THE LIABILITY OF ALASKA MENTAL HEALTH PROVIDERS FOR MANDATED TREATMENT

MARSHALL L. WILDE*

This Article analyzes the liability of mental health professionals for services rendered to patients who are ordered by a court to undergo mental health treatment. After a brief review of relevant legal authority, this Article examines mandated treatment under the framework of quasi-judicial immunity and continues by discussing the specific duties of mental health professionals to patients undergoing mandated treatment. The Article also comments on the unique issues that arise from treatment of patients under federal benefit programs. The Article concludes by arguing that mental health professionals do not enjoy a blanket exemption from malpractice liability and by suggesting a cautious course of action for such professionals.

I. INTRODUCTION

Court-ordered treatment programs for substance abuse and mental illness have become a popular tool to achieve the goals of the criminal justice system: to punish, rehabilitate, and deter criminal behavior. In Alaska, mental health providers serve an essential role in determining the disposition of offenders, minors, and incompetents, and have traditionally enjoyed immunity for their duties in these roles.[1] Outside the protection of immunity, mental

* Major, Judge Advocate General's Department, United States Air Force Reserve, 433rd Airlift Wing, Lackland Air Force Base, Texas; L.L.M., University of Houston Law Center, 2003; J.D., University of Oregon School of Law. 1997.

1. *See, e.g.,* Lythgoe v. Guinn, 884 P.2d 1085, 1089 (Alaska 1994) (granting judicial immunity based on the essential role of court-appointed experts in aiding judicial discretionary judgments); Howard v. Drapkin, 271 Cal. Rptr. 893, 901 (Cal. Ct. App. 1990) (ruling that a psychiatrist who wrongfully induced a voluntary patient into a sexual relationship was subject to suit for his improper actions while employed); LaLonde v. Eissner, 539 N.E.2d 538, 541 (Mass. 1989) ("Most jurisdic-

health providers also treat individuals who have been involuntarily committed or who are voluntary patients.[2] Difficult questions arise concerning a provider's liability when a patient does not fit into one of these categories. Provider liability is often an issue when treatment is made a condition of parole, custody, or another legal benefit, or when a patient receives mandated mental health care while still living in the community.[3]

This Article addresses a provider's liability for treating patients ordered to undergo mental health treatment. The Article begins with a brief review of the legal authorities for mandated treatment and then examines mandated treatment under the framework of quasi-judicial immunity. Next, it addresses the individual duties of a provider to a patient in mandated treatment and concludes with a discussion of the unique issues arising from treatment of patients under federal benefit programs.

II. FACTUAL AND LEGAL BACKGROUND

Alaska law provides for mandated treatment for mental health conditions that do not rise to the level of legal insanity. Under state criminal law, a defendant may be ordered into counseling as a condition of a suspended imposition of sentence,[4] probation,[5] or parole.[6] Additionally, in a "child in need of aid" ("CINA") case, counseling or drug and alcohol treatment may be a mandatory condition for regaining parental custody of children.[7] Such condi-

---

tions have held that common law immunity protects persons appointed by a court to conduct a medical or psychiatric evaluation and render an opinion or provide other expert assistance because of their integral relation to the judicial process.").

2. *See, e.g.,* Simmons v. United States, 805 F.2d 1363, 1368 (9th Cir. 1986) (upholding quasi-judicial immunity based on the connection of neutral third parties to the judicial process and the "relevant policy considerations of attracting to an overburdened judicial system the independent and impartial services and expertise upon which that system necessarily depends"); D.P. v. Wrangell Gen. Hosp., 5 P.3d 225, 226 (Alaska 2000) (permitting an involuntarily committed schizophrenic patient to sue a hospital for negligent care).

3. As used in this article, "provider" refers to a psychologist, psychiatrist, social worker, or other medical professional exercising independent medical or counseling discretion in the treatment of a patient.

4. ALASKA STAT. § 12.55.080 (Michie 2002).

5. *Id.* § 12.55.100 (amended 2003).

6. *Id.* § 33.16.150.

7. *Id.* § 47.10.011*; see also* Sherry R. v. State Dep't Health and Soc. Serv., Div. of Family & Youth Serv., 74 P.3d 896 (Alaska 2003) (upholding the termination of parental rights in a CINA case because the mother continued to place her children at substantial risk of harm by, *inter alia*, failing to comply with court-mandated substance abuse programs).

tions not only require a provider to perform evaluative functions, but also to recommend and implement a course of treatment.

Federal law adds additional categories of "mandated" patients. Since the federal government makes almost one-third of all health expenditures in Alaska, considerations of federal law are important.[8] Given the large military presence in Alaska, providers may treat pursuant to both federal and military law. Under the Department of Defense Directive No. 6400.1,[9] and those regulations specific to each branch of service, commanders may mandate treatment for service members in cases of substantiated spousal or child abuse.[10] The military may also require treatment as a condition of parole.[11] In addition to those treatment programs, there are several federal agencies funded by the Department of Health and Human Services, such as the Indian Health Service's ("IHS") Substance Abuse and Mental Health Services Administration, that also implement several forms of mandated treatment.[12] Although IHS does not have the judicial power to mandate treatment, many Alaska Natives and Native Americans, who have already been required to complete substance abuse or similar programs, utilize the services provided by IHS.[13] In both of these contexts, a provider is required to provide treatment in addition to evaluating a patient.

III. EVALUATIVE FUNCTIONS: QUASI-JUDICIAL IMMUNITY

In the same way judges generally have immunity from personal liability for actions done in the course of their official duties, judicially-appointed professionals, including mental health providers, are also protected from malpractice liability when they assist in making a judicial decision.[14] Such judicial decisions include: (1) de-

---

8. Inst. of Soc. and Econ. Research, *The Cost of Health Care in Alaska*, 53 Research Summary 1 (1992), *available at* http://www.isen.org/alaska.edu/publications/formed/vsummary/ps53.pdf.

9. UNITED STATES DEPT. OF DEF., DIRECTIVE NO. 6400.1, FAMILY ADVOCACY PROGRAM (FAP) (June 23, 1992).

10. *Id.* at ¶ 6.2.

11. UNITED STATES DEPT. OF DEF., INSTRUCTION NO. 1325.7; Administration of Military Correctional Facilities and Clemency and Parole Authority (July 17, 2001); Air Force Instruction 31-205, Air Force Corrections Program (Apr. 9, 2001).

12. Statement of Organization, Functions, and Delegations of Authority, 61 Fed. Reg. 30,617-02(E) (June 17, 1996).

13. *Id.*

14. Lythgoe v. Guinn, 884 P.2d 1085, 1087-88 (Alaska 1994); *see also* Denardo v. Michalski, 811 P.2d 315, 316 (Alaska 1991) (citing Bradley v. Fisher, 80 U.S. (13 Wall) 335, 351 (1871)) (holding that judges in Alaska are absolutely immune un-

terminations of criminal competency; (2) determinations of sufficient mental states for civil liability; and (3) determinations of mental fitness in child custody proceedings.[15]

The Alaska Supreme Court recognized "quasi-judicial immunity" for mental health providers in *Lythgoe v. Guinn*.[16] In that case, Defendant Guinn, a psychologist who had been appointed as a child custody investigator, was alleged to have engaged in certain misconduct.[17] The defendant investigated a dispute between Plaintiff Lythgoe and her ex-husband over the custody of their son.[18] The defendant recommended that the ex-husband receive custody.[19] The plaintiff then sued, claiming that, *inter alia*, the defendant acted as an advocate for her ex-husband, thereby forfeiting any immunity she might have had.[20] Rejecting the plaintiff's argument, the court held that the defendant "served as an 'arm of the court'" and performed a "function 'integral to the judicial process,'"[21] and thus had quasi-judicial immunity for her actions as they related to the case.[22]

The court also cited several public policy considerations relevant to extending judicial immunity to those acting in a quasi-judicial role.[23] First, the court approved a policy issue identified in *Seibel v. Kimbal*: exposure to liability may deter quasi-judicial officers from accepting court appointments.[24] The *Seibel* court held in favor of the mental health provider, recognizing that unless insulated from liability, providers would be less likely to accept judicial

---

less their acts are either not "judicial" or are outside their subject matter jurisdiction); David Cohen, Note, *Judicial Malpractice Insurance? The Judiciary Responds to the Loss of Absolute Judicial Immunity*, 41 CASE W. RES. L. REV. 267, 267 (1990).

15. *See generally* FED. R. CIV. PROC. 35 (2002); ALASKA STAT. §§ 12.47.10-.130 (Michie 2002); ALASKA CHILD IN NEED OF AID R. 16 (2002); ALASKA R. CIV. PROC. 35 (2002); ALASKA R. EVID. 504 (2002).

16. 884 P.2d at 1086.

17. *Id.*

18. *Id.*

19. *Id.*

20. *Id.*

21. *Id.* at 1088-89 (quoting Seibel v. Kemble, 631 P.2d 173, 179 (Hawaii 1981)).

