No. 91387-1
THE SUPREME COURT OF WASHINGTON

BEVERLY R. VOLK, as Guardian for Jack Alan Schiering, a minor; and as Personal Representative of the Estates of Philip Lee Schiering and Rebecca Leigh Schiering, and on behalf of the statutory beneficiaries of Philip Lee Schiering; and BRIAN WINKLER, individually,

Respondents/Cross-Petitioners,

v.

JAMES B. DEMEERLEER, as Personal Representative of the Estate of Jan DeMeerleer; HOWARD ASHBY, M.D., and "JANE DOE" ASHBY, husband and wife, and the marital community composed thereof; SPOKANE PSYCHIATRIC CLINIC, P.S., a Washington business entity and healthcare provider; and DOES 1 through 5,

Petitioners/Cross-Respondents.

BRIEF OF *AMICI CURIAE* WASHINGTON STATE MEDICAL ASSOCIATION, WASHINGTON STATE HOSPITAL ASSOCIATION, AMERICAN MEDICAL ASSOCIATION, WASHINGTON STATE PSYCHIATRIC ASSOCIATION, WASHINGTON CHAPTER--AMERICAN COLLEGE OF EMERGENCY PHYSICIANS, WASHINGTON STATE COUNCIL OF CHILD & ADOLESCENT PSYCHIATRY, WASHINGTON ACADEMY OF FAMILY PHYSICIANS, AND AMERICAN PSYCHIATRIC ASSOCIATION

Amended

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I. IDENTITY AND INTEREST OF *AMICI CURIAE*

Physician and Hospital *Amici* are the professional groups of physicians providing psychiatric care in Washington; the public and private hospitals in which emergency care, inpatient treatment, and psychiatric boarding occur; and the two national organizations of physicians who provide psychiatric care, as detailed in the motion for leave to file a brief of *amici curiae* ("Motion").[1] Physician and Hospital *Amici* have extensive experience in the difficult work of providing psychiatric care to those who need it. They also have a direct interest in the outcome of this case—it will affect their ability to provide effective care to future patients and their potential liability.

To ensure the broadest access to needed psychiatric care, balanced with protecting potential victims from violent behavior, this Court should expressly recognize that the legislature set public policy in 1987 when it adopted RCW 71.05.120(2): the duty owed by mental health professionals to third parties extends only to those reasonably identifiable persons actually threatened by a patient, in both inpatient and outpatient settings; and that the broader duty stated by the decision below is inconsistent with the legislative mandate of 1987, contrary to common sense, and unworkable.

[1] Physician and Hospital *Amici* are Washington State Medical Association; Washington State Hospital Association; American Medical Association; Washington State Psychiatric Association; Washington Chapter—American College of Emergency Physicians; Washington State Council of Child & Adolescent Psychiatry; Washington Academy of Family Physicians; and American Psychiatric Association.

II. ISSUE OF CONCERN TO *AMICI*

Physician and Hospital *Amici* are concerned with the lower court majority's unwarranted expansion of an outpatient clinical psychiatrist's duty to warn or protect third parties and the general public by its requirement they do the impossible: predict imminent dangerousness in patients who have not communicated any recent threats or indicated an intent to do harm, nor indicated a target for the harm that was not threatened. In such circumstances—like this case—the psychiatrist cannot meet the duty, which far exceeds the statutory duty set by the legislature.

The expanded duty imposed by the majority at Division III is unworkable because, as a practical matter, without the patient "communicat[ing] an actual threat of physical violence against a reasonably identifiable victim or victims," there is no one for the psychiatrist to warn until after the attack has occurred, when it is too late–the duty cannot be met. This broad duty, which approaches strict liability, is inconsistent with basic tort law since it cannot be met. As discussed *infra*, it will impede providing mental health care to all those who need it. There is a simple solution: to recognize the legislature stated the duty in 1987 in RCW 71.05.120(2) and that the majority below erred in not following it.

