ALASKA LEGISLATURE COMMITTEE FILES 1987-1988 8672
5270 SHES SB 481 - SB 495

842

SB
481

STATE OF ALASKA
1988 LEGISLATIVE SESSION

BILL VERSION : SB481
PUBLISH DATE :

FISCAL NOTE

REQUEST:

Revision Date:
Title : An Act relating to the duty of health professionals to warn......
Sponsor : Senate HESS Committee
Requestor :

Agency Affected : Health & Social Services
BRU : various

Components :

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-

	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-
REVENUE	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of Dollars)

	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
GENERAL FUND						
FEDERAL FUNDS						
OTHER						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS:

	FY 88	FY 89	FY 90	FY 91	FY 92	FY 93
FULL-TIME						
PART-TIME						
TEMPORARY						

ANALYSIS : (Attach a separate page if necessary)

Passage of SB481 would have no significant fiscal impact on the Department of Health & Social Services.

Prepared by : Mel Henry, Director
Division : Mental Health & Developmental Disabilities
Phone : 465-3370
Date :

Approved by Commissioner : Myra Munson
Agency : Health & Social Services
Date : 3-7-88

Distribution (by preparer):
- Legislative Finance
- Legislative Sponsor
- Requestor

page ___ of ___

FEB 24 1988

MEMORANDUM

TO: Interested Parties

FROM: Leonard D. Goodstein, Executive Officer

RE: Committee on Legal Issues: White Paper on DUTY TO PROTECT

The attached materials address a new cause of action against mental health service providers that is being created by state and federal courts across the country. It has come to be known as the "duty to protect" the public from the dangerous acts of violent mental patients. Psychotherapists and mental institutions are increasingly being held liable for civil damages where they violate this duty by failing to diagnose or predict dangerouaness, by failing to warn potential victims of violent behavior, by failing to civilly commit, and by prematurely discharging dangerous persons from the hospital.

In response to a proposal introduced in the APA Council of Representatives, the ad hoc Committee on Legal Issues, chaired by Patrick DeLeon, created a work group to develop a background paper on this issue. Their product, which is attached, has been accomplished with the help of Anne Marie O'Keefe, an attorney and clinical psychologist, who recently joined the APA staff.

These documents are intended to inform interested groups and individuals about recent developments and to outline options for dealing with them. These are not statements of policy by the American Psychological Association. The enclosures include: a legislative alert; a model bill; an explanation of the duty to protect and the need for legislative redress; an annotated bibliography of research on the prediction of violence; an annotated bibliography of research on the dangerousness of mental patients; a chronological listing and brief description of case law in this area.

Should your organization decide to pursue legislative redress, or legislation that would preempt the judicial imposition of this duty, please keep us posted on your progress, and let us know if we can be of further assistance. You may call Anne Marie in the Office of Professional Practice (202) 955-7640.

1200 Seventeenth St., N W
Washington, D C. 20036
(202) 955-7600

A MODEL BILL TO LIMIT PSYCHOTHERAPISTS' CIVIL LIABILITY
FOR THE VIOLENT ACTS OF MENTAL PATIENTS

(1) No monetary liability and no cause of action may arise against any [psychologist or psychiatrist/psychotherapist/service provider licensed under Chapter __] for failing to predict, warn of or take precautions to provide protection from a patient's violent behavior unless the patient has communicated to the [psychologist or psychiatrist/psychotherapist/service provider licensed under Chapter __] an actual threat of physical violence against a clearly identified or reasonably identifiable victim or victims.

(2) The duty to warn of or to take reasonable precautions to provide protection from violent behavior arises only under the limited circumstances specified in subsection (1) of this section. The duty shall be discharged by the [psychologist or psychiatrist/psychotherapist/service provider licensed under Chapter __] if reasonable efforts are made [to communicate the threat to the victim or victims] or [to seek civil commitment of the patient under Chapter __] or [to notify the police department closest to the patient's (or the victim's) residence of the threat of violence].

(3) No monetary liability and no cause of action may arise under Chapter __ [patient privacy and confidentiality act] against any [psychologist or psychiatrist/psychotherapist/service provider licensed under Chapter __] for confidences disclosed to third parties in an effort to discharge a duty arising under subsection (1) of this section according to the provisions of subsection (2) of this section.

NOTE: This document is intended to inform interested groups and individuals. It is not a statement of policy by the American Psychological Association.

850802

DUTY TO PROTECT: LEGISLATIVE ALERT

Federal and state courts across the country have begun holding psychologists, psychiatrists and mental hospitals liable for the violent acts of their patients. Lawsuits like these used to be rare and seldom successful because American law has traditionally imposed no affirmative duty to protect others. However, more and more courts are now adopting a different standard for psychotherapists whose patients kill or seriously hurt other people.

This new "duty to protect" (sometimes called "duty to warn") was first imposed where hospitals failed to keep specific promises to notify family members before releasing patients who had made overt threats of violence. In the 1970's the duty was extended to cover persons the therapist had never met, but against whom overt threats of physical violence had been made during treatment. Within the last few years damages have been awarded to plaintiffs who were total strangers to both the therapist and the patient, such as the victims of car accidents and members of a crowd into which a shotgun was discharged. Damages have also been awarded to the estates of persons who were warned, but who failed to stay away from the patients who killed them.

Increasingly, a line of liability is being attached to dangerous persons when they are admitted to hospitals or come under the care of private practitioners. In some jurisdictions this line is not broken by time or by crime. Rather, psychotherapists are expected to know who will be violent, and to somehow protect against it, although the courts have given little guidance on what specific actions might fulfill this duty.

Research has consistently shown that violent behavior cannot be accurately predicted on an individual basis. However, it is a well established statistical fact that those most likely to be violent in the future are those who have been violent in the past. Unfortunately for mental health professionals caught in this liability squeeze, reforms in civil commitment laws have worked to increase the proportion of mental patients who have criminal records and histories of violence. Together, these legal developments are redefining the role of psychotherapist as a predictor, a protector and a "deep pocket" defendant for the victims of violent crime.

Psychologists and other psychotherapists are encouraged to remedy this situation through legislation that limits their liability for the violent acts of patients. It is theoretically possible for a statute to protect psychotherapists with total immunity in situations like this, but such a bill would be highly unlikely to pass any state legislature. Of course, whatever options are chosen will depend on practitioners' needs and existing laws in each jurisdiction. For example, in some states a law on the duty to protect may have to be accompanied by legislative reform to give psychologists the option to civilly commit their patients. In any event, this seems an excellent issue on which to work in cooperation with other mental health disciplines, and to educate state legislators about the proper role of mental health professionals in our society.

850801

DUTY TO PROTECT: THE NEED FOR LEGISLATIVE REDRESS

During the late 1960's and '70's, civil commitment laws across the country underwent major reform. Due process was built into commitment hearings to protect the civil rights of persons threatened with involuntary hospitalization, and the burden of proof in such hearings was redefined as the state's responsibility. In addition, the criteria for evidence that would satisfy this burden were sharpened and confined. In general, the state's _parens patriae_ power — its power to decide what is best for an individual and to impose that decision even against the individual's will — was rejected as the basis for involuntary confinement. In its place, detention was justified by the state's police power — its power to protect the general public. Proof or prediction of dangerousness to self or others became a prerequisite for civil commitment in most states.

Two unintended results of these reforms have recently become apparent. First, mental patients as a whole have become increasingly more violent. Research in the 1920's, '30's and '40's showed that persons discharged from state mental hospitals were arrested far less often than were members of the general population. However, during the 1960's, studies began to find that arrest rates among ex-mental patients were exceeding those for the general population. Closer inspection of the data reveals that patients with prior criminal histories are largely responsible for these post-hospitalization arrests. Persons with no arrests before hospitalization continue to be more "peaceful" after discharge than the general population, but the proportion of inpatients with histories of violent behavior has increased dramatically. In

850803

general, reform in civil commitment has made the mental patient population more closely resemble a prison population. In particular, reform has created the "revolving door" patient who is readmitted repeatedly for short periods of time, often as a diversion from and an alternative to the criminal law system.

A second consequence of legal reforms that require psychotherapists to become predictors of dangerousness is that courts are beginning to hold psychologists, psychiatrists and mental hospitals responsible (i.e., civilly liable) for the violent acts committed by their patients. The most publicized of these cases was the 1976 California Supreme Court's decision in _Tarasoff v. Regents of the University of California_.

In _Tarasoff_, a patient made overt threats of violence against his girlfriend while he was in treatment at a university counseling center. The psychotherapist contacted the university's campus police, who picked up and briefly detained, but then released the patient. The therapist also initiated an involuntary commitment proceeding, but did not pursue it to completion. (Requirements for civil commitment in California are extremely stringent.) The therapist in this case did _not_ attempt to warn the girlfriend, and the patient killed her two months after treatment ended.

In holding that the victim's parents could sue the therapist for damages, the California Supreme Court created a new cause of action that has since become the tip of a civil liability iceberg. The court said that:

> ...once a therapist does in fact determine, or under applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger.

The California state courts extended this duty in subsequent cases to include persons in "close relationships" to potential victims, and who might also be in danger. A federal court in California also upheld the liability of a psychotherapist for the murder of a person who had been warned by three other sources of the danger posed by her lover, an outpatient who refused voluntary confinement.

More alarming are decisions by courts in other states that extend the psychotherapist's duty to require "reasonable precautions to protect anyone who might foreseeably be endangered by" an ex-mental patient's behavior. In the state of Washington, a public hospital was held liable when a patient took angel dust five days after discharge, and injured a woman in a car accident. In Nebraska, a V.A. hospital was held liable when a patient fired a shotgun into a crowded dining room 40 days after his discharge against medical advice.

The courts, the police and other components of law enforcement are immune from civil liability for the harm that flows from actions performed within their scope of authority. In many states mental health professionals are also immune from liability for good faith mistakes made in the commitment process. However, for many innocent victims of violent crimes committed by patients and ex-patients, mental health professionals have become the "deep pocket" for financial recovery. One very recent but very real effect of these court decisions is that the number of lawsuits filed against psychotherapists and institutional providers of mental health care has increased dramatically.

These new duties imposed on psychotherapists — to predict dangerousness in the patients they treat, and then to protect whomever might be harmed by those patients — are inconsistent with many of the demands of the psychotherapeutic relationship and the skills and training of psychotherapists. No diagnosis or treatment for "dangerousness" exists in

psychology or psychiatry, and nothing in the education and training of psychotherapists equips them to predict future violence.

The duty to predict dangerousness also contradicts the findings from a considerable body of research (see attached annotated bibliography). Regardless of how desireable predictions of future dangerousness are, studies have consistently shown that they simply cannot be made with accuracy on an individual basis. Short-term predictions are more exact than long-term, as are assessments based on observations in the patient's natural environment, compared to those performed in institutional settings. However, in general, whenever predictions of future violence are ventured by mental health professionals, they are wrong twice as often as they are right.

Statistical or actuarial approaches to such predictions, based solely on police records, have been shown consistently to be as good or better than any clinical model. In fact, the best single predictor of violence in the future is simply a history of past violence. This is partly because a very small percentage of the total population is responsible for a vastly disproportionate amount of violent crime. (One study showed that persons with four prior arrests have an 80 percent probability of being arrested a fifth time.)

Because criminal records are the best predictors of dangerousness, the courts, the police and other components of our law enforcement system could determine who is most likely to commit violent acts on an actuarial basis. However, under our constitution, statistical probability is not sufficient to justify preventive detention in the criminal system, or in civil commitment. This is one reason psychotherapists are used as expert witnesses in criminal

trials and civil commitments. Psychotherapists may not be able to provide any greater predictive accuracy than the average actuarial, but they alleviate some of the constitutional problems by providing an aura of psychomedical certainty.

Early research on the effects of Tarasoff suggested that the decision had not destroyed the privacy necessary for effective psychotherapy. However, many individual practitioners now report a new reluctance to treat dangerous persons, and several studies have documented increased uses of isolation, physical restraint and involuntary commitments. The only research to date on the effects of warning potential victims has found no difference in the incidence of subsequent attacks, but a correlation with less reported improvement in therapy. It does not appear that psychotherapists' new duty to protect has made society safer.

Decisions vary across jurisdictions, but several state and federal courts have found liability by balancing the duty to protect against the patient's right of confidentiality, and concluding that the former outweighs the latter. Courts have also rejected the defense that an ex-patient's violent crime constitutes an "intervening act" that breaks the chain of liability. In some cases, judges have simply refused to recognize the implications of psychotherapists' inability to accurately predict future dangerousness. Even after conceding the evidence showed "that psychiatrists and psychologists are accurate in no more than one out of three predictions of violent behavior", the U.S. Supreme Court maintained that they were "unconvinced...at least as of now, that the adversary process cannot be trusted to sort out the reliable from the unreliable evidence and opinion about future dangerousness" (Barefoot v. Estelle, 1983).

The new duty to protect, like most tort law, is judicially-created, or common law. In jurisdictions where judges have imposed this duty, the decisions are precedent, and therefore are binding on subsequent similar cases. However, where statutory law contradicts common law, statutory law overrides.

For these reasons, psychotherapists in several states are working to enact laws that will limit the liability for violent acts committed by mental patients. This effort represents the opportunity for professionals in psychology, psychiatry and social work to work together in educating their state legislatures about what mental health care can and cannot do. We urge you to join in these efforts.

RESEARCH ON THE PREDICTION OF DANGEROUSNESS

Hunt, R.C. & Wiley, E.D. Operation Baxstrom after one year. American Journal of Psychiatry. 1968, 124, 134-138.

White, L., Krumholtz, W.V. & Fink, L. The adjustment of criminally insane patients to a civil mental hospital. Mental Hygiene. 1969, 53, 34-40

Steadman, H.J. & Keveles, G. The community adjustment and criminal activity of the Baxstrom patients: 1966-1970. American Journal of Psychiatry. 1972, 129, 304-310.

One of the earliest natural experiments on the accuracy of predictions of violence came after the Supreme Court decision in Baxstrom v. Herald (383 U.S. 107 [1966]). That case focused on a group of nearly 1,000 mental patients in institutions for the criminally insane, many of whom had beeen held for much longer than would have been their maximum prison sentences for conviction of the original charges against them. The Supreme Court found that such indeterminate commitment violated these persons' right to due process and equal protection, and ordered that they be transferred to less restrictive treatment environments.

Follow-up research during the next year found that only seven of these patients had been returned to maximum security institutions, and more than one-third had been fully discharged from the receiving hospitals. Nearly one-fourth of those still institutionalized were living in open wards, and the use of psychotropic drugs among the entire population had been significantly reduced. Among a representative sample of 246 Baxstrom patients followed for four years, approximately half remained in mental hospitals, but only five had been returned to institutions for the criminally insane, and only nine had been convicted of crimes.

MacDonald, J.M. Homicidal threats. Springfield, IL: Charles C. Thomas Publisher, 1968.

MacDonald studied a series of 100 patients admitted to a Colorado psychiatric hospital during a 15-month period in 1961-62, "specifically because they had made homicidal threats". On a six month follow-up after hospital discharge, only one of these patients had committed a homicide, and one other had killed someone in what was adjudicated to be an accident. Although 23 patients could no longer be traced, follow-up between five and six years after admission showed that three patients had taken the lives of others, and four had taken their own lives. The long-term institutionalization of all 100 of these patients would have sacrificed the freedom of many false positive's for the preventive detention of a few true positive's.

850804

Kozol, H.L., Boucher, R.J., & Garofalo, R.F. The diagnosis and treatment of dangerousness. Crime and Delinquency, 1972, 18, 371-392.

The Kozol group reported on research conducted at the Center for the Care and Treatment of Dangerous Persons, established in 1959 to implement Massachusetts' new "sexually dangerous person" law. Over a ten-year period, 592 convicted offenders were processed at the Center, including 226 persons who were diagnosed as dangerous and committed indeterminately for treatment. Eighty-two of these persons were subsequently released, after an average of 43 months of treatment. The authors report a violent crime recidivism rate of only 6 percent within this group. Of the 304 persons diagnosed as not dangerous and released without treatment, 8.6 percent committed assaultive crimes. Within the group of 49 offenders released by the court against the recommendation of professionals at the Center, the authors report a criminal recidivism rate of 34.7 percent.

Hedlund, J.L., Slatten, I.W., Altman, H. & Evenson, R.C. Prediction of patients who are dangerous to others. Journal of Clinical Psychology, 1973, 29, 443-447.

This group studied the prediction of dangerousness among a group of 5525 patients processed by the Missouri Division of Mental Health. Because of heavy reliance on aggregate statistical probabilities, and because of the low incidence of assaultive behavior within their total population, their predictive success rate was deceptively high, ranging from 90 to 94 percent, depending on the criterion used. However, this impressive "hit" rate included a high incidence of false positive predictions, and the authors admit to the "inevitable dilemma of being wrong more often than right when a positive prediction is made". They conceded that prediction could be improved by simply always making a negative prognosis about dangerous behavior. "This way we would have a total hit rate of 92, 96 and 90%...".

Wenk, E.A., Robison, J.O. & Smith, G.W. Can violence be predicted? Crime and Delinquency. 1972, 18, 393-402.

These authors reported on attempts by the California Department of Corrections to isolate and treat potentially violent offenders. In 1965, the Department's Research Division had used extensive case history data to identify a group of offenders, 14 percent of whom were expected to violate parole through a violent or potentially violent act. Although this prediction was nearly three times as great as that for parolees in general (whose probability of violence by the same criteria was only 5 percent), this "most violent" group included only 3 percent of the total parolee sample. Therefore, even if treatment were 100 percent effective with this class of offenders, it would have been wasted on 86 percent of the treated parolees, and it would have left 92 percent of the total expected violence untreated and unprevented.

In spite of this, the California Department of Corrections Parole and Community Services Division used the same violence history screening procedure to classify and isolate for special parole supervision two categories of offenders with the greatest predilection toward violence. Violent crime rates among these "Most Potentially Aggressive" persons averaged 3.1 per thousand cases, compared to a rate of 2.8 among the "Less Aggressive" classes. These authors conclude that "the special precautions taken for identifying and handling the violent offender are unwarranted, given the actual level of danger".

To examine the incidence of violence during a 15-month parole period following release from the Reception Guidance Center of the California Youth Authority, Wenk et al. applied case history prediction and complete clinical assessment to a group of 4,146 wards of the state. Six percent of this sample had committed violent offenses prior to admission, and 2.5 percent were involved in similar offenses after their release. On the basis of past violent acts (the best single predictor variable), a group comprising 5 percent of the study population was identified and followed as "most violent". While the subsequent criminal violations committed by these persons were more often of a violent nature, these individuals actually breached parole less often than did the sample as a whole. These researchers concluded that "The best prediction available today, for even the most refined set of offenders, is that any particular member of that set will not become violent."

State of Maryland. Maryland's defective delinquency statute -- A progress report. Unpublished manuscript, Department of Public Safety and Correctional Servicves, 1973.

Steadman, H. A new look at recidivism among Patuxent inmates. The Bulletin of the American Academy of Psychiatry and the Law, 1977, 5, 200-209.

The Patuxent Institution of Maryland was created for the same purpose as the Massachusetts Center. During its first ten years, 421 patients with a minimum of three years treatment at the Institution were followed. Among the 286 of these persons released against the advice of professional staff, the recidivism rate during the next three years was 46 percent of those released directly, and 39 percent of those released conditionally. Among those patients released consistent with the staff's recommendation, and who continued in treatment on an outpatient basis, only 7 percent recidivated.

A more recent and methodologically sophisticated study of Patuxent patients by Steadman concluded that "the rearrest rate for both violent offenses and all offenses of all those released to the street with Patuxent approval vary much less from those of all relevant comparison groups than prior reports have demonstrated." Steadman found that 31 percent of those released as not dangerous -- i.e., consistent with staff recommendations -- were arrested for a violent crime during the next three years. Forty-one percent of those released against staff recommendations were arrested for violent crime during the same period. Partly because of these later research findings, the Maryland legislature abolished the defective delinquency statute under which the Institution operated.

Cocozza, J. & Steadman, H. The failure of psychiatric predictions of dangerousness: Clear and convincing evidence. Rutgers Law Review. 1976, 29, 1084-1101.

These authors followed, for a period of three years, 257 persons who were indicted for felonies in New York, but found incompetent to stand trial. Within this group, 60 percent were predicted to be dangerous, and 40 percent not dangerous. During their hospitalization, 42 percent of the former and 36 percent of the latter (a statistically insignificant difference) were assaultive . However, only 14 percent of those in the group designated dangerous, and 16 percent of those diagnosed as not dangerous, were later arrested for violent offenses. The authors call this "the most definitive evidence available on the lack of expertise and accuracy of psychiatric predictions of dangerousness....clear and convincing evidence of the inability of psychiatrists or of anyone else to accurately predict dangerousness."

See Also:

American Psychological Association, Report of the Task Force on the Role of Psychology in the Criminal Justice System. American Psychologist, 1978, 33, 1099- .

American Psychiatric Association, Report of the Task Force on Clinical Aspects of the Violent Individual, 1974.

Steadman & Morrissey, The statistical prediction of violent behavior. Law & Human Behavior, 1981, 5, 271-273.

Dix, Expert prediction testimony in capital sentencing: Evidentiary and constitutional considerations. American Criminal Law Review, 1981, 19, 1-

Schwitzgebel, Prediction of dangerousness and its implications for treatment. In W. Curran, A. McGarry & C. Petty, Modern Legal Medicine, Psychiatry, and Forensic Science, 1980, 783- .

Cocozza & Steadman, Prediction in psychiatry: An example of misplaced confidence in experts. Social Problems, 1978, 25, 265- .

Steadman & Cocozza, Psychiatry, dangerousness and the repetitively violent offender. Journal of Criminal Law & Criminology, 1978, 69, 226- .

Diamond, The psychiatric prediction of dangerousness. University of Pennsylvania Law Review, 1974, 123, 439- .

Ennis & Litwack, Psychiatry and the presumption of expertise: Flipping coins in the courtroom. California Law Review, 1974, 62, 693- .

Monahan, J. The Clinical Prediction of Violent Behavior (1981).

RESEARCH ON THE DANGEROUSNESS OF MENTAL PATIENTS

Ashley, M. Outcome of 1000 cases paroled from the Middletown State Hospital. State Hospital Quarterly, 1922, 8, 64-70.

