

IN THE SUPREME COURT OF PENNSYLVANIA
EASTERN DISTRICT

RONALD B. EMERICH, Administrator
of the Estate of Teresa M. Hausler,

Appellant

v.

PHILADELPHIA CENTER FOR HUMAN DEVELOPMENT, INC.,
and ALBERT EINSTEIN MEDICAL CENTER,

Appellees

RONALD B. EMERICH, Administrator
of the Estate of Teresa M. Hausler,

Appellant

v.

PHILADELPHIA CENTER FOR HUMAN DEVELOPMENT, INC.,
ALBERT EINSTEIN HEALTHCARE FOUNDATION,
ALBERT EINSTEIN MEDICAL CENTER,
HARVEY FRIEDRICH, ACSW,
ANTHONY J. SCUDERI, M.DIV., CAC, and
HACAN ULUS, Administratrix of the ESTATE of AHMET ULUS, M.D.,

Appellees

E.D. Allocatur Docket 1996
No. 145

BRIEF FOR *AMICI CURIAE*
American Psychological Association and the
Pennsylvania Psychological Association
In Support Of Appellees

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TABLE OF CONTENTS

INTEREST OF AMICI	1
INTRODUCTION AND SUMMARY OF ARGUMENT	2
ARGUMENT	5
I. THERE IS NO SOUND BASIS FOR IMPOSING A UNIQUE DUTY TO WARN ON MENTAL HEALTH WORKERS	5
A. No Other Person in the Same or Similar Position Is Charged With This Legal Duty or Subject to Litigation and Potential Liability	7
B. Mental Health Workers Are Not in a Better Position to Protect Third Parties Than Others	15
1. <i>Mental health workers have no special ability to predict who will commit a violent act</i>	15
2. <i>Mental health workers have no special means to control dangerous people</i>	22
C. Imposing a Duty to Warn On Therapists Cannot Be Expected to Increase Public Safety	24
1. <i>A duty to warn has not been shown to reduce violence</i>	24
2. <i>Imposing a Duty to Warn Disserves the Broader Public Safety Goals</i>	28
II. A DUTY TO WARN, IF IMPOSED, SHOULD BE FASHIONED IN THE MANNER LEAST DESTRUCTIVE TO PUBLIC SAFETY AND THE CONTINUING AVAILABILITY OF EFFECTIVE PSYCHOTHERAPY	32
A. Circumstances Under Which The Duty Arises	32
1. <i>Specific threat to identified or reasonably identifiable victim</i>	32
2. <i>Imminent threat of serious bodily injury or death</i>	33
B. Applicable Standard of Care	34
CONCLUSION	38

TABLE OF AUTHORITIES

CASES

<u>Ake v. Oklahoma</u> , 470 U.S. 68 (1985)	15
<u>Baxstrom v. Herald</u> , 383 U.S. 107 (1966)	16
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Ariz. Rev. Stat. Ann. § 36-517.02 (West 1996)	33
Cal. Civ. Code § 43.92(a) (West 1996)	33
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La. Code Civ. Ann. § 9:2800.2 (West 1996)	33
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Mich. Comp. Laws Ann., § 330.1946(1) (West)	33
Minn. Stat. Ann. § 148.975(subd. 2) (West 1996)	33
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Tenn. Code Ann. § 33-10-302(a) (1989)	33
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**BRIEF FOR AMICI CURIAE
AMERICAN PSYCHOLOGICAL ASSOCIATION AND
THE PENNSYLVANIA PSYCHOLOGICAL ASSOCIATION**

INTEREST OF AMICI

The American Psychological Association is a voluntary nonprofit, scientific and professional organization and has been the major professional association of psychologists in the United States since 1892. With a membership of more than 140,000, it represents the vast majority of psychologists holding doctoral degrees from accredited universities in this country. Its members in clinical practice treat hundreds of thousands of patients. The Pennsylvania Psychological Association is a voluntary, nonprofit, professional association of psychologists in Pennsylvania since 1933. With a membership of almost 3,000, it represents the majority of professional psychologists in Pennsylvania. The American Psychological Association and the Pennsylvania Psychological Association believe that this Court's decision whether to impose a duty to warn a third party on mental health workers, and the scope of any such duty, should consider the effects of such a duty on both public safety and mental health care and the present state of scientific knowledge with respect to the accuracy of assessments of future dangerousness and the consequences of legally-mandated warnings to third parties.

INTRODUCTION AND SUMMARY OF ARGUMENT

The goal of public safety would not be well-served by imposing a unique duty to warn on mental health workers. Indeed, such a duty raises concerns because of its potential to do more harm than good. In a typical duty of care question -- for example, whether a landlord owes a duty to place railings and bright lights on an outside stair -- the interests to be balanced are public safety versus the monetary expense of providing additional protections. Here, in contrast, public safety may be threatened as much or more by imposing the duty at issue than by declining to impose it. There is, for example, no evidence that imposition of a duty to warn on therapists will decrease the incidence of violence at all. Indeed, in some instances, such warnings have precipitated violence. On the other hand, requiring therapists to breach confidentiality not only intrudes upon patients' privacy, it risks the potential benefits of therapy in stabilizing those who have some violent impulses or fantasies and integrating them safely into society.

Tarasoff^{1/} and its progeny were understandably motivated by the tragedy of Ms. Tarasoff's death, by fear induced by the growing incidence of violence in this country in the early 1970s, and by fear of the growing number of mentally disordered people suddenly living outside of

^{1/} Tarasoff v. Regents of The University of California, 13 Cal. 3d 177, 529 P.2d 553 (1974), vacated, 17 Cal 3d 425, 551 P.2d 334 (1976).

institutions as a result of constitutional challenges and changing policies. With the advantage of time, it is now clear that the means adopted were ill-suited to the task as a practical matter, and at odds with the surrounding law as a matter of jurisprudence. Fortunately, it is also clear that, although the incidence of violence in this country remains an agonizing concern, the specific ill at which Tarasoff was aimed is a very rare event.

Thus, twenty years after Tarasoff first imposed such a duty on mental health workers, the rule remains a minority position. The majority of states have not adopted the rule, either as common law interpretation or through legislation.^{2/} Where the question has arisen, as here, in the context of mental health services to an outpatient, the lack of consensus is particularly evident.^{3/}

^{2/} P. Lake, Virginia Is Not Safe for "Lovers", 61 Brook. L. Rev. 1285, 1285 n.3 (1995). The rule Tarasoff ultimately imposed was a duty to protect as opposed to a duty to warn. See Tarasoff II, 17 Cal 3d 425, 551 P.2d 334. The precise contours of that duty were not defined. California has since provided that the duty is discharged by warning the victim and the police. Cal. Civ. Code § 43.92(b) (West 1996). Some states which have followed Tarasoff, either by judicial decision or legislation, have similarly imposed a duty to protect, and others have imposed a duty to warn either the potential victim or police, or both. Because this Court has limited the question as to what duty is owed to the question whether a mental health worker has a duty to warn, this brief focuses on the implications for public safety and public health of a duty to warn.