22. *Id.*

23. *Id.* at 1089-90.

24. *Lythgoe*, 884 P.2d at 1089 (citing *Seibel*, 631 P.2d 173, 180 (Hawaii 1981)) (finding that that there would be a chilling effect on the willingness of quasi-judicial officers to accept appointments as experts if they were subject to liability for their actions or testimony).

appointments for mental health evaluations.[25] Second, the *Lythgoe* court considered whether exposure to liability would taint the expert's exercise of discretion in his actions and testimony.[26] The United States Supreme Court has commented on the importance of such discretion in determining quasi-judicial immunity: "[w]hen judicial immunity is extended to officials other than judges, it is because their judgments are 'functional[ly] comparab[le]' to those of judges—that is, because they, too, 'exercise a discretionary judgment' as a part of their function."[27] Upholding this same principle, the Alaska Supreme Court held that "[t]he sine qua non of the exercise of such discretion is the freedom to act in an objective and independent manner."[28] Third, the court recognized that the threat of liability may cause quasi-judicial officers to be unduly inhibited in the performance of their functions.[29]

Following *Lythgoe*, the Alaska Supreme Court ruled in *Karen L. v. State*[30] that two doctors who evaluated both parties in a CINA proceeding were immune from tort liability.[31] The court held that the selection process for the physicians was irrelevant; it did not matter whether the court or the parties selected the physicians.[32] Rather, the question was "'whether [the doctor's] activity is an integral part of the judicial process so that to deny immunity would disserve the broader public interest that non-judicial officers act without fear of liability.'"[33]

While the Alaska Supreme Court has not enumerated a clear test for applying quasi-judicial immunity, both *Lythgoe* and *Karen L.* appear to employ two common elements: (1) the officer must be an arm of the court, "integral to the judicial process"[34]; and (2) the actions of the officer must involve some degree of discretion, the

25. *Id.* at 1093. This is especially true given the low rates of compensation often given to providers assisting courts. *Id.* Concerns about compensation and liability have often been cited as a reason why physicians are reluctant to serve on medical malpractice screening panels as well. *Id.*

26. *Id.*

27. Antoine v. Byers & Anderson, Inc., 508 U.S. 429, 436 (1993) (quoting Imbler v. Pachtman, 424 U.S. 409, 423 n.20 (1976)).

28. *Lythgoe*, 844 P.2d at 1089.

29. *Id.* at 1089-90.

30. 953 P.2d 871 (Alaska 1998).

31. *Id.* at 878-79.

32. *Id.*

33. *Id.* (citing *Lythgoe*, 884 P. 2d at 1088 (quoting Lavit v. Superior Court, 839 P.2d 1141, 1144 (Ariz. App. 1992))).

34. *See Karen L.*, 953 P.2d at 878 (ruling that such officer need not be selected by the court).

free exercise of which would be deterred by the threat of liability.[35] However, the courts have not identified these elements as such, or how these elements apply to continuing treatment. For example, a court has not yet addressed the issue of which provider actions, done in the course of implementing court-mandated treatment programs, will qualify for quasi-judicial immunity.[36] Courts have not considered the immunity issues surrounding continuing care beyond mere evaluation. Thus, the doctrine of quasi-judicial immunity protects a mental health provider when rendering an opinion necessary for adjudication, but does not necessarily protect a provider in his continued treatment.

IV. CONTINUING TREATMENT: DUTIES OWED TO THE PATIENT BY THE MENTAL HEALTH PROVIDER

Mental health providers have three primary duties with respect to their patients: (1) maintaining confidentiality; (2) ensuring informed consent; and (3) maintaining professional standards of care.[37] A court mandating treatment, according to a provider's recommendation, substantially alters a provider's duties of confidentiality and informed consent because such a recommendation requires divulging a patient's medical information and the mandated treatment obviates the need for informed consent.[38] Yet, the duty of care is not altered; providers generally must give the same standard of care for patients who have been involuntarily required to undergo treatment.

A. Confidentiality

Involuntary patients lose their right to complete confidentiality. A provider of mental health care does not owe an *absolute* duty of confidentiality to such a patient because the court mandating treatment expects a report on the patient's progress. While Alaska generally requires confidentiality for communications to licensed professional counselors, marriage and family therapists, psychologists and their associates, and physicians, the statutes carve out several exceptions. These exceptions limit the scope of

35. *Id.*

36. *Id.*

37. ALASKA STAT. §§ 08.29.200, 08.63.200, 08.86.200, 09.55.556; ALASKA R. EVID. 504 (Michie 2002); *see also* THE COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AM. MED. ASS'N, CODE OF MEDICAL ETHICS (2001), *available at* http://www.ama-assn.org/ama/pub/category/2498.html.

38. A provider may modify the duties of confidentiality and informed consent when specifically authorized to do so.

confidentiality and include provisions for mandatory and permissive reporting.[39] Furthermore, Alaska Rule of Evidence 504 carves out additional exceptions for court proceedings.[40]

1. *Development of the Psychotherapist-Patient Privilege in Alaska and Federal Courts*. The Alaska Supreme Court initially recognized the psychotherapist-patient privilege in 1976.[41] Prior to 1976, state law provided for a physician-patient privilege in civil proceedings, but not in criminal proceedings, and did not privilege a patient's communications to social workers.[42] In *Allred v. State*,[43] the court found a common law psychotherapist-patient privilege in criminal cases, but limited it to psychiatrists and licensed psychologists.[44] The court stated that communications to social workers could be privileged when they acted as psychological associates, but were not generally subject to privilege or the duty of confidentiality.[45]

The federal courts have also considered the issue of psychotherapist-patient confidentiality. The Supreme Court interpreted Federal Rule of Evidence 501[46] to include a psychotherapist-patient

---

39. ALASKA STAT. § 08.29.200 applies to licensed professional counselors. ALASKA STAT. § 08.63.200 applies to marriage and family therapists. ALASKA STAT. § 08.86.200 applies to psychologists and their associates. ALASKA R. EVID. 504 protects statements to physicians, except in criminal trials.

40. ALASKA R. EVID. 504(d).

41. Allred v. State, 554 P.2d 411, 428 (Alaska 1976).

42. ALASKA R. CRIM. PROC. 26; ALASKA R. CIV. PROC. 43(h)(4) (rescinded 1979); Fitzgerald v. A. L. Burbank & Co., 451 F.2d 670, 681 (2d Cir. 1971).

43. 554 P.2d 411 (Alaska 1976).

44. *Id.* at 421-22.

45. *Id.* at 422 (Boochever, J., concurring) (holding that a psychological associate is an otherwise unprivileged provider acting under the supervision of a provider entitled to the privilege).

46. FED R. EVID. 501.

> Except as otherwise required by the Constitution of the United States or provided by Act of Congress or in rules prescribed by the Supreme Court pursuant to statutory authority, the privilege of a witness, person, government, State, or political subdivision thereof shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience. However, in civil actions and proceedings, with respect to an element of a claim or defense as to which State law supplies the rule of decision, the privilege of a witness, person, government, State, or political subdivision thereof shall be determined in accordance with State law.

Id.

privilege.[47] The Court found it persuasive that every state had some form of a psychotherapist-patient privilege.[48] The Court also extended the privilege to licensed social workers, again noting that the majority of the states did the same.[49] While the dissent sharply criticized extending the privilege to social workers, the majority opinion cited the increasing prevalence and professional status of social workers in psychotherapy as a justification.[50] While Alaska was not compelled to alter its rules of evidence, the Alaska Legislature responded to *Jaffee* by modifying the Alaska Rules of Evidence to include a greater variety of professions.[51]

2. *Scope of the Psychotherapist-Patient Privilege*. Alaska law contains both statutory and evidentiary exceptions to the psychotherapist-patient privilege. In particular, Alaska law allows several exceptions to the duty of confidentiality. First, providers may divulge confidential information to other professionals in managed care and group practice situations, provided that no identifying information about the patient is released.[52] Second, providers may release patient information to defend themselves from malpractice or disciplinary actions, or when otherwise authorized to do so by the patient.[53] Third, providers are required to release patient information when reporting child abuse or abuse of the elderly and disabled.[54] Fourth, providers may warn third parties about imminent threats of substantial bodily harm.[55] Finally, providers may disclose a patient's medical information pursuant to the Alaska Rules of Evidence.[56]

a. *Consulting Other Professionals*. The Alaska Statutes allow disclosure of patient information, with identifying informa-

47. Jaffee v. Redmond, 518 U.S. 1, 18 (1996).

48. *Id.* at 13-14.

49. *Id.* at 16-17.

50. *Id.*; *see also* Jennifer S. Klein, Note, *"I'm Your Therapist, You Can Tell Me Anything": The Supreme Court Confirms the Psychotherapist-Patient Privilege in* Jaffee v. Redmond, 47 DEPAUL L. REV. 701, 701 (1998); Catharina J. H. Dubbelday, Comment, *The Psychotherapist-Client Testimonial Privilege: Defining the Professional Involved*, 34 EMORY L.J. 777, 819 (1985).

