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The Duty of Mental Health Care Providers to Restrain Their Patients Or Warn Third Parties

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I. INTRODUCTION

When should liability be imposed upon those who fail to prevent injury or ring the alarm bell? This article addresses two well worn and hotly debated issues from a Missouri perspective. First, should physicians, other mental health care providers, mental health care hospitals, and other facilities be liable for either: (1) the failure to restrain a patient, or (2) the release of a patient who subsequently injures an individual member of the general public? Second, should there be liability for failure to warn specific third persons, members of law enforcement, other officials, or the public generally in such situations?

Initially, a landmark California case thrust those issues into the national legal spotlight, and a national debate ensued.[1] Although the common law and philosophical foundation for imposing liability in such situations was neither new, nor presented for the first time in *Tarasoff*,[2] that decision triggered national debate and engendered what has been generally recognized as a virtual cottage industry of analysis.

Subsequently, almost every state has considered the issue and discussed *Tarasoff*. Many jurisdictions either have followed, or have indicated they

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1. Tarasoff v. Regents of University of California, 551 P.2d 334 (Cal. 1976) (en banc).

2. *See* Jarrett v. Wills, 383 P.2d 995 (Or. 1963); Fowler V. Harper & Porey M. Kime, *The Duty to Control the Conduct of Another*, 43 YALE L.J. 886 (1934).

would follow the lead of *Tarasoff* and impose liability for either failure to warn, failure to restrain, or both.[3]

Among those states that have embraced *Tarasoff*, Michigan, New Jersey, and Vermont have followed *Tarasoff*, and have established a common law duty of a psychotherapist to warn readily identifiable victims of their patients' violent intentions.[4] Connecticut and Delaware have expanded the duty to warn particular individuals to include identifiable classes of potential victims.[5]

Arizona, Nebraska, North Carolina, and Wisconsin have extended the *Tarasoff* duty to any foreseeable victim, even if there has been no specific threat to that victim.[6] Ohio and Georgia not only have recognized the duty to warn set out in *Tarasoff*, but also have extended it to include a duty to take reasonable measures to protect or control the patient.[7] And some courts which have failed to impose a duty based on the facts of individual cases, such as the

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3. *See, e.g.*, Semler v. Psychiatric Inst., 538 F.2d 121 (4th Cir. 1976); Bradley Ctr., Inc. v. Wessner, 296 S.E.2d 693 (Ga. 1982); Estate of Mathes v. Ireland, 419 N.E.2d 782 (Ind. Ct. App. 1981); Durflinger v. Artiles, 673 P.2d 86 (Kan. 1983); Pangburn v. Saad, 326 S.E.2d 365 (N.C. Ct. App. 1985); Leverett v. State, 399 N.E.2d 106 (Oh. Ct. App. 1978); Peterson v. State, 671 P.2d 230 (Wash. 1983).

4. *See* Bardoni v. Kim, 390 N.W.2d 218 (Mich. Ct. App. 1986) (finding duty to warn identifiable victim); McIntosh v. Milano, 403 A.2d 500 (N.J. 1979) (codified at N.J. STAT. ANN. § 2A:62A-16 (West Supp. 1995)); Peck v. Counseling Serv., 499 A.2d 422, 426 (Vt. 1985).

5. *See* Almonte v. New York Medical College, 851 F. Supp. 34, 41 (D. Conn. 1994); Naidu v. Laird, 539 A.2d 1064, 1073 (Del. 1988) (duty to warn the general public, which could have been injured as a result of an automobile accident with the psychotic patient) (codified at DEL. CODE ANN. tit. 16, § 5402 (Supp. 1994)) (providing that a duty exists when the "patient has communicated . . . an explicit and imminent threat to kill or seriously injure a clearly identified victim or victims, or to commit a specific violent act or to destroy property under circumstances which could easily lead to serious personal injury or death, and the patient has an apparent intent and ability to carry out the threat . . . .").

6. *See* Currie v. United States, 644 F. Supp. 1074 (M.D.N.C. 1986), *aff'd*, 836 F.2d 209 (4th Cir. 1987); Lopper v. Sears, Roebuck & Co., 497 F. Supp. 185 (D. Neb. 1980) (imposing duty to control anyone foreseeably endangered by a patient); Hamman v. County of Maricopa, 775 P.2d 1122, 1128 (Ariz. 1989) (foreseeable victim is anyone "within the zone of danger, that is, subject to probable risk of the patient's violent conduct"); Schuster v. Altenberg, 424 N.W.2d 159 (Wis. 1988).

The duty in Nebraska was subsequently limited by the Nebraska legislature to any "reasonably identifiable victim or victims." *See* NEB. REV. STAT. §§ 71-1, 206.30, 71-1, 336 (Supp. 1994).

7. *See, e.g.*, Littleton v. Good Samaritan Hosp. & Health Ctr., 529 N.E.2d 449 (Ohio 1988) (court found a duty to control in-patients but declined to decide if it extended to out-patients); Bradley Ctr., Inc. v. Wessner, 296 S.E.2d 693 (Ga. 1982) (duty on mental hospital to control patient in hospital's control).

lack of a specific threat, have indicated that they would impose a duty to warn an identified potential victim.[8]

Other jurisdictions have rejected *Tarasoff*, in whole or part. One court expressly rejected the holding of *Tarasoff*, reasoning that the nature of the relationship between the patient and the psychotherapist was insufficient to impose a duty to warn on the psychotherapist.[9] Subsequently, Florida passed legislation which allows a psychiatrist to disclose patient communications to the extent necessary to warn potential victims or law enforcement authorities.[10]

II. CASES ADDRESSING MENTAL HEALTH CARE PROVIDERS' DUTY TO RESTRAIN AND WARN.

A. Tarasoff v. Regents of University of California

When analyzing a psychiatrist's duty to warn, most commentators and judges include *Tarasoff* in their analysis. *Tarasoff* has been well reported in both legal and mental health care journals.[11] Missouri courts have relied on

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8. *See* Morton v. Prescott, 564 So. 2d 913, 916 (Ala. 1990) ("Once these specific threats are verbalized, then the possibility of harm to third persons becomes foreseeable and the psychiatrist's duty arises."); Eckhardt v. Kirts, 534 N.E.2d 1339, 1344 (Ill. App. Ct. 1989), *cert. denied*, 541 N.E.2d 1105 (1989); Leonard v. Latrobe Area Hosp., 625 A.2d 1228 (Pa. Super. Ct. 1993) (construing *Tarasoff* to apply to a specific threat, lacking in this case, to a specific person).

9. Boynton v. Burglass, 590 So. 2d 446, 448-49 (Fla. Dist. Ct. App. 1991). For other jurisdictions declining to impose liability on the basis of *Tarasoff*, *see* Brady v. Hopper, 751 F.2d 329 (10th Cir. 1984); Hasenei v. United States, 541 F. Supp. 999 (D. Md. 1982); Soutear v. United States, 646 F. Supp. 524 (E.D. Mich. 1986); Leedy v. Hartnett, 510 F. Supp. 1125 (M.D. Pa. 1981); Thompson v. County of Alameda, 614 P.2d 728 (Cal. 1980) (en banc); Leonard v. State, 491 N.W.2d 508 (Iowa 1992); Cairl v. State, 323 N.W.2d 20 (Minn. 1982).

10. *See* FLA. STAT. ANN. § 455.2415 (West 1991 & Supp. 1995).

11. Among the legal journals in which *Tarasoff* has been reported, *see, e.g.*, James C. Beck, *Violent Patients and the Tarasoff Duty in Private Psychiatric Practice*, 13 J. PSYCHIATRY & L. 361 (1985); Richard J. Hulteng, *The Duty to Warn or Hospitalize: The New Scope of Tarasoff Liability in Michigan*, 67 U. DET. L. REV. 1 (1989); Peter F. Lake, *Revisiting Tarasoff*, 58 ALB. L. REV. 97, 98 (1994); Michael L. Perlin, *Tarasoff and the Dilemma of the Dangerous Patient: New Directions for the 1990's*, 16 LAW & PSYCHOLOGY REV. 29 (1992); D.L. Rosenhan, et al., *Warning Third Parties: The Ripple Effect of Tarasoff*, 24 PAC. L.J. 1165 (1993); Robert F. Schopp & Michael R. Quattrocchi, *Tarasoff, The Doctrine of Special Relationships and the Psychotherapists Duty to Warn*, 12 J. PSYCHIATRY & L. 13 (1984); Alan A. Stone, *The Tarasoff Decisions: Suing Psychotherapists to Safeguard Society*, 90 HARV. L.

REV. 358 (1976); John V. Lee, Comment, *Psychiatry-Torts—A Psychotherapist Who Knows or Should Know His Patient Intends Violence to Another Incurs a Duty to Warn*, 7 CUMB. L. REV. 551 (1977); Comment, *Torts Psychiatry and the Law—Duty to Warn Potential Victim of a Homicidal Patient, Tarasoff v. Regents of the University of California*, 22 N.Y.L. SCH. L. REV. 1011 (1977); Steven J. Bednar, Note, *The Psychotherapists's Calamity, Emerging Trends in the Tarasoff Doctrine*, 1989 B.Y.U. L. REV. 261; Russell S. Newman, Note, *The Tarasoff Progeny: Creating a Weaponless Policeman with a "Deep Pocket"*, 15 CAP. U. L. REV. 699 (1986); Note, *Tarasoff v. Regents of the University of California*, 65 CAL. L. REV. 517 (1977); Robert N. Cohen, Note, *Tarasoff v. Regents of the University of California: The Duty to Warn: Common Law and Statutory Problems for California Psychotherapists*, 14 CAL. W. L. REV. 153 (1978); Brad S. Seligman, Note, *Untangling Tarasoff, Tarasoff v. Regents of the University of California*, 29 HASTINGS L.J. 179 (1977); Michael R. Geske, Note, *Statutes Limiting Mental Health Professionals' Liability for the Violent Acts of Their Patients*, 64 IND. L.J. 391 (1989); Maryellen Kelleher, Note, *Psychotherapists and the duty to Warn: An Attempt at Clarification*, 19 NEW ENG. L. REV. 597 (1983); Kent M. Morrow, Note, *Physicians & Surgeons Negligence—Psychotherapist Has a Duty to Warn an Endangered Victim Whose Peril Was Disclosed by Psychotherapist by Patient*, 53 N.D. L. REV. 279 (1976); Diane S. Salter, Note, *The Duty to Warn Third Parties: A Retrospective on Tarasoff*, 18 RUTGERS L.J. 145 (1986); Thomas J. Murphy, Note, *Affirmative Duties in Tort Following Tarasoff*, 58 ST. JOHN'S L. REV. 492 (1984); Alexander J. Olander, Note, *Discovery of Psychotherapist—Patient Communications after Tarasoff*, 15 SAN DIEGO L. REV. 265 (1978); Toni P. Wise, Note, *Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effect of Tarasoff*, 31 STAN. L. REV. 165 (1978); Andrew C. Greenburg, Note, *Florida Rejects a Tarasoff Duty to Protect*, 22 STETSON L. REV. 239 (1992); Marjorie B. Lewis, Note, *Duty to Warn Versus Duty to Maintain Confidentiality: Conflicting Demands on Mental Health Professionals*, 20 SUFFOLK U. L. REV. 579 (1986); Nancy A. Nesbitt, Note, *Tarasoff v. Regents of the University of California: Psychotherapist's Obligation of Confidentiality Versus the Duty to Warn*, 12 TULSA L.J. 747 (1977); Ginger M. McClarren, Note, *The Psychiatric Duty to Warn: Walking a Tightrope of Uncertainty*, 56 U. CIN. L. REV. 269 (1987); Theodore A. Olsen, Note, *The Duty to Warn: Imposing a Duty to Warn on Psychiatrists-Judicial Threat to the Psychiatric Profession*, 48 U. COLO. L. REV. 286 (1977).

Among medical journals in which *Tarasoff* has been reported, *see* Paul S. Appelbaum, M.D., *Tarasoff: An Update on the Duty to Warn*, 32 HOSP. & COMMUNITY PSYCHIATRY 14 (1981); James C. Beck, *Violent Patients and the Tarasoff Duty in Private Psychiatric Practice*, 13 J. PSYCHIATRY & L. 361 (1985); Alexander D. Brooks, *Mental Health Law—The Duty of Psychotherapists and Administrators to Protect Third Persons from the Potential Violence of a Patient*, 17 ADMINISTRATION AND POLICY IN MENTAL HEALTH 185 (1990); Elizabeth M. Crocker, *Judicial Expansion of the Tarasoff Doctrine: Doctors' Dilemma*, 13 J. PSYCHIATRY & L. 83 (1985); Everstine, *Privacy and Confidentiality in Psychotherapy*, 35 AM. PSYCHOLOGIST 828 (1980); Linn Turner Greenberg, M.D., *The Evolution of Tarasoff: Recent Developments in the Psychiatrist's Duties to Warn Potential Victims, Protect*

the reasoning and conclusions in *Tarasoff* to formulate Missouri law governing the duty a psychiatrist has to warn potential victims.

First, the *Tarasoff* court concluded that foreseeability was the most important consideration in establishing a duty.[12] Generally recognizing that there is no duty to control the conduct of another, the court noted an exception, found in the *Restatement (Second) of Torts* and *Prosser on the Law of Torts*. The Restatement recognizes a duty to control when one stands in a special relationship to either: (1) the person who needs to be controlled (i.e. a mental patient) or, (2) the foreseeable victim of a patient's conduct.[13]

Concluding that such a special relationship arises between a patient and his physician, the court held that relationship supports affirmative duties to third persons.[14]

The attendant liability of the hospital was added by a footnote:

> When a hospital has notice or knowledge of facts from which it might reasonably be concluded that a patient would be likely to harm himself or others unless preclusive measures were taken, then the hospital must use reasonable care in the circumstances to prevent such harm.[15]

The court explained that the hospital's liability was supported by several decisions holding a mental hospital liable if it negligently permits the escape or release of a dangerous patient.[16] Without any analysis, the court assumed

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the Public, and Predict Dangerousness, 12 J. PSYCHIATRY & L. 315 (1984); Howard Gurevitz, M.D., *Tarasoff: Protective Privilege Versus Public Peril*, 134 AM. J. PSYCHIATRY 289 (1977); Oldham, *Liability of Therapists to Non-Patients*, J. CLINICAL CHILD PSYCHOLOGY 187 (Fall 1987); Loren H. Roth & Alan Meisel, *Dangerousness, Confidentiality, and the Duty to Warn*, 134 AM. J. PSYCHIATRY 508 (1977); Lawson R. Wulsin, Bursztajn & Gutheil, *Unexpected Clinical Features of the Tarasoff Decision: The Therapeutic Alliance and the "Duty to Warn,"* 140 AM. J. PSYCHIATRY 601 (1983).