Ashley published one of the earliest reports on the post-hospital adjustment of mental patients. His study followed 1,000 persons "paroled" from the Middletown State Homeopathic Hospital in New York between 1912 and 1922. The author did not use a control group, and it is difficult to ascertain the characteristics of parolees (though two-thirds were female), or the duration of follow-up (which apparently ranged from one month to one year). However, the thrust of Ashley's report is clear: one-fourth of these parolees had later contact with hospital authorities, but only 12 of them were subsequently arrested. This would translate to an annual arrest rate of 37 per 1,000.

Pollock, H.M. Is the paroled patient a threat to the community? Psychiatric Quarterly, 1938, 12, 236-244.

Pollock published a report on the one-year follow-up of 5,833 patients paroled from all New York state hospitals during 1937. (Standard procedure at that time included a one-year parole prior to formal hospital discharge.) During this interval, ex-patients within the research group were arrested at an annual rate of 6.9 per 1,000. Pollock compared this to an annual rate of 98.5 arrests per 1,000 persons for the New York population as a whole, although this latter figure seems unusually high, and its derivation is not reported.

Cohen, L. & Freeman, H. How dangerous to the community are state hospital patients? Connecticut State Medical Journal, 1945, 9, 697-700.

This study followed, for an average of two years, 1,676 patients paroled and discharged from three Connecticut state hospitals between 1940 and 1944. Arrests among the entire group yielded an annual rate of 26 per 1,000. This was the first study to segregate patients with pre-hospital criminal records from those with no prior arrests, and to report separate post-hospitalization histories. The authors determined that the 18.4 percent of patients with prior records (314 individuals) accounted for 93 percent of post-hospital arrests among patients as a whole. Only six patients with no prior record were arrested during the follow-up period of this study. Cohen and Freeman note that most arrests, both pre- and post-hospitalization, were for relatively minor offenses.

850805

Brill, H. & Malzberg, B. Statistical report on the arrest record of male ex-patients released from New York State mental hospitals during the period 1946-48. In <u>Criminal acts of ex-mental patients</u> (Supplement No. 153), Washington, D.C.: American Psychiatric Association Mental Hospital Service, 1962.

These researchers followed 1,247 male patients discharged from New York state mental hospitals during fiscal year 1947 for the ensuing five and one-half years. Of the 15 percent of these patients who had previously been arrested, 34 percent were arrested after discharge, accounting for almost the total annual arrest rate among ex-patients of 12 per 1,000. This compared to a reported rate of 49 per 1,000 for the general population. Only two percent of patients with no prior criminal record were arrested during follow-up. These authors conclude that "statistically, the group of previously arrested patients behaves more like a segment of the correctional population than a primarily psychiatric one."

Rappaport, J. & Lassen, G. Dangerousness-arrest rate comparisons of discharged patients and the general population. <u>American Journal of Psychiatry</u>, 1965, <u>121</u>, 776-783.

Rappaport, J. & Lassen, G. The dangerousness of female patients: A comparison of the arrest rate of discharged psychiatric patients and the general population. <u>American Journal of Psychiatry</u>, 1966, <u>123</u>, 413-419.

These studies followed 1,401 patients released in fiscal year 1947, and 4,281 patients released in fiscal year 1957, from all Maryland psychiatric hospitals. Arrest records were examined for five years preceeding and five years following discharge in both studies, but data is reported only for five felony offenses involving violence. This restriction prohibits direct comparisons of total annual arrest rates with either the general population or other patient groups. However, based on their limited analyses, these authors conclude, as did Brill and Malzberg, that after hospital discharge, ex-patients with prior arrests are statistically similar to non-patients with the same criminal records.

Giovannoni, J. & Gurel, L. Socially disruptive behavior of ex-mental patients. <u>Archives of General Psychiatry</u>, 1967, <u>17</u>, 146-153.

Giovannoni and Gurel examined all police contacts among 1,142 males within four years after their discharge from Veterans Administration hospitals in 12 states. The annual arrest rate for serious criminal offenses among these patients measured 3.27, compared to .97 per 1,000 for the population as awhole. Ninety-five percent of these patients were diagnosed as chronic schizophrenics, and two-thirds of those arrested were rated as "problem drinkers". Patient arrests for violent crimes (except forcible rape) were reported as much higher, and for crimes against property as much lower, than for the general population. Unfortunately, these researchers did not examine pre-hospital arrests, and did not report post-hospital recidivism among their patient population.

Durbin, J., Pasewark, K. & Albers, D. Criminality and mental illness: A study of arrest rates in a rural state. American Journal of Psychiatry, 1977, 134, 80-83.

This research examined arrest records for five years before and after hospitalization of the 461 persons admitted during 1969 to the only state mental facility in Wyoming. Unfortunately, the exclusion of arrests for minor offenses, and the reporting of total arrests instead of number of persons arrested, defy direct comparison of these findings with those of other studies. The authors do report that patient arrests for all categories of violent crime, and most categories of crime against property, reflect annual rates of 3.0, compared to 1.6 for the population at large. In contrast to other research, this study did not detect a significant relationship between pre-hospitalization arrests and post-hospitalization recidivism; in fact, more than two-thirds of all patient arrests were recorded in the pre-hospitalization period. The authors do report an unusually high incidence of criminal contacts in the year immediately preceeding hospital admission, leading them to conclude that mental institutionalization "may often serve as a diversionary adjunct to the criminal justice system."

Zitrin, A., Hardesty, A., Burdock, E. & Drossman, A. Crime and violence among mental patients. American Journal of Psychiatry. 1976, 133, 142-149.

The Zitrin group examined arrest records for two years before and after admissions to Bellevue Psychiatric Hospital between 1969 and 1971. Of the 867 persons in this sample, 23 percent were arrested during the total four-year period, including 10 percent for crimes of violence. This latter group yielded an arrest rate among patients for violent crimes of 7.3 per 1,000, compared by the authors to a rate of 1.59 per 1,000 nationally, but to a rate of 6.26 per 1,000 persons within the hospital's catchment area. The authors reported that patients diagnosed as alcoholics and drug abusers, comprising 7 and 6 percent respectively of the total sample, accounted for nearly one-third of all arrests. Concurring with previous researchers, Zitrin et al. conclude that the alarming arrest rates within their patient population reflects an "increasing diversion of arrested persons from the criminal justice channels to mental hospitals."

Sosowsky, L. Crime and violence among mental patients reconsidered in view of the new legal relationship between the state and the mentally ill. American Journal of Psychiatry, 1978, 135, 33-42.

This study examined arrests and convictions of 301 San Mateo County residents admitted to California state hospitals from June 1972 through December 1973. Sosowsky reports having searched the state criminal records of these persons for six years prior to hospitalization, but he does not report on the follow-up period, and he does not segregate pre- and post-hospitalization rates. Annual arrest rates for violent crimes among these patients was 27.8, compared to 1.8 within the county population as a whole. The author states that a 1973 investigation by the California

Department of Health found that persons treated in state mental hospitals had been convicted and/or incarcerated for violent crimes at the rate of 3.49 per 1,000, compared to .47 per 1,000 for the general population. Among persons treated as outpatients in community mental health programs, this rate was 2.88.

Melick, M.E., Steadman, H.J. & Cocozza, J.J. The medicalization of criminal behavior among mental patients. Journal of Health and Social Behavior. 1979, 20, 228-237.

Steadman, H.J., Cocozza, J.J. & Melick, M.E. Explaining the increased arrest rate among mental patients: The changing clientele of state hospitals. American Journal of Psychiatry. 1978, 135, 816-820.

Steadman, H.J., Vanderwyst, D. & Ribner, S. Comparing arrest rates of mental patients and criminal offenders. American Journal of Psychiatry. 1978, 135, 1218-1220.

This research followed, for an average of 18 months, a sample of patients released from New York state psychiatric centers in 1967-68 (N = 1,920), and 1974-75 (N = 1,938), after legal reform had affected significant deinstitutionalization. Within the 1968 sample, total arrests among ex-patients produced an annual rate of 73.5 per 1,000, compared to 27.5 per 1,000 for the general population. These figures for the 1975 sample were 98.5 per 1,000 ex-patients, and 32.5 for the population as a whole. Post-hospitalization arrest rates for violent crimes only were 5.58 for the 1968 patient sample, and 12.03 for the 1975 group, compared to 2.29 and 3.62 respectively for the general population.

These authors report that "The variable most highly correlated with total subsequent arrests was a record of arrest before current mental hospitalization". This correlation — between arrests subsequent and prior to hospitalization — was .371 for the 1968 sample, and .351 for the 1975 group. Within the latter group, only 2.9 percent of ex-patients without prior records were arrested after discharge. "[T]he percentage increased to 15.5% for those with one arrest, to 32.0% for those with two prior arrests and to 36.3% for those with three or more prior arrests."

In a separate study, the Steadman group focused on ex-patients who were residents of Albany County, New York (N = 307 in 1968 and 204 in 1975), and compared post-hospital arrests with those of Albany County residents released during comparable periods from the local jail and state prisons (N = 167 and 252 respectively). Subsequent arrests among the ex-prisoner groups were substantially higher than the rates among ex-patients as a whole, but were surprisingly similar to the rates among subpopulations of ex-patients with prior criminal records. It is also significant that between 1968 and 1975, the percentage of male ex-mental patients with prior police records grew from 32 to 40 percent.

SUITS AGAINST MENTAL HEALTH CARE PROVIDERS FOR THE VIOLENT ACTS OF PATIENTS

CASE	STATE	COURT[a]		JUDGMENT[b]			INJURY	SETTING	FINAL DISPOSITION
		State	Fed.	Trial Ct.	1st App.	2nd App.			
Kendrick v. United States, 82 F. Supp. 430 (N.D. Ala. 1949)	AL		X	D			Murder	V.A. Hospital	Governmental Immunity
Smart v. United States, 207 F.2d 841 (10th Cir. 1953	IN		X	D	D		Injury from vehicular accident	V.A. Hospital	Governmental Immunity
Schwenk v. State, 129 N.Y.S. 2d 92 (Ct. Cl. 1953)	NY	X		D			Murder	State Hospital	Negligence/Case Not Proven
St. George v. State 124 N.E.2d 320 (NY 1954)	NY	X		D	D	D	Murder/Assault	State Hospital	Government Immunity
Fair v. United States, 234 F.2d 288 (5th Cir. 1956)	TX		X	D	P		Murder	Military	Nonfinal for P (upheld action)
Taig v. State, 251 N.Y.S.2d 495 (1963)	NY	X		D	D		Assault	State Hospital	Government Immunity
Milano v. State, 253 N.Y.S. 2d 662 (Ct. Cl. 1964)	NY	X		D			Murder/Sexual Assault	State Hospital	Negligence/Case Not Proven
Peters v. State, 267 N.Y.S. 2d 811 (Ct. Cl. 1964	NY	X		P	P		Assault	State Hospital	Nonfinal for P
Higgins v. State, 265 N.Y.S. 2d 254 (1965)	NY			P	D		Assault	State Hospital	Governmental Immunity
Underwood v. United States, 356 F.2d 92 (5th Cir. 1966)	AL		X	D	P		Murder	Military Hospital	Recovery Not Specified
Merchants Nat. Bank & Trust Co. of Fargo v. United States, 272 F. Supp. 409 (D.N.D. 1967)	SD		X	P			Murder	V.A. Hospital	$200,000 for P
Hanes v. United States, 407 F.2d 823 (4th Cir. 1969)	VA		X	D	D		Assault	V.A. Hospital	Negligence/Case Not Proven
Kravitz v. State, 87 Cal. Rptr. 352 (1970)	CA	X		D	D		Murder	State Hospital	Govt. Immunity Neg./Case Not Proven
Hernandez v. State of California, 90 Cal. Rptr. 205 (1970)	CA	X		D	D		Murder	State Hospital	Governmental Immunity
Greenberg v. Barbour, 322 F. Supp. 745 (E.D.Pa. 1971)	PA		X	P			Assault	State Hospital	Nonfinal for P (upheld action)
Orman v. State, 324 N.Y.S. 2d 958 (1971)	NY	X		D	D	D	Assault	State Hospital	Negligence/Case Not Proven

8508C6

CASE	STATE	COURT[a]		JUDGMENT[b]			INJURY	SETTING	FINAL DISPOSITION
		State	Fed.	Trial Ct.	1st App.	2nd App.			
Lewandowski v. State, 318 N.Y.S.2d 83 (Ct. Cl. 1971)	NY	X		D			Injury from vehicular accident	State Hospital	No Cause of Action
Cameron v. State, 331 N.Y.S. 2d 30 (1972)	NY	X		P	D	D	Assault	State Hospital	Negligence/Case Not Proven
Hicks v. United States, 511 F.2d 407 (D.C.Cir. 1975)	DC		X	P	P		Murder	Federal Hospital	$100,000 for P
Homere v. State, 370 N.Y.S. 2d 246 (1975)	NY	X		P	P		Assault	State Hospital	Recovery Not Specified
Heifetz v. Philadelphia State Hospital, 348 A.2d 455 (Pa. 1975)	PA	X		D			Sexual Assault	State Hospital	Governmental Immunity
Johnson v. United States, 409 F. Supp. 1283 (S.D.Cal. 1976)	CA		X	D			Murder/Assault	Military Hospital	Negligence/Case Not Proven
Semler v. Psychiatric Institute, 538 F.2d 121 (4th Cir. 1976)	VA		X	P	P	P	Murder	Private Hospital	$25,000 for P
Tarasoff v. Regents of the University of California, 118 Cal. Rptr. 129 (1974); 131 Cal. Rptr. 14 (1976)	CA	X		D	D	P	Murder	State Clinic	Nonfinal for P (upheld action)
Fresch v. Commonwealth, 370 A.2d 1163 (Pa. 1977).	PA	X		D	P		Murder	State Hospital	Nonfinal for P (upheld action)
Williams v. United States, 450 F. Supp. 1040 (D.S.D. 1978)	SD		X	P			Murder	V.A. Hospital	V.A. Liable, Recovery not Specified
Department of Health and Rehabilitative Services v. McDougall, 359 So. 2d 528 (Fla. App.)	FL	X		P			Murder	Private Hospital	70,000 for P
McIntosh v. Milano, 403 A.2d 500 (N.J. Super. Ct. Law Div. 1979)	NJ	X		P			Murder	Patient	Nonfinal for P (upheld action
Lipari v. Sears, Roebuck & Co., 497 F. Supp. 1985 (D.Neb. 1980)	NE		X	P			Murder/Assault	V.A. Hospital	Nonfinal for P (upheld action)
Shaw v. Glickman, 415 A.2d 625 (Md. App. 1980)	MD	X		D	D		Assault	Outpatient Clinic	No Cause of Action

CASE	STATE	COURT[a]		JUDGMENT[b]			INJURY	SETTING	FINAL DISPOSITION
		State	Fed.	Trial Ct.	1st App.	2nd App			
Thompson v. Alameda, 614 P.2d 728 (Cal. 1980)	CA	X				P	Murder/Sexual Assault	County Institution	Action Dismissed
Mathes v. Ireland, 419 N.E. 2d 782 (Ind. App. 1981)	IN	X		D	P		Murder	Outpatient Clinic	Nonfinal for P (upheld action)
Case v. United States, 523 F. Supp. 317 (S.D. Ohio 1981)	OH		X	D			Murder	V.A. Mental Health Clinic	No liability--murder 14 mos. after treatment
Leedy v. Hartnett, 510 F. Supp. 1125 (M.D. Pa. 1981)	PA		X	D	D		Assault	V.A. Hospital	Victim had frequent contact w/pt.
Hasenei v. United States, 541 F. Supp. 999 (D. Md. 1982)	MD		X	D			Vehicular Injuries	V.A. Outpatient Clinic	No duty or ability to control Pt.
Cairl v. State, 323 N.W.2d 20 (Minn. 1982)	MN	X		D	D	D	Murder/Assault	State H[illegible]spital	Victim had frequent contact w/pt.
Doyle v. United States, 530 F. Supp. 1278 (C.D. Cal. 1982)	CA		X	D			Murder	Patient	Victim not identifiable
Matter of Estate of Votteler, 327 N.W.2d 759 (Iowa 1982)	IA	X				D	Assault	Patient	Victim had knowledge of threats
Bradley Ctr. v. Wessner, 250 Ga. 199 (1982)	GA	X		P			Murder(s)	Private Hospital	Hospital may be held liable
Davis v. Lhim, 335 N.W.2d 481 (Mich. App. 1983)	MI	X		P	P		Murder	State Hospital	Duty owed to foreseeable victims/ $500,000
Chrite v. United States, 564 F. Supp. 341 (E.D. Mich. 1983)	MI		X	P			Murder	V.A. Outpatient	Nonfinal (action upheld)
Jablonski v. United States, 712 F. 2d 391 (9th Cir. 1983)	CA		X	P	P		Murder	V.A. Outpatient	Therapist should have known
Brady v. Hopper, 570 F. Supp. 1333 (D. Col. 1983)	CO		X	D			Injuries to Bystanders by Hinckley	Private Outpatient	Action Dismissed
Hedlund v. Superior Court, 699 P.2d 41 (Cal. 1983)	CA	X		P	P		Murder	Private Outpatient	3rd party could also reach

CASE	STATE	COURT[a]		JUDGMENT[b]			INJURY	SETTING	FINAL DISPOSITION
		State	Fed.	Trial Ct.	1st App.	2nd App.			
Petersen v. State, 671 P.2d 230 (Wash. 1983)	WA	X		P	P		Vehicular injury	State Hospital	Duty owed to all foreseeable victims
Durflinger v. Artiles, 673 P.2d 86 (Kan. 1983)	KS	X		P	P		Murder	State Hospital	Duty owed to all foreseeable victims
Sherrill v. Wilson, 653 S.W.2d 661 (Mo. 1983)	MO	X			D		Murder	State Hospital	No duty owed general public
Furr v. Spring Grove State 454 A.2d 414 (Md. App. 1983)	MD	X			D		Murder/Sexual Assault	State Hospital	Action dismissed
Beck v. Kansas University Psychiatry Foundation, 580 F. Supp. 527 (D. Kan. 1984)	KS		X	P			Murders (2)	State Penitentiary	Nonfinal (action upheld)
Sharpe v. South Carolina Dept. of Mental Health, 315 S.E.2d 112 (S.C. 1984)	SC	X			P		Murder	State Hospital	Final (action upheld)

[a]Indicates whether action was brought in state or federal court.

[b]Indicates which party prevailed and whether lower court decision was appealed.
P = Decision for Plaintiff
D = Decision for Defendant

An Act

HOUSE BILL NO. 1201.

BY REPRESENTATIVES Groff, Reeser, Bledsoe, Dambman, Fish, Johnson, Markert, Scherer, and Shoemaker;
also SENATORS Beatty, R. Powers, Baca, and Glass.

CONCERNING THE LIABILITY OF PERSONS PROVIDING MENTAL HEALTH SERVICES FOR THE VIOLENT ACTS OF PATIENTS.

Be it enacted by the General Assembly of the State of Colorado:

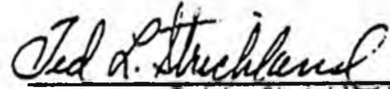
SECTION 1. Part 1 of article 21 of title 13, Colorado Revised Statutes, as amended, is amended BY THE ADDITION OF A NEW SECTION to read:

13-21-117. Civil liability - mental health care providers - no duty. No physician, social worker, psychiatric nurse, psychologist, or other mental health professional and no mental health hospital, community mental health center or clinic, institution, or their staff shall be liable for damages in any civil action for failure to warn or protect any person against a mental health patient's violent behavior, nor shall any such person be held civilly liable for failure to predict such violent behavior, except where the patient has communicated to the mental health care provider a serious threat of imminent physical violence against a specific person or persons. When there is a duty to warn and protect under the circumstances specified above, the duty shall be discharged by the mental health care provider making reasonable and timely efforts to notify any person or persons specifically threatened, as well as notifying an appropriate law enforcement agency or by taking other appropriate action including, but not limited to, hospitalizing the patient. No physician, social worker, psychiatric nurse, psychologist, or other mental health professional and no mental health hospital, community mental health center or clinic, institution, or their staff shall be liable for damages in any

Capital letters indicate new material added to existing statutes; dashes through words indicate deletions from existing statutes and such material not part of act.

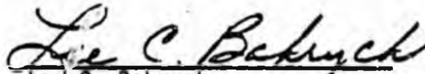
civil action for warning any person against or predicting a mental health patient's violent behavior, nor shall any such person be subject to professional discipline for such warning or prediction. For the purposes of this section, "psychiatric nurse" means a registered professional nurse as defined in section 12-38-103 (11), C.R.S., who by virtue of postgraduate education and additional nursing preparation has gained knowledge, judgment, and skill in psychiatric or mental health nursing. The provisions of this section shall not apply to the negligent release of a mental health patient from any mental 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 be mentally ill and, as a result of such mental illness, appears to be an imminent danger to others.

SECTION 2. Safety clause. The general assembly hereby finds, determines, and declares that this act is necessary for the immediate preservation of the public peace, health, and safety.



Carl B. Bledsoe
SPEAKER OF THE HOUSE
OF REPRESENTATIVES

Ted L. Strickland
PRESIDENT OF
THE SENATE



Lee C. Bahrych
CHIEF CLERK OF THE HOUSE
OF REPRESENTATIVES

Marjorie L. Nielson
SECRETARY OF
THE SENATE

APPROVED May 22, 1986 11:03 am

Richard D. Lamm
GOVERNOR OF THE STATE OF COLORADO

CHAPTER 380

Signed into Law 3/19/86

Effective: 8/1/86

SENATE
STATE OF MINNESOTA
SEVENTY-FOURTH LEGISLATURE

PRINTED PAGE NO. 1208

S.F. NO. 2135

Introduced by Reichgott.
Read First Time Feb. 26, 1986, and Referred to the Committee on Judiciary.
Committee Recommendation. To Pass as Amended.
Committee Report Adopted Mar. 4, 1986.
Read Second Time Mar. 4, 1986.
Pursuant to Rule 10, Made a Special Order Mar. 13, 1986.
Special Order. Amended Mar. 13, 1986.
Read Third Time as Amended Mar. 13, 1986.
Passed by the Senate as Amended Mar. 13, 1986.
Transmitted to the House Mar. 13, 1986.