51. *See* ALASKA R. EVID. 504 note to SCO 1337 (expanding the definition of "psychotherapist" to include licensed professional counselors).

52. ALASKA STAT. §§ 08.29.200(a)(2), 08.63.200(a)(1), 08.86.200(a)(1) (Michie 2002).

53. *Id.* §§ 08.29.200(a)(3)-(4), 08.63.200(a)(2)-(3), 08.86.200(a)(2),(5).

54. *Id.* §§ 08.29.200(b), 08.63.200(b), 08.86.200(b).

55. *Id.* §§ 08.29.200(a)(1), 08.86.200(a)(3). ALASKA STAT. § 08.63.200 does not contain this exception.

56. *Id.* §§ 08.29.200(a)(5), 08.63.200(a)(4), 08.86.200(a)(4).

tion redacted, for case conferences.[57] This disclosure is the least controversial because it allows better care for the patient by allowing the provider to seek other opinions for treatment. These provisions have never been discussed in a published appellate decision.

b. *Malpractice, Claim Defense, and Waiver*. The Alaska Statutes provide for exceptions to the duty of confidentiality when defending malpractice claims, suits regarding payment for services, and when authorized by the patient.[58] The first two aspects of the exception are not controversial because the services rendered by providers are of specific relevance in those cases. One minor point of contention could involve an involuntary patient's financial liability for services rendered, but is usually resolved by the trial court at the time of mandating treatment, and it has not been the subject of an appellate decision.

Waiver of confidentiality has presented a more difficult issue. In *Beaver v. State*,[59] Defendant Beaver made admissions during juvenile sex offender treatment that were used against him in a later proceeding.[60] The defendant alleged he was coerced into participating in the treatment and, as a result of the treatment, made incriminating statements to his counselor in group therapy.[61] He argued that admitting these statements in the later proceeding violated his right against self-incrimination.[62] Rejecting this argument, the trial court held that the statements were voluntary, and noted that the defendant had signed a contract specifically waiving confidentiality.[63] The court implicitly recognized the effectiveness of the defendant's waiver of the privilege through participation in group therapy and explicit agreement to waive confidentiality.[64] A

57. *Id.* §§ 08.29.200 (a)(2), 08.63.200(a)(1), 08.86.200(a)(1).

58. *Id.* §§ 08.29.200 (a)(3)-(4), 08.63.200(a)(2)-(3), 08.86.200(a)(2),(5).

59. 933 P.2d 1178 (Alaska Ct. App. 1997).

60. *Id.* at 1179.

61. *Id.* at 1179-80.

62. *Id.* at 1180.

63. *See id.* at 1180, 1186. Due to the lack of confidentiality, the contract provided that Beaver was not required to reveal detailed information about past offenses. *Id.* Beaver agreed, but disclosed identifying details of previous sex crimes regardless of the confidentiality waiver. *Id.*

64. *Id.* at 1181-85. The court instead focused on the privilege against self-incrimination and Beaver's allegations of coercion to discuss specific information about his past sex crimes. *Id*. An article in the *Alaska Law Review* later criticized the finding, arguing it would undermine the effectiveness of prison therapy. Christina Lewis, Note, *The Exploitation of Trust: The Psychotherapist-Patient Privilege in Alaska As Applied to Prison Group Therapy*, 18 ALASKA L. REV. 295, 311-312 (2001).

waiver under legal duress is still a valid waiver for the purposes of later prosecution.[65]

c. *Duties to Disclose*. Alaska requires mental health providers to report abuse of children, the elderly, and the disabled.[66] In *Walstad v. State*,[67] Defendant Walstad confessed to a counselor that he sexually abused a minor.[68] The counselor promptly reported the abuse as required by law, and upon investigation, the Alaska State Troopers obtained sufficient independent evidence to prosecute.[69] At trial, the judge excluded all evidence from the counselor, finding that the communications were covered by the psychotherapist-patient privilege.[70] However, the judge held that the counselor's report was not inappropriate because the counselor's duty to report creates a "limited abrogation" of those privileges.[71] On appeal, the defendant claimed that the reporting requirement did not abrogate the psychotherapist-patient privilege and thus evidence from the investigation should be suppressed.[72] Rejecting this argument, the Alaska Court of Appeals held that the Alaska Rules of Evidence do not preclude divulgence of privileged information in "all stages of all actions, cases, and proceedings."[73] Thus, the counselor's sexual abuse report was beyond the scope of the privilege.[74] Mandatory treatment reports may be privileged to the extent that the information contained therein may not be admissible in court, but information gained from investigations triggered by such reports is not so excluded.

d. *Warning Third Parties about Imminent Threats of Substantial Bodily Harm*. Another exception to the duty of confidentiality comes from the *Tarasoff* doctrine. The *Tarasoff* doctrine arose from a California Supreme Court decision, in which the court held that a therapist has a duty to use reasonable care when the therapist possesses knowledge that his patient will harm a third

65. Parker v. North Carolina, 397 U.S. 790, 794 (1970).

66. ALASKA STAT. §§ 08.29.200(b), 08.63.200(b), 08.86.200(b) (Michie 2002).

67. 818 P.2d 695 (Alaska Ct. App. 1991).

68. *Id.* at 696-97 (citing ALASKA STAT. § 47.17.020(a)(1), which requires practitioners of the "healing arts" to immediately report to authorities suspicions that a child has suffered harms as a result of child abuse or neglect).

69. *Id.* at 697.

70. *Id*.

71. *Id*. (citing ALASKA STAT. § 47.17.020).

72. *Id*.

73. *Id.* at 698.

74. *Id.* at 698-700 (referencing ALASKA R. EVID. 101(b), which restricts confidentiality privileges to the realm of "actions, cases, and proceedings").

party.[75] Alaska adopted a statutory *Tarasoff* provision allowing therapists to report imminent physical threats to third parties made during therapy, and has adopted statutes mandating reports of abuse of the elderly or disabled, and incidents of child abuse and neglect.[76]

These statutes do not extend to reporting by physicians. However, in *Chizmar v. Mackie*,[77] the Alaska Supreme Court recognized that a physician may reveal certain private information in particular circumstances.[78] The court affirmed a privacy right to certain medical information, but held that a physician could disclose a diagnosis of HIV to a patient's spouse.[79]

e. *Exceptions under the Alaska Rules of Evidence.* The current version of Alaska Rule of Evidence 504 contains a general privilege for physician-patient communications, a stronger privilege for psychotherapist-patient communications, and several exceptions.[80] Communications to physicians are generally privileged in civil proceedings, but admissible in criminal proceedings.[81] However, the Rule extends the privilege for psychotherapists to both criminal proceedings and civil proceedings.[82] "Psychotherapist" is broadly defined, and includes physicians treating mental or emotional conditions, psychologists, marriage and family therapists, and licensed professional counselors.[83] The Rule does not waive privilege for group therapy.[84] The Rule contains several exceptions, including: (1) when the patient's condition is an element of a claim or defense; (2) when the services were used to further a crime or fraud; (3) when there is an allegation of a breach of duty by the provider; (4) proceedings for hospitalization; (5) reports required

75. Tarasoff v. Regents of Univ. of Cal., 17 Cal. 3d 425, 439-42 (Cal. 1976).

76. ALASKA STAT. §§ 08.29.200(a)(1), 08.86.200(a)(3); *see also* ALASKA STAT. §§ 08.29.200(b)(2), 08.86.200(b).

77. 896 P.2d 196 (Alaska 1995).

78. *Id.* at 208.

79. *Id.*

80. ALASKA R. EVID. 504.

81. *Id.* at 504(b), (d)(7).

82. *Id.*

83. *Id.* at 504(a)(3).

84. *Id.* at 504(a)(4) (including communications made to "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 . . ., including members of the patient's family").

by statute or regulation; (6) examinations by order of a judge; and (7) criminal proceedings for physician-patient communications.[85]

Interpretation of Rule 504 has been uneven. Courts have reached different conclusions in a variety of situations, including circumstances involving the insanity defense, CINA cases, statements to a nurse, and evaluation in prior proceedings.[86]

The psychotherapist-patient privilege is waived when the defendant raises an insanity defense. In *Post v. State*,[87] Defendant Post claimed insanity in defense of kidnapping and assault charges, but tried to preclude the prosecution from introducing his statements to a psychiatrist regarding other attempts to avoid responsibility for criminal acts by feigning mental illness.[88] The Alaska Supreme Court admitted all his prior statements, holding that the express terms of Rule 504 waived the privilege when the defendant claimed an insanity defense.[89]

CINA Rule 9 limits the scope of the psychotherapist-patient privilege in CINA cases.[90] The CINA rule preserves the child's right to the privilege, except when waived by the child, or upon a showing by the party seeking disclosure that the need for the requested disclosure outweighs the child's interest in confidentiality.[91] The Rule abrogates the privilege with regard to parents, unless the parent can show that the need for confidentiality outweighs the need for the information.[92] In making this determination, the Rule requires the court to consider: (1) the content and nature of the communication; (2) the purposes of Alaska Statutes section

85. *Id.* at 504(d) (noting there is no exception for psychotherapist-patient communications in a criminal proceeding). The Legislature only extended the definition of psychotherapist to include licensed professional counselors in 1998 as part of a larger bill reforming the legal standing of counselors. *Id.* at 504 note to SCO 1337. The Legislature presumably added the section to clarify the position of counselors and social workers in light of *Allred* and *Jaffee.* *Id.* at 504 cmt. Physician and Psychotherapist-patient Privilege (3).

