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The Psychotherapist-Patient Privilege in Washington: Extending the Privilege to Community Mental Health Clinics

Most jurisdictions provide some form of evidentiary privilege for communications between psychotherapists and their patients.[1] Under the privilege, psychotherapists may refuse to testify, or may be prevented from testifying, about communications made to them by their patients. While many professional groups provide psychotherapeutic care, the number of groups that receive state protection for confidential communications varies greatly from jurisdiction to jurisdiction.[2] Washington has traditionally recognized the benefits of a psychotherapist-patient privilege, but has limited its coverage to psychiatrists and licensed psychologists.[3] This limitation works a hardship on the poor, who often can obtain help only from government-sponsored institutions, which have few, if any, psychiatrists or licensed psychologists on their staffs.[4]

This Comment examines recent amendments to Washington's Community Mental Health Services Act,[5] which arguably extend the privilege to communications made between patients and employees of state mental health clinics and agencies. After reviewing the justifications for the psy-

1. *See infra* notes 58–62 and accompanying text. For the purpose of this Comment, the term "psychotherapist-patient privilege" includes the psychiatrist-patient privilege, psychologist-patient privilege and any other privileges that protect communications made in a psychotherapeutic relationship. This Comment also uses the term "patient" to describe persons who receive psychotherapeutic care, even though many statutes use the term "client." *See, e.g.*, WASH. REV. CODE § 18.83.110 (1981), *infra* note 44.

2. *See infra* notes 58–62 and accompanying text. Indeed, simply defining the term psychotherapy presents a difficult task. There are at least 40 definitions found in scientific literature. OFFICE OF TECHNOLOGY ASSESSMENT, THE IMPLICATIONS OF COST-EFFECTIVENESS ANALYSIS OF MEDICAL TECHNOLOGY, BACKGROUND PAPER 3: THE EFFICACY AND COST EFFECTIVENESS OF PSYCHOTHERAPY 9 (1980) [hereinafter cited as COST EFFECTIVENESS]. This Comment defines psychotherapy as "the treatment of emotional and personality problems and disorders by psychological means." *Id.*

3. *See infra* notes 42–53 and accompanying text. The legislature has also extended the privilege to communications made by persons seeking help for drug or alcohol abuse at authorized agencies. WASH. REV. CODE § 69.54.070 (1981).

Psychiatrists are medical school graduates who have had a two- to three-year residency in psychiatry at an approved institution. Psychologists generally hold a doctoral degree (either a Ph.D. or a Psy.D.), and have had a one-year internship in a setting approved by the American Psychological Association. *See* COST EFFECTIVENESS, *supra* note 2, at 15–16.

4. *See infra* note 87. Limiting the privilege to psychiatrists and licensed psychologists has been referred to as creating an invidious discrimination against people who cannot afford to get help from other than a government-sponsored institution. State v. Gotfrey, 598 P.2d 1325, 1329 (Utah 1979) (Stewart, J., concurring in part and dissenting in part). In *Gotfrey*, the court narrowly construed a psychologist-patient privilege statute so that it did not extend to persons acting as agents for, or under the direction of, licensed psychologists. *Id.* at 1328.

5. Ch. 204, 1982 Wash. Laws 777 (codified at WASH. REV. CODE ch. 71.24 (Supp. 1982)).

chotherapist-patient privilege, part I of this Comment discusses the present structure of the privilege in Washington. Part II considers the amendments to the Community Mental Health Services Act and concludes that these amendments are beneficial because they extend the availability of confidential mental health treatment to the poor without greatly limiting the amount of admissible evidence. Last, this Comment proposes a comprehensive psychotherapist-patient privilege statute to provide uniformity for the psychotherapist-patient privilege in this state.

I. THE PSYCHOTHERAPIST-PATIENT PRIVILEGE

A. *Background*

Privileged communications are an exception to the general rule that all persons, when called upon to testify, must present all relevant facts inquired into in a court of law.[6] The use of a privilege allows a witness to withhold testimony that would otherwise be relevant. Because privileges tend to impede the search for truth in the courtroom, they are granted sparingly by the legislatures and the courts. Nonetheless, communications in certain relationships are granted privileged status. It is generally

6. 8 J. WIGMORE, EVIDENCE § 2285 (1961). Wigmore further states:

> For more than three centuries it has now been recognized as a fundamental maxim that the public . . . has a right to every man's evidence. When we come to examine the various claims of exemption, we start with the primary assumption that there is a general duty to give what testimony one is capable of giving and that any exemptions which may exist are distinctly exceptional, being so many derogations from a positive general rule . . . .
>
> . . . .
>
> . . . The vital process of justice must continue unceasingly. A single cessation typifies the prostration of society. A series would involve its dissolution. The pettiness and personality of the individual trial disappear when we reflect that our duty to bear testimony runs not to the parties in that present cause, but to the community at large and forever.
>
> It follows, on the one hand, that *all privileges of exemption from this duty are exceptional*, and are therefore to be discountenanced. There must be good reason, plainly shown, for their existence.

Id. § 2192, at 70–73.

The word privilege comes from the Latin words *privata lex*, a prerogative given to a person or a group of persons. A privilege was originally conveived of in England as a judicially recognized point of honor among lawyers. Allred v. State, 554 P.2d 411, 413 (Alaska 1976); *see also* Slovenko, *Psychiatry and a Second Look at the Medical Privilege*, 6 WAYNE L. REV. 175, 181 (1960). Only the attorney-client privilege was allowed under early common law. J. WIGMORE, *supra*, § 2290; *see also* Note, *Confidential Communications to a Psychologist: A New Testimonial Privilege*, 47 NW. U.L. REV. 384, 385 (1952). A physician, for example, could not refuse to testify under the original, common law view. 8 J. WIGMORE, *supra*, § 2380. Many other privileges have since been recognized by statute or judicial decision. In Washington, see, for example, WASH. REV. CODE § 18.53.200 (1981) (optometrist-patient privilege), *id.* § 5.60.060(1) (1981) (husband and wife privilege), and *id.* § 5.60.060(3) (1981) (priest-penitent privilege).

recognized that four fundamental conditions are necessary to establish an evidentiary privilege.[7] These conditions are:

> (1) The communications must originate in a confidence that they will not be disclosed.
> (2) This element of confidentiality must be essential to the full and satisfactory maintainence of the relation between the parties.
> (3) The relation must be one which in the opinion of the community ought to be sedulously fostered.
> (4) The injury that would inure to the relation by the disclosure of the communications must be greater than the benefit thereby gained for the correct disposal of litigation.[8]

When these four conditions are present, a privilege should be recognized. A few commonly recognized examples of privileges that meet these four conditions are the attorney-client privilege, the husband-wife privilege, and the privilege protecting communications among jurors.[9]

Statutory privileges have been enacted even when these four fundamental conditions are not met. The most common example is the physician-patient privilege. Despite broad acceptance by many state legislatures,[10] the physician-patient privilege has been frequently attacked as an unjustified frustration of the search for truth.[11] Due in large part to com-

7. 8 J. WIGMORE, *supra* note 6, § 2285. These four conditions have been accepted as fundamental to the establishment of a privilege in the State of Washington. *See* State *ex rel.* Haugland v. Smythe, 25 Wn. 2d 161, 168, 169 P.2d 706, 710 (1946). These criteria, however, have been criticized for allowing too many privileges. *See* Comment, *Functional Overlap Between the Lawyer and Other Professionals: Its Implications For the Privileged Communications Doctrine*, 71 YALE L.J. 1226, 1230 (1962).

8. 8 J. WIGMORE, *supra* note 6, § 2285, at 527 (emphasis omitted).

9. *Id.* at 528.

10. A New York statute, enacted in 1828, was the first statute to protect communications between a physician and a patient. 2 N.Y. REV. STATS. pt. III, ch. 7, tit. 3, art. 8, § 73 (1829), *reprinted in* Louisell & Sinclair, *Reflections on the Law of Privileged Communications—The Psychotherapist-Patient Privilege in Perspective*, 59 CALIF. L. REV. 30, 32 n.9 (1971). Today, over two-thirds of the states have adopted similar statutes. *See infra* notes 58–62.