1 A bill for an act

2 relating to liability; limiting the civil liability of
3 practitioners for the violent acts of patients;
4 providing immunity from liability for disclosure;
5 amending Minnesota Statutes 1985 Supplement, section
6 626.556, subdivision 4; proposing coding for new law
7 in Minnesota Statutes, chapter 148.

8

9 BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

10 Section 1. [148.975] [DUTY TO WARN; LIMITATION ON
11 LIABILITY; VIOLENT BEHAVIOR OF PATIENT.]

12 Subdivision 1. [DEFINITIONS.] (a) The definitions in this
13 subdivision apply to sections 1 and 2.

14 (b) "Other person" means an immediate family member or
15 someone who personally knows the patient and has reason to
16 believe the patient is capable of and will carry out the
17 serious, specific threat of harm to a specific, clearly
18 identified victim.

19 (c) "Practitioner" means a psychologist, school
20 psychologist, nurse, chemical dependency counselor, or social
21 worker who is licensed by the state or who performs
22 psychotherapy within a program or facility licensed by the state
23 or established pursuant to rules adopted under section 245.69,
24 subdivision 2.

25 (d) "Psychotherapy" means the professional treatment,
26 assessment, or counseling of a mental or emotional illness,

1 symptom, or condition.
2 (e) "Reasonable efforts" means communicating the serious,
3 specific threat to the potential victim and if unable to make
4 contact with the potential victim, communicating the serious,
5 specific threat to the law enforcement agency closest to the
6 potential victim or the patient.
7 Subd. 2. [LIABILITY STANDARD.] No monetary liability and
8 no cause of action may arise against a practitioner for failure
9 to predict, warn of, or take reasonable precautions to provide
10 protection from, a patient's violent behavior, unless the
11 patient or other person has communicated to the practitioner a
12 specific, serious threat of physical violence against a
13 specific, clearly identified or identifiable potential victim.
14 Subd. 3. [DUTY TO WARN.] The duty to predict, warn of, or
15 take reasonable precautions to provide protection from, violent
16 behavior arises only under the limited circumstances specified
17 in subdivision 2. The duty is discharged by the practitioner if
18 reasonable efforts are made to communicate the threat to the
19 potential victim.
20 Subd. 4. [DISCLOSURE OF CONFIDENCES.] No monetary
21 liability and no cause of action, or disciplinary action by the
22 state board of psychology or board of nursing may arise against
23 a practitioner for disclosing confidences to third parties in a
24 good faith effort to discharge a duty arising under this section.
25 Subd. 5. [CONTINUITY OF CARE.] Nothing in subdivision 3
26 shall be construed to authorize a practitioner to terminate
27 treatment of a patient as a direct result of a patient's violent
28 behavior or threat of physical violence unless the patient is
29 referred to another practitioner or appropriate health care
30 facility.
31 Subd. 6. [EXCEPTION.] This section does not apply to a
32 threat to commit suicide or other threats by a patient to harm
33 the patient, or to a threat by a patient who is adjudicated
34 mentally ill and dangerous under chapter 253B.
35 Sec. 2. [148.976] [OPTIONAL DISCLOSURE; LIMITATION ON
36 LIABILITY.]

1 Subdivision 1. [OPTIONAL DISCLOSURE.] Nothing in section 1
2 shall be construed to prohibit a practitioner from disclosing
3 confidences to third parties in a good-faith effort to warn
4 against or take precautions against a patient's violent behavior
5 for which a duty to warn does not arise under section 1.
6 Subd. 2. [LIMITATION ON LIABILITY.] No monetary liability
7 and no cause of action, or disciplinary action by the state
8 board of psychology or board of nursing may arise against a
9 practitioner for disclosure of confidences to third parties, for
10 failure to disclose confidences to third parties, or for
11 erroneous disclosure of confidences to third parties in a
12 good-faith effort to warn against or take precautions against a
13 patient's violent behavior for which a duty to warn does not
14 arise under section 1.
15 Sec. 3. Minnesota Statutes 1985 Supplement, section
16 626.556, subdivision 4, is amended to read:
17 Subd. 4. [IMMUNITY FROM LIABILITY.] (a) The following
18 persons are immune from any civil or criminal liability that
19 otherwise might result from their actions, if they are acting in
20 good faith:
21 (1) any person making a voluntary or mandated report under
22 subdivision 3 or assisting in an assessment under this
23 section; and
24 (2) any social worker or supervisor employed by a local
25 welfare agency complying with subdivision 10d; and
26 (3) any public or private school, facility as defined in
27 subdivision 2, or the employee of any public or private school
28 or facility who permits access by a local welfare agency or
29 local law enforcement agency and assists in an investigation or
30 assessment pursuant to subdivision 10.
31 (b) A person who is a supervisor or social worker employed
32 by a local welfare agency complying with subdivisions 10 and 11
33 or any related rule or provision of law is immune from any civil
34 or criminal liability that might otherwise result from the
35 person's actions, if the person is acting in good faith and
36 exercising due care.

1 (c) This subdivision does not provide immunity to any
2 person for failure to make a required report or for committing
3 neglect, physical abuse, or sexual abuse of a child.
4 Sec. 4. [EFFECTIVE DATE.]
5 Section 3 is effective the day following final enactment.
6 Sections 1 and 2 are effective August 1, 1986, and apply to
7 causes of action arising on or after that date.

AMENDED IN SENATE AUGUST 19, 1985

CALIFORNIA LEGISLATURE—1985–86 REGULAR SESSION

ASSEMBLY BILL No. 1133

Introduced by Assembly Members McAlister and Filante

February 28, 1985

An act to add Section 43.92 to the Civil Code, relating to personal rights.

LEGISLATIVE COUNSEL'S DIGEST

AB 1133, as amended, McAlister. Damages against certain professionals.

Existing law provides that certain professionals are immune from monetary liability or a cause of action for damages suffered by a person as a result of specified actions performed in the course of the professional's duties. However, case law has held that a psychiatrist may be liable for negligently failing to protect a person when a patient presents a serious danger to that person.

This bill would provide for immunity from liability for a psychotherapist who fails to warn of and protect from, or predict and warn of and protect from a patient's threatened violent behavior, except where the patient has communicated to the psychotherapist ~~an actual~~ *a serious* threat of violence against a reasonably identifiable victim. This bill would further provide that if a duty to warn and protect does exist, it would be discharged by the psychotherapist making reasonable efforts to communicate the threat to the victim *and to a law enforcement agency*.

Vote: majority. Appropriation: no. Fiscal committee: no. State-mandated local program: no.

EFFECTIVE: January 1, 1986

The people of the State of California do enact as follows:

1 SECTION 1. Section 43.92 is added to the Civil Code,
2 to read:
3 43.92. (a) There shall be no monetary liability on the
4 part of, and no cause of action shall arise against, any
5 person who is a psychotherapist as defined in Section 1010
6 of the Evidence Code in failing to warn of and protect
7 from a patient's threatened violent behavior or failing to
8 predict and warn of and protect from a patient's violent
9 behavior except where the patient has communicated to
10 the psychotherapist ~~an actual~~ *a serious* threat of physical
11 violence against a reasonably identifiable victim or
12 victims.
13 (b) If there is a duty to warn and protect under the
14 limited circumstances specified above, the duty shall be
15 discharged by the psychotherapist making reasonable
16 efforts to communicate the threat to the victim or victims
17 *and to a law enforcement agency.*

O

40370
86-0846
01

CHAPTER 175
Approved: 5/28/86
Effective: 1/1/87
HB 307

STATE OF NEW HAMPSHIRE

In the year of Our Lord one thousand
nine hundred and eighty-six

AN ACT

relative to a duty to protect third persons.

Be it Enacted by the Senate and House of Representatives in General Court convened:

175:1 New Subdivision. Amend RSA 329 by inserting after section 30 the following new section:

329:31 Civil Liability; Duty to Warn.

I. A physician licensed under this chapter has a duty to warn of, or to take reasonable precautions to provide protection from, a client's violent behavior when the client has communicated to such 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.

II. The duty may be discharged by, and no monetary liability or cause of action may arise against, a physician licensed under this chapter if the physician makes reasonable efforts to communicate the threat to the victim or victims, notifies the police department closest to the client's or potential victim's residence, or obtains civil commitment of the client to the state mental health system.

III. No monetary liability and no cause of action may arise concerning client privacy or confidentiality against a physician licensed under this chapter for information disclosed to third parties in an effort to discharge a duty under paragraph II.

IV. For purposes of this section, "physician" shall include persons providing treatment under the supervision of a physician licensed under this chapter.

175:2 New Subdivision. Amend RSA 330-A by inserting after section 21 the following new subdivision:

Duty to Warn of Violent Acts of Clients

320-A:22 Civil Liability; Duty to Warn.

I. A psychologist or person certified under this chapter has a duty to warn of, or to take reasonable precautions to provide protection from, a client's violent behavior when the client has communicated to such psychologist or person certified under this chapter 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.

II. The duty may be discharged by, and no monetary liability or cause of action may arise against, a psychologist or person certified under this chapter if the psychologist or person certified under this chapter makes reasonable efforts to communicate the threat to the victim or victims, notifies the police department closest to the client's or potential victim's residence, or obtains civil commitment of the client to the state mental health system.

III. No monetary liability and no cause of action may arise concerning client privacy or confidentiality against a psychologist or person certified under this chapter for information disclosed to third parties in an effort to discharge a duty under paragraph II.

IV. For purposes of this section "psychologist or person certified under this chapter" shall include persons providing treatment under the supervision of a psychologist or person certified under this chapter.

175:3 Effective Date. This act shall take effect January 1, 1987.

State of Michigan
In the Supreme Court

Supreme Court No. 77726

RUBY DAVIS, Administratrix,
of the Estate of Mollie Barnes,
Plaintiff-Appellee,

v.

DR. YONG-OH LHIM,
Defendant-Appellant.

BRIEF OF *AMICI CURIAE* AMERICAN PSYCHOLOGICAL ASSOCIATION MICHIGAN PSYCHOLOGICAL ASSOCIATION AND MICHIGAN PSYCHIATRIC SOCIETY IN SUPPORT OF DEFENDANT-APPELLANT

JOEL KLEIN
PAUL M. SMITH
ONEK, KLEIN & FARR
2550 M Street, N.W.
Washington, D.C. 20037
(202) 775-0184
Counsel for Amicus
MICHIGAN PSYCHIATRIC SOCIETY

THOMAS DOWNS (P 12922)
THOMAS DOWNS, P.C.
603 Capitol Savings & Loan Bldg.
Lansing, Michigan 48933
(517) 372-2990
Counsel for Amicus
MICHIGAN PSYCHOLOGICAL ASSOCIATION

DONALD N. BERSOFF
LAUREL PYKE MALSON
KIT ADELMAN-PIERSON
ENNIS, FRIEDMAN, BERSOFF & EWING
Suite 400
1200 - 17th Street, N.W.
Washington, D.C. 20036
(202) 775-8100
Counsel for Amicus
AMERICAN PSYCHOLOGICAL ASSOCIATION

July 22, 1986

WILSON - EPES PRINTING CO., INC. - 789-0096 - WASHINGTON, D.C. 20001

TABLE OF CONTENTS

	Page
INTEREST OF AMICI	1
STATEMENT OF FACTS	2
SUMMARY OF ARGUMENT	5
ARGUMENT	6
I. THERE IS NO PUBLIC POLICY OR EMPIRICAL JUSTIFICATION FOR IMPOSING LIABILITY ON THERAPISTS FOR FAILING TO ACCURATELY PREDICT THEIR PATIENTS' FUTURE DANGEROUSNESS	6
A. Mental Health Professionals Can Neither Reliably Nor Validly Predict Dangerousness	7
B. A Rule Imposing A Duty To Assess Dangerousness And Take Preventive Measures Will Have Adverse, Not Beneficial, Effects	15
1. Therapists Will Overpredict Violence	15
2. The Costs of Such a Rule Will Outweigh the Benefits	18
a. The efficacy of warnings	18
b. The efficacy of hospitalization	23
II. EVEN ASSUMING THAT THERAPISTS MAY SOMETIMES BE LIABLE FOR THE PATIENTS' ACTIONS, THERE IS NO JUSTIFICATION FOR IMPOSING LIABILITY ON THE PRESENT FACTS	26
III. THE DEFENDANT'S DECISIONS ARE IMMUNE FROM TORT LIABILITY	31
A. Acts By Public Employees That Require Significant Decisionmaking Are Immune From Tort Liability	32
B. Dr. Lhim's Acts Were "Discretionary-Decisional" And Are Immune From Tort Liability	33

TABLE OF AUTHORITIES

CASES: Page

Ake v. Oklahoma, 105 S. Ct. 1087 (1985) 7, 35
Barefoot v. Estelle, 463 U.S. 880 (1983) 8, 11, 39
Brady v. Hopper, 570 F. Supp. 1333 (D. Colo. 1983), *aff'd*, 751 F.2d 329 (10th Cir. 1984) 30
Cairl v. Minnesota, 323 N.W.2d 20 (Minn. 1982).... 25, 28, 30, 36
Canon v. Bernstein, 144 Mich. App. 604, 375 N.W.2d 773 (1985) 45, 46
Davis v. Lhim, 124 Mich. App. 291, 335 N.W.2d 481 (1983) ....*passim*
Davis v. Lhim, 147 Mich. App. 8, 382 N.W.2d 195 (1985) ....*passim*
Duvall v. Goldin, 139 Mich. App. 342, 362 N.W.2d 275 (1984)... 23
Eanes v. United States, 407 F.2d 823 (4th Cir. 1969) 24
Estate of Adams v. Northville State Hospital, 131 Mich. App. 583, 345 N.W.2d 207 (1983) 45, 46
Fisher v. State of Michigan, 422 Mich. 883, 363 N.W.2d 229 (1985) 5, 6, 31, 43
Fuhrmann v. Hattaway, 109 Mich. App. 429, 311 N.W.2d 379 (1981), *lv den.*, 414 Mich. 858 (1982) 43, 44, 46
Hamilton v. Reynolds, 129 Mich. App. 375, 341 N.W.2d 152 (1983), *lv den.*, 422 Mich. 890 (1985) 44, 46
[illegible] *v. Superior Court*, 34 Cal.3d 695, 669 P.2d [illegible] (Cal. 1983) 27
[illegible] *v. United States*, 511 F.2d 407 (D.C. Cir. 197[illegible]) 6
Humphrey v. Cady, 405 U.S. 504 (1972) 24
In re Estate of Votteler, 327 N.W.2d 759 (Iowa 1982) 28
In re Lifschutz, 2 Cal.3d 415, 85 Cal. Rptr. 829, 467 P.2d 557 (1970) 19
In re Zuniga, 714 F.2d 632 (6th Cir.), *cert. denied*, 464 U.S. 983 (1983) 19
Jablonski v. United States, 712 F.2d 391 (9th Cir. 1983) 6, 27, 28

TABLE OF AUTHORITIES—Continued

Page

Jarrett v. Wills, 383 P.2d 995 (Or. 1963) 45
Johnson v. United States, 409 F. Supp. 1283 (M.D. Fla. 1976), *rev'd on other grounds*, 576 F.2d 606 (5th Cir. 1978) 24
Knapp v. Moreno, 137 Mich. App. 768, 359 N.W.2d 560 (1984) 45, 46
Knight v. State of Michigan, 99 Mich. App. 226, 297 N.W.2d 889 (1980) 6-7
Lipari v. Sears, Roebuck & Co., 497 F. Supp. 185 (D. Neb. 1980) 6, 42
Mason v. Rosen, 124 Mich. App. 204, 333 N.W.2d 513 (1983), *vacated and remanded*, 422 Mich. 897, 368 N.W.2d 243 (1985) 45, 46
Mathes v. Ireland, 419 N.E.2d 782 (Ind. 1981) 42
Matter of Wagstaff, 93 Mich. App. 755, 287 N.W.2d 339 (1979) 25, 34
McIntosh v. Milano, 168 N.J. Super. 466, 403 A.2d 500 (1979) 7, 27, 42
McGhee v. Bhama, 140 Mich. App. 49, 363 N.W.2d 293, *remanded*, 422 Mich. 940, 369 N.W.2d 854 (1985) 45
Merchants National Bank & Trust Co. of Fargo v. United States, 272 F. Supp. 409 (D.N.D. 1967) 27
O'Connor v. Donaldson, 422 U.S. 563 (1975) 39
Papenhausen v. Schoen, 268 N.W.2d 565 (Minn. 1978) 45
Pomilee v. City of Detroit, 121 Mich. App. 121, 328 N.W.2d 595 (1982), *lv den.*, 422 Mich. 890 (1985) 44, 46
Ross v. Consumers Power Co., 420 Mich. 567, 363 N.W.2d 641 (1984) ..... *passim*
Shaw v. Glickman, 45 Md. App. 718, 415 A.2d 625 (1980) 30
Sherrill v. Wison, 653 S.W.2d 661 (Mo. 1983) 25, 45
Tarasoff v. Regents of the University of California, 13 Cal.3d 177, 529 P.2d 553, 118 Cal. Rptr. 129 (1974), *vacated*, 17 Cal.3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976) ..... *passim*
Taylor v. United States, 222 F.2d 398 (D.C. Cir. 10

TABLE OF AUTHORITIES—Continued

Page

Teasel v. Department of Mental Health, 419 Mich. 390, 355 N.W.2d 75 (1984) 36, 37, 38
Thompson v. County of Alameda, 27 Cal.3d 741, 614 P.2d 728, 167 Cal. Rptr. 70 (1980) 27
Tobias v. Phelps, 144 Mich. App. 272, 375 N.W.2d 365 (1985) 45, 46
Welke v. Kuzilla, 144 Mich. App. 245, 375 N.W.2d 403 (1985) 23
White v. United States, 244 F. Supp. 127 (E.D. Va. 1965), *aff'd*, 359 F.2d 989 (4th Cir. 1966) 8

STATUTES:

Michigan Mental Health Code:

MCL § 25.248 20
MCL § 330.1400a 35
MCL § 330.1401 ..... *passim*
MCL § 330.1419 ..... 3, 4, 33
MCL § 330.1420 ..... 33, 34, 35
MCL § 330.1465 25
MCL § 330.1476 36
MCL § 333.18237 19
MCL § 600.2157 19

Prop. Fed. R. Evid. 504 note, 56 F.R.D. at 242 (1976) 19

MISCELLANEOUS:

AMERICAN PSYCHIATRIC ASSOCIATION TASK FORCE REPORT, CLINICAL ASPECTS OF THE VIOLENT INDIVIDUAL (1974) 10, 11, 12
Beigler, *Tarasoff v. Confidentiality*, 2 BEHAV. SCIENCES & LAW 273 (1984) 19, 22
Bersoff, *Therapists as Protectors and Policemen: New Roles as a Result of Tarasoff*, 7 PROF. PSYCHOLOGY 267 (1976) 13, 30
T. BLAU, THE PSYCHOLOGIST AS EXPERT WITNESS (1984) 13
B. ENNIS & R. EMERY, THE RIGHTS OF MENTAL PATIENTS (1978) 10

TABLE OF AUTHORITIES—Continued

Page

Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CAL. L. REV. 693 (1974) 8, 10, 12, 14
Givelber, Bowers & Blitch, *Tarasoff, Myth and Reality: An Empirical Study of Private Law in Action*, WIS. L. REV. 443 (1984) 14, 18, 24
Gurevitz, *Tarasoff: Protective Privilege Versus Public Peril*, 134 AM. J. PSYCHIATRY 289 (1977) .. 21, 22
S. HALLECK, LAW IN THE PRACTICE OF PSYCHIATRY (1980) 22
Justice & Birkman, *An Effort to Distinguish the Violent from the Nonviolent*, 65 SO. MED. J. 703 (1972) 10
Kozol, Boucher, & Garofalo, *The Diagnosis and Treatment of Dangerousness*, 18 CRIME & DELINQUENCY 371 (1972) 8, 10, 13
Lanyon, *Psychological Assessment Procedures in Court-Related Settings*, 17 PROF. PSYCHOLOGY 260 (1986) 14
Leonard, *A Therapist's Duty to Potential Victims*, 1 LAW & HUM. BEH. 309 (1977) 41
MacDonald, *Homicidal Threats*, 124 AM. J. PSYCH. 475 (1967) 40
Menzies, Webster & Sepejak, *The Discovery of Dangerousness in a Pre-trial Forensic Clinic*, Paper presented at the Annual Meeting of the American Psychiatric Association (1982) 13
Monahan, *Prediction Research and the Emergency Commitment of Dangerous Mentally Ill Persons: A Reconsideration*, 135 AMER. J. PSYCHIATRY 198 (1978) 12
J. MONAHAN, THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR (1981) 8, 10, 11, 13
Monahan, *The Prediction of Violent Behavior: Toward a Second Generation of Theory and Policy*, 141 AM. J. PSYCHIATRY 10 (1984) 8, 15
Morse, *Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527 (1978) 10

TABLE OF AUTHORITIES—Continued

Page

Note, *Imposing a Duty to Warn on Psychiatrists—a Judicial Threat to the Psychiatric Profession*, 48 U. COL. L. REV. 283 (1977) 9, 38
Note, *Psychotherapists and the Duty to Warn: An Attempt at Clarification*, 19 NEW ENG. L. REV. 597 (1984) 7, 42
Note, *Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of Tarasoff*, 31 STAN. L. REV. 165 (1978) .... *passim*
Rector, *Who Are the Dangerous?* BULL. AM. ACAD. PSYCH. & L. 186 (July 1973) 10
Report of the American Psychological Association Task Force on the Role of Psychology in the Criminal Justice System, 33 AM. PSYCHOLOGY 1099 (1978) 10
Rosenhan, *On Being Sane In Insane Places*, 13 SANTA CLARA L. REV. 379 (1973) 10
Roth, *Clinical and Legal Considerations in the Therapy of Violence-prone Patients*, in 18 CURRENT PSYCHIATRIC THERAPIES 55 (J. Masserman ed. 1978) 12, 22, 41
Roth & Weisel, *Dangerousness, Confidentiality, and the Duty to Warn*, 134 AM. J. PSYCHIATRY 508 (1977) 40, 41
Rubin, *Prediction of Dangerousness in Mentally Ill Criminals*, 27 ARCH. GEN. PSYCHIATRY 397 (1972) 10
Schmid, Appelbaum, Roth & Lidz, *Confidentiality in Psychiatry: A Study of the Patient's View*, 34 HOSP. & COMM. PSYCHIATRY 353 (1983) 19
Schwitzgebel, *Prediction of Dangerousness and Its Implications for Treatment* in MODERN LEGAL MEDICINE, PSYCHIATRY, AND FORENSIC MEDICINE (W. Curran, A. McGarry & C. Petty, eds. 1980) .. 11
Scott, *Violence in Prisoners and Patients, Medical Care Of Prisoners And Detainees*, 123 U. PA. L. REV. 439 (1975) 10
Shah, *Dangerousness: A Paradigm for Exploring Some Issues in Law and Psychology*, 33 AM. PSYCHOLOGIST 224 (1978) 13

TABLE OF AUTHORITIES—Continued

Page

D. SHAPIRO, PSYCHOLOGICAL EVALUATION AND EXPERT TESTIMONY (1984) 10, 12, 13, 30

Small, *Psychotherapists' Duty to Warn: Ten Years After Tarasoff*, 15 GOLDEN GATE U. L. REV. 271 (1985) 14-15

Steadman, *The Right Not To Be a False Positive: Problems in the Application of the Dangerousness Standard*, 52 PSYCHIATRIC QUARTERLY 84 (1980) 8

Steadman, *Predicting Dangerousness Among the Mentally Ill*, 6 INT'L. J. L. & PSYCHIATRY 381 (1983) 10

Steadman & Cocozza, *Stimulus/Response: We Can't Predict Who Is Dangerous*, 8 PSYCH. TODAY 32 (Jan. 1975) 11

Steadman & Cocozza, *Psychiatry, Dangerousness, and the Repetitively Violent Offender*, 69 J. CRIM. LAW & CRIMINOLOGY 226 (1978) 11

Stone, *The Tarasoff Decisions: Suing Psychotherapists to Safeguard Society*, 90 HARV. L. REV. 358 (1976) .... *passim*

United States Department of Health, Education and Welfare, HEW NEWS (News Release, August 8, 1974) 10

W. WEBSTER, CRIME IN THE UNITED STATES—1977 (Federal Bureau of Investigation, 1978) 14

Wenk, Robinson & Smith, *Can Violence Be Predicted?*, 18 CRIME & DELINQUENCY 393 (1972) 8-9

Wettstein, *The Prediction Of Violent Behavior And The Duty To Protect Third Parties*, 2 BEH. SCIENCES AND THE LAW 291 (1984) 10

F. ZIMRING, CONFRONTING YOUTH CRIME: REPORT OF THE TWENTIETH CENTURY FUND TASK FORCE ON SENTENCING POLICY TOWARD YOUNG OFFENDERS (1978) 14

J. ZISKIN, COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY (3d ed. 1981) 14

State of Michigan
In the Supreme Court

Supreme Court No. 77726

RUBY DAVIS, Administratrix,
of the Estate of Mollie Barnes,
Plaintiff-Appellee,
v.