86. *Compare* M.R.S. v. State, 897 P.2d 63 (Alaska 1995); Post v. State, 580 P.2d 304 (Alaska 1978); Ramsey v. State, 56 P.3d 675 (Alaska Ct. App. 2002); State v. R.H., 683 P.2d 269 (Alaska Ct. App. 1984). These cases discuss waiver of privilege in the context of when the insanity defense is raised, when child protective proceedings occur, and when suicidal evaluations are made by a nurse, but each case notes that all court ordered psychological examinations of juveniles do not fall within the exception that these examinations are not privileged.

87. 580 P.2d 304 (Alaska 1978).

88. *Id.* at 306-07.

89. *Id.*

90. ALASKA CHILD IN NEED OF AID R. 9.

91. *Id.* at 9(b)(3)(B).

92. *Id.* at 9(b)(3)(C).

47.05.060 and of Alaska Rule of Evidence 504; (3) other possible ways to obtain the information; (4) the public interest and need for disclosure; and (5) the potential injury to the patient and the patient's psychotherapist relationship.[93]

The CINA Rule came into effect following *State v. R.H.*[94] In *R.H.*, a psychologist provided therapy to a parent pursuant to a court order in a CINA proceeding.[95] The State prosecuted R.H. for acts relating to the CINA proceeding and sought to introduce the testimony of his psychologist.[96] Despite the existence of a psychotherapist-patient privilege in criminal proceedings, the State argued that the child abuse reporting requirements of Alaska Statutes sections 47.17.010-.070 and the provisions of Alaska Rule of Evidence 504(d) made the therapy statements admissible.[97] Rejecting this argument, the Alaska Court of Appeals held that the reporting requirements did not waive the psychotherapist-patient privilege in criminal cases.[98] The court acknowledged differences in the privilege both with regard to CINA and criminal cases, and with regard to consultations with the counselor before the CINA case and after the consultation was ordered by the CINA Master.[99] While the case did not require the court to distinguish between admissions made prior to the evaluation and those made during the evaluation, the reasoning of the case demonstrates that there may be a distinction between the two settings with regard to the privilege.

Statements made to a nurse also implicate the psychotherapist-patient privilege. In *Ramsey v. State*, [100] Defendant Ramsey was arrested for fatally shooting two people at his high school.[101] While in jail, he was interviewed by a nurse as a part of an initial screening for suicide risk.[102] During the interview, the defendant denied that he was suicidal.[103] At trial, however, he claimed that he was suicidal at the time of the crime and therefore unable to form the requisite intent for murder.[104] However, the screening nurse testified that the

93. *Id.* at 9(b)(3)(D).
94. 683 P.2d 269 (Alaska Ct. App. 1984).
95. *Id.* at 273.
96. *Id.*
97. *Id.* at 274.
98. *Id.* at 281-82.
99. *Id.* at 275.
100. 56 P.3d 675 (Alaska Ct. App. 2002).
101. *Id.* at 676-77.
102. *Id.* at 677, 679.
103. *Id.* at 679.
104. *Id.* at 677.

defendant had not been suicidal.[105] On appeal, the defendant claimed that the use of his statements to the nurse violated his psychotherapist-patient privilege.[106] The Alaska Court of Appeals found that he had no expectation of privacy in his statements because he did not reasonably believe that the nurse was a psychotherapist and that she would not re-communicate his statements.[107] In fact, her stated purpose was to obtain information that she would pass along to a therapist, if he answered that he was suicidal.[108] While the case does not eliminate the privilege for nurses acting under the direction of a psychotherapist, it excludes statements made during triage.[109]

In addition to triage situations, Alaska courts have considered a defendant's prior psychological evaluation for admissibility. In *M.R.S. v. State*,[110] the State had used the statements of a defendant juvenile in a prior court-ordered evaluation to determine his amenability to treatment.[111] The defendant appealed, claiming that Rule 504 prohibited admission of the evaluation's contents.[112] In general, Rule 504 provides that court-ordered evaluations are not subject to privilege, given that the purpose of such an examination is to report back to the court.[113] However, the Alaska Supreme Court found the earlier statements privileged.[114] The court reasoned that the interests of full disclosure, particularly in juvenile cases, required maintaining the privilege for earlier proceedings.[115]

3. *Liability for Breach of Confidentiality*. There are relatively few Alaska cases involving tort liability for breach of confidentiality by a mental health provider. A significant body of literature supports imposition of tort liability for unjustified breach of confidentiality, but acceptance of the tort is not uniform.[116] The Alaska Supreme Court recently acknowledged, in dicta, a cause of action for invasion of privacy based on disclosure of medical information,

105. *Id.* at 679.
106. *Id.*
107. *Id.* at 680.
108. *Id.*
109. *Id.* at 679-80.
110. 897 P.2d 63 (Alaska 1995).
111. *Id.* at 64-65.
112. *Id.* at 64.
113. *See* M.R.S. v. State, 867 P.2d 836, 842-43 (Alaska Ct. App. 1994); *M.R.S.*, 897 P.2d at 67.
114. *M.R.S.*, 897 P.2d at 67-68.
115. *Id.*
116. For further discussion see Ellen W. Grabois, *The Liability of Psychotherapists for Breach of Confidentiality*, 12 J.L. & HEALTH 39 (1997).

but there have been no appellate cases upholding recovery for such a tort.[117]

Langdon v. Champion[118] first addressed liability for breach of confidentiality.[119] Plaintiff Langdon alleged that Defendant Champion had caused her personal injury when she fell through a trapdoor negligently left ajar.[120] The plaintiff provided a partial release of her medical records to the defendant, but only allowed consultations with her physicians in the presence of her attorneys.[121] The defendant requested an unlimited waiver from the trial court, including permission to discuss the case with the plaintiff's physicians outside the presence of her attorney.[122] The trial court granted the request, and the plaintiff appealed.[123] The Alaska Supreme Court upheld the defendant's right to request discussions with the plaintiff's physicians outside the presence of the plaintiff's attorneys, which the physicians could refuse.[124] The case did not specifically address the physician's liability for such disclosures.

Six years later, the supreme court addressed the same issue in *Arnett v. Baskous*.[125] In that case, Plaintiff Arnett was convicted of sexually abusing his minor daughter.[126] During the trial, the State served a subpoena *duces tecum* for the plaintiff's confidential medical records on his physician, Defendant Dr. Baskous.[127] The defendant complied with the subpoena and was subsequently sued by the plaintiff for breach of fiduciary duty.[128] The supreme court held that the defendant was not liable for releasing the medical records pursuant to the subpoena and that the plaintiff had failed to show that the early release of the records prejudiced his criminal action.[129] Despite this holding, the court cautioned the District Attorney "against seeking the release of confidential documents in a manner which violates the strict terms of a subpoena."[130]

---

117. Chizmar v. Mackie, 896 P.2d 196, 208 (Alaska 1995).
118. 745 P.2d 1371 (Alaska 1987).
119. *Id.*
120. *Id.* at 1372.
121. *Id.*
122. *Id.*
123. *Id.*
124. *Id.* at 1374-75.
125. 856 P.2d 790 (Alaska 1993).
126. *Id.*
127. *Id.* at 790-91.
128. *Id.*
129. *Id.* at 791-92 (noting that the doctor had released Arnett's records earlier than the date stated in the subpoena).
130. *Id.* at 792.

Langdon and *Arnett* set the stage for *Chizmar v. Mackie*.[131] In *Chizmar*, Plaintiff Chizmar alleged that Defendant Dr. Mackie negligently diagnosed her with HIV and, without permission, disclosed this diagnosis to her husband.[132] Although the defendant's disclosures were excused, the Alaska Supreme Court held that a common law action for invasion of privacy existed for disclosure of medical information.[133] The court based its decision on a New York case, *MacDonald v. Clinger,*[134] in which a psychiatrist had revealed confidential information to a plaintiff's spouse.[135] Thus, physicians owe a duty of confidentiality to their patients, and breach of that duty is compensable in tort.

While no Alaska cases have imposed tort liability for other mental health providers, *Chizmar*'s reasoning would permit a cause of action for disclosure by other providers. Mental health providers owe a modified duty of confidentiality towards their patients. A provider may disclose confidential information only when authorized by law and must limit their disclosure to only those facts authorized by law. Unauthorized disclosure *can* result in tort liability.