Physician and Hospital *Amici* have long sought to ensure the availability of psychiatric care for the treatment of mental illness.[2]

[2] *See, e.g.,* AMA House of Delegates health policies H-345.981 (AMA seeks to ensure the supply of psychiatrists and other mental health professionals and to remove the

As detailed in the motion to file this *amicus* brief, WSHA, WSMA and WC-ACEP participated as *amici* in *In re Detention of D.W.,* 181 Wn.2d 201, 332 P.3d 423 (2014), in which this Court held psychiatric boarding in hospitals was unlawful, helping provide impetus for rejuvenating the mental health system, along with recent federal court orders.[3] *Amici* are greatly concerned the expanded liability stated by the majority below will further burden a system that is just now receiving more resources, in part due to *In re D.W*.

In this case, the physician groups are especially concerned with the negative effect the underlying decision would have on two basic elements of medical care which are crucial in psychiatric care and treatment: (1) that a physician's primary obligation is to his or her patient; and (2) that maintenance of patient confidentiality is required to gain and keep the patient's trust. These core elements of medical practice are embodied in the Principles of Medical Ethics adopted by the AMA and the WSMA, particularly Principles IV, VIII, and IX.[4] They allow the patient to share his or her deepest

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barriers that keep Americans from seeking and obtaining treatment for mental illness); H-345.984 (AMA works to increase patient access to quality care for depression and other mental illnesses); and H-345.995 (AMA seeks to prevent unnecessary hospitalization or imprisonment of the mentally ill), found at https://www.ama-assn.org/ssl3/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=/resources/html/PolicyFinder/policyfiles/HOD-TOC.HTM (last visited 9/28/15).

[3] *See Trueblood v. Wash. State Dep't of Soc. & Health Servs.,* 2015 WL 1526548 (W.D. Wash. April 2, 2015), and fn. 21, *infra*.

[4] These Principles state:

> IV. A physician shall respect the rights of patients, colleagues, and other health professionals, and shall safeguard patient confidences and privacy within the constraints of the law.

thoughts and fears with the physician, a necessary aspect of effective mental health treatment, as is documented in Dr. Asby's briefs and petition, and in the *amicus curiae* brief below from the Wa. State Psychological Ass'n. ("WSPA COA Amicus Brief").

This case illustrates the difficulties in treating patients who have combinations of serious problems (bipolar disease; alcohol and/or drug abuse or misuse; depression), are not under the "control" of the psychiatrist, and do not meet the criteria for involuntary commitment. These patients must be encouraged to continue treatment by a secure and confidential relationship with their physician. Any diminution in patient confidentiality, as the decision below would do, will jeopardize the chances for continued and successful mental health treatment and will cause some practitioners to cease serving such patients.

III. DISCUSSION

A. The majority below erred by holding that, when treating outpatients, mental health professionals owe a duty of care to the general public, not just to reasonably identifiable third-parties who were threatened.

Jan DeMeerleer received voluntary outpatient treatment for depression and bipolar disorder from psychiatrist Dr. Howard Ashby

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> VIII. A physician shall, while caring for a patient, regard responsibility to the patient as paramount.
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> IX. A physician shall support access to medical care for all people.

AMA Principles of Medical Ethics, available at http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/principles-medical-ethics.page (last visited 9/28/15).

on an intermittent basis between 2001 and April 2010 and he "never identified Rebecca Schiering or her family members as targets of violence." *Volk v. DeMeerleer*, 184 Wn. App. 389, 417-18, 337 P.3d 372 (2014). In July 2010, without warning, DeMeerleer attacked Jack, Philip and Rebecca Schiering, and Brian Winkler, killed Rebecca and Philip Schiering, then committed suicide.

This appeal arises from a professional malpractice claim brought by DeMeerleer's victims against Dr. Ashby and a vicarious liability claim against the Spokane Psychiatric Clinic, P.S. where he worked. The trial court granted Dr. Ashby's and the Clinic's summary judgment motions on the basis that Dr. Ashby could not have reasonably identified the Schierings or Brian Winkler as DeMeerleer's targets because he communicated no threats of harm toward them during his sessions with Dr. Ashby. *Id.* at 395, 413.

