  
  o (b) special relationship giving rise to the duty provided in subsection (a) include: (4) a
    mental health professional with patients (587)

- However, in that case, no such special relationship was found to exist and therefore the
  application of the provision wasn’t actually considered.

Cases

Votteler’s Estate, Matter of, 327 N.W.2d 759 (Iowa 1982)

- [declines to recognize a general duty to warn]

- Facts:
  
  o psychiatric patient ran over plaintiff with her car while she was in treatment. Plaintiff
    alleged that psychiatrist was negligent in failing to interview the patient’s husband to
    determine her violent propensities and in failing to warn the patient’s husband so that
    he could have protect the patient (760).

  o Patient suffered from serious mental illness, which manifested by agitated, compulsive
    and aggressive behavior over two years. Plaintiff occasionally threatened violence
    against her husband, attempted suicide, and assaulted him (761).
○ Patient threatened to kill patient and husband more than once (761)
○ Last threat was made the night before the assault with the car. Prior to that even, she previously tried to run her husband over once and tried to run over both the plaintiff and the husband on two occasions (761)
○ Plaintiff stated that her knowledge of the patient’s violent nature or threats did not alarm her and only a warning from a professional would have done so (761)

• Discussion:
  ○ Reviews Tarasoff (760)
  ○ Declines to apply Tarasoff in the above circumstances, namely the facts that (1) a warning from the psychiatrist to the husband, who would have warned the victim, would have “done no good” and that (2) the patient’s husband never told the psychiatrist about her violent tendencies because he was not specifically asked. The plaintiff also acknowledges she knew of the patient’s threats and much about her aggressive behavior, including the two prior attempts to run and her and the husband down (761)
  ○ The present record lacks any basis for finding the therapist knew of the danger or should have known, and further, evidence sufficient force to charge victim with the knowledge of the danger as a matter of law (762)
  ○ Notes that California limited the Tarasoff duty to warn to “known and specifically foreseeable and identifiable victims” and that there is no occasion to determine whether the limitation would apply here but simply demonstrates that the Tarasoff duty is not “open-ended. It also supposes a conclusion that the duty should not be imposed when the foreseeable victim knows of the danger”

• Held: No duty to warn owed here because (1) the plaintiff was aware of the potential violence posed by the patient and (2) there was no known and specifically foreseeable and identifiable victim” from the psychiatrist’s POV (762)

Anthony v. State 374 N.W.2d 662 (1985)

• [declines to recognize a general duty to warn, adopts the “Thompson standard” which depends upon and arises from the existence of a prior threat to a specific identifiable victim]

• Facts: State prisoner on work release raped plaintiff.

• Discussion:
  ○ Begins by identifying the exception under §315 of the Restatement, and how it was invoked in Votteler’s Estate. Court follows that decision’s approach to narrow its holding, stating that this case does not decide whether to recognize the exception generally or whether it would apply to the present facts. “such far-reaching and sensitive issues will be better decided in a case where they are dispositive”. (668)
It addressed only “the scope of the duty to warn when actor in the State’s position has a duty to control the conduct of a third person to prevent that third person from causing physical harm to another.” (668) ... meaning circumstances where no evidence is adduced to show that third party prisoner had threatened the plaintiffs specifically (588)

Court acknowledges that a duty to warn may arise in some circumstances under “the Restatement Standard”, and then identifies and discusses Tarasoff (668-669)

Court goes on to consider a subsequent California case, that narrowed Tarasoff, Thompson v. County of Alameda. It discusses the case at length, noting the policy and other reasons for establishing that “the duty to warn depends upon and arises from the existence of a prior threat to a specific identifiable victim” (669)

Refers to it as the “Thompson standard” -- assuming the allegations were true, the court refused to recognize a duty of the county to warn the plaintiffs, the parents of other neighborhood children, the police, or even the offender’s mother, of the danger (669)

Absent evidence that prisoner had threatened to harm plaintiffs, State had no duty to warn plaintiffs of prisoner’s history of sex crimes

Note that’s Thompson has been followed by other courts and that cases, including Petersen, are distinguishable. The court stated: Petersen, “involved the general duty to protect the public against foreseeable harm, not the specific duty to warn potential victims who have not been threatened or who cannot readily be identified. Under Thompson, the steps to be taken to protect potential victims do not include a duty to warn persons who have not been threatened or who are not readily identifiable” (669)

• Held: "the duty to warn depends upon and arises from the existence of a prior threat to a specific identifiable victim."


• [declined to find a duty to warn the general public]

• Facts: recently discharged involuntary inpatient at defendant Mental Health Institute at Independence, Iowa (MHI) seriously injured plaintiff (509-510)

• Discussion:

  o First time the court has consider whether a psychiatrist has a duty to protect persons injured by a patient who is, or has been, under the doctor’s care (510)

  o Refers to special relation exception under 315 of the Restatement and how that exception is also governed by 319 (511)

  o “There can be little doubt that a special relationship existed between the [offender] and his treating physician at MHI. His continuing involuntary commitment only serves to reinforce that bond. Therefore MHI had a duty to control [offender]’s conduct, or at least not negligently release him from custody. But the Restatement rules cited above
do not answer the precise question ... Does the duty to refrain from negligently releasing dangerous persons from custody run from the custodian to the public at large or only to the reasonably foreseeable victims of the patient’s dangerous tendencies? (511)

- Acknowledges a spectrum of the universe of victims to which doctors owe a duty:
  - Public at large
  - Class of reasonably foreseeable victims of the patient’s dangerous propensities
  - Potential victims identified by the patient (511)

- Finds that the victim is a member of the general public because he can claim no other status (i.e. unacquainted with offender prior to discharge; no threats ever voiced by offender to attending physician) (512)

- Court has viewed the duties described in Restatement 315 and 319 “Quite narrowly”, guided by the principled that the scope of the duty turns on the foreseeability of harm to the injured person (511)

- Refers to strong policy concerns about the potential for limitless liability (512)

- Notes the “constitutionally and statutorily mandated requirement, to treat even seriously mentally impaired person in the least restrict environment medically possible (512)

- The court did “not decided what duty, if any, would attach to the discharge decision if the psychiatrist had reason to believe some particular person would be endangered by the patient’s release’ (512)

- **Held:** a psychiatrist holds no duty of care to an individual member of the general public for decisions regarding the treatment and release of mentally ill persons from confinement (512)

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**Estate of Long ex rel. Smith v. Broadlawns Medical Center, 656 N.W.2d 71 (2002)**

- **[Confirms no general Tarasoff duties recognized in Iowa]**

- **Facts:** husband murders wise after history of domestic abuse, including shooting a gun at her 6 days prior to the murder. Husband transferred from one facility to the next for voluntary psychiatric treatment in the intervening time, with the last transferer the subject of the suit.

- During the transfers, the wife was kept updated about her husband’s progress. She also had contact with police on the night of the gun incident and later received advice about whether to deliver some of his clothes to him. Conversation included the potential danger the wife would be in if she remained in the marital home (78)

- **Discussion:**
  - Supreme Court states that it has not previously adopted the duty principles enunciated in Tarasoff and does not do so now, in the instant case (80).
The underlying dispute here relates to an alleged promise made to the wife during the week of her husband’s treatment. Although a special relationship (in Tarsoff parlance) may have existed between the defendant and the husband, the real issue arises from whether the defendant failed “to exercise reasonable care in performing a promise to warn the wife of her husband’s discharge thereby increasing the risk of harm to her or resulting in harm to her because of her reliance on the promised warning. (80-81)

“Clearly, [the wife] was are of the danger posed by [her husband]”. But the duty does not arise based on relationship between defendant and husband, but between defendant and wife ... to prevail under increase of harm (§323, increase of harm, must identify the sins of commission rather than the sins of omission” (81)

**Held:** confirms that there is no common law *Tarasoff*-based duties recognized in Iowa

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- **[confirms no duty to warn general public, per Leonard v. State; but otherwise does not consider the issue due to lack of special relationship]**
- **Facts:** A sexual offender who was released from the state’s civil commitment unit for sexual offenders (CCUSO) was committed to a care center, where he sexually assaulted another patient (581)
- CCUSO met with care center staff, discussed his history as sex offender and diagnosis of pedophilia and dementia but denied that offender was a risk; did not make director aware that CCUSO previous opined that he was danger to others at the time of commitment to care center; care center understood him to be of no risk at all to older folks, just a child predator (582-583)
- State argued that it did not owed duty of care to supervisor and monitor offender once it discharged offender from CCUSO; estate of victim argues on state had duty of care to warn the residents and assure that safety protocols were in place to protect the residents from harm” (583)
- **Discussion:**
  - “Whether the state had a duty to warn the residents of the dangers [offender] presented in order to protect the residents from harm” (586)
  - Refers to three factors historically relied in determining whether a duty to exercise reasonable care exists: the relationship between the parties, the foreseeability of harm, and public policy ... not distinct and necessary elements but considerations employed in balance process (relying on Thompson v. Kaczinski, 774 N.W.2d 829, (Iowa 2009))(586)
  - Notes that the Supreme Court adopted the *Restatement (Third) of Torts: Liability for Physical and Emotional Harm* §7, refers to §41 in that text, and the issue of a defendant’s liability for the actions of a third party based on a special relationship with the person posing risks. *Restatement (Third) of Torts: Liability for Physical and Emotional Harm* §41, at 64-65, which provides in relevant part:
• (a) An actor in a special relationship with another owes a duty of reasonable care to third parties with regard to risks posed by the other that arise within the scope of the relationship.

• (b) special relationship giving rise to the duty provided in subsection (a) include: 
  (4) a mental health professional with patients (587)
  o Notes that prior to the Supreme Court’s adoption of the Restatement (Third), it found a special relationship in Leonard v. State, where it declined to find that a duty of care was owed to the general public on the basis that policy reasons militating against it.
  o The court also note that the analysis in Leonard “only addressed a psychiatrist’s duty to members of the general public, and we did ‘not decided what duty, if any, would attach to the discharge decision if the psychiatrist had reason to believe some particular person would be endangered by the patient’s release’ (587)

• Held: No occasion to consider how Leonard and §41 apply in the circumstances because there is no special relationship to invoke §41 because the courts, not the state, decided to release the offender. No duty to warn the resident. Nor is there a duty to assure that safety protocols were in place to protect the residents from harm (588)

Kansas

Summary

• There is no statutory duty to warn/protect third parties.

• So far, no state court has explicitly recognized a common law duty to warn/protect, although one federal court speculated that Kansas courts likely would recognize the Restatement § 315 approach to duty to warn/protect, limiting liability to “those persons who were foreseeably endangered.” Mahomes-Vinson. The only state court broaching the duty to warn/protect ruled only that there cannot be a duty to warn/protect when the third party is already aware of the danger. Boulanger.

• There is a common law duty to control. Adams. The duty does not extend to outpatients, id., or voluntary patients. Boulanger.

Cases


[Significance – there is no “duty to control” voluntary patients (i.e., “negligent release” tort does not apply outside of the inpatient setting); there is no “duty to warn” when the victim is already aware of the danger]

o Facts: Patient, ten days after discharge from intermediate healthcare facility, shot and injured plaintiff, his uncle. The plaintiff sued physician and healthcare facility, alleging that they had a duty to legally commit the patient to involuntary treatment or to warn
plaintiff of his release, and were negligent in releasing patient to the care and custody of his parents.

- **Held:**
  - (1) Kansas’s cause of action for negligent release of an involuntary mental patient is inapplicable to, and does not create a cause of action for, the alleged negligent release of a voluntary patient;
  - (2) the duty to warn does not arise when the victim already knows of the danger;
  - (3) under the facts of this case, no special relationship exists which would warrant a duty being imposed under Restatement (Second) of Torts § 315 because patient was free to terminate his relationship with psychiatrist at any time and to leave the facility

- **Discussion:**
  - Left the door open to § 315-based duty to warn: “Assuming, without deciding, that § 315 might be applicable under certain circumstances to the relationship between a psychiatrist and/or a mental health care facility and a voluntary patient, the facts in this case do not support the existence of the duty alleged by plaintiff.” 834.
  - The physician-patient relationship created a duty owed to the patient only, not to those outside the relationship. 297–98.

*Adams v. Bd. of Sedgwick Cty. Comm’rs, 214 P.3d 1173 (Kan. 2009).*

**[Significance – One who takes charge of a third person whom he knows or should know to be likely to cause bodily harms 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]**

- **Facts:** Deceased patient’s mother and daughter brought actions against board of county commissioners and mental health care professionals after patient, who had been treated as an outpatient at mental health center, attacked mother, which caused daughter to fatally shoot decedent.

- **Held:** “An outpatient mental health treatment facility does not take charge of a patient subject to an order for outpatient therapy in a manner that gives rise to a duty to control the patient’s conduct or to give rise to a special relationship with others who come in contact with the patient.” 1176.

- **Discussion:**
  - There is a “duty to control” in some circumstances
    - “There is no duty so to control the conduct of a third person as to prevent him from causing physical harm to another unless (1) 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 (2) a special relation exists between the actor and the other which gives to the other a right to protection. Restatement (Second) of Torts § 315.” 1184.
    - “A duty to control the conduct of a third person as to prevent him from causing physical harm to another may arise because of the relationship
between . . . persons in charge of one with dangerous propensities, and persons with custody of another.” 1184.

- One who takes charge of a third person whom he knows or should know to be likely to cause bodily harms 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. Restatement (Second) of Torts § 319. 1184.

- Statutes intended to protect the general public do not create a duty to individuals
  - Duty to report patient’s noncompliance with outpatient order to the general public does not create a duty to warn individual people. 1188.
  - “K.S.A. 59–2967(e), which imposes a duty on an outpatient mental health treatment facility to report material noncompliance with an outpatient order, creates a duty that is owed to the public in general but does not create a statutory duty that is owed to individuals who are injured by an outpatient.”


[Significance – Federal court case speculating that the Kansas Supreme Court would adopt Restatement § 315 approach to duty to warn/protect]

- **Facts:** A voluntary patient, who had a long history of sexual and physical violence, was discharged from a VA hospital and 8 days later, rapes, sodomized, and killed 2 young girls.

- **Discussion:**
  - “We believe that the Supreme Court of Kansas would also consider foreseeability in determining whether to impose liability under section 315 of the Restatement.” 922.
  - “we are of the opinion that the Kansas Supreme Court would adopt the section 315 Restatement approach and limit the liability of defendant to those persons who were foreseeably endangered by the alleged negligence of the [provider/hospital].” 923.

**Kentucky**

**Summary**

- Per Ky. Rev. Stat. Ann. § 202A.400 and Ky. Rev. Stat. Ann. § 645.270 (applies for minor patients) mental health providers have a mandatory duty to warn or to take reasonable precautions when a patient makes (1) a threat of physical violence against a clearly identified or reasonably identifiable victim, or (2) a threat of a specific violent act without a clearly identifiable victim.
  - Both statutes do not require an identifiable potential victim for the duty to arise.
In Devasier v. James the Kentucky Supreme Court interpreted the statutory language of Ky. Rev. Stat. Ann. § 202A.400 and held that the duty is also triggered when threat is communicated indirectly through agent of the mental health professional, and that "threat" refers to a current active verbal or non-verbal expression to the provider.

- Providers can discharge of the duty to warn by communicating the threat to the victim (in case an identifiable victim is involved) and to law enforcement authorities.
- Providers can discharge of the duty to take reasonable precautions by seeking civil commitment of the patient.

**Relevant legislation**


- Subsection 4. Statute applies to physicians, medical officers, psychologists, psychological practitioners, psychologist associates, nurses engaged in providing mental health services, clinical or certified social workers, marriage and family therapists, professional counselors, art therapists, and pastoral counselors
- Subsection 1. Duty to warn or to take reasonable precautions only arises
  - (1) when a patient has communicated an actual threat of physical violence against a clearly identified or reasonably identifiable victim, or
  - (2) when a patient has communicated an actual threat of some specific violent act
- Subsection 5. Definition of patient explicitly includes patients in outpatient care or treatment. (this was only added in the 2015 version of the statute)
- Subsection 2. Duty to warn is discharged:
  - In cases where a clearly identifiable victim is involved: if provider makes reasonable efforts to communicate the threat to the victim, and to notify the police department closest to the patient's and the victim's residence of the threat of violence.
  - In cases where patient has communicated threat of some specific violent act but has not clearly identified the victim: if reasonable efforts are made to communicate the threat to law enforcement authorities.
- Subsection 2. Duty to take reasonable precautions to provide protection from violent behavior is satisfied:
  - If reasonable efforts are made to seek civil commitment of the patient.
- Subsection 3. No monetary liability and no cause of action arises when a provider discloses confidential information to a third party in an effort to discharge of a duty to warn or a duty to take reasonable precautions.

- Applies to physicians, medical officer, psychiatrists, psychologists, psychological practitioners, psychologist associates, nurses engaged in providing mental health services, clinical or certified social workers, marriage and family therapists, professional counselors, art therapists, and pastoral counselors (see Ky. Rev. Stat. Ann. § 645.020 (West))

- Parallels Ky. Rev. Stat. Ann. § 202A.400 (West) with regards to content of Subsection (1), (2), and (3). Applies where patient is a child.

- Note: outpatient treatment and relationship not explicitly included in the statute.

Regulations and administrative guidance


Cases

Evans v. Morehead Clinic (Ky.App. 1988) 749 S.W.2d 696.

- [holding that Ky. Rev. Stat. Ann. § 202A.400 only applies prospectively due to the lack of clear expression of retroactive intent, establishing common law duty to warn prior to enactment of statute]

- Facts: Patient suffering from paranoid psychosis, delusions and dementia made threat against alleged young lover of 80-year-old wife. Psychologist voluntarily committed patient. Patient was later released upon son’s request. Patient sought further mental health treatment, and delusions about wife’s affair persisted. Patient then confronted victim Evans about alleged affair. Evans communicated conversation to patient’s son, but was never informed of patient’s mental health state. Two months later patient shot Evans. (This occurred in 1983, statute was enacted in 1986)

- Discussion: Appellants contend that physicians have a duty to warn reasonably foreseeable victims per Restatement of Torts §315.
  - Court looks to persuasive precedent (Tarasoff, Lipari v. Sears et al.) and concludes that appellant has a cause of action.
    - Relationship of psychiatrist and patient under § 315 is special relationship resulting in duties to third persons.
    - If the psychiatrist determined or reasonably should have determined that his patient poses a serious risk of violence, the psychiatrist or therapist has a duty
of ordinary care to protect a reasonably foreseeable victim (either identified or readily identifiable) of that danger.

- Court rejects application of statute due to lack of language that implicates express intent of retroactive application.

Devasier v. James, 278 S.W.3d 625 (Ky. Supr. Court 2009)

- [matter of first impression, interpreting language of Ky. Rev. Stat. Ann. § 202A.400, holding that duty is triggered when threat is communicated indirectly through agent, and that "threat" refers to a current active expression to the provider]

- Facts: Boyfriend had trouble with girlfriend’s attempted breakup. Performed several violent acts against her. GF and sister then brought him to seek mental health care. Provider concluded that civil commitment was not necessary. Couple fought again that same day, police was present. Next day boyfriend stabbed GF.

- Discussion: The Court is confronting two issues that arise from wording of the statute.
  - (1) meaning of “communicated to a mental health professional” - does this require an expression from the patient directly to the mental health professional, with no intervening agent; or, is an indirect communication through agents sufficient?
    - In experience of ordinary life information is often transferred by intermediaries – also the case in the medical setting.
    - Legislature did not limit use of “communicated” by using different word or adverb ‘directly’.
  - Holding: language includes threats communicated by a patient to the mental health professional indirectly through agents or ostensible agents of that professional who have a duty to relay the patient’s information.
  - (2) meaning of “an actual threat” - does this mean a threat communicated by a patient or a threat posed by a patient?
  - Holding: “Threat” requires a current, active expression, by words or gestures, verbal or non-verbal, to the professional; a threat capable of avoidance, not a mere passive presence from which the professional must attempt to discern if a patient poses a threat of harm. The statutory duty arises only when a patient has communicated directly or indirectly, by words or gestures, that he will commit an act of physical violence.
  - Here, no duty when a patient merely appears to be an actual threat of harm to another person. Only when the patient communicates to the provider, or his associates, an actual threat that provider may have liability. In this case no threat was communicated by the patient (patient's statement that he loved his girlfriend and did not want to harm her, but was afraid that he could not control himself was not clear and certain enough to constitute communication of “actual threat.”).


- Facts: Wife alleges psychiatrist was negligent in treating husband for depression, and that this negligence resulted in husband’s suicide. Psychiatrist notes that he was immune from liability under § 202A.400.

- Discussion: The Court interprets the statute as part of the “Kentucky Mental Health Hospitalization Act” which defines patients as those “persons under observation, care, or treatment in a hospital.” Legislature did not clearly express intend to extend immunity to patient’s other than hospitalized individuals.
  - Liability is limited to threats communicated by patients in the hospital setting.
- Holding: Statute operates to shield psychiatrist from liability for an outpatient’s acts.

Riley v. United Health Care of Hardin, Inc., 165 F.3d 28 (6th Cir. 1998)

- [applying Kentucky statutory and common law, finding that no duty to warn was triggered since mental health patient did not make actual threat of physical violence]

- Patient had expressed to hospital staff that he had thought about hitting his mother when they had argued in the past, that he occasionally perceived the need to “strike out,” that he had written disturbing song lyrics, and that he had a propensity toward violent conduct

- Court concludes that these statements do not constitute an actual threat of future physical harm to patient’s mother. Thus, requirements triggering the statutory duty to warn are not satisfied.

Louisiana

Summary

- Louisiana has a statutory duty to warn, under sub-section [A] of La. R.S. 9:2800.2, which is triggered only once a patient has communicated a threat of physical violence, deemed to be significant in the clinical judgment of the treating provider, against a clearly identified victim(s), coupled with the apparent intent and ability to carry out such threat.

- The statute, under sub-section [B] of La. R.S. 9:2800.2, further provides that the duty will be discharged if the provider makes a “reasonable effort” to communicate the threat to the potential victim(s) and to notify law enforcement authorities in the vicinity of the patient’s or potential victim’s residence.

- The statute provides immunity for disclosures of confidential information associated with discharging the duty to warn.
The statute applies to psychologists, psychiatrists, marriage and family therapists, licensed professional counselors, and social workers, registered pursuant to state regulations.

A fairly recent case, Jones v. Gaines, considering a split in opinions between the state circuit courts of appeal, affirmed that La. R.S. 9:2800.2 is the only applicable duty of care available to third parties injured by a defendant’s patient. No other circumstances outside those set out there give rise to a cause of action.

Relevant legislation

- Sub-section [A] provides immunity for a breach of confidentiality by psychologists, medical psychologists, psychiatrists, or social workers who warn of a threat made by a patient or takes precautions to provide protection from the patient’s violent behavior where the patient communicates a threat of physical violence, deemed to be significant in the clinical judgment of the treating provider against a clearly identified victim or victims, coupled with the apparent intent and ability to carry out such threat.

- Sub-section [B] states that provider’s duty to warn or take reasonable precautions to provide protection from violent behavior arises only under the circumstance specified in [A] of this section.

- Sub-section [B] further provides that the duty will be discharged if the treating provider (1) makes a reasonable effort to communicate the threat to the potential victim or victims and (2) to notify law enforcement authorities in the vicinity of the patient’s or potential victim’s residence.

- Sub-section [C] clarifies immunity noted in [A] further.

Regulations and administrative guidance
LA A.C. 115 – Confidentiality

- Confirms the exception to confidentiality rules as set out in 2800.2

Cases
Hutchinson v. Patel, 637 So. 2d 415 (La. 1994)

- [relies on a La. Statute for content of duty to warn, clarifies that the duty implied reasonable judgment, not reasonable professional judgment]

- Facts: wife sues hospital and husband’s psychiatrist for failure to warn to take reasonable precautions to protect wife against threat of physical violence communicated to psychiatrist by husband. Husband, a month after his released from voluntary commitment, shot plaintiff, paralyzing her, and then committed suicide.

- Discussion: [key issue on appeal is whether medical malpractice act applies to claims by third parties]
Re duty to warn – acknowledges Tarasoff and states that the Louisiana legislature recognize the existence of a therapist’s “duty to warn” under Louisiana law by enacted La.R.S. 9:2800.2 (418)

Refers to plaintiff’s claim as “Tarasoff claim” (419)

Once a therapist exercises his or her professional judgment in predicting or failing to predict that patient poses a serious danger of violence to others, his or her performance of the duty to warn or take reasonable precautions to protect foreseeable victim of that danger does not require any further exercise of therapist’s professional judgment, but only reasonable care under the circumstances (424)

Dunnington v. Silva, 916 So. 2d 1166 (La. Ct. App. 1st Cir. 2005)

- [statutory phrase “clearly identified victim or victims” includes identifiable victims – i.e. can readily or reasonably identify person who are the objects of their patients’ threats]

- [statute governing psychiatrist’s duty to warn or take reasonable precautions to provide protection from violent behavior is the exclusive remedy for third parties]

- Facts: estate of victims sue husband’s psychiatrist and medical center for wrongful death after husband murders wife and daughter before committing suicide.

- Discussion:
  - Recognizes La. R.S. 9:2800.2 as the state’s statute governing a psychiatrist’s duty to warn (1168)
  - According to the statute, a psychiatrist has a duty to protect third persons only in a limited scenario. ... before a duty to warn even arises, they must have made a threat to a clearly identifiable victim (relying on Grady v. Riley, 809, So.2d 567, 571) (1168-69)
  - No evidence that the patient made any threats ... pursuant to LSA-R.S. 9:2800.2, a duty to warn third persons arose only if [patient] had communicated a threat to [psychiatrist] of physical violence deemed to be significant in the clinical judgment of the [psychiatrist], against clearly identified victim or victims, coupled with the apparent intent and ability to carry out such threat. ... no evidence of such a threat (1170)

- Held: psychiatrist did not have a duty to warn patient’s wife and daughter of his possible violent behavior following his release from commitment; no evidence patient every communicated threats of violence to psychiatrist

Jones v. Gaines, 978 So.2d 522 (2008)

- [duty of care is established in La. R.S. 9:2800.2]

- Facts: schizophrenic, with history of relapse when using alcohol or drugs, checks out of hospital, and less than two days later, consumes alcohol, relapse, drove recklessly, ran red light and killed victim. Inpatient status voluntary. Gave 3 days’ notice, per requirement, and evaluation led to approved release.

- Discussion:
- Plaintiffs contend that cause of action lies in negligence, not La. R.S. 9:2800.2 (i.e. breach of a legal duty, not a statutory duty) (527)

- There is a split in the Louisiana circuit courts of appeal re: whether psychiatrists, psychologists, and the public entities that employ them have any duty to third persons beyond the limited context of La.R.S. 9:2800.2

- **Narrow scope of the duty:**
  - *Grady v. Riley, 809 So.2d 567 (2002), 5th circuit* held that a psychiatrist has a duty to protect third persons only in a limited scenario and affirmed SJ in favor of defendants
  
  - *Dunnington v. Silva, 916 So.2d. 1166 (2005), 1st circuit* held that a psychiatrists duty to warn or take reasonable precautions to provide protection from violent behavior arises only under the circumstances specified by La. R.S. 9:2800.2 and that statute is “exclusive as to claims by third parties” (Id at 1171)
  
  - *Sanchez v. State Through Dept. Health and Human Resources, 506 So.2d 777, 1st circuit*, where plaintiff alleged negligence against hospital and DHH for failing to protect the public by not recognizing a patient’s violent propensities and by releasing the patient from the hospital and thereby placing him in a position where he could commit violent acts. Patient, long history of mental illness, entered parents’ home, killed his sister and her husband three months after his release. Patient had made various threats on different commitment occasions. Appeals courts affirmed ruling in favor of defendants partially on the basis that the duty to confine the patient did not extend to the possibility that he would shit the victims (527)

- **Broader scope of the duty**
  - *Davis v. Puryear, 673 So.2d 1298, 4TH Circuit* held that state mental health institution and its physician employees owe a general duty to the public to exercise reasonable care under certain circumstances to guard against harm to third person and this duty extends beyond the duty to warn or a duty to identified potential victims
    
    - **Facts:** two days after inpatient escaped from hospital he raped and murdered victim. Patient had long history of mental illness with hx of violence to himself and others
    
    - Case criticized for impose strict liability on mental healthcare facilities when an injury follows a patient’s escape when there is no causal relationship between the negligence and the escape, and for deviating from legislative policy to limit confinement, legislative intent of the law regarding the duty (528)

- **Upshot:** 4th circuit in *Davis* imposes strict liability (if escape occurs, someone injured, facility liability), 1st circuit prohibits recovery absent strong causal relationship, especially rejects strict liability
Distinguishes Davis, since offender here was released under valid authority

Statutes dealing with release and duty to warn (La. R.S. 9:2800.2) establish the conditions and obligations for the release of patients like the offender and the duty of health care providers of these patients to warn “Clearly identified victims or victims” of a significant and “specific threat of violence”. (529-530)

Issue in this case was not about threats of violence, but whether hospital had full knowledge that patient would become after his release, incompetent to drive a car. No duty in this circumstance, and would otherwise violent the clear policy of release conditions provisions (530)

The police expressed in this law established that the interest of the sate is to protect and treat the patient not protect the public. ... facility’s duty should be first to the patient to ensure proper treatment and confinement periods (530)

**Held:** the applicable duty of care is established in La. R.S. 9:2800.2, and it does not apply here; clearly policy in favor of the interests of patients’ liberty

### Maine

**Summary**

- Maine does not have statutory or common law rules that address the duty to warn.
- Court decisions give an idea of the arguments involved in a duty to warn scenario:
  - The Maine Supreme Court has indicated a public policy to decline to extend liability of psychiatrists toward third parties.
  - In Joy v. E. Maine Med. Ctr. the Court recognized a physicians’ duty to third parties under limited circumstances.