11. For example, Professor McCormick states:

> The arguments of policy against the recognition of [the physician-patient privilege] seem overwhelming. The improvement of treatment by encouraging free disclosure seems an unrealistic justification. The patient has ample motive for full disclosure without the privilege and in most cases will not be thinking, when he considers what he will tell his doctor, about what may happen in the courtroom. As for the interest of privacy, usually the patient has opened up to the public, by pleadings and testimony, the issue of his condition long before the doctor is called upon to disclose his knowledge.

McCormick, *Some Highlights of the Uniform Evidence Rules*, 33 TEX. L. REV. 559, 570 (1955). *See generally* 8 J. WIGMORE, *supra* note 6 § 2380(a) (criticizing the physician-patient privilege). Wigmore has stated that the physician-patient privilege meets but one of his four conditions—that the relationship should be fostered by society. *Id.* at 829–30. He further argues that the "real support for the privilege seems to be mainly the weight of professional medical opinion pressing upon the legislature." *Id.* at 831.

mentators' attacks on the validity of the privilege, these statutes have often been narrowly construed,[12] and contain many exceptions.[13] Although the psychotherapist-patient privilege is an outgrowth of the physician-patient privilege,[14] there are greater justifications for confidentiality in the psychotherapist-patient relationship.

B. *The Justification for the Psychotherapist-Patient Privilege*

In recent years, several proposed privileges have been rejected[15] and other long-established privileges have been contracted.[16] Despite this trend, legal commentators have almost uniformly supported the adoption of some form of psychotherapist-patient privilege.[17] The privilege also appears to have growing support in the courts and in state legislatures.[18]

12. In Washington, see, for example, Department of Social and Health Servs. v. Latta, 92 Wn. 2d 812, 819–20, 601 P.2d 520, 525 (1979) (physician-patient privilege is not applicable to Department of Social and Health Services' audit of medical records of Medicaid recipients) and Randa v. Bear, 50 Wn. 2d 415, 420, 312 P.2d 640, 645 (1957) (patient waived privilege by filing a cross-complaint).

13. See FED R. EVID. 504 (Proposed 1972) advisory committee note, *reprinted in* 56 F.R.D. 183, 242 (1972) [hereinafter cited as *Proposed Rule 504*], where the committee listed the following common exceptions:

> [C]ommunications not made for purposes of diagnosis and treatment; commitment and restoration proceedings; issues as to will or otherwise between parties claiming by succession from the patient; actions on insurance policies; required reports (venereal diseases, gunshot wounds, child abuse); communications in furtherance of crime or fraud; mental or physical condition put in issue by patient (personal injury cases); malpractice actions; and some or all criminal prosecutions.

At least three of these exceptions exist in Washington: child abuse, patient-litigant, and involuntary civil commitment. *See infra* notes 51–53 and accompanying text. The privilege does, however, apply in criminal prosecutions in Washington. *See infra* note 44.

14. *See infra* notes 58–62 and accompanying text.

15. *See, e.g.*, United States v. Schoenheinz, 548 F.2d 1389 (9th Cir. 1977) (rejecting employer-stenographer privilege); *In re* Grand Jury Impaneled Jan. 21, 1975, 541 F.2d 373 (3rd Cir. 1976) (rejecting required reports privilege); Lewis v. Capital Mortgage Invs., 78 F.R.D. 295 (D. Md. 1978) (rejecting accountant-client privilege); State *ex rel.* Haugland v. Smythe, 25 Wn. 2d 161, 169–70, 169 P.2d 706, 711 (1946) (rejecting a welfare records privilege in Washington).

16. *See, e.g.*, Trammel v. United States, 445 U.S. 40 (1980) (restricting the privilege for communications between husband and wife); United States v. Mendoza, 574 F.2d 1373 (5th Cir.) (conversations between husband and wife about crimes in which they have participated do not fall within the scope of privileged marital communications), *cert. denied*, 439 U.S. 988 (1978).

17. *See, e.g.*, MCCORMICK'S HANDBOOK OF THE LAW OF EVIDENCE § 99, at 213 n.9 (E. Cleary 2d ed. 1972); Dubey, *Confidentiality as a Requirement of the Therapist: Technical Necessities for Absolute Privilege in Psychotherapy*, 131 AM. J. PSYCHIATRY 1093 (1974); Goldstein & Katz, *Psychyatrist-Patient Privilege: The GAP Proposal and the Connecticut Statute*, 36 CONN. B.J. 175, 178–79 (1962); Louisell, *The Psychologist in Today's Legal World: Part II*, 41 MINN. L. REV. 731, 740–45 (1957); Comment, *Underprivileged Communications: Extension of the Psychotherapist-Patient Privilege to Patients of Psychiatric Social Workers*, 61 CALIF. L. REV. 1050 (1973) [hereinafter cited as *Underprivileged Communications*]; Comment, *The Psychiatrist-Patient Privilege in Illinois*, 10 LOY U. CHI. L.J. 525, 528–29 (1979).

18. *See infra* notes 58–62 and accompanying text.

Although the privilege is generally created by statute, it has also been fashioned by common law,[19] and under the Constitution.[20] Support for the privilege is well founded because the psychotherapist-patient relationship fulfills Wigmore's four conditions.

First, communications between a patient and a psychotherapist are, by their very nature, confidential. Patients often reveal thoughts to psychotherapists that they have revealed to no one else:

> The psychiatric patient confides more utterly than anyone else in the world. He exposes to the therapist not only what his words directly express; he lays bare his entire self, his dreams, his fantasies, his sins, and his shame. Most patients who undergo psychotherapy know that this is what will be expected of them, and that they cannot get help except on that condition.[21]

Patients who have expressed such hidden thoughts and desires generally expect that such information will be kept confidential.[22]

The presence of the second condition, that confidentiality be essential to the relationship, is the subject of more debate. Some commentators have argued that because the practices of psychology and psychiatry have flourished in locations where the privilege does not exist, the privilege is not essential for an effective therapeutic relationship.[23] Despite this fact, numerous authorities maintain that confidentiality is essential to the maintenance of the psychotherapist-patient relationship.[24] Unless patients are

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19. *See, e.g.*, Allred v. State, 554 P.2d 411 (Alaska 1976). For a detailed discussion of the *Allred* case, see *infra* note 63; Binder v. Ruvell, Civ. Docket No. 52C2535 (Cir. Ct. Cooke Co. Ill. 1952) (plaintiff was not allowed to question his wife's psychiatrist concerning information she had revealed in psychiatric consultations), *cited in* 150 J. A.M.A. 1241 (1952). This case is commented on in Note, *Confidential Communications to a Psychotherapist: A New Testimonial Privilege*, 47 Nw. U.L. REV. 384 (1952).

20. *See infra* notes 33 & 35.

21. Taylor v. United States, 222 F.2d 398, 401 (D.C. Cir. 1955) (citing M. GUTTMACHER & H. WEIHOFEN, PSYCHIATRY AND THE LAW 272 (1952)). The language in *Taylor* has been cited in support of the psychiatrist-patient privilege in Washington. State v. Sullivan, 60 Wn. 2d 214, 225, 373 P.2d 474, 480 (1962).

22. *See* Meyer & Smith, *A Crisis in Group Therapy*, 32 AM. PSYCHOLOGIST 638, 639–40 (1977).

23. *See* Note, *Untangling* Tarasoff, Tarasoff v. Regents of the University of California, 29 HASTINGS L.J. 179, 197 (1977) [hereinafter cited as *Untangling* Tarasoff]. See also *In re* Lifschutz, 2 Cal. 3d 415, 426, 467 P.2d 557, 564, 85 Cal. Rptr. 829, 836 (1970), a leading case in support of the constitutional basis for the privilege, where the California Supreme Court stated: "[W]e cannot blind ourselves to the fact that the practice of psychotherapy has grown, indeed flourished, in an environment of non-absolute privilege."