DR. YONG-OH LHIM,
Defendant-Appellant.

BRIEF OF *AMICI CURIAE* AMERICAN PSYCHOLOGICAL ASSOCIATION MICHIGAN PSYCHOLOGICAL ASSOCIATION AND MICHIGAN PSYCHIATRIC SOCIETY IN SUPPORT OF DEFENDANT-APPELLANT

INTEREST OF AMICI

The American Psychological Association (APA) is a voluntary nonprofit, scientific, and professional organization with more than 60,000 members. It has been the major association of psychologists in the United States since 1892, and includes the vast majority of psychologists holding doctoral degrees from accredited universities in this country.

The Michigan Psychological Association, with over 900 members, is an affiliate of the APA and represents the scientific and professional interests of psychologists within Michigan.

The Michigan Psychiatric Society is a non-profit association of medical doctors who specialize in the field of

psychiatry in Michigan. It is also a "district branch" of the American Psychiatric Association, the largest national association of psychiatrists.

Amici consider this case to be of national importance to psychologists and psychiatrists, and to the public they serve. A decision to impose the dual duty to assess a patient's future dangerousness and to take steps to protect intended victims from their patients' dangerousness is flawed in several respects: (1) The rationale for the duty —protection of the public—is actually disserved by its imposition; (2) the scientific literature in the area overwhelmingly indicates that such predictions cannot be made with any acceptable degree of accuracy by psychotherapists; (3) the imposition of the dual duty conflicts with psychologists' and psychiatrists' obligations not to disclose confidences communicated by the patient; and (4) the duty to warn may have a profound effect on patients' willingness to undergo therapy, on therapists' willingness to treat violent patients, on patients' trust of the therapist, and on the effectiveness of therapy. Thus, this case raises questions of special concern to professional psychologists and psychiatrists and to *amici*.

Amici believe they can offer the Court relevant data and other information that will contribute to a thoughtful resolution of the serious questions confronting it on this appeal.

STATEMENT OF FACTS

Dr. Yong-Oh Lhim, defendant-appellant in this action and a psychiatrist at Northville State Hospital, provided inpatient psychiatric services to John Patterson from July 17, 1975 to August 4, 1975 and from August 21, 1975 to September 3, 1975. The second of these admissions was pursuant to a formal voluntary order. On both occasions Patterson was diagnosed as suffering from schizophrenia. On September 2, 1975, Patterson requested in writing a release from the hospital, and finding no

basis under MCL 330.1401 [1] on which to apply for involuntary commitment, Dr. Lhim discharged Patterson from the hospital, as required by MCL § 330.1419,[2] with instructions for follow-up care.

Subsequent to his discharge, Patterson was seen by another psychiatrist who, like Dr. Lhim, determined that Patterson did not meet the statutory criteria for involuntary hospitalization. Two months after his discharge from Northville and several days after the second psychiatrist had refused to seek Patterson's involuntary commitment, Patterson began firing a gun randomly and, when his mother tried to stop him, she was shot and killed.

Patterson's aunt, plaintiff-appellee in this case, thereupon brought a wrongful death action against Dr. Lhim, alleging that he had negligently discharged Patterson and negligently failed to warn the decedent that Patterson was a danger to her safety. The jury found for the plaintiff and, on appeal, the court of appeals rejected Dr. Lhim's claim of governmental immunity and upheld the jury's award. *Davis v. Lhim*, 124 Mich. App. 291, 335 N.W.2d 481 (1983). On appeal to this Court, the case was remanded to the court of appeals for reconsideration

---

[1] MCL § 330.1401 provides, in pertinent part, that a "person requiring treatment" under the statute means:

> (a) A person who is mentally ill, and who as a result of that mental illness can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure himself or another person, *and who has engaged in an act or acts or made significant threats that are substantially supportive of the expectation.*

(Emphasis added).

[2] MCL § 330.1419 provides, in pertinent part:

> Except [upon a determination that the patient is a person requiring treatment as defined in subsection 1401 and should remain in the hospital], a formal voluntary patient 18 years of age or over shall not be hospitalized more than 3 days, excluding Sundays and holidays, after he gives written notice of his intention to terminate his hospitalization and leave the hospital

in light of *Ross v. Consumers Power Co.*, 420 Mich. 567, 363 N.W.2d 641 (1984). On remand, the court of appeals reaffirmed its earlier opinion. *Davis v. Lhim*, 147 Mich. App. 8, 382 N.W.2d 195 (1985).

The court of appeals held that the determinations by Dr. Lhim not to seek involuntary commitment of Patterson and thereby to discharge him as required by MCL § 330.1419, and not to warn his mother of the "threats" made against her, were "ministerial" in nature, and thus were not entitled to governmental immunity. Secondly, the court of appeals held that the jury correctly applied the relevant standard of care in finding Dr. Lhim negligent. Dr. Lhim has appealed both of these holdings.

Amici wish to highlight several salient facts regarding the events leading up to Patterson's care and treatment by Dr. Lhim. First, although Patterson had been treated at Northville State Hospital on several occasions prior to Dr. Lhim's treatment of him, each occasion was pursuant to a voluntary admission by Patterson. Second, there was no evidence of a history of violent behavior on the part of Patterson. Third, the sole evidence adduced at trial of a "threat" by Patterson to his mother was a two-year old entry in emergency room records of Detroit General Hospital reflecting alleged statements made directly to the mother. The note quotes plaintiff-appellee in this case as saying that Patterson "paces the floor and acts strangely and keeps threatening his mother for money." 124 Mich. App. at 306, 335 N.W.2d at 490. Finally, Dr. Lhim was aware of this reported statement from the record, but found no current clinical evidence supportive of the statement during his treatment of Patterson, and determined, in his professional judgment, that the staleness, as well as the context, of the reported statement rendered the possibility of violence too remote to support a finding of future dangerousness, as required for involuntary commitment under Michigan law.

SUMMARY OF ARGUMENT

Amici present substantial data that show that psychiatrists and psychologists are unable to reliably or validly predict the future dangerousness of their patients. Indeed, empirical evidence demonstrates that two out of every three predictions are erroneous. In light of these data, there is little justification for the imposition of a duty on psychotherapists to assess the dangerousness of their patients and to take preventive measures based on those assessments. Moreover, the demonstrated inability of psychotherapists to agree on any useful guidelines for such assessments raises serious questions as to the existence of a "standard of care" within the profession which courts purport to apply in cases such as this one. In addition, the imposition of such a duty severely undermines the ability of therapists to foster therapeutic relationships with their patients, and to provide appropriate treatment. Most importantly, a legal duty to prevent violence ultimately would be antagonistic to the public interest purpose and social policy goals it was intended to serve.

Notwithstanding the lack of any meaningful rationale for the imposition of such a duty on psychotherapists, should this Court determine that a general duty to assess dangerousness and take preventive measures is appropriate in some circumstances, the "threat" in this case is sufficiently attenuated, and the absence of any other factors suggestive of Patterson's potential dangerousness to his mother so compelling, that the imposition of liability on Dr. Lhim is wholly unjustified.

Finally, even if the duty advocated by the plaintiff did exist, Dr. Lhim's conduct is immune from tort liability. In *Fisher v. State of Michigan*, 422 Mich. 883, 363 N.W.2d 229 (1985) (By Order), this Court upheld a trial court's ruling that a State employee's mental health decisions were discretionary and hence immune from liability under the rule established in *Ross v. Consumers*

Power Co., 420 Mich. 567, 363 N.W.2d 641 (1984). As the discretion exercised by Dr. Lhim is indistinguishable from that at issue in *Fisher*, Dr. Lhim also is clearly immune from tort liability.

ARGUMENT

I. THERE IS NO PUBLIC POLICY OR EMPIRICAL JUSTIFICATION FOR IMPOSING LIABILITY ON THERAPISTS FOR FAILING TO ACCURATELY PREDICT THEIR PATIENTS' FUTURE DANGEROUSNESS.

This Court has the unparalleled opportunity to halt, if not reverse, a decade of ill-advised, unsound, and empirically unsupportable judicial opinions concerning mental health professionals' duty to take preventive measures in response to threats uttered by their patients. In the view of *amici*, the proper way to resolve this appeal is to reject the basic tort claim raised here by appellee. The Court should flatly hold that mental health professionals are not, by virtue of that status alone, potentially liable to third parties for the violent conduct of their patients. A full examination of the issue makes clear that such a rule of third-party liability is an ineffectual and undesirable means of dealing with the problem of violent actions by mentally disabled persons.

Since the California Supreme Court's decisions in *Tarasoff v. Regents of the University of California*, 13 Cal.3d 177, 529 P.2d 553, 118 Cal. Rptr. 129 (1974), *vacated*, 17 Cal.3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976), a number of courts have imposed upon mental health professionals the duty to assess the future dangerousness of their patients and, in certain circumstances, to take reasonable care to protect intended victims from such dangers. *See, e.g., Jablonski v. United States*, 712 F.2d 391 (9th Cir. 1983); *Hicks v. United States*, 511 F.2d 407 (D.C. Cir. 1975); *Lipari v. Sears, Roebuck & Co.*, 497 F. Supp. 185 (D. Neb. 1980); *Knight v. State of*

Michigan, 99 Mich. App. 226, 297 N.W.2d 889 (1980); *McIntosh v. Milano*, 168 N.J. Super. 466, 403 A.2d 500 (1979). This duty has been construed, variously, to require therapists to seek commitment of their patients whom they determine, or "under applicable professional standards reasonably should [] determine[]," present a serious danger of violence to others, to notify appropriate law enforcement authorities, or to warn intended victims of their patients' dangerousness. *Tarasoff*, 551 P.2d at 345. *See generally* Note, *Psychotherapists and the Duty to Warn: An Attempt at Clarification*, 19 New Eng. L. Rev. 597, 598 (1984).

Notwithstanding the laudatory public safety goals that the imposition of this broad duty was intended to serve, the duty is premised upon faulty assumptions regarding the abilities of mental health professionals to predict with any degree of reliability or validity the future dangerousness of particular individuals. Because mental health professionals do not know which of many patients will commit violent acts, they will react to the threat of liability by "overpredicting" violence and taking preventive steps in a large number of cases. When therapists follow this broad-based approach, their actions have no positive effect on the overall level of public safety and lead to an increase in unnecessary involuntary hospitalization. Moreover, the imposition of this duty on therapists in many cases has the effect of undermining the therapeutic relationship, impeding effective treatment and resolution of the patient's mental disorder, and thereby increasing the very risk the duty was designed to diminish.

A. Mental Health Professionals Can Neither Reliably Nor Validly Predict Dangerousness.

Many recent decisions, in this and other contexts, have recognized the difficulties inherent in therapists' efforts to predict dangerousness.[3] The usual response to this recog-

[3] *See, e.g., Ake v. Oklahoma*, 105 S. Ct. 1087, 1096 (1985) ("Psychiatry is not . . . an exact science, and psychiatrists disagree widely

nition has been to hold therapists to the general "standard of care" for mental health professionals. In anticipating patient violence, therapists must stay "[w]ithin the broad range of reasonable practice and treatment in which professional opinion and judgment may differ." *Tarasoff*, 551 P.2d at 345.[4]

The problem with this approach is that the existence of such a "range" is unsupported by the empirical evidence. The consistent research finding is that mental health professionals fail to predict accurately future violence in two out of three cases,[5] and that there is no consistent professional standard for predicting violence.[6] In light of

---

and frequently on what constitutes mental illness, on the appropriate diagnosis to be attached to given behavior and symptoms, on cure and treatment, and on likelihood of future dangerousness."); *Barefoot v. Estelle*, 463 U.S. 880, 899, n.7 (1983); *White v. United States*, 244 F. Supp. 127, 131 (E.D. Va. 1965), *aff'd*, 359 F.2d 989 (4th Cir. 1966) (hospital not negligent when it failed to guard patient who escaped and stood in front of train); *Tarasoff v. Regents of University of California*. *See also Barefoot v. Estelle*, 463 U.S. at 921 & n.2 (Blackmun, J., dissenting).

[4] The *Tarasoff* court stated:

> Obviously we do not require that the therapist, in making th[e] determination [of dangerousness], render a perfect performance; the therapist need only exercise "that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of [that professional specialty] under similar circumstances."

131 Cal. Rptr. at 20, 551 P.2d at 345 (citations omitted).

[5] *See, e.g.*, J. MONAHAN, THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR (1981); Ennis & Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CAL. L. REV. 693, 713 (1974) [hereafter *Flipping Coins*]; Kozol, Boucher, & Garofalo, *The Diagnosis and Treatment of Dangerousness*, 18 CRIME & DELINQUENCY 371 (1972). *See also* Monahan, *The Prediction of Violent Behavior: Toward a Second Generation of Theory and Policy*, 141 AM. J. PSYCHIATRY 10, 11 (1984).

[6] *See* Steadman, *The Right Not To Be a False Positive: Problems in the Application of the Dangerousness Standard*, 52 PSYCHIATRIC QUARTERLY 84, 96 (1980) ("Nowhere in the research literature is there any documentation that clinicians can predict dangerous behavior beyond the level of chance."). *See also* Wenk, Robinson & Smith, *Can Violence Be Predicted?* 18 CRIME & DELINQUENCY 393,

these findings, the "standard of the profession" or the "range of reasonable practice and treatment" is inherently unreliable, and ultimately unworkable, as a standard by which to judge the assessments of other therapists and to impose liability based on those judgments.[7]

Social scientists, psychiatric authorities, and legal commentators are overwhelmingly in agreement that dangerousness cannot be predicted with any acceptable degree of reliability or validity.[8] Scientific studies clearly demon-

---

394 (1972) (finding it impossible to identify any subclass of offenders "whose members have a greater-than-even chance of engaging again in an assaultive act.").

[7] Commenting on the decision in *Tarasoff* to examine "the therapist's prediction of dangerousness" under the ordinary malpractice criterion of "'conformity to standards of the profession,'" Professor Stone writes: "One can only wonder what it means to apply standards to skills which do not exist. As Justice Mosk noted, dependence on such standards 'will take us from the world of reality into the wonderland of clairvoyance.'" Stone, *The Tarasoff Decisions: Suing Psychotherapists to Safeguard Society*, 90 HARV. L. REV. 358, 371 (1976) (quoting *Tarasoff v. Regents of the University of California*, 551 P.2d 334, 354 (1976) (Mosk, J., dissenting in part and concurring in part)) [hereafter *Stone*]. *See also Tarasoff*, 551 P.2d at 361 n.6 (Clark, J., dissenting) ("The majority's reliance on the traditional standard of care for professionals . . . is seriously misplaced. The standard of care assumes that to a large extent, the subject matter of the specialty is ascertainable. One clearly ascertainable element in the psychiatric field is that the therapist cannot accurately predict dangerousness, which in turn, means that the standard is inappropriate for lack of a relevant criterion by which to judge the therapist's decision. . . . The majority's attempt to apply a normative scheme to a profession which must be concerned with problems that balk at standardization is clearly erroneous."); Note, *Imposing a Duty to Warn on Psychiatrists—a Judicial Threat to the Psychiatric Profession*, 48 U. COL. L. REV. 283, 290-91 (1977) (same).

[8] "Reliability" refers to the degree of correlation or correspondence of judgment between professionals using the same method. Thus, if representative pairs of therapists, interviewing a representative sample of prospective patients, usually agree that each individual is or is not "dangerous," the judgment of "dangerousness" is said to be reliable. "Validity," by contrast, refers to how accurate the judgment in question is, without regard to the likelihood of agreement among therapists as to that judgment.

strate that predictions of dangerousness of mentally disabled persons are extremely inaccurate and are largely based on speculation.[9]

The American Psychiatric Association Task Force on Clinical Aspects of the Violent Individual (1974) [hereafter *Task Force*] concluded after an exhaustive review of the literature that judgments concerning the long-run potential for future violence and the "dangerousness" of a given individual are "fundamentally of very low reliability." *Task Force* at 23. The Task Force reported that "the state of the art regarding predictions of violence is very unsatisfactory. The ability of psychiatrists . . . to reliably predict future violence is unproved." *Id.* at 30. The Task Force found that efforts to predict violence of particular individuals resulted in an unacceptably high rate of "false positives"—*i.e.*, violent behavior was pre-

[9] *See* J. MONAHAN, THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR (1981); B. ENNIS & R. EMERY, THE RIGHTS OF MENTAL PATIENTS 20 (1978); Morse, *Crazy Behavior, Morals, and Science: An Analysis of Mental Health Law*, 51 S. CAL. L. REV. 527 (1978); *Report of the American Psychological Association Task Force on the Role of Psychology in the Criminal Justice System*, 33 AM. PSYCHOLOGY 1099 (1978); Steadman, *Predicting Dangerousness Among the Mentally Ill*, 6 INT'L. J. L. & PSYCHIATRY 381-90 (1983); AMERICAN PSYCHIATRIC ASSOCIATION TASK FORCE REPORT, CLINICAL ASPECTS OF THE VIOLENT INDIVIDUAL 28 (1974) (90 per cent error rate "unfortunately . . . is the state of the art"). *See generally* D. SHAPIRO, PSYCHOLOGICAL EVALUATION AND EXPERT TESTIMONY (1984); Wettstein, *The Prediction Of Violent Behavior And The Duty To Protect Third Parties*, 2 BEH. SCIENCES AND THE LAW 291 (1984); Scott, *Violence in Prisoners and Patients, Medical Care Of Prisoners And Detainees*, 123 U. PA. L. REV. 439 (1975); *Flipping Coins, supra* note 5, at 750-51; Rector, *Who Are the Dangerous?* BULL. AM. ACAD. PSYCH. & L. 186 (July 1973); Rosenhan, *On Being Sane In Insane Places*, 13 SANTA CLARA L. REV. 379 (1973); Justice & Birkman, *An Effort to Distinguish the Violent from the Nonviolent*, 65 SO. MED. J. 703 (1972); Kozol, Boucher & Garofalo, *The Diagnosis and Treatment of Dangerousness*, 18 CRIME & DELINQUENCY 371 (1972); Rubin, *Prediction of Dangerousness in Mentally Ill Criminals*, 27 ARCH. GEN. PSYCHIATRY 397 (1972); United States Department of Health, Education and Welfare, HEW NEWS (News Release, August 8, 1974).

dicted for individuals who did not demonstrate any violence within the period of the study. *Id.* at 23-24.[10]

Subsequent research has supported the Task Force's findings.[11] Professor Monahan,[12] in THE CLINICAL PREDICTION OF VIOLENT BEHAVIOR (1981) [hereafter CLINICAL PREDICTION], reported that no procedures used by

[10] This tendency to overpredict violence results not only from the difficulty of identifying factors that suggest future violence but also from the extremely low incidence of violence as a societal phenomenon:

> Predictions of dangerousness, like those of suicide, are, with few exceptions, predictions of rare or infrequent events . . . . This means that even if the characteristics of such future violent patients could be specified with fairly great accuracy, predictions based upon such characteristics will identify far more "false positives" than "true positives". Even if an index of violence proneness could be developed so as to correctly identify prior to release fifty percent of those individuals who will violate parole by committing violent offenses, the actual employment of such an index would identify eight times as many "false positives" as "true positives". This means that eight of the nine persons retained in prison as a result of application of the index would not have committed such offenses if released.