12. *Tarasoff*, 551 P.2d at 342.

13. *Id.* at 343 (citing RESTATEMENT (SECOND) OF TORTS § 314 cmt. c and PROSSER ON THE LAW OF TORTS § 56, at 341 (4th ed. 1971)).

14. *Id.*

15. *Id.* at 344 n.7 (citing Vistica v. Presbyterian Hosp., 432 P.2d 193, 196 (Cal. 1967) (en banc)).

16. *Id.* (citing Semler v. Psychiatric Institute of Washington, D.C., 44 U.S.L.W. 2439 (4th Cir. 1976); Underwood v. United States 356 F.2d 92 (5th Cir. 1966); Fair v. United States 234 F.2d 288 (5th Cir. 1956); Greenberg v. Barbour 322 F. Supp. 745 (E.D.Pa. 1971) (upholding a cause of action against a hospital staff physician whose negligent failure to admit a mental patient resulted in that patient assaulting the plaintiff)).

that the physician has control in such situations. The court quoted a law review article which concluded that:

> [T]here now seems to be sufficient authority to support the conclusion that by entering into a doctor-patient relationship the therapist becomes sufficiently involved to assume some responsibility for the safety, not only of the patient himself, but also of any third person whom the doctor knows to be threatened by the patient.[17]

The article explained that authority was consistent with "contemporary ground rules on the duty relationship."[18] The court side-stepped the American Psychiatric Association's argument that therapists cannot predict their patients' violent acts, and that psychiatric predictions are more often wrong than right.[19] The court dismissed these arguments by concluding that there was no question about predictability because the therapists had accurately predicted the patient's violence. The issue in *Tarasoff* was whether a therapist has a duty to act upon the accurate prediction that the patient would harm a specific individual.[20]

Acknowledging that imposing liability would inhibit free and open communication or violate California law governing the release of confidential information, the court said that unnecessary warnings were a reasonable price to pay.[21] The court next found the therapist was not exempt from liability for failure to warn based on statutory governmental immunity, primarily because of the lack of specific statutory language indicating immunity in the context of a therapist. The court also declined to extend immunity based on public policy.[22]

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17. *Tarasoff*, 551 P.2d at 344 (quoting John G. Fleming & Bruce Maximov, *The Patient or His Victim: The Therapist's Dilemma*, 62 CAL. L. REV. 1025, 1030 (1974)).

18. *See, e.g.*, Littleton v. Good Samaritan Hosp. & Health Ctr., 529 N.E.2d 449 (Ohio 1988) (court found a duty to control in-patients but declined to decide if it extended to out-patients); Bradley Ctr., Inc. v. Wessner, 296 S.E.2d 693 (Ga. 1982) (duty on mental hospital to control patient in hospital's control).

19. *Tarasoff*, 551 P.2d at 344 (citing People v. Burnick, 535 P.2d 352 (Cal. 1975)); John Monahan, *The Prevention of Violence*, *in* COMMUNITY MENTAL HEALTH AND THE CRIMINAL JUSTICE SYSTEM (Monahan ed. 1975); Bernard L. Diamond, *The Psychiatric Prediction of Dangerousness* 123 U. PA. L. REV. 439 (1975); Bruce J. Ennis & Thomas R. Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 CAL. L. REV. 693 (1974).

20. *Tarasoff*, 551 P.2d at 345.

21. *Id.* at 346-48.

22. *Id.* at 349-50.

The court conceded, however, that specific language under the Lanterman-Petris-Short Act,[23] provided immunity against a claim for failing to restrain or confine a patient.[24] The court noted that:

> Section 856 affords public entities and their employees absolute protection from liability for 'any injury resulting from determining in accordance with any applicable enactment . . . whether to *confine* a person for mental illness. . . .'
>
> The language and legislative history of section 856, however, suggest a far broader immunity. . . . The Legislature . . . broadly extended immunity to all employees who acted in accord with "any applicable enactment," thus granting immunity not only to persons who are empowered to confine, but also to those authorized to request or recommend confinement.
>
> The Lanterman-Petris-Short Act . . . eliminated any specific statutory reference to petitions by treating physicians, but it did not limit the authority of a therapist in government employ to request, recommend or initiate actions which may lead to commitment of his patient . . . . [T]he language of section 856 . . . protects the therapist who must undertake this delicate and difficult task. Thus the scope of the immunity extends not only to the final determination to confine . . . the person for mental illness, but to all determinations involved in the process of *commitment*.[25]

The Lanterman-Petris-Short Act offered no protection for the therapist in *Tarasoff*, however, because confinement was not the issue.[26] The court answered the issue of duty to warn in the affirmative and imposed liability on the therapist. The court did find immunity under the Act, however, for the police officers who released the patient after briefly confining him.[27]

B. Sherrill v. Wilson

In *Sherrill v. Wilson*, plaintiff sued the state of Missouri and various hospital officials and physicians because a mental patient killed plaintiff's relative.[28] A mental patient named Corley had been committed to a state hospital by court order. After being released on a two-day pass, Corley killed

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23. CAL. GOVT. CODE § 856 (1995).
24. *Tarasoff*, 551 P.2d at 351.
25. *Id.* at 351-52 (footnotes omitted) (emphasis added).
26. *Id.* at 353.
27. *Id.*
28. Sherrill v. Wilson, 653 S.W.2d 661 (Mo. 1983) (en banc).

plaintiff's relative.[29] The plaintiff alleged gross negligence for two reasons: (1) releasing Corley on a pass when the hospital knew of his severe mental illness and dangerous proclivities, and (2) failing to recapture Corley after he overstayed his pass.[30] The trial court held that the petition did not state a claim for relief and the Missouri Supreme Court affirmed.[31] The court noted that several Missouri statutes in Chapter 632 were on point, but did not take effect until after the death occurred.[32] Thus, the court explained, it did not have "to interpret or to apply the new statutes."[33] Instead, the court reasoned that the case had to be "decided on ordinary negligence principles."[34]

Although the fatal attack in *Sherrill* did not occur until several weeks after Corley was due to return from his pass, the court assumed "that the issuance of the pass was an event in the direct chain of causation."[35] The court identified the issue as whether the treating physicians owed "such a duty to the general public in deciding which involuntary patients should be released on pass . . . as to give rise to a civil action by a member of the general public for negligent exercise of judgment."[36] The court held that physicians owed no such duty to the general public.[37] The court reasoned:

> Corley was an involuntary patient, but he was not a convict. The law provides for involuntary confinement of persons in mental hospitals if it can be judicially established that they are dangerous to themselves or to the public, but the authority for confinement is hedged about by severe restrictions. The patients are required to be held in the least restrictive environment compatible with their safety and that of the public, and are entitled to treatment. The treating physicians, in their evaluation of the case, well might believe that Corley could be allowed to leave the institution for a prescribed period and that his release on pass might contribute to his treatment and recovery. We do not believe that they should have to function under the threat of civil liability to members of the general public when making decisions about passes and releases. The plaintiff could undoubtedly find qualified psychiatrists who would testify that the treating physicians exercised negligent judgment, especially when they are fortified by hindsight. The effect would be fairly predictable. The

29. *Id.* at 662.
30. *Id.*
31. *Id.* at 662, 669.
32. *Id.* at 664; *see* MO. REV. STAT. § 632 (1994) (effective January 2, 1979).
33. *Sherrill*, 653 S.W.2d at 664. The court did, however, observe that the statutes emphasize the need for the medical staff to exercise discretion and judgment.
34. *Id.*
35. *Id.*
36. *Id.*
37. *Id.*

> treating physicians would indulge every presumption in favor of further restraint, out of fear of being sued. Such a climate is not in the public interest.[38]

The court distinguished *Tarasoff* from the *Sherrill* case as involving a danger "to a particular individual, and the claimed breach of duty was the failure to warn that individual."[39]

The court found the petition in *Sherrill* contained no allegation that the defendant physicians knew that Corley posed a particular danger to the plaintiff's decedent. The court instead found the California case of *Thompson v. County of Alameda*[40] to be on point. In *Thompson*, the California Supreme Court distinguished between a mental patient known to pose a threat to "a foreseeable or readily identifiable target" and one alleged to be a danger to the general public.[41] The court in *Thompson* also expressly distinguished *Tarasoff* as involving threats to a specific individual.[42]

The court focused on the fact that the patient in *Sherrill* was involuntarily committed and, therefore, declined to follow *Mathes v. Ireland* and *Semler v. Psychiatric Institute*, and section 319 of the *Restatement (Second) of Torts*,[43] which deals with the assumption of care and control of dangerous mental patients.[44]

The court explained that even if it assumed Corley was a severely mentally ill person, and danger to the public could be reasonably anticipated, that:

> [t]he defendant physicians should not be held liable for even foreseeable civil damages simply because they might be found to have exercised negligent professional judgment in permitting him to leave the premises. The decision to hold a person against his will is a very serious one, especially when the detainee has not been convicted of a crime. We believe

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38. *Id.* (footnotes omitted).

39. *Id.* at 666 (citing Underwood v. United States, 356 F.2d 92 (5th Cir. 1966); Fair v. United States, 234 F.2d 288 (5th Cir. 1956)).

40. 614 P.2d 728 (Cal. 1980).

41. *Id.* at 734.

42. *Sherrill*, 653 S.W.2d at 666.

43. *See, e.g.*, Mathes v. Ireland, 419 N.E.2d 782, 786 (Ind. Ct. App. 1981) (allowing a cause of action to be stated against physiatric clinic); Semler v. Psychiatric Institute, 538 F.2d 121, 123 (4th Cir. 1976) (upholding a judgment against psychiatrists for negligence in care of a mental health patient which resulted in the death of plaintiff's daughter); and RESTATEMENT (SECOND) OF TORTS § 319 (1965).

44. *Sherrill*, 653 S.W.2d at 666.

> that 'an actual holding of liability would have worse consequences than the possibility of actual mistake.'[45]

The court then emphasized:

> the persons responsible for Corley's custody and treatment do not owe a civil duty to the general public, with regard to securing his return. The recognition of a duty of this kind could place a severe burden on the public service. It would probably not be difficult in many cases to make a case for the jury as to the foreseeability of injury, but this is not sufficient to establish a duty to the public at large.[46]

The court also dealt with plaintiff's argument based on *Missouri Revised Statute* section 202.430 (1969), now repealed, which authorized state hospital authorities to call upon the local sheriff to assist in apprehending escaped or strayed inmates.[47]

Plaintiff argued there was an affirmative duty to notify the sheriff in such situations. The court was reluctant to find an implied civil action from statutes that do not refer to civil liability in express terms.[48] The court held that, at a minimum, a plaintiff must be a member of a class for whose benefit the statute was enacted.[49]

The *Sherrill* court concluded that public interest and policy required denying a cause of action against public employees who fail to return to custody public mental hospital patients who were on temporary leave when said patients injure a member of the general public.[50] The treating

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45. *Id.* at 667 (quoting 2 FOWLER V. HARPER & FLEMING JAMES, THE LAW OF TORTS, § 29.10).

46. *Id.* at 668.

47. *Id.* at 668.

48. *Id.* at 669 (citing Shqeir v. Equifax, Inc., 636 S.W.2d 944 (Mo. 1982) (en banc).

49. *Id.* at 669 (citing 73 AM. JUR. 2D *Statutes*, §§ 432-33). The court explained:

> The statute here cited was not passed for the benefit of a discrete class. Its primary purpose is to authorize one governmental agency to call on another for help. There is no indication of any special duty in the language of the statute. The statute does not clearly require the hospital authorities to notify the sheriff. A statute of this kind will not be read as conferring a civil action by implication. Nor may the plaintiff base a civil action on the duty of the hospital authorities to keep the committed person in custody as initially directed by the juvenile court.

Id.

50. *Id.*

psychiatrists owe no duty to the public generally to impose tort liability for negligence.[51]

C. *Matt v. Burrell*

In 1995, the Missouri Supreme Court reaffirmed its stance articulated in *Sherrill*, by declining to change the lower court's holding that mental health care givers and facilities would not be liable for failure to restrain a patient who injures a previously unidentified member of the general public.[52]

Matt v. Burrell, Inc. was an action for the wrongful death of Mary Lynn Matt, who died as a result of a vehicular collision. Count I of the petition, seeking recovery against a mental hospital, two hospital employees and a doctor was dismissed for failure to state a claim upon which relief could be granted.

Plaintiffs argued that a claim was stated for the following reasons: (1) a special relationship of patient/mental health care providers existed between defendants and their patient, LeAnn Olshavsky, which imposed a duty upon defendants to use reasonable care to control her conduct toward third persons, such as Mary Lynn Matt, and (2) defendants had "taken charge" of Olshavsky, whom they knew or should have known to be likely to cause bodily harm to others if not controlled, and thus, they had a duty to exercise reasonable care to control her to prevent such harm.[53]

The Petition enumerated several allegations, which can be summarized as follows:

1. December 19, 1990, decedent died as a direct result of a collision when defendant Olshavsky drove her vehicle into decedent's lane, and into decedent.

2. Burrell is a community psychiatric rehabilitation center. Olshavsky was and had been a patient of Burrell.

3. Olshavsky had fifteen (15) prior hospitalizations for mental illness, and had made repeated attempts at suicide. Defendants knew of this history.

4. Olshavsky "presented herself" to Burrell at its facility and was seen there by Goodwin and Clement. Olshavsky was mentally ill, depressed and suicidal. Her condition was reported to McAfee.

5. Olshavsky stated that she was going to leave the Burrell facility and kill herself by wrecking her car. The four defendants knew her intent and knew she was a danger to herself and others if she were permitted to leave. Defendants failed to stop her departure.

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51. *Id.*
52. Matt v. Burrell, Inc., 892 S.W.2d 796 (Mo. Ct. App. 1995).
53. *Id.* at 797.

6. Burrell had taken charge of and treated Olshavsky since May 30, 1989, and participated in Olshavsky's involuntary detention in August and early December 1990.

7. Burrell developed on an ongoing basis a "Critical Intervention Plan" which included an involuntary 96-hour hold of Olshavsky should the need arise. Burrell and its employees had a duty to restrain Olshavsky on December 19, 1990.