**Cases**


- [holding that doctor who knows or reasonably should know that patient's ability to drive has been affected has duty to driving public as well as to patient to warn patient of such fact, acknowledging duty to third parties under limited circumstances]

- **Facts:** Suit brought against ER physician and medical center for injuries received by motorcyclist in collision with vehicle driven by patient, based on allegation that physician had duty to warn patient that his driving would be affected by placing of eye patch on patient's eye.

**Rousey v. United States, 115 F.3d 394 (6th Cir. 1997)**

- [applying Maine law, summarizing Maine Supreme Court policy not to extend psychiatrist liability to third parties]
• **Facts:** Psychiatric patient shot and killed four of six occupants of automobile, including his wife, three weeks after his release from psychiatric program at government medical center at which he was voluntarily admitted. Survivor of shooting sued government under FTCA, alleging negligent discharge and negligent treatment.

• **Discussion:** Court of Appeals is applying Maine law.
  
  o Maine Supreme Court in *Taylor v. Herst*, 537 A.2d 1163 (Me.1988) and *Darling v. Augusta Mental Health Institute*, 535 A.2d 421, 429 (Me.1987) has pronounced a policy that expansive liability of psychiatrists to third parties is socially undesirable. This favors isolation of psychiatrists from liability for failure to diagnose a patient to be seriously dangerous as a result of a mental illness and subject to involuntary commitment.

  o Any violation of duty of care by psychiatrist to adequately treat patient's mental affliction can, at most, engender liability only to patient himself or to specific other persons or classes of persons whom psychiatrist had reason to know are at special risk of violent injury at hands of patient.

• **Holding:** Under Maine law, even if patient had been deemed potentially dangerous at time of his discharge, hospital had no duty to warn victim of potential danger.

**Maryland**

**Summary**

  
  o In *Falk v. S. Maryland Hosp., Inc.*, the Court of Special Appeals found the statute to have clear meaning and confirmed that a provider is not liable for violent behavior of his patients unless he had actual knowledge of patient’s propensity for violence and the patient indicated to the provider in some way that he intended to harm a specific victim.

• Providers and administrators can discharge of the duty by seeking civil commitment of patient, by developing a treatment plan calculated to eliminate the possibility of the threat, or by notifying law enforcement and the potential victim.

**Relevant legislation**

*Md. Code Ann., Cts. & Jud. Proc. § 5-609 (West) - Mental health care providers or administrators*

• Subsection A. Applies to mental health care providers, administrators of the Behavioral Health Administration, and any facility corporation, partnership, association, or other entity that provides treatment or services to individuals who have mental disorders.

• Subsection B. No cause of action for failure to predict, warn of, or take precautions to provide protection from a patient's violent behavior, unless:
• The provider or administrator knew of the patient's propensity for violence and the patient indicated to the provider/administrator by speech, conduct, or writing, of the patient's intention to inflict imminent physical injury upon a specified victim or group of victims.

• Subsection C. Duty can be discharged when provider/administrator makes reasonable and timely efforts to:
  o (1) Seek civil commitment of the patient;
  o (2) Formulate a diagnostic impression and establish and undertake a documented treatment plan calculated to eliminate the possibility that the patient will carry out the threat; or
  o (3) Inform the appropriate law enforcement agency and, if feasible, the specified victim or victims of: the nature of the threat; the identity of the patient making the threat; and the identity of the specified victim or victims.

• Subsection D. Providers/Administrators are immune from liability under any patient confidentiality act for confidences disclosed in good faith to third parties in an effort to discharge a duty arising under this section.

**Md. Code Ann., Health-Gen. § 4-307 (West) – Confidentiality of mental health records, disclosures**

• Subsection J. A health care provider may disclose a medical record without the authorization of a person in interest as provided in § 5-609.

**Cases**


• [Finding Md. Code Ann., Cts. & Jud. Proc. § 5-609 to have clear meaning that is in line with reasoning in prior Maryland precedent, holding that provider is not liable for violent behavior of his patients unless he had actual knowledge of patient's propensity for violence and the patient indicated to the provider in some way that he intended to harm a specific victim]

• Facts: Involuntarily admitted psychiatric patient Ferguson attacked nurses and then knocked over other patient Seibert who, as a result of this fall, had to have hip surgery and died from surgery complications. Son Seibert filed medical malpractice suit against hospital and doctors, alleging that they had the responsibility to supervise Ferguson and protect Seibert from Ferguson, and that Seibert's death was a direct result of their failure to do so

• Discussion: Defendants moved for summary judgement based on § 5–6093. Court now analyzes statutory meaning to determine whether summary judgement was rightfully granted.
  o Court finds statute to have clear, unambiguous language: A mental health provider is not liable for the violent behavior of patients unless he or she 1) had actual knowledge of the patient's propensity for violence; and 2) the patient indicated to the mental health provider in some way that he or she intended to harm a specific victim.
Absent other case law interpreting the statute the court looks to prior precedent (Furr v. Spring Grove State Hosp., Shaw v. Glickman, Hartford Ins. Co. v. Manor Inn of Bethseda, Palsgraf v. Long Island R.R. Co.).

Court finds wording of statute to be entirely consistent with prior precedent.

**Holding:** Absent evidence that patient informed hospital staff that he intended to harm particular person, personal representative did not establish malpractice claim against either hospital or patient's treating psychiatrist. Appellant failed to meet the requirements of § 5–6093.

The subsequent decisions were overruled by enactment of Md. Code Ann., Cts. & Jud. Proc. § 5–609. However, the Court of Special Appeals has interpreted the scope of the statute in reference to the reasoning provided in these decisions.


- [rejecting Tarasoff reasoning where patient did not express intent to injure victim, extending patient-provider privilege]
- **Facts:** Triangle relationship between husband, wife and lover – all under the care of the same psychologist and psychiatric nurse. Husband shot former wife’s lover. Mental health care providers sued for injuries inflicted on lover by husband on theory that providers were negligent in failing to warn plaintiff of husband’s unstable and violent condition and the danger that it presented to plaintiff.
- **Discussion:** Court declined to hold providers liable. While providers knew of husband’s irate and bizarre behavior wearing a gun belt and a pistol, husband had not revealed intent to injure the lover. Court distinguished Tarasoff on the ground that the patient here expressed no intention to harm the victim.
  - Court also stated that provider could not warn the victim without violating the statutory privilege, extending the privilege to a patient’s confidences that he intends to commit a future crime.
  - Thus, pursuant to Shaw a therapist's choices were either to remain quiet or to seek the patient’s commitment to a mental institution on the grounds that the patient poses a clear and imminent danger to ... others.


- [rejecting Tarasoff, holding that duty to the victim is only triggered where the victim is foreseeable]
- **Facts:** Boy raped and murdered by patient who left state mental hospital where he was voluntarily admitted and receiving treatment for deviant sexual behavior. Patient was allowed
to leave hospital without notifying medical staff. Parents brought action against state hospital, state psychiatrist and hospital's director of admissions.

- **Discussion:** Court declined to adopt Tarasoff reasoning since Tarasoff imposed a duty only when the mental health provider knew the identity of the specific victim who was threatened
  
  o Court held that psychiatrist owed no duty to the victim because the victim was an unforeseeable plaintiff.


- [holding that duty of providers does not run to the public at large but only to identifiable, foreseeable victims]

- **Facts:** Car accident between the victim and a voluntarily committed psychiatric patient who had eloped from a state hospital. Patient spent night in hospital and then stole hotel van with which crashed into victim.

- **Discussion:** Court held that the State owed no duty toward the victim, arguing that it could not be foreseen that the patient, having eloped, would go to Bethesda, steal a van, and drive it negligently, thus causing an accident. Court concluded that duty of psychiatrists did not run to the public at large, but, rather, only to readily identifiable victims within a foreseeable zone of danger whose identities are known in advance.

Massachusetts

**Summary**

- “Licensed mental health professionals” have a statutory duty to warn/protect a third party when their patients communicate an explicit threat to kill or inflict serious bodily injury upon a reasonably identifiable victim and the patient has the apparent intent and ability to carry out that threat, OR when the provider knows of the patient’s history of physical violence and has a reasonable basis to believe that there is a clear and present danger that the patient will attempt to kill or inflict serious bodily injury against a reasonably identified victim. MASS. GEN. LAWS ch. 123, § 36B (1989). The mental health professional must take reasonable precautions.
  
  o “Reasonable precautions” means reasonable efforts to communicate the threat to the victim, notify law enforcement, or commit the patient. MASS. GEN. LAWS ch. 123, § 1 (1989).
  
  o “Reasonably identified victim” means a victim that a mental health professional has all of the information and knowledge necessary to identify without any additional investigation. Shea, 947 NE.2d at 107.

- Psychotherapists have a statutory duty to control potentially dangerous patients. MASS. GEN. LAWS ch. 233, § 20B(a) (2001). This duty arises if he determines that there is a threat of imminently dangerous activity against another person. It is discharged by committing patient or reporting to law enforcement. *Id.*
Relevant legislation


(1) There shall be no duty owed by a licensed mental health professional to take reasonable precautions to warn or in any other way protect a potential victim or victims of said professional's patient, and no cause of action imposed against a licensed mental health professional for failure to warn or in any other way protect a potential victim or victims of such professional's patient unless: (a) the patient has communicated to the licensed mental health professional an explicit threat to kill or inflict serious bodily injury upon a reasonably identified victim or victims and the patient has the apparent intent and ability to carry out the threat, and the licensed mental health professional fails to take reasonable precautions as that term is defined in section one; or (b) the patient has a history of physical violence which is known to the licensed mental health professional and the licensed mental health professional has a reasonable basis to believe that there is a clear and present danger that the patient will attempt to kill or inflict serious bodily injury against a reasonably identified victim or victims and the licensed mental health professional fails to take reasonable precautions as that term is defined by said section one. Nothing in this paragraph shall be construed to require a mental health professional to take any action which, in the exercise of reasonable professional judgment, would endanger such mental health professional or increase the danger to potential victim or victims.

(2) Whenever a licensed mental health professional takes reasonable precautions, as that term is defined in section one of chapter one hundred and twenty-three, no cause of action by the patient shall lie against the licensed mental health professional for disclosure of otherwise confidential communications.


“Reasonable precautions”, any licensed mental health professional shall be deemed to have taken reasonable precautions, as that term is used in section thirty-six B, if such professional makes reasonable efforts to take one or more of the following actions as would be taken by a reasonably prudent member of his profession under the same or similar circumstances:

1. communicates a threat of death or serious bodily injury to the reasonably identified victim or victims;
2. notifies an appropriate law enforcement agency in the vicinity where the patient or any potential victim resides;
3. arranges for the patient to be hospitalized voluntarily;
4. takes appropriate steps, within the legal scope of practice of his profession, to initiate proceedings for involuntary hospitalization.


All communications between a licensed psychologist and the individuals with whom the psychologist engages in the practice of psychology are confidential. . . . No psychologist . . . shall
Cases


[Significance – fleshes out some of the language in MASS. GEN. LAWS ch. 123, § 36B; holds that § 36B abrogated any common-law duty owed by a mental health professional]

- Facts: Mental health patient killed his step-father. Executrix brought wrongful death action against psychiatrist and two licensed social workers for negligence in failing to hospitalize patient or warn stepfather of patient’s dangerous propensities.
- Law:
    - “To show that a licensed mental health professional had a statutory duty to warn the potential victim regarding a patient who had not made an explicit threat to kill or inflict serious bodily injury, a plaintiff must establish that: (1) the patient had a history of physical violence which was known to the professional; (2) the professional had a reasonable basis to believe there was a clear and present danger the patient would
attempt to kill or inflict serious bodily injury; and (3) the potential victim was reasonably identified.” 104–05.

- **Held:**
  - Defendants lacked a reasonable basis to believe there was a clear and present danger that patient would attempt to kill or inflict serious bodily injury, and
  - Patient’s stepfather was not a reasonably identifiable victim.

- **Discussion:**
  - To meet the requirement for a patient to have a history of physical violence which is known to the licensed mental health professional, it is not necessary for the patient’s history of physical violence to be directly connected to a reasonably identified victim or victims. 105.
  - Licensed mental health professionals lacked reasonable basis to believe there was a clear and present danger that patient would attempt to kill or inflict serious bodily injury because patient denied having any suicidal or homicidal ideations, clinical social worker concluded that patient was alert, oriented, and logical and that he displayed fair judgment and impulse control despite poor insight, and psychiatrist noted patient’s good control prior to his discharge from voluntary admission to hospital. 106.
  - “Reasonably identified victim” means a victim that a mental health professional has all of the information and knowledge necessary to identify without any additional investigation. 107.
  - Statute addressing a licensed mental health professional’s duty to warn a patient’s potential victim abrogated any common-law duty owed by a mental health professional. 108.

**Michigan**

**Summary**

- *Mich. Comp. Laws Ann. § 330.1946* establishes a mandatory, statutory duty to warn in situations where a patient has communicated a threat of physical violence against a reasonably identifiable third person and where the patient has the apparent intend and ability to carry out this threat.

  - Providers can discharge of the duty to warn by either hospitalizing the patient, or informing the third party and the law enforcement. Special notification requirements apply if the threatened individual is a minor or incompetent.

  - The duty applies to mental health professionals, partially licensed professionals if under the supervision of a fully licensed professional (see *People v. Carrier*), and mental health institutions (see *Swan v. Wedgewood*).

  - Case law, eg. *Jenks v. Brown*, has established that the statutory duty to warn only extends to the reasonably identifiable third party.
• Previous to the enactment of the statute, Michigan Courts adopted the *Tarasoff* reasoning and recognized a common-law duty to warn in cases where a third party is “readily identifiable as foreseeably endangered” by a psychiatrist’s patient (see Davis, Bardoni).
  
  o To date the Courts have not determinatively resolved whether the common law duty to warn has survived the enactment of the statute. Thus, Michigan mental health professionals could be liable under either the statute, or the common-law.

**Relevant legislation**

*Mich. Comp. Laws Ann. § 330.1946 (West) - Mental health professionals; duty to warn third parties; discharge of duty; team treatment; privilege of confidentiality, exceptions*

• Applies to an individual who is trained and experienced in the area of mental illness or developmental disabilities and who is either a physician, a psychologist, a registered professional nurse, a licensed master's social, a licensed professional counselor, or a marriage and family therapist (Mich. Comp. Laws Ann. § 330.1100b (West)).

• Subsection 1. If a patient communicates a threat of physical violence against a reasonably identifiable third person to a treating provider, and if the patient has the apparent intent and ability to carry out that threat in the foreseeable future, the provider has a duty to take action.

• Subsection 2. A provider has discharged this duty if he timely does one or more of the following:
  
  o (a) Hospitalizes the patient or initiates proceedings to hospitalize the patient;

  o (b) Makes a reasonable attempt to communicate the threat to the third person and to the local police department or county sheriff for the area where the third person resides or for the area where the patient resides, or to the state police;

  o (c) In cases where the provider has reason to believe that the threatened person is a minor or incompetent, takes the steps set forth in (b) and communicates the threat to the department of social services in the county where the minor resides and to the third person's custodial parent, noncustodial parent, or legal guardian, whoever is appropriate in the best interests of the third person.

• Subsection 3. If the patient is treated through team treatment in a hospital, the hospital shall designate an individual to communicate the threat as described in Subsection 2.

• Subsection 4. Providers are exempt from privilege if they determine in good faith that a particular situation at issue presents a duty under this section, and if they make attempts to discharge of that duty.

**Cases**

*Dawe v. Dr. Reuven Bar-Levav & Assocs., P.C., 485 Mich. 20, 780 N.W.2d 272 (Supr. Ct. of Mi. 2010)*
• [Duty to warn under MCL 330.1946 did not abrogate common-law cause of action based on a provider's duty of reasonable care towards his patients (where injured third party was also a patient of the same provider)]

• Facts: Psychiatric patient injured when former patient of psychiatrist entered psychiatric office and shot her and others, including psychiatrist. Plaintiff brought action under MCL 330.1946 for failure to warn her of or protect her from a threat claiming that former patient had previously made threatening statements to defendants and that he had demonstrated his ability to carry out the threats when he came to defendants' office with a gun on an earlier occasion.

• Discussion: Can the plaintiff bring a common-law medical malpractice claim when the provider allegedly negligently placed plaintiff in danger of harm, or does MCL 330.1946 abrogate a common law claim based on the provider's duty arising from the "special relationship" between patient and provider when no threat per MCL 330.1946 was communicated?
  o Before the enactment of MCL 330.1946 providers owed a common-law duty of reasonable care to their patients, and a duty to warn third persons of or protect them from potential dangers posed by patients based on the special relationship between patient and psychiatrist.
  o The statute partially abrogated common law duties, but the statute also limited its own scope: MCL 330.1946(1) only modified a mental health professional's common-law duty to warn or protect a third person when a “threat as described in [MCL 330.1946(1)]” was communicated to the mental health professional. Thus, the statutory duty only arises when three elements are present: (1) a patient makes a threat of physical violence, (2) the threat is against a reasonably identifiable third person, and (3) the patient has the apparent intent and ability to carry out the threat. If these elements are not met, the statutory duty is not triggered. The statutory language is not so comprehensive as to indicate that legislature intended to completely abrogate the common law in this area as the statute does not cover all the details of a professional's duty to provide reasonable care.
  o As a result of this limitation, both the statutory duty or the common-law duty could apply.


• [analyzing viability of a common law claim, finding that defendants owed plaintiff a duty to take reasonable precautions to protect her since plaintiff was within a foreseeable group of victims]

• Discussion: On remand the Court of Appeals found that defendants owed patient a duty to protect her from harm by a third party. This duty is based on their established psychiatrist-patient relationship and the element of control between them (duty to protect is imposed upon the person in control because he is best able to provide a place of safety).
  o When plaintiff was placed in group therapy by defendants she entrusted her well-being to the control of the defendants. It is foreseeable that a patient who is not healthy

- Limited license social worker was “mental health professional” within scope of MCL 330.1946 due to existent supervision of fully licensed social worker; waiver of privilege implicated in duty to warn situations extends to disclosure of communicated threats in court cases or proceedings.

- Facts: Def. charged with making terroristic threats. He filed motion to exclude statements that he had made over the telephone to an emergency services specialist while specialist was manning mental health crisis hotline. After the call emergency services specialist called 911 and reported the threats the def. had made to law enforcement.

- Discussion: The disclosure of crisis hotline communications made in court proceedings turns on two issues:
  
  1. Was emergency services specialist a “mental health professional” per MCL 330.1946?
     - Limited license, bachelor degree social worker that received the call is not within the statutory definition of “mental health professional” as provided in MCL 330.1100b.
     - But, because of limited license he practiced under supervision of licensed social worker. He worked in tandem with supervisor and there was a duty to warn and protect per MCL 330.1946.
  
  2. After a communication was disclosed in a duty to warn situation, can there be further disclosures of these communications?
     - No statutory language that addresses the status of such communications post disclosure.
     - However, statute was enacted to protect the safety of a third person from a patient who voiced a threat of physical violence. Professional can satisfy the duty to warn by communicating threat to victim and law enforcement. Protection the legislature intended to afford third persons can only be logically realized within the statutory intent if threatening communications can also be disclosed in court cases or proceedings.


- Duty to warn of threats made toward child did not extend toward custodial father of child since child was the only reasonably identifiable third person]
• **Facts:** Former husband of psychiatric patient brought action against psychiatrist and hospital alleging that defendants had failed to warn husband about intent of patient, expressed during treatment, to kidnap child who was in husband’s custody.

• **Discussion:** Court analyzes to whom a mental health practitioner owes a duty under MCL 330.1946.
  
  o Prior to statute enactment the common law duty to warn had been extended to unnamed third parties and even to property. In response to these developments legislature intended limited a mental health practitioner's duty. In order for any duty to arise, a patient must communicate “a threat of physical violence against a reasonably identifiable third person.”
  
  o Plaintiff alleges that threat against child was made, so the child is the only “reasonably identifiable third person”.

• **Holding:** The defendants did not owe a duty to the plaintiff, only to his child.


• [statute applies in cases where patient has communicated no threat against identifiable third person because only duty owed by professionals to third parties is duty under the statute, statute only protects reasonably identifiable individuals against whom a threat is made, statute applies to claims brought against mental health institutions]

• **Facts:** Boyfriend killed by his live-in girlfriend's son, during son’s release from residential psychiatric treatment facility for unsupervised home visit. Estate of decedent brought negligence action against facility.

• **Discussion:** Plaintiff argued that MCL 330.1946 did not apply in the present case because statute only applies in situations where a psychiatric patient has communicated a threat to a mental health professional against a reasonably identifiable third person, and because plaintiff's claim is based on defendant's negligence in treating son, not on failure to warn.
  
  o Legislature intended statute to limit a mental health practitioner's duty to third parties to the duty provided in the statute. The only duty owed is a duty to warn in those situations where a patient communicates a threat and the object of the threat is reasonably identifiable. Here, there is no evidence that the patient ever made any threats against the victim prior to the assault. Therefore, the defendant owed no duty to the decedent.
  
  o Plaintiff's assertion of a negligence action cannot survive as defendant owed such duties to the son, but not the plaintiff as a third party. In addition, the statute provides unambiguously that except as provided in subsection 1 a mental health professional does not have a duty to warn a third person of a threat. This limits the duty a professional owes to third parties.
  
  o Plaintiff further argues that MCL. § 330.1946 only applies to suits brought against a particular health professional, not a mental health institution. Court draws from
common law (see Hinkelman v. Borgess Medical Center) to conclude that the duty to warn may be imposed upon psychiatric hospitals or other entities that undertake to render psychological treatment.

- Michigan Courts have established a duty of reasonable care toward only those third parties who are “readily identifiable as foreseeably endangered”. Here, no foreseeable danger to decedent was made known during defendant's treatment of son. Thus, court is not required to analyze whether common law duty to warn survived statutory duty to warn.


- [affirming order granting defendant's motion for summary disposition, duty of a provider does not vary depending on the cause of action, duty to warn is limited to situations where a patient communicates a threat of physical violence to the provider (Court relying on Swan)]

While the Court of Appeals expressed in Swan that the Legislature intended the statute to limit a mental health practitioner's duty to third parties to the duty provided in the statute, the Court does not clearly confirm an abrogation of the common law duty to warn.

The common law duty arises only in situations where the third party is "readily identifiable as foreseeably endangered" (Jenks v. Brown citing Marcelletti v. Bathani, 198 Mich.App. 655, 661, 500 N.W.2d 124 (1993)). The Court of Appeals first adopted the Tarasoff reasoning in Davis v. Lhim, 124 Mich.App. 291, 301, 335 N.W.2d 481 (1983) and held that a psychiatrist owes a duty of reasonable care to a person who is foreseeably endangered by his patient. While the Supreme Court reversed this decision on other grounds in Canon v. Thumudo, 430 Mich. 326, 422 N.W.2d 688 (1988), later cases have confirmed the standard established in Davis v. Lhim. See eg. Bardoni v. Kim below.


- [confirming the standard established in Davis v. Lhim]

- Facts: Patient assaulted wife and murdered brother and mother. Complaints alleged that psychiatrist failed to properly diagnose patient and failed to warn members of the patient's family who were foreseeable victims of his violence.

- When a psychiatrist determines or, pursuant to the standard of care of his profession, should determine that his patient poses a serious danger of violence to a readily identifiable third person, the psychiatrist has a duty to use reasonable care to protect that individual against such danger.

  - In order to establish a duty, a plaintiff must be able to show that (1) the defendant psychiatrist knew or, according to the standards of his profession, should have known that his patient posed a serious threat of danger to others, and that (2) the psychiatrist knew or should have known that his patient was dangerous specifically to the injured third party.
In Swan the Court declined to rule on this issue, as the victim in this case was not foreseeably endangered. But left a common law cause of action open per dicta. Thus, subsequent claims based on a duty to warn situation relied on both: a statutory and common law duty.


- Plaintiffs argue that common law duty to protect applies where no threat was made pursuant to MCL 330.1946.
- Court relies on the standard in Swan: a common law duty might survive where a foreseeable danger is made known to the practitioner during the course of the patient’s treatment.
  - Here, plaintiffs failed to show that patient exhibited a foreseeable danger. Court does thus decline to resolve the question of existence of a common-law duty.


- [examining applicability of statutory duty to warn and common law duty to warn, duty did not arise under both theories as son did not make threats against father during time of hospitalization]
- Facts: Father admitted son to defendant Hospital after son displayed violent and destructive behavior and threatened father’s life. Less than a month after the hospital discharged his son, father took son on vacation, during which son fatally shot father. Plaintiff brought wrongful death action against Hospital and psychiatrist who treated son, alleging that defendants violated statutory and common-law duties to warn father of the threat posed by son.
- Discussion: Court examines statutory duty and common law duty in defendant’s appeal of denied motion for summary disposition.
  - 1. Statutory duty: MCL 330. 1946(1) duty did not arise because plaintiff failed to establish facts that support that son made threats against father during the time of hospitalization.
  - 2. Common law duty: Per Davis v. Lhim, and Cannon v. Thumudo a mental health professional owed “a duty of reasonable care to a person who is foreseeably endangered by his patient.” The common-law duty is limited to only those persons readily identifiable as foreseeably endangered. Evidence failed to show that son communicated any threat of violence against father. Thus, no issue of material fact regarding the existence of a common law duty was established.
- Holding: Defendants should have been granted motion for summary disposition. Trial Court reversed.
Minnesota

Summary

- Minnesota has a statutory duty to warn as well as a common law duty to control.
- Under M.S.A. §148.975, there exists duties to “predict, warn of, or take reasonable precautions to provide protection from violent behavior”.
- Case law such as State v. Expose, articulate M.S.A. §148.975 as created a duty to warn though, and it arises only when a client or other person (such as a family member or someone close to the client) communicates to the psychologist a specific, serious threat of physical violence against a specific, clearly identified or identifiable potential victim.
  - The statutory duty is discharged if reasonable efforts—a defined term under the section, and includes comprises warning the potential victim or the law enforcement agency close to the victim—are made to communicate the threat.
  - The statutory duty applies to psychologists and related trainees,
  - Provides immunity for breaches of confidence related to good faith efforts to discharge the duty to warn (State v. Expose).
- Minnesota doctors are also subject to a duty to control on MHPs, per the Supreme Court case, Lundgren v. Fultz, if there is a “special relationship” between the doctor and the client, per §315 of the Restatement (Second) of Torts, and the harm is foreseeable.
- Implicit in the duty to control is an ability to control, without which the only duty that may arise is a duty to warn (i.e. to call the police), as discussed in a more recent Court of Appeals case, Stuedemann v. Nose.