^{3/} See, e.g., Fraser v. United States, 236 Conn. 625, 674 A.2d 811, 814 (1995) ("We have no compelling precedents on which to draw, and courts in other jurisdictions have not arrived at a consensus.").

Increasingly, states have either narrowed the Tarasoff rule, or rejected it outright. See, e.g., Nasser v. Parker, 249 Va. 172, 455 S.E.2d 502 (1995) (rejecting Tarasoff's legal reasoning and finding no common law duty because therapists have no control over voluntary patients such as would create a duty toward third persons); Boynton v. Burglass, 590 So. 2d 445 (Fla. Dist. Ct. App. 1991) (en banc) (rejecting Tarasoff rule); Ohio Rev. Code Ann. § 5122.34 (1996) ("No person shall be liable for any harm that results to any other person as a result of failing to disclose any confidential information about a mental health client, or failing to otherwise attempt to protect such other person from harm by such client."). Significantly, although Tarasoff initiated discussions in other countries such as England, Canada and Australia, no other nation appears to have adopted such a rule, either by judicial decision or statute.^{4/}

The American Psychological Association and the Pennsylvania Psychological Association urge this Court to reject the invitation to depart from the general tort rule^{5/} to impose a unique legal duty on mental health workers. Pennsylvania does not impose such a duty on others in as good, or better, a position to learn of threats of violence

^{4/} S.A. Anfang and P.S. Appelbaum, Twenty Years after Tarasoff: Reviewing the Duty to Protect, 4 Harv. Rev. Psychiatry 67, 71 (1996).

^{5/} See, e.g., Restatement (Second) of Torts § 298 (1965) (imposing a duty to act in a manner that does not create an unreasonable risk of harm to another).

and warn the people at risk. Rather, the rule here is that those involved in a confidential relationship with a person issuing violent threats are permitted, in their discretion, to breach confidentiality if apparently necessary to avert the threatened tragedy. Those not bound by confidentiality are free to warn or not, for any reason.

Amici support a rule that would provide mental health workers with the same discretion with respect to warnings as is enjoyed in Pennsylvania by other professionals and by non-professionals. If this Court instead determines to impose a duty to warn on mental health workers, amici urge the Court to carefully delimit the circumstances under which the duty would arise, and to adopt a professional judgment rule as the applicable standard.

ARGUMENT

I. THERE IS NO SOUND BASIS FOR IMPOSING A UNIQUE DUTY TO WARN ON MENTAL HEALTH WORKERS.

Pennsylvania, in keeping with every other state, does not impose a general duty to warn third parties of verbal threats to harm them.^{6/} The duty imposed is the duty to avoid creating danger for others. There is no general duty to prevent someone else from endangering others.

^{6/} See, e.g., Restatement (Second) of Torts § 314 (1965) ("The fact that the actor realizes or should realize that action on his part is necessary for another's aid or protection does not of itself impose upon him a duty to take such action.").

The recognized bases for departing from this well-established rule are not present here. This Court has discussed the factors to be considered in determining whether a duty is owed: "[t]he hand of history, our ideas of morals and justice, the convenience of administration of the rule, and our social ideas as to where the loss should fall."^{7/} "The hand of history" counsels against imposing a duty to warn. Until 20 years ago, no such duty was recognized, and no such duty is yet recognized by the majority of jurisdictions. Society's "ideas of morals and justice" do not support the imposition of such a rule. Far from bearing moral blame for the violent acts of disturbed patients, therapists who treat potentially violent patients are dedicating their professional lives to averting such acts, sometimes at considerable risk to their own safety.

Further, the rule this Court is invited to adopt does not reflect a reasoned view of "where the loss should fall"; nor is it convenient to administer. Therapists are not uniquely in a position to avoid the particular harm at issue here, because they do not uniquely have access to either the information or the means that are asserted necessary to avoid it, Pt. I.A. The rule is not convenient to administer because therapists have no methods that reliably predict which of the many verbal threats expressed in therapy will be acted upon, Pt. I.B. Finally, experience

^{7/} Gardner by Gardner v. Consolidated Rail Corp., 524 Pa. 445, 454-55, 573 A.2d 1016, 1020 (1990) (explaining bases for determining the existence of a duty) (quoting Dean Prosser).

and research indicate that imposition of this duty is unlikely to serve the public by reducing the overall incidence of violence, and may well have the opposite effect, Pt. I.C. Thus, the "sum total of those considerations of policy" which lead the law to impose a duty^{8/} counsel against imposing a new duty uniquely on mental health workers here.^{9/}

A. No Other Person in the Same or Similar Position Is Charged With This Legal Duty or Subject to Litigation and Potential Liability.

A duty to warn imposed on mental health workers would be an anomaly in the law in Pennsylvania and place mental health workers at risk of incurring liability that is not imposed on anyone else in the same or similar position. Friends, family members, and co-workers of a mentally disordered person -- or of any person -- who makes violent threats against another are under no obligation to warn the potential victim or to take any other action to prevent the threatened act. No duty has been found even though friends,

^{8/} Id.

^{9/} The alternative policy foundation sometimes asserted to justify tort rules -- designation of a deep pocket -- cannot justify the rule at issue here. Victims of violent crimes committed by mental health patients are not differently situated from victims of violent crimes committed by non-patients. Nor are the great majority of violent crimes committed by mental health patients. If the policy goal is indeed adequate compensation, a far more sensible policy for the state would be to develop an overall victim compensation plan. Imposing a special liability on therapists for the comparatively rare violence inflicted by a patient simply creates random windfalls for relatives of the unfortunate victims -- to which the relatives of the vast majority of innocent victims are apparently not entitled.

family members, and/or co-workers may be in an as likely, or better, position to know relevant facts, such as whether the person voicing the threat has been dwelling on real or imagined grievances, whether he has previously committed violent acts, whether he abuses alcohol or drugs, whether he has access to a weapon, and more.

Further, there is no duty even though friends, family members, and co-workers are as capable of warning threatened victims as is a therapist, and may already know where to find them. Friends and family members are also capable of initiating involuntary commitment proceedings, see 50 Pa. Cons. Stat. § 4404(a) (1969 and 1996 Supp.). In addition, because Pennsylvania law permits any government or private health or welfare organization to apply for commitment in the interest of any person in need of such care, any concerned person can determine whether commitment is an available remedy by contacting such an organization.

No duty to warn is imposed on other professionals in a confidential relationship when presented with such threats. For example, a lawyer whose client threatens violence toward a third party is permitted the discretion to warn that third party, but is not obligated to do so, and will not be found liable if he chooses another course. Rule 1.6(c)(1) of the Pennsylvania Rules of Professional Conduct expressly provides: "A lawyer may reveal such information to the extent that the lawyer reasonably believes necessary . . . to prevent the client from committing a criminal act that

the lawyer believes is likely to result in death or substantial bodily harm"

The accompanying commentary then makes clear that lawyers are under a duty only to consider whether to disclose this information; they are under no duty to warn or to take other preventive actions. See 47 Pa. Cons. Stat. RPC Rule 1.6 (comment). Significantly, the state's basis for the rule applicable to lawyers is that: "It is very difficult for a lawyer to 'know' that a client will carry out such an intent, for the client may have a change of mind. The Rule must be based on the lawyer's discretion." Id.