B. Informed Consent

The Alaska Statutes modify the duty of informed consent in limited circumstances. The Alaska Supreme Court originally refused to address the "difficult and complex questions . . . regarding the duty and scope of disclosure required by the informed consent doctrine" in the tort setting.[136] For that reason, the Alaska Legislature codified the informed consent doctrine in 1976.[137] The Legislature addressed the specific needs of involuntary patients by carving out narrow exceptions to the usual requirements for informed consent.[138] In general, Alaska mental health providers must obtain informed consent, and are only excused from respecting the patient's

131. 896 P.2d 196 (Alaska 1995).

132. *Id.* at 198.

133. *See id.* at 207.

134. 84 A.D.2d 482 (N.Y. App. Div. 1982).

135. *Id.* at 482.

136. Poulin v. Zartman, 542 P.2d 251, 275 (Alaska 1975) (holding that the father of an infant blinded after oxygen treatment failed to make out a prima facie informed consent claim because he failed to show that he would have declined the procedure if he had known of alternative treatment).

137. ALASKA STAT. § 09.55.556 (establishing informed consent liability and defenses to malpractice claims based on informed consent).

138. *See, e.g.,* ALASKA STAT. § 47.30.825 (regarding patient rights).

right to refuse treatment when specifically authorized by statute or court order.

1. *The Development of the Doctrine of Informed Consent in Alaska*. At common law, the performance of a medical procedure without the patient's informed consent constituted an actionable battery.[139] In enacting Alaska Statutes section 09.55.556, the Legislature recognized a cause of action for failure to obtain informed consent.[140] For a provider to be liable under the statute, a patient must prove that she would not have consented to the treatment if she had been informed of the common risks and reasonable alternatives to the treatment.[141] Further, the statute carves out exceptions to disclosing a risk or alternative if: (1) the risk is too commonly known or too remote; (2) the patient stated that she would undergo the procedure no matter the risks or stated that she did not want to know the risks; (3) the circumstances made consent impossible; or (4) the provider reasonably believed that full disclosure would have a substantially adverse effect on the patient's condition.[142]

Alaska courts have interpreted the informed consent statute in consideration of patient's rights. In describing the physician-patient relationship, the Alaska Supreme Court stated that "[a] physician therefore undertakes, not only to treat a patient physically, but also to respond *fully* to a patient's inquiry about his treatment, i.e., to tell the patient everything that a reasonable person would want to know about the treatment."[143] Expanding upon this view, the Alaska Supreme Court held in *Korman v. Mallin*[144] that, unlike in a medical malpractice case, expert testimony regarding standards of disclosure is not required in an informed consent case.[145] Informed consent cases focus on the "reasonable patient" rule, which measures the required scope of disclosure "by what a reasonable patient would need to know in order to make an informed and intelligent decision."[146] Therefore, expert testimony regarding the standards of disclosure in the professional community is not necessary to resolve whether the "reasonable patient"

139. RESTATEMENT (SECOND) OF TORTS §§ 18-20 (1965); W. PAGE KEETON ET AL., PROSSER & KEETON ON THE LAW OF TORTS § 9, at 39 (5th ed. 1984).

140. ALASKA STAT. § 09.55.556.

141. *Id.* § 09.55.556(a).

142. *Id.* § 09.55.556(b).

143. Pedersen v. Zielski, 822 P.2d 903, 909 (Alaska 1991).

144. 858 P.2d 1145 (Alaska 1993).

145. *Id.* at 1149.

146. *Id.*

rule has been satisfied.[147] Recently, the Alaska Supreme Court held in *Trombley v. Starr-Wood Cardiac Group*[148] that a clear case of failure to obtain informed consent constitutes a battery regardless of proof of damages.[149] In *Trombley*, the court held that the physician's decision to harvest a vein from the plaintiff's right leg, despite her stated preference for harvesting from the left leg, could be actionable in the absence of a later consent to using the right leg.[150]

Regulations may further add to the requirement of informed consent. In *Sweet v. Sisters of Providence*,[151] Plaintiff-parents alleged that Defendant-physicians failed to obtain their informed consent before circumcising their son.[152] The child later developed a systemic infection and brain damage, allegedly from an infection of the circumcision site.[153] Alaska Administrative Code Chapter 7, Section 12.120(c) requires that a written informed consent be included in the patient's medical records before surgery.[154] The hospital lost the patient's medical records.[155] The trial court agreed with the defendants that the Administrative Code regulation was obscure and unknown, and therefore could not be used as the basis of a negligence per se claim.[156] The Alaska Supreme Court reversed, holding that while the trial court's conclusion could be correct, the court needed to hold an evidentiary hearing to establish whether the regulation was obscure and unknown, or "whether it could be fairly interpreted to set the standard of care."[157] In sum, the supreme court has consistently held health providers to the statutory requirement of informed consent.

2. *Application of Informed Consent in Involuntary Treatment.* The law provides the patient with a strong right to refuse treatment. Justice Benjamin Cardozo wrote, "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body."[158] The United States Supreme Court has

147. *Id.*

148. *Id.*

149. *See* Trombley v. Starr-Wood Cardiac Group, 3 P.3d 916, 924 (Alaska 2000).

150. *See id.* at 924.

151. 895 P.2d 484, 486-87 (Alaska 1995).

152. *Id.*

153. *Id.* at 489.

154. ALASKA ADMIN. CODE tit. 7, § 12.120 (c)(2002).

155. *Sweet*, 895 P.2d at 487.

156. *Id.* at 493-94.

157. *Id.* at 494.

158. Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914). Judge Cardozo wrote this opinion when he was a New York appellate court judge.

recognized that a competent person has a liberty interest under the Due Process Clause to refuse unwanted medical treatment.[159] Explicit in these cases is that the patient must be of sound mind. However, mandated treatment encompasses both competent and incompetent patients.

Generally, Alaska law protects the right of the competent patient to refuse consent as well as the right of the incompetent patient to have treatment decisions made by a court or attorney-in-fact.[160] The general patient rights statute contains several protections.[161] First, it allows the patient, patient's counsel, guardian, previous provider, representative, attorney-in-fact, and responsible adult otherwise appointed to participate in decisions regarding the patient's treatment to the maximum extent possible and forbids the withholding of information regarding the patient's status.[162] Second, the statute allows any patient capable of giving informed consent to refuse such consent, except in a narrowly defined emergency.[163] Third, the statute requires the following: (1) the "least restrictive" restraint available be used in protecting a patient; (2) the patient or representative be able to choose between medically acceptable restraints; (3) a restrained patient be adequately observed; and (4) records regarding such restraint be kept in the patient's medical record.[164] The statute forbids the use of electroconvulsive therapy and aversive conditioning against the patient's will, even if the patient is not capable of giving consent, unless such treatment is authorized by a court, by the patient's attorney-in-fact, or by the patient through an advance directive.[165] Even greater restrictions are placed on psychosurgery, lobotomy, and other forms of surgical treatment. These procedures must be authorized by the patient, or the patient's guardian if the patient is a minor or incapable of giving informed consent, or by a court after a hearing

159. *See* Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261, 278 (1990) (holding that the right of a competent person to refuse medical care is inferred from prior Supreme Court decisions).

160. *See* ALASKA STAT. § 47.30.825(b) (Michie 2002).

161. *Id.* § 47.30.825.

162. *Id*. § 47.30.825(b).

163. *Id*. § 47.30.825. The statute does allow surgical treatment in an emergency that does not permit enough time to obtain the consent of the "proper relatives" or court. However, it requires a written opinion by the patient's attending physician, the consent of the "professional person in charge," and prohibits such surgery if the patient's objection to the surgery is religious and the patient is not a minor. *Id* § 47.30.825(h).

164. *Id*. § 47.30.825(d).

165. *Id.* § 47.30.825(f).

"compatible with full due process."[166] Finally, upon discharge, the statute gives the patient the right to participate as much as practicable in developing a plan for follow-up care.[167]

Alaska Statutes section 47.30.836 specifically limits the administration of psychotropic medications in non-emergencies.[168] A patient may only receive psychotropic medication if he consents, he has executed an advance directive consenting, his attorney-in-fact consents, or he is determined by a court to lack the capacity to give informed consent.[169] A patient is capable of giving informed consent if he is competent and the consent is voluntary and informed.[170] In informing a patient, the mental health facility desiring to administer the medication must ensure that they give the information necessary for informed consent in the manner most understandable to the patient.[171]

The section carefully defines "competent," "informed," and "voluntary."[172] A "competent" patient: (1) "has the capacity" to understand the facts relevant to the treatment decision and is able to appreciate his position "with regard to those facts;" (2) appreciates that he has a mental illness; (3) "has the capacity to participate in treatment decisions by means of a rational thought process;" and (4) "is able to articulate reasonable objections to using the medication."[173] The first part of the test ensures at least minimal mental capacity. The third part of the test does not require a reasoned thought process taking into account the same values as the provider, but does require an internal consistency to the patient's decisions. The second and fourth parts ensure that the patient can at least articulate an objective analysis of his condition, regardless of whether he agrees with that analysis.