24. *See, e.g.*, *Proposed Rule 504*, *supra* note 13, at 242 (quoting Group For the Advancement of Psychiatry, Report No. 45 92 (1960)):

> Among physicians, the psychiatrist has a special need to maintain confidentiality. His capacity to help his patients is completely dependent on their willingness and ability to talk freely. This makes it difficult if not impossible for him to function without being able to assure his patients of confidentiality and, indeed, privileged communication. Where there may be excep-

assured that information they relate to their psychotherapist will remain confidential, they may become reluctant to communicate all their thoughts. This silence defeats the purpose of psychotherapeutic treatment. Treatment would be ineffectual if patients "knew that all they say—and all that the psychiatrist learns from what they say—may be revealed to the world on the witness stand."[25] Without the assurance of confidentiality, patients might refuse treatment or be substantially less inclined to obtain treatment.[26]

In accord with Wigmore's third condition, the psychotherapist-patient relationship is one that society fosters. Society's recognition of the need for psychotherapists and the benefits they provide is evidenced by the billions of dollars spent annually in both the public and private sectors on mental health care.[27] Psychotherapeutic treatment has the potential to prevent or reduce antisocial behavior, thereby reducing criminal acts.[28] As the California Supreme Court has noted: "The swiftness of change—economic, cultural, and moral—produces accelerated tension in our society, and the potential for relief of such emotional disturbances offered by psychotherapy undoubtedly establishes it as a profession essential to the preservation of societal health and well being."[29] Because psychotherapy has the potential for curing many social and psychological ills before they are

tions to this general rule . . . there is wide agreement that confidentiality is a sine qua non for successful psychiatric treatment. The relationship may well be likened to that of the priest-penitent or the lawyer-client. Psychiatrists not only explore the very depths of their patients' conscious, but their unconscious feelings and attitudes as well. Therapeutic effectiveness necessitates going beyond a patient's awareness and, in order to do this, it must be possible to communicate freely. A threat to secrecy blocks successful treatment.

25. Taylor v. United States, 222 F.2d 398, 401 (D.C. Cir. 1955) (quoting M. GUTTMACHER & H. WEIHOFER, PSYCHIATRY AND THE LAW 272 (1952)).

26. Project, *Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of* Tarasoff, 31 STAN. L. REV. 165, 183 (1978); *see* Meyer & Smith, *supra* note 22, at 638–40; *Untangling* Tarasoff, *supra* note 23, at 194–95 (quoting CAL EVID. CODE § 1014 comment of the Senate Committee on the Judiciary (West 1966)).

27. See Comment, *The Psychotherapist-Patient Privilege: Are Some Patients More Privileged Than Others?* 10 PAC. L.J. 801, 802 (1979) [hereinafter cited as *More Privileged*], where the author states: "Mental health care is no longer an infrequent occurrence in American society. In quest of mental health, billions of dollars are spent annually and millions of persons are affected either directly or indirectly." In Washington, the state's Mental Health Program (DSHS) proposed a budget of $97,117,000 for 1979–81, a 19.1% increase over the prior term. Department of Social and Health Services, Governor's Operating Budget, Human Resources, Mental Health Program 418 (1981) (copy on file with the *Washington Law Review*).

28. *See* Allred v. State, 554 P.2d 411, 429 (Alaska 1976), (Dimond, J., concurring). See also Smith, *Constitutional Privacy in Psychotherapy*, 49 GEO. WASH L. REV. 1, 39 (1980), where the author argues:

> The societal interest in protecting the confidentiality of therapy is to promote emotional and mental health, which ultimately will reduce antisocial activity and other societal burdens that result from untreated or poorly treated mental problems. Successful psychotherapy may reduce social problems such as juvenile delinquency, marital complications, and violent crime.

29. *In re* Lifschuftz, 2 Cal. 3d 415, 421–22, 467 P.2d 557, 560, 85 Cal. Rptr. 829, 832 (1970).

manifested in the form of delinquent social acts, the privilege should be and is "sedulously fostered" by our society.

The fourth condition involves a balancing between the need for truth in the courtroom[30] and the need for confidentiality in certain relationships. It is necessary to decide whether the interests of society will best be served if psychotherapists can ensure their clients of confidentiality, or if they are instead required to testify about confidential communications with their clients. Because the use of the privilege encourages people to seek psychotherapeutic treatment, and that treatment may prevent crimes or other social problems before they occur, the privilege should be favored.[31] Special exemptions and exceptions can be carved out for those areas where the need for the testimony outweighs the benefit of confidentiality.[32]

Two additional arguments support the justification for the psychotherapist-patient privilege. First, forced disclosure of these communications may violate the patient's constitutional right of privacy.[33] Some commentators also argue that the failure to extend the privilege to the poor may violate the equal protection clause.[34] The California Supreme Court was the first court to recognize a constitutionally based psychotherapist-pa-

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30. Chief Justice Burger's statement in United States v. Nixon, 418 U.S. 683, 709 (1974), is one example of the judicial desire for truth in the courtroom:

> We have elected to employ an adversary system of criminal justice in which the parties contest all issues before a court of law. The need to develop all relevant facts in the adversary system is both fundamental and comprehensive. The ends of criminal justice would be defeated if judgments were to be founded on a partial or speculative presentation of the facts. The very integrity of the judicial system and public confidence in the system depend on full disclosure of all the facts, within the framework of the rules of evidence. To ensure that justice is done, it is imperative to the function of courts that compulsory process be available for the production of evidence needed either by the prosecution or by the defense.

See also State v. Gotfrey, 598 P.2d 1325, 1327–28 (Utah 1979), where the court complained that the creation of a psychologist-patient privilege closes "another window to the light of truth."

31. *See* Allred v. State, 554 P.2d 411, 429 (Alaska 1976) (Dimond, J., concurring). Judge Dimond stated:

> [T]he purpose of the psychotherapist-patient relationship is the prevention and curing of antisocial behavior. . . . If this type of activity is successful, then many potential crimes will not be committed. The prevention of a number of similar defendants being prosecuted in future cases is more than an adequate balance for the hampering of the truth-finding function in an individual case.

32. *See infra* notes 51–53 and accompanying text (listing the Washington exceptions).

33. For an in depth analysis of the constitutional argument, see Smith, *supra* note 28; Note, *Psychotherapy and* Griswold: *Is Confidence a Privilege or a Right?*, 3 CONN. L. REV. 599 (1971). The right of privacy limits government intrusion into important areas of people's lives. The Supreme Court first recognized a specific right to privacy in Griswold v. Connecticut, 381 U.S. 479 (1965), where in a divided opinion it struck down a statute which prohibited married couples from using contraceptives. In Eisenstadt v. Baird, 405 U.S. 438 (1972), the Court used the constitutional right of privacy to reverse the defendant's conviction for selling contraceptives to an unmarried person.

34. *See Underprivileged Communications*, *supra* note 17, at 1061–68; *More Privileged*, *supra* note 27, at 815–18.

tient privilege. It held that the confidentiality of the psychotherapeutic session falls within one of the zones of privacy guaranteed by the Bill of Rights.[35] Even though the Washington Supreme Court has not endorsed this position,[36] the proximity of these communications to constitutional zones of privacy emphasizes the need for the privilege.

Second, the psychotherapist-patient privilege prevents the courts from forcing psychotherapists into a "cruel trilemma."[37] Under the "cruel trilemma," psychotherapists are obligated to choose among one of three undesirable results: (1) to violate the extraordinary trust imposed upon them by their clients and profession;[38] (2) to lie, and thereby commit perjury; or (3) to refuse to testify and thereby be held in contempt of court. Due to the "cruel trilemma," psychotherapists have been known to fabricate, to have "memory lapses" on the witness stand, or to keep two sets of records.[39] Rather than requiring the psychotherapist to resolve these conflicting demands, a court or a state legislature may prefer to grant the privilege.[40]

C. The Psychotherapist-Patient Privilege in Washington

1. Present Statutory Structure

In Washington, two groups of psychotherapists, psychiatrists and licensed psychologists, have statutory privileges for communications made to them by a patient. A third group of professionals, the employees in the state's mental health services clinics, arguably have a privilege created by recent amendments to the Community Mental Health Services Act.[41] This possibility is discussed in detail in part II.

Because psychiatrists are medical doctors, they have traditionally come

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35. *In re* Lifschutz, 2 Cal. 3d 415, 431–32, 467 P.2d 557, 567, 85 Cal. Rptr. 829, 839 (1970). The Pennsylvania Supreme Court has also recognized a constitutionally based psychotherapist-patient privilege. *In re* B., 482 Pa. 471, 394 A.2d 419, 425 (1978).