Task Force at 23-24 (footnotes omitted).

[11] *See, e.g.*, Schwitzgebel, *Prediction of Dangerousness and its Implications for Treatment* in MODERN LEGAL MEDICINE, PSYCHIATRY, AND FORENSIC MEDICINE 784 (W. Curran, A. McGarry & C. Petty, eds. 1980); Steadman & Cocozza, *Psychiatry, Dangerousness, and the Repetitively Violent Offender*, 69 J. CRIM. LAW & CRIMINOLOGY 226 (1978). *See generally supra* note 9. *See also* Steadman & Cocozza, *Stimulus/Response: We Can't Predict Who Is Dangerous*, 8 PSYCH. TODAY 32, 35 (Jan. 1975):

> Because psychiatrists cannot accurately predict who will become violent, they frequently err. Rather than random errors, however, their inaccurate predictions are consistently on the safe side. They overpredict. They assume that since some patients are dangerous, the one under consideration might be. The result of this practice is that as many as twenty harmless persons are incarcerated for every one who will commit a violent act.

[12] Professor Monahan, a research psychologist on the faculty of the University of Virginia Law School, has been described as the "leading thinker on [the] issue" of the prediction of violence. *Barefoot v. Estelle*, 463 U.S. 880, 920 (1983) (Blackmun, J., dissenting).

psychotherapists had succeeded in reducing the high rate of "false positive" predictions of violent behavior. Even allowing for possible distortions in certain of the research data, Monahan concluded that "it would be fair to [state] that the 'best' clinical research currently in existence indicates that *psychiatrists and psychologists are accurate in no more than one out of three predictions of violent behavior over a several year period." Id.* at 47.[13]

The notion that mental health professions have expertise in predicting dangerousness of individuals is based, in part, on the popularly held views that mentally disordered individuals are more likely to engage in violent acts than the general population, and that the presence of a mental disorder, *per se*, makes the prediction of violence easier and more accurate than would otherwise be the case. There is no empirical support for these propositions. *See* D. SHAPIRO, PSYCHOLOGICAL EVALUATION AND EXPERT TESTIMONY 157-60 (1984) [hereafter SHAPIRO]; *Flipping Coins, supra* note 5, at 716 (and citations contained therein). Professor Monahan has observed that "[t]he most relevant *noncorrelate* of violence is 'mental

[13] The studies above refer primarily to the inability of psychotherapists to make medium to long-term predictions of the violent behavior of their patients. Although there are very few studies of the reliability and validity of short-term predictions, Professor Monahan has observed that short-term emergency commitment of mentally ill persons predicted to be imminently violent may be exempt from the systematic inaccuracy found in the current research. Monahan, *Prediction Research and the Emergency Commitment of Dangerous Mentally Ill Persons: A Reconsideration*, 135 AMER. J. PSYCHIATRY 198 (1978). This difference is due, in part, to the fact that short-term predictions are usually made in the context of specific, and usually acute, mental disorders. *See generally* Roth, *Clinical and Legal Considerations in the Therapy of Violence-prone Patients*, in 18 CURRENT PSYCHIATRIC THERAPIES 55, 58 (J. Masserman ed. 1978). However, even the few studies that exist regarding short-term predictions of "imminent" violence limit the ability to predict to several days. *Id.* Because, under any of these standards, Dr. Lhim's alleged failure to predict in this case was not "short-term," *amici* rely on the above-cited studies reporting the general inability of psychotherapists to predict future violent behavior by their patients.

illness'." CLINICAL PREDICTION at 77 (emphasis added). Indeed, "schizophrenics and other psychotic persons ha[ve] a history of lower violence and fewer incarcerations than [do] other accused persons. . . ." Menzies, Webster & Sepejak, *The Discovery of Dangerousness in a Pre-trial Forensic Clinic*, Paper presented at the Annual Meeting of the American Psychiatric Association (1982).[14]

The best indicator of future violence is past violence on the part of the individual—a factor having nothing to do with the patient's mental disorder for which he or she is being treated, and, a factor of which even the most careful therapist may not necessarily be aware. *See* SHAPIRO at 157; Shah, *Dangerousness: A Paradigm for Exploring Some Issues in Law and Psychology*, 33 AM. PSYCHOLOGIST 224-38 (1978); CLINICAL PREDICTION at 71.[15] And in circumstances such as those presented by this case where there is no history of violence on the part of the patient, predictions of dangerousness are extremely difficult, if not impossible.[16]

[14] Although therapy patients often express thoughts of violence, they rarely carry them out—the very nature of psychotherapy actuates clients to voice such ideation. Bersoff, *Therapists as Protectors and Policemen: New Roles as a Result of Tarasoff*, 7 PROF. PSYCHOLOGY 267 (1976). However, such ideation should not be confused with impulse. Many studies on aggression demonstrate that frequently expressing violent thoughts in fantasy is precisely what prevents the person from acting on that fantasy. SHAPIRO at 160.

[15] *But see* T. BLAU, THE PSYCHOLOGIST AS EXPERT WITNESS 49-50 (1984) ("Some have suggested that 'the past is a prologue' and that dangerousness can be best predicted from a history of violence. Recent evaluation of the violent history paradigm does not support this concept. It is suggested that violence is frequently due to transitory psychological state[s] that emerge in response to atypical circumstances and is a fairly poor indicator of future violence."). (Citations omitted.)

[16] *See* Kozol, Boucher, & Garofalo, *The Diagnosis and Treatment of Dangerousness*, 18 CRIME & DELINQUENCY 371 (1972):

> The difficulty involved in predicting dangerousness is immeasurably increased when the subject has never actually performed an assaultive act . . . . We submit that to properly assess indi-

Other demographic factors that correlate positively with violent behavior include age (a disproportionate amount of crime is committed by persons between the ages of fifteen and twenty);[17] gender (nearly 90 percent of all persons arrested for violent crimes are male);[18] environmental circumstances (family, peer, jobs), as well as the availability of victims, weapons, and alcohol or other drugs. Lanyon, *Psychological Assessment Procedures in Court-Related Settings*, 17 PROF. PSYCHOLOGY 260, 264 (1986). The assessment of these factors and the ability to make predictions of violence based on them is not within the particular expertise of mental health professionals. It is not surprising that much of the research in this area has found that psychotherapists have no greater ability to predict future dangerousness than do non-psychotherapists.[19]

Although one study suggests that some psychotherapists believe that they can employ objective professional standards for evaluating the potential likelihood of dangerousness,[20] considerable doubt remains that their self-confidence actually reflects their abilities. *See* Small, *Psychotherapists' Duty to Warn: Ten Years After Tarasoff*,

---

cations of *possible* dangerousness in the absence of an actual instance of dangerous acting out requires the highest degree of psychiatric expertise and may well exceed the present limits of our knowledge. . . . *No one can predict dangerous behavior in an individual with no history of dangerous acting out.*

[17] *See* F. ZIMRING, CONFRONTING YOUTH CRIME: REPORT OF THE TWENTIETH CENTURY FUND TASK FORCE ON SENTENCING POLICY TOWARD YOUNG OFFENDERS (1978).

[18] See W. WEBSTER, CRIME IN THE UNITED STATES—1977 (Federal Bureau of Investigation, 1978).

[19] *See, e.g., Flipping Coins, supra* note 5, at 707, n.43 ("There are a few studies comparing the diagnostic reliability of psychologists and laymen, most of which report no significant difference."). *See generally* 1 J. ZISKIN, COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY 263 (3d ed. 1981).

[20] *See* Givelber, Bowers & Blitch, *Tarasoff, Myth and Reality: An Empirical Study of Private Law in Action*, WIS. L. REV. 443 (1984) [hereafter *Givelber, et al.*]

15 GOLDEN GATE U. L. REV. 271 (1985). In response to this optimistic report, Professor Monahan states:

> No one thinks that the prediction of violence is on the verge of attaining a validity comparable to that of the prediction of the weather. . . . There may indeed be a ceiling on the level of accuracy that can ever be expected of the clinical prediction of violent behavior. That ceiling, however, may be closer to 50% than to 5% among some groups of clinical interest.

Monahan, *The Prediction of Violent Behavior: Toward a Second Generation of Theory and Policy*, 141 AM. J. PSYCHIATRY 10, 11 (1984). Thus, at best, given the development of more accurate and reliable assessment techniques, psychotherapists may be able to successfully predict violence only one out of every two times. Given these odds, there is little justification for holding therapists liable for failing to predict accurately their patients' dangerousness.

B. A Rule Imposing A Duty To Assess Dangerousness And Take Preventive Measures Will Have Adverse, Not Beneficial, Effects.

In view of therapists' fundamental inability to predict dangerous conduct, there is no valid argument for a new form of third-party liability for therapists for the violent acts of their patients. An effort to improve public safety by imposing a duty on professionals who lack the ability to predict or prevent violence will lead either to failure or to other adverse social consequences that outweigh any benefits.

1. *Therapists Will Overpredict Violence.*

The first problem with any rule imposing liability on therapists for their patients' conduct is that the response of the mental health professionals will necessarily affect a large number of patients—far more than the number who actually commit violent acts. Therapists cannot identify which of their many patients with potential violent "tendencies" will actually resort to violence. The only rational

response to this lack of knowledge, in the face of a threat of liability, is to assume that every patient who expresses violent emotions will act on those emotions. As a result, therapists will vastly "overpredict" violence, and will begin making decisions on that basis.

The majority below, although aware of these predictive problems,[21] rejected the notion that therapists would "overreact" in this way to a risk of liability. The majority apparently believed that a liability rule based on the prevailing "professional standard of care" would not have any real impact on the large majority of therapists who are attempting to do their jobs in good faith. But this belief is untenable, in view of the absence of a professional consensus about what facts may properly lead to a prediction of violence. Because there is no acknowledged professional approach to predicting violence, therapists treating potentially violent patients will necessarily be preoccupied with other ways of minimizing their legal exposure.

There are several rational responses for these therapists faced with a "duty" that they feel unable to fulfill. First, they can seek to avoid altogether the patients that cause the problem. A rule of third-party liability is certain to discourage many mental health professionals from treating any patients whose history or behavior suggests that future violence is a possibility. Even without such a rule, many therapists already tend to avoid these kinds of patients because they are notoriously difficult to communicate with and treat.[22] If these therapists are now told that they may be held responsible for their patients' violent conduct—despite their acknowledged inability to predict that violent conduct—they will be even more reluctant to begin treatment. This, in turn, could lead to

[21] 124 Mich. App. 291, 301; 335 N.W.2d 481, 487 ("Medical doctors cannot predict with perfect accuracy whether or not an individual will do violence to himself or to someone else.").

[22] *See Stone, supra* note 7, at 371-372.

less effective care for the very patients about whom the majority below was most concerned.

Among those therapists who remain willing to treat potentially dangerous patients, there will be another, equally predictable response. They will increase dramatically the number of occasions on which they anticipate violence and act on that prediction. They will know that, in the event of a lawsuit, the "dangerousness" of a particular patient who has committed a serious violent act will seem obvious. A court or jury, with the benefit of hindsight, is not likely to be moved by abstract protestations about the difficulties of behavioral predictions. Nor will it do much good to describe the many other patients with comparable violent "tendencies" who have been stabilized and integrated successfully into society. Once a homicide or other crime has been committed, there will be an almost irresistible temptation, on the part of the legal system, to determine that the therapist should have done something more to prevent it.[23]

Faced with this prospect, therapists are bound to recognize an additional fact: the potential costs of inaction far outweigh any costs, for them personally, of taking action. In any individual case, if they guess that a patient is not really violent and take no preventive steps, they face potentially huge liabilities in the event they are wrong. If, on the other hand, they assume that this same patient is violent, and take "appropriate" action, the impact on them is minimal. Depending on what the facts and law seem to require in a given case, they can avoid the risk of liability simply by making a warning phone call, or by adjusting their own decisionmaking about a given clinical issue like a hospital discharge.

[23] *See Tarasoff v. Regents of the University of California*, 551 P.2d at 361 (Clark, J., dissenting) (since "the decision not to warn or commit must always be made at the psychiatrist's civil peril, one can expect most doubts will be resolved in favor of the psychiatrist protecting himself"); Note, *Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of Tarasoff*, 31 STAN. L. REV. 165, 188 (1978) [hereafter *Stanford Note*].

Thus, the major impact of routine overpredictions of violence will not be on the therapist but on the patients themselves. It is they, after all, who will have their confidences spread to family members, friends, and business associates through warnings. Or it is they who will be kept in psychiatric hospitals despite a therapist's clinical judgment that a discharge would be desirable.

For all of these reasons, the Court would be wise not to minimize the likely effects of a liability rule on the behavior of psychotherapists. Regardless of whatever cautionary language the Court might use to lower the standard of care, the potential for liability for patient violence will predictably lead therapists to act differently in a large number of cases, whenever they have any suspicion whatever that they are dealing with a potentially violent person.[24]

2. *The Costs of Such a Rule Will Outweigh the Benefits.*

Whether such a broad-ranging change in clinical behavior is desirable, of course, depends on exactly what decisions and actions are being encouraged by the tort system. The ultimate issue is whether society will be better off if it moves from the present system to one where therapists are forced to consider warnings and/or hospitalization whenever patients utter violent thoughts. We analyze the utility of each of these two available types of responses in turn.

a. *The efficacy of warnings.*

The most commonly discussed preventive measure when patients are suspected of future violence is to warn the potential victim, if identifiable. The lack of a warning in the present case, for example, was central to the ruling

[24] This effect has been demonstrated empirically. *See Givelber, et al., supra* note 20, at 477 ("The most dramatic effect of *Tarasoff* can be seen exactly where one would expect it: in increased willingness to notify potential victims, public authorities, and police.") (citations omitted).

of the court below that the evidence supported a finding of negligence.[25] And *Tarasoff* itself is often labelled, only somewhat inaccurately, as a "duty to warn" case. So it can safely be assumed that one of the responses of mental health professionals in Michigan, if faced with a rule of third-party liability for patient violence, would be to make a great many more warnings. The question is whether this would accomplish anything.

The most central concern about forcing therapists to make warnings to victims is the fact that they constitute a breach of the confidential treatment relationship between therapist and patient. Effective psychotherapy requires that patients be able to reveal their innermost thoughts and feelings, secure in the knowledge that those thoughts and feelings will be kept confidential. As the Sixth Circuit has noted, a therapist's "'capacity to help his patients is completely dependent upon their willingness and ability to talk freely.'" *In re Zuniga*, 714 F.2d 632, 638 (6th Cir.), *cert. denied*, 464 U.S. 983 (1983) (*quoting* Prop. Fed. R. Evid. 504 note, 56 F.R.D. at 242 (1976)).[26] This fact, in turn, "'makes it difficult if not impossible for him to function without being able to assure his patients of confidentiality. . . . A threat to secrecy blocks successful treatment.'" *Id.* In sum, a warning, like any other breach of confidence, is far from

[25] 124 Mich. App. 291, 308-09; 335 N.W.2d 481, 491.

[26] *See Taylor v. United States*, 222 F.2d 398, 401 (D.C. Cir. 1955); *In re Lifschutz*, 2 Cal.3d 415, 431, 85 Cal. Rptr. 829, 467 P.2d 557 (1970). *See also* MCL §§ 333.18237, 600.2157 (creating psychologist-patient and physician-patient testimonial privileges). For clinical discussion of these issues, *see, e.g.*, Beigler, *Tarasoff v. Confidentiality*, 2 BEHAV. SCIENCES & LAW 273, 277 (1984) [hereafter *Beigler*] ("[A]ny evidence of breach of confidentiality will undermine the patient's trust of the therapist, deter the patient from taking advantage of treatment, and deprive the patient and society of the beneficial effects of psychiatric interventions."); Schmid, Appelbaum, Roth & Lidz, *Confidentiality in Psychiatry: A Study of the Patient's View*, 34 HOSP. & COMM. PSYCHIATRY 353 (1983) (empirical study confirming importance of confidentiality to patients).

cost-free. It necessarily represents a threat to the treatment process itself.

To be sure, we do not suggest that this confidential relationship should be inviolate in every conceivable situation. State law, for example, generally requires a report to the authorities whenever a therapist learns about ongoing child abuse.[27] And most therapists would acknowledge moral responsibility to take some discretionary action if they are convinced that a patient is about to commit a violent crime. But the question here is whether the law should force a large increase in the number of warnings being made—*i.e.*, whether it is desirable to enact a rule that will lead, predictably, to warnings that are motivated, not by the clinical and moral judgment of therapists, but by their fear of being second-guessed in a later tort suit.[28]

Such a development would erode significantly the ability of psychotherapists to treat the very persons who are causing the problem—those who may have some urge to violence. As we have discussed, the number of patients likely to be affected by this rule is quite large. These patients will know that if they reveal these impulses, even in a confidential therapy session, the therapist is likely to describe these feelings to the very family member, friend, or business associate who is directly involved. This breach of secrecy, in turn, not only will be painful for patients but almost certainly will have collateral consequences, *e.g.*, loss of employment, estrangement from family, and the like. Faced with this prospect, the natural response of patients will be to avoid treatment, or to avoid the very statements during treatment that may be most essen-

[27] *See, e.g.*, MCL § 25.248.

[28] *See Stanford Note*, *supra* note 23, at 190 (distinguishing the effects of "discretionary" disclosures from the effects of a legal duty to warn).

tial to their recovery.[29] Such reticence, in turn, may end up *increasing* the likelihood that patients will actually carry out their secret violent impulses.[30]

This danger is more than mere speculation. In a survey of California psychotherapists conducted by the *Stanford Law Review* after the *Tarasoff* decision, a majority of those surveyed "thought that patients will withhold information important to treatment if they believe the therapist may breach confidentiality." [31] And fully one-fourth of the respondents "reported actually observing their patients' reluctance to discuss their violent tendencies when informed of the possibility of an exception to absolute confidentiality." [32]

This risk might be worth taking if there were reason to believe that the warnings themselves are an effective means of preventing violence. But that is hardly clear in

[29] *See Tarasoff*, 551 P.2d at 359 (Clark, J., dissenting) (majority's rule will deter persons from seeking treatment, prevent full disclosure of patients' thoughts, and interfere with the development of a trusting relationship between therapist and patient); *Stone*, *supra* note 7, at 370 ("Anyone who has worked in a therapeutic program serving drug addicts, prisoners, parolees, probationers, or juvenile delinquents can attest that the duty to breach the patient's privacy as required by *Tarasoff II* would eviscerate whatever possibility of treatment exists with these difficult patients.").

It is noteworthy that the patient in *Tarasoff* never returned for further treatment to his psychotherapist after the therapist disclosed his patient's threat to third parties. It would be two months before the patient's [illegible] victim returned, yet the therapist had no opportunity to treat his patient or further assess his capacity for violence during this time.

[30] *See Stone*, *supra* note 7, at 373 (duty to warn "will reduce rather than increase public safety because it will diminish the ability and motivation of therapists to treat effectively mentally disturbed and potentially dangerous people"); Gurevitz, *Tarasoff: Protective Privilege Versus Public Peril*, 134 AM. J. PSYCHIATRY 289 (1977) [hereafter *Gurevitz*].

[31] *Stanford Note*, *supra* note 23, at 183.

[32] *Id.*

itself. First, there is the problem of what a potential victim can do to forestall a violent act even after receiving a warning. The options are certainly few.[33] Indeed, in many circumstances, a warning may precipitate a confrontation and thus "may in fact increase the likelihood of violence." [34] In such a case, other options are obviously far preferable. "Most patients will tolerate a variety of other protective forms of crisis intervention by the therapist with much less damage to the therapeutic alliance and with much less rage towards both the therapist and the potential victims because their psychological implications are much less sinister to the patient." [35] In sum, a warning is not a very effective way to prevent patient violence.[36]

For all of these reasons, *amici* believe it is a serious mistake to create a tort rule that encourages therapists to make a warning whenever there is a possibility of patient violence. A decision about how to respond to a patient's threats of violence is often complex and difficult. Under the present system, therapists can decide, on a case-by-case basis, whether a given threat is serious enough to outweigh the need for confidentiality and whether, in the particular circumstances involved, a warning will improve matters or simply make them worse. Under the ruling below, by contrast, the likely result will

[33] S. HALLECK, LAW IN THE PRACTICE OF PSYCHIATRY 81-82 (1980).

[34] *Stone, supra* note 7, at 370. *Accord* Roth, *supra* note 13, at 58 ("warnings may increase rather than decrease the likelihood of subsequent violence."); *Beigler, supra* note 26, at 283; *Gurevitz, supra* note 30, at 290.

[35] *Stone, supra* note 7, at 370-71.

[36] Dr. Lhim could have selected the alternative of contacting the police, but until an overt violent act occurs, there is virtually nothing that the police can do to protect a potential victim. In *Tarasoff*, for example, the campus police were notified and they temporarily detained the patient. That did not prevent the victim's homicide.

be a large number of warnings motivated primarily by the risks of tort liability—a development that, more likely than not, will be counterproductive.

b. *The efficacy of hospitalization.*

A warning to third parties is not the only type of action, that, under the majority rule below, a therapist may be required to take in order to avoid liability for patient violence. Therapists may also be held liable if a court subsequently determines that their clinical decisions failed adequately to take into account the risk of violent actions by their patients. In particular, the court below expressed a willingness to second-guess a decision that a particular patient is ready to be discharged from a hospital setting.[37]

This kind of rule might, in theory, reduce the number of violent acts by mentally ill persons, but it would do so only by drastically increasing the number and duration of psychiatric hospitalizations. This solution thus raises once again the problem that those persons who will actually commit violent acts cannot be systematically identified. If their actions are to be prevented through isolation in a hospital, it will require "preventive detention" of the far *larger* group of people who exhibit some *potential* for violence.[38]

[37] In analogous cases, the trend toward a broader "duty to protect" third parties has gone even further. In two recent cases involving physicians' liability to third parties for automobile accidents allegedly caused by their patients' epileptic condition, *Duvall v. Goldin*, 139 Mich. App. 342, 362 N.W.2d 275 (1984), and medication, *Welke v. Kuzilla*, 144 Mich. App. 245, 375 N.W.2d 403 (1985), the courts have relinquished any requirement that the third-party victim be "identifiable" in advance. The *Welke* court went so far as to suggest that third-party liability is desirable here because doctors typically are covered by malpractice insurance. *Id.*

[38] There is evidence that third-party liability rules do promote more hospitalizations of potentially dangerous patients. In the Stanford survey of the effects of the *Tarasoff* decision, several responding psychiatrists volunteered that the decision had made them more likely to commit patients who made threats of violence. *Stan-*

It follows that a decision to deal with patient violence by second-guessing treatment decisions would be effective only if it had a major impact on the existing balance struck in our society between two competing values: the value of preventing violence against third parties, and the value of allowing many mentally disabled persons to receive appropriate treatment in a nonrestrictive outpatient setting. This is not an easy balance to strike. Any enthusiasm for use of physical isolation as a means to control violence by the mentally disabled has to be tempered by due recognition of the costs of such an approach.