Relevant legislation

Minn. Stat. § 148.975 – duty to warn, incl. definitions

- Sub-division [2] creates a duty to predict, warn of, or take reasonable precautions to provide protection from violent behavior when a client or other person has communicated to the licensee a specific, serious threat of physical violence against a specific, clearly identified or identifiably potential victim.
- Sub-division [2] states that the discharged if reasonable efforts are made to communicate the threat.
- Sub-division [1] provides definitions:
  - Other person – immediate family member or someone who personally knows the client and has reason to believe the client is capable of and will carry out the series, specific threat of harm to a specific, clearly identified or identifiable victim.
o Reasonable efforts – communicating the serious, specific threat to the potential victim and if unable to make contact with that person, to the law enforcement agency closest to that person

o Licensee – psychologists (doctoral degree in psychology), including practicum psychology students, predoctoral psychology interns, and those in the process of completing their postdoctoral supervised psychological employment to qualify for licensensure

- Sub-division [3] provides immunity for a licensee for failures to predict, warn of, or take reasonable precaution to provide protection from patient’s violent behavior if the circumstance does not fall within parameters of Sub-division [2]
- Sub-division [4] states that good faith compliance with the duty to warn does not constitute a breach of confidence and cannot not result in liability
- Sub-division [5] requires licensees to continue care unless there is a transfer to another practitioner or facility notwithstanding the client’s violent behavior or threat of such
- Sub-division [6] states that duty to warn does not apply to a threat of suicide or other threats of self-harm or where the threat is made by a client who is adjudicated mentally ill and dangerous under the state’s civil commitment statute
- Sub-division [7] clarifies that licensees are not prohibited from disclosures of confidence to third parties in a good faith effort to warn against or take precautions against client’s violent behavior (i.e. outside the circumstances described in [2])
- Sub-division [8] provides immunity, including disciplinary action on regulatory/licensing issues, for (1) disclosure of confidences to third parties (3) failure to disclose confidences to third parties (3) erroneous disclosure of confidence so long as in good faith

Cases

Lundgren v. Fultz, 354 N.W.2d 25 (Minn.1984)

- [recognizes a common law duty to control in the mental patient context if there is a special relationship and the harm is foreseeable]

- **Facts:** woman shot and killed by paranoid schizophrenic, who was admitted to psychiatric hospital after brandishing a gun in a restaurant, was considered violent and spoke of killing or being killed; after initial discharge, purchased multiple guns, in and out of hospital on voluntary basis, continued to see psychiatrist on outpatient basis. Psychiatrist provided affirmation in July 1970 that man in remission, and could have his guns returned to him; outpatient treatment continued; in November 1971, patient admitting to going off meds and stopped attending appointments, in December 1971, shot woman, random and unprovoked (26-27)

- **Discussions:**
o Referencing §315 of the Restatement, states there is ‘no duty to control the conduct of a third person to prevent that person from causing injury to answer’ unless there exists a special relationship
o Implicit in the duty to control is the ability to control (27)

o Psychiatrist could prevent police from returning schizophrenic’s confiscated guns to him – he could not have control access to guns entirely but there is a question of fact whether he had the ability to control, to some extent (28)

o There is no duty to control unless the harm is foreseeable (28)

o Psychiatrist fully aware of patient’s brandishing guns in public places, his violent predilections; police captain considered returning guns to patient extremely unwise. ... a jury could conclude that psychiatrist should have foreseen that harm to a member of the public might result (29)

**Held:** common law duty to control a patient cannot be imposed on an MHP who does not have a special relationship with the patient that includes the ability to control the patient

o Harm must be foreseeable before a psychotherapist can be found liable for failing to control or commit a patient

**Stuedemann v. Nose, 713 N.W.2d 79 (2006)**

**[affirms common law duty to control where defendant has (1) ability to control and (2) harm is foreseeable]**

**Facts:** Resident of foster home leaves property after being told he did not have permission to leave, and ultimately, under influence of drugs and alcohol, sexually assaults and then murders plaintiffs’ daughter. Plaintiffs sue foster home owners and psychologist who provides counseling and chemical-dependence treatment for the residents.

**Discussion:**

o Discusses there being no general duty to control another, but certain relationships impose a duty to control the third person’s conduct for the protection of either (relying on §315 and §319 of the Restatement (84)

o To the extent responded had authority to control the resident’s behavior, the respondents had a duty to exercise it to prevent him from engaging in violent conduct but they didn’t have authority to physically restrain him, nor could they force him to return after he left, per laws governing group-home licensing in the state (84)

o At most, respondents had a duty to call the police and report him as a runaway, which they did after a few hours – as such there was no breach of the duty (84)

o Relying on Lundgren, the court also disagrees the second element governing the duty to control another’s conduct – foreseeability – and states that the test is whether a defendant was aware of facts suggesting that a plaintiff was being exposed to an unreasonable risk of harm. Ask whether danger objectively reasonable to expect, not simply whether it was within the realm of any conceivable possibility (84)
• resident’s behavior was unforeseeable (85)

• Held: no duty to control arises – no ability to control and no foreseeable harm; absent a duty to control, the only duty could be to call the police – which was done here


• [discusses duty to warn statute in the context of therapist-patient privilege]

• Facts: patient threatens a case worker involved in child protection case to his MHP, who determines that statements not idle threats, concludes they are specific threats of physical violence against identifiable person, triggering duty under M.S. 148.975, so informs supervisor, the casework, and police. (SC, 255)

• Discussion:

Court of Appeal

• The duty-to-warn statute requires a licensee to “take reasonable precautions to provide protection” to a potential victim of violent behavior “only when a client ... has communicated to the licensee a specific, serious threat of physical violence against a specific, clearly identified or identifiable victims (referencing sub-division §148.975 [2]). Reasonable efforts means communicating the ... threat to the potential victim and if unable to make contact with the potential victim, communicating the series, specific threat to the law enforcement agency closest to the potential victim or the client (CA, 435)

• The duty-to-warn statute makes no reference to a psychologist later testifying in court, and it does not contain any language that it creates exception to the privilege (CA, 435-436)

• The purpose of the duty to warn statute is to protect a third person’s safety, not to facilitate criminal prosecution (CA, 436)

Supreme Court

• The duty to warn statute creates a discrete duty for psychologists to warn a “Clearly identified or identifiable potential victim of a specific, serious threat of physical violence; notes the duty is discharged if threat communicated to potential victim or law enforcement but how it says nothing about the duties of confidence to the client once the psychologist has discharged the duty to warn (SC, 258)

• Held: legislature did not intend for the limited disclosure required by the duty-to-warn statute to create an exception to the psychologist-client privilege (CA, 436)

Expose v Thad Wilderson & Associates, 889 N.W.2d 279 (2016)

• [considers definition of “licensee”; does not apply to an unlicensed intern-therapist]

• [same facts as Expose case above; offshoot litigation]
• Mental health therapist was not entitled to the immunity granted under §148.975 because she was neither a licensed psychologist nor a licensed psychological practitioner when she counseled the patient, even though as a student, she was licensed by the Board of Psychology’s rules of ethical conduct.

Mississippi

Summary
• Mississippi Legislature has established a mandatory duty to warn.
• Where a patient has “communicated an actual threat of violence against a clearly identified or reasonably identifiable potential victim or victims” (Miss. Code. Ann. § 41-21-97), the patient’s records and treatment information shall be disclosed by the provider either to
  o Law enforcement,
  o The potential victim or victims, or
  o The parent or the guardian in cases where the potential victim is a minor.

Relevant legislation
Miss. Code. Ann. § 41-21-97 (West) – Confidentiality (Title 41 Public Health, Chapter 21 Mentally Ill and Mentally Retarded Persons)
• Applies to treatment facilities, physicians, psychologists, licensed master social workers and licensed professional counselors.
• Subsection E. Hospital records and information pertaining to patient treatment shall be disclosed when the patient has communicated an actual threat of physical violence against a clearly identified or reasonably identifiable potential victim or victims.
  o In such cases the provider may only communicate the threat to the potential victim or victims, a law enforcement agency, or the parent or guardian of a minor who is identified as a potential victim.

Cases
• [no duty to warn existed prior to 1991 amendment of § 41-21-97]
• Facts: Veteran, who had been previously admitted to the VA hospital on numerous occasions and received treatment at the VA Hospital on an outpatient basis, murdered his daughter and then committed suicide. Wife of patient and mother of victim filed suit against U.S. seeking damages for wrongful death of daughter.
• **Discussion:** District Court analyzes Mississippi law to examine whether psychiatrist owed daughter of patient a Tarasoff-like duty.
  
  o The events in the present case occurred in 1990. Subsection E, which establishes a duty to warn on behalf of the provider, was not enacted until 1991. Thus, the information with regards to the patient’s treatment was confidential. While subsection D of the old version of the statute allowed disclosure for other lawful purposes, there is no evidence in Mississippi law that such a disclosure would have been lawful in a duty to warn situation.

• **Holding:** Defendant was under no duty under Mississippi law to inform any members of the patient’s family of his threats of violence or his dangerous propensities.

**Missouri**

**Summary**

• Missouri has a common law mandatory duty to warn standard:
  
  o “When a psychologist or other health care professional *knows or pursuant to the standards of his profession should have known that a patient presents a serious danger of future violence to a readily identifiable victim* the psychologist has a duty under Missouri common law to *warn the intended victim or communicate the existence of such danger to those likely to warn the victim including notifying appropriate enforcement authorities.*” (*Bradley v. Ray*)

  o In *Virgin v. Hopewell Ctr.* the Court of Appeals declined to extend this duty to warn to the general public.

• Apart from the common law duty to warn, *Mo. Ann. Stat. § 632.300* places an obligation on a very limited number of mental health professionals (“mental health coordinators”) to investigate cases in which an individual poses a likelihood of serious harm. If the investigation produces reasonable cause to believe that the individual does pose a likelihood of serious harm, the coordinator is required to inform police to take the individual into custody if the danger is of imminent nature, and to start commitment proceedings with a court if not.

**Relevant legislation**

*Mo. Ann. Stat. § 632.300 (West) - Procedure when a likelihood of serious harm is alleged (Chapter 632 Comprehensive Psychiatric Services, Civil Detention Procedures)*

• Applies to mental health coordinators. Per *Mo. Ann. Stat. § 632.005* a mental health coordinator is defined as a “mental health professional who has knowledge of the laws relating to hospital admissions and civil commitment and who is authorized by the director of the department, or his designee, to serve a designated geographic area or mental health facility and who has the
powers, duties and responsibilities provided in this chapter.” Thus, the statute only applies to a limited number of professionals who are in the right position to take action under this section.

- Subsection 1. When the coordinator receives information alleging that a person, as the result of a mental disorder, presents a likelihood of serious harm to himself or others, he shall:
  - (1) Conduct an investigation;
  - (2) Evaluate the allegations and the data developed by investigation; and
  - (3) Evaluate the reliability and credibility of all sources of information.

- Subsection 2. If the coordinator, from personal observation or investigation, has a reasonable cause to believe that person due to mental illness presents likelihood of serious harm to self or others, the coordinator may file for detention of that person with the court.

**Cases**

*Bradley v. Ray, 904 S.W.2d 302 (Mo. Ct. App. 1995)*

- [establishing common law duty to warn based on Tarasoff where a patient presents a serious danger of future violence to a readily identifiable victim]

- **Facts:** Prolonged sexual abuse of stepchild. When mother became aware of abuse, she made stepfather seek treatment with two psychologists. Psychologists were aware of the abuse, but did not report abuse to law enforcement authorities. Plaintiff alleges common law negligence against psychologist for failing to warn appropriate officials of suspected child abuse.

- **Discussion:** Court analyses whether duty to warn exists as issue of first impression.
  - Court decides on whether to follow Tarasoff based on the recognition of various legal principles and policies in Missouri law:
    - (1) Foreseeability of harm.
      - Missouri law has recognized that a duty of care arises out of circumstances in which there is a foreseeable likelihood that particular acts or omissions will cause harm or injury. In *Kuhn v. Budget Rent–A–Car, 876 S.W.2d 668 (Mo.App.1994)* defendant owed a duty to control the conduct of a third person based on the foreseeability of potential injury.
    - (2) Special relationship between the psychotherapist and patient.
      - Per Missouri law a duty to control the conduct of third persons will be imposed if a “special relationship” exists between the parties (Court references Restatement (Second) Torts § 315). Physicians already have duty to warn in HIV cases, so why not extend the duty to mental health issues, were third parties can be similarly at risk.
    - (3) Public policy of the state to discourage or prevent foreseeable harm.
• Missouri public policy favors duty to warn based on a social consensus to favor protection against child abuse. Supreme Court has recognized tort actions as deterrent to child abuse.

• Holding: Legal Principles and state policy give rise to a duty on the part of defendants to warn appropriate authorities of the risk of future harm.

• Common law duty to warn standard: “When a psychologist or other health care professional knows or pursuant to the standards of his profession should have known that a patient presents a serious danger of future violence to a readily identifiable victim the psychologist has a duty under Missouri common law to warn the intended victim or communicate the existence of such danger to those likely to warn the victim including notifying appropriate enforcement authorities.”

Virgin v. Hopewell Center, 66 S.W.3d 21, 27 (Mo.App.E.D.2001)
• [duty to warn only extends to identifiable victims, not the general public]
• Facts: Motorist involved in a head-on collision with psychiatric patient (who had expressed that she had a death wish while driving) brought action against psychiatric patient’s healthcare providers for negligence in failing to warn appropriate persons and authorities of the danger of the patient presented to the general public.

• Discussion: Relying on Bradley v. Ray the court argues that foreseeability as to a readily identifiable person will sustain a duty. Since there is no readily identifiable victim in this case to which the Court could hold the defendants responsible, no duty arose under the common law standard established in Bradley v. Ray.

• Holding: Mental health care providers had no duty to warn the general public about the dangerous propensities of their patient.

Montana

Summary

• Montana has a statutory duty to warn under section 27-1-1102, MCA, which is triggered only where (1) there is an actual threat of physical violence (2) by specific means (3) against a clearly identified or reasonably identifiable victim.

• In Gudmundsen v. State, the Montana Supreme Court described the statutory duty as a “extremely narrow”

• More recently, the Montana Supreme Court reiterated its position in Woods v. State, where it added that the statutory duty to warn governs the area entirely, and no general common law principles of foreseeability such as those recognized in Tarasoff are recognized. Further:
  o “Being” a threat generally of committing physical violence does not satisfy the statute
- The statute does not impose upon MHPs a broad duty to infer, investigate, or otherwise deduce whether their patients may pose a potential threat to other individuals.

- **Section 27-1-1102, MCA**, provides that the duty is discharged if the MHP has:
  - (1) made reasonable efforts to communicate the threat to the victim and notify the law enforcement agency closest to the patient’s or the victim’s residence of the threat of violence; and
  - (2) supplied a requesting law enforcement agency with any information the MHP has concerning the threat of violence

- **Section 27-1-1103, MCA**, provides immunity for situations arising outside of the narrow parameters of 1102, including any breaches of confidentiality and/or privilege.

- **Section 27-1-1102, MCA**, provides the definition of MHP, which includes a variety of professions including physicians, professional counselors, psychologists, social workers, and APRNs

**Relevant legislation**

*Mont. Code. Anna. §27-1-1101 – MHP definition*

- Mental health professional includes a physician, professional counselor, psychologist, social worker, advanced practice registered nurse, with a clinical specialty in psychiatric mental health nursing

*Mont. Code. Anna. §27-1-1102 – Duty to warn*

- A mental health professional has a duty to warn of or take reasonable precautions to provide protection from violent behavior only if the patient has communicated to the MHP an actual threat of physical violence by specific means against a clearly identified or reasonably identifiable victim.

- The duty is discharged if the MHP has
  - (1) made reasonable efforts to communicate the threat to the victim and notify the law enforcement agency closest to the patient’s or the victim’s residence of the threat of violence; and
  - (2) supplied a requesting law enforcement agency with any information the MHP has concerning the threat of violence

*Mont. Code. Anna. §27-1-1103 – Immunity*

- Subsection (1) provides immunity for failing to predict, warn of, or take precautions to provide protection from a patient’s threatened violent behavior unless the circumstances set out in 27-1-1102 apply

- Subsection (2) provides immunity for disclosing confidential or privileged information in an effort to discharge duty arising under 27-1-1102
Cases


- [describes duty to warn as “extremely narrow” - need an actual threat of physical violence]
- **Facts:** Man with schizo-affective disorder, killed his brother after they got into an argument shortly after the man was recently from involuntary commitment. While hospitalized, man did not show signs of harming others.

**Discussion:**
  - Identifies the two provisions regarding liability for MHPs – 27-1-1102 and 27-1-1103, which were enacted in response to cases from other jurisdictions decided the question of whether a therapist, whose patient poses a danger of violence to others, has a duty to warn potential victims (reference 1987 Mont. Laws, chapter 214) (816)
  - Discusses Tarasoff and how the California Supreme Court later narrowed its holding, stating that a therapist’s duty to warn is limited to a “named or readily identifiable victim”.
  - Section 27-1-1102 imposes a duty on MHPs to warn of or take reasonable precautions to provide protection from violent behavior “only if the patient has communicated to the [MHP] an actual threat of physical violence by specific means against a clearly identified or reasonably identifiable victim”. Absent those circumstances, the MHP has immunity for “failing to predict, warn of, or take precautions to provide protection from a patient’s threatened violent behavior (816)
  - Rejects argument that the statutory immunity applies only to the MHP, and not the State. … where Montana law protects private citizens from liability, it also protects the State. In this case, if a MHP would not be liable under the conditions indicated in the statutes, neither would the State be liable under those same conditions (816-817)
  - The statute requires proof that the man made “an actual threat of physical violence by specific means against a clearly identified or reasonably identifiable victim”. This exception to liability is extremely narrow. (818)
  - There was no proof offered that the [man] made an actual threat of physical violence by specific means against [his brother]. Accordingly, in as much as the [plaintiff] did not offer proof that the man engaged in conduct which triggered the specific statutory exception, the State is entitled to immunity (818)

- **Held:** since there was no evidence of an actual threat of physical violence by specific means, the state has no duty to warn


- **Confirms** that statutory duty to warn is the only duty that exists, and that no less than an actual threat of physical violence by specific means against a reasonably identifiable victim will trigger the duty
• **Facts:** Approximately one month after being discharged from involuntary commitment, man with long history of various mental illnesses, shot and killed his girlfriend and assaulted the person she was with. During course of admission, man acknowledged alcohol-related issues including that he sometimes became aggressive towards his girlfriend. Therapist thought he was referring to verbal, rather than physical, aggression. But the therapist acknowledged that the man had a history of violent behavior, and that his violence directly related to substance abuse. (1255-1256)

• **Discussion:**
  
  o Discusses how 27-1-1102 was enacted in 1987 in response to legal developments occurring in other jurisdictions, notably, *Tarasoff* (quoting *Gudmundsen*), and that that case was subsequently narrowed by *Thompson*, which established that the duty to warn arose only where a threat existed against “a named or readily identifiable victim or group of victims who can be effectively warned of the danger…” (1257)
  
  o Statutes passed in response, like Montana’s, may be narrower yet, requiring communicating of an actual threat of physical violence against a named or reasonably identifiable victim (referencing *Gudmundsen*) (1257)
  
  o The duty to warn exists only where there exists proof of (1) an actual threat of physical violence, (2) by specific means, (3) against a clearly identified or reasonably identifiable victim. (e.g. *In re Mental Health of M.C.D.*, 2010 MT 15, 225 P.3d 1214, court considered a man’s statement that he would kill his wife his bare hand if she ever called the police to constitute an actual threat of physical violence by specific means against an identified victim) (1247)
  
  o “Being” a threat generally of committing physical violence does not satisfy the statutory criteria of communicating an actual threat of physical violence by specific means. Absent a specific expression or gesture against a reasonable identifiable victim, the duty to warn is not triggered (1247)
  
  o The fact that the man may have presented a threat to his girlfriend in certain circumstances, including his continued alcohol abuse and the end of their relationship, is not sufficient to trigger the statutory duty to warn (1257-1258)
  
  o Section 27-1-1102 does not impose upon MHPs a broad duty to infer, investigate, or otherwise deduce whether their patients may pose a potential threat to other individuals.
  
  o In Montana, there is no common law in any case where the law is declared by statute – and so rejects that general common law principles of foreseeability, similar to those recognized in *Tarossof*, apply (1258)

• **Held:** Absent a specific expression or gesture against a reasonable identifiable victim, the duty to warn is not triggered
Nebraska

Summary

- Nebraska has a statutory duty to warn, under Neb. Rev. Stat. §38-3132 (for psychologists) and Neb. Rev. Stat. §38-2137 (for mental health practitioners) which triggers the duty to warn of and protect from a patient’s violent behavior when the patient has communicated to the professional a serious threat of physical violence against a reasonably identifiable victim or victims.
  - Under those statutes, the duty is discharge if a reasonable effort is made to communicate the threat to the victim(s) and law enforcement.
  - Further, immunity extends to the disclosure of information in furtherance of the duty.
- The Nebraska Supreme Court extended the statutory duty to psychiatrists in Munstermann ex. Rel. Rowe v. Alegent Health-Immanuel Medical Center, where it referred to the narrowing of Tarasoff in California and noted that the two states’ statutory language was identical.
- Thus, Nebraska law requires that the patient communicate an actual threat against a reasonably identifiable patient—and the reasonably identifiable class must be more specific than the city in which the violence took place, per Holloway v. State.
- The Nebraska Supreme Court has also held that absent a custodial relationship, there is no common law duty, per Holloway v. State.
- Of note is that the Nebraska Supreme Court adopted section 41(b) of the Restatement (Third) of Torts—a source of controversy in Volk v. DeMeerleer—in a very recent decision, Rodriguez v. Catholic Health Initiatives. It affirmed that in the context of a hospital and inpatient, a duty to control exists.

Relevant legislation


- Subsection (1) provides immunity for a psychologist for failing to warn of and protect from a patient’s threatened violent behavior or failing to predict and warn of and protect from a patient’s violent behavior except where the patient has communicated to the psychologist a serious threat of physical violence against himself, herself or a reasonably identifiable victim or victims.
- Subsection (2) clarifies that the duty to warn or to take reasonable precautions to provide protection from violent behavior only arises under the limited circumstances of subsection (1).
- Subsection (2) provides that the duty is discharged if the psychologist makes reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency.
- Subsection (3) provides immunity in relation to disclosure of information arising in an effort to discharge the duty.
Neb. Rev. Stat. §38-2116 - The Mental Health Practice Act

- Subsection (1) defines mental health practitioner as a person who holds himself or herself out as a person qualified to engaged in mental health practice or renders mental health practice services, including social workers, master social workers, professional counselors, and marriage and family therapists


- Subsection (1) provides immunity for anyone “who is licensed or certified pursuant to the Mental Health Practice Act” for failing to warn of and protect from a patient’s threatened violent behavior or failing to predict and warn of and protect from a patient’s violent behavior except where the patient has communicated to the MHP a serious threat of physical violence against himself, herself or a reasonably identifiable victim or victims.
- Subsection (2) clarifies that the duty to warn or to take reasonable precautions to provide protection from violent behavior only arises under the limited circumstances of subsection (1)
- Subsection (2) provides that the duty is discharged if the MHP makes reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency
- Subsection (3) provides immunity in relation to disclosure of information arising in an effort to discharge the duty

Cases


- [first time the Nebraska Supreme Court addresses Tarasoff – finds that psychiatrists are subject to the same duty to warn at common law as psychologists and mental health practitioners by statute]
- Facts: man with history of depression and suicidal ideation checks himself into hospital in January 2002, where he was examined and observed for homicidal risk factors, and discharged; check himself back in in February, again denied homicidal ideation, but at appointment with psychiatrist, note is made that he is thinking of hurting his girlfriend because she doesn’t understand that she’s hurting him. man discharged a few days later. The next week he murdered her.
- Discussion:
  - Reviews the Tarasoff facts and analysis, particularly §315 of the Restatement (842)
  - Finds the vast majority of courts that have considered the issues accepted the Tarasoff analysis (842)
  - Refers to the federal case, Lipari v. Sears, Roebuck & Co, 497 F. Supp. 185 (D. Neb. 1980), where the U.S. Distract Court for the District of Nebraska “correctly predicted that this Court would adopt §315 (citing references omitted) and that it would adopt Tarasoff as well ... but that the California legislature adopted Cal. Civ. Code §43.92 to
restrict the scope of Tarasoff, and several states enacted similar statutes based upon California’s example, including Nebraska (842)

**Nebraska Statutes**

- Discusses the predecessor duty to warn statutes to §38-2137 (§71-1336) and §38-2024 (§71-1102), which specific the scope of Tarasoff liability for psychologists and “mental health practitioners” but do not provide corresponding statutory language for psychiatrists (843)

- Finds that in contrast to psychologists and other mental health professionals, psychiatrists, as medical doctors, are not protected by statute; the psychiatrist’s duty is still controlled by common law (845)

**Psychiatrists’ duty**

- Court holds that given its prior endorsement of §315 of the Restatement, and the clearly articulated public policy expressed in the duty to warn statutes, in some circumstances, a special relation may exist between a psychiatrist and patient which imposes a duty upon the psychiatrist to warn or protect a reasonably identifiable victim when a patient has communicated a serious threat of physical violence against the potential victim. However, given the Legislature’s decision to limit Tarasoff by enacting the duty to warn statutes for psychologists and mental health practitioners, the Court found that the limitations set forth in those sections should also be applied to psychiatrists (846)

- The Legislature has made a public policy determination with respect to the Tarasoff duty that the Court is bound to respect – no rational basis for distinguishing the Tarasoff duty of psychiatrists from that of psychologists or other MHPs.

- Refers back to the California statute “identical statutory language” and the fact that the intent of the statutes was not to overrule Tarasoff but to preempt an expansive ruling that a therapist can be held liable for the mere failure to predict potential violence by his or her patient – the statutory language represents an effort to strike an appropriate balance between conflicting policy interests (846)

- Psychiatrists are held to the same duty as is required of psychologists and other mental health practitioners as established by statute (847)

- Relying on discussion in California cases Ewing v. Northbridge Hosp. Medical Center, and Calerdon v. Glick, states that the questions is whether a serious threat of physical violence was actually “communicated” to the psychiatrist.

  - **Held** a duty to warn and protect arises only if the information communicated to the psychiatrist leads the psychiatrist to believe that his or her patient poses a serious risk of grave bodily injury to another (848)

*Holloway v. State, 293 Neb. 12, 875 N.W.2d 435 (2016)*

- [must communicate an actual threat ... against a reasonably identifiable victim. The population of a city does not constitute a reasonably identifiable class]
• Facts: follow release from lengthy incarceration, man shot woman in her front yard, resulting in her suffering permanent brain damage and incurring medical bills. Woman sued, among others, the entity contracted by the state to provide the man mental health services, alleging that once the man informed agents of the state that he intended to cause bodily harm and injury to persons at random, the provider owed a duty to her and the public insofar as the man posed a risk to all citizens in Omaha. Victim alleged that all citizens of Omaha were potential victims.

• Discussion:
  o Court rejects the argument that a city such as Omaha, with 300,000 inhabitants, can constitute a “reasonably identifiable victim or victims” (449)
  o No allegation that the man ever communicated a serious threat of physical violence against her and thus, the provider cannot be liable as a mental health provider under Nebraska law. (449)
  o Further, the provider owed no (common law) legal duty to the victim. Based on §315 of the Restatement, the court notes that there is no special relation here as the relationship necessary for liability is a custodial relationship and that is not present in this case. The relationship between the provider and offender was “more attenuated”, and the offender was never in the provider’s custody (450)

• Held: There must be a communication of a serious threat of physical violence against a reasonably identifiable victim. The population of a city does not constitute a reasonably identifiable group.