Given the state's clear policy with respect to lawyers, it is difficult to understand what policy considerations warrant a different rule for therapists. Therapists as a group are far less likely than criminal lawyers to encounter clients likely to commit a violent act. Research on the relationship between even major mental illness and violence indicates that the vast majority, as much as 90 percent, of those who are currently disordered are not violent.^{10/} Although recent research indicates that those with major mental illnesses are modestly more likely to be violent than the general population, "mental health status

^{10/} J. Monahan, Mental Disorder and Violent Behavior, 47 Am. Psychologist 511 (1992). Studies such as this and others cited in this brief that have been published in scientific journals are typically subject to rigorous examination and peer review prior to publication. Acceptance in a peer review journal is a means by which the research is judged as having been properly conducted and otherwise meeting scientifically acceptable standards.

makes at best a trivial contribution to the overall level of violence in society."^{11/} Indeed, "people with mental illness are more likely to be victims than perpetrators of violence."^{12/} In comparison, the contribution to the overall level of violence in society made by the clientele of the criminal bar is significant.

Lawyers are also as likely as therapists, if not more likely, to be aware of relevant facts with which to evaluate the seriousness of a threat. Criminal lawyers in particular will know whether their clients have been arrested or convicted of violent acts in the past and/or whether they are currently accused of committing a violent crime. Such lawyers will certainly know whether their clients were abusing alcohol or drugs or carrying a weapon when arrested, and are likely to know whether they own a gun, regularly abuse alcohol or drugs, and a great deal more.

Similarly, lawyers are as able as therapists to provide a warning to the potential victim or to initiate

^{11/} Id. at 519. "The answer provided by this research depends on the question put to it. If the question is, 'Is there any relationship between major mental illness and the commission of violent behavior to others?' the answer provided by current research is, 'Yes.' But if the question is, 'Is there a strong relationship between major mental illness and the commission of violence to others?' the answer to emerge from recent studies is equally clear, 'No.'" J. Monahan and J. Arnold, Violence by People with Mental Illness, 19 Psychiatric Rehabilitation Journal 67, 69 (1996).

^{12/} Mental Illness and Violent Crime, National Institute of Justice Research Preview (Oct. 1996) (summary of presentation by John Monahan, Ph.D., U. of Va. School of Law). Moreover, relatively few patients with respect to whom a duty to warn issue is raised -- outpatients -- are even diagnosed as having a major mental illness.

commitment proceedings, if appropriate, by alerting an appropriate government or private agency. Under current Pennsylvania law, therapists and lawyers are treated similarly.^{13/} Imposing a duty to warn on therapists, however, would generate an inconsistency in the law not based on genuine differences in the respective positions of the members of the two professions with respect to the risks and remedies at issue.

In jurisdictions where such a duty has been recognized, it has led to further anomalies because of the state's immunity rules. For example, in Tarasoff, both the murderer's therapist and the police knew about the threats and the identity of the potential victim. Both had the ability to warn and the ability to detain. The police had, in fact, taken the man into custody and spoken to him about his threats, then let him go. Further, the police failed to initiate the civil commitment that the therapist had requested. Yet, the police, although in at least an equal position to prevent the tragedy -- arguably a better position to investigate the whereabouts of a potential victim and protect that person -- were shielded by the immunity laws. The therapist alone was subject to potential liability.

^{13/} See, e.g., 42 Pa. Cons. Stat. Ann. § 5944 (West 1996) (providing that "[t]he confidential relations and communications between a psychologist or psychiatrist and his client shall be on the same basis as those provided or prescribed by law between an attorney and client"); 49 Pa. Code § 41.61(5)(b)(1) (1996) (permitting mental health workers, in their discretion, to disclose confidences if necessary to protect others).

If this Court were to impose such a duty on therapists, similar anomalies would be generated. Pennsylvania courts have held that police who know, or should know, that people are at risk are not specially obligated to warn or protect them unless the police voluntarily undertake to do so.^{14/} Although amici are not aware of any decision in this state addressing whether the police would incur liability for failing to warn under Tarasoff-type circumstances, the caselaw appears to preclude it.

Many mental health workers are also immune from liability absent willful misconduct or gross negligence for discharging, treating, denying an application for voluntary or involuntary care, or reducing the restraints on a mental health patient.^{15/} With respect to decisions regarding voluntary outpatients, to which the mental health statute is not applicable, state-employed therapists, but not private, appear to enjoy at least conditional immunity.^{16/}

^{14/} See, e.g., Melendez v. City of Philadelphia, 320 Pa. Super. 59, 65, 466 A.2d 1060, 1064 (1983) (plaintiff must demonstrate that the police department voluntarily assumed, in light of [its] knowledge of an individual's potential for particular harm', to protect the individual from the precise harm which was occasioned.) See also, Morris v. Musser, 84 Pa. Comm. 170, 478 A.2d 937 (1984) (police have no duty to protect an individual member of the public in the absence of a specific promise to do so).

^{15/} See 50 Pa. Cons. Stat. Ann. § 7114(a) (West 1996).

^{16/} See, 42 Pa. Cons. Stat. Ann. § 8524 (West 1996); see also Heifetz v. Philadelphia State Hospital, 22 Pa. Comm. 325, 348 A.2d 455 (Comm. Ct. of Pa. 1975), rev'd on other grounds, 482 Pa. 386, 393 A.2d 1160 (1978).

Appellants' reliance on the duty to prevent the spread of contagious diseases to establish the consistency of a duty to warn or protect here is misplaced. Contagious diseases as a category are quite different from the type of threat at issue here. Few disclosures of contagious disease risk the potentially debilitating backlash posed by a warning that someone is mentally ill and probably violent.

In contrast, the closest analogy from the field of contagious disease to the duty at issue here would be a duty to warn that someone is HIV-positive, in terms of potential repercussions from employers, friends, and even family. Significantly, for this situation, Pennsylvania has rejected the background rule applicable to most contagious diseases -- i.e., the duty to prevent spread of the disease -- and has instead carefully fashioned a separate rule to balance the interests of both the HIV-positive patient and third parties under these circumstances.

A physician may disclose that a patient is HIV-positive to a known contact of that patient if the physician reasonably believes that the patient poses a significant risk of infection to that contact and will not provide the warning himself. See 35 Pa. Cons. Stat. Ann. § 7609 (West 1996). Disclosure is at the discretion of the physician; no duty is imposed. According to a recent court opinion, no court has found a common law duty to inform an at-risk third party of a

patient's HIV status.^{17/} Furthermore, mental health workers are not even permitted to warn if an HIV-positive patient threatens purposefully to infect others -- absent a specific court order. See id. § 7607.

