R. Cohen

NO. 15344

IN THE

APPELLATE COURT OF ILLINOIS

FOURTH DISTRICT

NANCY SCHNEIDER, Administrator of the Estate of Terri Schneider, Deceased, and HERBERT J. APER, Executor of the Estate of Lloyd C. Schneider, Deceased, and Phyllis J. Schneider, Deceased, Plaintiffs-Appellants, vs. VINE STREET CLINIC, FENTON DRAKE, and JAY MOGERMAN, Defendants-Appellees.	Appeal from the Eleventh Judicial Circuit Logan County, Illinois Honorable John T. McCullough Presiding Judge

BRIEF OF

THE ILLINOIS PSYCHIATRIC SOCIETY, THE ILLINOIS SOCIETY FOR CLINICAL SOCIAL WORK, THE AMERICAN ORTHOPSYCHIATRIC ASSOCIATION, THE ASSOCIATION OF CHILD PSYCHOTHERAPISTS, THE FAMILY SERVICE ASSOCIATION OF AMERICA, THE ILLINOIS ASSOCIATION OF FAMILY SERVICE AGENCIES, THE ILLINOIS PSYCHOLOGICAL ASSOCIATION, AND THE NATIONAL ASSOCIATION OF SOCIAL WORKERS

AMICI CURIAE

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ORAL ARGUMENT REQUESTED

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NATURE OF THE CASE

Plaintiffs appeal from dismissal of their amended complaint in which they charge a clinic, a psychiatrist and a social worker with negligence. The allegations are that one Michael Drabing, who was a patient/client of defendant Vine Street Clinic, was in need of mental treatment, that he had a serious mental illness, that he intended to "kill rich people," and that by reason thereof, immediate hospitalization of Drabing was necessary for the protection of others from physical harm by him. Plaintiffs further contend that the defendants were negligent in (1) failing to obtain involuntary hospitalization of Drabing; and (2) failing to warn Drabing's family and his personal physician as to his alleged dangerousness; and that this negligence was the proximate cause of the deaths of plaintiffs' decedents, who were murdered by Drabing.

INTEREST OF AMICI CURIAE

The Illinois Psychiatric Society is a professional association of some nine hundred sixty three (963) members, comprising some ninety percent of all psychiatrists practicing in this State. It is a constituent part of the American Psychiatric Association and is closely associated with the Illinois Medical Society.

The Illinois Society for Clinical Social Work is a professional association of some one hundred psychiatric social workers practicing individually and privately in this State.

The American Orthopsychiatric Association is a national membership and educational organization of some seven thousand (7,000) behavioral, medical and social sciences professionals working collaboratively on problems of human behavior and their treatment.

The Association of Child Psychotherapists is an interdisciplinary organization of mental health professionals practicing in Illinois and Wisconsin who specialize in the mental health treatment of children and adolescents.

The Family Service Association of America is a national organization of some two hundred seventy-one (271) voluntary (private sector) family service agencies delivering social casework and related services to families, couples and individuals in forty-three states and the District of Columbia.

The Illinois Association of Family Service Agencies is an organization of some thirty-nine voluntary (private sector) family service agencies providing social casework and related services to families, couples and individuals throughout this State.

The Illinois Psychological Association represents some twelve hundred (1200) psychologists practicing throughout this State.

The National Association of Social Workers is a national organization of some eighty thousand (80,000) professional social workers practicing throughout the country. The Illinois chapter of the National Association of Social Workers represents some five thousand (5,000) professional social workers practicing in this State.

Each of these associations has a professional commitment to the diagnosis, care and treatment of persons suffering from mental or emotional problems. Each of the associations espouses and requires of its membership the highest standards of mental health care and social casework treatment. Each requires scrupulous adherence to codes of professional ethics applicable to the care provider/patient-client relationship. The associations and their members, being cognizant of the extraordinary responsibilities to patients/clients inherent in their professional callings, are committed to fulfilling those obligations according to the highest prevailing standards of knowledge and skill.