Rodriquez v. Catholic Health Initiatives, 297 Neb 1 (2017)

• [recognizes a duty to control where the patient is in the custody of the institution]

• Facts: after a history of assault and battery against the victim, a mentally ill man was taken under emergency protective custody and transferred to the defendant hospital. The hospital refused to release the man regarding his outstanding arrest warrant (related to acts against the victim) and he subsequently left hospital custody, murdered the victim, and returned later that day. The hospital did not notify law enforcement that he had left the premises (5-6). Among the allegations at issue was a failure to control by the hospital and failure to warn by the staff psychiatrist.

• Discussion:
  Duty to Control (hospital)
  o Plaintiffs contend that due to their custodial relationship with the patient, the hospital defendants owed a common law duty of care to the victim. (5)
  o Court notes that it previously adopted certain special relationship provisions in the Restatement (Third), then acknowledges that special relationships are also described in §41(a): “An actor in a special relationship with another owes a duty of reasonable care to third parties with regard to risks posed by the other that arise within the scope of the
relationship. Section §41(b): lists special relationships, including the custodial relationship, and the comments include hospitals for the mentally ill (6)

- Court calls §41(b) consistent with its jurisprudence and prudent, and adopts it (6)
- Based on (Third) custodial relationship need not be “full-time physical custody giving the custodian complete control over the other person” but that to the extent “there is some custody and control of a person posing danger to others, the custodian has an affirmative duty to exercise reasonable care, consistent with the extent of custody and control (6)
- The patient was in the hospital’s custody, and the facts give rise to a duty (6-7)

**Duty to Warn (psychiatrist)**

- Refers to the duty to warn statutes (The Mental Health Practice Act, Neb. Rev. Stat. §§38-2102 to 38-2139 and the Psychology Practice Act, Neb. Rev. Stat. §§38-3101 to 38-3132) for the legal framework, even though the defendant is a psychiatrist. (9)
- Discusses Munstermann, and how the Court concluded that the duty described in the foregoing statutes should be required of psychiatrist and that the “question is whether a serious threat of physical violence was actually ‘communicated’ to the psychiatrist” (9)
- The psychiatrist is exposed to liability in the limited circumstance where information has been communicated to her which leads her to believe that [the patient] poses a serious threat of physical harm against a reasonably identifiable victim. (10)

- **Held:** Allegations against both hospital and psychiatrist can withstand motion to dismiss (appeal granted).

**Nevada**

**Summary**

- Nevada does not have a duty to warn or a duty to protect a victim from a dangerous patient, at common law or by statute.

- There are cases that consider whether there exists a duty to warn/duty to protect based on whether there exists a special relationship between the parties in certain contexts (e.g. landowner-tenant, see: Scialabba v. Brandise Const Co. Inc, 112 Nev. 965, 921 P.2d 928 (1996)),

- However, the state courts do not appear to have considered the issue of hospital-patient in the mental health context, in particular.

- Note that the Supreme Court of Nevada did consider Tarasoff but in the context of a wrongful death action predicated upon a patron who murdered his cab driver in Mangeris v. Gordon, 94 Nev. 400, 580 P.2d 481 (1978). It appeared to accept the key principles – namely the presence of special relationship between the defendant and the dangerous person and the foreseeability of the victim (id. 483) but no cases appear to consider the issue in the mental health context.
New Hampshire

Summary

- New Hampshire recognizes a common law duty to warn in addition to several statutory duties to warn.
- The following health professionals have a duty to warn, or take reasonable precautions to provide protection from a client’s violent behavior, when the client communicates a threat of physical violence against a clearly identified or reasonably identifiable victim:
- The duty to warn for physicians, psychologists, mental health practitioners and psychiatric APRNs is discharged if he or she makes reasonable efforts to communicate the threat to the victims, notifies the police department closest to the client or potential victim’s residence, or obtains civil commitment of the client (sub-section II of all the above statutes).
- For nurses, the duty is discharged if he or she notifies his or her supervisor or the treating provider.
- The statutes also provide immunity for any confidentiality/privacy-related claims arising from efforts to discharge the duty.
- In Powell v. Catholic Med. Ctr, the New Hampshire Supreme Court rejected the argument that the statutes represented the universe of liability in respect of a practitioner’s potential liability regarding a patient harming a third party.
- In Powell v. Catholic Med. Ctr, the New Hampshire Supreme Court held that the statutes represented only the narrow parameters explicitly set out therein, and that they did not circumscribe or otherwise effect the common law duty to warn. However, the Court did not clarify precisely what that duty to warn entailed or to whom it applied, apart from a brief discussion confirming that jury instructions about foreseeability correctly described the principle as a matter of “possibility”, not “probability”.
- The only other case discussing the duty to warn, Carlisle v. Frisbie, reiterated only that the statute was narrowly construed (that case’s main holding was that the duty to warn does not apply to threats of suicide).
Relevant legislation


- Sub-section [I] imposes a duty to warn of, or to take reasonable precautions to provide protection from a client’s violent behavior on a nurse when the client has communicated to the licensee a serious threat of physical violence against a clearly identified or reasonably identifiable victim or victims, or a serious threat of substantial damage to real property
- Under Sub-section [II], the duty may be discharged if:
  - The nurse notifies his or her supervisor or the treating provider; or
  - In the case of psychiatric APRNs, the licensee:
    - Makes reasonable efforts to communicate the threat to the victim(s); or
    - Notifies the police department closest to the client or potential victim’s residence; or
    - Obtains civil commitment of the client to the state mental health system
- Sub-Section [III] specifically provides immunity concerning client privacy and confidentiality for disclosure of information in an effort to discharge the duty pursuant to sub-section [II]


- Sub-section [I] imposes a duty to warn of, or to take reasonable precautions to provide protection from a client’s violent behavior on a psychologist when the client has communicated to the licensee a serious threat of physical violence against a clearly identified or reasonably identifiable victim or victims, or a serious threat of substantial damage to real property
- Under Sub-section [II], the duty may be discharged if a physician:
  - Makes reasonable efforts to communicate the threat to the victim(s); or
  - Notifies the police department closest to the client or potential victim’s residence; or
  - Obtains civil commitment of the client to the state mental health system
- Sub-section [II] also provides immunity if the duty is charged in the circumstances set out in sub-section [I]
- Sub-Section [III] specifically provides immunity concerning client privacy and confidentiality for disclosure of information in an effort to discharge the duty pursuant to sub-section [II]


- Sub-section [I] imposes a duty to warn of, or to take reasonable precautions to provide protection from a client’s violent behavior on a physician when the client has communicated to the physician a serious threat of physical violence against a clearly identified or reasonably identifiable victim or victims, or a serious threat of substantial damage to real property
- Under Sub-section [II], the duty may be discharged if a physician:
  - Makes reasonable efforts to communicate the threat to the victim(s); or
  - Notifies the police department closest to the client or potential victim’s residence; or
  - Obtains civil commitment of the client to the state mental health system
- Sub-section [II] also provides immunity if the duty is charged in the circumstances set out in sub-section [I]
- Sub-Section [III] specifically provides immunity concerning client privacy and confidentiality for disclosure of information in an effort to discharge the duty pursuant to sub-section [II]
• Sub-section [IV] interprets “physician’ to refer to persons providing treatment under the supervision of licensed physicians


• Sub-section [I] imposes a duty to warn of, or to take reasonable precautions to provide protection from a client’s violent behavior on a “person licensed under this chapter” when the client has communicated to the physician a serious threat of physical violence against a clearly identified or reasonably identifiable victim or victims, or a serious threat of substantial damage to real property
• Under Sub-section [II], the duty may be discharged if a physician:
  o Makes reasonable efforts to communicate the threat to the victim(s);
  o Notifies the police department closest to the client or potential victim’s residence; or
  o Obtains civil commitment of the client to the state mental health system
• Sub-section [II] also provides immunity if the duty is charged in the circumstances set out in sub-section [I]
• Sub-Section [III] specifically provides immunity concerning client privacy and confidentiality for disclosure of information in an effort to discharge the duty pursuant to sub-section [II]


• Sub-section VII defines “mental health practitioner” as a person licensed under the chapter as psychotherapists, clinical social workers, clinical mental health counselors, or marriage and family therapists. Clinical social worker included independent clinical social worker.

_Cases_

_Powell v. Catholic Medical Center, 145 N.H. 7, 749 A.2d 301 (2000)_

• [holds that there is a common law duty to warn apart from the statutory duty to warn]
• **Facts:** elderly patient admitted to hospital to the rehab unit, post-stroke; required blood draw and attacked phlebotomist second time she attempted a routine blood sample. Progress reports prior to the assault show patient was agitated, restless, aggressive.
• **Discussion:**

_Statutory duty_

• Considers RSA 329:31 [Physician’s duty to warn statute]
• Distinguishes statute and _Tarasoff_ from case on the basis that at no time did the patient communicate an intent to harm an identified or identifiable victim – at no time did the patient communicate a threat of physical violence regarding any specific staff member. The patient may have been a threat, but he did not communicate that threat (10)
• Rejects the defendants’ argument that the statute intended to place the common law since the statute applies only where the patient has communicated a serious threat of physical violence against a clearly identified or reasonably identifiable victim; therefore, the statute
does not explicitly preempt all common law claims for a physician’s failure to warn, only those that are addressed by its language (10-11)

- the statute does not implicitly repeal the common law duty to warn of a potential violent patient who may pose a danger to others (11)

**Common law duty**

- reviews the jury instruction, which was based on §315 of the Restatement, which stated: generally, there is no duty on the defendants to provide a warning regarding the conduct of a third person such as the [the patient], to prevent him from causing physical harm to the plaintiff unless, one: a special relationship exists between the defendants and the third person which imposes a duty upon the defendants to control the third person’s conduct ...(11-12)
- rejects argument that common law duty should be based on a “reasonable professional” standard rather than a “reasonable person” standard – it is an “ordinary duty of care case” (12)
- in this case, the progress notes of the patient detail numerous prior events that served to put [the physician] and the hospital on notice that the patient may have been a threat (12)
- rejects the argument that foreseeability requires a finding of probability (as opposed to possibility) (13)
- rejects argument that jury should have been instructions that plaintiff required to prove that the patient communicated a serious threat of physical violence against a clearly identified or reasonably identified victim – that would be to impose the requirements of RSA 329:31 on the plaintiff’s common law duty to warn claim (13)
- **Held:** there is a common law duty to warn where it the harm is foreseeable; the physician’s statutory duty to warn is inapplicable in the circumstances

**Carlisle v. Frisbie Memorial Hosp., 152 N.H. 762, 888 A.2d 405 (2005)**

- [reiterates that the statutory duty to warn is limited; confirms that suicide does not constitute a threat triggering the duty to warn]
- **Facts:** Woman attends hospital while drunk and experiencing suicidal ideation. Doctor asks her if she will speak to mental health services, she declines, he phones police, who arrest her and hold her. Woman sues doctor for negligence, doctor argues he was complying with his duty to warn
- **Discussion:**
  - The doctored argued that the plaintiff’s statement contemplating suicide was a “serious threat of physical violence” and made her “clearly identified victim” under RSA 329:31, l.
  - Plain reading of the statute reveals that it does not apply to suicide (773)
  - Referencing *Powell*, the Court states that it previously recognized that “[t]he subject matter embraced by RSA 329:31 is limited to a physician’s duty to warn of a client’s
violent behavior when the client has communicated a serious threat of physical violence against a clearly identified or reasonably identifiable victim” (773)

- There is no warning necessary for a threat of suicide, because the potential attacker and potential victim are the same person. The victim already knows the danger (774)

**Legislative history**

- The House and Senate enacted RSA 329:31 as part of a bill entitled ‘An Act Relative to a Duty to Protect Third Persons.’ Laws 1986, ch. 175. (774)
- The House Judiciary Committee’s report on the bill states, “This bill limits the civil liability of certain medical and mental health providers ... so long as the providers contact the threatened victim, or the police, or seek civil commitment,” (references omitted) (774)

- **Held:** the statutory duty to warn does not apply in the case of threatened suicide

**New Jersey**

**Summary**

- New Jersey has established a statutory mandatory duty to warn and protect per N.J. Rev. Stat. §2A:62A-16 where:
  - A patient has communicated a threat of imminent, serious physical violence against a reasonably identifiable individual, and where
  - A professional would believe that the patient intended to carry out an act of imminent, serious physical violence against a reasonably identifiable individual.

- The statute prescribes specified measures for discharge of this duty to warn and protect.
- Statute does not limit medical malpractice liability of providers (*Marshall v. Klebanov*).

**Relevant legislation**

_N.J. Rev. Stat. §2A:62A-16 - Health, mental health, and counseling professionals; immunity from liability; duty to warn; disclosure of privileged communications_

- Applies to anyone licensed to practice psychology, psychiatry, medicine, nursing, clinical social work or marriage counseling.
- Subsection B. A duty to warn and protect arises when:
  - the patient has communicated to a practitioner a *threat of imminent, serious physical violence* against a *readily identifiable individual or himself* and a reasonable professional in the practitioner's area of expertise would believe the *patient intended to carry out* the threat; or
o a reasonable professional in the practitioner’s area of expertise would believe the
patient intended to carry out an act of imminent, serious physical violence against a
readily identifiable individual or against himself.

- Subsection C. The practitioner can discharge of the duty to warn and protect by doing one or
more of the following:
  o Arrange for voluntary commitment,
  o Initiate procedures for involuntary commitment,
  o Advise law enforcement of the intended threat and the identity of the victim,
  o Warn the identified victim, or if a minor, warn the parents or the guardian,
  o Warn the parents or guardian if minor patient threatens injury upon self.

- Subsection D. No liability for disclosure of privileged information when complying with
Subsection C.

Governor’s Reconsideration and Recommendation accompanying Enactment in 1991:

- Bill does not address an important provision under federal law which would preempt this act
and could result in the imposition of federal criminal penalties against certain practitioners who
rely solely on state law.

- Current federal law and regulations prohibit counselors in federally assisted drug and alcohol
abuse programs from disclosing any identifying details about a patient unless a prior court order
is obtained. See: 42 U.S.C.A. Sec. 290dd-3 and Sec. 290ee-3; 42 C.F.R. part 2.

- Disclosures have to be authorized by a court after showing of “good cause” (whether the public
interest and need for disclosure outweighs the injury to the patient, to the physician-patient
relationship and to the treatment services).

Proposed Legislation: 2017 Session - Requires firearms seizure when mental health professional
determines patient poses threat of harm to self or others.

Regulations and administrative guidance


- Privileging any communication between a licensee or a certificate holder and the person or
persons counseled while performing counseling. Privilege can be waived when disclosure is
Cases


- [Court clarifies purpose of statute, statute does not bar negligence action against provider]
- **Facts:** Suit against wife’s treating psychiatrist for malpractice and wrongful death, resulting from wife’s suicide. Wife had history of suicide attempts and suicidal thoughts.
- **Discussion:** Defendant argued that that N.J.S.A. 2A:62A-16 shields a mental health professional from liability for deviations from the standard of care in all instances except where the patient's suicide is imminent and moved the Court for dismissal. Judge granted motion to dismiss. Plaintiff appealed
  - Statute is only implicated if case involves a duty to warn and protect.
  - The statute does not establish the only means by which a psychiatrist can be subject to a duty to protect a patient from self-inflicted harm; a duty to protect may arise without a duty to warn.
  - Legislature did not intend to sweep as broadly as defendant argued. Intentions to do so would have been signaled with greater clarity.
- **Holding:** The plain purpose of immunity statute for mental health care practitioners is to codify the practitioner's duty to “warn and protect” others of a patient's imminent threat of violence or suicide without fear of violating ethical restraints by disclosing confidential information. of suicide or the gravity of the practitioner's deviation from the pertinent standard of care.
  - Grant of motion to dismiss is reversed. Negligence action is not barred by statute.


- [§2A:62A-16 provides hospital with immunity from liability where hospital liability was alleged based on respondeat superior]
- **Facts:** Victim assaulted by formerly involuntarily committed patient. Patient had never before threatened or had any type of altercation with victim, and patient never mentioned victim to the doctors or hospital staff during his commitment. Victim brought action against doctors who had approved patient’s release and hospital that employed them. Trial Court granted hospital and doctor’s motion for summary judgement.
- **Discussion:** Plaintiff argues that the statute's use of the word “person” means that it may immunize the doctors against any failure to warn claim, but it does not immunize the hospital.
  - Court rejects “hyper-literal reading”. Here, hospital was solely alleged to be liable under the doctrine of respondeat superior. Plaintiff conceded that the doctors could not be liable for a failure to warn. Thus, the statute cloaked the hospital with immunity from liability for any failure to warn.
• Relying on Marshall v. Klebanov Court affirms that statute does not immunize doctors from malpractice action.

→ Standard to Warn Previous to Statute Enactment

*McIntosh v. Milano, 168 N.J. Super. 466 (Law Div. 1979)*

• [establishing duty to protect prior to statute enactment in 1991]
• Facts: Court denied summary judgment to psychiatrist who failed to warn of his patient's violent fantasies directed toward decedent.
• Standard established: “psychiatrist or therapist may have a duty to take whatever steps are reasonably necessary to protect an intended or potential victim of his patient when he determines, or should determine, in the appropriate factual setting and in accordance with the standards of his profession established at trial, that the patient is or may present a probability of danger to that person.”

**New Mexico**

**Summary**

• There is no statutory duty to warn/protect third parties.
• No state court has recognized a common law duty to warn/protect third parties.
  - “New Mexico has noted that many courts recognize 'a duty to warn when a specific, identifiable third party [victim] was known to the doctor,' . . . although it does not appear that the state has resolved this question for itself.” *Weitz* at 1182.
• A federal court, interpreting N.M. law, speculated that “New Mexico would not impose [a duty to warn] in any event where the victim was already subjectively aware of the patient's violent tendencies and specific threats.” *Id.*
• A theme of exercising extreme caution in recognizing new duties to third parties for healthcare providers runs throughout the case law. See discussion at *Ross*, 229 P.3d at 1258–60.
• There can be a duty to control owed to third parties, which turns on the foreseeability of the danger. See *Ross* at 1258–59. But it is likely limited to the inpatient context: a federal court, interpreting N.M. law, speculated that N.M. courts would probably not recognize a duty to control in the outpatient context. *Weitz*.

**Cases**

*Ross v. City of Las Cruces, 229 P.3d 1253 (N.M. Ct. App. 2009).*

[Significance – The duty to control a patient turns on the foreseeability of the danger]
Facts: Estate of deceased pedestrian brought wrongful death action against hospital and psychiatrist after mental patient, who had been discharged from their care 12 days prior, struck him with his automobile.

Law:

- “The general rule regarding duty, recognized in New Mexico, is that “an individual has no duty to protect another from harm.” Estate of Eric S. Haar v. Ulwelling, 2007–NMCA–032, ¶ 23, 141 N.M. 252, 154 P.3d 67. . . . In order to impose a duty, a relationship must exist that legally obligates the defendant to protect the plaintiff’s interest. Id. ¶ 15. In addition to that legal obligation, where a duty is based on a special relationship, the defendant must have “the right or ability to control another's conduct.” Id. ¶ 23 (internal quotation marks and citation omitted).” 1257.
- “More specific to the duty owed by health care providers to third parties, our Supreme Court has stated that the general rule in New Mexico is that “a physician owes a duty to his or her patient, and not to third party non-patients.” Lester ex rel. Mavrogenis v. Hall, 1998–NMSC–047, ¶ 25, 126 N.M. 404, 970 P.2d 590.”

Held:

- Likelihood of injury to pedestrian was not foreseeable to the extent necessary to create a duty owed by providers to pedestrian because the accident occurred 12 days after the patient’s last contact with providers, it did not appear that patient at time of accident had an ongoing patient-provider relationship with those providers, and an outpatient follow-up appointment had been scheduled with a separate provider.
- Public policy did not warrant imposition of duty on providers to protect pedestrian.

**Weitz v. Lovelace Health Systems, Inc., 214 F.3d 1175 (10th Cir. 2010).**

**[Significance – Federal court, interpreting N.M. law, recognizing that N.M. has not settled duty to warn law and speculating that N.M. would probably not recognize it in situation where plaintiff was already aware of danger]**

- Facts: Relative of sister and niece who had been shot by sister’s husband brought negligence action against mental health care provider which had provided counseling services to husband.
- Held: Trial court’s finding that health care provider did not owe duty to control husband or warn wife and daughter was not unreasonable.
- Discussion:
  - “The strong weight of authority suggests that New Mexico would not find [a duty to control] under these circumstances.” Id. at 1181–82.
  - The court noted that the relationship between a psychiatric outpatient and their health care provider is less involved than that of an inpatient because the outpatient status “affords the health care provider only limited opportunity to supervise the patient.” 1182. As a result of the limited interaction between provider and patient, the court held that “imposing a duty to control in the
outpatient context would require providers to exercise a degree of care and oversight that would be practically unworkable.” Id.

- “New Mexico has noted that many courts recognize “a duty to warn when a specific, identifiable third party [victim] was known to the doctor,” . . . although it does not appear that the state has resolved this question for itself.” Weitz, 1182.
- “[I]t is probable that New Mexico would not impose [a duty to warn] in any event where the victim was already subjectively aware of the patient’s violent tendencies and specific threats.” 1182.

**New York**

**Summary**

- New York has a common law duty to protect only where the mental health provider has a special relationship with the third-party patient that includes the ability to control the patient, per the state high court’s very recent ruling in *Oddo v. Queens Village Committee for Mental Health*
  - This statement has been made repeatedly over the years. See e.g. *Wagshall v. Wagshall, Engelhart v. County of Orange* and *Citera v. County of Suffolk*
- The said, a federal circuit court decision reviewing New York law suggests that there is no bright line rule regarding whether a duty may be owed by mental health providers in respect of harm caused by outpatients, since the *Mental Hygiene Law* (the state’s civil commitment regime) does provide a basis for exercising control. In *Rivera v. New York City Health & Hospitals Corp*, it was held that the presence of a duty (or not) would depend on the facts

- New York’s duty to warn is less clear cut. *N.Y. Mental Hyg. Law §33.13 (c)(6)* permits treating psychologists or psychiatrists to disclose otherwise confidential patient information when it is for the purposes of warning an endangered person and law enforcement when he or she has determined there is a serious and imminent threat to that individual
  - The law does not clarify the class of persons who may qualify as “endangered”, it is limited to only psychologists and psychiatrists associated with state mental health facilities, and it is permissive, not mandatory (see *Scott Ragge article*)
- There is also a recent 2013 statute (*N.Y. Mental Hyg. Law §9.46(b)*) which requires an MHP to report to the director of community services (or designate), “as soon as is practicable” when a person he or she is treating is, in the MHP’s reasonable professional judgment, likely to engage in conduct that would result in serious harm to the person or others
- *N.Y. Mental Hyg. Law §9.46(b)* further specifies that the director (or designate) must then report to the criminal justice division, which information shall be used to determine whether the person should be prohibited from possessing or applying for a license to possess a firearm
• **N.Y. Mental Hyg. Law §9.46(d)** provides MHPs immunity from criminal and civil liability for a failure to report as well as the decision to report, so long as it is made in good faith

**Relevant legislation**

**N.Y. Mental Hyg. Law §9.46**

• Sub-section (a) defines the term mental health professional to include a physician, psychologist, registered nurse or licensed clinical social worker

• Under sub-section (b), when an MHP who is currently providing treatment services to a person determined in the exercise of reasonable professional judgment, that the person is likely to engage in conduct that would result in serious harm to the person or others, the MHP is required to report, as soon as practicable, to the director of community services, or the director’s designee, who shall report to the division of criminal justice services whenever the reportee agrees that the person is likely to engage in such conduct.

• Sub-section (b) specifies that information transmitted to the criminal justice services must be limited to names and other non-clinical identifying information to be used for determining whether a person should be prohibited from possessing a firearm, either as a licensed gun owner or an applicant for such a license

• Sub-section (c) clarifies that nothing in this section requires MHPs to take action that, in the exercise of reasonable professional judgment, would endanger themselves or increase the danger to the potential victim(s).

• Sub-section (d) provides MHPs criminal and civil immunity for failure to report as well as the decision to report, so long as it is made in good faith

**N.Y. Mental Hyg. Law §33.13 (c)(6)**

• (c) Information about patients or client ... shall not be a public record and shall not be released by the offices or its facilities to any person or agency outside of the office except .. (6) to an endangered individual and a law enforcement agency when a treating psychiatrist or psychologist has determined that a patient or client presents a serious and imminent danger to that individual.
  
  o The reasons for any such disclosures shall be fully documented in the clinical record.
  
  o Nothing in this paragraph shall be construed to impose an obligation upon a treating psychiatrist or psychologist to release information pursuant to this paragraph

**Cases**


• [no duty to control in the voluntary outpatient treatment setting; no duty to warn where the plaintiff aware of patient’s dangerous propensities]
• **Facts:** husband and wife enter couples counselling, and execute an agreement with mental health providers to store their handguns in an accessible place. Seven to eight months after treatment terminated, wife shot and injured husband. Husband sues defendants for failing to control his wife and to warn him of the danger he posed

• **Discussion:**
  
  o It is firmly established that absent a special relation between an actor and a third person, there is no duty to control the conduct of that third person so as to prevent him from causing physical harm to another, referencing §§315-319 of the Restatement, and New York case law including *Purdy v. Public Adm’r of County of Westchester, 72 N.Y.2d 1* (446)
  
  o Liability has only been found where the defendant had the ability to control the actions of a person known to be violent, referencing *Abernathy v. United States, 773 F.2d 184,189* (446-447)
  
  o In a voluntary outpatient treatment setting, a defendant clinic has been held to have no duty to control its patient’s conduct, referencing *Cartier v. Long Is. Coll. Hosp., 111 A.D.2d 894* and *Purdy* (447)
  
  o Therefore, the defendants (appellants) had no duty to control or restrain [the wife], a voluntary outpatient client had not visited their facility for several months prior to the shooting (447)
  
  o Nor did the defendants (appellants) have a duty to warn the plaintiff of his wife’s violent propensities, as he was well aware of the peril, having been attacked by his wife on prior occasion (she attacked him five weeks before the instance assault). Even if there was a duty to warn, the breach thereof could not have been the proximate cause of the plaintiff’s injuries (447)

• **Held:** there is no duty to control when the patient had been a voluntary and had no visited the facility in months; nor is there a duty to warn


• [A psychiatrist employed at a state facility is not in breach of his duty of confidence to patient if the patient poses a serious and imminent threat to an individual and the disclosure is to warn the endangered person and the authorities]

• **Facts:** man threatens the life of his son’s schoolmate during therapy session and his therapist reports the man to the police, stating that he is dangerous. The therapist also told his patient’s wife to obtain the names and addresses of the potential victim. Then therapist called the family of the potential victim to warn them that the patient was violent. The man sues his therapist for breach of confidentiality, among other issues. (114)

• **Discussion:**
  
  o Defendant established that there is no triable issue of fact as to whether he was justified in disclosing the confidence (114)
Defendant was an employee at a psychiatric institution, a state facility, at the time of his session with the plaintiff. (114)

Contemporaneous clinical records kept by defendant document his finding that the plaintiff presented a serious and imminent danger and authorized him to disclose the threat to the authorities and to the family of the boy, referencing Mental Hygiene Law 33.13(c)(6) (114)

- **Held**: Mental Hygiene Law 33.13(c)(6) permits disclosure of patient confidences if the criteria under the statute are met, including contemporaneous document setting out the presence of a serious and imminent threat to an individual

von Ohlen v. Piskacek, 277 A.D.2d 375, 717 N.Y.S.2d 221 (2d Dep't 2000)

- [There is no duty to warn the plaintiff of the patient’s violent tendencies when the plaintiff is aware of them]
- **Held**: there is no duty to warn the wife of her husband’s vicious tendencies as she was well aware of those tendencies because her husband had stepped her on a previous occasion


- [there is a common law duty owed to third parties in certain circumstances, regarding outpatients, dependent on the facts]

- **Facts**: a homeless, paranoid schizophrenic man pushed the plaintiff in front of an oncoming subway train at the time that he was receiving medical care or other assistance from three medical facilities and two homeless shelters. Victim and his wife sue the facilities and shelters for failing to protect the public from the man.