36. *See generally* State v. Fagalde, 85 Wn. 2d 730, 735, 539 P.2d 86, 89 (1975). The Washington court has specifically rejected a constitutional privilege for physicians and their patients. Department of Social and Health Servs. v. Latta, 92 Wn. 2d 812, 819, 601 P.2d 520, 525 (1979).

37. The term "cruel trilemma" was coined by Professor Robert Aronson, Professor of Evidence at the University of Washington. While courts have not used the specific terminology of Aronson's cruel trilemma, *but see* Murphy v. Waterfront Comm'n, 378 U.S. 52, 55 (1964) (using the term in the context of the fifth amendment privilege against self-incrimination), they may refer to this general principle when establishing or denying a privilege. *See, e.g.*, Allred v. State, 554 P.2d 411, 418 (Alaska 1976) (adopting a psychotherapist-patient privilege at common law).

38. Smith, *supra* note 28, at 30.

39. *Underprivileged Communications, supra* note 17, at 1054.

40. *See, e.g.*, Allred v. State, 554 P.2d 411, 418 (Alaska 1976).

41. Ch. 204, 1982 Wash. Laws 848 (codified at WASH REV CODE ch. 71.24 (Supp. 1982)).

within the physician-patient privilege.[42] The purpose of the physician-patient privilege is to encourage patients to disclose their ailments to a physician in order to receive proper treatment.[43] In Washington, unlike some jurisdictions, the physician-patient privilege applies to criminal as well as civil proceedings.[44] Licensed psychologists are privileged under a separate statute.[45] Under the latter statute, communications between a psychologist and a patient are privileged to the same extent as communications between an attorney and a client.[46] Nonetheless, in some circumstances, such as child abuse, the court has construed the psychologist-client privilege to be less extensive than the attorney-client privilege.[47] The Washington Supreme Court has expressed some perplexity over the use of the attorney-client privilege to define the psychologist-client privilege: "It is puzzling that the statute relates the psychologist-client relationship to that of attorney and client, rather than that of physician and patient, which would appear to have a more logical relation."[48] The use of separate privileges for psychiatrists and psychologists has been criticized because it can lead to anomalous results.[49]

42. WASH. REV. CODE § 5.60.060(4) (1981) provides:

A regular physician or surgeon shall not, without the consent of his patient, be examined in a civil action as to any information acquired in attending such patient, which was necessary to enable him to prescribe or act for the patient, but this exception shall not apply in any judicial proceeding regarding a child's injuries, neglect or sexual abuse, or the cause thereof.

In State v. Sullivan, 60 Wn. 2d 214, 226, 373 P.2d 474, 481 (1962), the court held that statements by a patient to a psychiatrist were privileged under the physician-patient privilege.

43. State v. Fackrell, 44 Wn. 2d 874, 877, 271 P.2d 679, 681 (1954).

44. State v. Sullivan, 60 Wn. 2d 214, 223, 373 P.2d 474, 479 (1962). The extension of the privilege to criminal proceedings is based on three statutes: WASH. REV. CODE § 5.60.060(4) (1981), *supra* note 42; *id.* § 10.52.020 which provides: "Witnesses competent to testify in civil cases shall be competent in criminal prosecutions, but regular physicians or surgeons, clergymen or priests, shall be protected from testifying as to confessions, or information received from any defendant, by virtue of their profession and character . . . ."; and *id.* § 10.58.010 which provides: "The rules of evidence in civil actions, so far as practicable, shall be applied to criminal prosecutions."

45. WASH. REV. CODE § 18.83.110 (1981) provides: "Confidential communications between a client and a psychologist shall be privileged against compulsory disclosure to the same extent and subject to the same conditions as confidential communications between attorney and client."

The attorney-client privilege, codified at *id.* § 5.60.060(2), provides: "An attorney or counselor shall not, without the consent of his client, be examined as to any communication made by the client to him, or his advice given thereon in the course of professional employment."

For articles discussing the difficulties inherent in comparing the psychotherapist-patient privilege to the attorney-client privilege, see *infra* note 49.

46. WASH REV. CODE § 18.83.110 (1981).

47. State v. Fagalde, 85 Wn. 2d 730, 733 n.1, 539 P.2d 86, 88 n.1 (1975). *See infra* notes 50 & 74 and accompanying text.

48. State v. Fagalde, 85 Wn. 2d 730, 733 n.1, 539 P.2d 86, 88 n.1 (1975).

49. *See infra* notes 100 & 101 and accompanying text. *See also* Louisell, *The Psychologist in Today's Legal World: Part II*, 41 MINN. L. REV. 731 (1957); Comment, *Evidence: Justification for Extension of the Psychotherapist Privilege*, 17 WASHBURN L.J. 672, 677–78 (1978).

Both privileges are strictly construed because the Washington courts regard these statutes as procedural safeguards which are "in derogation of common law."[50] Each privilege is subject to at least three exceptions. First, both privileges include exceptions for the reporting of child abuse.[51] Second, the privilege does not apply in certain involuntary civil commitment proceedings.[52] Third, the privileges are waived if the patient calls on the psychotherapist to testify, or puts his psychological state at issue in a trial.[53] This third exception is commonly referred to as the patient-litigant exception.

2. *The Need for a More Equitable Privilege*

By restricting the privilege to psychiatrists and licensed psychologists, Washington has failed to provide the poor with access to confidentiality in psychotherapy. One commentator has argued that the privilege should not be limited to psychiatrists and psychologists, but should be extended further to psychiatric social workers or social workers generally.[54] Patients visit these professionals for the same reason that others visit psychiatrists and licensed psychologists.[55] Because money may be the only determinative factor in choosing one type of therapist over another, providing the privilege solely to patients who are able to afford higher-paid professionals discriminates against the poor. On the other hand, since invoking the privilege precludes the admission of relevant evidence, courts are justifiably concerned with restricting the number of groups protected by the privilege.[56] Once the privilege has been extended to one group, such as

50. Department of Social and Health Servs. v. Latta, 92 Wn. 2d 812, 819, 601 P.2d 520, 525 (1979); *see also In re* Henderson, 29 Wn. App. 748, 752–53, 630 P.2d 944, 947 (1981).

51. WASH. REV. CODE § 26.44.020, .030, .060 (1981). In State v. Fagalde, 85 Wn. 2d 730, 539 P.2d 86 (1975), the court found that the psychotherapist-patient privilege was overridden by the Washington statute protecting children from abuse. *Id.* at 735, 539 P.2d at 90. WASH. REV. CODE § 26.44.030 (1981) provides in part:

> When any practitioner, professional school personnel, registered or licensed nurse, social worker, psychologist, pharmacist, or employee of the department of social and health services has reasonable cause to believe that a child or adult developmentally disabled person has suffered abuse or neglect, he shall report such incident, or cause a report to be made, to the proper law enforcement agency or to the department of social and health services.

52. WASH. REV CODE § 71.05.250 (1981).

53. *See* State v. Tradewell, 9 Wn. App. 821, 515 P.2d 172 (1973), *cert. denied*, 416 U.S. 985 (1974).

54. *See, e.g., Underprivileged Communications, supra* note 17.

55. *Id.* at 1052.

56. This concern applies to all privileges. The Washington courts, for example, do not favor privileges:

> It is an inherent power of a court of justice, within the sphere of its jurisdiction, to compel witnesses to appear before it and testify concerning any relevant facts within their knowledge, in

psychiatric social workers, the failure to extend it to all groups ostensibly providing psychotherapeutic care may be difficult to justify. However, extending the privilege to the many groups that arguably perform counseling or psychotherapeutic functions[57] would bar so much relevant evidence that it would make a mockery of many judicial proceedings.

While many states have adopted some type of psychotherapist-patient testimonial privilege, the statutes vary in form. Likewise the court decisions have differed in determining the extent of the psychotherapeutic relationship covered. Most jurisdictions, including Washington, have a physician-patient privilege, which covers communications made to psychiatrists.[58] Recognizing that many of the objections to the physician-patient privilege do not apply to psychiatrists, several jurisdictions adopted a special privilege for this profession.[59] Many states extended the privilege further to licensed psychologists, since they perform much the same function as psychiatrists, but are not protected under the physician-patient privilege.[60] In order to provide uniformity for the privilege in a

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a case then pending in that court. Without such power, courts would cease to function and causes presented to them could not be conducted. . . .