On appeal, in examining a mental health professional's duty owed to third parties to protect them from "the violent behavior of the professional's outpatient client," *id*. at 394, the majority focused on "whether a mental health professional holds a duty to protect a third person, when an outpatient, who occasionally expresses homicidal ideas, does not identify a target," *id.* at 414, though no homicidal ideas had been expressed for over five years. The majority held that mental health professionals treating voluntary outpatient clients owe a duty to protect "all foreseeable victims, not

only those reasonably identifiable victims who were actually threatened by the patient." *Id.* at 426.

The majority concluded that the legislature's specification of the duty in 1987, that mental health professionals owed a duty to third parties only where the patient communicated an actual threat of physical violence against a reasonably identifiable victim, did not apply outside of the involuntary commitment context. *Id.* at 423-26. The majority applied the rule from *Petersen v. State*, 100 Wn.2d 421, 671 P.2d 230 (1983). Using the *Petersen* test, the majority held there was sufficient expert evidence for a jury to find that the victims were foreseeable and reversed for trial on that issue. The full panel affirmed dismissal of the claim Dr. Ashby should have involuntarily committed DeMeerleer, 184 Wn. App. at 426, and further review of that issue was not sought.

Judge Brown dissented in part: he would have affirmed the total dismissal because he believed the plaintiffs failed "to show Mr. DeMeerleer ever communicated to respondents any actual threat of physical harm concerning these third-party appellants during his treatment." *Id.* at 435 (Brown, J., dissenting in part).

B. The majority decision takes Washington law on a different path than that chosen by the legislature in 1987, which balanced the interest in protecting public safety with the interests in providing effective treatment and safeguarding individual rights.

1. The legislature resolved the competing policy interests in 1987 by narrowing the scope of the duty stated in *Petersen* in adopting what became RCW 71.05.120(2), which limits mental health professionals' liability to only reasonably identifiable people actually threatened by patients.

"Under the common law, a person had no duty to prevent a third party from causing physical injury to another." *Petersen*, 100 Wn.2d at 426. An exception exists for circumstances in which there is a special relationship between the defendant and the person causing the physical injury.[5] *Petersen* held that the defendant psychiatrist at Western State Hospital "incurred a duty to take reasonable precautions to protect ***anyone*** *who might foreseeably be endangered* by [his patient]'s drug-related mental problems[]" upon release from involuntary confinement, regardless of whether the victim was readily identifiable. 100 Wn.2d at 426 (emphasis added).[6]

In 1987, as part of a general tort reform bill, the legislature abrogated *Petersen*'s holding with respect to the liability of the State,[7] and added a new subsection to RCW 71.05.120, a statute

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[5] *Petersen*, 100 Wn.2d at 426, citing RESTATEMENT (SECOND) OF TORTS § 315 (1965) ("There is no duty so to control the conduct of a third person as to prevent him from causing physical harm to another unless (a) a special relation exists between the actor and the third person which imposes a duty upon the actor to control the third person's conduct[.]").

[6] The majority opinion below itself recognized that *Petersen* presented "the ***extreme*** version of the duty imposed on a mental health professional to protect others." *See Volk*, 184 Wn. App. at 419 (emphasis added).

[7] The legislature added the State as a party to whom immunity was granted in the absence of gross negligence "for performing duties pursuant to this chapter with regard to the decision of whether to admit, discharge, release, . . . or detain a person for evaluation and treatment[.]" RCW 71.05.120(1); Laws of 1987, ch. 212, § 301. *Accord Hertog, ex*

originally enacted in 1973 as part of the Involuntary Treatment Act. *See* RCW 71.05.150 (providing for civil commitment). The mental health providers charged with making civil commitment determinations were granted immunity if they acted "in good faith and without gross negligence."[8]

The new subsection to RCW 71.05.120 clarified that the immunity provision did not relieve "***a person*** from . . . the duty to warn or to take reasonable precautions to provide protection from violent behavior where the patient has communicated an ***actual threat*** of physical violence against a ***reasonably identifiable victim or victims***." Laws of 1987, ch. 212, § 301, codified as RCW 71.05.120(2) (emphasis added).