8. Defendant negligently failed to: (a) prevent Olshavsky from leaving the facility, (b) to diagnose and treat Olshavsky's mental illness, (c) "timely call the police or other authority to restrain Olshavsky." Decedent's death was the direct and proximate result of defendants' negligence.[54]

The court in *Matt* found there was no breach of duty to restrain the patient or warn others.[55] The court recognized the duty regarding the acts of a voluntary outpatient is less than that owed regarding a voluntary inpatient, and the highest duty is imposed concerning a person who has been involuntarily committed by court order.[56] The court found that Olshavsky was a voluntary patient, and thus, a lower duty was imposed on the defendant.[57]

The court expanded the *Matt* plaintiffs' narrow interpretation of *Sherrill* by holding that non-liability was not based on governmental immunity.[58] Specifically, the court explained:

> Although *Sherrill* held that the state was protected from liability by the doctrine of sovereign immunity, that immunity was not available to some of the individual defendants, nevertheless they owed no duty to the general public. In the absence of a duty, there could be no breach, and thus no liability for the death of Mindy Matt. Any issue of immunity would come into play only if liability otherwise existed.[59]

The court also held that no physician-patient or hospital-patient relationship existed between the instant plaintiffs, or their decedent, and defendants, thus refuting plaintiffs' special relationship argument.[60]

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54. *Id.* at 798-99; *see* Petition for Wrongful Death, Legal File pp. 2-8.

55. *Matt*, 892 S.W.2d at 801. *See also* State *ex rel.* Twiehaus v. Adolf, 706 S.W.2d 443, 448 n.4 (Mo. 1986) (en banc) (noting that *Sherrill* held "that treating physicians owed no tort duty to members of the general public regarding the decision to release a mental patient under involuntary commitment.").

56. *Matt*, 892 S.W.2d at 801.

57. *Id.*

58. *Id.*

59. *Id.*

60. *Id.*

Although not necessary to its holding, the court commented in dicta that, "[s]trangely, none of the parties to the instant appeal had cited any Missouri statute."[61]

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61. *Id.* The court cited several sections of the Missouri Revised Statutes as relevant to the case at hand:

Section 632.105 reads, in pertinent part:

> 1. The head of a private mental health facility may, and the head of a department mental health facility shall, except in the case of a medical emergency and subject to the availability of suitable programs and accommodations, accept for evaluation, on an outpatient basis if practicable, any person eighteen years of age or over who applies for his admission . . . .
>
> 2. If a person is diagnosed as having a mental disorder, other than mental retardation or developmental disability without another accompanying mental disorder, and is determined to be in need of inpatient treatment, the person may be admitted by a private mental health facility and shall be admitted by a departmental health facility, if suitable accommodations are available, for care and treatment as an inpatient for such periods and under such conditions as authorized by law . . . .
>
> 3. A person who is admitted under this section is a voluntary patient and shall have the right to consent to evaluation, care, treatment and rehabilitation and shall not be medicated without his prior voluntary and informed consent; except that medication may be given in emergency situations.

MO. REV. STAT. § 632.105 (1994).

Section 632.150 reads:

> 1. A voluntary patient who has applied for his own admission may request his release either orally or in writing to the head [As used in Chapter 632, "Head of mental health facility" means "superintendent or other chief administrative officer of a mental health facility, or his designee." *See* § 632.005(6).] of the mental health facility [As used in Chapter 632, "Mental health facility" means "any residential facility, public or private, which can provide evaluation, treatment and inpatient care to persons suffering from a mental disorder or mental illness and which is recognized as such by the department . . . ." *See* § 632.005(11).] and shall be released immediately; except, that if the head of the facility determines that he is mentally disordered and, as a result, presents a likelihood of serious physical harm to himself or others, the head of the facility may refuse the request for release.
>
> 2. If the request for the release is refused, the mental health facility may detain the person only if a mental health coordinator, a licensed physician, a registered professional nurse designated by the facility and approved by the department, a mental health professional or a peace officer completes an application for detention for evaluation and treatment to begin the involuntary detention of the patient under this chapter.

The court recognized that section 632.150.1 imposes a duty on a mental health facility to release a voluntary patient who orally or in writing requests release. There is a statutory exception when the facility head may refuse the request upon determination that the patient is mentally disordered, and thus, is likely to seriously harm himself or others. However, the court in *Matt* found no allegation that the head of the facility made such a determination.[62] The court noted in dicta that even if such an allegation had been made, as in *Sherrill*, Missouri courts are reluctant to find an implied civil action from a statute which does not expressly refer to civil liability.[63] The court also noted that, as a member of the general public, plaintiffs' decedent in *Matt* would not meet the requirement that plaintiff be a member of the general class for whose benefit the statute was enacted (i.e. abuse of children).[64]

The medical community was relieved that the Missouri Supreme Court left intact the *Matt* and *Sherrill* decisions and therein declined to broaden the scope of the duty that the medical community owes to the public regarding dangerous mental patients. The Missouri Supreme Court's non-decision and subtle reaffirmation of *Sherrill* properly limits the liability of mental health providers and is sound for several reasons. First, mental health care and treatment, as recognized some twenty years ago by then Chief Justice Warren Burger, is not an exact science.[65] Mental health providers should not be liable for mere mistakes in judgment, measured by hindsight, in deciding whether to release or restrain patients. Second, predicting actual specific violent behavior is virtually impossible.[66] In addition, a decision recognizing a cause of action in *Matt* would result in: (1) diagnosis and treatment not in the best interests of the patient, but with an eye toward potential liability of the care giver, and (2) resolving doubts in favor of restraint, rather than less restrictive treatment. Foremost, the Missouri Supreme Court's stance is sound because the duty that the medical community owes to the public regarding restraint of mental patients should be decided by the legislature, not the courts.

MO. REV. STAT. § 632.150 (1994) (definitions added).

62. Specifically, the judge found exhibit F, attached to the petition, did not constitute such a determination. That exhibit, dated September 6, 1990, dealt with a prior hospitalization of Olshavsky and was signed by case worker, but it did not state that Olshavsky was mentally disordered or presented a likelihood of serious physical harm to herself or others. *Matt*, 892 S.W.2d at 802 n.4.

63. *Id.* at 800.

64. *Id.* at 801-02.

65. Warren E. Burger, *Psychiatrists, Lawyers and the Courts*, 20 FED. PROB. 3, 7 (1964).

66. *See infra* discussion at Part III.B of this article.

D. Bradley v. Ray

A third Missouri case of importance *Bradley v. Ray* addresses the duty to warn. As such, it should perhaps be discussed, along with *Tarasoff*, in Part III.D. of this article. Because Missouri courts have analyzed the foundation of both the duty to restrain and the duty to warn under the same criteria, however, it is appropriate to conjunctively analyze *Bradley* with *Matt* and *Sherrill* under duty to restrain.

In 1995, the Missouri Court of Appeals recognized a duty of a health care provider to warn of a mental patient's propensity to abuse his stepdaughter.[67] Notwithstanding the Missouri Supreme Court's affirmations of no duty to warn, the *Bradley* court reversed a trial court decision dismissing a claim against psychologists treating a child abuser. The trial court held that there was no common law duty to warn appropriate officials of the child abuse.[68] The petition alleged the child was abused by the perpetrator, her stepfather, for nine years, starting when she was four years old in 1980. The defendants were licensed Missouri psychologists who began counseling the perpetrator/patient for abuse of the child in 1988, "but shortly thereafter terminated the counseling."[69]

The *Bradley* court reversed the trial court's holding that there was no duty by relying on the statutory duty to report child abuse. The statute reads in pertinent part:

> When any . . . psychologist, . . . has reasonable cause to suspect that a child has been or may be subjected to abuse or neglect or observes a child being subjected to conditions or circumstances which would reasonably result in abuse or neglect, that person shall immediately report or cause a report to be made to the division . . . .[70]

The court also relied on *Tarasoff* and held that when a health care professional knows or should have known under his professional standard that a patient is a serious threat to injure a readily identifiable third party, the health care professional has a Missouri common law duty to warn the intended victim or those capable of warning the intended victim.[71]

The court did limit its holding by noting that "there [was] no duty to actually control the conduct of the potential wrongdoer".[72]

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67. Bradley v. Ray, 904 S.W.2d 302 (Mo. Ct. App. 1995).
68. *Id.* at 312.
69. *Id.* at 305.
70. *Id.* at 305-06. *See also* MO. REV. STAT. § 210.115 (1994).
71. *Bradley*, 904 S.W.2d at 312.
72. *Id.* at 312 n.7.

Bradley was in a unique context: child abuse. Thus, in light of *Sherrill* and *Matt* (refusing to impose a duty), and the egregious facts in *Bradley*, the holding in *Bradley* should be construed narrowly.

The court reasoned that the psychologists in *Bradley*: (1) should have reasonably foreseen the threat of serious future harm to the identified victim, a child; (2) were specifically retained to counsel the perpetrator/patient regarding child abuse; (3) commenced treatment and were aware of the possibility of continuing and future abuse; and (4) failed to notify law enforcement authorities "during the counseling and upon termination of their services as required by the Child Abuse Reporting Act, Section 210.115." The plaintiff contended that the patient perpetrator continued to abuse the child as a result of defendant's failure to report the abuse.

The court's negligence analysis focused on whether the psychologists had a duty to warn the child. The court found that this was an issue of first impression in Missouri.[73]

The *Bradley* court held that a duty to warn was supported by Missouri law in a child abuse case:

> The concept of imposition of a legal duty on certain members of the medical profession in order to protect from future harm by a patient is . . . not new in Missouri. For instance, physicians are under a legal duty to report any patients who are infected with HIV to the Department of Health in order to protect the public health.[74] Physicians are also allowed to disclose confidential patient information to warn spouses and care givers of the HIV status of a patient,[75] ostensibly in order to warn them of possible future harm. Other courts have noted that there is "no reason why a similar duty to warn should not exist when the 'disease' of the patient is a mental illness that poses an analogous risk of harm to others".[76] For these reasons, and in keeping with the vast majority of courts which have considered this issue, we hold that the relationship between psychologists and their patients is the kind of "special" relationship on which liability can be based for failure to warn.[77]

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73. *Id.* at 306. One might question whether this was really a case of first impression. After all, *Sherrill* and *Matt* clearly answered in the negative the question of whether a mental health provider has the duty to restrain a mental patient. In the context of child abuse, however, the court chose not to follow this precedent.

74. *Id.* at 311 (citing MO. REV. STAT. § 191.653.3 (1994)).

75. *Id.* (citing MO. REV. STAT. § 191.656.2 (1994)).

76. *Id.* (citing Peck v. Counseling Serv., 499 A.2d 422, 425 (Vt. 1985) (citations omitted)).

77. *Id.* (citing Naidu v. Laird, 539 A.2d 1064, 1072 (Del. 1988); McIntosh v. Milano, 403 A.2d 500, 509 (N.J. 1979); Almonte v. New York Medical College, 851 F. Supp. 34, 41 (D. Conn. 1994); Lipari v. Sears, Roebuck & Co., 497 F. Supp. 185, 189 (D. Neb. 1980); Littleton v. Good Samaritan Hosp. & Health Ctr., 529 N.E.2d

The court distinguished *Sherrill* by pointing out that it was considering a particular identified victim, and not a duty to the general public, as was at issue in *Sherrill*.[78] The court also emphasized the importance of the harm being foreseeable, noting that the duty arises not from any "special relationship" of the parties, but from the defendant's knowledge of a dangerous threat to the plaintiff, and time and ability to prevent the attack.[79]

The court then concluded that while generally an individual is not liable for the intervening criminal act of a third person, the rule does not cover the situation where the defendant had reasons to anticipate that criminal act.[80] Whether the plaintiff can prove the continued abuse was reasonably foreseeable is not yet known because the case is on remand. But *Bradley*, at the least, aligns Missouri with those states recognizing a duty to warn in the child abuse context.

What is left open by the *Bradley* decision is whether that duty to warn could have been satisfied by warning the victim, her mother, or persons other than the police. The closest the court came to addressing that issue was when it indicated that communicating the existence of such danger *to those likely to warn the victim*, including notifying appropriate law enforcement authorities, would satisfy the psychologist's duty to warn.[81]

The *Bradley* court recognized that, in certain circumstances, the threat of harm to an identified or identifiable potential victim, and the likelihood of serious harm, may be so great that there should be a duty to warn. The problem is that in *Bradley*, both the victim and her mother knew of the abuse, and there is no evidence they informed the police or any other authorities. Without the cooperation of the victim or her mother, it is uncertain whether the police or others could have intervened. Likewise, the victim and her mother should be estopped from claiming the mental care providers failed to go to the police because the mother and victim did not go to the police or other appropriate authorities.

What if the psychologists had reported the suspected abuse to the police, who then arrested the perpetrator, only to discover there had been no continuing abuse since the perpetrator began treatment? Absent a statute protecting them, they would be liable for violating the patient/physician privilege. What about the psychological damage to the family if the problems had stopped prior to the police involvement? Exactly what factors trigger the

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449, 455 (Ohio 1988)).

78. *Id.* at 309-10.

79. *Id.* at 311 (citing Reed v. Hercules Constr. Co., 693 S.W.2d 280, 282 (Mo. Ct. App. 1985)).

80. *Id.* at 312 (quoting Bradley Ctr., Inc. v. Wessner, 296 S.E.2d 693, 696 (Ga. 1982)).

81. *Id.* at 306 (emphasis added).

duty to warn, and how does one prove that it was the psychologists' failure to call the police that caused the harm? *Bradley* leaves these questions unanswered.

III. FACTORS ANALYZED BY THE COURTS IN DUTY TO WARN AND DUTY TO RESTRAIN CASES

A. Analysis of the "Special Relationship Argument" under Missouri Law

The four cases discussed in the preceding section demonstrate the effort to base cases of failure to restrain or warn on recognition of a special relationship between the defendant and a perpetrator. Under section 319 of the *Restatement (Second) of Torts*, when there is a special relationship between individuals, there is a duty, the breach of which creates liability.

In general, however, a person has no duty to control the actions of another for the protection of a third person.[82] One recognized exception to the rule is that "special relationships" can give rise to such a duty.[83]

In *Matt*, the plaintiffs asserted that the health care providers were liable based on *Restatement (Second) of Torts* section 319.[84] That section provides that "[O]ne who takes charge of a third person whom he knows or should know to be likely to cause bodily harm to others if not controlled is under a duty to exercise reasonable care to control the third person to prevent him from doing such harm."[85] Prior to *Bradley*, no Missouri court had ever applied *Restatement (Second) of Torts* section 319 to impose liability on mental health care providers. In *Bradley*, however, the court recognized a duty to warn in the context of the case, but specifically held that "there is no duty to actually control the conduct of the potential wrongdoer, only a duty to warn."[86]

The plaintiffs argued in *Matt* that Missouri follows the "special relationship" rule found in Restatement sections 315-19.[87] But while the

82. Faheen v. City Parking Corp., 734 S.W.2d 270, 272 (Mo. Ct. App. 1987).

83. *Id.*; RESTATEMENT (SECOND) OF TORTS §§ 315-19 (1965).

84. *Matt*, 892 S.W.2d at 800.

85. RESTATEMENT (SECOND) OF TORTS § 319 (1965).

86. *Bradley*, 904 S.W.2d at 312 n.7.