The statute's definition of "informed" includes a broad range of information that the patient must receive.[174] This information includes diagnosis, prognosis, the proposed medication, its effects, its interactions with other drugs and substances, a review of the patient's medical history, alternative treatments and their risks and benefits, and a notification that the patient has the right to refuse

166. *Id.* § 47.30.825(g). However, the statute does not specify which protections constitute "full due process."

167. *Id.* § 47.30.825(i).

168. *Id.* § 47.30.836.

169. *Id.*

170. *Id.* § 47.30.837(a).

171. *Id*. § 47.30.837(b).

172. *Id*. § 47.30.837(d)(1).

173. *Id.*

174. *Id.* § 47.30.837(d)(2).

treatment that can only be overridden by a court.[175] The definition of "voluntary" allows encouragement by the provider, but rules out coercion, force, and threats.[176] If the facility cannot obtain a patient's informed consent, then it must seek court approval to administer the medication.[177]

A facility may administer psychotropic medication in an emergency without the patient's consent, but the statute strictly limits the definition of an emergency.[178] A physician or registered nurse must determine that the medication is necessary to preserve the life of the patient or to prevent significant physical harm.[179] The medication must be authorized by a physician and may only prescribe medication for an initial period of twenty-four hours with two extensions, for a total of seventy-two hours.[180] Once the patient has been stabilized, the provider must discuss the incident with the patient and take the patient's recommendations into account when planning future treatment.[181] If the emergency repeats or it appears that it might occur repeatedly, the provider may only medicate the patient against her will three times without court approval.[182]

A facility may petition for court-ordered administration of psychotropic medication if the patient appears incapable of giving informed consent in a non-emergency situation, or has repeated emergencies requiring administration of psychotropic medications.[183] Upon request, the patient has the right to an attorney and a guardian ad litem.[184] If the court determines "by clear and convincing evidence" that the patient lacks the ability to give informed consent, then the court may approve the proposed use of the medication for the requested period.[185] However, the facility must ask the court for any extensions beyond the approved period.[186]

It is important to note that the statutes described above for administration of medication are separate from the statutes re-

175. *Id.*
176. *Id*. § 47.30.837(d)(3).
177. *See id*. § 47.30.839.
178. *See id*. § 47.30.838 (suggesting that an emergency is defined as "a crisis situation . . . that requires immediate use of medication to preserve the life of, or prevent significant harm to, the patient or another person").
179. *Id.* § 47.30.838(a)(1).
180. *Id*. § 47.30.838(a)(2).
181. *Id*. § 47.30.838(b).
182. *Id*. § 47.30.838 (c).
183. *Id.* § 47.30.839.
184. *Id.* § 47.30.839(c).
185. *Id.* § 47.30.839(g).
186. *Id.*

garding involuntary admission. While involuntary admission may become necessary and carries with it an authorization for treatment, additional determinations of fact must be made to justify an involuntary commitment.[187] Specifically, the fact finder must determine from "clear and convincing evidence, that the respondent is mentally ill and as a result is likely to cause harm to the respondent or others or is gravely disabled."[188] However, the patient rights statute applies to both involuntarily committed patients and mandated outpatients.[189] Alaska also allows continuing involuntary treatment of outpatients.[190] In practice, the sections regarding administration of psychotropic medications are most helpful in instances where the patient need not be involuntarily committed, has been released from involuntary commitment but still needs treatment, or is already criminally committed.

Further, Alaska has regulations regarding informed consent. The Alaska Administrative Code requires community mental health centers receiving state funds to have a patient's informed consent in cases of experimental, nonstandard, or demonstration treatment.[191] Under the Alaska Administrative Code, prisoners retain the right to refuse any medication not specifically ordered by a court.[192] Residential psychiatric treatment centers are further enjoined from medicating residents unless the medication has been approved by the resident's parent, guardian, or Indian custodian.[193] These regulations reinforce the general principles of informed consent set forth in the statutes.

3. *Application of the Alaska Statutes in Practice*. As a practical matter, a mandated patient may arrive at a therapist's office under a variety of circumstances. A court may have ordered outpatient treatment,[194] the patient may have been released from inpatient status but has continuing involuntary outpatient treatment requirements,[195] or a court may have ordered the patient to accept treatment in a CINA or criminal case.[196] As such, the need for informed consent is eliminated to the extent that the authorization

187. *See id*. § 47.30.735.
188. *Id.*
189. *Id*. § 47.30.835.
190. *Id*. § 47.30.795.
191. ALASKA ADMIN. CODE tit. 7, § 71.205.
192. *Id.* tit. 22, § 5.122.
193. *Id.* § 50.875.
194. ALASKA STAT. § 47.30.660(b)(1).
195. *Id.* § 47.30.795.
196. *Id.* § 47.10.087.

explicitly addresses a particular form of treatment, but is preserved for other types of treatment.[197]

In criminal, civil, or CINA situations, the provider should recognize that the court order generally does not specifically authorize any treatment and the patient may still refuse to consent.[198] If the service is evaluative, the provider probably enjoys the benefits of quasi-judicial immunity.[199] However, if the service continues after an evaluation or there is treatment beyond evaluation, the patient must give her informed consent.[200] Should the patient fail to consent, the provider's role is to report the patient's non-compliance to the court, rather than to enforce the court order.[201]

C. Care

Mental health providers generally owe the same duty of care to mandated patients as voluntary patients.[202] However, analogous to the quasi-judicial immunity mental health providers enjoy, Alaska Statutes section 47.30.815 prohibits criminal or civil liability of, *inter alia*, "the attending staff of a public or private agency" for initiating commitment proceedings, or for detaining or releasing a patient in good faith and without gross negligence in civil commitment proceedings.[203] The Statute does not provide similar immunity for continuing care beyond the evaluation stage. While no applicable precedent directly applies, both case law regarding voluntary admissions and statutory law protecting the civil rights of those involuntarily committed support the conclusion that mental health providers must give the same level of care to involuntary patients as voluntary ones.[204]

1. *Defining the Standard of Care*. Defining a standard of care for mental health providers regarding malpractice has presented

197. *Id.* §§ 47.30.755, 47.30.822.

198. *Id*. § 47.30.825(a).

199. *Id.* § 47.30.705.

200. *Id*. § 9.55.556.

201. *Id*. § 47.30.839.

202. *See, e.g.,* Jeff D. v. Andrus, 899 F.2d 753, 764 (9th Cir. 1989) (holding that the statutes do not differentiate between the care required for involuntarily committed children and voluntarily committed children); s*ee also* ALASKA STAT. § 47.30.835 (protecting the civil rights of psychiatric patients).

203. ALASKA STAT. § 47.30.815. *But see* Jensen v. Lane County, 222 F.3d 570, 577 (9th Cir. 2000) (finding a physician not entitled to immunity under a similar Oregon statute for acts performed in evaluating a prisoner).

204. *See* D.P. v. Wrangell Gen. Hosp., 5 P.3d 225, 230 (Alaska 2000) (recognizing an involuntary patient's right to sue for negligence).

some difficulties.[205] However, several cases dealing with other issues have implied the existence of such a duty.[206] In *Doe v. Samaritan Counseling Center*,[207] Plaintiff Doe sought malpractice damages after her therapist started a sexual relationship with her during therapy.[208] In deciding that the therapist's employer could potentially be held liable for the therapist's conduct, the Alaska Supreme Court noted that the therapist's conduct was tortious.[209] In *D.P. v. Wrangell General Hospital*,[210] the Alaska Supreme Court held that an obvious case of hospital negligence, allowing a patient on a psychiatric hold to leave contrary to her physician's express orders, did not require the otherwise necessary testimony of an expert witness.[211] Despite deciding the case on other grounds, the court recognized the right to redress the injury.[212] Finally, in *Karen L. v. State*,[213] the court found that quasi-judicial immunity applied to Defendant-doctors appointed to do evaluations in a CINA case.[214] However, the court also addressed the plaintiff's allegation that the defendants treated her child in addition to evaluating him, noting:

> There is no evidence in the record to support Karen's alternative argument that the doctors were not entitled to quasi-judicial immunity because they "treated" C.L. The doctors provided evaluations and recommendations to assist the CINA court in determining the proper placement and counseling needs of C.L.; they themselves did not provide therapy.[215]

The court implied that an exception to quasi-judicial immunity for treatment beyond mere evaluation exists.[216]

2. *Statutory Patient Protections*. There have been no decisions involving malpractice on an involuntary psychiatric patient. However, Alaska Statutes section 47.30.835 provides:

---

205. *See generally* Lawrence P. Hampton, Note, *Malpractice in Psychotherapy: Is There a Relevant Standard of Care?* 35 CASE W. RES. 251, 253 (1985).