This state's policy decision to grant physicians the discretion to disclose a patient's HIV status without imposing an affirmative duty -- even though all HIV-positive patients are contagious -- argues strongly against imposition of an affirmative duty on therapists -- only a few of whose patients who express violent impulses actually pose a danger of carrying them out.^{18/} The one rule consistent with this state's policies, statutes, and decisions would be a rule providing, or merely clarifying, that therapists have discretion to disclose a patient's violent threats to protect potential victims -- as do family members, friends, co-workers, and lawyers -- but are not subject to a legal duty and to potential liability imposed on no one else.^{19/}

^{17/} Lemon v. Stewart, 1996 WL 544394 (Md. Ct. Spec. App. 1996).

^{18/} Even Tarasoff recognized that few of the violent threats made during therapy are ever executed. Tarasoff, 17 Cal. 3d at 441, 551 P.2d at 327.

^{19/} Although such discretion appears to be consistent with Pennsylvania's Code of Ethics for Licensed Psychologists, see 49 Pa. Code § 41.61 (5)(b)(1) (West 1996), there remains uncertainty under decisions of the lower courts. See, e.g., Hopewell v Adibempe, No. GD 78-28756, slip op. (Court of Common Pleas, Allegheny County, Pa., June 1981) (psychiatrist found liable for warning personnel director at patient's employer that patient had made violent threats focused on co-workers).

B. **Mental Health Workers Are Not in a Better Position to Protect Third Parties Than Others.**

Public safety considerations cannot justify imposing a duty on therapists that is not imposed on others, because therapists are not in a better position than others to determine which people are dangerous, or to avert that danger.

1. *Mental health workers have no special ability to predict who will commit a violent act.*

Despite concentrated research in this area for the 20 years since Tarasoff was decided, and before, the ability of mental health workers to assess dangerousness is well below a threshold that would justify the imposition of liability.^{20/} Moreover, the one approach that appears most promising as a prediction technique -- the use of actuarial factors -- is no more available to mental health workers than to a patient's family members, friends, co-workers, the police, and others.

Studies of the accuracy of predictions of violence in the 1960s and 1970s indicated that mental health workers failed to forecast future violence accurately in

^{20/} See, e.g., Ake v. Oklahoma, 470 U.S. 68, 85 (1985) ("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.").

approximately two out of three cases.^{21/} Because mental health workers lack the types of instruments physicians use to diagnose physical illness, they invariably overpredict. When those predictions were tested, the results were startling. For example, in New York State, psychiatrists had judged 969 people so dangerous that they were consigned to maximum security hospitals run by the Department of Corrections. That decision was successfully challenged in court, see Baxstrom v. Herald, 383 U.S. 107 (1966), and the 969 were sent to civil hospitals. Despite the earlier assessments that they were all highly dangerous, after one year only seven had committed or even threatened to commit violence so as to be transferred to a Department of Corrections hospital. A representative sample of 246 of the original 969 was then followed for four years. Of these 246 people, all judged earlier to be highly dangerous, only five had been transferred to an institution for the criminally

^{21/} See J. Monahan, The Clinical Prediction of Violent Behavior (1981); H. Kozol, R. Boucher, & R. Garofalo, The Diagnosis and Treatment of Dangerousness, 18, 371 (1972) (of those identified as likely to commit a violent act, only one-third had done so even five years later); Report of the American Psychological Association Task Force on the Role of Psychology in the Criminal Justice System, 33 Am. Psychology 1099 (1978). See also American Psychiatric Association Task Force Report, Clinical Aspects of the Violent Individual, 28 (1974) (90 percent error rate "unfortunately . . . is the state of the art"); D. Faust & J. Ziskin, The Expert Witness in Psychiatry and Psychology, 241 Science 31 (1988) (discussing the large body of research indicating that mental health workers' ability to predict violence in individual cases is severely limited).

insane after four years, and only nine had been convicted of crimes (of which only two were felonies).^{22/}

In addition, studies showed that mental health workers also underpredict violence in patients who do present a serious threat at the same time that they overpredict violence for patients who do not. Almost consistently in studies of clinical assessments of dangerousness, mental health workers failed to identify approximately a third of those patients who are, in fact, dangerous. For example, in one study following patients for three years after discharge from the Patuxent Institution in Maryland, 31 percent of those judged not dangerous were later arrested for committing violent crimes. In addition, the mental health workers had also overpredicted violence for other patients. Of those released against staff recommendations -- that is, considered dangerous by mental health workers -- only 41 percent were later rearrested for violent crime. Thus, 60 percent of the patients assessed by the mental health staff as too dangerous to release were apparently not dangerous.^{23/}

^{22/} H.J. Steadman & G. Keveles, The Community Adjustment and Criminal Activity of the Baxstrom Patients: 1966-70, 129 Am. J. of Psychiatry 304 (1972); T.E. Gammon & J.K. Hulston, The Duty of Mental Health Care Providers to Restrain their Patients or Warn Third Parties, 60 Mo. L. Rev. 749, 771-772 & n. 116 (1995). See also D.S. Sepejak, R.J. Menzier, C.D. Webster & F.A. Jensen, Clinical Predictions of Dangerousness: Two Year Follow-up of 408 Pre-trial Forensic Cases, 11 Bull. Am. Acad. Psych. & Law 171 (1983) (two years after being rated by clinicians as having a medium or high likelihood of being dangerous to others, almost two-thirds -- 61% -- had committed no dangerous acts).

^{23/} H.J. Steadman, A New Look at Recidivism Among Patuxent Inmates, 5 Bull. Am. Acad. Psych & Law 200 (1977).

Other studies found assessments of dangerousness and non-dangerousness no more accurate than chance. In one study, 257 people who had been indicted for felonies but incompetent to stand trial were followed for three years. Of those assessed to be dangerous, 58 percent were not assaultive in the hospital. However, 36 percent of those expected to be non-dangerous were assaultive. Moreover, after release, only 14 percent of those previously designated dangerous were later arrested for violent offenses, but 16 percent of those designated non-dangerous were.^{24/}

The most recent studies, despite increasingly sophisticated methodology, have also failed to demonstrate a level of accuracy that could justify the imposition of liability. Indeed, in the study that found the highest success rate for clinical prediction, 36 percent of those judged not dangerous by mental health personnel at the acute psychiatric emergency room of a large civil hospital committed violent acts within the following six months, yet barely more than half (53 percent) of the patients judged likely to commit a violent act actually did. Moreover, the

^{24/} J. Cocozza & H.J. Steadman, The Failure of Psychiatric Predictions of Dangerousness: Clear and Convincing Evidence, 29 Rutgers Law Rev. 1084 (1976). See also P. Werner, T. Rose, J. Yesavage, & K. Seeman, Psychiatrists' Judgments of Dangerousness in Patients on an Acute Care Unit, 141 Am. J. of Psych. 263 (1984) (finding no statistically significant correlation between clinical predictions and actual violence during first week of hospitalization).

clinicians' accuracy with respect to female patients was no better than chance.^{25/}

Leading researchers in the field have begun to concentrate more on the use of actuarial factors. Characteristics such as age, gender, socioeconomic class, prior history of violence, and prior or current substance abuse correlate significantly with subsequent violent behavior by mental health patients^{26/} -- as well as by the general population. These studies, for example, find that approximately 25-30 percent of the men who are released from civil hospitals, with at least one violent incident in their past, are violent within one year of discharge.^{27/}

Nothing in this research provides support for the imposition of a duty to warn, however promising it appears for other purposes. First, none of the research has been

^{25/} C. Lidz, E.P. Mulvey & W. Gardner, The Accuracy of Predictions of Violence to Others, 269 J. Am. Med. Assn. 1007 (1993).