. . . .

For several centuries it has been recognized as a fundamental maxim that it is the general duty of every man to give what testimony he is capable of giving. Any exemptions from that positive general rule are distinctly exceptional.

State *ex rel.* Haugland v. Smythe, 25 Wn. 2d 161, 167–68, 169 P.2d 706, 710 (1946).

57. A list of persons who perform psychotherapeutic services would include psychiatrists, clinical psychologists, nonpsychiatric physicians, social workers, psychiatric social workers, school psychologists, marriage, family and child counselors, pastoral counselors, educational psychologists, occupational therapists, and some paraprofessionals. For a discussion of the background and services performed by some of these groups, see *Cost Effectiveness, supra* note 2, at 14–16.

Arguably, the list could be extended even further to include self-appointed therapists, faith healers, members of the police department, bartenders, or even hairdressers. *See* Slovenko, *Psychotherapist-Patient Testimonial Privilege: A Picture of Misguided Hope*, 23 CATH. U.L. REV. 649, 664–65 n.29 (1974); Smith, *Constitutional Privacy in Psychotherapy, supra* note 28, at 49 n.271.

58. ARIZ. REV. STAT. ANN. § 13-4062(4) (1978); CAL. EVID. CODE §§ 990–1007 (West 1966 & Supp. 1983); COLO. REV. STAT. § 13-90-107 (Supp. 1976); D.C. CODE ANN. § 14-307 (1981); IDAHO CODE § 9-203(4) (Supp. 1982); ILL. ANN. STAT. ch. 51, § 5.1 (Smith-Hurd Supp. 1982); IND. CODE § 34-1-14-5 (Supp. 1982); IOWA CODE § 622.10 (Supp. 1982); KAN. STAT. ANN. § 60-427 (1976); KY. REV. STAT. § 213.200 (1982); LA. REV. STAT. ANN. § 15:476 (1981); MICH. COMP. LAWS § 27A.2157 (1976); MINN. STAT. ANN. § 595.02(4) (West. Supp. 1983); MISS. CODE ANN. § 13-1-21 (Supp. 1982); MO. REV. STAT. § 491.060(5) (Supp. 1983); MONT. CODE ANN. § 26-1-805 (1981); N.H. REV. STAT. ANN. § 329:26 (Supp. 1981); N.J. REV. STAT. § 2A:84A-22.2 (1976); N.Y. CIV. PRAC. LAW § 4504 (McKinney Supp. 1982); N.C. GEN. STAT. § 8-53 (1981); OHIO REV. CODE ANN. § 2317.02(B) (Page 1981); OR. REV. STAT. § 40.235 (1981); TEX. REV. CIV. STAT. ANN. art. 4495b, § 5.08 (Vernon Supp. 1982); UTAH CODE ANN. § 78-24-8(4) (1977) and UTAH R. EVID. 27; VA. CODE § 8.01-399 (1977)); WASH. REV. CODE § 5.60.060(4) (1981); WYO. STAT. § 1-12-101 (1977).

59. CONN. GEN. STAT. § 52-146d (Supp. 1982); GA. CODE § 38-418(5) (1981); KY. REV. STAT. § 421.215 (1979); TENN. CODE ANN. § 24-1-207 (1980).

60. ARIZ. REV. STAT. ANN. § 32-2085 (Supp. 1982); ARK. STAT. ANN. § 72-1516 (1979); COLO. REV. STAT. § 12-43-120 (Supp. 1982); CONN. GEN. STAT. § 52–146c (Supp. 1982); D.C. CODE ANN. § 2-1704.16 (1981); GA. CODE § 84-3118 (1979); IDAHO CODE § 54-2314 (1979); ILL. ANN. STAT. ch.

psychotherapeutic setting, some states have adopted a "psychotherapeutic patient" privilege.[61] Still other states have a single rule covering communications to physicians, psychiatrists and psychologists.[62] While many jurisdictions have accepted the view that the privilege should be granted to psychiatrists and licensed psychologists, extension of the privilege beyond that point remains an intensely debated issue.[63]

The variety of state statutes and judicial resolutions are an outgrowth of the search for an equitable solution that reconciles the desire of the courts to hear relevant evidence, with the goal of providing poor patients with the opportunity to receive confidential psychotherapeutic treatment. Some authorities have proposed a functional approach, arguing that "there is little justification for extending privileged status to one group and denying it to another that is functionally accomplishing the same thing."[64] This approach would establish the privilege where the psy-

111, § 5306 (Smith-Hurd Supp. 1982); IND. CODE § 25-33-1-17 (Supp. 1982); KAN STAT. ANN § 74-5323 (1980); KY REV. STAT. § 319.111 (1982); LA. REV STAT. ANN. § 37:2366 (West 1974); MINN. STAT. § 595.02(7) (Supp. (West 1974); MINN. STAT. § 595.02(7) (Supp. 1983); MISS. CODE ANN. 73-31-29 (1973); MO. REV. STAT § 337.055 (Supp. 1983); MONT CODE ANN. § 26-1-807 (1981); N.H. REV STAT. ANN. § 330-A:19 (Supp. 1981); N.Y. CIV. PRAC. LAW § 4507 (McKinney Supp. 1982); N.C. GEN. STAT § 8-53.3 (1981); OHIO REV CODE ANN § 4732.19 (Page Supp. 1983); TENN. CODE ANN § 63-11-213 (1982); VA. CODE § 8.01-400.2 (Supp. 1982); WASH. REV CODE § 18.83.110 (1981); WYO STAT § 33-27-103 (1977).

61. ALA CODE § 34-26-2 (Supp. 1982); CAL. EVID CODE §§ 1010–1026 (West 1966 & Supp. 1983); FLA STAT § 90.503 (1979); MD CTS. & JUD. PROC. CODE ANN. § 9-109 (1980 & Supp. 1982); N.M.R. EVID 504; TEX. REV CIV STAT. ANN. art. 5561h, §§ 1–6 (Vernon Supp. 1982).

62. DEL. R. EVID 503; HAWAII R. EVID. 504 & 504.1; LA REV. STAT ANN § 13.3734 (Supp. 1983); MASS GEN. LAWS ANN. ch. 233, § 20B (1974 & Supp. 1983); NEV REV. STAT. §§ 49.215–.245 (1977); N.D.R. EVID. 503; OKLA. STAT. tit. 12, § 2503 (Supp. 1982); R.I. GEN. LAWS §§ 5-37.3-1 to 5-37.3-11 (Supp. 1982); S.D. CODIFIED LAWS ANN. §§ 19-13-6 to 19-13-11 (1979 & Supp. 1982); WIS. STAT § 905.04 (Supp. 1982).

63. An excellent example of this conflict is Allred v. State, 554 P.2d 411 (Alaska 1976). The court divided in determining the scope of the privilege. In *Allred*, the defendant was arrested for shooting and killing a friend in a hotel room. While at the police station, Allred spoke with his drug counselor, employed at a local psychiatric clinic. Allred admitted to the counselor that he killed the victim, but stated that he had done so at the victim's request. The testimony of the counselor concerning this conversation was admitted in court. The Supreme Court of Alaska, after establishing the existence of a common law psychotherapist-patient privilege, split on whether it should be extended to Allred's counselor. Two judges determined that the privilege should cover the communications with the counselor because Allred sought her aid in resolving mental and emotional problems, and because the relationship between the counselor and Allred fulfilled Wigmore's four canons. *Id.* at 425–26. Two judges would not have applied the privilege in Allred's case because the counselor was neither a psychiatrist nor a licensed psychologist. They preferred to keep the privilege within strict boundaries, applying it solely to two professional groups, and only for psychotherapeutic treatment, not counseling. *Id.* at 421–22. The fifth judge believed that an Alaska statute, which prevented psychologists from revealing "to another person a communications made to him by a client," created a psychotherapist's testimonial privilege, and that it was not necessary to find a common law basis for the privilege. *Id.* at 422.