The two subsections are structurally and linguistically separate and distinct. Subsection (1) begins with a detailed listing of the persons and entities to whom it applies. In contrast, subsection (2) begins simply by stating "This section does not relieve **a person**" from giving certain notices "***or*** the duty to warn or to take reasonable precautions. There is no conjunction, making the sections structurally independent. The contrast between "a person" in subsection (2) with the list of specific persons and entities in

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rel. S.A.H. v. City of Seattle, 138 Wn.2d 265, 293 n.1, 979 P.2d 400 (1999) (Talmadge, J., concurring). Justice Talmadge had been the Chair of the Senate Judiciary Committee that put forward the 1987 provision.

[8] *See* Laws of 1973 1st ex. ses., ch. 142, § 17; Laws of 1973 2d ex. ses., ch. 24, § 5; Laws of 1974 1st ex. ses., ch. 145, § 7; Laws of 1979 ex.s., ch. 215, § 7 (codified at RCW 71.05.120).

subsection (1) means that subsection (2) is not limited in terms of who it addresses in the way that subsection (1) is. It applies to any "person" in a situation who receives that information. It therefore applies to psychiatrists and other clinical mental health professionals in out-patient settings. It is not limited to those in institutional settings or in involuntary commitment situations.

By stating what the duty is, RCW 71.05.120(2) defines the parameters of the duty, as the legislature is entitled to do. Judge Brown's dissent is in accord.[9]

In sum, after *Petersen* held that mental health professionals owed duties to all foreseeable victims under the common law, the legislature acted to narrow the duty. *See Volk*, 184 Wn. App. at 438-39 (Brown, J., dissenting in part) (noting the legislature's new subsection to the then-existing immunity provision effectively limited the liability of mental health professionals).[10]

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[9] *See Volk*, 184 Wn. App. at 440, n. 4 (Brown, J., dissenting in part) ("Subsection (2) clearly addresses the same case law duty" as *Petersen, Tarasoff,* and *Lipari*).

[10] As Judge Brown explained, California's legislature followed a similar path after *Tarasoff v. Regents of University of California*, 17 Cal.3d 425, 131 Cal. Rptr. 14, 551 P.2d 334 (1976), and related cases, ultimately passing legislation to clarify that mental health professionals would not be liable to third-parties except where the patient has communicated "a serious threat of physical violence against a reasonably identifiable victim or victims." Cal. Civ. Code § 43.92; *Barry v. Turek*, 218 Cal. App. 3d 1241, 1244, 267 Cal. Rptr. 553 (1990) (noting that California's legislature clarified the duty owed in 1985). Similarly, in 1993 Nebraska's legislature limited the duty announced in *Lipari v. Sears, Roebuck & Co.*, a case relied on in *Petersen* and in *Volk*. 497 F. Supp.2d 185, 194-95 (D. Neb. 1980). *See* Neb. Rev. St. § 38-2137 (precluding any cause of action against a mental health professional for failing to warn of and protect from a patient's violent act "except where the patient has communicated to the mental health practitioner a serious threat of physical violence against himself, herself, or reasonably identifiable victims or victim.")

The majority below, however, concluded that the legislature intended to exclude from the duty specified by subsection (2) mental health professionals treating patients suffering from mental illness in a voluntary outpatient setting by holding that it did not apply outside of the involuntary commitment context, even though the majority also recognized that there is "no reason to differentiate between treating a mental health patient in the context of involuntary commitment and treating a patient outside that context. Under either circumstance, predicting violent behavior and the target of violent behavior is difficult." *Volk*, 184 Wn. App. at 426.