^{26/} See, e.g., D. Klassen and W. O'Connor, A Prospective Study of Predictors of Violence in Adult Male Mental Patients, 12 Law and Human Behavior 143 (1988). Some predictors of violence appear counter-intuitive. An earlier study by these researchers found that the more friends a released patient reported having in the community and the more time he spent with those friends, the more likely he was to commit a violent act. D. Klassen and W. O'Connor, Predicting Violence Among Ex-mental Patients (1985) (paper presented at the annual meeting of American Society of Criminology).

^{27/} J. Monahan, supra n.10, at 514. A 1990 study of 10,000 mentally disordered people, including patients who had never been hospitalized as well as those who had, demonstrated that violence is seven times as prevalent among the young as the old, twice as prevalent among men as women, three times as prevalent among people from the lowest socioeconomic class as from the highest. Id. at 516.

done with outpatients as subjects. The distinction is likely significant as outpatients, as a group, are even less likely to be dangerous than current or former inpatients, many of whom have committed at least one violent act in the past and probably all of whom have been judged at some point to have been dangerous to themselves or others.^{28/} Second, the accuracy of predictions using actuarial methods is still far below a level that would reasonably permit the imposition of a duty.^{29/}

Third, virtually none of the actuarial factors found to correlate with subsequent violence are factors particularly characteristic of the mentally ill as compared with the general population or are factors particularly known to a therapist as distinguished from the patient's friends, family members, co-workers, or others. The one factor that might possibly be viewed as an exception is the existence of active serious psychotic symptoms. Those who are currently having delusions that others wish them harm, that their minds are dominated by forces beyond their control, and that others' thoughts are being put into their heads, are more likely to be violent than the general population, including

^{28/} J. Monahan, supra n.10, at 515.

^{29/} For example, in a highly respected study of inpatients using actuarial techniques to evaluate both high and low risks of dangerousness, two of every three patients judged high risk exhibited no physically assaultive behavior (68%) but one of every five patients judged low risk were physically assaultive (18%). D.E. McNiel & R.L. Binder, Screening for Risk of Inpatient Violence, 18 Law and Human Behavior 579 (1994).

mental health patients who are not actively experiencing such psychotic symptoms.^{30/}

Even this promising research, however, does not provide a legitimate foundation for imposing a duty to warn solely on therapists. For one reason, this factor still does not yield sufficiently accurate discriminations between patients. Researchers were still only accurate in predicting subsequent assaultive behavior for 60 percent of the subjects. Forty percent, with equivalently high scores on these indicators, were not even involved in fistfights. In addition, active delusions of being possessed by a spirit or having one's mind dominated by forces beyond one's control are likely to be as noticeable to untrained friends, family members, co-workers and others as to mental health professionals.

Moreover, imposing a duty to warn on therapists on the ground that they are well situated to discover people experiencing active delusions would be wholly inconsistent in a state that imposes no duty to warn on those aware of factors that are many times better predictors of subsequent

^{30/} J. Monahan, supra. n.10, at 517; Mental Illness and Violent Crime, supra, n.12 at 2 (discussing Threat Control Override Symptoms study by Bruce Link and Ann Stueve which found also "when patients were not actively experiencing psychotic symptoms, their risk of violence was not appreciably higher than demographically similar members of their home community who had never been treated"). Outpatients, such as the murderer in the case at bar, almost invariably fall into non-suspect demographic mental health categories. An outpatient who exhibited active psychotic symptoms of this type to a mental health provider would be hospitalized.

violence, such as alcohol or drug abuse. "Compared with the magnitude of risk associated with alcoholism and other drug abuse, the risk associated with major mental disorders such as schizophrenia and affective disorder is modest indeed."^{31/} Likewise, no duty to warn is imposed on those who know that a person currently voicing violent threats has previously been arrested, a far more reliable predictor of violence than delusions.^{32/}

2. *Mental health workers
have no special means
to control dangerous people.*

Mental health workers have no greater ability to control the actions of their voluntary outpatients (or voluntary inpatients who leave the facility) than do those patients' family members, friends, or co-workers. Voluntary outpatients see therapists if they choose, decline to see therapists if they choose, take prescribed medication if they choose, and conduct their lives as they choose. The only methods of actual control available to a psychotherapist are persuasion or initiating an application for involuntary commitment -- methods which are similarly available to family members, friends, and co-workers. Likewise, the method of intervening by alerting a third party to a potential danger,

^{31/} J. Monahan, supra n.10, at 519.

^{32/} See, e.g., H.J. Steadman, D. Vanderwyst & S. Ribner, Comparing Arrest Rates of Mental Patients and Criminal Offenders, 135 Am. J. of Psychiatry 1218 (1978) ("variable most highly correlated with total subsequent arrests was a record of arrest before current mental hospitalization").

whether the threatened victim or the police, is at least as available to family members, friends, and co-workers as it is to a therapist. More effective methods of intervening are far more available to police than to therapists, as police carry weapons and are trained to avert physical violence.

The distinguishing characteristic of therapists is that they are trained and experienced with particular methods of interacting with patients designed to help their patients understand and address their problems rather than act out in destructive ways. Therapists have a range of therapeutic approaches they can attempt when patients are struggling with violent impulses. When the threats are to family members or others close to the patient, it can prove helpful to involve the potential victim in the therapy. Therapists may also increase the frequency of sessions; schedule an immediate session when informed of the patient's threatened intentions; keep the patient in that session for an extended period of time; medicate the patient or refer him to a physician for medication; initiate voluntary hospitalization; refer the patient to a partial hospitalization, residential care, or other structured program; discuss the necessity of warning the threatened victim with the patient and have the patient take the responsibility to provide the warning from the therapist's office. All of these therapeutic approaches, however, require the patient's cooperation. Furthermore, complainants in Tarasoff-type cases, including appellant,

have not challenged mental health workers for failing to take any of these steps.^{33/}