Each of the amicus associations espouses a code of ethics requiring that its members maintain the highest degree of confidentiality as to communications made to them by their patients/clients in the course of service delivery. These ethical codes demand a course of conduct consistent with the best interests of the patient/client. Amici submit that the strictest confidentiality is fundamental to the trust relationship which is the sine qua non of mental health care and social casework treatment. The threat of absence of confidentiality, the fear of disclosure of embarrassing, sensitive and frightening information about oneself is a major stumbling block to treatment for many persons who desperately require it. Amici are supportive of the trial court's recognition that plaintiffs' contention that service providers owe a duty to the public to breach patient/client confidentiality is violative of the law and against public policy.

Members of the amicus associations include direct service providers (those professionals who directly treat patients/clients), professors, researchers, administrators and supervisors. They practice in mental hospitals, general hospitals, community mental health centers and other medical and mental health out-patient treatment settings; in family service and other social service agencies; in schools and universities; in court-affiliated programs and in the juvenile justice and adult correctional systems. They combine in this brief to offer to this honorable Court their collective

experience and expertise in approaching the issues presented by this cause. Among these varied professional groups and their individual members are many areas of doctrinal difference; they employ varied approaches based on personal and professional predilection and scientific viewpoint. It is particularly noteworthy, therefore, that these varied groups collectively agree on the concepts elucidated in this brief. The significance of this consensus must be apparent to the Court in considering the views of amici in arriving at its decision in this cause.

Amici and their members find themselves facing a dilemma. Constitutional theorists have averred, and courts have agreed, that the mental health professions must approach treatment of persons suffering from mental illness or emotional disturbance in terms of the least intrusive, least restrictive treatment modality. The overwhelming trend in mental health care delivery has been in the direction of community-based outpatient care. Involuntary treatment of patients/clients is looked upon as the last resort as a matter of public policy. At the same time that the law is placing these strictures on mental health care and social casework agencies and professionals in treatment planning and decision-making, it is being suggested by plaintiffs in this case that these agencies and professionals have a duty to protect the public by involuntarily hospitalizing any patient/client who expresses a wish or fantasy to do away with a certain

class of persons. The trial court has recognized that, in the face of the constitutional and public policy demands for treatment outside of institutions, adoption of plaintiffs' view would create for the care provider an intolerable double bind.

Amici have undertaken the lead in developing and promulgating theory and practice of mental health care and social casework. Members of amicus associations live and raise their families in our communities and are vitally interested in the public peace and safety, as well as the treatment of persons suffering from mental illness and emotional disturbance. They have a unique interest in fostering a climate which will encourage patients/clients to seek necessary treatment, a strong commitment to assuring citizen access to mental health and social casework services, and to assuring patients/clients that they can avail themselves of treatment without fear of abuse, harrassment or stigma. Amici are convinced that ready and non-threatening access to mental health care and social casework services are the best insurance for the community against violent, criminal behavior of mentally ill or emotionally disturbed persons. Conversely, amici are convinced that establishing practical barriers to obtaining these services would result in increased mental illness and emotional dysfunction, and ultimately in a tragic increase in human suffering and social/economic cost.

The instant case presents for resolution an apparent conflict among precious and important rights: the right of

the individual to seek needed care without fear of incarceration or other unwanted consequences, and the right of the community to public peace and safety. Amici are uniquely qualified by experience, knowledge and philosophical commitment to advise the Court as to the clinical and legal aspects of this case and to offer suggestions for balancing the countervailing interests.

ISSUES PRESENTED FOR REVIEW

1. Whether a mental health care or social casework agency or professional has a duty to unidentified potential third-party victims of a patient/client to predict and prevent dangerous criminal behavior.

2. Whether a mental health care or social casework agency or professional has a duty to hospitalize or obtain involuntary hospitalization of a patient/client.

3. Whether a mental health care or social casework agency or professional has a duty to unidentified potential third-party victims of a patient/client to breach statutory or common law duties of confidentiality to a patient/client.

4. Whether it is the public policy of the State of Illinois to favor the least restrictive mental health treatment alternative.

5. Whether it is the public policy of the State of Illinois to encourage access to and utilization of mental health and social casework services in the interests of protecting the individual human resources and collective safety of the community.