- **Discussion**:
  - Begins the analysis by setting out the general rule that a defendant owes no duty to control the conduct of a person to prevent him from causing harm to others unless there exists a special relationship between the defendant and a third person, referencing §315 of the Restatement and where one “takes charge” of a third person whom he knows or should know is likely to cause bodily harm to others if not controlled is under a duty of reasonable care to control that third person to prevent him from doing such harm, referencing §319 of the Restatement – and that New York courts adhere to these principles (4217-418)

**Medical and Psychiatric Care Providers**

- States the general rule that medical doctors owe a duty of care to their patients and persons they know or reasonably should have known were relying on them for services to the patient (a group narrowly construed), but they do not owe a duty to the public at large (418)
- The duty owed to third parties by a psychiatrist or mental health practitioner is somewhat different in that, in addition to their general duty to exercise professional judgment owed to patients and the narrow category of individual the physician could
expected to be affected by the treatment, they may owe a duty in certain circumstances to the outside public as well, referencing *Winters v. New York City Health & Hospitals Corp*, 223 A.D.2d 405, 636 N.Y.S.2d 320 (1996), and *Schremph v. State*, 66 N.Y.3d 289, 496 N.Y.S.2d 973 (1985)(418)

- In *Winters*, a hospital released a psychiatric patient who later killed someone – appeal court affirmed denial of summary judgment on the basis that there were issues of fact related to the hospital’s decision to release the patient (419)

- In *Schremph*, a man with history of institutionalization who was receiving outpatient treatment at the state hospital killed a man – appeal court acknowledged that there is a duty to the outside public to restrain dangerous, or potentially dangerous, persons so they may not harm others, and that the state has been frequently liable for breaching its duty, the court reversed the finding of liability on the basis that any errors were in the course of exercising their professional judgment (419)

**Inpatient and Outpatient Treatment**

- There is no bright-line rule regarding liability for failing to control or commit a voluntary outpatient who later harms a member of the public (419)

- New York has not adopted a bright-line rule (419)

- Substantial New York case law has concluded that health care providers may be liable to third parties in outpatient situations – in *Schremph*, the court recognized that the State’s control over the voluntary patient and its consequent duty to prevent him from harming others, is more limited than one involving an inpatient but nevertheless still present (420)

- There is substantial case law from other jurisdiction holding that MHPs may have a duty to protect others from the actions of voluntary patients (with reference to *Tarasoff*). Although *Tarasoff* involved a specifically identifiable victim, other courts have found a duty to all foreseeable victims, including members of the general public (citing references omitted)(420)

- Notwithstanding important policy considerations associated with imposing liability on psychotherapists, they must still act with reasonable care and competence (420)

**The Mental Hygiene Law**

- Reviews the commitment laws regime in the context of the question of whether the psychotherapist has the ability to control the actions of a patient who presents a danger to others – and determines that there are mechanisms by which to seek control of patients, including outpatients, who are threat to themselves or others, in addition

- **Held**: there is no bright-line rule regarding the presence of a duty of care by a mental health provider in respect of the general public regarding the treatment of an outpatient; it turns on the facts – psychotherapists owe a duty to third party in certain circumstances (422-423)
Motions by medical providers to dismiss, or for summary judgment, on the grounds they owned no duty to protect the victim and the public, are denied.

**Citera v. County of Suffolk, 95 A.D.3d 1255, 945 N.Y.S.2d 375 (2d Dep’t 2012)**

- [a common law duty to control a patient can only be imposed upon an MHP who has a special relationship with the patient that includes the ability to control the patient]
- **Facts:** psychiatrist visits outpatient at home after being informed the outpatient, who had been released from a state psychiatric center, was in a verbal and physical altercation; psychiatrist concludes that outpatient was stable and did not need further evaluation or psychiatric admission. The following day the outpatient murdered his mother
- **Discussion:**
  -
- **Held:** an outpatient psychiatric treatment provider does not have the necessary authority or ability to exercise requisite control over an outpatient’s conduct so as to give rise to a duty to protect a member of the general public

**Oddo v. Queens Village Committee for Mental Health, 28 N.Y.2d 731, 71 N.E.3d 946 (2017)**

- [duty to protect does not arise where defendant does not ability to control third party]
- **Facts:** man attending diversion program to avoid criminal prosecution admitted to a mental health program but was discharged after breaching policies related to violence and alcohol. Shortly after being discharged, he assaulted his mother’s boyfriend. Boyfriend sued the mental health program for failing to control/negligently releasing the man.
- **Discussion:**
  - Begins the discussion with the general rule that there is no duty to control the conduct of third persons to prevent them from harming others, even if practically, the defendant could have exercised such control (referencing Purdy v. Public Adm’r of County of Westchester, 72 N.Y.2d 1) (735-736)
  - Although a duty may arise where there is a special relationship, such as where “there is a relationship between defendant and a third-person tortfeasor that encompasses defendant’s actual control of the third person’s actions” such as master and servant, parent and child, common carriers and passengers (736)
  - In the case, the mental health program discharged the man from its facility and was no longer in charge of him when the incident occurred (736)
  - Further, although voluntary departure from the program could trigger adverse legal consequences (i.e. criminal prosecution), residents could leave at any time. That is, the program cannot force participants to remain on the premises; these facilities are not prisons (736-737)
Referencing *Eiseman v. State of New York*, 70 N.Y.2d 175, 518 N.Y.S.2d 608 (1986), the Court must be cognizant not to impose on a party “limitless liability to an indeterminate class of persons conceivably injured by any negligence” – so in the instance case, it is difficult, if not impossible, to determine when the program’s duty to protect the public from the man would end of any duty existed beyond his discharge (737)

- It is unreasonable to impose upon facilities like [the program] a duty to protect the public from individuals they have dismissed from their charge because the duty would essentially be limitless (737)
- Imposing a duty could also undermine the policy goals associated with operating these types of program, and therefore contrary to public policy (737)

**Held:** there is no duty to control third persons for the protection of individuals of the general public once in the context of programs that do not have the ability to control participants.

**Other sources**

*Scott Rogge, Liability of Psychiatrists under New York Law for Failing to Identify Dangerous Patients, 20 Pace L. Rev. 221 (2000)*

- Available at: [http://digitalcommons.pace.edu/plr/vol20/iss2/1](http://digitalcommons.pace.edu/plr/vol20/iss2/1)
- New York responded to Tarasoff by passing an exception to its patient-therapist confidentiality laws (N.Y. Mental Hyg. Law §33.13(c)(6) (McKinney 1996) (226)
  - The exception was passed in 1984 as an amendment to the section of the Mental Hygiene Law governing the confidentiality of records.
  - It appears to give clinicians permission to release relevant medical records with immunity (226)
- **Caveats to the law:**
  - Only expressly applies to New York State Office of Mental Health operated or licensed facilities – most psychiatric hospitals and clinics are licensed by OMH, nevertheless there are those that are not
  - Only refers to psychiatrists and psychologists, but not psychotherapists or other mental health providers (e.g. psychiatric social work or nurse clinicians)
  - Gives permission for a Tarasoff-type disclosure but expressly imposes no obligation
  - Circumstances permitting the disclosure are narrowly defined – when treating physician has determined that the patient presents a “serious and imminent danger” to “an endangered individual” (226-227)
North Carolina

Summary

- Does not recognize a duty to warn/protect. Gregory.
- Does recognize a duty to control involuntary committed mental patients. Davis.

Cases


[Significance – Expressly rejects Tarasoff’s duty to warn]

- **Facts:** Executor of wife's estate brought wrongful death action against psychiatrist for, among other things, failing to warn the wife of husband's dangerous propensities.
- **Held:** Psychiatrist had no duty to warn the wife.
- **Discussion:** “[U]nlike the holding in Tarasoff, North Carolina does not recognize a psychiatrist's duty to warn third persons.”


[Significance – Re-affirming N.C.’s recognition of a mental health institution's duty to control]

- **Facts:** The N.C. Department of Human Resources appealed a decision of the N.C. Industrial Commission, awarding the plaintiff, as administrator of the estate of the deceased, damages for injuries occurring when a mental patient was released from a state mental hospital where he had been involuntarily committed, and subsequently killed the deceased.
- **Law:**
  - “The general rule is that there is no duty to protect others against harm from third persons. King v. Durham County Mental Health Auth., . . . . A recognized exception, however, exists where a person has been involuntarily committed for a mental illness, in which case there is a duty on the institution to exercise control over the patient “with such reasonable care as to prevent harm to others at the hands of the patient.” Pangburn v. Saad.”
- **Held:** Patient was involuntarily committed into defendant’s custody and it, therefore, had a duty to exercise control with reasonable care in the protection of third parties from injury by patient.

North Dakota

Summary

- No duty to warn/protect; no duty to control.
Ohio

Summary

- Ohio has a detailed statutory duty to protect, under Ohio Rev. Code Ann. §2305.51(B), which is triggered when there has been an explicit threat of imminent and serious physical harm to a clearly identifiable person and there is reason to believe that the client/patient has the intent and ability to carry out the threat
  - An “explicit threat” is a threat against the person who was subsequently injured (Stewart v. North Coast Ctr.)
- The duty applies to mental health professionals (i.e. those who provides medical, psychiatric, counselling, social work and therapist services) and mental health organizations (i.e. those which employ MHPs) (§2305.51(A))
- Under Ohio Rev. Code Ann. §2305.51(B)(v), the duty may be discharged if the MHP or MHO takes one or more of the following steps:
  - exercises authority to hospitalize patient either on emergency basis, voluntarily or involuntarily
  - establishes an appropriate treatment plan to thwart the threat and obtains a second risk assessment
  - warns law enforcement and the potential victim(s) of the nature of the threat, the person making the threat and each potential victim of the threat
- Under Ohio Rev. Code Ann. §2305.51(C), provides added components to the duty including that the MHP or MHO consider which course of action is appropriate and to chart the basis for the ultimate course of action
- If the stipulations under Ohio Rev. Code Ann. §2305.51(B) and (C) are met, the MHP/MHO has statutory immunity

Other notes

- The majority opinion in Volk v. DeMeerleer relied heavily on the Ohio case, Estates of Morgan v. Fairfield Family Counseling Ctr, which is reviewed in length below. Of note:
  - Morgan is a duty to control case, and the Volk decision deals with a failure to warn/protect and it denies that there is a duty to control (insofar as it denies the ability to control is a requisite component of the duty)
  - Among the holdings in Morgan is that there are enough elements of control in the outpatient context to impose a duty to control; and there is no “reasonably identifiable victim” requirement in the duty to control context, as there is in the duty to warn context
  - Morgan was subsequently superseded by statute, as discussed in Bhola v. Northcoast Behavioral Health Care Ct as well as the Rhode Island Supreme Court case, Santana v. Rainbow Cleaners (discussed in that state’s section, below)
**Relevant legislation**

*Ohio Rev. Code Ann. §2305.51 – Liability of mental health professionals and organizations for violent behavior of mental health clients or patients*

- **Subsection (A)(1)** provides a list of definitions applying in the section, including:
  - Mental health professional – individual licensed, certified, or registered under the Revised Code, or otherwise authorized in this state, to provide mental health services, which involved medical, psychiatric, psychological, professional counseling, social work, marriage and family therapist, or nursing principles or procedures
  - Mental health organization – engages one or more mental health professionals to one or more mental health clients or patients
  - Knowledgeable person – individual with reason to believe that a mental health client or patient has the intent and ability to carry out an explicit threatening of inflicting imminent and serious physical harm to or causing the death of a clearly identifiable potential victim(s) and who is either an immediately family members of the client or an individual who otherwise personally knows the client or patient.
  - **Sub-section (A)(2)** states that in the event of a treat to a readily identifiable structure, “clearly identifiable potential victim” includes any potential occupant of the structure

- **Sub-section (B)** provides immunity for MHPs and MHOs for serious physical harm or death of a third party resulting from failing to predict, warn of, or take precautions to provide protection from the violent behavior of a mental health client or patient unless:
  - (i) the client or a knowledgeable person has communicated to the professional or organization
  - (ii) an explicit threat of inflicting imminent and serious physical harm to or causing the death of one or more
  - (iii) clearly identifiable potential victims
  - (iv) the professional or organization has reason to believe the client or patient has the intent and ability to carry out the threat
  - [discharge of duty] (v) and fails to take one or more of the following actions in a timely manner:
    - (1) Exercise authority to hospitalize the client or patient on an emergency basis
    - (2) Exercise authority to have the client or patient involuntarily or voluntarily hospitalized
    - (3) Establish and undertake a documented treatment plan that is reasonably calculated to eliminate the possibility that the threat will be carried out; and, obtain a second opinion risk assessment
    - (4) Communicate to a law enforcement agency with jurisdiction in area where each potential victim resides, and if feasible communicate to each potential
victim (a) nature of the threat (b) identity of client or patient making the threat (c) identity of each potential victim of the threat

• **Sub-section (C)** states that when a MHP or organization takes one or more of the actions set forth in (B):
  
  o (1) MHP or organization will consider each of the alternative and document the reasons for choosing or rejected each alternative
  
  o (2) MHP or organization may take into account which alternative would least abridge the rights of the mental health client or patient
  
  o (3) MHP or organization not responsible to take action which would, in the exercise of reasonable professional judgment, would physically endanger the professional or organization, increase the danger to a potential victim, or to the client or patient
  
  o (4) MHP or organization has immunity regarding disclosing any confidential information of a client or patient which is disclosed for the purposes of taking any of the above actions

Ohio Rev. Code Ann. §5122.24 Liability (under Chapter 5122: Hospitalization of Mentally Ill)

• **Sub-section (A)** provides that persons including mental health services providers, acting in good faith ... who .... Assists in the hospitalizations or discharge, determination of appropriate placement, court-ordered treatment, have immunity from criminal and civil liability

• **Sub-section (B)** states that regardless of whether any affirmative action has taken place under the chapter – except as provided under section 2035.51 [the duty to protect provision] - no person shall be liable for any harm that results to any other person as a result of failing to disclose any confidential information about the mental health client or patient, or failing to otherwise attempt to protect such other person from harm by such client or patient

Cases

*Littleton v. Good Samaritan Hosp. & Health Center, 39 Ohio St. 3d 86, 529 N.E.2d 449 (1988)*

• [Common law duty to protect arises where there is a special relationship between therapist and patient]

• **Facts:** two weeks after being released from voluntary hospitalization, a mother with post-partum depression and other mental disorders, killed her infant daughter. Throughout her treatment, and the basis of her treatment, were feelings of wanting to get rid of her daughter (i.e. put her up for adoption) and was afraid her daughter would break up her family.

• **Discussion:**
  
  o A duty between the plaintiff and the defendant depends on the foreseeability of the injury – court finds no difficulty with the proposition that a reasonably prudent psychiatrist would have anticipated that an injury to Carly could result from discharging the patient without adequate precautions (92)
However, there is no duty to control the conduct of another person so as to prevent him from causing harm to another person unless a “special relation” exists, per §315 of the Restatement, and that a special relation exists when one takes charge of a person whom he knows or should know is likely to cause bodily harm to others if not controlled, per §319 of the Restatement (92)

Even though the patient was voluntarily in hospital, special relationship exists (92) – with a fn: we are not deciding whether a psychiatrist’s duty to protect a person from the violent propensities of the psychiatrist’s patient extends to the outpatient setting, referencing Tarasoff

As such, the defendant had a duty to take reasonable precautions to protect the daughter from the mother’s violent propensities (93)

- **Held:** in the context of a decision to discharge a voluntarily admitted inpatient, there is a duty to protect third parties where there exists a special relationship between the defendant and the patient involving a “take charge” relationship

_Estates of Morgan v. Fairfield Family Counseling Ctr., 77 Ohio St. 3d 284, 1997-Ohio-194, 673 N.E.2d 1311 (1997)_

- [the outpatient context provides elements of control to impose a common law duty to control]
- [when a therapist knows or should know that patient is likely to represent a substantial risk of harm to others, duty to prevent such to harm from occurring]
- [there is no ‘reasonably identifiable victim’ requirement in a duty to commit/duty control case]
- **Facts:** son with schizophrenia murders his parents and injures his sister, with a gun, following a year of examination and counseling from various mental health professionals at the defendant counseling center (285)
- **Discussion:**
  - Court notes that it is picking up where _Littleton_ did not go – to determine whether a psychiatrist’s duty to protect a person from the violent propensities of the psychiatrist’s patient extends to the outpatient setting (292)
  - Foreseeability alone is not sufficient to establish the existence of a duty; there must also be some special relation that justify the imposition of liability, referencing among others, _Littleton_ (294)
  - Reviews the relevant provisions of the _Restatement (Second) of Torts_ (§§315-319)
  - The issues is whether the relationship between a psychotherapist and the outpatient constitute a “special relation” which imposes a duty upon the psychotherapist to protect others against and/or control the patient’s violent conduct (295)
• Tarasoff is used as example of special relation with outpatient, and how the Tarasoff court subject to section 315 to an expansive reading (295)

• Since Tarasoff, court finds that a majority of courts that have considered the issue and finds 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. Thus, although psychotherapist 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 (296)

• No dispute that the psychotherapist-outpatient relationship justifies the imposition of a common-law duty upon the psychotherapist to control the violent propensities of the patient (297)

• Acknowledges, however, some courts conclude that in order for there to be a duty to control there must be the right, power or ability to control (297)

• To resolve the issue the court considers factors related to the issue of the presence of control:

(1) ability to control the outpatient (297)

• There is a current in the Restatement that in order for a special relation to exist there must be the ability to control the third party’s conduct (298)

• Courts that find the ability to control to be lacking in the outpatient setting take a rather myopic view of the level of degree of control needed to impose the duty by assuming that there must be actual constraint or confinement. (298-299).

• Just as there are diverse levels of control, there are different levels of taking “charge”, per Restatement (Second) of Torts §319 (299)

• The outpatient setting nevertheless embodies sufficient elements of control to warrant a corresponding duty to control. (299)

• There are a number of anticipatory measures that can be taken to prevent patient’s violent propensities from coming to fruition (299)

  • (i.e. prescribing medication, fashioning a program for treatment, using whatever ability she has to control access to weapons or to persuade patient to voluntarily enter a hospital, issuing warnings or notifying the authorities, and if appropriate, initiating involuntary commitment proceedings)(from 297)

• Psychotherapist-outpatient relation embodies sufficient elements of control to warrant a corresponding duty to control (300)

(2) the public’s interest in safety from violent assault

• Society has strong interest in protecting itself from mentally ill patients who pose a substantial risk of harm; MHPs play significant role in identifying and containing such risks, and therefore
broad based responsibility to protect community against danger associated with mental illness (301)

(3) difficulty inherent in attempting to forecast whether a patient represents a substantial risk of physical harm to others

- Difficulty inherent in forecasting whether a particular patient may pose a danger to others does not justify a blanket denial of recovery (301)
- Psychotherapist not required to render perfect prediction of future violence; just that she arrive at an informed assessment of the patient’s propensity for violence (301-302)
- To hold that assessments of dangerousness are so plagued by uncertainty would be to raise serious question as to entire present basis for civil commitment (302)

(4) goal of placing mental patient in least restrict environment and safeguarding patient’s rights to be free from unnecessary confinement

- Important interests not to be lightly infringed upon … but there is no reliable statistical support for the concern that therapists will attempt to insulate themselves from liability by involuntarily hospitalizing nonviolent mental patients (302-303)

(5) social importance of maintain the confidential nature of psychotherapeutic communication

- American Medical Association has long allowed breaches of confidence when “it becomes necessary in order to protect the welfare of the individual or of the community”
- Refers to immunity provided under R.C.5122.34 for breaches of confidentiality (304)
- R.C. 5122.34 applies only to the civil commitment context, and failures to warn or protect must be connected to that commitment context (304-305)

The Nature of the Duty

- The nature of the duty imposed requires therapists to determine the interrelated questions of whether a patient poses a risk of harm to others and how to prevent such harm from coming to fruition, and what is required depends on the facts and allegations of each case (306)
- When courts indiscriminately refer to the duty to warn or the duty to hospitalize, they are merely describing how particular therapists, under particular circumstances, failed to fulfill their overall duty. Court rejects the notion that there are divergent standards of care should be applied to what is essentially a single duty (306)
- Duty to control the conduct of a third person is commensurate with such ability as the defendant actually has at the time

Specific threats to specific victims rule

- Three elements –
  - (A) that the therapist is actually aware that the patient presents a threat of harm to other: Court rejects, states may also be that therapist should be aware – whether the treating psychiatrist actually knows of a target and whether that target is actually
identified is not always the appropriate focus in determining extent of the duty (308-309)

- (B) that the threat of harm be specific: Court rejects, on the basis that it is not necessarily required for involuntary commitment (309)
- (C) target of such threats be precisely and specifically identified – the “readily identifiable victim” rule is born, lives and grows in failure-to-warn cases, in which a therapist needs to know the identity of the victim in order to adequately act but the same policy considerations and practical difficulties are not present in a duty to commit case. It is not wise to limit the duty of care in a case alleging negligent failure to commit a patient to specific victims. Evidence of specific threats was not required to hospitalize a mentally ill patient against his will (311)

- **Held:**
  1. Psychotherapist-outpatient relation embodies sufficient elements of control to warrant a corresponding duty to control (300)
  2. When a psychotherapist knows or should know that his or her outpatient represents a substantial risk of harm to others, the therapist is under a duty to exercise his or her professional judgment to prevent such harm from occurring (307)
  3. In duty to commit case, there is no need to limit to require that the victim be reasonably identifiable and so the limitation is rejected (312)


- [discussion of how statute superseded *Estates of Morgan*]
- **Facts:** inpatient murders roommate; victim’s estate sues for failure to protect him while under custody
- **Discussion:**
  - In a lengthy footnote (no.3), discusses how **R.C. 5122.34 [Liability in civil commitment context]** was amended and **section 2305.51 [Liability of mental health professionals and organizations for violent behavior of mental health clients or patients]** to abrogate the holding in *Estates of Morgan* that determined that that provision did not impose a duty upon psychotherapists to protect against or control the patient’s violent propensities and that the bill introducing those legislative addition/amendment thereby, supersedes the second, third and fourth syllabus paragraph holdings of the court:
    - [2]. R.C. 5122.34 does not preclude the finding that a special relation exists between the psychotherapist and the outpatient which imposes a common-law duty on the therapist to take affirmative steps to control the patient’s violent conduct
    - [3] the relationship between the psychotherapist and the patient in the outpatient setting constitutes a special relation justifying the imposition of a
duty upon the psychotherapist to protect against and/or control the patient’s violent propensities

- [4] when a psychotherapist knows or should know that his or her outpatient represents a substantial risk of harm to others, the therapist is under a duty to exercise his or her best professional judgment to prevent such harm from occurring


- [statutory immunity in effect where there is no evidence of patient’s intention to harm victims, or that he had ability to carry out an explicit threat of inflicting imminent and serious physical harm or death, as is required under R.C. 2305.51(B)]

- **Facts:** a boy in foster care robs a gas station, kills employee and injuring a patron. Foster parents and mental health treatment facility sued. Boy planned on going to the mall and a movie with friends.

- **Discussion:**
  - Defendant facility is a mental health organization, as defined by R.C. 2305.51(A)(1)(c), as it “engages one or more mental health professionals to provide mental health services to one or more mental health clients or patient (4)
  - Therefore, the facility is immune from liability, pursuant to 2305.51(B). Based on the record,
    - no evidence of any discussion with the mental health professionals that the boy intended to shoot the victims (4)
    - no evidence to establish that the facility had any reason to believe that the boy had both the intent and ability to carry out an explicit threat of inflicting imminent and serious physical harm or death against the victims (4)
  - Victims failed to show that the serious physical harm or death resulted from the facility’s failure to ‘predict, warn of, or take precautions to provide protection from the violence behavior’ (2305.51(B)

- **Held:** no duty to protect because the statutory requirements under 2305.51(B) are not met.

**Campbell v. Ohio State University Medical Center, 108 Ohio St.3d 376, 843 N.E.2d 1194 (2006)**

- [R.C. 2305.51 is the exclusive means by which a mental health patient may establish liability for harm caused by another patient – must establish explicit threat of inflicting imminent and serious physical harm]

- **Facts:** Patient A of the defendant mental health institution attacked another patient. The next day Patient A attacked and severely injured another patient, the plaintiff.

- **Discussion:**
Issue on appeal is whether a patient of mental health institution who is injured by another patient who brings a lawsuit against the institution for negligence for breach of its duty under R.C.5122.29(B)(2) to protect her from assault and battery must also meet the requirements of R.C. 2305.51, governing mental health organization’s liability for violent patients

- R.C.5122.29(B)(2) expressly states that a mental health institution will not be liable for harm that results from failing to protect a patient from another patient unless the injured patient establishes liability under R.C.2305.51 (378)
- When a patient of a mental health institution is assaulted or battered by another patient, the institution may be held liable for harm that results only if the injured patient establishes liability under R.C. 2305.51 (378)
- No evidence of an explicit threat of an attack was communicated to the hospital – in fact, no warning of an attack by Patient A (378)

- **Held:** R.C. 2305.51 is the exclusive means by which a mental health patient may establish liability for harm caused by another patient, notwithstanding the duty to protect patients imposed by R.C. 5122.29(B)(2)

**Stewart v. North Coast Ctr., 2006 WL, 1313098, 2006 -Ohio- 2392 (Court of Appeals, 11th district)**

- [an “explicit threat” is a threat against the particular individual who was subsequently injured”]

- **Facts:** man in outpatient treatment murders girlfriend and then kills himself. Both man and woman sought mental health treatment at the same facility, sees same practitioners, but there is no overlap in time and neither person identifies the other to the practitioner.

- **Discussion:**
  - there was no explicit threat of imminent harm to the decedent by the outpatient communicated to the practitioners (7)
  - Plaintiff-appellant failed to show that the serious physical harm or death resulted from practitioners failure to “predict, warn of, or take precautions to provide protection from the violent behavior” of the outpatient (7)
  - The record does not show any explicit threat of imminent harm to the decedent by the outpatient communicated to the practitioners. As such, practitioners had no statutory duty to take any actions under R.C. 2305.51. The record does not establish that the practitioners knew that the decedent dated the outpatient, since she referred to him only as “Alex”. Also, there is no evidence that the practitioners knew that the outpatient’s girlfriend was in fact the decedent (7)

- **Held:** No statutory to take any action under R.C. 2305.51 where there is no explicit threat of imminent harm
Oklahoma

Summary

- Licensed psychologists have an affirmative duty to “take reasonable precautions,” including warning a potential victim, notifying law enforcement, or committing the patient (voluntarily or involuntarily), when a patient (1) communicates “an explicit threat to kill or inflict serious bodily injury upon a reasonably identified person and the patient has the apparent intent and ability to carry out the threat” OR (2) “has a history of physical violence which is known to the psychologist and the psychologist has a reasonable basis to believe that there is a clear and imminent danger that the patient will attempt to kill or inflict serious bodily injury upon a reasonably identified person.” OKLA. STAT. tit. 59, § 1376.

- Psychiatrists have a duty to exercise reasonable professional care in the discharge of mental patients, which arises only when the therapist knows or should know that his patient's dangerous propensities present an unreasonable risk of harm to others. The duty extends to such persons as are foreseeably endangered by the patient’s release. id.

Relevant legislation


All communications between a licensed psychologist and the individual with whom the psychologist engages in the practice of psychology are confidential. . . . No psychologist, colleague, agent or employee of any psychologist, whether professional, clerical, academic or therapeutic, shall disclose any information acquired or revealed in the course of or in connection with the performance of the psychologist's professional services . . . except under the following circumstances:

***

3. Upon the need to disclose information to protect the rights and safety of self or others if:

***

b. the patient has communicated to the psychologist an explicit threat to kill or inflict serious bodily injury upon a reasonably identified person and the patient has the apparent intent and ability to carry out the threat. In such circumstances the psychologist shall have a duty to take reasonable precautions. A psychologist shall be deemed to have taken reasonable precautions if the psychologist makes reasonable efforts to take one or more of the following actions:
1. communicates a threat of death or serious bodily injury to the reasonably identified person,

2. notifies an appropriate law enforcement agency in the vicinity where the patient or any potential victim resides,

3.安排患者自愿住院，或

4. 采取适当步骤启动根据法律的强制性住院程序，

c. 患者有历史的身体暴力，这是已知的由心理学家和心理学家合理理由认为存在明确和立即危险，患者将试图杀死或施加严重身体伤害于一个合理地识别的人员。在这种情况下，心理学家有义务采取合理预防措施。心理学家应被视作已采取合理预防措施，如果心理学家作出合理努力采取以下一项或多项行动：

   1. 传达死亡或严重身体伤害的威胁给一个合理地识别的人员，

   2. 通知在患者或任何潜在受害者居住的附近地区适当的执法机关，

   3. 安排患者自愿住院，

   4. 采取适当步骤启动根据法律的强制性住院程序，

d. 本段b节中所含内容不会要求心理学家采取任何行动，该行动在合理专业判断下会危及心理学家或增加对潜在受害者或受害者的危险，或

e. 心理学家只应披露那些必要保护其他人权利和安全的信息；

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Cases

[Significance – Recognizes a psychiatrist’s duty to exercise reasonable professional care in the discharging of mental patients]

- **Facts:** Mother of released mental patient brought action against hospital for negligent release and failure to supervise resulting in patient’s killing of his stepfather.