C. **Imposing a Duty to Warn On Therapists Cannot Be Expected to Increase Public Safety.**

1. *A duty to warn has not been shown to reduce violence.*

Despite the 20 years since Tarasoff was decided -- 22 years since that court's first opinion imposing a duty to warn -- and despite the imposition of a similar or broader rule in more than a dozen states, amici know of no evidence indicating that imposition on mental health workers of a duty to warn third parties of violent threats has been beneficial. There is no evidence that warnings to potential victims have reduced the incidence of violence. There is no evidence that warnings to police have reduced the incidence of violence. There is, in short, no evidence that imposing a Tarasoff-type

^{33/} Although therapists have to some extent greater control over involuntary patients, their decisions with respect to treatment and discharge of such patients are shielded by the immunities provided in Pennsylvania's Mental Health Procedures Act, 50 Pa. Cons. Stat. Ann. § 7114 (West 1996). A duty to warn can arise when such a patient is discharged. But because patients are discharged only when the mental health workers conclude that they are able to function in society and are not dangerous to themselves or others, a duty to warn can apply only if therapists, whose decisions to release patients are not actionable, are held liable to warn potential victims of dangers they have affirmatively determined do not exist. It is difficult to conceive what policy considerations would direct the imposition of a duty to warn on the ground that a therapist should, in fact, have realized that the patient was dangerous when it is the state's express policy that the therapist may not be subjected to liability for failing to realize that the patient was dangerous in determining whether he should be discharged.

duty has increased the level of public safety in any jurisdiction.

Early studies of the impact of Tarasoff-type rules and clinical experience do, however, suggest why such warnings may have very little positive impact even for the particular third parties involved. In many cases, patients who make threats to third parties in therapy have already threatened the third party directly or through a mutual friend or family member. Thus, warnings provided by therapists may not tell third parties, in most cases, anything they did not already know. A study of Tarasoff warnings between 1985 and 1990 in California, found that the targets of almost half of the patients' threats were family members.^{34/} In another study, also in California, in almost three-quarters of the cases in which the mental health worker was able to reach the potential victim, the potential victim already knew about the threats.^{35/}

Further, initial research suggests that those threatened often will ignore warnings based on their own beliefs as to the dangerousness of the person making the

^{34/} D.E. McNiel, et al., Management of Threats of Violence Under California's "Duty to Protect" Statute (paper presented at the Biennial Conference of the American Psychology-Law Society/Division 41 of the American Psychological Association (Feb. 29, 1996) (the authors note that this figure is consistent with results found in others' research).

^{35/} R.L. Binder & D.E. McNiel, The Application of Tarasoff: Effect on the Victim and on the Therapeutic Relationship, Psychiatric Services (scheduled for publication November 1996).

threats, as did the victim in the case at bar.^{36/} At least two state courts have declined to impose any duty to warn where the victims were already aware of the attacker's propensities and threats. See In Re Estate of Votteler, 327 N.W.2d 759 (Iowa 1982); Wagshall v. Wagshall, 538 N.Y.S.2d 597 (2d Dept. App. Div. 1989).

As a practical matter, in the rare instances where the patient actually intends to carry out the threat, warnings may not be particularly effective preventive measures. Certainly the limited value of warnings to police was demonstrated by Tarasoff itself. Although the police were warned, the killer had not yet violated any law, and after promising to stay away from the intended victim, the police let him go. In addition, some research suggests that those who genuinely are dangerous, unable to reach their intended victim, may simply transfer the hostility to another. See D.E. McNiel & R.L. Binder, Relationship Between Preadmission Threats and Later Violent Behavior by Acute Psychiatric Inpatients, 40 Hosp. & Community Psych. 605, 607 (1989) (concluding that "the results of this study suggest that when acutely psychotic patients threaten violence, the

^{36/} Id. (almost half of those who had previously known of the threats insisted the patient would never hurt them and one quarter of those who had no previously knowledge of threats told the mental health worker they had no intention of changing their behavior).

danger extends to others besides the intended victim of the threat").^{37/}

Most worrisome is the observation that warnings can themselves precipitate violence that otherwise would not have occurred. Patients may feel challenged to live up to the therapist's expectations. See B. Weiner, Provider-patient Relations, Confidentiality and Liability, The Mentally Disabled and the Law 585 (S. Brakel, J. Parry & B. Weiner ed.) (3d ed. 1985). Sadly, and ironically, clinicians have also experienced situations in which the potential victim (or a friend or relative of the potential victim) responds to a warning by attacking or killing the patient.^{38/}

^{37/} The researchers found that 58 percent of the patients in the study who had made threats before admission to an acute psychiatric inpatient unit -- and were therefore unable to reach their threatened victims -- required seclusion for dangerous behavior and 32 percent of the patients who had made threats before admission assaulted someone in the hospital. Id. at 605-607.

^{38/} Id. at 585. See also Stone, The Tarasoff Decisions: Suing Psychotherapists to Safeguard Society, 90 Harv. L. Rev. 358, 370 (1976) (noting the risk that warnings may precipitate a confrontation and thus "may in fact increase the likelihood of violence"; accord Roth, Clinical and Legal Considerations in the Therapy of Violence-prone Patients, 18 Current Psychiatric Therapies 55, 58 (J. Masserman ed. 1978); Gurevitz, Tarasoff: Protective Privilege Versus Public Peril, 134 Am. J. Psychiatry 289, 290 (1977).

2. *Imposing a Duty to Warn
Disserves the Broader
Public Safety Goals.*

Although intended to protect the public from violence by mentally disordered people, the rule at issue here, if adopted and enforced, is more likely to have the opposite effect by thwarting effective treatment for people with violent impulses or fantasies and by intervening in a destructive way in the lives of many who would not otherwise have acted on those impulses. Therapy encourages patients to disclose not only their thoughts but their emotions and fantasies, including angry and threatening impulses that are suppressed in their everyday lives, in order for the patient and therapist to defuse these feelings in a safe and comfortable atmosphere. The very nature of therapy stimulates patients to express violent thoughts and fantasies they have no real intention of carrying out.^{39/}

Where those expressions appear to represent real intentions, mental health workers should be at liberty to warn the intended victim, or if possible, persuade the patient to warn the intended victim. However, imposition of legal liability for failure to warn will necessarily result in overassessment of dangerousness -- if mental health workers are forced to defend themselves in court and

^{39/} The utterance of a threat in the presence of mental health provider may indicate merely "blowing off steam" or at least an ambivalence toward harming the third party. Indeed, expressing such thoughts may be precisely what prevents patients from acting them out. See D. Shapiro, Psychological Evaluation and Expert Testimony 160 (1984).

subjected to large financial penalties -- because the unreliability of known predictive methods leaves them no other means to protect themselves.^{40/}

Overprediction, in turn, would result in disclosures to the friends, family members, or employers of large numbers of patients of the hidden rages or fantasies of people who present no real danger of violent behavior. At the very least, such warnings could have a very negative effect on such patients' lives, precipitating a deteriorating situation and capable of generating the very type of violent responses the rule was intended to protect against.