That observation rings true from the standpoint of practitioners, as Physician *Amici* expressly affirm from their experience. The majority erred by concluding that the legislature must have intended for *different* duties to apply to mental health care professionals making the *same* difficult determination (whether the patient poses a danger to others) depending on whether the determination is made in an inpatient or outpatient setting. It makes no policy or logical sense for the legislature to give more protection to providers who have greater authority and control over psychiatric patients, while leaving a more sweeping duty and less protection to those practitioners who, by the nature of their practice and relationship with the patient, have far less control over their patients. Having such different standards will only confuse practitioners, resulting in less care for those who need it and frustrating the

underlying policies stated in RCW 71.05.010, which call for providing prompt, community-based mental health services as widely as possible.

2. The 1987 legislation narrowing the scope of the duty owed was enacted as a tort reform measure and its applicability is not limited to decisions made in the context of involuntary commitment.

The majority takes Washington law down the wrong path through a misunderstanding of the process leading to the enactment of what became subsection (2) of RCW 71.05.120. While the 1987 legislation had the effect of amending and adding to RCW 71.05.120, that legislature did not "enact a new involuntary treatment act" in 1987, as the majority mistakenly believed. *See Volk*, 184 Wn. App. at 422. Instead, SSB No. 4068 (Laws of 1987, ch. 212, § 301) contained revisions to the sweeping Tort Reform Act of 1986. WSMA was among the parties lobbying for the narrowed duty based on the concern that the duties imposed by *Petersen* would leave mental health professionals "vulnerable to greater liability and that the effect of this would lead to the dismantling of the mental health community."[11]

[11] *See* Fay Anne Freedman, "The Psychiatrist's Dilemma: Protect the Public or Safeguard Individual Liberty?", 11 U. Puget Sound L. Rev. 255, 256 n. 10 (1988). Testimony in favor of having the legislature narrow the duty from *Petersen* cited to findings "demonstrating that violent behavior is not consistently foreseeable[]" and warned of the unintended consequences that flowed from the *Petersen* decision, including an increase in involuntary commitment proceedings and evaluations arising from vague threats. *See* Benjamin, G. A. H., Kent, L., & Sirikantrepon, S., "A review of the duty to protect statutes, cases and procedures for positive practice," in J.L. Werth, E.R. Welfel, and G. A. H. Benjamin (eds.), *The Duty to Protect: Ethical, Legal, and Professional Responsibilities of Mental Health Professionals. Washington, DC: APA Press* (2009), at 18.

The ungainly title of the 1987 act[12] reflects its origins as a catch-all tort reform measure. *See State v. T.A.W.*, 144 Wn. App. 22, 26, 186 P.3d 1076 (2008) (the title of a legislative enactment has "legal import in determining legislative intent."). In fact, the 1987 legislation would have been unconstitutional if it had been enacted as a "new involuntary treatment act" because, if that had been the case, there was no rational unity between that subject and the other provisions of the act related to tort reform measures.[13] The general subject of SSB No. 4068 as reflected in the title, was revisions to the tort reform measures, and not a "new" Involuntary Treatment Act.

That section 301 of the 1987 bill was placed among the codified provisions of the 1973 Involuntary Treatment Act does not justify the majority's conclusion that the provision defining and narrowing the duty owed by "a person" was enacted as part of a new Involuntary Treatment Act and thus applied only in the context of involuntary commitment. Rather, this Court should recognize the language and history of the 1987 statute, as did Judge Brown, and affirm that the legislature addressed the duty owed by mental health

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[12] "An Act Relating to mandatory arbitration; frivolous lawsuits; release of patients in the mental health system; immunity for elected and appointed officials, volunteer emergency personnel, corporate directors, design professionals, nonprofit corporations, and hospitals; studies on excess insurance, settlement conferences, examination of jurors, appellate evaluation conferences, and offers of settlement; consortium; limitation of actions involving felonies and intoxication; statute of limitations on health care; physician-patient privilege waiver; attorneys' fees; and workers compensation liens[.]"