206. *Id.* at 255. *See generally* Doe v. Samaritan Counseling Center, 791 P.2d 344 (Alaska 1990); Karen L. v. State, 953 P.2d 871 (Alaska 1998).

207. 791 P.2d 344.

208. *Id.* at 345.

209. *Id.* at 348 (citing Simmons v. United States, 805 F.2d 1363, 1369-70 (9th Cir. 1986)).

210. 5 P.3d 255 (Alaska 2000).

211. *Id.* at 230.

212. *Id.*

213. 953 P.2d 871 (Alaska 1998).

214. *Id.* at 878.

215. *Id.* at 879, n.11.

216. *Id.*

> A person may not deny to a person who is undergoing evaluation or treatment under AS 47.30.660–47.30.915 a civil right, including but not limited to, the right to free exercise of religion and the right to dispose of property, sue and be sued, enter into contractual relationships, and vote.[217]

Courts have not interpreted this statute, but the plain language preserves the right of involuntary patients to sue. As a further protection, another section of the statute provides psychiatric patients with additional rights, presumably enforceable through malpractice or statutory violation claims.[218]

3. *Negligent Release as a Framework for Testing the Standard of Care*. Negligent release claims provide a useful framework for examining psychiatric malpractice. Although not an Alaska case, *Perreira v. Colorado*[219] presents the typical facts for a negligent release claim.[220] In *Perreira*, an involuntary patient at a mental health center shot and killed an individual while undergoing outpatient care.[221] The victim's wife sued the State for negligently releasing the patient.[222] The Colorado Supreme Court held that the state (and by extension, the physician) could be liable for malpractice.[223] The Colorado court expressly limited its finding to involuntary patients whose physicians failed to meet the standard of care, noting, "The task of assessing dangerousness is not viewed as being beyond the competence of individual therapists or as a matter upon which therapists cannot agree."[224] However, this conclusion is suspect, as one classic study showed that a simple blind algorithm actually predicted parole violations and future dangerousness better than prison psychiatrists.[225]

---

217. ALASKA STAT. § 47.30.835 (Michie 2002).

218. *See generally id*. §§ 47.30.825-47.30.865. These rights include, but are not limited to the following: (1) the right of the patient, her guardian, her counsel, and other agents to participate fully in therapy and evaluation; (2) the right to give and withhold consent to medication in non-crisis circumstances; (3) the right to be free from experimental treatment; (4) the right to a proper diet; and (5) the right to privacy and personal possessions. *Id.*

219. 768 P.2d 1198 (Colo. 1989).

220. *Id.* at 1203-07.

221. *Id.* at 1204.

222. *Id.* at 1205-06.

223. *Id.* at 1220.

224. *Id.* at 1217 (citing Schuster v. Altenberg, 144 Wis. 2d 223, 248 (Wis. Ct. App. 1988) (quoting Givelber, Bowers & Blitch, *Tarasoff, Myth and Reality: An Empirical Study of Private Law in Action,* 1984 WIS. L. REV. 443, 486 (1984)).

225. *See generally* PAUL E. MEEHL, CLINICAL VERSUS STATISTICAL PREDICATION: A THEORETICAL ANALYSIS AND REVIEW OF THE EVIDENCE (1954).

Three Alaska cases indirectly address this issue: *D.P. v. Wrangell General Hospital,*[226] *Burcina v. City of Ketchikan,*[227] and *Division of Corrections v. Neakok.*[228] *D.P.* targeted hospital liability rather than mental health liability, but presents a case in which the plaintiff alleged injury from a failure to meet the standard of mental health care.[229] Plaintiff D.P. checked into Wrangell General Hospital with delusions.[230] The physician on duty wrote in his hospitalization order: "[S]hould stay in building, under observation/suicide precautions."[231] However, the plaintiff left the hospital, and met a temporary forest worker, whom the plaintiff believed was Jesus.[232] Under this misperception, she had sex with him.[233] The plaintiff then sued the hospital, claiming they should have kept her in the facility.[234] The central issue was whether the plaintiff should have been required to call an expert witness regarding malpractice.[235] However, the decision implicitly recognized that medical facilities owe a duty of care to psychiatric patients.[236]

Burcina v. City of Ketchikan[237] may also have implicitly recognized a duty of care to involuntary psychiatric patients.[238] Plaintiff Burcina suffered from schizophrenia and had been convicted and committed to the Alaska Psychiatric Institute after assaulting several police officers during a psychotic episode.[239] After his release, he received treatment from Defendant Huffman, a psychiatrist with a state contract to treat emergency psychiatric patients, and other physicians.[240] While under treatment, the plaintiff set fire to

---

See also Allen Kirk, *The Prediction of Violent Behavior During Short-term Civil Commitment*, 17 BULL. AM. ACAD. OF PSYCHIATRY & L. 345 (1989).

226. 5 P.3d 225 (Alaska 2000).

227. 902 P.2d 817 (Alaska 1995).

228. 721 P.2d 1121 (Alaska 1986).

229. *D.P.*, 5 P.3d at 226.

230. *Id.*

231. *Id.*

232. *Id.*

233. *Id.*

234. *Id.* at 227.

235. *Id.* at 228. The court decided that she was not required to call an expert witness, as the issue was less one of malpractice liability and more one of ordinary negligence. *Id.* at 229.

236. *Id.* at 230.

237. 902 P.2d 817 (Alaska 1995).

238. *Id.* at 823.

239. *Id.* at 818 n.1.

240. *Id.* at 819. Although not explicitly stated in the case, Burcina saw these physicians as a condition of his release.

his mental health clinic.[241] For this, he was convicted of arson, although he claimed he was suffering from delusions at the time.[242] The Alaska Supreme Court dismissed his claims against his physicians for injuries arising from the fire, citing a public policy rationale of preventing recovery for injuries suffered during the commission of the crime for which the plaintiff was convicted.[243] Thus, while *Burcina* does not expressly recognize a cause of action for malpractice in mandated treatment, neither does it rule it out.

Division of Corrections v. Neakok[244] addressed by analogy the duty of mental health providers. *Neakok* involved a parolee whom the state released back into his community without active supervision.[245] The parolee subsequently killed three people.[246] The families of the victims sued the state, alleging a duty to protect them from the foreseeable harms created by a parolee under those circumstances.[247] The Alaska Supreme Court found that the state had a duty to protect the public:

> The state thus stands in a special relationship with a parolee, both because of its increased ability to foresee the dangers the parolee poses and because of its substantial ability to control the parolee. Given this special relationship, it is not unreasonable to impose a duty of care on the state to protect the victims of parolees.[248]

By analogy, Alaska mental health providers probably owe the public a duty to protect them from the foreseeable violent acts of inpatients released into the community. However, this analogy should not be taken too far. Alaska courts have never directly addressed the issue, and other jurisdictions have not extended this duty to outpatient care.[249]

In the absence of a case permitting recovery for a breach of the standard of care in the mandated mental health treatment context, it is difficult to know in which contexts the courts will impose liability. Based on similar precedents and Alaska law, however, it appears that Alaska would at least recognize a cause of action for third parties injured by a negligent discharge from an inpatient setting. Alaska also appears to recognize a patient's right to sue for

---

241. *Id.*
242. *Id.*
243. *Id.* at 820-21.
244. 721 P.2d 1121 (Alaska 1986).
245. *Id.* at 1124.
246. *Id.* at 1123.
247. *Id.*
248. *Id.* at 1126-27.
249. *See* Perreira v. Colorado, 768 P.2d 1198, 1212 (Colo. 1989) (focusing on "committed patients").

malpractice, whether that patient seeks services voluntarily or receives them involuntarily, with the exception of evaluative services performed pursuant to court order.

4. *Competence and Care*. Another important issue concerns the standard of care regarding non-professional providers. In *Ramsey v. State*,[250] the court held that a nurse was not acting as an agent of a mental health professional and therefore was not subject to the same standard of confidentiality as is required of a treating professional.[251] Further, *Allred v. State*[252] considered the issue of confidentiality of communications between patients and psychotherapists, and decided that the privilege covered only communications to psychiatrists and licensed psychologists.[253] The privilege was further extended by statute and by the Supreme Court in *Jaffee v. Redmond*.[254]

Court-ordered classes in anger management, life skills, and family violence prevention may be provided by a mental health professional, a paraprofessional under the guidance of a mental health professional, or a non-professional.[255] The mental health professional must adhere to the standard of care for her profession, as discussed above,[256] but the non-professional has no duty of care (unless unlawfully practicing counseling).[257] The provision of services by a non-professional who acts under the supervision of a professional raises unique competence and duty of care issues. Under general agency law, the principal is generally liable for the torts of the agent:

> One who represents that another is his servant or other agent and thereby causes a third person justifiably to rely upon the care or skill of such apparent agent is subject to liability to the third person for harm caused by the lack of care or skill of the one appearing to be a servant or other agent as if he were such.[258]

Thus, while the issue remains open in Alaska, it appears that the agents of a mental health provider may be subject to the same

250. 56 P.3d 675 (Alaska Ct. App. 2002); *see also* Catharina J.H. Dubbelday, *The Psychotherapist-Client Testimonial Privilege: Defining the Professional Involved*, 34 EMORY L. J. 777 (1985).