One fundamental concern is the significant reduction in patients' liberty. "Because of the virtual impossibility of predicting dangerousness, such an approach would necessarily lead to prolonged incarceration for many patients who could become useful members of society." *Johnson v. United States*, 409 F. Supp. 1283, 1293 (M.D. Fla. 1976), *rev'd on other grounds*, 576 F.2d 606 (5th Cir. 1978). This sizeable group of people would experience significant restrictions on their freedom, *Humphrey v. Cady*, 405 U.S. 504, 509 (1972), solely to protect the rest of society from the violent acts that a *very few* of their number would otherwise commit.

This isolation, in turn, would become a major impediment to further treatment for these many patients. In most cases, effective treatment of mental disability cannot be fully carried out unless, at some point, the therapist allows the patient to leave a controlled hospital environment. This decision will often be a "calculated risk," but it is a risk that must be taken "if there is any reasonable possibility that the patient will ever again be able to mix with society and become a useful citizen." *Eanes v. United States*, 407 F.2d 823, 824 (4th Cir. 1969).

---

ford Note, *supra* note 23, at 189, n.24. And a later survey found that therapists are, in fact, more likely to seek involuntary hospitalizations if they feel they are bound by the *Tarasoff* rule. *Givelber, et al.*, *supra* note 20, at 478.

By restricting involuntary commitment of the mentally disabled to cases in which there is "clear and convincing" evidence of dangerousness, *see* MCL § 330.1465; *Matter of Wagstaff*, 93 Mich. App. 755, 287 N.W.2d 339 (1979), the Michigan Legislature has drawn a balance between these social risks and benefits that strongly favors deinstitutionalization of the mentally disabled in cases of doubt. The rule adopted by the majority below is completely inconsistent with this legislative judgment, because it effectively means that mental health professionals who discharge the mentally disabled do so at their peril. After all, in the context of individual court cases, the appropriateness of a patient's discharge will always be assessed after a patient has in fact proved to be dangerous and an innocent person has been seriously injured. In these circumstances, it will always seem unreasonable for a mental health professional to have "risked" a violent occurrence by failing to isolate a given patient.

Facing this possibility (and unable to protect themselves by complying with "standards" in the profession that simply do not exist), mental health professionals will be forced to "indulge every presumption in favor of further restraint, out of fear of being sued." *Sherrill v. Wilson*, 653 S.W.2d 661, 664 (Mo. 1983).[30] The inevitable result will be pressure in only one direction—toward hospitalizing patients who show any sign of violence, even though the vast majority could be successfully treated in the community.

---

[30] In *Sherrill*, the court explained that "[t]he plaintiff could undoubtedly find qualified psychiatrists who would testify that the treating physicians exercised negligent judgment, especially when they are fortified by hindsight. The effect would be fairly predictable. The treating physician would indulge every presumption in favor of further restraint, out of fear of being sued. Such a climate is not in the public interest." 653 S.W.2d at 664. *See also Cairl v. Minnesota*, 323 N.W.2d 20, 23 note 3 (Minn. 1982) (same); *supra* note 23.

Amici strongly believe that if the prevailing social balance is to be fundamentally altered in this way, the decision should be made by the Legislature, not the courts. For all of these reasons, we strongly urge the Court to reject the legal duty established by the lower court.

II. EVEN ASSUMING THAT THERAPISTS MAY SOMETIMES BE LIABLE FOR THE PATIENTS' ACTIONS, THERE IS NO JUSTIFICATION FOR IMPOSING LIABILITY ON THE PRESENT FACTS.

Even if the Court determines that mental health professionals can sometimes be held liable for failing to predict patient violence and warning third parties, the concerns raised in Part I should demonstrate vividly the need for careful delineation and application of such a liability rule. The decision of the court of appeals illustrates vividly the dangers of failing to specify the exact circumstances in which a therapist has a duty to take some preventive action. If liability can be imposed on the present facts, then the persons treating the mentally disabled in Michigan will effectively become strictly liable for *any* act of patient violence. This degree of legal exposure, in turn, will lead to even more over-prediction of patient violence, and thus to a greater number of unnecessary warnings and ill-advised hospitalizations.

The majority's opinion unreasonably broadens the extent to which therapists may be subjected to liability for failing to protect those who are subsequently harmed by their patients. In this case, Dr. Lhim was held to have a duty to protect the decedent even though the evidence establishing Patterson's dangerousness was sketchy at best. The only real evidence of Patterson's dangerousness to his mother (or anyone else) was an entry in the emergency room record two years prior to his mother's death, which was based on an unverified oral report submitted by Patterson's aunt that Patterson "paces the floor and acts strangely and keeps threatening his

mother . . . ." *Davis v. Lhim*, 335 N.W.2d at 490. The only indication that Patterson's mother was a potential victim was this two-year-old incident, during which Patterson had allegedly threatened his mother because he needed money. There is no evidence that Patterson had a long history of violence, had threatened to kill his mother, had ever acted upon or repeated his threat two years earlier, or had exhibited any violent behavior or aggressive emotions to Dr. Lhim. Nevertheless, the majority inferred that appellant should have taken some preventive action because Patterson would need money again once he left the hospital and that his mother was one possible source of money.

This set of facts contrasts sharply with the facts in *Tarasoff* and its progeny, where the patients conveyed *specific* and *express* threats to their psychotherapists that they were going to harm readily identifiable victims. *See, e.g., Jablonski v. United States*, 712 F.2d 391 (9th Cir. 1983); *Merchants National Bank & Trust Co. of Fargo v. United States*, 272 F. Supp. 409 (D.N.D. 1967) (patient threatened to kill his wife, and wife indicated to his therapists that she feared for her safety); *Hedlund v. Superior Court*, 34 Cal. 3d 695, 669 P.2d 41 (Cal. 1983) (patient told therapist of his intent to commit serious bodily injury upon victim); *McIntosh v. Milano*, 403 A.2d 500 (N.J. Super. 1979) (patient fired a gun at the car of the victim or her boyfriend, exhibited knife to the defendant psychiatrist, and expressed jealousy and desire for revenge because victim dated other men).[40] Moreover, in many of these cases the patients' dangerousness was obvious to the treating professionals and the violence was clearly imminent. *See Tarasoff*, 551 P.2d at 345 (psychologist "did in fact predict that [the patient]

[40] *See also Thompson v. County of Alameda*, 27 Cal. 3d 741, 614 P.2d 728, 735, 167 Cal. Rptr. 70 (1980), where the duty to warn arises only when the patient "poses a *predictable* threat of harm. . . ." *Id.* at 738. (Emphasis added.)

would kill . . . .").[41] *See generally Cairl v. Minnesota*, 323 N.W.2d 20, 26 (Minn. 1982) (". . . if a duty to warn exists, it does so only when *specific* threats are made against specific victims) (emphasis added).

In addition, the alleged "threat" in this case was made *to the victim and not to the therapist*. Thus, to the extent the two-year-old "threat" signified Patterson's violent impulses toward his mother, she was fully aware of whatever threat her son presented her. The fact that the "threat" was not made in the presence of the therapist made it even more difficult for the therapist to assess its significance. Indeed, Patterson's mother, unlike Dr. Lhim, was a witness to the patient's alleged efforts to force her to give him money, and was therefore in a much better position than Dr. Lhim to anticipate any future similar conduct. In this situation, as at least two courts have held, it is simply indefensible to hold a mental health professional liable for failing to warn the victim. *In re Estate of Votteler*, 327 N.W.2d 759 (Iowa 1982); *Cairl v. Minnesota*, 323 N.W.2d 20 (Minn. 1982) (no duty to warn one who already knows of the danger).

To be sure, the court below did seek to limit its holding in one way, by stating that lawsuits may only be brought by victims who were "readily identifiable" in advance. But this limitation is essentially meaningless, for two reasons. First, the court did not require that the patient make a specific threat of violence toward this "identifiable" victim during therapy. Instead, it suggested that the therapist must comb the patient's history and determine if there are any persons who, for any reason, are likely victims of potential violence. Moreover, the evidence they are required to consider apparently can be as slender as a two-year-old, unverified oral description of alleged efforts to coerce a mother to turn over some money. Obviously, under this approach, it will be only the rare case in which therapists will be able to feel confident that they have identified, and dealt with, every potential victim who might later be deemed "identifiable."

[41] Similarly, in *Jablonski v. United States*, 712 F.2d 391 (9th Cir. 1983), the patient's medical records indicated that he had a "'homicidal ideation towards his wife,'" that he had tried to kill her on numerous occasions, and that "'the possibility of future violent behavior was a distinct probability . . . .'" *Id.* at 393. Moreover, approximately ten days before murdering his girlfriend, the patient had threatened the victim's mother with a knife and apparently had attempted to rape her; the victim twice indicated to hospital personnel her fear of the patient; the psychiatrists believed that the patient was dangerous; the patient admitted that "he had had frequent problems all his life with violent reactions . . ."; and there were indications that his violence was likely to be directed against women, like the victim, who were very close to him. *See id.* at 393, 394, 398.

Second, even if these potential plaintiffs could be identified with precision, the court did not suggest that a therapist can safely avoid liability in every case through a warning. Instead, by authorizing a claim of "negligent discharge," the court suggested the possibility of a claim that the therapist had a broader duty, in lieu of, or in addition to, a duty to warn—*i.e.*, a duty to prevent violence itself. This broader duty presumably would be carried out by initiating or continuing an involuntary commitment to a mental hospital, if, with the benefit of hindsight, a jury determines that that was the most "reasonable" course of action.

Taken together, these features of the court's approach—the extraordinarily low threshold for a later finding of dangerousness, the indeterminacy of the potential plaintiffs, and the indeterminacy of the conduct required to forestall liability—mean that the ruling, in effect, is no different from the broadest possible rule of third-party liability. Therapists seeking to avoid liability under the court's test have no real choice but to do everything in their power to prevent any violence by any patient against any person.

Although *amici* do not believe that any rule of third-party liability for patient violence is justified, should the Court disagree, there is a way to frame the rule that would be far preferable to the version espoused by the court below. Under this rule, liability could only arise if, in the therapist's presence,[42] a patient makes a specific threat of imminent violence toward a specific individual. A therapist would not be required to sift through a patient's entire history—much of which may not even be available to the therapist—and seek to identify his/her most likely victims at every turn. In addition, the therapist must actually believe that the patient poses a serious risk of imminent violence to the threatened individual.[43] Third, the threatened individual must be unaware of the threat. Finally, the rule should make clear that therapists who warn the intended victims thereby satisfy their legal duties. There should then be no further legal duty to "control" the patient through hospitalization or some other means, although the therapist would remain free to determine that some such alternate approach is clinically more desirable than a warning.

Under this rule, mental health professionals could be reasonably confident of knowing the circumstances in which they are required to act, would not be required to take action where the victim is already aware of the risk, and could be quite confident about the type of action required for them to satisfy their legal obligations. Such a rule, while imperfect and probably ineffectual as a measure to protect the public, would be far preferable to the much broader and ill-defined liability rule enunciated

[42] *Cf. Brady v. Hopper*, 570 F. Supp. 1333 (D. Colo. 1983), *aff'd*, 751 F.2d 329 (10th Cir. 1984); *Shaw v. Glickman*, 45 Md. App. 718, 415 A.2d 625 (1980); *Cairl v. Minnesota*, 323 N.W.2d 20 (Minn. 1982).

[43] The tort system certainly should not require a warning in every case where a patient makes an idle threatening comment, absent some genuine and supportable reason to believe that the comment should be taken seriously. *See supra* note 14.

here by the court of appeals. However, *amici* would reemphasize our fundamental view that the Court should hold that there is *no* legal duty to warn or otherwise protect allegedly suspected victims.

III. THE DEFENDANT'S DECISIONS ARE IMMUNE FROM TORT LIABILITY.

In *Ross v. Consumers Power Co.*, 420 Mich. 567, 363 N.W.2d 641 (1984), this Court held that lower-level government employees are immune from tort liability for "discretionary" decisions (as contrasted with "ministerial" acts) unless those decisions are *ultra vires* or made in bad faith. When the instant case was remanded for reconsideration in light of *Ross*, a majority for the court of appeals ruled that the immunity recognized in *Ross* did not protect Dr. Lhim's decisions. The court reasoned that Dr. Lhim's discretion was constrained by the "relevant standard of care." Because the jury found that Dr. Lhim violated this standard, the majority concluded that Dr. Lhim's decision was ministerial. *Davis v. Lhim*, 382 N.W.2d 195, 198 (Mich. App. 1985). The dissent objected to this view because "[w]hether John Patterson should have been discharged from the state mental hospital or whether there was a need to warn plaintiff's decedent, involved complex medical discretionary decision-making." 382 N.W.2d at 200 (Cynar, J., dissenting).

The majority's ruling cannot be reconciled with *Ross*. *Ross* expressly protects public employees from the risk of tort liability when they are required to exercise significant decisionmaking in the performance of their duties. As this Court recognized in *Fisher v. State of Michigan*, 422 Mich. 883, 363 N.W.2d 229 (1985) (By Order), and many other Michigan cases have held, mental health decisions such as those made by Dr. Lhim are discretionary and hence immune from tort liability. By characterizing these decisions as ministerial whenever the "relevant standard of care" is violated, the majority below would eliminate the immunity afforded public employees

in negligence actions. *Amici* urge the Court to reject this view and hold that Dr. Lhim's decisions are precisely the kind that *Ross* immunizes from tort liability.

A. Acts By Public Employees That Require Significant Decisionmaking Are Immune From Tort Liability.

In *Ross*, this Court addressed the unsettled law in Michigan concerning the immunity of State employees from tort liability. The Court explained that immunity for public servants was required "to ensure that a decision maker is free to devise the best overall solution to a particular problem, undeterred by the fear that those few people who are injured by the decision will bring suit." 363 N.W.2d at 666. Consequently, the Court held that lower level government officials, employees and agents are immune from tort liability when they are:

1) acting during the course of their employment and acting, or reasonably believe they are acting, within the scope of their authority;

2) acting in good faith; and

3) performing discretionary, as opposed to ministerial acts.

363 N.W.2d at 667-68.

Because the third prong of this test had sometimes been difficult to apply, the Court carefully explained the distinction between discretionary and ministerial acts. Discretionary acts were not limited to those involving "quasi-judicial or policymaking authority." 363 N.W.2d at 668. Instead, this Court cited with approval Professor Prosser's definition of "discretionary acts" as those which "require personal deliberation, decision and judgment." *Ross v. Consumers Power Co.*, 420 Mich. 567, 363 N.W.2d 641 (1984). Hence, "[a]n individual who decides whether to engage in a particular activity and how best to carry it out engages in discretionary activity." *Id.* The Court

characterized the protected conduct as " 'discretionary-decisional' acts." *Id.*

Discretionary-decisional acts were contrasted with conduct in which the actor had little or no choice or was merely executing a prior decision. Characterizing the latter conduct as "ministerial-operational," the Court ruled that such conduct is not immune from tort liability. The Court concluded that the "distinction between 'discretionary' and 'ministerial' acts is that the former involves significant decision-making, while the latter involves the execution of a decision and might entail some minor decision-making." *Id.*

Although in some cases the line between acts involving significant decisionmaking and those involving execution of a decision and minor decisionmaking may blur, this is not such a case. The decisions made by Dr. Lhim clearly required the exercise of substantial discretion, and a straightforward application of the principles articulated in *Ross* indicates that those decisions are immune from tort liability.

B. Dr. Lhim's Acts Were "Discretionary-Decisional" And Are Immune From Tort Liability.

The plaintiff's claim against Dr. Lhim included two distinct acts of negligence: the decision not to seek involuntary hospitalization for Patterson after he requested release, and the decision not to warn Mollie Barnes that Patterson presented a danger to her. Each of these decisions by Dr. Lhim required significant decisionmaking and hence is protected from tort liability.

1. The Decision Not to Apply for Involuntary Hospitalization of Patterson.

Because Patterson had been voluntarily admitted to the hospital, he had a statutory right to be released within three days after requesting release, unless the commitment procedures provided in § 330.1420 of Michigan's Mental Health Code were initiated. MCL § 330.1419(1).

That section provides that after a patient requests release, an application for involuntary hospitalization shall be filed in court if it is determined that the patient is "a person requiring treatment as defined in [the statute] *and should remain in the hospital.*" MCL § 330.1420 (emphasis added). The relevant language in § 330.1401 defines a "person requiring treatment" as, *inter alia*:

> [a] person who is mentally ill, and who as a result of that mental illness can reasonably be expected within the near future to intentionally or unintentionally seriously physically injure himself or another person, and who has engaged in an act or acts or made significant threats that are substantially supportive of the expectation.

MCL § 330.1401. Before a court will approve the involuntary hospitalization of a patient, the State must prove by clear and convincing evidence that the patient is a person requiring treatment within the meaning of the statute. *Matter of Wagstaff*, 93 Mich. App. 755, 287 N.W.2d 339 (1979).

Following Patterson's request for release, Dr. Lhim determined that Patterson could not reasonably be expected within the near future to intentionally or unintentionally cause significant physical harm to himself or another person. Testimony of Dr. Lhim, Vol. 7, at 103. Consequently, Dr. Lhim did not apply for Patterson's continued hospitalization, and Patterson was instead released and referred to the South-West Mental Health Clinic for outpatient treatment. Two months later, a second psychiatrist also determined that Patterson was not a "person requiring treatment". and refused to admit Patterson to a mental hospital on an involuntary basis. Testimony of Ruby Davis, Vol. 4, at 73.

In deciding whether an application to involuntarily hospitalize Patterson was appropriate, Dr. Lhim was required to exercise significant discretion. The criteria specified in § 330.1401 of the Mental Health Code neces-

sitate several very difficult judgments, including: (1) whether the person has a "substantial disorder of thought or mood which significantly impairs judgment, behavior, capacity to recognize reality, or ability to cope with the ordinary demands of life," MCL § 330.1400a (defining "mental illness"); (2) whether the person can reasonably be expected within the near future to seriously physically injure himself or another person, MCL § 330.1401(a); and (3) whether the persons' acts or threats are "substantially supportive" of this expectation. *Id.*

These criteria require the mental health professional to diagnose mental disorders, assess the degree of the disorder and its effects, and attempt to predict the probability of violent behavior in the future. In describing the criteria in very general language, the Legislature has correctly recognized that their application requires the exercise of considerable judgment, based on a careful (and necessarily uncertain) balancing of many factors. Which factors should be taken into account, and the relative weight they should be given, is a matter of substantial disagreement. As the United States Supreme Court has recently observed:

> Psychiatry is not ... an exact science, and psychiatrists disagree widely and frequently on what constitutes mental illness, on the appropriate diagnosis to be attached to given behavior and symptoms, on cure and treatment, and on likelihood of future dangerousness.

Ake v. Oklahoma, 105 S. Ct. 1087, 1096 (1985). Perhaps the one conclusion that can definitively be reached about the mental health professional's role in resolving such questions is that it requires "personal deliberation, decision and judgment." *Ross*, 363 N.W.2d at 668.

It should also be emphasized that in deciding whether to apply for involuntary hospitalization under § 330.1420, the criteria specified in § 330.1401 are not the only considerations. This section provides that involuntary hos-

pitalization should only be sought if these criteria are satisfied *and* a determination is made that the patient "should remain in the hospital." Nothing in the statute constrains the determination of whether a voluntary admittee who satisfies the § 330.1401 criteria "should remain in the hospital." In making this determination, the mental health professional will consider factors such as the therapeutic consequences of refusing a voluntary admittee's request for release, the feasibility of satisfactory outpatient treatment and the advantages of integrating the patient back into the community. *See Cairl v. Minnesota*, 323 N.W.2d 20, 23 (Minn. 1982) (indicating that the assessment and balancing of factors such as these in deciding whether to release mentally retarded patient requires "precisely the type of governmental decision that discretionary immunity was designed to protect from tort litigation by after-the-fact review.").[44]

In *Teasel v. Department of Mental Health*, 419 Mich. 390, 355 N.W.2d 75 (1984), this Court recognized the discretion that such decisions entail. Discussing the decision to discharge a patient, the Court indicated that:

> Manifestly, the decision whether a hospitalized patient is "clinically suitable for discharge" or "no longer meets the criteria of a person requiring treatment" is a matter of professional judgment. The nature of psychiatric care and treatment to be provided to a hospitalized patient and the decision whether treatment is any longer necessary are matters calling for the exercise of informed medical judgment....

[44] Section 330.1476 of the Mental Health Code also provides that a mental health professional may decide that a "person requiring treatment" should be discharged from a mental hospital. While § 330.1476(2) requires a discharge if the criteria are *not satisfied*, even if they are met, § 330.1476(1) provides that a patient may be discharged "at any time" if deemed "clinically suitable for discharge." MCL § 330.1476(1).

> ... [I]t is clear to us that the decision to release a judicially hospitalized patient is discretionary with health care professionals.