[13] *See* Const. art. II, § 19 ("No bill shall embrace more than one subject, and that shall be expressed in the title."); *Scott v. Cascade Structures*, 100 Wn.2d 537, 673 P.2d 179 (1983) (an act is constitutional if there is a rational nexus between the general subject reflected in the title and the subsections).

professionals to third parties in 1987; that the duty applies in outpatient settings; and that per the statute such duty extends only to reasonably identifiable people actually threatened by a patient.

C. Holding mental health professionals liable to third-party victims who were not reasonably identifiable as targets of actual threats places an impossible burden on mental health professionals and limits their ability to treat patients.

1. The broad duty created by the majority's decision imposes liability on mental health professionals for failing to accomplish the impossible.

Mental health professionals are dedicated to giving effective treatment for patients who pose a risk of violence, but they cannot accurately predict whether and when any particular patient will have a violent outburst, much less the target of that violence, particularly where, as here, no threat of harm was made and no victim was indicated. The majority recognized this dilemma, agreeing that "empirical evidence establishes that psychiatry is an ill predictor of violent behavior." *Volk*, 184 Wn. App. at 420.[14]

Amici know from their experience that mental health professionals are not equipped to undertake a duty to protect all foreseeable victims where the best practices of their profession still do

[14] Citing Michael A. Norko and Madelon V. Baranoski, *The Prediction of Violence; Detection of Dangerousness*, 8 BRIEF TREATMENT & CRISIS INTERVENTION 73, 77–78 (2008); Mairead Dolan & Michael Doyle, *Violence Risk Prediction: Clinical and Actuarial Measures and the Role of the Psychopathy Checklist*, 177 THE BRIT. J. PSYCHIATRY 303 (2000). *See also* text and scientific studies cited at pp. 8-10 of the WSPA COA Amicus Brief, documenting the general inability to accurately predict future dangerousness.

not allow them to reliably foresee their patients' potential for violence. This applies with extra force here, in the absence of a threat of imminent harm or a potential target. RCW 71.05.120(2) recognizes this limitation by limiting the duty to warn or protect to ***only*** where the patient has communicated an actual threat of physical violence against a reasonably identifiable person. Requiring an "actual threat" before a duty arises recognizes that mental health professionals cannot always determine the risk of future violence, while still maintaining public safety goals by providing protection from "actual threats." But imposing a duty without the actual ability to comply with it imposes an unfair burden. The majority below erred because there is no basis in tort to hold a person to duties that cannot be met. The legislature properly required an "actual threat" and identifiable target to trigger the duty to warn or protect. This Court should affirm that this standard applies outside of the involuntary treatment context, as the legislature intended.

The *Petersen* standard used by the majority below imposes an impossible burden in other ways. It assumes mental health professionals will be able to actually identify and warn unidentified, but in theory foreseeable, victims. But if the victim is not reasonably identifiable, mental health professionals will be unable to determine who to warn without being excused from their duty under the majority's decision. Breaching patient confidentiality to alert the authorities also would be futile in such circumstances because the authorities would not know who to warn either. The legislature's

requirement that the victim be reasonably identifiable conforms with a mental health professional's abilities, practical reality and common sense.

2. The dual-duty regime is unworkable in practice and imposes an undue burden to distinguish between the duties owed based on the setting in which treatment is provided.

Upholding the majority decision would result in the creation of a dual-duty regime in Washington, where the duty would depend on the setting in which the mental health professional makes the determination as to the patient's dangerousness. Where the decision below can "discern no reason to differentiate between treating a mental health patient in the context of involuntary commitment and treating a patient outside that context[,]" it is too much to expect practitioners to discern such a difference for the purpose of conforming their actions to third parties accordingly, assuming it would even be possible for a mental health professional to conform her actions to the all-foreseeable-persons standard. Mental health professionals, and their patients, deserve clear standards for those limited circumstances when practitioners are required to breach patient confidentiality in order to fulfil their duty to warn those at risk, to take other reasonable precautions to provide protection from the potentially violent behavior of the patient.

3. The narrower duty specified by the legislature allows for effective treatment of patients in a manner consistent with statutes governing patient confidentiality, and enhances access to care.