87. Appellant's Brief at 13-15, Matt v. Burrell, Inc., 892 S.W.2d 796 (Mo. Ct. App. 1995) (Missouri Supreme Court No. 77334) (citing Virginia D. v. Madesco Inv. Corp., 648 S.W.2d 881 (Mo. 1983); Meadows v. Friedman R.R. Salvage Warehouse, 655 S.W.2d 718, 721 (Mo. Ct. App. 1983)) ("Such relationships are usually delineated as those of innkeeper-guest, common carrier-passenger, school-student, and sometimes employer-employee.").

cases cited by the plaintiffs in *Matt* recognize relationships which give rise to a duty to protect, they are not of a type contemplated by the Restatement sections on which they rely. The proper analysis of a sections 315-19 case requires a relationship between two persons that causes one of those persons to protect a third person who is not part of the relationship.[88] The cases cited by the plaintiffs in *Matt*, however, establish a duty upon one person in the relationship to protect the other in the relationship from the actions of a third person.[89]

Missouri cases prior to *Bradley* did not base a "special relationship" duty on *Restatement (Second) of Torts* sections 315-19, but rather on section 344, which deals with premises-based liability. In general, the duty to protect is imposed upon a landowner who knows, or should know, the potential for the type of attack suffered by the plaintiff. While Missouri courts recognize a section 344 duty, they severely restrict it. In *Faheen v. City Parking Corp.*, the plaintiff offered evidence of a series of prior violent crimes, including arson, robbery, assault, burglary and stealing, which occurred in defendant's parking garage.[90] The plaintiff also proved that the defendant knew of these crimes. The plaintiff argued that the landowner was liable for failing to protect plaintiff's decedent from a fatal attack. The court held that while the defendant had knowledge of prior violence, there had been no prior car bombings or murders in the parking garage. The court in *Faheen* concluded that because the assault on the decedent was a bomb blast, there was no liability.[91] Generally, Missouri courts have been loathe to impose liability for a defendant's failure to control a third party's actions.[92]

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88. *See* Clark v. Mincks, 364 N.W.2d 226 (Iowa 1985) (suit brought by parents of a deceased child against social host who had served the intoxicated driver who crashed into child's vehicle); Williams v. Gorman, 520 A.2d 761 (N.J. Super. Ct. App. Div. 1986) (suit against a landlord after a motorcycle gang member injured a tenant where the landlord had notice of the gang member's violent acts but failed to evict him) as examples of the argument that defendant had a special relationship to the one causing harm which created a duty to protect third persons, *i.e.* the plaintiff.

89. *Matt*, 892 S.W.2d at 799. The opinion cites several cases plaintiff relied upon, including Semler v. Psychiatric Institute, 538 F.2d 121 (4th Cir. 1976), Lopper v. Sears, Roebuck & Co., 497 F. Supp. 185 (D. Neb. 1980), and Tarasoff v. Regents of University of California, 551 P.2d 334 (Cal. 1976) to name a few.

90. *Faheen*, 734 S.W.2d at 271.

91. *Id.* at 274.

92. *See, e.g.*, Stottle v. Brown Group, Inc., 801 S.W.2d 479, 481 (Mo. Ct. App. 1990) (social host not liable for serving alcohol to a guest who later injures another); Jackson v. Bi-State Transit Sys., 550 S.W.2d 228, 232 (Mo. Ct. App. 1977) (bus line not liable for injuries to passenger caused when assailant threw rock through bus window); Hammers v. Farm Bureau Town & Country Ins. Co., 792 S.W.2d 19, 21 (Mo. Ct. App. 1990) (insurer not liable for negligence of insured driver, even if insurer

In *Bradley*, however, the court declared that the issue of placing a duty on the treating psychologist to warn the victim or those likely to warn the victim, was one of first impression. The court found such a duty based on several factors. First the court recognized the importance of imposing a duty where it might protect children from child abuse (a fact peculiar to *Bradley* among the four cases discussed). This importance has been recognized by the legislature [and the Missouri Supreme Court] in adopting *Missouri Revised Statute* section 210.115.[93]

Another reason the *Bradley* court imposed a duty to warn was because of the special relationship between a physician and a patient.[94] The court, without citing *Matt*, found this special relationship based on *Restatement (Second) of Torts* section 315 and the statutory duties to warn in the *Missouri Revised Statutes* section 191.653.3 and section 191.656.2. Once the court finds that a special relationship exists, the duty to warn is the same, regardless of whether the "disease" is physical or mental.[95] Finally, the *Bradley* court imposed a duty because the harm to the child was clearly foreseeable.[96]

Although the court in *Bradley* found no duty to control the potential wrongdoer, it did find a duty to warn.[97] To find "special relationship" liability under the *Restatement (Second) of Torts* section 319, a Missouri court should be required to find: (1) that the defendant had taken charge of the third person, (2) the defendant knew the third person would likely cause harm to others, and (3) the defendant failed to use reasonable care to control the third person. In short, the issue of control should play a larger role in the court's analysis of "special relationship."

In *Sherrill*, the patient had been involuntarily committed and released on a pass. In *Matt*, the patient was a voluntary outpatient. Under Missouri law, a voluntary psychiatric patient has the right to consent to any and all care, treatment and medication.[98] A voluntary patient also has the right to be released immediately.[99] The Illinois Supreme Court has held that a voluntary

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knew driver was incompetent when policy was issued).

93. *Bradley*, 904 S.W.2d at 310 (citing State ex rel. D.M. v. Hoester, 681 S.W.2d 449, 552 (Mo. 1984) (en banc) (noting the importance of tort actions as a deterrent to child abuse)); MO. REV. STAT. § 210.115 (1994).

The court in *Bradley* did, however, specifically decline to find a private cause of action based on § 210.115, and thus sustained the trial court's dismissal of that count of the petition. *Bradley*, 904 S.W.2d at 314.

94. *Bradley*, 904 S.W.2d at 311.

95. *Id.*

96. *Id.* at 311-12.

97. *Id.* at 312 n.7.

98. MO. REV. STAT. § 632.105 (1994).

99. MO. REV. STAT. § 632.150 (1994).

outpatient is not under the control of the institution for section 319 purposes.[100] In *Estate of Johnson v. Condell Memorial Hosp.*, the decedent's estate sued a mental hospital after the decedent was killed by a police car that was chasing an escaped mental patient.[101] The court noted that a voluntary mental patient in Illinois is entitled, by statute, to be released whenever the person wishes during the facility's day shift.[102] The court held that since the patient retained that right at the time he left the facility it could not "infer that [the patient] had been committed to [the facility's] custody."[103]

Likewise, a Colorado court held that there is no element of control by the mental health care provider when a patient is a voluntary one.[104] The court imposed a duty on the health care provider not to release a mental patient when the mental patient was committed involuntarily and had a propensity for violent behavior and continuing mental illness.[105]

In another case, a patient being treated at a hospital for schizophrenia told a licensed clinical social worker that voices in his head were telling him to do "bad things."[106] After voluntarily admitting himself into an "open" ward at the hospital, the patient walked away and sexually assaulted a woman. The victim sued the mental health care providers claiming they owed her a duty to restrain the patient. The court, recognizing the patient was in the hospital voluntarily, held that there was no control, and therefore, no duty under section 319.[107]

These decisions recognize the tension between the duty owed to the public and potential victims of mental patients, and the duty owed to the patient, which many believe includes the least restrictive treatment possible.

Early in the *Tarasoff* debate, Fleming and Maximov posited the psychotherapist's dilemma as how to protect the public without abusing the psychotherapists "awesome preemption of legal authority." That preemption, according to Fleming and Maximov, arises from the fact the psychotherapist often "serves not only as arresting officer, but as prosecutor, judge, and jailer

100. In Estate of Johnson v. Condell Memorial Hosp., 520 N.E.2d 37 (Ill. 1988).
101. *Id.* at 38.
102. *Id.* at 41.
103. *Id.* at 42.
104. Perreira v. State, 768 P.2d 1198, 1216 (Col. 1989).
105. *Id.* at 1219.
106. Burchfield v. United States, 750 F. Supp. 1312, 1314 (S.D. Miss. 1990).
107. *Id.* at 1319. *See also* Currie v. United States, 836 F.2d 209 (4th Cir. 1987) (the defendant lacked control); Paddock v. Chacko, 522 So. 2d 410 (Fla. Dist. Ct. App. 1988) (holding that a mental health professional was under no legal duty to involuntarily commit a patient); Santa Cruz v. Northwest Dade Community Health Ctr., Inc., 590 So. 2d 444 (Fla. Dist. Ct. 1991) (the "right to take charge" under a § 319 analysis does not apply to voluntary patients).

as well" when he involuntarily commits a mental patient, and thereby deprives the patient "of liberty, stigmatizes him, destroys his will to resist, and breaches [his] confidentiality".[108]

Another problem with applying section 319 to patient/therapist relationships is that there is a wide range of relationships between patients and their mental health care giver. In some instances, patients voluntarily surrender to their care givers a great deal of control. In other instances control of a mental patient is involuntarily thrust upon a psychotherapist by a court ruling. The doctrine of special relationships seems better suited in the context of innkeeper/guest, where the particular circumstances of the relationships require little scrutiny, and there is little variance in the actual relationship between most innkeepers and their guests.

Sometimes mental patients, either expressly or by their actions, give a particular therapist or mental health care giver control, but do not give control to other mental health care givers. While the Missouri cases prior to *Bradley* distinguish between voluntary and involuntary control, that distinction now seems questionable. A voluntary patient may, during moments of sanity, recognize his dangerous proclivities and authorize voluntary control by others. Should care givers with greater control have less liability just because the initial commitment was voluntary? Is the duty to warn less? This Article suggests that it should not be less.

B. Predictability of Harm

The United States Supreme Court has recognized that "the subtleties and nuances of psychiatric diagnoses render certainties virtually beyond reach in most situations."[109] Unlike other health care providers, whose diagnoses can be verified at the outset by a CAT scan, MRI, x-ray, blood tests, palpation and surgery, psychiatric and mental health professionals cannot verify their diagnoses, treatment or discretionary judgment, except through hindsight.[110] Former Chief Justice Warren Burger observed that psychology is an infant among the family of science.[111] Recognizing that psychiatry is not an exact science, the United States Supreme Court has noted:

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108. Alan A. Stone, *The Tarasoff Decisions, Suing Psychotherapists to Safeguard Society*, 90 HARV. L. REV. 358, 362 (1976) (quoting John G. Fleming & Bruce Maximov, *The Patient or His Victim: The Therapist's Dilemma*, 62 CAL. L. REV. 1025, 1046 (1974)).

109. Addington v. Texas, 441 U.S. 418, 429 (1979).

110. *See* Thomas B. Almy, *Psychiatric Testimony: Controlling the "Ultimate Wizardry" in Personal Injury Actions*, 19 THE FORUM 233, 243 (1984), *quoted in* Boynton v. Burglass, 590 So. 2d 446, 450 (Fla. Dist. Ct. 1991).

111. Burger, *supra* note 65, at 7.

> "[P]sychiatrists 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."[112]

As inexact as psychiatry is in general, using psychiatric evidence to predict the future dangerousness of a patient borders on clairvoyance. Prophecies about future violence in a particular situation cannot be guided by statistical evidence.

One commentator on a psychiatrist's duty to warn, predating the final decision in *Tarasoff*, pointed out that most of the scientific analysis focuses on the "reliability" of psychiatric predictions, which simply refers to agreement between observations of independent observers, and is not the same as "validity," which refers to how accurate the judgments are.[113]

Scientific analysis focusing on the validity of psychiatric predictions concludes that the predictions are inaccurate.[114] In one study, for example, only a small percentage of criminally insane patients who were released from a British hospital were found to have later committed murders.[115]

Probably the most remarkable study was summarized by the court in *Tarasoff*:

> Psychiatrists predicted that 989 persons were so dangerous that they could not be kept even in civil mental hospitals, but would have to be kept in maximum security hospitals run by the Department of Corrections. Then, because of a United States Supreme Court decision, those persons were transferred to civil hospitals. After a year, the Department of Mental Hygiene reported that one-fifth of them had been discharged to the community, and over half had agreed to remain as voluntary patients. During the year, only 7 of the 989 committed or threatened any act that was sufficiently dangerous to require retransfer to the maximum security

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112. Ake v. Oklahoma, 470 U.S. 68, 81 (1985).

113. *See* Ennis & Litwack, *supra* note 19, at 699.

114. *See, e.g.*, John Monahan, *The Prediction of Violent Behavior, Toward a Second Generation of Therapy and Policy*, 141 AM. J. OF PSYCHOLOGY 10 (1984); Joseph J. Cocozza & Henry J. Steadman, *The Failure of Psychiatric Predictions of Dangerousness: Clear & Convincing Evidence*, 29 RUTGERS L. REV. 1084 (1976); Ennis & Litwack, *supra* note 19, 701-03 (citing J. ZISKIN, COPING WITH PSYCHIATRIC AND PSYCHOLOGICAL TESTIMONY (Law and Psychology Press)); Philip Ash, *The Reliability of Psychiatric Diagnosis*, 44 J. ABNORMAL & SOCIAL PSYCHOLOGY 272 (1949); Hermann O. Schmidt & Charles P. Fonda, *The Reliability of Psychiatric Diagnosis: A New Look*, 52 J. ABNORMAL & SOCIAL PSYCHOLOGY 262 (1956).

115. *Violence and Violent Patients: Part I*, THE HARVARD MENTAL HEALTH LETTER (Harvard Medical School, Boston, MA) June 1991, v. 7, No. 12, at 3.

hospital. Seven correct predictions out of almost a thousand is not a very impressive record.[116]

The above study illustrates that psychiatric judgments that are intended to be humane may subject people to an unnecessary loss of liberty.[117] In addition, other studies show that psychiatric incompetence-to-stand-trial judgments often harm rather than help defendants.[118] Numerous other studies have reached the same conclusion.[119] Faced with such reports, it is not

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116. *Tarasoff*, 551 P.2d at 360 n.5; *see also* People v. Burnick, 535 P.2d 352, 365-66 n.17 (Cal. 1975); BRUCE J. ENNIS, PRISONERS OF PSYCHIATRY: MENTAL PATIENTS, PSYCHIATRISTS, AND THE LAW (1972); Ennis & Litwack, *supra* note 19, at 712:

> "Operation Baxstrom" [involved] 969 prisoner-patients in New York State who were affected by the Supreme Court's decision in Baxstrom v. Herold. The Court held that those persons remaining in Department of Corrections hospitals after their prison terms had expired must be released, and committed civilly, if at all. Each of the 969 patients had been detained in maximum-security hospitals because psychiatrists determined that they were mentally ill and too dangerous for release or even for transfer to civil hospitals. Nevertheless, one year after the patients were transferred to civil hospitals, 147 had been discharged to the community and the 702 who remained were found to present no special problems to the hospital staff. Only 7 patients were found to be so difficult to manage or so dangerous as to require recommitment to a Department of Corrections hospital. Several years later, 27 percent of the patients were living in the community, only 9 had been convicted of a crime (only 2 of felonies), and only 3 percent were in a correctional facility or hospital for the criminally insane.