355 N.W.2d at 83.[45]

It is equally clear in this case that Dr. Lhim's determination that an application for involuntary commitment was unwarranted involved "significant decisionmaking." As *Ross* expressly protects acts requiring "significant decisionmaking," 363 N.W.2d at 668, Dr. Lhim's conduct is immune from tort liability.[46]

Without questioning the fact that a decision concerning commitment involves substantial discretion, the majority below stated that Dr. Lhim's judgment was constrained by the "relevant standard of care"—"the conduct of a reasonable psychiatrist practicing medicine in the light of present-day scientific knowledge." 382 N.W. 2d at 198. According to the majority, if the relevant standard of care is violated, *i.e.*, there is negligence, a public employee's decision is transformed into a ministerial one. In so holding, ***the majority opinion effectively eliminates the doctrine of individual immunity in all negligence actions, for if the elements of the negligence***

[45] *See also id.* at 86 ("the nature of decisions concerning psychiatric care, treatment, and discharge from hospitalization involves the application of specialized knowledge, experience, and professional judgment."). Although stating that this decision was judgmental and discretionary, the Court also held that an official deciding to release a judicially hospitalized patient must make an informed decision "according to the criteria for discharge established by the Legislature." *Id.* at 83. In this case, Dr. Lhim's decision was in fact based on the statutory criteria; the appellee's argument is simply that Dr. Lhim wrongly decided that the statutory criteria were not satisfied. This is exactly the type of judgment that the Court found to be clearly discretionary in *Teasel*.

[46] It should be noted that "[t]here is no suggestion" in this case "that defendant was not acting within ... the scope of his authority or that defendant was not acting in good faith." 382 N.W.2d at 196.

claim are established the defense of immunity is forfeited.[47]

Nothing in *Ross* remotely hints at this drastic limitation on the scope of individual immunity. To the contrary, in protecting significant decisionmaking by public employees from tort liability, *Ross* intended "to ensure" that the decisionmaking process is not encumbered by the fear of litigation.

By restricting this assurance to decisions that fall within the "relevant standard of care," the majority opinion completely undermines this objective. No matter what decision is made, if an injury results this will pose a significant risk of litigation, with its attendant burdens, embarrassment and potential for liability. If a plaintiff properly alleges negligence, a public employee (and the State if indemnification is provided) will be subjected to the costs of discovery and other pretrial proceedings. If the plaintiff's proof even raises a question of fact as to negligence, the employee will face the burdens and risks of a jury trial.

The implications are particularly disturbing in a case such as this, where the "relevant standard of care" governing predictions of dangerousness is at best both unclear and subject to widespread disagreement, and at worst a fiction.[48] If the majority's view is adopted, men-

[47] The fact that the majority found that the standard of care included the statutory criteria in § 330.1401 does not limit the scope of the majority's ruling. As its holding on the failure to warn issue indicates, the majority would reach the same result even absent statutory "constraints."

Moreover, as explained *supra*, the statutory scheme requires the exercise of significant discretion and there is no suggestion that Dr. Lhim stepped outside the boundaries of the statute by considering impermissible factors. *See supra* note 45. For reasons developed in the text, Dr. Lhim's highly discretionary decision that the statutory criteria were not satisfied should not be deemed "ministerial" simply because it was later determined that he decided incorrectly.

[48] *See supra* note 7.

tal health professionals will know that if they decide that a patient is not dangerous, and the patient later injures someone, the reasonableness of their judgment will be second-guessed by a jury with the knowledge that they were in fact wrong. Because the majority's rule effectively eliminates the protection afforded such decisions by *Ross*, it provides a strong incentive to choose the course of action entailing the least risk of litigation and liability.

This is exactly what *Ross* was intended to prevent. *Amici* urge the Court to adopt Judge Cynar's view and hold that Dr. Lhim's decision that involuntary hospitalization was unwarranted involved "complex . . . discretionary-decision making" and is immune from tort liability.[49]

2. *The Decision Not to Warn the Eventual Victim.*

Like the decision not to seek involuntary hospitalization of a patient, the decision to warn a third party about a patient's threats is not ministerial. To the contrary, the courts and commentators have uniformly recognized that there are many possible responses to such threats. In choosing between those alternatives, the men-

[49] It is also important to note that characterization of such decisions as ministerial has implications far beyond the context in which this case arises. Increasingly, mental health professionals are being asked to make extraordinarily difficult predictions of dangerousness—judgments they are ill-equipped to make, but are demanded by society's needs to make. On these judgments, decisions affecting freedom or institutionalization, and even life or death, may turn. *See, e.g., Barefoot v. Estelle*, 463 U.S. 880 (1983) (mental health testimony is admissible to aid jury's determination of whether defendant presented a future threat to society, for purposes of imposing death penalty); *O'Connor v. Donaldson*, 422 U.S. 563 (1975) (limiting State's authority to civilly commit *nondangerous* individuals).

Although the necessity for these judgments is easily understood their consequences make it critical to dispel any notions of scientific objectivity. These are not ministerial tasks. They are decisions involving significant discretion, and if they are to be given appropriate (rather than dispositive) weight, they must be recognized as such.

tal health professional must exercise "personal deliberation, judgment and decision." The choice reached in each case clearly is a "discretionary-decisional" act and hence is immune from tort liability.

The first determination that must be made by the mental health professional confronted with this choice, is the probability that a threat will be acted upon. As demonstrated in Part I, this judgment is both extremely difficult and necessarily uncertain.[50] It involves an assessment and balancing of many factors, such as the clinical diagnosis of the patient, the context in which the threat is uttered, the way in which the threat is expressed, the patient's opportunity to act on the threat, the patient's past history of violence or suicide attempts, the factors that provoked the threat (*e.g.*, stress, a specific act, etc.) and whether they are likely to continue, the patient's response to treatment, the patient's resources outside the hospital (*e.g.*, a supportive family), the patient's relationship with the specified "victim," and the ability of that person to protect him/herself.[51]

Assuming that the mental health professional concludes that the threat presents a serious risk, the possible responses must be assessed. These alternatives include:

> (1) Intensifying the therapy by increasing the frequency of treatment, (2) requesting the patient to turn over his planned weapon to the temporary custody of the therapist, (3) starting the patient on tranquilizing medication, (4) increasing the dosage of a patient already on medication, (5) convincing the patient to submit to a brief voluntary hospitalization, (6) urging the patient to return for his regularly scheduled visit, and to call the therapist if the patient in the interim fears a loss of control.[52]

In some cases, it may be deemed necessary to warn the police, the patient's family, a person who will have custody of the patient or the specified victim. Involuntary hospitalization may also be considered.

In deciding what is the most appropriate response to a given situation, judgments must be made about the seriousness of the threat, "the impact of the proposed intervention on future therapy" and the likelihood that the intervention will prove successful in preventing violence.[53] Needless to say, this decision is not ministerial—it requires significant discretionary decisionmaking by the mental health professional.

Those courts that have followed the *Tarasoff* rule have uniformly recognized the importance of preserving this discretion. In fact, in *Tarasoff* the court stated that there was a "broad range of reasonable practice and treatment" and the proper manner to discharge the duty

---

[50] *See, e.g.*, Roth & Weisel, *Dangerousness, Confidentiality, and the Duty to Warn*, 134 AM. J. PSYCHIATRY 508, 509 (1977) ("[T]he bulk of expert opinion and research data indicates that neither psychiatrists nor anyone else can reliably predict the likelihood of a mentally ill patient's future violence. The clinician willing to make such judgments is necessarily uncertain as to the accuracy of his predictions, save for the certainty that he will overpredict that which he fears to be possible.") [hereafter *Ross & Weisel*].

[51] *See, e.g.*, MacDonald, *Homicidal Threats*, 124 AM. J. PSYCH. 475, 479-80 (1967).

[52] Leonard, *A Therapist's Duty to Potential Victims*, 1 LAW & HUM. BEH. 309, 313-14 (1977). *See also*, Roth, *Clinical and Legal Considerations in the Therapy of Violence-prone Patients*, in 18 CURRENT PSYCHIATRIC THERAPIES 55, 57-58 (1978) (indicating that instead of issuing warnings, therapists alternatively may decide that "other persons, even the threatened person . . . [should] be brought into the therapy, the patient's environment may be restructured (ridding the patient of weapons), or increased frequency of psychotherapeutic contacts may be recommended. Some patients, given knowledge of the therapist's dilemma and their legitimate concern for the welfare of others may themselves be willing to warn others of a potential danger or else may give permission for the therapist to warn others."); *Roth & Weisel*, *supra* note 50, at 510 (indicating that "even when danger seems likely[,] several alternatives are often available that permit continuing management of the violent or potentially violent patient without compromising treatment").

[53] *Roth & Weisel*, *supra* note 50, at 511.

of care would necessarily vary with the facts of each case . . . ." *Tarasoff v. Regents of University of California*, 131 Cal. Rptr. 14, 551 P.2d 334, 345 (1976).[64] The court further stated that patients' threats are infrequently executed and "[c]ertainly a therapist should not be encouraged routinely to reveal such threats; such disclosures could seriously disrupt the patient's relationship with his therapist and with the persons threatened." 551 P.2d at 347.

The dispute now before the Court provokes a stark illustration of the discretion involved in such decisions. In this case the patient had no history of violence, the only specific threat was made outside the presence of Dr. Lhim, the threat was made two years earlier and had not been acted upon, and the threat was made directly to the victim. In these circumstances, Dr. Lhim had a wide range of options to choose from (including taking no specific action in response to such an attenuated threat), and the appropriateness of warning the victim was, to say the least, highly questionable.

In holding that Dr. Lhim's failure to warn Mollie Barnes was a ministerial act, the majority below did not question the difficulty of determining the appropriate response to a patient's threat. Instead, it ruled that such decisions become "ministerial" whenever they are made negligently, *i.e.*, they violate the standard of care. This diminution of the protection that *Ross* affords public

[64] *See also*, *Lipari v. Sears, Roebuck & Co.*, 497 F. Supp. 185, 193 (D. Neb. 1980) ("This duty requires that the therapist initiate whatever precautions are reasonably necessary to protect potential victims of this patient."); *Mathes v. Ireland*, 419 N.E.2d 782, 785 (Ind. 1981) (duty is "to exercise reasonable care under the circumstances"); *McIntosh v. Milano*, 168 N.J. Super. 466, 403 A.2d 500, 511-12 (1979) ("duty to take whatever steps are reasonably necessary"); Note, *Psychotherapists and the Duty to Warn: An Attempt at Clarification*, 19 New Eng. L. Rev. 597, 598 (1984) ("The common thread that runs through the cases is the duty to use reasonable care under the circumstances. The discharge of that duty depends on the circumstances of each case.").

employees should be rejected. Dr. Lhim's decision was highly discretionary and falls squarely within the individual immunity recognized in *Ross*.

C. Michigan Case Law Clearly Establishes That Mental Health Decisions By State Employees Are Discretionary And Are Immune From Tort Liability.

Issues very similar to those raised here have previously been considered by this Court and by the Michigan Court of Appeals on numerous occasions. These cases overwhelmingly establish that Judge Cynar correctly found that mental health decisions involve "complex . . . discretionary-decision making" and that public employees making these decisions are immune from tort liability.

Most importantly, in *Fisher v. State of Michigan*, 422 Mich. 883, 363 N.W.2d 229 (1985) (By Order), this Court held that a trial court had properly granted summary judgment in favor of individual state defendants who were being sued for negligent hospitalization and detention of the plaintiff in a state mental institution. The court of appeals had reversed the trial court and held that the defendant psychiatrists had not been engaged in discretionary acts. After holding the appeal of that decision in abeyance pending a decision in *Ross*, this Court summarily ordered reinstatement of summary judgment in favor of the individual defendants. We urge the Court to adhere to its decision in *Fisher* here and hold that Dr. Lhim's decisions were discretionary and immune from tort liability.

With the exception of the majority below, all other Michigan cases support this result. In a case much like this, *Fuhrmann v. Hattaway*, 109 Mich. App. 429, 311 N.W.2d 379 (1981), *lv den.*, 414 Mich. 858 (1982), the court of appeals affirmed the trial court's decision granting summary judgment in favor of the defendant psychiatrists. In *Fuhrmann*, the two defendants had certified that a patient was mentally ill but was not dangerous to

himself or to other persons. The patient was then released from the Center for Forensic Psychiatry, and four months later shot the plaintiff. Although the plaintiff alleged that the defendants acted negligently, the court of appeals ruled that their actions were discretionary and, hence, immune. It reasoned:

> Plainly, the activities of the defendant psychiatrists are anything but ministerial. The decisions required of these persons are perhaps the ultimate in discretion. To determine the state of a person's psyche is, in itself a task requiring great discretion and when this task is conjoined with the even more imposing job of resolving another's liberty, the consequent decision cannot be said to be "ministerial" in any sense of that word. . . .

311 N.W.2d at 382.

Similarly, in *Hamilton v. Reynolds*, 129 Mich. App. 375, 341 N.W. 152 (1983), *lv den.*, 422 Mich. 890 (1985), a suit was brought after a patient at a state-operated psychiatric hospital left the hospital grounds and killed the plaintiff's decedent. The plaintiff alleged that one of the defendants, the patient's treating physician, had negligently given the patient a grounds pass. The trial court ruled that as a public employee, the defendant was immune as a matter of law. The court of appeals had little difficulty affirming this conclusion and observed "[t]hat the exercise of considerable discretion is required of those charged with the responsibility of determining whether psychiatric hospital patients shall be confined to the hospital building cannot be gainsaid." 341 N.W.2d at 154-55. *See also Pomilee v. City of Detroit*, 121 Mich. App. 121, 328 N.W.2d 595, 596 (1982), *lv den.*, 422 Mich. 890 (1985) (affirming grant of summary judgment in favor of doctor and clinical psychologist who were responsible for care, treatment and attention of patients in mental hospital. Explaining that this result was required by either the discretionary/ministerial or "scope of employment" test of immunity, court indicated that "very little" of what a psychologist does is ministerial).[55]

Subsequent to *Ross*, in *Canon v. Bernstein*, 144 Mich. App. 604, 375 N.W.2d 773 (1985), the court of appeals reviewed a trial court's decision that employees at a public mental health facility were immune from suit for negligence in counseling and treating a mental patient. The Court of Appeals affirmed the lower court's ruling, holding that as a matter of law the alleged conduct involved "discretionary acts." 375 N.W.2d at 775.

Finally, in *Tobias v. Phelps*, 144 Mich. App. 272, 375 N.W.2d 365 (1985), the court considered an action brought by the estate of a patient who died at a state medical facility. The estate alleged that the physicians

---

[55] *Accord Knapp v. Moreno*, 137 Mich. App. 768, 359 N.W.2d 560, 563 (1984) (where plaintiff claimed that staff psychiatrist had been negligent in diagnosis and treatment of patient, trial court's grant of summary judgment based on psychiatrist's immunity was affirmed; court of appeals stated that this result was dictated by either the "scope of employment" or "discretionary/ministerial" test for immunity); *Estate of Adams v. Northville State Hospital*, 131 Mich. App. 583, 345 N.W.2d 207, 208 (1983) (holding that diagnosis and treatment of patient at state mental hospital was a discretionary activity); *Mason v. Rosen*, 124 Mich. App. 204, 333 N.W.2d 513, *vacated and remanded*, 422 Mich. 897, 368 N.W.2d 243 (1985) (holding that various allegations of negligence relating to the care and treatment of mentally ill person concerned discretionary acts and hence public employee was immune from liability); *cf. McGhee v. Bhama*, 140 Mich. App. 49, 363 N.W.2d 293, *remanded*, 422 Mich. 940, 369 N.W.2d 854 (1985) (noting the "reluctance of other panels" to follow *Davis*, and holding that psychiatrist at state facility was immune from liability based on the "scope of employment" test).

It should be noted that while *Mason* and *McGhee*, along with many other Michigan Court of Appeals cases, were remanded for reconsideration in light of *Ross*, this Court did not indicate how that issue was to be resolved on remand. *Cf. Fisher v. State of Michigan*, 422 Mich. 883, 363 N.W.2d 229 (1985).

The same conclusion has been reached in other jurisdictions. *See Papenhausen v. Schoen*, 268 N.W.2d 565 (Minn. 1978); *Sherrill v. Wilson*, 653 S.W.2d 661, 664-67 (Mo. 1983); *Jarrett v. Wills*, 383 P.2d 995, 997-98 (Or. 1963).

involved had been negligent in treating and monitoring the patient and providing instructions to the staff. After observing that numerous cases prior to *Ross* had ruled that such conduct was "inherently discretionary," 375 N.W.2d at 369, the court recognized a less absolute—but nevertheless very broad—immunity for such conduct. The court stated that

> [t]he decisions whether to wean decedent from the medication and whether or how often to monitor her condition during the weaning process involved medical judgments. These are discretionary determinations. However, if defendants in fact decided that monitoring was necessary to guard against deterioration of the decedent's condition, negligent execution of that decision would fall outside the scope of their individual immunity. . . . In addition, if defendants decided that monitoring was necessary, a failure to inform or properly inform the staff of the decedent's condition was a ministerial act.

Id.

If this test is applied to Dr. Lhim's decisions, those decisions clearly are protected from tort liability. Like decisions about the appropriateness of treatment and monitoring, deciding whether a patient is dangerous, whether involuntary hospitalization is warranted and whether a warning is appropriate is highly discretionary. There is no allegation in this case that after making these decisions, Dr. Lhim was negligent in executing them.

Finally, two points should be made about the decisions in *Fuhrmann, Hamilton, Pomilee, Knapp, Adams, Mason, Canon* and *Tobias*. First, all of these cases implicitly reject the view of the majority below that a decision is ministerial simply because it is made negligently. Second, these cases uniformly hold that decisions very similar to those at issue here involve significant discretion and are immune from tort liability. We believe that these cases were correctly decided in both respects and we urge the Court to adopt the same position.

CONCLUSION

For the reasons stated above, the judgment of the court of appeals should be reversed and judgment should be entered in favor of the defendant.

Respectfully submitted,

JOEL KLEIN
PAUL M. SMITH
ONEK, KLEIN & FARR
2550 M Street, N.W.
Washington, D.C. 20037
(202) 775-0184
Counsel for Amicus
MICHIGAN PSYCHIATRIC SOCIETY

THOMAS DOWNS (P 12922)
THOMAS DOWNS, P.C.
603 Capitol Savings & Loan Bldg.
Lansing, Michigan 48933
(517) 372-2990
Counsel for Amicus
MICHIGAN PSYCHOLOGICAL ASSOCIATION

DONALD N. BERSOFF
LAUREL PYKE MALSON
KIT ADELMAN-PIERSON
ENNIS, FRIEDMAN, BERSOFF & EWING
Suite 400
1200 - 17th Street, N.W.
Washington, D.C. 20036
(202) 775-8100
Counsel for Amicus
AMERICAN PSYCHOLOGICAL ASSOCIATION

July 22, 1986

Are Therapists Liable for Their Patients' Violence?

Nine states have passed legislation addressing this issue of conflicting concerns: protecting mental health professionals, protecting victims, protecting patients.

By Martha King

In 1981, when John Hinckley Jr. shot President Reagan and his press secretary, James Brady, many fingers pointed at Hinckley's Colorado psychiatrist, blaming him for allowing someone so disturbed to "run loose." Brady unsuccessfully sued the psychiatrist in a Denver federal court. At the time, Colorado law was silent on the major issues raised in the case.

Violence by mental patients and their therapists' responsibility for the violent behavior are areas of growing concern in state legislatures. At least nine states have passed legislation to limit the liability of mental health professionals under specified circumstances (California, Colorado, Indiana, Kentucky, Louisiana, Minnesota, Montana, New Hampshire and Washington). Several other states considered the issue in 1987.

Generally, the laws protect therapists from liability for a patient's violent acts unless the patient has told the therapist about a specific threat of violence against a specific victim. In the case of such a threat, the laws require the therapist to warn or protect the potential victim.

A 1969 landmark case, *Tarasoff vs. Regents of the University of California*, illustrates the liability issues for mental health professionals. Prosenjit Poddar, a graduate student under treatment through Berkeley's student health service for "acute paranoid schizophrenia," murdered a fellow student, Tatiana Tarasoff, after she rebuffed his advances. Poddar had told a university therapist that he intended to kill her. The therapist in turn notified campus police of the threat in order to initiate involuntary commitment proceedings. Poddar was not committed, however, after promising to stay away from Tarasoff.

The California Supreme Court ruled that a cause of action could be maintained against the therapist for failing to warn the victim. Although the case was settled before it was determined whether the therapist was at fault, the ruling is interpreted to have created a legally enforceable "duty to warn," or otherwise protect, potential victims.

Because Colorado law did not address the liability issue at the time of the Brady suit against Hinckley's psychiatrist, the Denver court's ruling was based, in part, on the *Tarasoff* decision. The court found there was no duty owed because no specific threat was made against a specific person and, therefore, Brady's injury was not foreseeable.

Except for the very disturbed patient, "...predicting violent behavior is a crapshoot in a way," says Joel Klein, general counsel for the American Psychiatric Association, in an interview for *Hospital and Community Psychiatry* (October 1986). He says psychiatrists do not know how to predict violence with any degree of sophistication or accuracy.

Continuing a patient's hospitalization or committing him involuntarily "flies in the face of almost two decades of civil libertarian thinking about over-institutionalizing patients as well as views about what constitutes good medical care," says Klein. In addition, a therapist can be sued for deprivation of civil rights.

"It's a terribly cruel dilemma," observes Klein, pointing out further that a therapist who warns a victim can be sued for breach of confidentiality.

Colorado adopted legislation in 1986 to address liability problems faced by mental health professionals. Representative JoAnn Groff, sponsor of the bill, reports that although the Hinckley case brought national attention to the state, it was a relatively minor contributing factor to the introduction of her bill. "More important," says Groff, "1986 was Colorado's year for liability reform, and the legislation really stemmed from the *Tarasoff* case and a few local incidents."

The local chapters of psychiatric, psychological and mental health associations initiated the Colorado proposal. "Therapists were finding it tough to get malpractice insurance, and the coverage they could find was getting more expensive," reports Groff. "The legislature needed to determine a threshold for how much responsibility

Martha King is senior staff associate of NCSL's Mental Health project.

providers should have for their patients' behavior."

The Colorado legislation illustrates the major issues, sometimes conflicting, that confront lawmakers across the country: protecting therapists, protecting victims and protecting patients.

• Protecting therapists. The statutes that limit the liability of mental health professionals for violent acts committed by their patients generally state that no monetary liability and no cause of action may arise against the practitioner for failure to predict, warn of or take precautions against a patient's violent behavior, unless the patient has communicated an intent to perform the violent act.

Photo: Associated Press

Groff says the Colorado legislature was already addressing medical malpractice, which is often easier to identify than malpractice by a mental health professional. "If a patient must sacrifice a limb to cancer and the surgeon amputates the wrong leg, it's a pretty clear-cut case," she says. "When dealing with an illness of the mind malpractice is not so clear. When and how should we hold someone else liable for an inexact science?"