64. Slovenko, *supra* note 57, at 664; *see Underprivileged Communications, supra* note 17, at 1058–60; *More Privileged, supra* note 27, at 820. This is especially true because there is no evidence

chotherapeutic function is the foundation of the relationship, and would protect those who, in the course of their employment, practice psychotherapy.[65] A functional approach would provide the poor with greater access to confidential communications by increasing the number of groups covered under the privilege. The approach would do little, however, to address the problem of excluding large amounts of relevant testimony.[66]

A more adequate solution must address both issues. To this end, a state should delineate the number of groups protected by the privilege, and guarantee that at least one of these groups provides psychotherapeutic care to the poor. With the recent amendments to the Community Mental Health Services Act,[67] the state of Washington appears to have adopted just such a compromise solution.

II. PROPOSED IMPROVEMENTS FOR THE PSYCHOTHERAPIST-PATIENT PRIVILEGE IN WASHINGTON

A. *The Mental Health Services Act*

The Community Mental Health Services Act ("the Act") was first adopted in Washington in 1967.[68] The purpose of the Act was to give financial assistance to counties in order to develop community mental health programs.[69] The Act laid the foundation for the community mental

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that one form of psychotherapy is more effective than another. *See* Slovenko, *supra* note 57, at 664–65.

65. *See Underprivileged Communications, supra* note 17, at 1058–60; Slovenko, *supra* note 57, at 664; *More Privileged, supra* note 27, at 820.

66. If there is no restriction on the groups covered by the privilege, it could exclude large amounts of evidence from the trier of fact. See *Proposed Rule 504, supra* note 13, at 243, where the advisory committee, in support of its goal to limit the privilege, stated that the "requirement that the psychologist be in fact licensed, and not merely be believed to be so, is believed to be justified by the number of persons, other than psychiatrists, purporting to render psychotherapeutic aid and the variety of their theories."

A functional approach could prove unsatisfactory for a second reason. In order for the privilege to be effective, patients must know, when entering into the relationship, that their communications will remain confidential. It is this confidentiality that forms the basis of the trust in the relationship. Under a functional test, the professional could not guarantee confidentiality for each session, as each session would be open to a case-by-case examination so that a court could determine whether a particular session was "psychotherapeutic." This result could enervate the trust that is essential to psychotherapy.

67. Ch. 204, 1982 Wash. Laws 848 (codified at WASH. REV. CODE ch. 71.24 (Supp. 1982)).

68. Ch. 111, 1967 Wash. Laws Ex. Sess. 1925 (codified at WASH. REV. CODE ch. 71.24 (1981) (amended 1982)).

69. WASH. REV. CODE § 71.24.010 (1981) (repealed 1982). The Act authorized the Secretary of the Department of Social and Health Services (DSHS) to make grants to counties to provide mental health services. *Id.* § 71.24.030 (1981) (amended 1982). The Mental Health Division of DSHS directs the mental health program in Washington. D. Kole, An Overview, Mental Health Division,

health clinics by allowing counties to provide mental health services directly, or by contracting for such services with a nonprofit organization.[70] The original Community Mental Health Services Act made no explicit guarantee of confidentiality for communications between clinic employees and patients.[71]

In 1982, substantial amendments to the 1967 Act were proposed to provide a clear direction for the administration and delivery of mental health service.[72] The overall goal of the new Act is to clarify, in law, the roles of the state, the counties and the mental health services providers, and to provide for greater accountability in the delivery of mental health services provided by the state.[73] The most important amendment, for the purpose of this Comment, is the provision guaranteeing the confidentiality of cli-

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Department of Social and Health Services 2–4 (March 1980) (copy on file with the *Washington Law Review*).

70. WASH. REV CODE § 71.24.050 (1981) (repealed 1982).

71. The Washington Supreme Court, however, discussed a method for extending the psychotherapist-patient privilege to clinic employees under the old Act in State v. Fagalde, 85 Wn. 2d 730, 539 P.2d 86 (1975). The defendant Fagalde was convicted of assaulting a minor child and appealed the trial court's admission of the testimony of two mental health clinic employees concerning their conversations with the defendant. Fagalde contended that these communications were privileged by references, subsequently deleted, in the confidentiality section of WASH. REV. CODE § 69.54.070, the Drug and Alcohol Rehabilitation Act, to the old Community Mental Health Services Act. WASH. REV. CODE § 69.54.070, in force at that time, provided in part: "When an individual submits himself for care, treatment [or] counseling . . . to any organization, [or] institution . . . approved pursuant to this chapter and [the Community Mental Health Services Act,] such individual is guaranteed confidentiality." WASH REV. CODE § 69.54.070 (1981) (amended 1982).

Although the court ultimately resolved the issue on other grounds, *see supra* note 51, the court indicated in dicta that it was amenable to the defendant's statutory interpretation:

> The legislative scheme proposed by the [defendant] is not an irrational one. Certainly, the legislature, in RCW 71.24 . . . has manifested an intent that persons with emotional problems . . . should seek and receive help. It would seem that the legislature would be reluctant to discourage this by requiring disclosure of information given during counseling.

Fagalde, 85 Wn. 2d at 735, 539 P.2d at 89–90.

The solution proposed in *Fagalde* is no longer available as all references to the Community Mental Health Services Act have been delected from the Drug and Alcohol Rehabilitation Act. Ch. 193, 1982 Wash. Laws 805 (codified at WASH. REV. CODE ch. 69.54 (Supp. 1982)).

The court also identified a second possible method for extending the psychologist-patient privilege based on the patient's reasonable belief that the psychologist was licensed. *Fagalde*, 85 Wn. 2d at 737, 539 P.2d at 91 (1975). The court left this issue open as well. Extending the privilege to all persons reasonably believed to be licensed psychologists, as is done with attorneys, does little to resolve the conflict discussed in this Comment. First, there would be no limit on the number of groups to which the privilege could extend. Second, the standard does not adequately provide the poor with access to confidential communications because they could use the privilege only so long as they remained ignorant of their counselor's status. Once they discovered the counselor was not licensed, future communications could not be privileged. Third, this interpretation could lead to anomalous results concerning the privilege for psychiatrists and psychologists. *See infra* notes 100–101 and accompanying text.

72. SENATE COMM. ON SOCIAL AND HEALTH SERVICES, REPORT ON ESSB 4786 MODIFYING THE COMMUNITY MENTAL HEALTH SERVICES ACT 1 (1982) (copy on file with the *Washington Law Review*).

73. *Id.*

ent information.[74] As a result of the Act and the 1982 amendments, community mental health services are available in all counties, provided by approximately seventy-five public and private nonprofit agencies.[75] Services include outpatient, inpatient and twenty-four hour emergency treatment, as well as consultation, education and community support services.[76] These community mental health clinics, staffed by over 1700 employees,[77] provided services to approximately 68,000 clients in 1979.[78]

B. Extending the Testimonial Privilege to Employees of the Mental Health Services Clinics

The new Community Mental Health Services Act requires the state to develop an information system to identify patients' participation in the mental health program.[79] Unlike the predecessor Act, this new section guarantees the confidentiality of client information.[80] Although statutorily imposed confidentiality does not always create a testimonial privilege,[81] both public policy and statutory interpretation support the conclusion that the new Act extends the psychotherapist-patient privilege to clinic employees.

1. Public Policy

One important goal of the new Act is to provide access to mental health services for underserved populations, including "minorities, children, the elderly, disabled, and low income persons."[82] In 1978, at a time when only 8.6% of the state's population was below the federal poverty level, 33.4% of the case load in the community mental health centers consisted of persons below that level.[83] Patients at the clinics are charged a "sliding scale" fee based on their ability to pay.[84] These clinics can

74. WASH. REV. CODE § 71.24.035(4)(h) (Supp. 1982).

75. Mental Health Program, *Budget Proposal Divisions, Bureaus & Regions* 2-65 (1981) (copy on file with the *Washington Law Review*).

76. *Id.*

77. Letter from Carol Knobel, Department of Social and Health Services to William Hague (April 15, 1982) (copy on file with the *Washington Law Review*). Education of staff members varies from paraprofessional to M.D.-Psychiatry. *Id.*

78. Mental Health Program, *supra* note 75, at 2-65.

79. WASH. REV. CODE § 71.24.035(4)(h) (Supp. 1982).

80. *Id.*

81. *See infra* notes 91–92.