For example, disclosing a hostile statement or threat to a family member or friend may well seriously interrupt a relationship which might be acting as a positive structure in the patient's life. Similarly, providing a warning to a co-worker or employer may well result in loss of employment, removing another stabilizing structure from the

^{40/} See D.J. Givelber, W.J. Bowers, & C.L. Blitch, Tarasoff, Myth and Reality: An Empirical Study of Private Law in Action, Wis. L. Rev. 443 (1984); T.P. Wise, Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of Tarasoff, 31 Stan. L. Rev. 165, 181 (1978) (four years after Tarasoff I, therapists in California reported lowering the threshold at which they considered dangerous and subsequently either warned a third party or committed the patient; see also D.E. McNeil & R.L. Binder, supra n.35, at 3 (demonstrating that the number of warnings increased each year between 1985 and 1990 in California). The McNeil/Binder study also demonstrated that mental health workers had many times more often chosen to initiate civil commitment rather than warnings. Id. at 5.

patient's life.^{41/} And being fired under those circumstances could make re-employment particularly difficult, placing the patient under even greater stress.

A further concern is that requiring therapists to disclose violent statements or fantasies may undermine treatment. People with mental health problems may be reluctant to attempt therapy, or more reluctant to fully confide. Thus, a legal duty to warn risks the "atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears" on which "[e]ffective psychotherapy ... depends."^{42/} Indeed, "the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment."^{43/} There is evidence that the duty to warn or protect rules already in effect have had that unfortunate result.^{44/} The warning itself, if given, can

^{41/} See, e.g., Hopewell v. Adibempe, No. GD 78-28756, slip op. (Court of Common Pleas, Allegheny Co., June 1981) (patient was fired after psychiatrist warned patient's employer of her hostility and threats to co-workers).

^{42/} Jaffee v. Redmond, ___ U.S. ___, 116 S. Ct. 1923, 1928 (1996).

^{43/} Id.

^{44/} D. Nowell & J. Spruill, If It's Not Absolutely Confidential, Will Information Be Disclosed, Ethical Conflicts in Psychology 185 (Donald N. Bersoff, ed.) (1995) (student subjects less willing to disclose information concerning high-severity items when told of Tarasoff-type exception to confidentiality); (T.P. Wise, supra n.41, at 183 (California therapists reported that patients were more reluctant to discuss violent tendencies when informed of the therapists' duty to breach confidentiality); see also K.M. Woods & J.R. McNamara, Confidentiality: Its effect on Interviewee Behavior, 11 Prof. Psychiatry 714 (1980).

even more severely sabotage the ability of the therapist to stabilize the patient by provoking the patient to abandon therapy, as in Tarasoff itself.^{45/} Importantly, the risk here is undermining the effectiveness of therapy not just for those who pose an immediate threat of violence but for the much larger number who are not currently dangerous but who are caught in the web of overprediction.

In addition, the effect of litigation and liability under a duty to warn rule could discourage psychotherapists from treating patients with violent tendencies, or discourage them from probing these areas, reducing the availability of therapy to help significant numbers of people.^{46/} Certainly the increased reluctance of physicians with a specialty in

^{45/} The effect of a warning given in an inpatient setting may be less disruptive. See R.L. Binder & D.E. McNiel, supra n.35, at 6-7 (8 of 23 inpatients responded angrily when informed that a warning had been provided; residents evaluated the effect on the therapeutic relationship as negative in 5 cases). The researchers noted that the effect on the therapeutic relationship might well be different in the outpatient setting where there is a more traditional psychotherapist-patient relationship. Id. at 11.

^{46/} See D.L. Rosenhan, T.W. Teitelbaum, K.W. Teitelbaum, & M. Davidson, Warning Third Parties: The Ripple Effects of Tarasoff, 24 Pac. Law J. 1165 (1993) (greater cautiousness in treating patients with violent tendencies); T.P. Wise, supra n.41, at 187 (greater anxiety in dealing with patients because of Tarasoff); but see D.G. Givelber et al., supra n.41 (clinicians still treating violent patients). Nonetheless, no empirical data on the impact of Tarasoff-type rules on the willingness of therapists to treat potentially violent patients is yet informative because so few actions have been brought and so few judgments imposed. See, e.g., J.C. Beck, The Psychotherapist's Duty to Protect Third Parties from Harm, 11 Ment. & Phys. Dis. L. Rep. 141, 141 (1987). Given the low number of warnings that appear to be given, this supports the view that the incidence of this type of violence is quite rare, undercutting the rationale for the rule in the first instance.

obstetrics/gynecology to accept patients interested in pre-natal and childbirth services cautions that increased litigation and liability, with the inevitable effect on the cost and availability of insurance, can significantly disserve the public interest by frightening needed care providers away.

II. A DUTY TO WARN, IF IMPOSED, SHOULD BE FASHIONED IN THE MANNER LEAST DESTRUCTIVE TO PUBLIC SAFETY AND THE CONTINUING AVAILABILITY OF EFFECTIVE PSYCHOTHERAPY.

If this Court decides to impose a duty to warn on mental health workers, amici urge the Court to delineate this duty carefully in order to limit negative effects on the safety of potential victims, patients, and the public generally, in light of the inadequate predictive tools available and the risks posed to public safety and health by overprediction and hindsight-driven liability.

A. Circumstances Under Which The Duty Arises

1. *Specific threat to identified
or reasonably identifiable victim*

The vast majority of those states that have adopted a Tarasoff-type rule have, by judicial decision or statute, limited its applicability to situations in which a patient, during a therapeutic session, makes an actual, serious threat to seriously physically harm or kill a particular person or persons, identified either by name or by easily understood

description.^{47/} As a practical matter, it is unclear how a therapist could comply with a duty to warn people who are not reasonably identifiable.

Even in those states that have adopted a broader duty to protect, that duty generally arises only where patients make serious, actual threats with respect to identified (or reasonably identifiable) people. To expand the duty beyond such circumstances would make therapists virtual guarantors of the actions of patients whom they see only under limited circumstances and whom they do not control.