As one of the authors explained elsewhere:

> In statistical terms, Operation Baxstrom tells us that psychiatric predictions are incredibly inaccurate. In human terms, it tells us that but for a Supreme Court decision, nearly 1,000 human beings would have lived much of their lives behind bars, without grounds privileges, without home visits, without even the limited amenities available to civil patients, all because a few psychiatrists, in their considered opinion, thought they were dangerous and no one asked for proof.

BRUCE J. ENNIS, THE RIGHTS OF MENTAL PATIENTS, IN THE RIGHTS OF AMERICANS 487 (Dorsen ed. 1970).

117. *Tarasoff*, 551 P.2d at 360 n.5.

118. *See* A. Louis McGarry, *The Fate of Psychotic Offenders Returned For Trial*, 127 AM. J. PSYCHIATRY 1181 (1971).

119. As reported by Ennis & Litwack:

> Another recent study, described by one observer as "the most extensive study to date on the prediction . . . of dangerousness in criminal offenders, (citing John Monahan, *Dangerous Offenders: A Critique of Kozol*, 19 CRIME & DELINQUENCY 418 (1973) confirms the lesson of

surprising that the court in *Tarasoff* concluded that, "[p]sychiatrists simply cannot predict dangerous behavior."[120]

Conclusions have not changed much in the almost twenty years since *Tarasoff*.[121] Monahan summarized his review of the literature on predictions of violence in 1973, concluding that violence is overpredicted:

> Of those predicted to be dangerous, between 65 percent and 95 percent are false positives—that is, people who will not, in fact, commit a dangerous act. Indeed, the literature has been consistent on this point ever since Pinel

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> Baxstrom. A Team of at least five mental health professionals, including two or more psychiatrists, was asked to conduct unusually thorough clinical examinations of individuals who had been convicted previously of serious assaultive crimes (often sexual in nature), assigned to special treatment programs after conviction, and who were then eligible for release. Based upon the examinations, extensive case histories, and the results of psychological tests, the team attempted to predict which individuals again would commit assaultive crimes if released. These predictions of dangerousness were made prior to the court hearings at which the ultimate release decision were made. Of 49 patients considered by the evaluating team to be dangerous and therefore not recommended for release, but who nevertheless were released after a court hearing, 65 percent had not been found to have committed a violent crime within five years of returning to the community. In other words, two-thirds of those released despite predictions of dangerousness by the professional team did not in fact turn out to be dangerous.
>
> Still another study found that only five of 1,630 parolees (.31 percent, or less than one-third of one percent) identified by the California Department of Corrections at the time of release as "Potentially Aggressive" (based on a history of aggressive behavior and psychiatric predictions) actually committed known violent crimes after release, as compared with .28 percent of those parolees (17 of 6,082) who were not predicted to be potentially aggressive. (citing Ernst A. Wenk, James O. Robison & Gerald W. Smith, *Can Violence be Predicted?*, 18 CRIME & DELINQUENCY 393 (1972)). [E]ven for individuals know to have committed a violent act, the best prediction available today . . . is that any particular member of that will not become violent . . . There has been no gross successful attempt to identify, within either of the offender groups, a sub-class whose members have a greater-than-even chance of engaging again in a assaultive act. *Id.* at 394.

Ennis & Litwack, *supra* note 19, at 750-51.

Equally illustrative studies have been conducted. *See* D.L. Rosenhan, *On Being Sane in Insane Places*, 13 SANTA CLARA L. REV. 379, 384 (1973).

120. People v. Burnick, 535 P.2d 352, 365 n.17 (Cal. 1975).

121. *See* Edward P. Mulvey & Charles W. Lidz, *Measuring Patient Violence Is Dangerous*, 17 LAW & HUM. BEHAV. 277 (1993).

> took the chains off the supposedly dangerous mental patients at La Bicetre in 1792, and the resulting lack of violence gave lie to the psychiatric predictions [which] justified their restraint. Violence is vastly overpredicted whether simple behavioral indicators are used or sophisticated multivariate analyses are employed and whether psychological tests are administered or thorough psychiatric examinations are performed. It is also noteworthy that the population used . . . [in recent] . . . studies was highly selective and biased toward positive results-primarily convicted offenders, "sexual psychopaths," and adjudicated delinquents. The fact that even in these groups, with higher base-rates for violence than the general population, violence cannot be validly predicted bodes very poorly for predicting violence among those who have not committed a criminal act.[122]

Similarly, Ennis and Litwack concluded that the literature fails to confirm that the mentally ill are more dangerous than the general population, or that the psychiatric disturbance, per se, makes it easier to predict violence.[123]

Part of the problem with psychiatric predictions is that the psychotherapist simply cannot accurately anticipate the pressures and situations that patients will encounter. In addition, the likelihood of an aggressive act may largely depend on fortuitous and unpredictable circumstances.[124]

Thus, it is not surprising that the court in *Brady v. Hopper*[125] held that a policy which would impose liability upon mental health professionals for the improper exercise of their professional judgment would establish a strict liability standard of care. In essence, it would "require therapists to be ultimately responsible for the actions of their patients . . . [T]herapists would be potentially liable for all harm inflicted by persons presently or formerly under psychiatric treatment."[126] The *Brady* court concluded that "[h]uman behavior is simply too unpredictable to justify liability on psychiatrists for the behavior of their patients."[127]

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122. John Monahan, *The Prediction of Violence, in* VIOLENCE AND CRIMINAL JUSTICE 15, 20 (Chappell & Monahan eds., 1975).

123. Ennis & Litwack, *supra* at 19, at 716.

124. *See* Ennis & Litwack, *supra* note 19, at 734 (citing Guttmacher, *A Review of Cases Seen by a Court Psychiatrist*, 111 THE CLINICAL EVALUATION OF THE DANGEROUSNESS OF THE MENTALLY ILL, 17 (J. Rappeport ed. 1967)); Monahan, *supra* note 122, at 25-26 (citing Gulevich & Bourne, *Mental Illness and Violence*, VIOLENCE AND THE STRUGGLE FOR EXISTENCE (1970) and John Monahan, *Dangerousness and Civil Commitment* (testimony before the California Assembly Select Committee on Mentally Disordered Criminal Offenders, Dec. 13, 1973)).

125. Brady v. Hopper, 570 F. Supp. 1333, 1338 (D. Colo. 1983), *aff'd*, 751 F.2d 329 (10th Cir. 1984).

126. *Id.* at 1339.

127. *Id.*

On the other hand, it is not surprising that the Missouri Court of Appeals in *Bradley* reversed the dismissal of psychologists who failed to warn officials when their patient had been abusing an identified child victim for several years, and the chance of continued abuse was clearly foreseeable.[128]

While it is beyond the scope of this Article to discuss all of the reasons psychiatric judgments are unreliable and invalid, the following are the primary reasons: (1) lack of training in medical schools, and specifically the inclination to diagnose illness rather than non-illness (*i.e.* the reluctance to diagnose someone as "normal"),[129] (2) class and cultural bias of the evaluations, the personal bias and backgrounds of the evaluators, and lack of feedback on the accuracy of the evaluator's judgments,[130] and (3) the ambiguity of psychiatric data, and inadequacies of the diagnostic systems.[131]

Any study is potentially subjective, but a study of dangerousness is particularly so. Theoretically, there are at least four psychiatric judgments relevant to civil commitment cases: (1) is the patient "mentally ill", (2) is he dangerous, (3) does his condition justify or require involuntary commitment or treatment, and (4) whether such commitment or treatment will benefit the patient.[132]

If one were to study the incident of certain dominant or recessive traits, it would be relatively easy to get a cross section sample and to be objective in reaching a conclusion. Of course, there would be a certain range of variance, depending on the sample size, but the principles of statistics and genetics are relatively objective. If you try to discuss predictability of dangerousness, however, you immediately run into subjectiveness of defining the sample.

The first task is to identify those who are mentally ill. The controversy begins with the identification of the mentally ill population because there is

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128. *Bradley*, 904 S.W.2d at 311.

129. Ennis & Litwack, *supra* note 19, at 720 (citing Ronald Leifer, *The Competence of the Psychiatrist to Assist in the Determination of Incompetency: A Sceptical Inquiry into the Courtroom Functions of Psychiatrists*, 14 SYRACUSE L. REV. 564, 572-73 (1963); Joseph M. Livermore, et al., *On the Justifications for Civil Commitment*, 117 U. PA. L. REV. 75; Shah, *Crime and Mental Illness: Some Problems in Defining and Labeling Deviant Behavior*, 57 MENTAL HYGIENE 21 (1969); Maurice K. Temerlin, *Suggestion Effects in Psychiatric Diagnosis*, 147 J. NERV. MENT. DIS. 349 (1968)).

130. Ennis & Litwack, *supra* note 19, at 720 (citing Goldberg, *Simple Models on Simple Processes: Some Research on Clinical Judgments*, 23 AM. PSYCHOLOGY 483, 484 (1963)).

131. Ennis & Litwack, *supra* note 19, at 720.

132. Ennis & Litwack, *supra* note 19, at 699.

much disagreement as to what constitutes a mental disease or defect.[133] Second, how does one decide who is dangerous to begin with? If it is not based on past acts of violence, what determines "dangerousness?" How does one apply the same standards to each person in the study? Regardless of the size of the sample, or its make-up, there will always be a potentially more dangerous study group or less dangerous study group because of the varying degrees of dangerousness.

Even the seemingly simpler task of identifying which members in the study group subsequently prove to be dangerous may be more difficult than might appear at first blush. Does one take those convicted of a felony involving force, or those charged with violent acts, regardless of whether or not they were convicted? What about the different circumstances in which the violent acts occurred? Does one consider the tendency of such individuals to be in situations where the violent acts are more likely to occur? In sum, these variables make predicting violent behavior of mental patients much more difficult than predicting the probable incidence of dominant and recessive traits using genetic calculations.

C. Foreseeability and Special Problems of Hindsight

The most important element in establishing a duty by one individual to prevent harm to another is the foreseeability of the victim.[134] Going back as far as Judge Benjamin J. Cardozo's opinion in *Palsgraf v. Long Island Railroad Co.*,[135] courts have viewed negligence in terms of a foreseeable harm to a foreseeable victim.

California's approach to foreseeability in the duty to warn context was refined four years after *Tarasoff* in *Thompson v. County of Alameda.*[136] In *Thompson*, a mental patient had made nonspecific threats against nonspecific victims. Without a "foreseeable or readily identifiable target," the court said there could be no duty on the part of the mental health care providers.[137] This parallels the explanation in *Brady* that "unless a patient makes specific threats, the possibility that he may inflict injury to another is vague, speculative and a matter of conjecture."[138] The *Thompson* court concluded that the specific threat/specific victim rule was a workable and fair limit on

133. *See* Emily Campbell, Comment, *The Psychopath and the Definition of "Mental Disease" or Defect Under the Model Penal Code Test of Insanity: A Question of Psychology or a Question of Law*, 69 NEB. L. REV. 190 (1990).

134. *Tarasoff*, 551 P.2d at 342.

135. 162 N.E. 99 (N.Y. 1928).

136. *See* Thompson v. County of Alameda, 614 P.2d 728 (Cal. 1980).

137. *Id.* at 734.

138. *Brady*, 570 F. Supp. at 1338.

the liability of mental health care professionals for the acts of their patients.[139]

In *Rollins v. Peterson*, the Utah Supreme Court read into section 319 of the Restatement a requirement that "the 'others' to whom such bodily harm is 'likely' . . . must be *reasonably identifiable* by the custodian [of the patient] either individually or as a member of a distinct group."[140] In *Rollins*, a mental patient stole a car and collided with another vehicle, killing the driver.[141] The hospital, the patient and the owners of the stolen car were all sued by the estate of the decedent.[142] Because the victim was not reasonably identifiable, the psychiatrist owed no duty to protect him.[143] The *Rollins* court concluded that "[the victim] was simply a member of the public, no more distinguishable to the hospital than any other person. . . . [The patient] had not set himself apart in terms of dangerousness to [the victim] personally or to any distinct group of which [the victim] was a member."[144] The court held that drivers of automobiles do not qualify as a distinct and identifiable group.[145] As a result, because the victim in *Rollins* was not identifiable, he was not foreseeable. The court concluded that without a specific threat to a specific victim, no duty could arise.[146]

Missouri's test of foreseeability requires the resulting injury to be the "natural *and probable* consequence" of the defendant's negligence.[147] In *Baldwin*, the plaintiff was the son of a patient who repeatedly threatened and attempted suicide.[148] The patient was eventually released from a mental institution.[149] The following day, he shot and killed the plaintiff's mother.[150] Although Georgia recognized the theory of liability established by section 319 of the Restatement, the court said section 319 did not apply because the patient in *Baldwin* was not under the control of the mental hospital.[151]

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139. *Thompson*, 614 P.2d at 736-38.

140. Rollins v. Peterson, 813 P.2d 1156, 1161 (Utah 1991) (emphasis added).

141. *Id.* at 1158.

142. *Id.*

143. *Id.* at 1162.

144. *Id.*

145. *Id.*

146. *Id.*

147. Callahan v. Cardinal Glennon Hosp., 863 S.W.2d 852, 865 (Mo. 1993) (en banc) (emphasis added); *see also* Baldwin v. Hospital Authority, 383 S.E.2d 154 (Ga. Ct. App. 1989).

148. *Baldwin*, 383 S.E.2d at 155.

149. *Id.*

150. *Id.*

151. *Id.* at 157.

More importantly, the appellate court concluded that during the entire period of treatment, the patient had not harmed or threatened to harm anyone other than himself.[152] The court reasoned that because the patient only threatened harm to himself, there was no basis to charge any defendant "with the breach of a duty to foresee and prevent injury to third persons."[153]

The message of *Baldwin* and similar cases is that the risk of harm does not translate into the foreseeability of harm to a particular individual. In *Thompson*, the defendant had recently released a juvenile offender from its care. The defendant knew that the juvenile was extremely dangerous and violent, and "had indicated that he would, if released, take the life of a young child residing in [his] neighborhood."[154]

Almost immediately after his release, the juvenile offender in *Thompson* killed plaintiff's young son. He had told the defendant that he would kill a young child in his neighborhood, and he did just that. Nevertheless, the California Supreme Court said that while the victim was a member of the group threatened by the juvenile, he was not the "known and specifically foreseeable and identifiable victim of the patient's threats."[155] Because the juvenile's threats were not made against a specific, identifiable victim, the actual victim was not foreseeable.