82. WASH. REV. CODE § 71.24.015(1) (Supp. 1982).

83. D. Kole, *supra* note 69, at 8.

84. WASH. REV. CODE § 71.24.215 (Supp. 1982).

thus be referred to as "the poor man's psychiatrist."[85] Extending the testimonial privilege to these clinics would provide the poor with an opportunity to have confidentiality when receiving psychotherapeutic treatment.

Although the clinics treat many of the same mental and social disorders as do psychiatrists and licensed psychologists,[86] very few of the employees in the clinics are members of either profession. Presently, less than seven percent of the professionals working in Washington's clinics can guarantee confidentiality under the physician-patient or psychologist-client privileges.[87] Because these clinics provide essentially the same services as psychiatrists and licensed psychologists, patients consulting clinic employees should have the same need for confidentiality as patients consulting the more expensive professional groups.[88]

Extending the privilege to the clinics will not preclude the testimony of all persons who purport to provide psychotherapeutic services. Rather, it will limit the privilege to three professional groups over which the state retains some control. The state, through licensure proceedings, has a mechanism for supervising the quality of services provided by psychiatrists, psychologists and employees of the mental health clinics.[89] Members of each group could lose their right to practice for inappropriate treatment. The state can provide the privilege to these groups without fear of abuse. Extending the privilege to the clinics resolves the conflict discussed in this Comment: it provides low income persons the opportunity to receive confidential care for mental disorders, and it limits the privilege to specified professional groups. The courts are not forced to analyze each case by a vague functional approach, and patients can know, in advance, whether their conversations are subject to disclosure.

85. Allred v. State, 554 P.2d 411, 421 (Alaska 1976).

86. See WASH REV CODE § 71.24.015(1) (Supp. 1982), which provides: "It is the intent of the legislature to establish a community mental health program which provides for . . . access to mental health services for residents of the state who are acutely mentally ill, seriously disturbed or chronically mentally ill."

In 1979, the community mental health agencies served 68,233 clients, 56% of whom were "seriously disturbed." Mental Health Program, *supra* note 75, at 2-65.

87. In 1980, of the 1706 employees in the community health centers around the state, only 55 were psychiatrists and 44 were licensed psychologists. Letter from Carol Knobel, Department of Social and Health Services to William Hague (April 15, 1982) (copy on file with the *Washington Law Review*).

88. *See supra* notes 24–26 and accompanying text.

89. *See* WASH. REV CODE § 18.71.020–.051, .120–.145 (1981) (physicians); WASH. REV CODE § 18.83.070–.100 (1981) (psychologists); WASH. REV CODE § 71.24.035(c)(i), .035(4)(i), .220 (Supp. 1981) (mental health clinics).

2. *Statutory Interpretation*

The recognition of privileged communications with clinic personnel is further supported by statutory references to the confidentiality of client information and records in the new Act.[90] Although several Washington cases have held that statutory references to confidentiality do not necessarily prevent a judge from compelling the production of evidence,[91] the use of the word "confidential" in a statute can convince the court to adopt a privilege. The resolution of this question requires an examination of the legislative intent and the application of Wigmore's four canons.[92] Because the clinics treat the same mental and emotional disorders as do psychiatrists and licensed psychologists, the four canons apply not only to

90. See WASH. REV. CODE § 71.24.035(4)(h) (Supp. 1982), which provides in part: "Confidentiality of client information and records shall be maintained as provided in RCW 71.05.390 . . . ." WASH. REV. CODE § 71.05.390 (1981), part of Washington's involuntary civil commitment statute, provides in part: "The fact of admission and all information and records compiled, obtained, or maintained in the course of providing services to either voluntary or involuntary recipients of services at public and private agencies shall be confidential."

The statute then lists eight exceptions that are not relevant here and concludes:

> The fact of admission, as well as all records, files, evidence, findings, or orders made, prepared, collected, or maintained pursuant to this chapter shall not be admissible as evidence in any legal proceeding outside [the involuntary civil commitment chapter] without the written consent of the person who was the subject of the proceeding.

Id.

91. See, for example, State v. Mark, 23 Wn. App. 392, 394–95, 597 P.2d 406, 407–08 (1979), where the court found that the confidentiality requirements of the Washington Board of Pharmacy did not create an evidentiary privilege.

92. *See* State *ex rel.* Haugland v. Smythe, 25 Wn. 2d 161, 169 P.2d 706 (1946); Mebust v. Mayco Mfg. Co., 8 Wn. App. 359, 506 P.2d 326 (1973). In *Haugland,* the court faced the issue of whether a judge could compel a county welfare department administrator to produce the confidential file of a delinquent minor child. Although a statute provided safeguards against the disclosure of information, the court rejected a welfare records privilege because of the absence of two of Wigmore's four canons. The court held that the confidentiality of the communications must be combined with Wigmore's four canons to establish a privilege. 25 Wn. 2d at 168, 169 P.2d at 710. See *supra* notes 21–32 and accompanying text for the application of Wigmore's conditions to the psychotherapist-patient privilege.

In *Mebust,* the issue was whether "RCW 51.28.070, by making industrial insurance claim files and records 'confidential,' place[d] them beyond the reach of judicial discovery process." 8 Wn. App. at 360, 506 P.2d at 326. The court, quoting from State v. Thompson, 54 Wn. 2d 100, 104, 338 P.2d 319, 322 (1959), stated:

> It does not necessarily follow from the use of the word "confidential," that it was the legislative intention that this word have the same import as the word "privileged."
>
> . . . .
>
> The intention of a lawmaking body to place [a] report in a class which is not subject to judicial inquiry or process, cannot be determined by the use of the term "confidential" as used in the cited section in the statute. The legislative intent must be gleaned from an examination of the enactment in its entirety.

8 Wn. App. at 360–61, 506 P.2d at 327.

these two professions, but also to the clinic employees.[93] Thus, the legislative intent must be examined to determine whether the use of the term "confidential" in the new Act creates a statutory privilege.

The legislature intended to help the poor obtain access to mental health services when it amended the Act.[94] This legislative goal can best be effectuated by extending the psychotherapist-patient privilege to clinic employees. Confidentiality is essential to assure the best treatment possible. Any breach of confidentiality would contravene the legislative purpose of providing mental health services to the poor.

The legislative intent to create a testimonial privilege is buttressed by the direct reference in the Act to the confidentiality section of the involuntary civil commitment statute.[95] That statute provides that "records, files, evidence, findings or orders made . . . pursuant to this [civil commitment] chapter shall not be admissible in any legal proceeding outside this chapter without the written consent of the person who was the subject of the proceeding."[96] By reference, any information received from a client at a mental health services clinic can be used only in a court proceeding for involuntary civil commitment. Reference to the involuntary civil commitment statute may not be a precise method for creating a privilege, as the purposes of that Act vary from the purposes of the Community Mental Health Services Act.[97] Nonetheless, the mandate for confidentiality found in the involuntary civil commitment statute, combined with the fulfillment of Wigmore's canons, and with the legislative intent to help the poor, are probably sufficient to create an evidentiary privilege for communications made to professionals working in the mental health services clinics.

C. *Proposed Uniform Statute for Washington*

Extending the privilege to professionals working in the community mental health clinics resolves, to a large extent, the conflict discussed in this Comment. It provides confidentiality to the poor who seek treatment while safeguarding the courts' need for relevant testimony. Nevertheless, Washington now has three separate privileges that protect confidentiality

93. See *supra* note 86 for the services performed by the clinics. See *supra* notes 21–32 and accompanying text for the application of Wigmore's four conditions to psychotherapists.

94. *See supra* note 82 and accompanying text.

95. *See supra* note 90.

96. WASH. REV. CODE § 71.05.390 (1981).

97. Both acts were created in order to provide treatment for persons with mental disorders. The Involuntary Civil Commitment Act goes further in that its main purpose is to end inappropriate and indefinite commitment of mentally disordered persons and to safeguard individual rights. WASH. REV CODE § 71.05.010 (1981).

in a psychotherapeutic setting. Psychiatrists are covered under the physician-patient privilege, the psychologist-patient privilege refers to the attorney-client privilege, and clinic employees may be covered under the new Act.