Confidentiality is crucial to a mental health professional's ability to treat patients. *Amici* know from their experience that therapy is not effective if patients stay away or do not open up when they do seek treatment. *See* the accompanying motion, pp. [7-8]. *Accord,* WSPA COA Amicus Brief, pp. 14-15. And patients stay away or fail to open up if they cannot trust that their confidences are being kept to the greatest extent possible.[15] Such "opening up" is critical to treatment for such patients. Physician and Hospital *Amici*'s experience as noted in the motion to file this brief, is that when patients open up and disclose adverse thoughts and feelings, these benefits can occur:

- The mere act of externalizing the thoughts and feelings allows the patient to process his/her emotional or behavioral response to the underlying issue;
- The externalizing of the thoughts and feelings prevents the patient from ruminating or "catastrophizing";
- The externalizing can simply vent the effects of the underlying issue and thereby release internal pressures tied to the issue;
- The provider can better assess the depth of the problems facing the patient;

[15] The majority below also recognized this concern that patients "will withhold thoughts of violence for fear the professional will disclose those thoughts to others. The bond of trust between doctor and patient will dissolve," *Volk*, 184 Wn. App. at 419, but dismissed them on the basis the legislature supposedly did not extend protections to mental health therapists outside of the involuntary commitment context. The majority's implicit holding that the legislature must have been indifferent to effective mental health treatment for outpatients is at odds with the efforts of the legislature to ensure a statutory structure to enable those with serious mental disorders to receive care and to protect patient privacy to the extent possible, notwithstanding funding issues.

- The provider can add perspective (address underlying issues, coping skills, equating patient's condition to others etc.);
- The provider can better assess whether there is any real threat behind the angry words by (1) confronting the patient (i.e., "do you really want to hurt X?") and (2) assessing the non-verbal, psychomotor conduct of the patient. This psychiatrist suggested that many, many patients make angry, emotion filled statements but then quickly explain that their words do not reflect actual intent.
- The patient can discover and express their own insights into their emotions and the reaction to the underlying issue if the provider can help the patient talk about the same.

The legislature has recognized in legislative findings the importance of confidential communications for public health and safety in RCW 70.02.005(1) and (3).[16] The legislature has also enacted statutes to protect confidential communications between patients and the professionals who treat them.[17] Confidentiality also has its limits consistent with the duty stated in RCW 71.05.120(2). A health care provider is allowed to disclose health care information

> about a patient without the patient's authorization to the extent the recipient needs to know the information, if the disclosure is: . . . (c) To any person if the health care provider . . . *reasonably believes* that disclosure will avoid or minimize

[16] "Health care information is personal and sensitive information that if improperly used or released may do significant harm to a patient's interest in privacy, health care, or other interests[,]" and that "In order to retain the full trust and confidence of patients, health care providers have an interest in assuring that health care information is not improperly disclosed and in having clear and certain rules for the disclosure of health care information."

[17] *See* RCW 18.83.110 ("Confidential communications between a client and a psychologist shall be privileged against compulsory disclosure to the same extent and subject to the same conditions as confidential communications between attorney and client."). *See also* RCW 5.60.060(4) (providing that, subject to exceptions, "a physician . . . shall not, without the consent of his or her patient, be examined in a civil action as to any information acquired in attending such patient, which was necessary to enable him or her to prescribe or act for the patient[.]").

> an *imminent danger* to the health or safety of the patient or any *other individual*, however there is no obligation under this chapter on the part of the provider to disclose.

RCW 70.02.050(1)(c) (emphasis added).[18] "Imminent" means "the state or condition of being likely to occur at any moment or near at hand, rather than distant or remote." RCW 70.02.010(20) (referring to 71.05.020(20)).