Courts must take care not to confuse the depth of the tragedy with the scope of the alleged negligence. As Judge Charles B. Blackmar intimated in *Sherrill*, it is not difficult to look back from a tragedy and assess blame.[156] On the other hand, there has been an ongoing history of violence and abuse in *Bradley*. In the context of ongoing abuse, the burden is justifiably shifted to the health care provider to show the harm was not foreseeable.

One commentator has developed a theory of "neuristics," defined as the "implicit devices that individuals use to simplify complex information-processing tasks leading to distorted and systematically erroneous decisions." One example of "neuristics" is the vivid outrageous case which overwhelms reams of abstract data.[157] When there is a loss of human life, society's first

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152. *Id.*

153. *Id.*

154. *Thompson*, 614 P.2d at 730.

155. *Id.* at 734.

156. *Sherrill*, 653 S.W.2d at 668; *see also* Jackson v. City of Wentzville, 844 S.W.2d 585, 588 (Mo. Ct. App. 1993).

157. *See* Michael L. Perlin, *Tarasoff and the Dilemma of the Dangerous Patient: New Directions for the 1990's*, 16 LAW & PSYCHOLOGY REV. 29, 53 (1992) and references cited therein. Perlin explains:

> "Availability" refers to the way that we tend to judge the probability or frequency of an event based upon the ease with which we recall occurrences of that event; "typification" involves the characterization of a current experience as one which

reaction may be to impose liability and hold someone responsible. Injury or death at the hands of a released mental patient, or anyone, is a tragedy. If liability is imposed on mental health providers in Missouri, it should be placed on the mental health care providers only when their decisions are made in bad faith or with gross negligence. With the exception of the recent *Bradley* decision, Missouri courts have been unwilling to reduce this standard and extend liability because of the isolated outrageous case that seems to overwhelm reams of data.

Bradley and cases like it are not necessarily inconsistent with Missouri precedent. Where there is a long history of abuse of a particular identified victim, the foreseeability of harm can not easily be denied. On the other hand, the psychologists may be able to establish unforeseeability, due to the fact that the patient received medication, other therapy, or was rehabilitated. In addition, the passage of time, or other intervening factors, may also cut off liability.

D. The Duty to Warn

The holding in *Tarasoff* focused on a psychiatrist's duty to warn. Should there be a duty to warn? Should a duty to warn, created either by judicial holding or statute, include an immunity from breach of confidentiality created by warnings made in good faith?

The rationale for creating a duty to warn when there is a clear and imminent danger of harm seems simple enough. Many argue that a trained professional who is, because of their particular training and vocation, in a unique position to know of imminent danger to a third party should have a duty to warn that third party of imminent danger. It is at best questionable, however, whether that presumption holds up under judicial scrutiny. It is hard to say exactly what steps the psychotherapist should take and when. In what, if any, circumstances is the duty expanded? One commentator posed the many questions that arise: Having once warned the victim, is there a continuing duty to keep the victim advised? If there is a duty to warn, should the psychotherapist advise the victim of what to do? If the therapist's advice is wrong, does that create liability to the victim?[158]

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is familiar to an individual through reference to past stereotypic behavior under "attribution theory."

Id. Basically he explains that once we adopt a stereotype, we interpret a wide variety of additional information so as to reinforce that stereotype.

158. Robert N. Cohen, Note, *Tarasoff v. Regents of the University of California: The Duty to Warn: Common Law and Statutory Problems for California Psychotherapists*, 14 CAL. W.L. REV. 153, 169-70 (1978).

Other questions include: Who should be warned—the victim, the police, or others? Several situations may arise from warning the victim. First, a victim might panic and flee, which may or may not eliminate the problem. Second, the victim might take some significant action, such as attacking the patient first. This raises the question: Should the therapist be liable to his patient if the warning precipitates a violent assault upon the patient? One corollary is whether the therapist held a higher duty to the patient or to the patient's victim? Third, the warning might create anxiety, inducing a mental disturbance of the victim, or cause the victim to alter his lifestyle and become anxious and nervous.

The victim's friends or relatives may threaten or harm the patient. Notification of law enforcement officials may create only a temporary and prophylactic solution. *Tarasoff* amply demonstrates the limitations of the police in handling such situations.

The warning itself is problematic. When should the psychotherapist warn? How does he distinguish an idle or remote threat from an immediate threat? Should every homicidal fantasy be reported? Does failure to report a vague threat create liability? In sum, *Tarasoff* requires the mental health professional to overpredict the danger, and second guess every evaluation. Since energies are diverted from treatment to making legal evaluations regarding commitment, the duty to warn may well be counterproductive.[159]

The court in *Tarasoff* provided little help in answering these specific concerns. Instead, the court couched its analysis in terms of generalities, such as does discharge of the duty require the therapist to take other steps?[160]

That discussion was enough to raise fears of litigation in the psychotherapy community.[161] Not surprisingly, psychotherapists, and those who study them, have begun to write about "litigaphobia," and specifically the impact that the fear and reality of litigation have on the practice of psychiatry and psychology.[162] Some commentators have predicted the over-commitment

159. Cohen, *supra* note 158, at 169-70.

160. *Tarasoff*, 551 P.2d at 340.

161. *See* Perlin, *supra* note 157, at 53; Paul Applebaum, *Statutory Approaches to Limiting Psychiatrists' Liability for their Patients' Violent Acts*, 146 AM. J. PSYCHIATRY 821 (1989).

162. *Compare* Perlin, *supra* note 157, at 53 (discussing the impact of litigation on decisions of mental health professionals resulting from imposing *Tarasoff* liability), *with* Robert D. Miller, *Psychotherapists' Duty to Prevent Foreseeable Harm, Schuster v. Attenbert*, 62 WIS. L. REV. 10, 68 (1989) (criticizing courts for ignoring emotional trauma and loss of professional reputation and time by sued psychotherapists); *See also* Stanley L. Brodsky, *Litigaphobia: A Professional Disease*, 28 CONTEMP. PSYCH. 204 (1983); Stanley L. Brodsky, *A Case Report of Litigaphobia Release from and Industry Commitment*, 2 PUB. SER. PSYCH. 11 (1983).

of patients.[163] Other predictions included: (1) that the warnings might cause the putative victims unnecessary emotional distress, (2) that the warnings would lead to preemptive retaliatory violence by the warned putative victims, and (3) that the duty to warn would drive therapists away from treating potentially violent patients.[164]

When there is a clear and present danger to an identifiable victim, there probably should be a duty to warn. Such a duty was specifically recognized in Missouri in *Bradley*. *Bradley* leaves unclear, however, why that duty exists if the victim knows of the danger, or, in the case of a minor, if his or her guardian knows. More particularly, *Bradley* fails to spell out who must be warned, and how to warn, and what, if any, other action besides communication of the danger to the victim or the victim's guardian must occur to discharge the duty.

E. Should the Solution Come From the Legislature?

1. Current Missouri Statutes

Interestingly, part of the holding in *Tarasoff* relied on statutory immunity.[165] In addition, every Missouri court faced with the issue at least touched upon the Missouri statutes.[166] Why? Because, arguably, the policy decision of creating liability or exempting liability on a *per se* basis is a question best decided by the legislature, rather than the courts.

Was the court's attempt in *Matt* to focus its attention on the statutory language, despite the parties' attempts to leave that out of the case, right on target? The *amicus* brief of the Missouri Hospital Association in *Matt* attempted to raise the issue.[167] During oral argument before the Missouri Supreme Court, however, counsel for both sides sought to divert and evade the court's questions concerning statutory immunity. In the end, the court left the question of statutory immunity unanswered.

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163. *See supra* notes 114-15.

164. *See* Perlin, *supra* note 157, at 36-37 (citing, e.g., Theodore A. Olsen, Note, *Imposing a Duty to Warn on Psychiatrists A Judicial Threat to the Psychiatric Profession*, 48 U. COLO. L. REV. 283, 297 (1977); Elwin J. Griffith & Ezra E.H. Griffith, *Duty to Third Parties, Dangerousness,and the Right to Refuse Treatment: Problematic Concepts for Psychiatrist and Lawyer*, 14 CAL. W.L. REV. 241, 247 (1978); Howard Gurevitz, M.D., *Tarasoff: Protective Privilege Versus Public Peril*, 134 AM. J. PSYCHIATRY 289)).

165. *Tarasoff*, 551 P.2d at 352.

166. *Sherrill*, 653 S.W.2d at 669; *Matt*, 892 S.W.2d at 801; *Bradley*, 904 S.W.2d at 313.

167. *See Amicus* brief of Missouri Hosp. Ass'n, pp. 8-13.

A statute such as *Missouri Revised Statute* section 632.440, which exempts from liability ordinary negligence regarding decisions to restrain, is well grounded in sound policy reasoning. First, from a conventional tort perspective, limiting liability protects the confidentiality of patient-physician communications and the physicians duty of primary concern for their patients. In addition, section 632.440 also allows the elected representatives of the people to decide what is the greatest good for the greatest number. In sum, immunity for decisions to restrain is best left to the deliberative and representative branch of government to decide.

As a matter of fact, statutory law governing psychiatric facilities is quite extensive. Missouri has developed a comprehensive statutory plan to supervise, manage, license and oversee all psychiatric facilities in the state. Chapter 632 of the state code creates the Division of Comprehensive Psychiatric Services to carry out this plan.[168] This plan includes a provision immunizing the good faith decision making of mental health care providers:

> No officer of a public or private agency, mental health facility, nor the head, attending staff or consultants of any such agency or facility, nor any mental health coordinator, registered professional nurse, licensed physician, mental health professional . . . performing functions *necessary* . . . *[shall be civilly liable] for detaining, transporting, conditionally releasing or discharging* a person pursuant to this chapter at or before the end of the period for which he was admitted or detained for evaluation or treatment, so long as such duties were performed in good faith and without gross negligence.[169]

Section 632.440 "essentially codified the common law" of public official immunity.[170] By adding the word "private," it extended the immunity to private agencies, facilities and professional staff as well. In *Porter v. Maunnangi*, plaintiff brought a wrongful death action after her son, a mental patient, killed himself following discharge from a state hospital. The court recognized decisions regarding the discharge of mental patients are "functions necessary for the administration of Chapter 632," and carry no civil liability.[171]

In a more recent case, an involuntary mental patient released from care later slit a woman's throat, and then stabbed her would-be rescuer to death.[172] Plaintiffs alleged that the mental health provider was negligent in his decision to release the patient. The court, assuming without deciding that

168. *See* MO. REV. STAT. § 632.010 (1994).

169. MO. REV. STAT. § 632.440 (1994) (emphasis added).

170. *See* Porter v. Maunnangi, 764 S.W.2d 699, 700 (Mo. Ct. App. 1988).

171. *Id.*

172. Boyer v. Tilzer, 831 S.W.2d 695, 697 (Mo. Ct. App. 1992).

632.440 confers a private right of action upon persons injured by a released mental patient, held that liability could only attach if the plaintiff proved the defendant mental health care provider acted in bad faith or with gross negligence.[173] Proving "bad faith" is a heavy burden. It requires proof that the defendant acted with "a dishonest purpose, moral obliquity, conscious wrongdoing, breach of a known duty through some ulterior motive or ill will partaking of the nature of fraud."[174]

Proving "gross negligence" is equally as difficult. After repeated holdings that there are no "degrees of negligence,"[175] Missouri courts have struggled to define the term because of the General Assembly's penchant for using it.[176] The court in *Sherrill* defined it as "reckless conduct done with knowledge that there is a strong possibility of harm and indifference as to that likely harm."[177] Mistakes in diagnosis or judgment or even simple negligence do not rise to the level of "conscious indifference" or "willful and wanton abrogation of professional duties."[178]

Decisions regarding both detention and release of patients, and qualified immunity for those decisions, are expressly covered by Chapter 632. Logic dictates that the same immunity should apply to decisions not to admit a patient. The same discretion and professional judgment must be exercised by a health care professional in deciding to hospitalize a patient or release a patient already hospitalized, as in deciding not to hospitalize or not to release a hospitalized patient. To hold that section 632.440 applies only to the actions of "detaining, transporting, conditionally releasing or discharging," and not to decisions not to detain, transport, release or discharge would be illogical. Although the authors are aware of no Missouri case where a party attempted to draw this distinction, and thus it has not been addressed by the courts, it would seem likely to occur given the similar argument raised in *Matt* that immunity covered public but not private psychotherapists because they specifically described the former but not the latter.[179] If courts were to recognize distinctions between whether to act or forego acting, physicians would be forced to commit a patient, even one who did not require inpatient or involuntary care, just to take advantage of the statutory immunity for releasing that patient.

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173. *Id.*

174. State *ex rel.* Twiehaus v. Adolf, 706 S.W.2d 443, 447 (Mo. 1986) (en banc).

175. *Sherrill*, 653 S.W.2d at 664.

176. *Boyer*, 831 S.W.2d at 697.

177. *Id.* at 698 (quoting Duncan v. Missouri Bd. of Architects, 744 S.W.2d 524, 533 (Mo. Ct. App. 1988)).

178. *Id.*

179. *See* Appellant's Reply Brief at 6-7, Matt v. Burrell, Inc., 892 S.W.2d 796 (Mo. Ct. App. 1995) (No. 18983-2) (Missouri Supreme Court No. 77334).

This flies in the face of the statutory plan of comprehensive psychiatric services, which requires patients be placed in the "least restrictive environment" possible consistent with the "best interests of the patient."[180] Chapter 632 "emphasize[s] the need for the exercise of discretion and judgment" by health care providers.[181] Deciding to detain is discretionary. Deciding to release should be discretionary. A holding that detention and immediate release would give the doctor immunity but failure to detain would not, would be ludicrous. A decision not to detain a patient, provided it is done in good faith and without gross negligence, is a professional judgment that should qualify for statutory immunity. To hold otherwise would conflict with the statutory plan by "encouraging an 'all or nothing' approach to detention of mental health patients."[182]

In *Bunting v. Huckstep*, a husband sued a mental hospital for wrongful death after his wife wandered from the facility and was struck by a car. The Missouri court held that under any theory, the liability of the defendants would be "inextricably linked" to professional decisions about the detention and restraint of the patient. Those decisions are "precisely the sort of discretionary judgment the legislature has seen fit to render immune from civil liability."[183] Otherwise "treating physicians would indulge every presumption in favor of further restraint, out of fear of being sued. Such a climate is not in the public interest."[184]

The plain language of section 632.440 applies the doctrine of qualified immunity equally to public and private mental health care providers. The Missouri Supreme Court has proclaimed that "the primary rule of statutory construction is to ascertain the legislative intent from the statute's language . . . [considering] the words in their plain and ordinary meaning."[185] "Private is not defined in the statute, but courts should give the word its 'plain and ordinary' meaning as found in the dictionary."[186] Webster's Third New International Dictionary defines "private" as "not invested with or engaged in public office or employment."[187] In other words, every mental health care provider, whether it is a state hospital or a private mental health facility, is governed by Chapter 632 and is vested with the same qualified immunity.[188]

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180. MO. REV. STAT. § 632.385 (1994).