Each of these groups provides essentially the same service[98] and confidentiality is essential to treatment in all three settings.[99] Granting separate privileges to each group serves no beneficial purpose, and it creates the potential for confusing and inconsistent results. Although the current statutory structure should provide the same degree of confidentiality, there is no guarantee of consistency when separate statutes are applied to each relationship. For example, the psychologist-patient privilege arguably extends to situations where the patient reasonably believes his therapist is a licensed psychologist.[100] On the other hand, this "reasonable belief" extension would not apply to psychiatrists as their privilege is based upon the physician-patient privilege, not the attorney-client privilege. Wigmore notes that the physican must be a professional and provides no reasonable belief exception.[101] Thus, communications by a patient who reasonably believed that his therapist was a psychologist may be privileged, but statements by a patient who believed his therapist was a psychiatrist would not. Further, the privilege for clinic employees, as set forth in this Comment, is based largely on the confidentiality section of the involuntary civil commitment statute. That section is subject to a series of exceptions that are not applicable to the other two privileges.[102]

Providing one statute for all three privileges would eliminate the potential for disparate results. In order to establish a uniform application of the privilege to psychotherapeutic communications, several states have en-

98. *See supra* note 86.

99. *See supra* notes 24–26.

100. The Washington Supreme Court discussed this possibility in State v. Fagalde, 85 Wn. 2d 730, 539 P.2d 86 (1976). Because that privilege is equated with the attorney-client privilege, it could be extended based on a patient's belief in the status of his psychologist. The *Fagalde* court, in a footnote, referred to 8 J. WIGMORE, EVIDENCE § 2302 (1961). 85 Wn. 2d at 737 n.2, 539 P.2d at 91 n.2. The cited section of WIGMORE states:

> The theory of the privilege . . . clearly requires that the client's bona fide belief in the status of his adviser as an admitted attorney should entitle him to the privilege. No doubt an intention to employ only such a person is necessary, as well as a respectable degree of precaution in seeking one. But from that point onward he is entitled to peace of mind and need not take the risk of a deception or of a defective professional title.

8 J. WIGMORE, *supra* note 6, § 2302.

Under this theory, if patients reasonably believe their psychotherapists are licensed psychologists, they could claim the privilege.

101. 8 J. WIGMORE, *supra* note 6, § 2382.

102. WASH. REV. CODE § 71.05.390 (1981).

acted general psychotherapist-patient privileges.[103] These statutes expand or contract the scope of the privilege by their definition of "psychotherapists." Many states limit the privilege to psychiatrists and licensed psychologists,[104] while others are more expansive.[105] The Washington legislature could avoid disparity among the privileges for its three protected groups, psychiatrists, licensed psychologists, and clinic employees, by

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103. *See supra* notes 61 & 62. Several of these statutes are based on the *Proposed Rule 504*, *supra* note 13, which provides:

RULE 504. PSYCHOTHERAPIST-PATIENT PRIVILEGE

(a) Definitions.

(1) A "patient" is a person who consults or is examined or interviewed by a psychotherapist.

(2) A "psychotherapist" is (A) a person authorized to practice medicine in any state or nation, or reasonably believed by the patient so to be, while engaged in the diagnosis or treatment of a mental or emotional condition, including drug addiction, or (B) a person licensed or certified as a psychologist under the laws of any state or nation while similarly engaged.

(3) A communication is "confidential" if not intended to be disclosed to third persons other than those present to further the interest of the patient in the consultation, examination, or interview, or persons reasonably necessary for the transmission of the communication, or persons who are participating in the diagnosis and treatment under the direction of the psychotherapist, including members of the patient's family.

(b) *General Rule of Privilege.*

A patient has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications, made for the purposes of diagnosis or treatment of his mental or emotional conditions including drug addiction, among himself, his psychotherapist, or persons who are participating in the diagnosis or treatment under the direction of the psychotherapist, including members of the patient's family.

(c) Who May Claim the Privilege.

The privilege may be claimed by the patient, by his guardian or conservator, or by the personal representative of a deceased patient. The person who was the psychotherapist may claim the privilege but only on behalf of the patient. His authority so to do is presumed in the absence of evidence to the contrary.

(d) Exceptions.

(1) Proceedings for Hospitalization. There is no privilege under this rule for communications relevant to an issue in proceedings to hospitalize the patient for mental illness, if the psychotherapist in the course of diagnosis or treatment has determined that the patient is in need of hospitalization.

(2) Examination by Order of Judge. If the judge orders an examination of the mental or emotional condition of the patient, communications made in the course thereof are not privileged under this rule with respect to the particular purpose for which the examination is ordered unless the judge orders otherwise.

(3) Condition an Element of Claim or Defense. There is no privilege under this rule as to communications relevant to an issue of the mental or emotional condition of the patient in any proceeding in which he relies upon the condition as an element of his claim or defense, or, after the patient's death, in any proceeding in which any party relies upon the condition as an element of his claim or defense.

See Proposed Rule 504, *supra* note 13, at 240–41. The proposed federal rule may be unnecessarily long. At any rate, it is inadequate because it does not provide the poor with access to confidentiality.

104. See, for example, the text of *Proposed Rule 504*, *supra* note 103.

105. See, for example, CAL. EVID. CODE § 1010 (West Supp. 1983), which includes clinical social workers, school psychologists and marriage counselors within the definition of psychotherapist.

adopting a uniform statute. A proposed statute, based on Proposed Rule 504, [106] is set forth below:

The Psychotherapist-Patient Privilege

a. A psychotherapist shall not, without the consent of his patient, be examined as to any confidential communication made by the patient to the psychotherapist for the purpose of diagnosis or treatment of the patient's mental or emotional condition. This privilege extends to all persons who are participating in the diagnosis or treatment under the direction of the psychotherapist. Provided, this privilege shall not apply in any judicial proceeding involving child abuse under RCW Ch. 26.44, nor any involuntary civil commitment proceeding under RCW Ch. 71.05. Nor shall this privilege apply to communications relevant to an issue of the mental or emotional condition of the patient in any proceeding in which the patient relies upon the condition as an element of his claim or defense.

b. A psychotherapist is (i) a person authorized to practice medicine in any state while engaged in the diagnosis or treatment of a mental or emotional condition, (ii) a person licensed or certified as a psychologist under RCW Ch.18.83, while similarly engaged, or (iii) an employee of an agency which is a licensed service provider according to RCW Ch. 71.24, also while similarly engaged.

The proposed statute has several advantages not found in the present system. First, recognizing that there are basic differences between psychotherapist-patient relationships and those of attorney-client or physician-patient, this uniform statute does not refer to those privileges in defining its scope. Second, consistent with this Comment, the statute provides the poor with access to confidential communications in psychotherapy by including clinic employees within the privilege.[107] It also protects the courts' need for relevant evidence by limiting the privilege to specific professional groups. Third, the three current exemptions from the privilege, child abuse, involuntary civil commitment, and patient-litigant, are identified in the statute. Last, the statute is a uniform and comprehensive privilege that provides the same degree of confidentiality in various psychotherapeutic settings.

CONCLUSION

The legislature has accepted the validity of the psychotherapist-patient

106. See the text of *Proposed Rule 504*, *supra* note 103.

107. This Comment argues that the new Community Mental Health Services Act protects confidential communications by creating a privilege for clinic employees. *See supra* notes 68–97 and accompanying text. Nevertheless, the Act is susceptible to a contrary interpretation by the courts. The interests of the poor would be better served if the privilege were clearly delineated in a statute that codified all the psychotherapist-patient privileges together.

privilege by creating a privilege for psychiatrists and psychologists and their patients. By limiting the privilege to psychiatrists and licensed psychologists, however, Washington has in the past prevented the poor from having access to confidential communications with psychotherapists. The new Community Mental Health Services Act appears to have created an evidentiary privilege for the mental health services clinics. These clinics were created to meet the special needs of low income persons. This extension serves two purposes: (1) it protects the courts' interest in obtaining evidence by clearly delineating the number of groups the psychotherapist-patient privilege covers, and (2) it provides the poor with confidentiality in psychotherapy. While the legislature has provided for a resolution to the difficulty in the privilege's scope, it has done so in a disjointed fashion by creating three separate privileges for the three groups of mental health care providers. This should be resolved by adopting a comprehensive statute that applies equally to all three groups.

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