While a mental health therapist could make the disclosures required by the duty to warn under RCW 71.05.120(2) in a manner consistent with the disclosure allowed by RCW 70.02.050(1)(c), it would not always be the case under the duties imposed by the decision below, as this case illustrates. For example, where the patient communicates to the provider a threat of harm to a reasonably identifiable victim, the mental health professional can properly disclose confidential information pursuant to RCW 70.02.050(1)(c) and alert the victim or law enforcement. But under the majority decision below and the facts here, the duty to warn per *Petersen* is deemed triggered but the statute does not permit disclosure because, here, there was no basis for Dr. Ashby in April, 2010 to discern an "imminent" threat of harm since DeMeerleer did not communicate he contemplated any imminent harmful acts, much less directed to any identifiable person.

[18] As it relates to the facts of this particular case, the exception allowing for disclosure in effect at the time of the summary judgment order was codified at former RCW 70.02.050(1)(d) (2007), but the current exception allowing for disclosure under RCW 70.02.050(1)(c) is materially the same. Neither provision was in effect at the time of the *Petersen* decision.

Physician and Hospital *Amici* cannot emphasize strongly enough that the duties and obligations of mental health professionals to their patients and potential victims must be clear and consistent to prevent confusion, enhance compliance with the law governing their practice including warning potential, identifiable victims without breaching patient confidences, while also ensuring the availability of psychiatric care for all patients who need it in this difficult area.

4. The narrower duty is consistent with the purpose of the Involuntary Treatment Act and will better uphold the rights of patients.

The expansive *Peterson* duty, if applied outside of the context of involuntary commitment, is still inconsistent with the purposes of the involuntary treatment act. At the time of the summary judgment ruling, the purposes of chapter 71.05 RCW included:

> (1) to prevent inappropriate, indefinite commitment of mental disordered persons and to eliminate legal disabilities that arise from such confinement; (2) To provide prompt evaluation and timely and appropriate treatment of persons with serious mental disorders; (3) To safeguard individual rights; . . . and (7) To protect public safety.

Former RCW 71.05.010 (1998).[19] Applying the expansive duty from *Petersen* will encourage liability-averse mental health practitioners to refer more patients for involuntary commitment

[19] Those purposes, largely the same, now state in relevant part:

"The provisions of this chapter are intended by the legislature: (a) to protect the health and safety of persons suffering from mental disorders and to protect public safety . . . (b) To prevent inappropriate, indefinite commitment of mentally disordered persons . . . (c) to provide prompt evaluation and timely and appropriate treatment of persons with serious mental disorders; (d) to safeguard individual rights. . . ." RCW 71.05.010.

assessment,[20] increasing the burden on those doing assessments and interfering with the goal of prompt evaluation and timely and appropriate treatment. Unnecessary hospitalization could also result, undercutting the goal of preventing inappropriate commitment and further exacerbating an overloaded psychiatric care system which this Court and the federal courts are trying to get corrected so that proper care is available to those who need it.[21] Risk averse providers would limit their practices to avoid patient groups seen likely to have higher risk of violence issues, restricting the availability of care.[22]

IV. CONCLUSION

Physician and Hospital *Amici* respectfully suggest the Court should hold that the duty stated in RCW 71.05.120(2) applies to mental health practitioners in the outpatient setting and vacate the parts of the decision below which are inconsistent, to give effect to the legislative determination of the proper balance of providers' duties, public safety, and the availability of mental health care.

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[20] *See, e.g.,* WSPA COA Amicus Brief, pp. 9-10; Motion, p. 7.

[21] *See In re Detention of D.W., supra* (ruling that "single-bed certifications" for continued detentions for involuntary treatment under RCW 71.05.010 *et seq.,* was illegal, describing the current lack of resources); *Trueblood, supra*; "Judges Issue Contempt Orders, $700,000 in Fines in Boarding Cases of Mentally Ill," Seattle Times, Sept. 17, 2015, available at http://www.seattletimes.com/seattle-news/judges-issue-contempt-orders-fines-in-competency-cases/, last accessed 9/27/15 ("Judges across the state have continued to issue contempt orders and fines against an agency and two psychiatric hospitals for failing to provide timely competency services, despite federal [District Judge Pechman's] ruling requiring faster evaluations and treatment.").

[22] *See* Motion, pp. 6-7.

Respectfully submitted this 20th day of October 2015.

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