181. *Sherrill*, 653 S.W.2d at 664.

182. Bunting v. Huckstep, 853 S.W.2d 448, 450 (Mo. Ct. App. 1993).

183. *Id.*

184. *Sherrill*, 653 S.W.2d at 664.

185. Brownstein v. Rhomberg-Haglin & Assoc., 824 S.W.2d 13, 15 (Mo. 1992) (en banc).

186. Asbury v. Lombardi, 846 S.W.2d 196, 201 (Mo. 1993) (en banc).

187. WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 1805 (3rd ed. 1971).

188. *See Twiehaus*, 706 S.W.2d at 448 n.4 (holding that *Sherrill* gave immunity

This statutory scheme approximately immunizes care givers for ordinary acts of negligence.

2. The Duty to Warn and Need for Legislation

Missouri statutory immunity, as it stands now, focuses only on the duty to restrain. In addition, Missouri has statutory provisions creating a duty to warn in limited circumstances involving particular medical conditions.[189] There are no statutes in Missouri, however, that specifically require that warnings be given to potential victims of mental patients. In addition, no Missouri statute grants immunity for such warnings, or immunity when no warning is given.

It is less likely that legislatures will focus on creating liability or immunity for liability regarding failure to warn. Professor Alan Stone, in his article following *Tarasoff*, noted that while it may be appropriate in certain circumstances for the psychotherapist to warn the police of dangers presented by a patient, it would be counterproductive to impose on the psychotherapist a duty to warn victims.[190] This is so because warning victims is incompatible with an effective therapeutic relationship. Imposing this duty would have the effect of deterring both patients and therapists from undertaking treatment, and thus, would further increase the risk of violent behavior.[191] The same type of confidential relationship exists between an attorney and a client. An attorney is under an ethical duty to warn of future crime. Perhaps in both situations it is, or should be, a moral or an ethical, not a legal duty.[192] It is difficult to understand why, other than the fact the psychotherapist may have the actual ability to control or restrain the patient, the same duty to potential third party victims should not be imposed on the attorney, teacher, clergy or others who knew of threatened harm.[193]

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to "treating physicians," not just state-employed physicians).

189. *See* MO. REV. STAT. §§ 210.115, 191.653.3, and 191.656.2 (1994).

190. Stone, *supra* note 108, at 368.

191. Stone, *supra* note 108, at 368; *see also*, Note, *Duty to Report*, 7 J. CONTEMP. H. L. & POLICY 87 (1991).

192. This is not just a theoretical consideration. For instance, the *Matt* plaintiffs based a large part of their argument on a "moral blame" theory. *See* Appellant's Brief at 41-43, Matt v. Burrell, Inc., 892 S.W.2d 796 (Mo. Ct. App. 1995) (Missouri Supreme Court No. 77334). The plaintiffs argued, "social morality dictates that there is a duty to avoid this harm, if such harm could be reasonably avoided. *Id.* at 43.

193. One possible distinction would be the argument that the psychotherapist is specifically trained to identify abnormal behavior, evaluate threats and the ability of the patient to carry them out, while the teacher, attorney or clergy may not be similarly educated. This article goes on to note, however, that a psychiatrist's ability to predict violent behavior is limited. *See infra* notes 194-95 and accompanying text.

The psychotherapists' dilemma may in part be one of their own making:

> For years, psychiatrists as advisors to the judicial system have fostered the belief that they are the only professionals who can predict violence. Courts, parole boards, legislatures, and the public at large have taken their word for it. Now, when this belief has become a double-edged sword, they are retreating from their long held position.
>
> This inconsistent position leads to some interesting anomalies. Dr. Lee Coleman, writing to the Supreme Court after a rehearing was granted in the *Tarasoff* case, said: "It is hard for me to understand how the psychiatric community can have it both ways—to be free of an obligation to warn on the basis of *inability* to predict dangerousness, and yet to have the authority to incarcerate patients on the basis of an *ability* to predict dangerousness."[194]

Legislative guidance on the duty to warn may be helpful. One useful safeguard that could be added by the legislature to counteract the propensity to overpredict dangerousness would be to require a second independent professional opinion before either involuntary commitment, or breaking confidentiality to warn third parties.[195] A second safeguard would be to provide in any statute granting immunity for involuntary commitment or warning that such initiative be taken only when danger is truly imminent.[196] A third safeguard would be to require psychotherapists to inform patients of the psychotherapist's potential duty to warn before the patient divulges any information and to get the patient's consent.[197] Informed consent includes: (1) informing the patient before therapy of the limits to confidentiality and, (2) informing the patient of the implicit risk to him of disclosures beyond the agreed limits.[198] The purposes of such informed consent are two-fold: (1) it is an essential condition for the patient's right to accept or reject therapy under conditions of informed consent, and (2) it may help make assessment of dangerousness more accurate by screening out some exaggerated threats of

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194. Brad S. Seligman, Note, *Untangling Tarasoff, Tarasoff v. Regents of the University of California*, 29 HASTINGS L.J. 179, 203 (1977) (quoting Letter to California Supreme Court, March 11, 1975, *quoted in* R. Jack Ayres, Jr. & John T. Holbrook, *Law, Psychotherapy, and the Duty to Warn: A Tragic Trilogy?*, 27 BAYLOR L. REV. 677, 686 (1975)) (first footnote omitted).

195. *See* John G. Fleming & Bruce Maximov, *The Patient or His Victim: The Therapist's Dilemma*, 62 CAL. L. REV. 1025, 1065 (1974).

196. Fleming & Maximov, *supra* note 195, at 1065. Another writer called this imposed standard one of clear danger. *See* Seligman, *supra* note 194, at 209.

197. Fleming & Maximov, *supra* note 195, at 1066.

198. Fleming & Maximov, *supra* note 195, at 1066.

harm.[199] In addition, the therapist may properly give more weight to confessions the patient makes knowing that they might be disclosed to others.

A fourth safeguard would be to statutorily mandate that any civil commitment be based on proof of necessity beyond a reasonable doubt. Commentators have noted that both the prospective patient and the accused criminal are subjected to a potentially coercive process which may result in loss of liberty.[200] The patient has fewer procedural protections than the criminally accused. Proof beyond a reasonable doubt is one example.[201] In *In Re Winship*, however, the United States Supreme Court disregarded the civil-criminal distinction and required proof beyond a reasonable doubt before "civilly" committing the alleged juvenile delinquent.[202] Whether the purpose of the proceeding was therapeutic or punitive was irrelevant. The Supreme Court rejected the "good intentions" rationale because the potential outcome of the proceeding, incarceration in a state institution,[203] was a consequence which mandated the safeguards.

Another commentator urging for more safeguards concerning a mental health provider's duty to warn explains that emerging trends reveal a pattern of expanding liability in that: (1) the requirement of a specific and identifiable victim appears to be losing strength, (2) the imminence of danger required to trigger the duty to protect appears to be lessening, (3) the initially broad buffer zone of reasonable practice is beginning to erode as clinical choices, such as civil commitment, become legal duties, and (4) the judiciary appears to be generating more confidence in psychotherapists' ability to predict dangerousness.[204]

One writer identified the dilemma posed between the *Tarasoff* decisions and the confidentiality provision in the California statutes:

> The duty to warn recited in *Tarasoff* and the confidentiality provisions of LPSA hold a California psychotherapist, treating patients under LPSA, in an apparently inextricable dilemma. If the psychotherapist does not give the warning under the *Tarasoff* standard, then he may be liable for civil damages, or if he does give the warning, the patient whose confidence he

199. Fleming & Maximov, *supra* note 195, at 1066.

200. *See supra* notes 114-17.

201. *In re* Winship, 397 U.S. 358, 363-64 (1970) (reiterating that proof of guilt beyond a reasonable doubt is a constitutional requirement in criminal proceedings); *See also* Ennis & Litwack, *supra* note 19, at 750-51 (citing Speiser v. Randall, 357 U.S. 513, 520-26 (1958); Leland v. Oregon, 343 U.S. 790, 795 (1952)).

202. *Winship*, 397 U.S. at 365-66.

203. *In re* Gault, 387 U.S. 1, 36-37 (1967).

204. Steven C. Bednar, Note, *The Psychotherapists' Calamity: Emerging Trends in the Tarasoff Doctrine*, 1989 B.Y.U. L. REV. 261, 281.

> has betrayed may sue him on the statutory basis of section 5330 of the Welfare and Institutions Code.[205]

The commentator then identified four ways to reconcile *Tarasoff* and California statutory law:

> One alternative for the legislature would be to amend section 5328 of the Welfare and Institutions Code to include a dangerous patient exception . . .
>
> A second alternative would be to repeal the statutory cause of action embodied in section 5330 of the Welfare and Institutions Code which allows a patient to recover damages for disclosure of confidential information . . .
>
> A third alternative, which may be an adequate compromise, is to allow the legislature to add immunity provisions to both the Evidence Code and the Welfare and Institutions Code with regard to the warning . . .
>
> A fourth alternative, which is supported by the American Psychiatric Association, is to limit the *Tarasoff* decision and hold that provisions of LPSA regarding involuntary commitment of a dangerous person apply to the *Tarasoff* facts.

Another way to reconcile the duty to warn with the duty of confidentiality would be to require the following steps before a mental health provider could be eligible for immunity from civil suits for breach of either duty:

> (1) Attempt to convince the patient to seek voluntary confinement.
>
> (2) Attempt to limit or identify, if possible, the person(s) endangered by the patient's conduct in the event he must be warned.
>
> (3) If the patient is diagnosed as dangerous to himself or others, commence involuntary commitment proceedings.
>
> (4) If involuntary commitment is impossible, notify local law enforcement agencies.
>
> (5) If the intended victim is in immediate or imminent danger of physical harm, warn the victim, his family, or his friends.[206]

Of course, the most extreme course would simply be to categorically grant immunity from duty to warn suits to mental health professionals for the future acts of their patients.[207]

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205. Cohen, *supra* note 158, at 178.

206. Cohen, *supra* note 158, at 178-79.

207. *See* Paul Appelbaum et al., *Statutory Approaches to Limiting Psychiatrists' Liability for Their Patients' Violent Acts*, 146 AM. J. PSYCHIATRY 821 (1989); *see also* Michael R. Geske, Note, *Statutes Limiting Mental Health Professionals' Liability for*

3. Current Legislation and Models

Currently, there is no pending Missouri legislation addressing either the issues raised or holdings in the recent Missouri appellate court decisions (i.e. *Bradley*, *Matt*, and *Sherrill*), or which would change the current Missouri statutory scheme.[208] On March 3, 1995, however, Missouri Governor Mel Carnahan established the nineteen member McBride Commission "to recommend enhancements to civil involuntary treatment laws as well as circumstances under which outpatient involuntary mental health treatment should be mandated."[209]

While a full analysis of the McBride Commission's report[210] is beyond the scope of this article, it should be noted that findings and recommendations that would impact the issues presented in *Bradley*, *Matt*, and *Sherrill* may include the following: (1) The Commission recommends that persons with mental illness and their caregivers statutorily be provided with effective and rapid access to mental health services; (2) The Commission recommends increased use of public administrators, quicker access to courts, and enhancement of various client/patient rights statutes to protect and care for patients; (3) The Commission recommends statutes which would clarify the law, including provisions for more consumer input and provisions for the proper use of medical records.[211]

Although it is one of the first, the McBride Commission Report will hardly be the last word on the subject in Missouri. Its implementation would clearly create additional rights for mental health patients, responsibilities for mental health care providers, and provide faster state intervention. The questions left unanswered include at what cost can this be accomplished, and are these added protections realistic?

At least seventeen states have adopted legislation to clarify and/or limit the liability under *Tarasoff* and its progeny.[212]

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the Violent Acts of Their Patients, 64 IND. L.J. 391, 412 (1989).

208. MO. REV. STAT. § 632.040 (1994).

209. Missouri Exec. Order No. 95-09 (March 3, 1995).

210. THE MCBRIDE COMMISSION, REPORT TO THE HONORABLE MEL CARNAHAN, GOVERNOR, STATE OF MISSOURI (Sept. 29, 1995).

211. MCBRIDE COMMISSION REPORT, *supra* note 210, at 1-4.

212. CAL. CIV. CODE § 43.92 (West 1995); COLO. REV. STAT. § 13-21-117 (1987); DEL. CODE ANN. tit. 16 § 5402 (1994); FLA. STAT. ANN. § 455.2415 (West 1991 and Supp. 1995); IDAHO CODE § 6-1902, 1903 (Supp. 1995); IND. CODE. ANN. §§ 34-4-12.4-1 to -4 (Burns 1995 Supp.); KAN. STAT. ANN. § 65-5603 (1992); KY. REV. STAT. ANN. § 202 A.400 (Michie/Bobbs-Merrill 1991); LA. REV. STAT. ANN. § 9:2800.2 (West 1991 and 1995 Supp.); MASS. GEN. LAWS ANN. ch. 112, § 129A (West Supp. 1995); MICH. COMP. LAWS ANN. § 330.1946 (West Supp. 1989); MINN. STAT. ANN. § 148.975-976 (West 1989); MONT. CODE ANN. § 27-1-1101 to -03

One commentator offers the following suggested model for such a statute:

> Mental Health Professionals' Liability for the Violent Acts of Patients.
>
> Section 1. A mental health professional is immune from liability to persons other than a patient for failing to predict or warn or take precautions to protect from a patient's violent behavior, unless
>
> A) the patient communicated a threat to the mental health professional, and
>
> B) the threat is coupled with the apparent intent and ability to carry out the threat that the patient will use physical violence or other means of harm to cause serious personal injury or death to reasonably identifiable persons.
>
> Section 2. Regardless of any other provision of law, a mental health professional's duty to warn or take precautions arises only under the limited circumstances described in section 1.
>
> Section 3. A mental health professional's duty to warn of or take precautions to protect another from the threatened violence of a patient is discharged by the mental health professional giving a warning or taking precautionary actions such as
>
> A) communicating the threat to the potential victim or victims,
>
> B) informing a law enforcement agency having jurisdiction in the patient's or victim's place of residence,
>
> C) seeking civil commitment of the patient, or
>
> D) any other actions,
>
> *provided that* the action which the professional takes is reasonably suited to the circumstances. The professional to whom a threat is communicated may also discharge the duty under section 1 by informing a person designated by the professional's employer as the individual who has the responsibility to warn or take precautions.
>
> Section 4. A mental health professional is immune from liability under state statutes which protect patient privacy and confidentiality for actions taken in good faith to discharge the duty which has arisen or may have arisen under section 1.[213]

The Michigan statutory provision, incorporating many of the above ideas, should provide a model for Missouri law:

> (1) If a patient communicates to a mental health practitioner who is treating the patient a threat of physical violence against a reasonably identifiable third person and the patient has the apparent intent and ability to carry out that threat in the foreseeable future, the mental health

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(1993); N.H. REV. STAT. ANN. § 329:31, 330-A:22 (1994); OHIO REV. CODE ANN. § 5122.34 (Anderson 1993); UTAH CODE ANN. § 78-14a-101 to -102 (1992 & Supp. 1995); WASH. REV. CODE ANN. § 71.05.120 (West 1992).