- **Held:** Patient’s killing of father, occurring two years after last treatment by defendant, was too remote and unforeseeable to create any liability on part of hospital.

- **Discussion:** “[A] psychiatrist has a duty to exercise reasonable professional care in the discharge of a mental patient. The professional standard of care must take into consideration the uncertainty which accompanies psychiatric analysis. This duty arises only when in accordance with the standards of his profession the therapist knows or should know that his patient’s dangerous propensities present an unreasonable risk of harm to others. The duty extends to such persons as are foreseeably endangered by the patient’s release.” 520.

**Oregon**

**Summary**

- Oregon has a statutory duty to control the acts of patients, under Or. Rev. Stat. Ann. § 161.336, which applies to certain mental health providers who accept patients on conditional release under the purview of the state’s Psychiatric Security Review Board.

- In *Cain v. Rijken*, the Supreme Court of Oregon, expressly declined to consider the common law principles arising under *Tarasoff*, and whether there is a common law action for a third party physically injured by the acts of a psychiatrist’s patient given the “controversial thicket” of cases, including *Tarasoff* and its progeny, and in light of the existing duty to control generated by Or. Rev. Stat. Ann. § 161.336.

- Oregon also recognizes a statutory duty to warn as an exception to patient confidentiality laws, under Or. Rev. Stat. §179.505 (12), but it is permissive:
  - A health care services provider *may* report information to the appropriate authority that indicates that an individual is a clear and immediate danger to others or to society.
  - The provision, however, states that a decision not to disclose information under this subsection does not subject the provider to any civil liability.

**Relevant legislation**


- Under sub-section (4)(a), a person on conditional release may be ordered to be returned to state hospital for evaluation and/or treatment.
• Under sub-section (4)(b), a variety of professionals and law enforcement who are responsible for the person on conditional release, may take the person into custody or request the person be taken into custody “if there is reasonable cause to believe the person is a substantial danger to others because of mental disease or defect and that the person is in need of immediate care, custody or treatment”

• Under sub-section §179.505 (12), information obtained in the course of diagnosis, evaluation or treatment of an individual that, in the professional judgment of the health care services provider, indicates a clear and immediate danger to others or to society may be reported to the appropriate authority. A decision not to disclose information under this subsection does not subject the provider to any civil liability.
  o Under sub-section (1)(b), a health care services provider means (A) “medical personnel or other staff employed by or under contract with a public provider to provide health care or maintain written accounts of health care provided to individuals” (B) units, programs or services designated, operated or maintained by a public provider to provide health care or maintain written accounts of health care provided to individuals

Cases
Cain v. Rijken, 300 Or. 706, 717 P.2d 140 (1986)
• [MHP who accepts a patient under the jurisdiction of the Psychiatric Security Review Board (PSRB) has a duty to control patient’s conduct for the protection of the public]
  
• Note: specific sub-provisions are different today than as referenced in the case; but the language is the same (see legislative references above)
• Facts: Man with schizophrenia, on condition release from mental institution under order of PSRB, and enrolled in day treatment program with defendant institution (as a condition of release), speeding, ran red lights, killed another in car accident. Plaintiff sued defendant institution, among others.

• Discussion:
  o The defendant’s obligations to supervise the patient’s conduct for the protection of the public was imposed by sources other than the common law of negligence – the court considers the statutes that may create the MHP’s duty towards patients and the general public (715)
  o Based on cases recognizing that one who violates a statute enacted for protection of others may be civilly liable in damages for injury the protected interest even there is no basis for recover at common law. ... therefore, the court “need not decide whether there is a common law civil action for a third party who is injured by the acts of a psychotherapist’s patient. Nor need [it] venture into the controversial thicket of tort law that grows from Tarasoff” (715-716)

135
The decision is not based on the common law principles on which Tarasoff (and its ilk) was decided. “Those decisions are essentially irrelevant” because the MHP’s obligation is derived from the statues defining the assignment it undertook for the PSRB.

Common law principles of reasonable care and foreseeability of harm are relevant because this case does not fall within a mandated statutory duty ... because ORS 161.336(6) states only that the [MHP] may take a person into custody (718).

This does not exclude a duty to exercise reasonable care since although it did not have custody over the patient, the statute did authorize that he be taken into custody if he was a “substantial danger to others because of mental disease or defect and was in need of immediate care, custody or treatment”, referencing Or. Rev. Stat. Ann. § 161.336 (718).

Notes elsewhere in the statute that that of primary concern is the protection of society (718).

This duty to protect the public does not evaporate once PSRB conditionally releases a person to a community mental health provider. Reading the two relevant provisions together [the ability to take the patient into custody and the purpose of protecting society], authorizes mental health providers to take patients into custody to protect members of the public, which included the decedent (718).

The fact that the patient did not threaten to harm any person or threaten to drive so as to injure persons reduced the MHP’s ability to foresee his harm harmful acts. Indeed, some courts have considered this fact in limiting liability to readily identifiable victims (see e.g. Thompson v. County of Alameda). But in the case at bar, instead of limiting the duty of care in all cases to readily identifiable victims, the court considered the purpose of the state on this issue: the MHP “had a duty to control [the patient], not just the patient’s sake, but for the peace and safety of the general public. The purpose of the conditional release statute is to keep mental patients out of hospitals while at the time protecting the public.” (719-720)

- **Held:** An MHP (institution), having accepted a patient under ORS 161.390 [re: assignment to mental institution] had a duty of reasonable care in treating its patients and controlling its patients’ acts (707).


- **[Discusses how Oregon recognizes a “duty to disclose” threats to intended victim as an exception to the rule of confidentiality under Or. Rev. Stat. §179.505 (12)]**

- **Facts:** Outpatient with various mental illnesses informs his psychiatrist that he intends to kill FBI agents who were investigating matters he was involved with, and that he kept a notebook containing names, addresses and SSNs of those people and others. Psychiatrist informed the FBI. Issue on appeal related to admissibility of doctor’s testimony in respect of conviction of patient for threats by patient.

- **Discussion:**
Most states have a dangerous-patient exception to their psychotherapist-patient confidentiality laws (984)

Some of these exceptions allow, and some require, a psychotherapist to disclose threats made by a patient during therapeutic sessions if the psychotherapist determines that the patient poses a risk of serious harm to self or other. This exception is often referred to as the Tarasoff duty (academic citing references omitted) (984)

Referring to Or. Rev. Stat. §179.505 (12), Oregon recognizes this exception to the rule of confidentiality. Under Oregon law, an MHP may disclose “[i]nformation obtained in the course of diagnosis, evaluation or treatment of an individual that in the professional judgment of the health care services provider, indicates a clear and immediate danger to others or to society. (984-985)

Court has no doubt that the psychiatrist properly disclosed the threats that the Defendant had related regarding several specific individuals (985)

Pennsylvania

Summary

- Pennsylvania has a mandatory common law duty to warn standard as established in Emerich v. Philadelphia Ctr. for Human Dev..

- Mental health providers have a duty to exercise reasonable care to protect the intended victim by warning the victim, where the provider determines/should have determined according to the standard of care of his profession that his patient presents a serious danger of violence to a third party.
  - The duty is only triggered in limited circumstances: the patient communicates a specific and immediate threat of serious bodily injury, and the threat is made against a specifically identified or readily identifiable victim. (This standard has been confirmed in later decisions by DeJesus and Swisher)

- The Penn. Courts have not resolved the following open questions:
  - what actions might be necessary to satisfy the duty (Court only mentioned that warning should be the least expansive under the circumstances)
  - definition of the term mental health professional
  - what constitutes a “specific and immediate threat”

- While Emerich involves an outpatient treatment relationship, the decision suggests that the Court may “support a broader duty to protect or commit to inpatient treatment.” (Emerich, 720 A.2d at 1044 n. 13.)
Relevant legislation


Cases


- **[providers have no duty to warn where there was no readily identifiable victim]**
- **Facts**: Voluntary patient treated at VA Hospital for paranoid schizophrenia and chronic alcoholism. Hosp. personnel aware of a history of violent outbursts by patient, spanning at least 10 years. After release patient stayed with plaintiffs. One night they all got drunk, and patient beat the plaintiffs. Plaintiffs alleged that the hospital owed to them a duty to warn them of patient's assaultive tendencies.
- **Discussion**: Plaintiffs argument: Plaintiffs rely on the theory that the hospital's relationship to Hartnett triggered a duty to warn plaintiffs of violent tendencies.
  - Court references Tarasoff and Thompson v. County of Alameda finding that in order to keep Tarasoff reasoning within workable limits, those charged with patient care must be able to know to whom to give warning.
  - Here, danger posed by patient was same to plaintiffs as to anyone with whom patient might be in contact. This is not the type of readily identifiable victim or group of victims to which the California Supreme Court made reference in Tarasoff or Thompson.
- **Holding**: Hospital personnel did not have a duty to warn plaintiffs of tendency toward violence when drinking. SJ for defendants confirmed.


- Finding no duty to warn others where psychiatrist has no right or ability to control patient conduct in a voluntary outpatient treatment relationship, which lacked sufficient elements of control necessary to establish special relationship based on Restatement §315. (relying in part on Leedy)


- **[mental health providers owe no duty to third party where no treat to inflict harm on a particular individual was made]**
- **Facts**: Patient in treatment with psychiatrist, doctor recommended discontinuing use of medication. After use was discontinued patient became “nasty” and “violent”. Live-in girlfriend
was strangled by patient in cafeteria. GF’s estate filed suit against cafeteria, cafeteria joined mental health care providers. Appeal from grant of motion of SJ.

- **Discussion**: Due to lack of Pen. case law, Court looks to other jurisdictions and references Tarasoff. Court finds that Tarasoff rationale should be confined to very limited circumstances of that case.

- **Holding**: A psychologist (or psychiatrist) owes no duty to warn or protect a non-patient where the patient has not threatened to inflict harm on a particular individual.
  
  o Here, Court finds that defendants did not share with GF a “special relationship” as contemplated by Tarasoff that would justify the imposition of a duty to warn. Patient communicated no resolve, nor manifested any inclination to harm GF prior to the date that he strangled her. Victim was non-foreseeable.

- SJ confirmed.


- [psychiatrist or psychologist owes no duty to warn or otherwise protect nonpatient, including patient’s spouse, if patient has not threatened to harm specific person]

- **Facts**: Two months after release from psychiatric hospital, patient shot and killed his wife.

- **Discussion**: Court looks to decisions in Dunkle (interpreting Tarasoff) and Leedy. Court confirms that foreseeability of general danger, and in particular identity of a specific victim must be brought to the attention of the physician, before duty can be imposed.

- **Holding**: Grant of SJ on behalf of providers is affirmed. No duty existed here since no specific individual was threatened.

→ **Tarasoff duty established in Pennsylvania:**


- [mental health professional has duty to warn the endangered victim where the patient has communicated a specific and immediate threat of serious bodily injury against a specifically identified or identifiable victim]

- **Facts**: Patient in outpatient mental health treatment for drug, alcohol problems, explosive and schizo-affective personality disorders. History of abusing his girlfriend and his former wife. Boyfriend threatened to murder girlfriend. GF terminated relationship. On morning of murder patient contacted counselor to threaten former GF. Counselor advised patient to commit himself and advised GF, who had contacted the counselor, to stay away from former BF. GF then went to former common residence, where she was fatally shot by BF.

- **Discussion**: Court recognizes a duty to warn based on Tarasoff because:
  
  o (1) Consistent with other case law. Court has found liability for breach of duty to third party in cases where provider was grossly negligent in discharging patient and where
provider failed to warn third party of contagious disease. Court finds duty to warn when mental illness that poses risk to others is involved analogous to context of contagious disease.

- (2) Superior Courts have recognized Tarasoff duty in two cases, although facts of the cases did not result in imposition of duty (See Dunkle and Leonard)
- (3) Policy argument that societal interest in protection of citizens from harm (vs. policies underlying protection of therapist-patient privilege) mandates finding of duty in favor of adopting the duty

- **Holding:** “Special relationship (predicated on §315 Restatement Torts) between a mental health professional and his patient may, in certain circumstances, give rise to an affirmative duty to warn for the benefit of an intended victim. (...) A mental health professional who determines, or under the standards of the mental health profession, should have determined, that his patient presents a serious danger of the mental health profession, should have determined, that his patient presents a serious danger of violence to another, bears a duty to exercise reasonable care to protect by warning the intended victim against such danger.

  - The duty arises under extremely limited circumstances:
    - (1) existence of a specific and immediate threat of serious bodily injury that has been communicated to the professional.
    - (2) the threat is made against a specifically identified or readily identifiable victim.

- The Court recognizes the importance of the therapist-patient relationship and finds that the warning to the intended victim should be the least expansive based upon the circumstances.

- Here, duty to warn was triggered, and the provider’s statement to the GF, that she should not go to the patient’s apartment satisfied the provider’s duty to warn.

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*DeJesus v. U.S. Dept. of Veterans Affairs, 479 F.3d 271 (3d Cir. 2007) (applying Pennsylvania law)*

- **[provider had no duty to warn or protect victims where there was no immediate threat of serious harm]**

- **Facts:** Patient murdered his two children and neighbor’s two children 18 hours after he was released from VA inpatient care residential housing. Wife and neighbor sued VA asserting claims of gross negligence and negligent infliction of emotional distress. VA argues it had no duty to protect the children.

- **Discussion:** Court declines to apply Emerich standard since the present case does not involve a (and plaintiffs agree on that) specific and immediate threat of serious harm.

- **Holding:** Under Penn. Common law mental health provider had no duty to warn wife regarding patient’s behavior, and no duty to protect murdered children from patient.

- [refusing to expand psychologists’ duty to warn where there is no threat of serious bodily injury]

- **Facts:** Psychologist treated plaintiff’s ex-wife before and during their marriage. Psychologist knew that wife was unable to keep the marriage commitment, but continued to encourage the relationship. After divorce husband filed action based on intentional infliction of emotional distress and professional negligence.

- **Discussion:** Relying on Emerich, the Court argues that there was no threat of serious bodily injury in this case (only possibility of emotional distress). Thus, no duty to warn can be imposed.

- **Holding:** Psychologist did not have a duty to warn patient’s ex-husband that her patient could not commit to a marriage.

Other sources
See secondary sources in state folder for more detailed commentary.

Rhode Island

**Summary**

- Under, R.I. Gen. Laws §5-37.3.4, Rhode Island permits a health care provider to release or transfer confidential health care information, without the patient’s consent, if the provider releases the information to:
  1. appropriate law enforcement; or
  2. a person who the health care provider believes is either personally in danger from a patient, or has a family member who is in danger from a patient

- The Rhode Island Supreme Court did not recognize a duty of reasonable care to protect a third party in the context of a mental health provider and a patient in Santana v. Rainbow Cleaners. In so holding, it held:
  - The question of legal duty in cases involving a mental health provider and a patient are multifaced, resulting in no uniform standard to apply to the issue. The approach is *ad hoc* and turns on the particular factors of a given case, namely:
    1. The relationship between patient and provider
    2. The foreseeability of harm to the plaintiff
    3. The extent of the burden to defendant and the consequences of imposing a duty with resulting liability for b reach
    4. Public policy considerations
A duty to control may conceivably arise in the outpatient context but the presence of a special relationship between outpatient and mental health provider alone does not give rise to a duty; there needs to be the authority and opportunity to exercise control.

Relevant legislation

*R.I. Gen. Laws §5-37.3-4 – Limitations on and Permitted Disclosures [Confidentiality of Health Care Communications]*

- Under subsection (b)(4)(i), a health care provider does not require consent to release or transfer confidential health care information if it is to appropriate law enforcement personnel, or to a person if the health care provider believes that person, or his or her family, is in danger from a patient.

*Laws governing civil commitment (discussed in Santana v. Rainbow Cleaners)*

*R.I. Gen. Laws § 40.1-5-7 – Emergency Certification*

- Under subsection (a), an emergency situation, an examining physician or a qualified mental health professional who believes that an individual “is in need of immediate care and treatment, and is one whose continued unsupervised presence in the community would create an imminent likelihood of serious harm by reason of mental disability,” may apply for emergency certification to a facility.

- Under subsection (b), the application must be based on the applicant’s personal observations of the individual within the five days before the date of filing.

- Under subsection (c), if the psychiatrist believes the person is a proper subject for emergency certification, then the application is confirmed, “provided the facility is one which would impose the least restraint on the liberty of the person consistent with affording him or her the care and treatment necessary and appropriate to his or her condition and that no suitable alternatives to certification are available.

*R.I. Gen. Laws §40.1-5-8 – Civil Court Certification*

- Under subsection (a), “[a] verified petition may be filed in the district court, for the certification to a facility of any person who is alleged to be in need of care and treatment in a facility, and whose continued unsupervised presence in the community would create a likelihood of serious harm by reason of mental disability.

- Under subsection (b), the petition must be based upon the personal observation of the petitioner within the ten days; it must indicate what alternatives to certification are available, what alternatives have been investigated, and why they are not suitable.

*R.I. Gen. Laws § 40.1-8.5-1 – Policy and Purpose*

- Sub-section (a) state recognizes that children and adults with mental disability are entitled to appropriate, accessible, and adequate mental health services in the least restrictive environment which appropriately can serve their needs.
• Sub-section (b) provides that the state recognizes private, nonprofit community mental health centers which provide mental health services to children and adults with mental disabilities, and the states policy is to suppose these centers as an adjunct and alternative to inpatient services

Cases

Santana v. Rainbow Cleaners, 969 A.2d 653 (R.I. 2009)

• [A duty to control may conceivably arise in the outpatient context but the presence of a special relationship between outpatient and mental health provider alone does not give rise to a duty]

• Facts: Outpatient brutally attacks the owner of a dry cleaner near where he lives and regularly worked and spent time. The victim sues the community mental health center that the outpatient received services from, and from which the outpatient had not been in four months leading up to the attack.

• Discussion:
  o First time R.I. Supreme Court considers whether a duty of reasonable care to protect a third party is owed in the context of a mental health provider and a patient (659)
  o Since Tarasoff, Tarasoff-type duties have been widely accepted throughout the country and imposed through either the common law or by statute; there have been a variety of different approaches; some courts treated both warning a potential victim and controlling a dangerous patient as options under a duty to protect, while other courts have reasoned that warning victims and controlling patients are separate duties, each with different requirements that trigger the respective duty (660)
    • Compares Lipari v. Sears, Roebuck and Co., 497 F.Supp 185, 193-94 (D.Neb 1980)(holding that duty to protect requires a therapist to initiate whatever precautions are reasonably necessary, which may include warning potential victims or committing a patient to a facility under appropriate circumstances) with Emerich v. Philadelphia Center for Human Development, Inc., 554 Pa. 209, 720 A.2d 1032, 1043, 1044 n. 13 (1998) (holding that duty to warn exists under very limited circumstances, but not addressing any separate duty to commit a patient to inpatient treatment).
    • Typically, when courts recognize a duty to warn, they require a threat directed toward a specific or readily identifiable victim. See Thompson v. County of Alameda, 27 Cal.3d 741, 167 Cal.Rptr. 70, 614 P.2d 728, 738 (1980)
    • When the duty is to control, and not to warn a specific person, courts generally require the existence of a special relationship, where the defendant: (1) knew or should have known that the patient posed a serious risk of violence to others; and (2) had the legal right and ability to control the patient. See Abernathy v. United States, 773 F.2d 184, 189 (8th Cir.1985); Hinkelman v. Borgess Medical Center, 157 Mich.App. 314, 403 N.W.2d 547, 551-52 (1987).
When the duty is to control, and not to warn a specific person, courts generally require the existence of a special relationship, where the defendant: (1) knew or should have known that the patient posed a serious risk of violence to others; and (2) had the legal right and ability to control the patient. See Abernathy v. United States, 773 F.2d 184, 189 (8th Cir.1985); Hinkelman v. Borgess Medical Center, 157 Mich.App. 314, 403 N.W.2d 547, 551-52 (1987).

Other courts, as discussed below, however, suggest that mental health providers may have a duty to exercise control by seeking commitment when appropriate, even in the case of an outpatient. (661)

- Reviews the state’s law governing the commitment of persons with mental disabilities, emphasizes that it is discretionary and not mandatory, and “a very difficult undertaking”, notwithstanding the potential “likelihood of serious harm”, including the timelines and process for seeking commitment on emergent and nonemergent bases ((661-662)
- The question of legal duty in cases involving a mental health provider and a patient are multifaced, resulting in no uniform standard to apply to the issue. There is no clear cut formula. Rather, the approach is ad hoc and turns on the particular factors of a given case, namely:
  5. The relationship between patient and provider
  6. The foreseeability of harm to the plaintiff
  7. The extent of the burden to defendant and the consequences of imposing a duty with resulting liability for b reach
  8. Public policy considerations (664-665)

The relationship between patient and provider

- Focus is on the nature of the relationship between voluntary outpatient and a community mental health provider that treated the patient and the degree of control, if any, that the facility may have exercised over the patient as a result of the relationship (665)
- A common thread in these types of cases is whether the provider had the ability to control the conduct of the patient (665)
- Court declines to decide whether an outpatient can never give rise to an affirmative duty to control the patient’s conduct, although it acknowledges there is undoubtedly less ability to control an outpatient than within the inpatient setting; the relationship may in some circumstances, conceivably give rise to a duty (665) – see NOTE below
- However, Court declines to recognize the argument that the relationship between a mental health provider and its patient, in and of itself, is sufficient to give rise to a duty to control the patient. ... “To impose a duty to control, there must be an opportunity to exercise such control.” (665)
Based on the record, there’s no evidence that the provider possessed the legal authority or the opportunity to exercise control (i.e. (1) evidence that supported an application for involuntary commitment, (2) what the man’s condition was at the time he was ordered into counselling with the provider, (3) his condition when he was last treated at the provider, 4 months prior to the attack) (665-666)

**Foreseeability of harm**

The foreseeability inquiry considers generally whether ‘the category of negligent conduct at issue is sufficiently likely to result in the kind of harm experienced that liability may appropriately be imposed on the negligent party’ (citing references omitted) – no evidence submitted that patient could have been committed to conclude that the type of harm suffered was a foreseeable consequence of a failure to initiate commitment proceedings (666)

**Extent of Burden to Defendant and the Consequences of Imposing a Duty with Resulting Liability for Breach**

Finds that it would be “manifestly unjust” to impose a duty, in this case, in the absence of evidence and that it would “certainly” lead to “pressure to choose” initiating commitment proceedings over potential liability. This would be contrary to the statutory purpose and policy to imposing the least restrict environment on persons with mental disability – reference R.I. Gen. Laws § 40.1-8.5-1 (666).

**Public Policy Concerns**

Recognizes three interests that must be balanced:

1. The important and difficult services provided by community mental health centers, such as the defendant
2. The public’s interest in being protected from unprovoked, violent attacks
3. The liberty interests of the individual suffering from mental illness – an interest which is constitutionally protected (referencing U.S. Supreme Court Case, *Addington v. Texas*, 441 US 418, 99 S.Ct 1804 (1979) and that Rhode Island Mental Health Law was “carefully crafted” to ensure that a patient’s liberty would be “scrupulously protected”, citing references omitted) (667)

Finds that it would be unfair to impose duty on the facts of this case

**Held:** Declines to find a duty to control on the basis that

- Outpatient relationship not in itself sufficient to establish duty, there must be the opportunity to exercise control and the authority to do so, and no evidence presented to suggest there was either
- No basis to conclude that the harm suffered was foreseeable consequence of failure to initiate commitment proceedings
- Unjust to encourage mental health providers to seek commitment proceedings to avoid liability
• It would undermine the patient’s constitutionally-protected liberty interests

• **NOTE:** In footnote no. 16 on the point of whether to recognize a duty to control in the outpatient context, the court notes the rationale of the Ohio Supreme Court in Estates of Morgan v. Fairfield Family Counseling Center, 77 Ohio St.3d 284, 673 N.E.2d 1311 (1997), where a duty was imposed on a psychiatrist treating an outpatient. The court said: “[T]hose courts which find the ability to control to be lacking in the outpatient setting tend to take a rather myopic view of the level or degree of control needed to impose the duty. They appear to assume that in order to satisfy Section 315 in general, or Section 319 in particular, there must be actual constraint or confinement, whereby the third person’s physical liberty is taken away or restricted. In viewing the issue in this way, these courts fail to recognize that the duty to control the conduct of a third person is commensurate with such ability to control as the defendant actually has at the time. * * * In other words, it is within the contemplation of the Restatement that there will be diverse levels of control which give rise to corresponding degrees of responsibility.” Estates of Morgan, 673 N.E.2d at 1323. In response to the holdings in Estates of Morgan, the Ohio General Assembly amended § 5122.34 and enacted §2305.51 of the Ohio Revised Code Ann. (LexisNexis 2008, 2005) to limit the liability of mental health providers

**South Carolina**

**Summary**

• Duty to warn recognized in limited circumstances. Recognition based on reasoning in *Tarasoff* (See *Bishop v. S.C. Department of Mental Health*).

  o (1) ELEMENT OF CONTROL: Premised on ability to monitor, supervise, and control an individual’s conduct, a special relationship exists. As a result of this special relationship a provider may have a common law duty to warn potential victims of the individual’s dangerous conduct. (South Carolina duty to warn cases have all involved situations where individual was released from direct custodial control or medical evaluation, eg. *Bishop and Rogers*)

  o (2) EXISTENCE OF SPECIFIC THREAT: Duty to warn exists where the individual has made a specific threat of harm directed at a specific individual. If provider knew or should have known a specific threat was made, provider had a duty to warn the threatened third party.

• MHPs are allowed to disclose privileged communications in an emergency where information about the patient is needed to prevent harm to others (*S.C. Code Ann. § 44-22-90*). (It is not specified what an emergency is and no case law has interpreted the application of this section to duty to warn situations).
Relevant legislation

S.C. Code Ann. § 44-22-90 - Communications with mental health professionals privileged; exceptions.

- Applies to general physicians, psychiatrists, psychologists, psychotherapists, nurses, social workers, or other staff members employed in a patient therapist capacity or employees under supervision of them.

- Subsection A. Privileging communications between patients and mental health professionals.
  - Communications may be disclosed in an emergency where information about the patient is needed to prevent the patient from causing harm to himself or others.

Cases


- [recognizing duty to warn where person is released from custody and where person has made specific threat of harm against specific individual]

- Facts: Victim robbed, murdered by assailants who were just released from prison into furlough program and who were in jail because they had previously broken into victim’s house.

- Discussion: Analyzing whether Department of Parole had duty to warn victim of release of individuals.
  - Court recognizes a duty to warn when a person being released from custody has made a specific threat of harm directed at a specific individual. (based on Rayfield v. South Carolina Dep't of Corrections; Restatement (Second) of Torts §§ 315 and 319)
  - Since no specific threat was made here, parole officials had no duty to warn victim of release.


- [element of control necessary for existence of duty to warn]

- Facts: Nursing home set on fire and burned down by employee. Nursing home residents sued employee’s psychiatrist for failure to warn employer of employee’s dangerous potential.