Representative Gilbert Romero, a Colorado attorney who opposed the Groff bill, disagrees with the threshold of accountability it established. "This is a very narrow provision," says Romero. "The therapist is off the hook unless the patient specifically names his victim and the threat is imminent.

"From a public policy point of view," he continues, "this gives carte blanche to the professional to deal with the patient without the responsibility that should come when others may be in danger." It's not that Romero opposes legal protection for therapists. Rather, he believes the insulation from liability shouldn't be so broad.

"Mental health professionals are trained to understand the patient's problems, they have more information about the patient than others, and we should hold them to a higher standard than this law provides," he says.

After John Hinckley Jr. above, shot Reagan, the issue of therapists' liability for the violent acts of their patients was raised. After being found innocent by reason of insanity, Hinckley has been kept at St. Elizabeths Hospital in Washington, right.

The original Colorado proposal provided immunity to therapists for failure to predict or warn of a patient's violent behavior. One of several amendments that made the bill less objectionable to Romero provides that the immunity does not apply to the "negligent failure to initiate involuntary (short-term) treatment and evaluation" if a patient "appears to be an imminent danger to others" as a result of mental illness. It also does not immunize the negligent release of a mental health patient from a mental hospital or ward.

In Louisiana, the law does not address protection from liability for a patient's violent behavior. Instead, it establishes a duty to warn or protect a potential victim and protects the

therapist from breach of confidentiality when complying with that duty. The Minnesota statute does not provide immunity in the context of a threat by a patient to commit suicide, nor when a patient is adjudicated "mentally ill and dangerous." The Indi-

Photo: John Sunderland/Photostaff Inc.

"Mental health professionals are trained to understand the patient's problems. . . and we should hold them to a higher standard than this law provides."

Romero

ana legislation protects therapists who comply with the law from being liable "to persons other than the patient" for failure to predict or warn or take precautions against violent behavior.

The scope of the liability protections for "mental health professionals" varies by state. For example, the Louisiana statute is limited to psychologists and psychiatrists, while the Indiana law protects a range of 12 identified professions or types of institutions.

• **Protecting victims.** The laws immunizing mental health professionals generally require action by them to protect potential victims under specified circumstances. The circumstances that invoke this duty to warn or protect range from very specific threats communicated by a patient (for example, in Louisiana, ". . . an immediate threat of physical violence against a clearly identified victim or victims, coupled with the apparent intent and ability to carry out that threat") to broader threats that may include the general public (for example, in Indiana, if a patient ". . . 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"). The New Hampshire law also imposes a duty on the therapist if the client communicates a "serious threat of substantial damage to real property."

The duty to warn or protect generally requires the therapist to make "reasonable efforts" to warn the potential victim or to notify appropriate law enforcement officials, or both, and may also be accomplished by involuntarily institutionalizing the patient, if appropriate, in some states. Minnesota defines "reasonable efforts" and Colorado requires "reasonable and timely efforts."

In cases of potential violence, Romero tends to side more with the victim than the therapist or patient. Although civil liberties are important to him, he says that in warning a victim or in confining a potentially violent patient, "if we err on the side of caution, so be it."

Groff's primary concern was to establish legal standards by which to judge a therapist's action. "This doesn't mean there aren't moral or ethical issues involved," she says. "Therapists aren't precluded from acting on their good judgment. The key is that they do so in good faith."

• **Protecting patients.** The most universally accepted patient rights are those providing confidentiality in the therapist/client relationship and the right to treatment in the most appropriate, least restrictive setting. When a patient threatens a violent act against another person, a balance must be struck between his rights and those of the potential victim.

Klein says a patient may feel that he can talk about violent impulses with a therapist, but if he thinks the information will be disclosed ". . . it could disrupt the one intervention that might prevent the violence."

Some therapists feel they are being asked to become "gatekeepers" for the criminal justice system and ask, "When does a healer become the informer?"

Klein maintains that, given the difficulty of prediction, reporting threats will invariably lead to unnecessary disclosures. But, he adds, "It might be that if one in a hundred patients commits a violent act, maybe that's sufficient reason to breach confidence with the other 99."

The liability statutes generally provide immunity to therapists who disclose confidential information in order to comply with the duty-to-warn requirements. In addition, the Minne-

Photo: Tom Gardner

"This doesn't r[illegible] aren't moral or ethical is[illegible] Therapists aren't preclu[illegible] on their good judgment. The key is that they do so in good faith."

Groff

sota law allows optional disclosure to warn against a patient's violent behavior even when the duty-to-warn conditions are not met, as long as the therapist acts in "good faith."

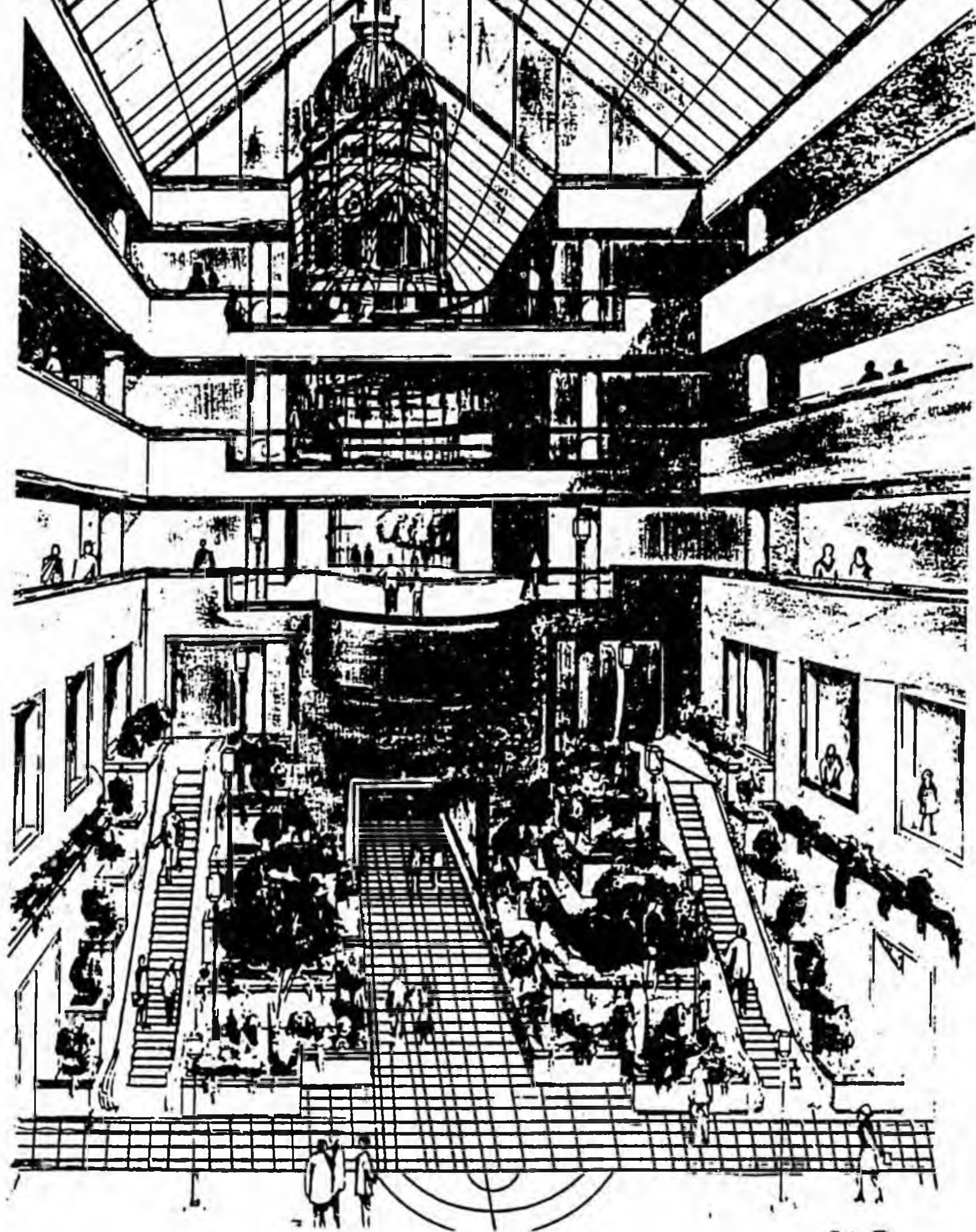
Although Klein says that sex between therapist and patient continues to be the biggest single liability problem facing mental health professionals as a group, responsibility for a patient's violent behavior is the new area of greatest concern. Recent legislative actions indicate it will continue to be an issue in state capitols. Klein agrees there is ample room for tort reform, but cautions that there will continue to be homicides by mental patients. "And when there are, we're going to see lawsuits," he says.

Groff stresses the importance of providing community resources to treat mentally ill persons. "We give community programs the responsibility, but not the adequate resources to treat the mentally ill," she says. "We, as legislators, have to take responsibility too."

STATE LEGISLATURES

February 1988

The National Conference of State Legislatures



SUITS AGAINST MENTAL HEALTH CARE PROVIDERS FOR THE VIOLENT ACTS OF PATIENTS

CASE	STATE	COURT[a]		JUDGMENT[b]			INJURY	SETTING	FINAL DISPOSITION
		State	Fed.	Trial Ct.	1st App.	2nd App.			
Kendrick v. United States, 82 F. Supp. 430 (N.D. Ala. 1949)	AL		X	D			Murder	V.A. Hospital	Governmental Immunity
Smart v. United States, 207 F.2d 841 (10th Cir. 1953	IN		X	D	D		Injury from vehicular accident	V.A. Hospital	Governmental Immunity
Schwenk v. State, 129 N.Y.S. 2d 92 (Ct. Cl. 1953)	NY	X		D			Murder	State Hospital	Negligence/Case Not Proven
St. George v. State 124 N.E.2d 320 (NY 1954)	NY	X		P	D	D	Murder/Assault	State Hospital	Government Immunity
Fair v. United States, 234 F.2d 288 (5th Cir. 1956)	TX		X	D	P		Murder	Military	Nonfinal for P (upheld action)
Taig v. State, 251 N.Y.S.2d 495 (1963)	NY	X		D	D		Assault	State Hospital	Government Immunity
Milone v. State, 253 N.Y.S. 2d 662 (Ct. Cl. 1964)	NY	X		D			Murder/Sexual Assault	State Hospital	Negligence/Case Not Proven
Peters v. State, 267 N.Y.S. 2d 811 (Ct. Cl. 1964	NY	X		P	P		Assault	State Hospital	Nonfinal for P
Higgins v. State, 265 N.Y.S. 2d 254 (1965)	NY			P	D		Assault	State Hospital	Governmental Immunity
Underwood v. United States, 356 F.2d 92 (5th Cir. 1966)	AL		X	D	P		Murder	Military Hospital	Recovery Not Specified
Merchants Nat. Bank & Trust Co. of Fargo v. United States, 272 F. Supp. 409 (D.N.D. 1967)	SD		X	P			Murder	V.A. Hospital	$200,000 for P
Hemps v. United States, 407 F.2d 823 (4th Cir. 1969)	VA		X	D	D		Assault	V.A. Hospital	Negligence/Case Not Proven
Kravitz v. State, 87 Cal. Rptr. 352 (1970)	CA	X		D	D		Murder	State Hospital	Govt. Immunity Neg./Case Not Proven
Hernandez v. State of California, 90 Cal. Rptr. 205 (1970)	CA	X		D	D		Murder	State Hospital	Governmental Immunity
Greenberg v. Barbour, 322 F. Supp. 745 (E.D.Pa. 1971)	PA		X	P			Assault	State Hospital	Nonfinal for P (upheld action)
Orman v. State, 324 N.Y.S. 2d 958 (1971)	NY	X		D	D	D	Assault	State Hospital	Negligence/Case Not

.850806

CASE	STATE	COURT[a]		JUDGMENT[b]			INJURY	SETTING	FINAL DISPOSITION
		State	Fed.	Trial Ct.	1st App.	2nd App.			
Lewandowski v. State, 318 N.Y.S.2d 83 (Ct. Cl. 1971)	NY	X		D			Injury from vehicular accident	State Hospital	No Cause of Action
Cameron v. State, 331 N.Y.S. 2d 30 (1972)	NY	X		P	D	D	Assault	State Hospital	Negligence/Case Not Proven
Hicks v. United States, 511 F.2d 407 (D.C.Cir. 1975)	DC		X	P	P		Murder	Federal Hospital	$100,000 for P
Homere v. State, 370 N.Y.S. 2d 246 (1975)	NY	X		P	P		Assault	State Hospital	Recovery Not Specified
Heifetz v. Philadelphia State Hospital, 348 A.2d 455 (Pa. 1975)	PA	X		D			Sexual Assault	State Hospital	Governmental Immunity
Johnson v. United States, 409 F. Supp. 1283 (S.D.Cal. 1976)	CA		X	D			Murder/Assault	Military Hospital	Negligence/Case Not Proven
Semler v. Psychiatric Institute, 538 F.2d 121 (4th Cir. 1976)	VA		X	P	P	P	Murder	Private Hospital	$25,000 for P
Tarasoff v. Regents of the University of California, 118 Cal. Rptr. 129 (1974); 131 Cal. Rptr. 14 (1976)	CA	X		D	D	P	Murder	State Clinic	Nonfinal for P (uphold action)
French v. Commonwealth, 370 A.2d 1163 (Pa. 1977).	PA	X		D	P		Murder	State Hospital	Nonfinal for P (uphold action)
Williams v. United States, 450 F. Supp. 1040 (D.S.D. 1978)	SD		X	P			Murder	V.A. Hospital	V.A. Liable, Recovery not Specified
Department of Health and Rehabilitative Services v. McDougall, 359 So. 2d 528 (Fla. App.)	FL	X		P			Murder	Private Hospital	70,000 for P
McIntosh v. Milano, 403 A.2d 500 (N.J. Super. Ct. Law Div. 1979)	NJ	X		P			Murder	Patient	Nonfinal for P (uphold action)
Lipari v. Sears, Roebuck & Co., 497 F. Supp. 185 (D.Neb. 1980)	NE		X	P			Murder/Assault	V.A. Hospital	Nonfinal for P (uphold action)
Shaw v. Glickman, 415 A.2d 625 (Md. App. 1980)	MD	X		D	D		Assault	Outpatient Clinic	No Cause of Action

CASE	STATE	COURT[a]		JUDGMENT[b]			INJURY	SETTING	FINAL DISPOSITION
		State	Fed.	Trial Ct.	1st App.	2nd App.			
Thompson v. Alameda, 614 P.2d 728 (Cal. 1980)	CA	X				P	Murder/Sexual Assault	County Institution	Action Dismissed
Mathos v. Ireland, 419 N.E. 2d 782 (Ind. App. 1981)	IN	X		D	P		Murder	Outpatient Clinic	Nonfinal for P (uphold action)
Case v. United States, 523 F. Supp. 317 (S.D. Ohio 1981)	OH		X	D			Murder	V.A. Mental Health Clinic	No liability--murder 14 mos. after treatment
Leedy v. Hartnett, 510 F. Supp. 1125 (M.D. Pa. 1981)	PA		X	D	D		Assault	V.A. Hospital	Victim had frequent contact w/pt.
Mensonal v. United States, 541 F. Supp. 999 (D. Md. 1982)	MD		X	D			Vehicular Injuries	V.A. Outpatient Clinic	No duty or ability to control Pt.
Cairl v. State, 323 N.W.2d 20 (Minn. 1982)	MN	X		D	D	D	Murder/Assault	State Hospital	Victim had frequent contact w/pt.
Doyle v. United States, 530 F. Supp. 1278 (C.D. Cal. 1982)	CA		X	D			Murder	Patient	Victim not identifiable
Matter of Estate of Votteler, 327 N.W.2d 759 (Iowa 1982)	YA	X				D	Assault	Patient	Victim had knowledge of threats
Bradley Ctr. v. Wessner, 250 Ga. 199 (1982)	GA	X		P			Murder(s)	Private Hospital	Hospital may be held liable
Davis v. Lhim, 335 N.W.2d 481 (Mich. App. 1983)	MI	X		P	P		Murder	State Hospital	Duty owed to foreseeable victims/ $500,000
Chrite v. United States, 564 F. Supp. 341 (E.D. Mich. 1983)	MI		X	P			Murder	V.A. Outpatient	Nonfinal (action uphold)
Jablonski v. United States, 712 F. 2d 391 (9th Cir. 1983)	CA		X	P	P		Murder	V.A. Outpatient	Therapist should have known
Brady v. Hopper, 570 F. Supp. 1333 (D. Col. 1983)	CO		X	D			Injuries to Bystanders by Hinkley	Private Outpatient	Action Dismissed
Hedlund v. Superior Court, 669 P.2d 41 (Cal. 1983)	CA	X		P	P		Murder	Private Outpatient	3rd party could also reach

CASE	STATE	COURT[a]		JUDGMENT[b]			INJURY	SETTING	FINAL DISPOSITION
		State	Fed.	Trial Ct.	1st App.	2nd App.			
Petersen v. State, 671 P.2d 230 (Wash. 1983)	WA	X		P	P		Vehicular injury	State Hospital	Duty owed to all foreseeable victims
Durflinger v. Artiles, 673 P.2d 86 (Kan. 1983)	KS	X		P	P		Murder	State Hospital	Duty owed to all foreseeable victims
Sherrill v. Wilson, 653 S.W.2d 661 (Mo. 1983)	MO	X			D		Murder	State Hospital	No duty owed general public
Furr v. Spring Grove State 454 A.2d 414 (Md. App. 1983)	MD	X			D		Murder/Sexual Assault	State Hospital	Action dismissed
Beck v. Kansas University Psychiatry Foundation, 580 F. Supp. 527 (D. Kan. 1984)	KS		X	P			Murders (2)	State Penitentiary	Nonfinal (action upheld)
Sharpe v. South Carolina Dept. of Mental Health, 315 S.E.2d 112 (S.C. 1984)	SC	X			P		Murder	State Hospital	Nonfinal (action upheld)

[a] Indicates whether action was brought in state or federal court.

[b] Indicates which party prevailed and whether lower court decision was appealed.
P = Decision for Plaintiff
D = Decision for Defendant

THE PRECEDING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

SB
495

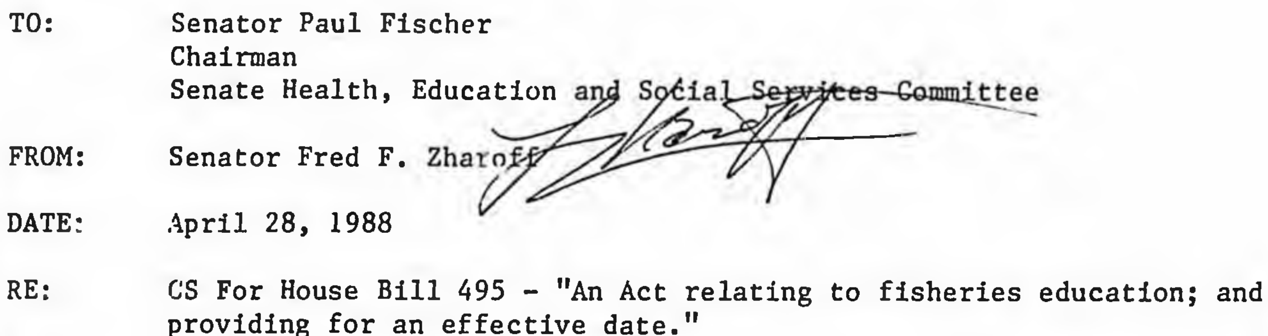
SENATOR FRED F. ZHAROFF
ALASKA STATE LEGISLATURE

P.O. BOX 405, KODIAK, ALASKA 99615 (907) 486-5259
DURING SESSION:
P.O. BOX V, JUNEAU, ALASKA 99811 • (907) 465-3473 • 465-3474

DISTRICT N

ALASKA PENINSULA • ALEUTIAN CHAIN • BRISTOL BAY • KODIAK ISLAND • LAKE CLARK/LAKE ILIAMNA • PRIBILOF ISLANDS • SHUMAGIN ISLANDS

MEMORANDUM



TO: Senator Paul Fischer
Chairman
Senate Health, Education and Social Services Committee

FROM: Senator Fred F. Zharoff

DATE: April 28, 1988

RE: CS For House Bill 495 - "An Act relating to fisheries education; and providing for an effective date."

I respectfully request that CSHB 495 be scheduled for a hearing at the committee's earliest convenience.

CSHB 495 would allow a school board to establish a fisheries education program in elementary, secondary, vocational and community schools in its district or regional educational attendance area. The program would include instruction related to the importance to the state of the commercial fishing and seafood processing industry, opportunities for jobs or careers in the industry, and skills relevant to employment in the industry. The Department of Education would develop and implement model fisheries education programs and instructional materials, and encourage and assist school districts in developing the programs.

The bill also would establish a Fisheries Education Fund in the Department of Education. This fund would consist of appropriations, federal funds, private grants, endowments, and contributions. In making grants from the fund, the department would consider programs that are designed to assist in the economic development of the attendance area served by the applicant, and give priority to programs in elementary and secondary schools. In addition, the department would be required to report to the governor and the legislature on a summary of its activities during the preceding calendar year.

Backup information for the bill is attached, as follows:

1. Department of Education fiscal note.

2. Letter of support from the University of Alaska Cooperative Extension Service.

3. Resolution supporting fisheries education from the Southwest Alaska Municipal Conference.

4. Letter of support from the Bristol Bay Borough School District.

5. Letter of support from Cordova Public Schools.

6. Brochure about Cordova Public Schools' Commercial Fisheries Apprenticeship Program.

7. Report on "Alaskan Youth Preparing for a Fishing Future in Alaska", Commercial Fisheries Apprenticeship Program, Cordova. The Cordova program is an example of the type of program that would benefit from CSHB 495 and that could be duplicated in other school districts.

8. "Renewable Natural Resources/Agriculture Curriculum" for secondary and postsecondary education, developed by the Department of Education.

9. Report on "Education and Training as a Solution to the Problem of Alaska Hire in the Alaska Seafood Industry", by A.W. Hall.