213. Geske, *supra* note 199, at 419.

practitioner has a duty to take action as prescribed in subsection (2). Except as provided in this section, a mental health practitioner does not have a duty to warn a third person of a threat as described in this subsection or to protect the third person.

(2) A mental health practitioner has discharged the duty created under subsection (1) if the mental health practitioner, subsequent to the threat, does [one] or more of the following in a timely manner:

(a) Hospitalizes the patient or initiates proceedings to hospitalize the patient under chapter 4 or 4a.

(b) Makes a reasonable attempt to communicate the threat to the third person and communicates the threat to the local police department or county sheriff for the area where the third person resides or for the area where the patient resides, or to the state police.

(c) If the mental health practitioner has reason to believe that the third person who is threatened is a minor or is incompetent by other than age, takes the steps set forth in subdivision (b) and communicates the threat to the department of social services in the county where the minor resides and to the third person's custodial parent, noncustodial parent, or legal guardian, whoever is appropriate in the best interests of the third person.

(3) If a patient described in subsection (1) is being treated through team treatment in a hospital and if the individual in charge of the patient's treatment decides to discharge the duty created in subsection (1) by a means described in subsection (2)(b) or (c), the hospital shall designate an individual to communicate the threat to the necessary persons.

(4) A psychiatrist or psychologist [or psychiatric social worker] who determines in good faith that a particular situation presents a duty under this section and who complies with the duty does not violate. . . . [the applicable laws]. . . . [or] physician-patient privilege. . . .[214]

The above model and Michigan statute have many positive aspects. Rather than a duty arising whenever a therapist determines the patient presents a danger, both require a specific communicated threat as a prerequisite to a duty to warn or hospitalize. Both also require, as a prerequisite, that the patient has the apparent intent and ability to carry out the threat in the foreseeable future against a reasonably identifiable third person. Foremost, both the model and the Michigan statute offer alternatives to disclosing confidential information by exonerating from liability a psychotherapist who hospitalizes the dangerous patient, or seeks involuntary commitment.

Arguably, these models appear to provide the clarity lacking in the *Tarasoff* decision. However, ambiguities are hidden in statutory language, such as what constitutes a threat, exactly how far the therapist must go to seek

214. MICH. COMP. LAWS ANN. § 330.1946 (West 1992 & Supp. 1995) (footnotes omitted).

commitment, or what other actions would relieve the therapist from liability.

A more detailed model might take the form of the following:

Mental Health Professionals' Liability for the Violent Acts of Patients.

Section 1. A mental health professional including psychiatrist, psychologist, licensed nurse practitioner and those operating under their direction and supervision are immune from liability to persons other than a patient for failing to predict or warn or take precautions to protect others from a patient's violent behavior, except where:

A) the patient communicates a threat of physical harm to the mental health professional, and

B) the threat is coupled with the apparent intent and ability to carry out the threat that the patient will use physical violence to cause serious personal injury or death to reasonably identifiable persons.

Section 2. Regardless of any other provision of law, a mental health professional's duty to warn or take precautions arises only in the limited circumstances described in section 1.

Section 3. A mental health professional's duty to warn of or take precautions to protect another from the threatened violence of a patient is discharged by the mental health professional giving a warning or taking reasonable precautionary actions, including, but not limited to:

A) communicating or attempting to communicate the threat to the potential victim or victims,

B) informing a law enforcement agency having jurisdiction in the patient's or victim's place of residence of the threat, and the whereabouts of the patient and victims, if known,

C) seeking civil commitment of the patient by initiating a formal process of commitment or taking reasonable steps precedent to initiating such commitment, or

D) providing medication or other medical treatment to the patient which is reasonably calculated to eliminate or decrease the threat.

The professional to whom a threat is communicated may also discharge the duty under section 1 by informing a person designated by the professional's employer as the individual who has the responsibility to warn or take precautions, except that where the identified or potential victim is a minor the healthcare profession must inform appropriate authorities pursuant to MO. REV. STAT. section 210.115.

Section 4. A mental health professional is immune from any and all liability under state statutes and from any common law rights or causes of action which protect patient privacy and confidentiality, for actions taken in good faith to discharge the duty which has arisen or may have arisen under section 1.

While the above model is based on Missouri case law and present Missouri Statutes, the need for a national standard may be appropriate.[215] For example, just as most states have adopted the *Restatement of Torts* and the *Uniform Commercial Code*, states could also be encouraged to adopt a uniform law governing psychotherapist duty and immunity.

Arguably such a statute would settle the law, rather than leaving it to the courts to develop or limit a duty on an incremental case by case basis in an area where bad facts may encourage a bad judicial solution, as was arguably the result in *Tarasoff*. Professional psychotherapists would know what duty they had in specified circumstances, and they could document the facts and their actions by appropriate record keeping, establishing that they had complied with the statute. Of course, a uniform code will not extinguish litigation. Litigation will frequently be necessary to determine whether the psychotherapist can establish facts bringing them under the statutory immunity. However, at least, there would be a national standard to offer guidance in this new and undefined area of the law.

The authors, however, do not endorse the adoption of the last model, or of any model, it is preferable that the legislature, rather than the courts, decide if and when the case law immunity should be abrogated, if that is to occur.[216] On the other hand, if the legislature decides not to grant blanket immunity, it should detail the exact circumstances and scope of the duty, and how it can be discharged to avoid liability.

CONCLUSION

A duty to restrain is more onerous than a duty to warn on both the patient, who is normally unrestricted by any warning, and the psychotherapist, who can normally communicate a warning with much less effort than restraining an unwilling subject. This article focuses on an analysis of Missouri law governing the duty, if any, owed by a psychotherapist, or other mental health care provider, to potential third party victims. This article does not focus on the distinctions between restraint or warning, or even other ways that duty might be fulfilled, but answers the more general question of whether a mental health care provider in Missouri owes a duty to third party victims.

Because of the incremental development of case law occasioned by the facts of the specific cases, and the various forms of statutes addressing the issue, any particular state may have recognized a duty to warn, but not a duty

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215. *See* Maryellen Kelleher, Note, *Psychotherapists and the Duty to Warn, an Attempt at Clarification*, 19 NEW ENG. L. REV. 597, 614 (1983).

216. For example, the child abuse context would be a situation when case law immunity should be abrogated. *See generally* Bradley v. Ray, 904 S.W.2d 302 (Mo. Ct. App. 1995).

to restrain, or vice versa. Along the same lines, a state may have enacted legislation granting immunity for restraint, but not for warning (i.e., breach of confidentiality). Finally, there may be other things that mental health care providers can and should do which would satisfy the duty, if any, besides restraint or warning. Such precautionary actions include counseling, medication, or other treatment of the patient. The focus of this article, i.e., when a duty arises, does not address the issue of what constitutes performance or breach of that duty. The issue of breach depends on the idiocentric facts of a particular case.

Notwithstanding the above, if Missouri courts were to impose a duty on the part of the mental health care providers to the general public to protect them from the violent acts of their patients, particularly without specific guidelines, hospitals, treatment facilities, and mental health care providers throughout the state would suffer a wide-ranging and detrimental effect.

Regardless of the circumstances under which the court imposes a duty to warn or a duty to restrain, a holding of liability would likely increase the numbers of involuntary commitments to mental health facilities in Missouri. One need not be clairvoyant to appreciate that fact. Faced with a choice between commitment of a patient and potential liability for misdiagnosis of wellness (even a misdiagnosis that is well within the standard of care), the therapist would be pressured to choose commitment. Such a decision would not only be based on something other than the best interests of the patient, but would fly in the face of Missouri's statutory plan for psychiatric treatment.

Section 632.385 provides that patients shall be placed in the "least restrictive environment" consistent with the best interests of the patient. This requires mental health professionals to employ a two-step analysis before involuntary commitment: (1) would involuntary commitment in any circumstances be in the best interest of this particular patient, and (2) is involuntary commitment the least restrictive means of caring for this patient? A judicial determination which would have liability flow from a therapist's mistaken answer to either of those questions would pressure the therapists to answer "yes" to both questions. Although there is immunity for good faith decisions, that defense will not likely thwart lawsuits or prevent the case from going to a jury. Once the case goes to the jury, a good faith defense is not likely to impress a jury who, with the benefit of 20/20 hindsight, sees the clear path from the threatened behavior to commitment of the injurious act.

The public policy of the state of Missouri is to use restraint and detention only as a last resort.[217] Restraint on a patient is only authorized "when less restrictive alternatives have failed."[218] If a patient is not currently acting out

217. *See* MO. CODE. REGS. tit. 9, § 30-4.044 (1995) ("Every effort should be made to minimize the likelihood that [restraint] will be needed.")

218. MO. CODE REGS. tit. 9, § 30-4.004(2)(A) (1995).

violent tendencies toward another, how is a therapist or mental health professional to know that the less restrictive alternatives they have chosen to treat that patient have failed?

The patient's liberty interests are also at stake. The Missouri Supreme Court was concerned about the liberty interest of the involuntary patient in *Sherrill*.[219] Concern about the liberty interests of an involuntary patient committed under civil commitment proceedings should extend to a voluntary outpatient who subsequently becomes an involuntary patient. A climate that would lead to involuntary restraints for no more reason than a private citizen's suspicion that a patient is dangerous would not be in the public's best interest.[220]

If mental health professionals are subject to liability for their decisions to release patients, then few patients will ever be released. The now discredited practice of "warehousing" mental patients will once again become the norm, and the hope of recovery and rehabilitation for patients currently held for their protection will be hindered at best, and eliminated at worst.[221] These dire predictions are somewhat consistent with the actual results from a California survey following *Tarasoff*:

> The survey revealed that therapists, acting under professional and ethical standards, have often given warnings to third parties in the past: it thereby suggests that *Tarasoff* did not mandate a radical change in therapeutic practice. But the study also revealed that imposing on therapists a *legal* duty to warn, as opposed to the traditionally discretionary professional duty, has had potentially detrimental effects on psychotherapy. Therapists report feeling serious anxiety because of their uncertainty about the scope of their new duty to warn. More specifically, many therapists report altering the character of their dialogue with their patients by focusing their own clinical attention as well as their patients' attention on the patients' capacity for violent behavior and the possibility of breaches in confidentiality to respond to the risk of such behavior.[222]

If people suffering from mental problems were faced with the prospect of being "warehoused," locked behind bars where the principal concern of the

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219. "Corley was an involuntary patient, but he was not a convict." *Sherrill*, 653 S.W.2d at 664.

220. *Id.* It has been recognized that *mental illness may be caused or intensified by institutionalizing mental patients. Paddock*, 522 So. 2d at 413-14 (emphasis added).

221. *See* Paradies v. Benedictine Hosp., 431 N.Y.S.2d 175, 178 (N.Y. App. Div. 1980).

222. Toni P. Wise, Note, *Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effect of Tarasoff*, 31 STAN. L. REV. 165, 190 (1978).

staff was not recovery and rehabilitation, but restraint and detention, how many of those people would be willing to consult therapists and other mental health professionals?

Insane asylums have flunked the test of time. Missouri courts should not resurrect Bedlam by imposing unsound duties on mental health care providers. The risk of imposing liability for the professional judgments of therapists is too great, and the price to be paid by mental patients is too high, for society to return to the ancient practice of insane asylums.[223]

Perhaps of lesser importance, but also significant, is the nature of the duty that *Tarasoff* places on psychotherapists. As one writer aptly expressed it, "It is reprehensible that therapists should have to suffer civil and statutory penalties for failing to perform a function which they are incapable of performing properly."[224]

Since *Bradley*, there is at least a narrow duty to warn in the context of child abuse. The duty to warn could easily be, and is likely to be, extended to other professionals in similar situations, including, but not limited to, attorneys,[225] college counselors, social workers, marriage counselors, the clergy, friends, relatives and business associates,[226] and volunteers in crisis-prevention centers.[227] While the duty to warn is less onerous on both the psychotherapist, in most situations, and the patient, it has its own set of problems: confidentiality, who must be warned, when, what are the consequences when, for example, the warning alters relationships, or results in the potential victim attacking the patient.

To paraphrase Ennis & Litwack, the decision to deprive individuals of liberty is a serious one, but because human behavior is difficult to understand, and presently impossible to accurately predict, society must decide how much it values individual freedom, self-determination, and the privacy of patient/psychotherapist communications when assessing what duties should be imposed on the psychotherapist.[228] In this context, the decision to deprive

223. A co-author recalls decades ago when families sometimes elected to keep at home a demented member. This would avoid the disgrace of "Nevada," a state asylum. A hasp and pin secured the upstairs room, with boards or tin nailed over the outside window.

224. *See* Cohen, *supra* note 152, at 182.

225. *See* Marc L. Sands, *The Attorneys Affirmative Duty to Warn Foreseeable Victims of a Client's Intended Violent Assault*, 21 TORT & INS. L.J. 355 (1986).

226. *See* Terry W. Milne, Note, *"Bless me Father, for I am About to Sin . . . ", Should Clergy Counselors have a Duty to Protect Third Parties*, 22 TULSA L.J. 139 (1986).

227. *See* Theodore A. Olsen, Note, *The Duty to Warn*, 48 COLO. L. REV. 283, 308 (1977).

228. *See* Ennis & Litwack, *supra* note 19, at 749-51.

one of liberty or the confidentiality of their communications is a social, not a psychiatric, judgment, which should be made, if at all, only under clear guidelines. Those guidelines should come from the legislature.

The authors would recommend that the law, as embodied in the Missouri Statutes and announced in the *Sherrill* and *Matt* decisions, not be altered, and that the liability in *Bradley* be limited to the circumstances of that decision. The legislature should not intervene at this point. If the legislature is to take any action, it should only be to codify those decisions. Missouri law should remain that health care professionals are not liable for injuries to third parties caused by their patients or for failure to warn such third parties, except when (1) it is child abuse, or (2) there is likely harm to an identified potential victim, and the mental health care provider is proved to have acted in bad faith or with gross negligence.