- Discussion: Affirming element of control for imposition of duty as specified in Rogers: “when a defendant has the ability to monitor, supervise, and control an individual's conduct, a special relationship exists between the defendant and the individual, and the defendant may have a common law duty to warn potential victims of the individual's dangerous conduct.”
  - Here, no specific threat made against plaintiff individually. Court declines to extend duty to warn to “foreseeable” victims where an identifiable threat to a specific, small group of individuals exists.
**Bishop v. S.C. Dep't of Mental Health, 331 S.C. 79, 86, 502 S.E.2d 78, 81 (1998) – (Supreme Court)**

- **[recognizing duty to warn standard based on Tarasoff]**

- **Facts:** Grandmother involuntarily committed daughter, who had made threats against her own daughter who was living with grandmother at the time. Daughter was released a few days later. After release went to grandmother's home. Grandmother allowed mother to enter and to leave with daughter. Mother then returned daughter with green markings over her body. Grandmother filed suit for the physical abuse allegedly received at the hands of mother alleging Department was negligent in releasing mother, in failing to warn of her release, and in failing to properly diagnose and treat mother for those illnesses which caused her to have dangerous propensities towards victim.

- **Discussion:** Court relies on Tarasoff and interpretation of duty based on Restatement (Second) of Torts §§ 315-320.
  - When defendant has the ability to monitor, supervise, and control an individual's conduct, a special relationship exists between the defendant and the individual. Then, defendant may have a common law duty to warn potential victims of the individual's dangerous conduct.
  - Here: Department had special relationship with mother because the Department had custody and control of mother. Thus, if Department knew or should have known a specific threat was made by mother, Department had a duty to warn the threatened third party of mother's release. Department was aware mother had made specific threats to harm victim in the past. This was sufficient to trigger duty to warn victim of mother's release because a specific threat had been made by mother to harm a specific person.

- **Holding:** Grants summary judgement for defendants, since breach of duty to warn was not proximate cause of injuries. Department could not reasonably foresee that grandmother would allow mother to visit with victim unsupervised since only three days earlier grandmother had mother involuntarily committed because mother was threatening to harm victim.


- District Court specifically states that “South Carolina does not recognize a general duty to warn of the dangerous propensities of others”. Citing Sharpe v. S.C. Dep't of Mental Health, 354 S.E.2d 778 (S.C. Ct. App. 1987). Court states that only in very limited circumstances, a reasonably foreseeable third party can maintain a suit against a medical provider for negligence (references Bishop and Hardee (holding that if dialysis center knew that patient could experience ill effects following dialysis treatment, dialysis center owed motorists injured by crash caused by patient a duty to warn patient of the risks of driving.)


- **[special relationship situations in which duty to warn arises]**
• Analyzing existence of special relationship that gives rise to a duty to third parties.
• Court recognizes five exceptions in which a duty to control the conduct of another or to warn a third person or potential victim of danger can arise:
  o (1) where the defendant has a special relationship to the victim;
  o (2) where the defendant has a special relationship to the injurer;
  o (3) where the defendant voluntarily undertakes a duty;
  o (4) where the defendant negligently or intentionally creates the risk; and
  o (5) where a statute imposes a duty on the defendant.

*Doe v. Marion, 373 S.C. 390, 645 S.E.2d 245 (2007)*

• [not duty to warn exist where there was no specific threat made against the victim and the victim merely belonged to a group of future foreseeable victims]
• Facts: Physician, who was in previous treatment by psychiatrist (treatment began several years before alleged abuse), sexually abused child. Father of child brought action arguing that psychiatrist had a duty to warn all future foreseeable victims.
• Discussion: Court generally relies on Bishop and Tarasoff. In particular, Court focuses on whether there was a threat made against a readily identifiable third party. Citing Gilmer the Court states that “it is not simply foreseeability of the victim which gives rise to a person’s liability for failure to warn; rather, it is the person’s awareness of a distinct, specific, overt threat of harm which the individual makes towards a particular victim.”
  o Here, there was no allegation of a specific threat that was made. Thus, no duty to warn existed.
• Holding: psychiatrist did not have a common law duty during his treatment of the physician to warn future foreseeable victims of physician’s predilection for child molestation of his patients.

**South Dakota**

**Summary**

• Statutory duty to warn applies only to marriage and family therapists (*S.D. Codified Laws § 36-33-31*).
  o Duty to warn arises where a client has communicated a serious threat of physical violence against a reasonably identifiable victim.
  o Duty to warn can be discharged by making reasonable efforts to communicate threat to victim and law enforcement.
• Permissive duty to disclose information per *S.D. Codified Laws § 27A-12-29.*
If a person has communicated a serious threat of serious physical injury against a reasonably identifiable victim, information can be disclosed to victim or law enforcement, or both.

- In *Small* and *Riley* Supreme Court found duty to protect third party.
  - “One 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.”

**Relevant legislation**

*S.D. Codified Laws § 36-33-31 - Duty to warn against client's violent behavior*
- Applies to marriage and family therapists.
- Therapist can incur liability for failure to warn if client has communicated a serious threat of physical violence against a reasonably identifiable victim.

*S.D. Codified Laws § 36-33-32 – Discharge of Duty to Warn*
- Marriage and family therapists can discharge of the duty to warn by making reasonable efforts to communicate the threat to the victim and to law enforcement.
- No liability arises for disclosure of information based on this section.

*S.D. Codified Laws § 27A-12-29 - Discretionary disclosure of confidential information*
- Subsection 5. The holder of the record has the discretion to disclose information if person has communicated a serious threat of serious physical injury against a reasonably identifiable victim.
  - The person with knowledge of the threat may disclose the threat to the potential victim or to any law enforcement officer, or both.
  - No cause of action against person who, in good faith, discloses the threat victim or law enforcement.

**Cases**

*Small v. McKennon Hosp., 403 N.W.2d 410 (S.D. 1987)*
- [Duty to protect based on Restatement § 319 and existence of a “take charge” relationship]
- Facts: Victim was raped and murdered after abducted from hospital parking lot by parolee. Estate brought negligence action against hospital, parole officer executive director of Board of Pardons and Paroles.
• Discussion: Analysis whether individual who has control over another with dangerous propensities owes duty to protect third person. Plaintiff argues that duty exist per Restatement § 319.
  o Court examines whether defendant had “taken charge” of the parolee.
    ▪ Parolee was free to conduct daily affairs, officer did not supervise on daily basis.
• Holding: parole officer did not take charge of parolee and had no duty to protect the plaintiff’s wife from harm.

_E.P. v. Riley, 1999 S.D. 163, ¶ 26, 604 N.W.2d 7, 14_
• [finding duty to control to prevent harm to third party where State Department knew or should have known that individual was likely to cause bodily harm to others]
• Facts: Minor child was sexually abused by neighbor’s foster child. Parents of minor brought action against employees of Department of Social Services and foster parents.
• Discussion: Analysis based on reasoning in Small: “[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.”
  o Here, Department employees had sufficient control over foster child to establish a common law duty to protect:
    ▪ Department had legal custody and supervisory control.
    ▪ Record shows that Department employee had at least four personal contacts with foster child.
    ▪ While foster child was in their custody Department was given information that should have caused concern about his propensity to harm others.
• Holding: Department “knew or should have known” that foster child was “likely to cause bodily harm to others if not controlled,” therefore, they were “under a duty to exercise reasonable care to control him to prevent him from doing such harm.” (Citing Small). Department employees owed common law duty to protect.

In _Abernathy v. United States_ (773 F.2d 184, 187–88 (8th Cir. 1985)), the Federal Courts applied South Dakota law on an issue analyzing a duty to control situation. Based on a discussion of the Restatement § 315(a), the Federal Court of Appeals found that no special relationship existed here, and thus no duty could be imposed based on South Dakota law.
Other sources

Tennessee

Summary

- “Qualified mental health professional[s]” have a statutory duty to “take reasonable care to predict, warn of, or take precautions to protect” third parties when (1) a patient “communicates an actual threat of bodily harm against a clearly identified victim” and (2) the provider determines or through reasonable care should determine that the patient has the ability and is likely to carry out the threat. TENN. CODE ANN. § 33-3-206.
  - The duty can be discharged by warning the third party, voluntary or involuntary committing the patient, or “[p]ursuing a course of action consistent with current professional standards that will discharge the duty.” TENN. CODE ANN. § 33-3-207.
  - If the threat is made to the provider’s employee who normally acts as a liaison between the patient and provider, that employee has a statutory duty to inform the provider. TENN. CODE ANN. § 33-3-208.
  - If the duty is discharged, the provider and his or her employees are immune from civil liability for failing to warn/protect. TENN. CODE ANN. § 33-3-209.
  - This duty does not preempt the psychiatrist’s common law duty to protect. Stewart.

- Psychiatrists have common law duty to protect third parties from their patient’s violent behavior when, in accordance with professional standards, they know or reasonably should know that their patient poses an unreasonable risk of harm to a foreseeable, readily identifiable third person. Turner. Outpatient status is not dispositive of the duty. Stewart.

Relevant legislation


IF AND ONLY IF

(1) a service recipient has communicated to a qualified mental health professional or behavior analyst an actual threat of bodily harm against a clearly identified victim, AND

(2) the professional, using the reasonable skill, knowledge, and care ordinarily possessed and exercised by the professional’s specialty under similar circumstances, has determined or reasonably should have determined that the service recipient has the apparent ability to commit such an act and is likely to carry out the threat unless prevented from doing so,

THEN

(3) the professional shall take reasonable care to predict, warn of, or take precautions to protect the identified victim from the service recipient’s violent behavior.
**Tenn. Code Ann. § 33-3-207 (discharge of duty)**

The duty imposed by § 33-3-206 may be discharged by the professional or service provider by:

1. Informing the clearly identified victim of the threat;
2. Having the service recipient admitted on a voluntary basis to a hospital;
3. Taking steps to seek admission of the service recipient to a hospital or treatment resource on an involuntary basis pursuant to chapter 6 of this title; or
4. Pursuing a course of action consistent with current professional standards that will discharge the duty.


IF AND ONLY IF

1. an employee of a service provider is normally responsible for transmitting or recording communications from a service recipient to a qualified mental health professional or behavior analyst, AND
2. the employee receives a communication from a service recipient of an actual threat of bodily harm against a clearly identified victim,

THEN

3. the employee shall communicate the threat to the professional employed by the service provider.


If a professional or an employee has satisfied the person’s duty under § 33-3-206, § 33-3-208, or § 33-3-210, no monetary liability and no cause of action may arise against the professional, an employee, or any service provider in whose service the duty arose for the professional or employee not predicting, warning of, or taking precautions to provide protection from violent behavior by the person with mental illness, serious emotional disturbance, or developmental disability.

**Tenn. Code Ann. § 33-1-101 (definition of “qualified mental health professional”)**

As used in this title, unless the context otherwise requires:
***

(20) “Qualified mental health professional” means a person who is licensed in the state, if required for the profession, and who is a psychiatrist; physician with expertise in psychiatry as determined by training, education, or experience; psychologist with health service provider designation; psychological examiner or senior psychological examiner; licensed master's social worker with two (2) years of mental health experience or licensed clinical social worker; marital and family therapist; nurse with a master's degree in nursing who functions as a psychiatric nurse; professional counselor; or if the person is providing service to service recipients who are children, any of the above educational credentials plus mental health experience with children;

***

Cases


[Significance – the psychiatrist’s statutory duty to warn/protect third parties from patient’s violent behavior (§ 33-3-206) does not preclude a psychiatrist’s other common law duties to third parties (e.g., duty to protect through reasonable care in treatment, Turner (below)); duty to warn/protect can exist in the outpatient setting]
  - Facts: A man receiving outpatient treatment from a psychiatrist shot and killed his wife and himself. Patient's daughter filed wrongful death action against psychiatrist.
  - Held:
    - Although § 33-3-206 does not apply in this case because the patient did not communicate any threat of harm toward the victim to the psychiatrist, *5, the psychiatrist still may have had a common law duty to protect the victim (see Turner) so summary judgment was in error.
  - Discussion:
    - Even in the absence of a communicated threat, a psychiatrist could have a duty to protect third parties from the violent behavior of his patient: “The statutory duty to protect arises only in the context of an actual threat of bodily harm to a specific victim. We do not, however, interpret the statute as eliminating any other type of duty that a psychiatrist might have to a non-patient as established by common law.” *5.
    - Outpatient status does is not dispositive about existence of a psychiatrist’s duty to third parties. It is merely a factor to consider. *8.

Turner v. Jordan, 957 S.W.2d 815 (Tenn. 1997).

[Significance – Psychiatrists have a common law duty to protect when, in accordance with professional standards, he knows or reasonably should know that a patient poses an unreasonable risk of harm to a foreseeable, readily identifiable third person and the psychiatrist has control over the patient.]
o Facts: A hospital nurse who was attacked and severely injured by a hospitalized mentally ill patient sued the patient’s attending psychiatrist, arguing that her injuries were caused by the psychiatrist’s failure to use reasonable care in his treatment of the patient.

o Held: The psychiatrist owed a duty of care to the nurse because he knew of the patient’s prior violent conduct while hospitalized and present dangerousness, and failed to consider reasonable measures to prevent the risk the patient posed to other patients, staff members, or other readily identifiable foreseeable victims.

o Discussion:
  - “[A] duty of care may exist where a psychiatrist, in accordance with professional standards, knows or reasonably should know that a patient poses an unreasonable risk of harm to a foreseeable, readily identifiable third person.” 820–21.
  - “Although we have generally held that a person has a duty to use reasonable care to refrain from conduct that will foreseeably cause injury to others . . . this duty does not extend to the protection of others from the dangerous conduct of third persons unless the defendant ‘stands in some special relationship to either the person who is the source of the danger, or to the person who is foreseeably at risk from the danger.’” 818. The psychiatrist/patient relationship is such a special relationship. 820.
  - “In Bradshaw[v. Daniel, 854 S.W.2d 865 (Tenn. 1993)] we cited with approval Tarasoff v. Regents of University of California . . .” 819.
  - “Although [the patient’s] unreasonable risk of harm was reasonably apparent, Dr. Jordan, who had the ability to control Williams in the inpatient psychiatric ward, took no action . . . Although the defendant now contends that he had no control over Williams and that he was obligated to apply the least restrictive means of treatment, the record indicates that he never considered other reasonable measures to prevent the risk Williams posed to other patients, staff members, or other readily identifiable foreseeable victims.” 820.

Texas

Summary

- Permissive duty exists per § 611.004.
  - Provider may inform medical or law enforcement personnel if provider determines that probability of imminent physical injury by patient to others exists.
  - Providers make such a disclosure at their own risk. (See interpretation in Thapar v. Zeulka)

- Mandatory duty to warn has been rejected per Supreme Court decision in Thapar v. Zeulka.

- Note on existence of duty to control:
Per decision in *Van Horn v. Chambers* (970 S.W.2d 542 (Tex. 1998)), there is generally no relationship between doctor and patient that would provide the type of control necessary to create a duty to third persons. “Aside from the fact that a physician-patient relationship is not ‘special’ so as to impose a duty to control, as we have discussed, there is nothing inherent in the relationship that gives a doctor the right to control his patient.”

**Relevant legislation**

*Tex. Health & Safety Code Ann. § 611.004 (West) - Authorized Disclosure of Confidential Information Other than in Judicial or Administrative Proceeding (Subtitle E. Special provisions relating to mental illness and retardation)*

- Applies to person authorized to practice medicine in any state or nation; person licensed or certified to diagnose, evaluate, or treat any mental or emotional condition or disorder; or a person the patient reasonably believes is authorized, licensed, or certified (See *Tex. Health & Safety Code Ann. § 611.001)*
- Confidential information may be disclosed to:
  - “medical or law enforcement personnel if the professional determines that there is a probability of imminent physical injury by the patient to the patient or others or there is a probability of immediate mental or emotional injury to the patient.”
- § 611.005 provides that civil cause of action can be brought against provider for improper disclosure. Thus, the legislature has created a disincentive for disclosure.

**Cases**

Prior to the Supreme Court’s ruling in *Thapar v. Zezulka*, which definitively rejected a duty to warn, several lower Texas Courts have recognized a duty to warn based on *Tarasoff*.

*Williams v. Sun Valley Hosp., 723 S.W.2d 783 (Tex. App. 1987), writ refused NRE (Sept. 16, 1987)*

- [accepted the *Tarasoff* and *Thompson* as controlling law, but found the plaintiff’s facts not compelling enough to escape summary judgment]
- Facts: mental patient escaped confinement and injured woman when he jumped in front of her car.


- [health care provider who can reasonably foresee that patient poses threat to injure or kill identifiable victim has duty to warn victim of threat]
• **Discussion:** Court looked to previous TX and CA case law. Circumstances in which duty could exist: foreseeability of some injury and foreseeability in the form of a readily identifiable victim.

• **Holding:** Here, risk that husband would injure or kill woman was not reasonably foreseeable and did not give rise to duty.

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**Thapar v. Zezulka, 994 S.W.2d 635 (Tex. 1999) – Supreme Court**

- [rejecting common law mandatory duty to warn unanimously]

- **Facts:** Treatment relationship betw. psychiatrist and patient existed for 3 years mainly on *outpatient, voluntary basis* (patient admitted on 6 occasions). In last session of admitted care patient expressed that he felt like killing his stepfather, but had decided against it. Provider did not inform patient’s family or law enforcement personnel. Patient was discharged. Month later patient shot stepfather. Wife brought suit against provider alleging negligence in failure to warn victim or his family of threat.

- **Discussion:** Court looks primarily to legislative intent and related public policy.
  - 3 years post Tarasoff, TX legislature decided to protect confidentiality of MHP-patient communications unless exception applies.
    - Disclosure to family. Would have violated the confidentiality statute since no exceptions apply. Thus, provider was prohibited from warning one of his patient’s potential victims and had no duty to warn the family.
    - Disclosure to warn law enforcement. Statutory exception for disclosure as per § 611.004 applies. Statute permits disclosures, but does not require it.
  - Imposing legal duty to warn third parties of patient’s threats would conflict with legislative scheme by making disclosure of such threats mandatory.
    - Confidentiality statute does not make disclosure of threats mandatory.
    - Statute does not penalize mental-health professionals for not disclosing threats.
    - Statute does not shield mental-health professionals from civil liability for disclosing threats in good faith. Mental-health professionals make disclosures at their peril.

- **Holding:** Psychiatrist had no common-law duty to warn victim or victim's family. Psychiatrist was prohibited from disclosure and had no statutory duty to warn.

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**Estate of Smith ex rel. Richardson v. United States, 509 F. App’x 436 (6th Cir. 2012)**

- [relying on Thapar v. Zezulka and interpretation of § 611.004, finding no duty to warn third parties or law enforcement]

- **Facts:** Victim was killed by military police officer, who had been in treatment for PTSD and violent behavior, while walking to school on property owned by United States Army. FTCA suit filed alleging that doctors and medical staff knew or should have known that there was a
probability of imminent physical injury to others from patient, and therefore, they were negligent in failing to disclose that information.

- **Holding:** mental health professionals at Army base owed no duty to disclose threat posed by officer

→ **Duty to Control Analysis**

*Texas Home Mgmt., Inc. v. Peavy, 89 S.W.3d 30 (Tex. 2002)*

- **Facts:** Patient who was on family leave from court-mandated residence at intermediate care facility for the mentally retarded shot and killed victim. Victim’s family sued mental health management company that owned and managed the residence.

- **Discussion:** Analysis of existence of duty to control.
  - Facility’s control over patient was greater than the control ordinarily exercised by a physician. Per contract facility provided patient not only with room and board, but also with a plan for his training and treatment. Employed professionals continually monitored and reported on patient’s progress to the State.
  - Right to control arises from facility’s contract with the state.


- **Facts:** Emergency room patient for whom hospital had attempted to obtain an emergency detention order left the hospital and committed three murders.

- Special relationship did not exist. Patient had not yet been admitted or been committed to a state mental health care facility. Hospital had no contract with state requiring supervisory control. Hospital had no lawful right to restrain or detain patient.

**Other sources**

See secondary sources (law review articles, commentary) in state folder for more extensive elaboration of duty-to-warn standard history in Texas case law.

**Utah**

**Summary**

- Therapists have a statutory duty to warn/protect third parties from the violent behavior of their patient when the patient “communicate[s] to the therapist an actual threat of physical violence against a clearly identified or reasonably identifiable victim.” *Utah Code Ann. § 78B-3-502* (2008). The duty is discharged when the therapist makes reasonable efforts to communicate the threat.
to the victim and notifies law enforcement. Id. If the victim is not clearly identified, there is no duty. Robinson.

- All other mental health providers have a common law duty to protect/control when the provider knows or should know that the person is likely to cause harm to others. Wilson (finding that non-therapist mental health providers have a duty even where they don’t know but through reasonable care should know of threat). When the provider has custody over the patient, the others need not be identifiable. Scott (finding that custodians of mental patients have a duty to protect third parties even if potential victims are not “reasonably identifiable”).

Relevant legislation


1. A therapist has no duty to warn or take precautions to provide protection from any violent behavior of his client or patient, except when that client or patient communicated to the therapist an actual threat of physical violence against a clearly identifiable or reasonably identifiable victim. That duty shall be discharged if the therapist makes reasonable efforts to communicate the threat to the victim, and notifies a law enforcement officer or agency of the threat.

2. An action may not be brought against a therapist for breach of trust or privilege, or for disclosure of confidential information, based on a therapist's communication of information to a third party in an effort to discharge his duty in accordance with Subsection (1).

3. This section does not limit or effect a therapist's duty to report child abuse or neglect in accordance with Section 62A-4a-403.

Cases


[Significance – Under Utah Code Ann. § 78B-3-502, therapists do not have a duty to warn unidentified third parties when a patient does not make a specific threat]

- Facts: A therapist called the police for assistance with a suicidal patient she was treating. The therapist was aware that the patient had a history of threatening violent behavior and had sometimes waved a gun around at home, threatening himself and his family. She also knew that the patient sometimes kept a gun in his truck. At one point during his therapy session the patient returned to his truck. At another point during the session Ms. Harris asked the patient if he had a weapon, to which the patient replied, “Maybe I do, maybe I don’t.” A struggle ensued when the officers attempted to escort the patient out of the clinic. During the struggle, a handgun in the patient's pocket discharged, striking a police officer in the foot. The officer sued.
- Held: Therapist did not have statutory duty to warn police officer who was called to transport client to hospital that client might be armed because the client here made no actual threat of physical violence to the responding police officer. 336.
Discussion:
- “while therapist was aware that client had a history of threatening violent behavior, that client sometimes kept a gun in his truck, and that client admitted to therapist during session that he might have weapon on him, client never communicated to therapist any actual threat of physical violence against officer.” HN 2.


[Significance – Non-therapist mental health providers have a common law duty to protect/control even when they don’t know but through reasonable care should know of the threat of harm by patient; in contrast, therapists do not have a duty unless there is an actual threat.]

- Facts: Parents of murder victim brought negligence action against mental health hospital, alleging that it breached its duty to the victim by not properly treating patient who strangled victim.
- Law:
  - “[W]e generally adhere to the basic tort principle that one has no duty to control the conduct of others. See Rollins, 813 P.2d at 1159; Higgins, 855 P.2d at 235. However, as our case law has developed, it has become clear that the duty to control another person may arise where a special relationship exists.” 419.
  - “[W]e will find a special relationship and consequent duty when a defendant knew of the likely danger to an individual or distinct group of individuals or when a defendant should have known of such danger.” Rollins at 240.
- Held: Because defendant was a “therapist,” UTAH CODE ANN. § 78B-3-502 applied, imposing a duty only if the therapist was actually aware of danger (not common law standard: “should have known”), thereby shielding her from liability for negligence because patient did not communicate actual threat.
- Discussion:
  - “[UTAH CODE ANN. § 78B-3-502] exclusively defines the duty of a therapist in cases where it is alleged that a therapist had a duty to warn or take precautions to provide protection from the violent behavior of a client. There is no such duty unless there is an actual threat of physical violence against a clearly identified or reasonably identifiable victim communicated by the patient to the therapist. In cases not involving therapists, our case law still governs.”


[Significance – custodians of mental patients have a duty to protect third parties even if potential victims are not “reasonably identifiable”]

- Facts: Victim of violent sexual assault by prisoner who had escaped from private business’s work site brought negligence action, for improper screening and placing prisoner in county’s work-release program, against county, placement company, and private business.
Hold: To impose a duty to protect others from one in the custody of another, the “others” likely to be harmed need not be identifiable (overruling Higgins v. Salt Lake County, 855 P.2d 231 and Rollins v. Petersen, 813 P.2d 1156).

Discussion:

- “Like any duty determination, the Rollins rule ([“[b]efore any duty is imposed to protect others from bodily harm caused by one” in the custody of another, “the ‘others’ to whom such bodily harm is ‘likely’ . . . must be reasonably identifiable by the custodian either individually or as members of a distinct group”]) is a policy choice. In making that choice, we departed from the rule that appears to be followed in most jurisdictions, which imposes a duty of care on the custodian of a dangerous person if the custodian “knows or should know” that the person is “likely to cause bodily harm to others if not controlled.” There is no requirement that the threat target a specific individual or distinct group of people. . . . Consequently, even though departing from the rule may upset the reliance interests of correctional facilities and health care providers that regularly house dangerous individuals, we overrule Rollins.” 1178–81 (emphasis added).

Vermont

Summary

- Mandatory duty to warn standard as established per common law based on a special relationship found in outpatient relationship per Restatement of Torts §315. See Peck v. Counseling Serv. of Addison Cty..

  - A “mental health professional who knows or, based upon the standards of the mental health profession, should know that his or her patient poses a serious risk of danger to an identifiable victim has a duty to exercise reasonable care to protect him or her from that danger”.

  - Court defines mental health professional as “a person with professional training, experience and demonstrated competence in the treatment of mental illness, who shall be a physician, psychologist, social worker, nurse or other qualified person designated by the commissioner.”

  - The duty requires to provider to take “whatever steps are reasonably necessary to protect the foreseeable victim of that danger”.

  - The standard appears to apply to injuries to person and to property.

  - In Kuligowski v. Brattleboro Retreat the Supreme Court extended the duty to warn as defined in Peck where a third party is immediately involved in patient’s care and is within “zone of danger” of patient’s conduct, even though the patient has not communicated an explicit threat against this third party.
Relevant legislation

- Codifying evidentiary privilege.
- A mental health professional shall not be allowed to disclose any information “acquired in attending a patient in a professional capacity, including joint or group counseling sessions, and which was necessary to enable the provider to act in that capacity”.
- Disclosures can be made if the patient waived the privilege or if the privilege is waived by an express provision of law.

Regulations and administrative guidance

**12-8 Vt. Code R. § 2 – Reporting of Offender Information**
- Based on 33 V.S.A. § 4913(a); Peck v. Counseling Service of Addison County, Inc., 146 Vt. 61 (1985); 28 V.S.A. § 505(b); 28 V.S.A. § 204(a), the regulation establishes guidelines for the reporting of offender information to courts, state's attorneys, the Vermont Parole Board, the Commissioner of Social and Rehabilitative Services, and third parties.
- The policy applies to all Department of Correction’s employees, volunteers, and service providers and to all offender information in the control and custody of the Department.
- Department employees, volunteers, and service providers shall report offender information to state officials and third parties when an offender poses a serious risk of danger to an identifiable victim.
  - Serious risk of danger is defined as “a case-by-case determination by a therapist, a medical professional, or mental health professional, or other person as defined in 12 V.S.A. § 1612(a) that is based upon: (1) the offender's proclivity to violent behavior as evidenced by prior criminal background or history of mental health treatment; and (2) the expressed intent of that offender to harm the person or property of an identifiable third party.