251. *Ramsey*, 56 P.3d at 680.

252. 554 P.2d 411 (Alaska 1976).

253. *Id.* at 411.

254. 518 U.S. 1 (1996) (extending the privilege to encompass psychotherapists).

255. *See* ALASKA STAT. § 12.55.101 (Michie 2002).

256. *See supra* IV(C).

257. ALASKA STAT. § 12.55.101.

258. RESTATEMENT (SECOND) OF AGENCY § 267 (1958).

standard of care required of the provider when acting under her supervision.

Mandated treatment changes the duties of confidentiality and informed consent owed to a mental health patient, but does not fundamentally alter the duty of care. The Alaska Statutes acknowledge and define the differences in the duties of confidentiality and informed consent. Mental health providers should construe these exceptions narrowly, as the express language of the statutes provides that involuntary patients maintain those rights not specifically abrogated by statute. While no Alaska case involving liability for a provider under these circumstances has yet reached the appellate level, providers can face liability for going beyond the scope of the exceptions.

V. SPECIAL CONSIDERATIONS UNDER FEDERAL LAW

Certain federal programs provide additional liability protection for providers of mental health services. While Medicare and Medicaid do not provide limitations on liability or otherwise alter the legal status of the provider and patient, providing care to military and public health service patients under an employment agreement with the government can give the provider additional procedural protections under federal law.[259] However, these protections for providers only apply to situations in which both the provider and patient are employees of the United States and do not extend to contractors or providers seeing patients under the auspices of TRICARE, the military's managed care entity.[260]

The United States enjoyed sovereign immunity for torts committed by its employees and agents until 1949, when Congress passed the Federal Tort Claims Act ("FTCA").[261] The FTCA permits the United States to be sued for tort claims in the federal courts on the same terms as a private party could be sued, though it requires filing an administrative claim, denying a jury trial, denying punitive damages, and adding certain defenses unique to the government.[262] Employees of the United States sued pursuant to their official duties are excused from the case, and the United States is substituted as the real party, provided that the employee was acting within the scope of her employment.[263]

---

259. *See, e.g.,* 42 U.S.C. § 233 (2002); Feres v. United States, 340 U.S. 135, 146 (1950); Persons v. United States, 925 F.2d 292, 298 (9th Cir. 1991).

260. 28 U.S.C. § 2617 (2002).

261. 28 U.S.C. § 1346(b) (2002).

262. 28 U.S.C. §§ 2673, 2675, 2676 (2002).

263. 28 U.S.C. § 1346(b)(1) (2002).

Soon after Congress passed the FTCA, the Supreme Court decided *Feres v. United States*.[264] *Feres* held that no one may recover against the United States in tort for an injury to a military member.[265] The Ninth Circuit Court of Appeals affirmed the extension of the doctrine to military medical malpractice in *Persons v. United States*.[266] *Feres* and *Persons* only protect the United States, and by extension its employees, from liability, and only then for injuries to military members.[267] They do not prohibit recovery for injuries to non-military beneficiaries of the TRICARE system, nor do they protect non-employee providers of services to military members. Not only are providers subject to suit from these individuals, but the United States will not reimburse the provider for losses if the provider loses the suit.[268]

Certain contractors have successfully raised a defense to tort claims based on the government's involvement in the contracting process.[269] The reasoning employed by the government contractor defense is that the government forced the contractor to make certain decisions based on the government's specifications. Therefore, the contractor cannot be held liable for the government's acceptance of risk in these specifications. However, the government contractor defense generally applies to products, not services, and will probably not protect a provider from most negligence claims.[270]

In order to claim the government contractor defense, a contractor must show the following: "(1) the United States approved reasonably precise specifications; (2) the equipment conformed to those specifications; and (3) the supplier warned the United States about the dangers in the use of the equipment that were known to the supplier but not to the United States."[271] This argument constitutes the "devil made me do it" defense, which implies that the actions of the United States are truly to blame, rather than any negligence on the part of the contractor, who merely filled the order to

264. 340 U.S. at 135.

265. *Id.* at 146.

266. 925 F.2d 292 (9th Cir. 1991).

267. *Feres*, 340 U.S. at 146; *Persons*, 925 F.2d at 294.

268. Stencel Aero Engineering Corp. v. United States, 431 U.S. 666, 673-74 (1977).

269. *See generally* Boyle v. United Technologies Corp., 487 U.S. 500 (1988) (discussing the defense employed by a supplier of military helicopters to the United States).

270. *Id.* at 512.

271. *Id.*

the government's specifications.[272] The plain language of the test demonstrates its focus on goods, rather than services, and indeed the defense has not been extended to encompass services. However, even if one were to attempt such an extension, one would find that the government does not provide much in the way of precise specifications in its terms for participation in the TRICARE program, but does specifically require, as all federal medical programs do, that the care provided fall within the relevant standard of care. As such, this defense is unlikely to be successfully applied to the garden-variety malpractice claim premised on a lack of due care.

The government contractor defense may extend to instances in which the government's conduct caused the breach of duty. For instance, if a service member attempted to sue his mental health provider, who violated her confidentiality by disclosing her records to her commander, the provider would have a potential defense on the grounds that the government required the action under the terms of his contract. In fact, the conditions of participation for TRICARE specifically require that a copy of the patient's records be placed in his government file, probably protecting the provider from liability for that particular disclosure. A civilian provider of services to military personnel is therefore best advised to follow the terms of the conditions for participation closely. In general, mental health services providers, who are not government employees, will not enjoy the protections of the Federal Tort Claims Act and may be sued in state court for malpractice.

While all federal employees enjoy the protection of the Federal Tort Claims Act, the *Feres* doctrine and the government contractor defense, when available, apply only to military employees and contractors.[273] Certain contractors with Public Health Service entities may also share the protections of the Federal Tort Claims Act.[274] Congress enacted the Federally Supported Health Centers Assistance Act in 1992 to reduce the growing costs of malpractice insurance to private nonprofit health centers that provide health services to medically underserved populations, under 42 U.S.C. § 245(b).[275] The Act makes the government the medical malpractice insurer for the health centers, their officers, employees, and contractors, allowing the health centers to eliminate the expense of

---

272. *See* David E. Seidelson, *The Government Contractor Defense and the Negligent Contractor: The Devil Made Me Do It*, 7 WIDENER J. PUB. L. 259 (1998).

273. Nielsen v. George Diamond Vogel Paint Co., 892 F.2d 1450, 1454-55 (9th Cir. 1990) (holding that these doctrines did not apply to a civilian).

274. 42 U.S.C. § 233 (2000).

275. Dedrick v. Youngblood, 200 F.3d 744, 744-45 (11th Cir. 2000).

private malpractice insurance.[276] However, to qualify, a provider must spend at least 32.5 hours a week working on the contract, unless he or she is an internist, pediatrician, family practitioner, or obstetrician.[277] The courts have construed this provision narrowly to exclude employees of subcontractors.[278] In essence, unless the provider works full time for a qualifying health center, the provider will not enjoy the benefits of the Federal Tort Claims Act.

The provision of services through a federal program does not change the obligations of a provider to the patient. While full-time employees and certain contractors enjoy certain additional protections through the Federal Tort Claims Act, these protections are not available to providers simply participating in federal programs. Providers participating in government health care funding programs should follow the conditions of participation carefully, as they will not enjoy any protection beyond the limited disclosures authorized by those conditions.

VI. CONCLUSION

When one asks a layman what duties a mental health provider owes to a mandated patient, common responses are "none" and "exactly the same as any other patient." However, neither is true. Alaska providers of mandated mental health services neither have a blanket exemption from their duties of confidentiality, informed consent, and care, nor do they have the identical duties to these patients as voluntary patients.

Mandated care modifies the duties of confidentiality and informed consent, but a provider should construe these exceptions narrowly. Providers employed by the United States may enjoy some additional protections from liability through the Federal Tort Claims Act and *Feres* doctrine, but these protections do not generally extend to private providers working under a federal contract. The safest course of action for a provider of mandated mental health services is to treat the mandated patient as much as possible like a voluntary patient and to adapt the provider's practices only as specifically authorized by the terms of the mandate.

To avoid liability problems, providers and institutions that routinely care for mandated patients should consider developing policies regarding confidentiality and informed consent that follow the requirements of Alaska law. Providers who only occasionally see mandated patients may want to consult carefully with the refer-

276. *Id.* at 745.
277. 42 U.S.C. § 233(g)(5) (2000).
278. *Dedrick*, 200 F.3d at 746.

ring authority to determine the scope of their mandate and any limitations on confidentiality that may arise from the specific circumstance and discuss these with the patient in advance of treatment. Mandated care can be an important vehicle for helping those who would otherwise not get help. However, the mental health providers who care for mandated patients should be aware of their modified duties towards them.