2. *Imminent threat of serious
bodily injury or death*

By operation of the common law doctrine of foreseeability or specific statutory terms, most states that have imposed a Tarasoff-type duty impose it only where a

^{47/} See Fraser v. United States, 236 Conn. 625, 674 A.2d 811, 816 (1995) ("state courts in other jurisdictions have overwhelmingly concluded that an unidentifiable victim has no claim in negligence against psychotherapists who were treating the assailant on an outpatient basis") (citing cases); Alaska Stat. § 08.86.200 (West 1962-1995); Ariz. Rev. Stat. Ann. § 36-517.02 (West 1996); Cal. Civ. Code § 43.92(a) (West 1996); Ill. Comp. Stat. § 5/6-103 (West 1996); Ind. Code Ann. § 16-39-2-6 (West 1894-1996); Ky. Rev. Stat. Ann. § 202A.400(2) (West 1996); La. Code Civ. Ann. § 9:2800.2 (West 1996); Md. Code Ann. Cts. Jud. Proc. § 5-316(b) (1996); Mass. Gen. Laws Ann. Ch. 112, § 129A(3) (1996); Mich. Comp. Laws Ann., § 330.1946(1) (West); Minn. Stat. Ann. § 148.975(subd. 2) (West 1996); Mont. Rev. Code Ann. § 27-1-1102 (Smith 1996); N.H. Rev. Stat. § 330-A:22(I) (1995); N.J. Stat. Ann. § 2A:62A-16(2) (West 1991); Ohio Rev. Code Ann. § 5122.34 (Anderson 1996); Tenn. Code Ann. § 33-10-302(a) (1989); Utah Code Ann. § 78-14a-102(1) (1989); Va. Code Ann. § 54.1-2400.1(b) (Michie 1996); Wash. Rev. Code § 71.05.120(2) (West 1996).

therapist has information indicating that a patient is likely and ready to act on a threat and where serious personal injury or life is at stake.^{48/} Because a Tarasoff-type duty is not imposed on others with the same or similar information, it would be particularly inappropriate to impose it when only comparatively trivial harms such as property damage are at risk. Similarly, because most statements or fantasies with violent elements revealed during therapy do not represent a genuine threat, it is necessary to focus the duty on the precise situation which does present a risk and is most likely to be discernible to a therapist. Therefore, such a duty, if imposed, should be limited to credible threats of violence in the immediate future.

B. Applicable Standard of Care

If this Court imposes a special duty, it should consider the difficulties of assessing dangerousness and the particular susceptibility of such judgments to hindsight bias in determining the standard by which a therapist's actions will be measured. An ordinary negligence standard is inappropriate both because there is no clear agreed-upon standard for assessing when a patient is genuinely dangerous and because erring on the side of warnings is not a suitable

^{48/} Only one jurisdiction imposes a duty by statute where only property is at risk. See N.H. Rev. Stat. § 330-A:22(I) (1995); but see also Peck v. Counseling Service of Addison County, 499 A.2d 422 (Vt. 1985) (imposing a duty where the patient threatened to burn a barn because anyone in the building at the time could have been killed in the fire).

policy choice due to the potential for warnings to increase violence.^{49/} Furthermore, hindsight bias is particularly troublesome here where juries, with little if any everyday experience with the subject and a likely exaggerated belief as to therapists' ability to predict and prevent violence -- and faced with an actual murder and the victim's grieving family -- will be almost irresistibly tempted to find something the therapist could have done that was not done, no matter how reasonable the therapist's response was at the time it was made.^{50/}

The law's response in an analogous area -- the duty owed by a director of a company in making business decisions -- provides an appropriate model if a duty is imposed on therapists. Like directors of companies who, under normal circumstances, are motivated to apply their best efforts to

^{49/} Similarly a generalized duty to protect, under an ordinary negligence standard, encourages therapists to "indulge every presumption in favor of further restraint, out of fear of being sued. Such a climate is not in the public interest." Sherrill v. Wilson, 653 S.W.2d 661, 664 (Mo. 1983). This risks unnecessary commitments, depriving patients of their liberty, and removing them from functioning lives in society, when they do not actually present any danger to others but have merely expressed hostility. Unnecessary commitments also risk severe collateral consequences, disrupting relationships and employment, and seriously impairing the patient's ability to retrieve his situation when he is released.

^{50/} See, e.g., S.J. LaBine and G. LaBine, Determinations of Negligence and the Hindsight Bias, 20 Law and Human Behavior 501 (1996) (study of hindsight bias in hypothetical determinations of negligence in Tarasoff-type case found violence more foreseeable and therapist actions less reasonable by group informed of violent outcome than by groups informed of non-violent outcome or given no information about outcome).

achieving business success, therapists are motivated to protect the public and deter their patients from committing acts of violence. Further, the duty owed by a director of a company has the same troublesome prediction and hindsight bias problems inherent in a Tarasoff-type duty. The absence of objective and reliable criteria for predicting business conditions in the future, and the "obviousness" of correct decisions after the fact, yields an unacceptable risk of distorted results when those decisions are challenged post hoc -- as here.

The business judgment rule, developed in recognition of these circumstances, safeguards society's interests by imposing liability for decisions which are genuinely suspect: self-dealing, bad faith, or so unreasonable as not to be a legitimate business judgment.^{51/} An analogous professional judgment rule here would similarly safeguard society's interests by imposing liability for decisions which are genuinely suspect -- those made in bad faith or with indifference to the consequences -- without subjecting thoughtful and concerned therapists to de facto strict liability on those rare occasions when an unforeseen tragedy occurs.^{52/}

^{51/} See 19 C.J.S. Corporations § 482 (1990).

^{52/} See also Youngberg v. Romeo, 457 U.S. 307, 322-23 (1982) (adopting a professional judgment rule as the applicable standard of review for adequacy of training provided for institutionalized mentally retarded persons on the ground that "there certainly is no reason to think judges or juries are better qualified than appropriate professionals in making

(continued...)

Such a rule would also be more consistent with this state's policy with respect to other decisions by mental health workers implicating treatment and safety concerns. See 50 Pa. Cons. Stat. Ann. § 7114(a) (West 1996) (providing immunity in the absence of willful misconduct or gross negligence). Several courts have already adopted a professional judgment rule. See Littleton v. Good Samaritan Hospital & Health Ctr., 39 Ohio 3d 86, 99-100, 529 N.E.2d 449, 460-61 (1988) (finding "liability only in the absence of good faith or a failure to exercise professional judgment" because a malpractice rule is inappropriate and unworkable "where there are no professional standards"); Jenks v. West Carrollton, 58 Ohio App. 3d 33, 567 N.E. 2d 1338 (Mont. Co. 1989) (same); Currie v. United States, 644 F. Supp. 1074 (M.D. N.C. 1986).^{53/}

^{52/} (...continued)
such decisions" and finding liability appropriate "only when the decision by the professional is such a substantial departure from accepted professional judgment, practice, or standards as to demonstrate that the person responsible actually did not base the decision on such a judgment").

^{53/} In addition to avoiding the distortion of hindsight bias, a professional judgment rule recognizes that the jury necessarily focuses on the one tragedy that did occur, and not on the range of tragedies the therapist must work to avert. Therapists must consider the impact on their patients' subsequent behavior of an unsuccessful attempt at involuntary commitment, or temporary detention by the police. A patient committed for evaluation, or taken into custody, who is later released might be more likely to become violent and less amenable to working out these impulses through therapy. Thus, the remedial action that appears, in hindsight, to have been capable of averting the tragedy that occurred might have merely postponed the tragedy to a different day, or a different victim, or a group of victims. It may also have been wholly ineffective.

CONCLUSION

For the foregoing reasons, amici urge this Court to decline appellant's invitation to impose a new duty to warn solely on mental health workers. If the Court instead determines to fashion such a duty, amici urge this Court to cabin the circumstances that trigger such a duty and to adopt the professional judgment rule as the applicable standard.

Respectfully submitted,



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