Cases

**Peck v. Counseling Serv. of Addison Cty., Inc., 146 Vt. 61, 499 A.2d 422 (1985)**
- [Establishing duty to warn where patient poses a serious risk of danger to another, provider has duty to take whatever steps are reasonably necessary to protect the foreseeable victim of that danger]
- Facts: Parents of mental outpatient brought action against mental health agency to recover damages for their property loss after outpatient set fire to their barn. Patient told therapist that he “wanted to get back at his father.” In response to how he would get back at his father, patient stated, “I don't know, I could burn down his barn.” Patient then made promise to provider not to burn down barn. Plaintiffs brought action to recover damages for property loss.
• **Discussion:** Relying mainly on *Tarasoff* and *Lipari*.
  
  o Finding a special relationship exception to the general rule in Restatement of Torts §315 in an outpatient treatment situation. Court recognizes relationship as “sufficient to create a duty to exercise reasonable care to protect a potential victim of another’s conduct” based on the ruling in Tarasoff and other Vermont statutes where physicians are required to warn others to protect public health.

  o While Court recognizes difficulty of predicting dangerous behavior, difficulty does not justify barring recovery in all situation.

  o Consequentially the Court holds that, “once a therapist determines, or, based on the standards of the mental health professional community, should have determined that his or her patient poses a serious risk of danger to another, then he or she has the duty to take whatever steps are reasonably necessary to protect the foreseeable victim of that danger.”

  o Court states that physician-patient privilege is not sacrosanct and can be waived in the appropriate circumstances and based on public policy considerations (other statutory exceptions to the physician-patient privilege already exist, eg. child abuse). Court finds that threat of serious harm to identified patient is one of these appropriate circumstances.

• **Holding:** A mental health professional who knows or, based upon the standards of the mental health profession, should know that his or her patient poses a serious risk of danger to an identifiable victim has a duty to exercise reasonable care to protect him or her from that danger.


• [District Court applies reasoning in Peck to determine existence of special relationship and duty to warn, Court declines to rule on issue due to lack of evidence in the record]


• [expanding Peck in very narrow circumstances, recognizing duty to warn third party of patient’s general violent propensities where third party is immediately involved in patient’s care and is within “zone of danger” of patient’s conduct]

• **Facts:** Victim was assaulted by patient of psychiatric hospital and outpatient treatment center. After being diagnosed with psychotic disorder hospital determined that patient was a danger to others and, if released, would pose a danger to his family. Patient was discharged even though he did not significantly improve and was likely to discontinue his medications after release. Patient underwent outpatient treatment at center after discharge. While visiting grandparent’s apartment patient assaulted victim, who was working on the furnace in the apartment building. Victim’s wife brought action against facilities alleging failure to warn of patient’s danger to
others, failure to train patient's parents in handing patient, failure to treat, improper release, and negligent undertaking.

- **Discussion:** Decision reviews the May 6, 2016 version of the judgement (imposed a “duty of care to provide sufficient information” to a patient's “caretakers” so those individuals can “fully assume their caretaker responsibilities to assist [the patient] and protect against any harmful conduct in which he might engage.”) Court responded to several motions for reargument and vacated the judgement for further clarification.

- Plaintiffs argue that Retreat was negligent in failing to warn patient’s parents that patient posed a risk to the general public.
  - While the Court mentions the existence of a duty based on Restatement (Third) of Torts: Liability for Physical and Emotional Harm § 41, the Court declines to rely on this section and rather looks to existent persuasive case law interpreting Restatement (Second) of Torts §315.

- Court cites Tarasoff, Thomson and Peck to clarify the duty as referenced in §315 and later version §41.
  - Court states that while holding in Peck finds a duty to warn an identifiable victim, this holding does not state that liability is limited to those circumstances. (In fact Peck Court draws on public health cases where there is no identifiable victim)
  - The Court declines to extend Peck to apply to a duty to warn the general public. However, the present case alleges a more limited duty. The duty to warn the patient’s care takers.
  - Court concludes that facility had duty to issue such warnings. Reasons:
    - (1) The parents were directly involved in patient’s care and were involved in controlling his conduct. They had assumed responsibilities, the discharge of which could be affected by the information they received. By transferring custody of patient to caretakers whom they knew lacked training and experience. Facility owed a duty of care to provide reasonable information to the parents to enable them to recognize the dangers and fulfill the responsibilities envisioned for them in the treatment plan.
    - (2) Patient’s parents fell within the “zone of danger” from patient’s conduct. Court follows reasoning in Hamman v. City of Maricopa (Az.): most likely affected victims were parents, since in constant physical proximity and thus in obvious zone of danger and identifiable.

- **Holding:** Facility had a duty to warn patient’s parents.
  - Narrow duty that applies only when caregiver is actively engaging with the patient's provider in connection with care or treatment plan, the provider substantially relies on that caregiver's ongoing participation, and the caregiver is himself or herself within the zone of danger of the patient's violent propensities
• **Discussion:** Plaintiff also alleges that facility had a duty to protect relying on the general duty expressed in *Tarasoff, Peck* and the duty described in Restatement (Third) § 41(b)(4) (claiming negligent discharge and undertaking to render service to patient to protect third parties etc.)
  
  o Court concludes that if mental health professionals have a broad duty of public protection to institutionalize patients who may be dangerous, child protection workers would have a similar duty to institutionalize a juvenile who may be dangerous to the public. This would clash with earlier decision in *Sorge*. Court declines to impose such a duty and specifically rejects reliance on the Restatement (Third) of Torts § 41(b)(4).

• **Holding:** Defendant facilities had no duty, as matter of public protection, to refrain from releasing patient.

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**Virginia**

**Summary**

• Virginia has a statutory mandatory duty to warn standard that applies to licensed mental healthcare providers and corporations or partnerships of licensed providers (*VA Code Ann. § 54.1-2400.1*).
  
  o Duty arises when patient communicated specific and immediate threat to cause serious bodily injury or death to an identified or identifiable person or persons, and if the provider believes that patient has intent and ability to carry out the threat
  
  o Duty can be discharged by taking one or more of prescribed precautions (See list in Subsection C).

• Per *VA Code Ann. § 32.1-127.1:03* health care entities are authorized to disclose health records in accordance with statutory duty to warn.

• Note on Duty to Control: Virginia Supreme Court disagrees with *Tarasoff*; a doctor-patient relationship or a hospital-patient relationship alone is not sufficient. Court requires "take charge" relationship for existence of duty to control third party to prevent harm to others.

**Relevant legislation**

*VA Code Ann. § 54.1-2400.1 - Mental health service providers; duty to protect third parties; immunity*

• Applies to mental health service providers. Defined in this section as: “(i) a person who provides professional services as a certified substance abuse counselor, clinical psychologist, clinical social worker, licensed substance abuse treatment practitioner, licensed practical nurse, marriage and family therapist, mental health professional, physician, physician assistant, professional counselor, psychologist, qualified mental health professional, registered nurse, registered peer recovery specialist, school psychologist, or social worker; (ii) a professional corporation, all of whose shareholders or members are so licensed; or (iii) a partnership, all of whose partners are so licensed.”
Subsection B. The duty to take precautions to protect third parties arises when

- The client has communicated - orally, in writing, or via sign language – a specific and immediate threat to cause serious bodily injury or death to an identified or identifiable person or persons.
- The duty arises only if the provider reasonably believes, or should believe according to the standards of his profession, that the client has the intent and ability to immediately or imminently carry out the threat.
- If the third party is a child the provider also has a duty to protect the child from threats of physical or sexual abuse.
- The duty to protect only attaches if the threat has been communicated while the provider is engaged in his professional duties.

Subsection C. Discharge of duty if provider does one or more of the following:

- (1) seeking involuntary admission,
- (2) making reasonable attempts to communicate threat to victim/victims or parents/legal guardian of victim,
- (3) making reasonable efforts to notify law enforcement,
- (4) taking steps available to provider to prevent client from inflicting harm until law enforcement agency can take custody of client
- (5) providing therapy to the client in the session in which the threat has been communicated until the provider reasonably believes that client no longer has the intent or the ability to carry out the threat,
- (6) In case the threat was communicated to a peer recovery specialist, or a provider not licensed by health regulatory board – reporting threat to licensed provider so necessary steps of precaution can be taken.

Subsection D. Provider is exempt from liability for breach of confidentiality in connection with discharge of duty to protect, failing to predict harm to third party where no specific threat was made, failing to take precautions other than the ones listed in Subsection C.

VA Code Ann. § 32.1-127.1:03 - Health records privacy

- Health care entities may disclose health care records in accordance with Subsection B of § 54.1-2400.1.

Cases

Merely Nasser v. Parker (249 Va. 172, 180, 455 S.E.2d 502, 506 (1995)) discuses Tarasoff duty. However, Virginia Supreme Court disagrees with the holding of Tarasoff that a doctor-patient relationship or a hospital-patient relationship alone is sufficient, as a matter of law, to establish a "special relation" under Restatement § 315(a). Court finds no duty to control here, based on lack of “take charge” relationship.
The Court in *Sage v. United States* (974 F. Supp. 851, 859 (E.D. Va. 1997)) applied *Nasser* standard in analyzing whether a hospital had a duty to control psychiatric patient who committed shootings. A “duty to protect one from the wrongful acts of a third party may exist because of a ‘special relationship’ between the defendant and the third party.” (Citing *Nasser v. Parker*). Special relationship exists where "take charge" relationship exists. Then, duty to exercise reasonable care to control the third person to prevent him from doing such harm exists. Here, hospital did not take charge of or exercise control over patient. Thus, no duty to protect victims of wrongful acts of patient.

**Washington**

**Summary**

*See (1) Washington Cases and (2) Washington Cases – Chronology in the Washington folder for a fulsome review of relevant case law. The review below summarizes the narrowest view of the duty to warn/duty to protect in the state*

**General**

- Washington has a common law duty to take reasonable precautions to protect anyone who might foreseeably be endangered by a patient’s dangerous propensities, as established by the Washington Supreme Court in *Petersen v. State*, and affirmed by *Volk v. DeMeerleer*

- The Washington legislature enacted *Wash. Rev. Code §71.05.120*, in response to *Petersen* (as acknowledged in the *Volk v. DeMeerleer* Court of Appeal decision), in attempt to circumscribe the duty to protect anyone foreseeable, to “a duty to warn or take reasonable precautions to provide protection from violent behavior where the patient has communicated an actual threat of physical violence against a reasonably identifiably victim or victims.”

- However, in its ruling in *Volk v. DeMeerleer*, the Washington Supreme Court effectively denied that the statute applied to the outpatient context, in which it held that the “the §315 Petersen duty” to protect anyone foreseeable applies.
  - In so ruling, the Court relied on §315 of the *Restatement (Second) of Torts*, which states: “a person has a duty to control the conduct of a third person and thereby to prevent physical harm if: (a) a special relation exists between the actor [MHP] and the third person [the patient] which imposes a duty upon the act to control the third person’s conduct”
• Volk states that Petersen applies equally to the inpatient and outpatient setting, relying on its discussion of the issue in Taggart v. State, a parole officer/parolee case, in which the Supreme Court stated “whether the patient is a hospital patient or an outpatient is not important”; thus, to the Volk court, the duty to “the reasonably foreseeable victims” exists provided a special relation exists, per §315 of the Restatement, regardless of the setting in which the relation is formed.

• It is unclear then how Wash. Rev. Code §71.05.120 applies post-Volk v. DeMeerleer:
  o The Volk Court of Appeal decision held that the provision applied to the inpatient setting but not the outpatient setting—based on the legislature intending to circumscribe the liability arising from Petersen and involuntary commitment proceedings;
  o The Volk Supreme Court decision emphasizes that control, which is readily apparent in the inpatient setting, is irrelevant to the application of the duty and that Petersen is the most “relevant analog” to Volk, an outpatient case.
  o How can Petersen apply regardless of the setting (therefore applying to both), and yet the provision enacted to circumscribe its reach apply to only one setting, the one in which there is more control (i.e. inpatient); or stated the other way, how can the provision not apply to one of the settings, and in particular, the setting in which there is less control (e.g. outpatient)? The principles seem impossible to reconcile.
  o Volk does not engage with these questions whatsoever; its discussion is entirely focused on the common law duty and the framing of the special relation under the Restatement.
  o In Jackson v. City of Mountlake Terrace, the only relevant case to discuss the Supreme Court’s ruling in Volk since, a federal district court treated the statutory provision as providing statutory immunity regarding the decision to commit the patient (specifically referencing Wash. Rev. Code §71.05.120(1)) and that that immunity is separate from a general (common law duty).
    ▪ Note: that decision does not address Wash. Rev. Code §71.05.120(3), the language which provides immunity against liability unless there is a specific threat of actual violence against an identified or identifiable person(s)

• The Volk duty, with its emphasis on the presence of a special relationship, does not apply to situations where there is not a definite, established and continuing relationship, per Estate of Davis v. State of Washington, Department of Corrections. This means that a sole assessment does not create a legal duty, as recently held in Jackson v. City of Mountlake

Other points
• No duty to initiate involuntary commitment procedure, due to statutory immunity granted in Wash. Rev. Code §71.05.120(1); that aspect of the claim in Volk v. DeMeerleer, which was dismissed in a summary judgment motion, was affirmed on appeal
• Effective April 1, 2018, Wash. Rev. Code §71.05.120(1) will cover “designated crisis responders”, a term encompassing mental health professionals as well as those working in the substance abuse context
Relevant legislation

*Wash. Rev. Code §71.05.120 (effective until April 1, 2018) – Duty to Warn Identified or Identifiable Victims of a Communicated Threat*

- Sub-section (1) provides immunity against civil liability and criminal charges to, among others, mental health professionals in respect of their performance of duties with respect to “the decision of whether to admit, discharge, release, administer antipsychotic medications, or detain a person for evaluation and treatment” so long as the duties are performed (1) in good faith and (2) without gross negligence.

- Section (3) clarifies that the provision does relieve a person from ... “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.”

- Section (3) adds that 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.”

*Wash. Rev. Code §71.05.120 (effective April 1, 2018) – Duty to Warn Identified or Identifiable Victims of a Communicated Threat*

- Sub-section (1) replaces “designated mental health professionals” with “designated crisis responder”, so that the provisions of the ITA, specifically the standards for detention, can apply to someone with either mental illness or substance abuse issues.

Cases

*Petersen v. State, 100 Wash. 2d 421, 671 P.2d 230 (1983)*

- [established Washington’s common law duty to take reasonable precautions to protect anyone who might foreseeably be endangered by a patient’s dangerous propensities – inpatient case]

- **Facts:** 5 days after being newly released from involuntary commitment, patient involved in MVA (ran a red light and crashed into car); victim sues state for injuries sustained. Patient had been committed a month earlier for schizophrenia-like reaction to drugs. Patient was on parole at the time, conditioned on him not using illicit drugs.

- **Discussion:**
  - References Kaiser v. Suburb Transp., and states this is the first time the court has consider whether a psychiatrist has a duty to protect against injuries caused by a patient (Id. 426)
  - Discusses Tarasoff and how that decision did not emphasize the identifiability of the victim but that subsequent California decisions have (i.e. Thompson v. County of Alameda), while other courts have required only that the therapist “reasonably foresee that the risk engendered by the patient’s condition would endanger others” (Id. 428, referencing various circuit court and federal cases, including Lipari v. Sears, Roebuck &
Co, 497 F. Supp 185 (D. Neb. 1980), where psychiatric patient entered nightclub and shot strangers)

- **Holding:** Follows approach utilized in Lipari, supra, and Kaiser, supra, such that therapist “incurred a duty to take reasonable precautions to protect anyone who might foreseeably be endangered by [the patient’s dangerous propensities i.e.] drug-related mental problems.”
  - Psychiatrist breached the duty owed, by failing to petition the court for a 90-day commitment or to take other reasonable precautions to protect those who might be foreseeably endangered by the patient’s drug-related mental problems (428-29)


- [holding that a duty does not arise where a mental health counselor assesses a patient one time; does not rise to a ‘definite, established and continuing’ relationship’]
- **Facts:** victim murdered by person seen by mental health counselor for assessment of mental health issues; the counselor did initial assessment to determine if individual could benefit from further counselling; counselor initially concerned that person might be a danger to himself but he denied suicidal ideation; counsellor referred individual to clinical program for individual therapy (Id. 490)
- **Discussion:**
  - “[the mental health counselor] saw [the individual] only one time. He performed an initial assessment to determine if [the individual] would benefit from further counselling. This sole contact is not a definite, established, and continuing relationship that would trigger a legal duty (Id. 492)


- [affirmed Petersen as governing – it did not address Wash. Rev. Code §71.05.120, or its effect on Petersen – and confirmed that the duty to protect all foreseeable victims applies to mental health providers in the outpatient context]
- **Facts:** five months after his last visit with his therapist, an outpatient killed his ex-girlfriend one of her sons, and stabbed another, before killing himself. The patient had seen the therapist off and on for nine years, and had a history of homicidal and suicidal ideation, with the last homicidal ideation seven years prior to the index offense. The patient did not voice threats about his ex-girlfriend or her sons to the therapist.
- **Procedural History:**
  - The therapist and the hospital successfully moved for summary judgment at first instance, relying on R.C.W. 71.05.120, on the grounds that they did not a duty to anyone in general or to the victims in particular since the patient never threatened them in the therapist’s presence.
- A majority of the court of appeal reversed, in part, on the grounds that the “limited duty to warn” identifiable individuals under R.C.W. 71.05.120 applied only to professionals in the involuntary commitment/inpatient setting and did not preclude a broader duty in the outpatient setting – notwithstanding its acknowledgment that R.C.W. 71.05.120 was specifically enacted to curtail Petersen, which is recognized as “the extreme” extension of Tarasoff (Id. 425-26).

- According to the majority, the legislature saw fit to protect professionals in one context but not the other (Id. 426).

- Accordingly, therapists operating in the outpatient context owed a duty to “all foreseeable victims”, not “only victims identified by the outpatient” (Id. 424)

**Discussion:**

- Once a special relationship, per Restatement (Second) of Torts §315, is formed, mental health professionals owe their outpatients’ “foreseeable victims a duty of reasonable care” (Id. 262)

- “The §315 duty, as articulated by this court in Petersen, is owed by the medical professional to a victim based on a special relationship between the mental health professional and the professional’s patient. ... The foreseeability of the victim, as well as what actions are required to fulfill this duty, is informed by the standards of the mental health profession” (Id. 262)

- “This court has held that a special relationship exists under §315, triggering the imposition of a duty to protect against foreseeable dangers, on a showing that a definite, established, and continuing relationship exists between the defendant and the third party” (Id. 263)

- Describes Petersen as the most relevant analog to the case (with emphasis on this being an outpatient case), and that case’s precedent as, once a mental health professional and a patient establish a relationship pursuant to §315, the professional “incur[s] a duty to take reasonable precautions to protect anyone who might foreseeably be endangered by” the patient’s condition (Id. 263).

- Rejects argument that the Petersen should be interpreted as a “take charge” case under §319—which defines the “take charge relationship” as “one 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 case to control the third person to prevent him from doing such harm” – which the court says arises in the cases of parole officer/parolee, probation officer/probationer, and corrections officer/community custody offender (Id. 264-265)

- The nature of the relationship provides a doctor unique insight, combined with professional expertise allows the physician to “standing in the distinct position of being able to mitigate or prevent the dangerousness of his patient and the ability to ‘take whatever steps [were] necessary under the circumstances, including possibly warning the intended victim or notifying law enforcement officials”’ (Id. 265-66, quoting Petersen)
The amount of control or the nature of control Ashby had over DeMeerleer is not determinative of whether [the doctor] was under a duty to act for the benefit of [the patient’s] victims (Id. 266)

Policy reasons discussed, including (1) psychotherapists’ ability to control outpatients, (2) public’s interest in safety from violent assaults, (3) difficulty in assessing mental health dangerousness, (4) the goal of placing mental patient in the least restrictive environment and safeguarding the patient’s right to be from unnecessary confinement, and (5) the social importance of maintaining the confidential nature of psychotherapeutic communications, all analyzed as favoring the application of the duty to anyone foreseeable (Id. 267-270)

- **Note:** this list is pulled from the Ohio case *Estates of Morgan*, briefed above

- “The *Petersen* duty should apply equally to the outpatient setting provided a special relation exists” ... 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 hypothetically ability to confine or control the patient (Id. 270-271)

- Discusses its decision in *Taggart v. State*, 118 Wash.2d 195, 822 P.2d 253 (1992), a parole officer/parolee case, in which it clarified that “the §315 *Petersen* duty did not require control and was, therefore, not limited to the inpatient setting (Id. 271, quoting that case at length, including “whether the patient is a hospital patient or an outpatient is not important”) as support for an interpretation that “unambiguously permit[s] the extension of the §315 *Petersen* duty to the outpatient setting” (Id. at 271)

- **Holding:** “once a mental health professional and his or her outpatient form a special relationship that satisfies the requirements of Restatement §315, the mental health professional is under a duty of reasonable care to act consistent with the standards of the mental health profession and to protect the foreseeable victims of his or her patient (Id. 272)

- **Dissent:**
  - Disagrees with the majority’s interpretation of Restatement (Second) of Torts §§315-319, and with its “un heralded” option of the “substantially broadened” Restatement (Third) of Torts: Liability for Physical and Emotion Harm §41:
  - §315 states “[t]here is no duty to so control the conduct of a third person ... unless ... a special relation exists. The Third Restatement, however, and the majority’s holding, 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 (275)
  - The majority functionally adopts the Third Restatement §41, declining to find any capacity for control before imposing a duty to control (275)
  - The Second Restatement does not establish a duty to control where there is no ability to control -- §315 requires a party to exercise control, the ensuring sections list relationships allowing for such control
- Consistent with the Court’s approach to third-party liability in *Binschus v. Department of Corrections*, 186 Wash.2d 573, 380 P.3d 468 (2016) (see Washington Cases document) -- “Crucial to our analysis,” we emphasized, “is the nature of that duty: ‘to control the third person’s conduct’” (276)

- In *Binschus*, the Court explained that some of its case may be misinterpreted to suggest there is a “broad duty to prevent all reasonably foreseeable dangers” independent of the ability to control and that certain language from *Taggart* could be taken out of context. Thus, we clarified: “duty ... to control” is, indeed, a duty to control...” (276)

  o The majority’s interpretation is inconsistent with the language of §§315-319 ... although the lists in §§316-319, although not exclusive, narrow the scope of special relationships to those situations where the ability to control exists. This narrowing is logical as without the ability to control, the §315 requirement to exercise control would be to no effect (276)

  - The requirement to exercise “control” is shed by the Third Restatement §41

  - Volk concedes that Ashby lacked the ability to control DeMeerleer; this lack was the reason for the failure of Volk’s §319 argument

  o Disagrees with the majority that the amount of control or nature of control in the relationship is not determined

  o Disagrees with the majority that a special relationship is sufficient to create a “duty to protect against foreseeable dangers”, noting particularly, that in *Petersen* there was the ability to exercise control, leading to the imposition of a §315 duty (277)

  o The adoption of the Third Restatement would substantially broaden liability to third parties and it was premature to adopt it, especially since it has not been explicitly adopted by any state, and its implications have not been fully explored (277-278)

  o Finds that the public policy case does not support broadening liability where there is no control (278)

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*Jackson v. City of Mountlake Terrace, 2017 WL 841751 (only westlaw citation currently available)*

- [Relies on *Volk* and *Petersen* in stating that “a duty of reasonable care to any foreseeable victim of the patient” only arises upon the establishment of a “definite, established and continuing relationship between the defendant and third party”]

- **Facts:** Man brought to Swedish Medical Center for involuntary commitment but was released, and killed the plaintiffs’ son shortly after. Decedent’s parents claim SMC negligent in releasing him, alleging it “violated their own internal policies, practices, and mandates with regard to the creation” of danger and “caused harm to Plaintiffs in such a way that was avoidable and preventable” (Id. 2)

- **Discussion:**
Pursuant to RCW 71.05.120(1), “a mental health professional is immune from tort liability in the performance of his duties unless he acted in bad faith or with gross negligence” (Id. 5) ... no facts alleged for gross negligence or bad faith

Relying on Volk, states that Washington courts recognize “a duty to act for the potential victim of a psychiatric patient when ’a special relation exists between the act and the third person which imposes a duty upon the act to control the third person’s conduct’ (quoting Petersen and §315)

Quoting Volk, “Stated another way, once a special relationship 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”

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” ... none exists here, negligence claims against medical center defendants also fails

- **Note**: discusses the facts of Petersen at length, but not the facts of Volk

**West Virginia**

**Summary**

- Statutory, permissive duty to warn standard that allows discretion in disclosure of confidential information (W. Va. Code Ann. § 27-3-1).

- Information can be disclosed to protect against a clear and substantial danger of injury by a patient to himself or others.

**Relevant legislation**

*W. Va. Code Ann. § 27-3-1 (West) - Definition of confidential information; disclosure*

- Subsection A. Communications and information obtained in the course of treatment or evaluation are confidential.

- Subsection B. Confidential information can be disclosed “to protect against a clear and substantial danger of imminent injury by a patient or client to himself, herself or another”.

**Wisconsin**

**Summary**

- Common law duty to warn standard base on Wisconsin tort law (See Schuster v. Altenberg).
Duty to warn exists when foreseeability of harm to third party by failure to warn can be established.

Determination of foreseeability is based on analysis whether provider acted within “degree of care and skill which is exercised by the average practitioner in the class to which he belongs, acting in the same or similar circumstances”.

Standard does not require identified or identifiable individual.

- Court explicitly rejects Tarasoff in favor of a more extensive, broadly construed liability theory.

**Relevant legislation**

Wis. Stat. Ann. § 905.04 enforces the provider-patient privilege. Exceptions to that privilege are listed in Subsection 4. Duty to warn situation not part of these exceptions.

**Cases**

*Schuster v. Altenberg, 144 Wis. 2d 223, 424 N.W.2d 159 (1988) – Supreme Court of Wisconsin*

- [rejecting Tarasoff standard and identifiability requirement, duty to warn/to commit exists when foreseeability of harm to third party by failure to warn/commit can be established]

- **Facts:** Patient of psychiatrist with psychotic condition had automobile accident, in which patient was killed and patient’s daughter was injured. Daughter and husband of patient allege that psychiatrist was negligent in management and care for patient in failing to recognize or take appropriate actions, including failing to seek her commitment, to modify her medication, to alert and warn the patient or her family of her condition or its dangerous implications.

- **Discussion:** Review of judgement on the pleadings for defendants. Court analyzes failure to commit claim alongside failure to warn third parties (since commitment paramount is justified as a measure to protect the public). Analysis based on elements of duty and foreseeability per Wisconsin tort law. Specifically rejects *Tarasoff’s* “readily identifiable victim theory” (adopting minority position in *Palsgraf*).

  - Extends physicians liability arising from contagious disease of patient to situation where injuries are caused by patient of psychotherapist. Citing *McIntosh v. Milano*.

  - Generally, a duty exists per Wisc. law when it is established that it was foreseeable that act or omission to act may cause harm to someone. Thus, Court reasons that duty to warn or to institute commitment proceedings is not limited to situations where threats were made to an identifiable target.

  - In determining whether harm was foreseeable, psychotherapist is held to “that degree of care and skill which is exercised by the average practitioner in the class to which he belongs, acting in the same or similar circumstances.” -> Liability only if expert testimony establishes that professional failed to conform to the accepted standard of care.
• **Holding:** Psychotherapist could have had a duty to warn third parties or to institute commitment proceedings for the protection of the patient or the public.
  
  o Here, if foreseeability of harm to third party by failure to warn/failure to commit of psychiatrist could be proven, negligence would be established.

**Wyoming**

**Summary**

• No general mandatory or permissive duty to warn standard.

• Psychologists, professional counselors, marriage and family therapists, social workers, and chemical dependency specialists are permitted to disclose confidential information in judicial or administrative proceedings (see *Wyo. Stat. Ann. § 33-38-113* and *Wyo. Stat. Ann. § 33-27-123*).
  
  o Disclosure may be made where an immediate threat of physical violence against a readily identifiable victim was disclosed to the provider.

**Relevant legislation**

*Wyo. Stat. Ann. § 33-38-113 (West) - Privileged communication*

• Applies for judicial and administrative proceedings.

• Applies to professional counselors, marriage and family therapists, social workers, and chemical dependency specialists.

• Applicable provider may disclose information communicated to him or agent for the purpose of diagnosis, evaluation or treatment of any mental or emotional condition or disorder where
  
  o (iv) an immediate threat of physical violence against a readily identifiable victim is disclosed to the person licensed or otherwise authorized to practice under this act.

*Wyo. Stat. Ann. § 33-27-123 (West) - Privileged communication*


• Applies to psychologists in the setting of judicial/administrative proceedings.

• Psychologist may disclose information where (iv) an immediate threat of physical violence against a readily identifiable victim is disclosed to psychologist.