STATUTES INVOLVED

Illinois Revised Statutes, Ch. 91 1/2, §6.1

Illinois Revised Statutes, Ch. 91 1/2, §7.1

Illinois Revised Statutes, Ch. 111, §6324

Illinois Revised Statutes, Ch. 111, §6323

Illinois Revised Statutes, Ch. 111, §406

Illinois Revised Statutes, Ch. 51, §5.1

Illinois Revised Statutes, Ch. 51, §5.2

POINTS AND AUTHORITIES

I.

MENTAL HEALTH CARE AND SOCIAL CASEWORK AGENCIES AND PROFESSIONALS HAVE NO DUTY TO PREDICT DANGEROUS CRIMINAL BEHAVIOR.

Baxtrom v. Herold, 383 U.S. 107 (1966).
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III.

IT IS NOT POSSIBLE FOR MENTAL HEALTH CARE AND SOCIAL CASEWORK AGENCIES OR PROFESSIONALS TO CONTROL THE BEHAVIOR OF THEIR PATIENTS/CLIENTS; NEITHER THE RULE OF REASON NOR THE LAW IMPOSE UPON THEM ANY DUTY TO UNIDENTIFIED POTENTIAL THIRD-PARTY VICTIMS OF A PATIENT/CLIENT TO PREVENT DANGEROUS CRIMINAL ACTS

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V.

IT IS THE PUBLIC POLICY OF THE STATE OF ILLINOIS TO ELIMINATE BARRIERS AND ENCOURAGE ACCESS TO AND UTILIZATION OF MENTAL HEALTH AND SOCIAL CASEWORK SERVICES IN THE INTERESTS OF PROTECTING THE INDIVIDUAL HUMAN RESOURCES AND COLLECTIVE SAFETY OF THE COMMUNITY.

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ARGUMENT

I.

MENTAL HEALTH CARE AND SOCIAL CASEWORK AGENCIES AND PROFESSIONALS HAVE NO DUTY TO PREDICT DANGEROUS CRIMINAL BEHAVIOR.

In a series of state and federal cases in the several states, some of which have undergone consideration by the United States Supreme Court, the issue of criteria for involuntary hospitalization of mental patients has been much reviewed. See e.g., Baxtrom v. Herold, 383 U.S. 107 (1966); Specht v. Patterson, 386 U.S. 605 (1967); McNeil v. Director, Patuxent Institution, 407 U.S. 245 (1972); Murel v. Baltimore City Criminal Court, 407 U.S. 335 (1972); Miller v. Gomez, 412 U.S. 914 (1973); affirming 341 F. Supp. 323 (S.D.N.Y. 1972); Mathew v. Nelson 461 F. Supp. 707 (N.D. Ill. 1978). These cases have dealt largely with the constitutionality of state commitment statutes and have explored rather thoroughly the circumstances under which a state could compel a patient/client to undergo hospitalization.

A number of cases have dealt with the liability of a care provider for negligence in discharging from a mental hospital a patient/client who had been known to have committed violent acts. It must be emphasized that these cases deal with decisions of psychiatrists to release hospitalized patients; they do not address the issue of failure to hospitalize.

See Semler v. Psychiatric Institute of Washington, D.C., 538 F.2d 125 (4th Cir. 1976), cert. den. 97 S.Ct. 83; Hicks v. United States, 511 F.2d 407 (D.C. C.A. 1975); St. George v. State of New York, 127 N.Y.S.2d 147, 283 App. Div. 245, aff'd. 308 N.Y. 681, 124 N.E.2d 320; Homere v. State, 361 N.Y. Supp.2d 820 (1974); Cameron v. State, 322 N.Y.S.2d 562, 37 A.D.2d 46 (4th Dept. 1971); aff'd 30 N.Y.2d 596, 282 N.E.2d 118, 331 N.Y.S.2d 30 (1972). Amici have been unable to locate a single case in any jurisdiction holding that mental health care or social casework professionals have a duty to third parties to predict dangerous behavior of a patient/client or to hospitalize.

The issue of a duty on the part of a mental health care or social casework provider to take steps toward protecting a specific intended victim of a patient-client has been determined, insofar as amici have been able to ascertain, in only one case, Tarasoff v. Regents of University of California, 551 P.2d 334 (1976). In that case, as distinguished from this cause, the patient/client had expressed a direct intention to kill a specific person; the intended victim was identified by the patient/client to the mental health care provider. The court, interpreting a particular California Statute which exempts from a psychotherapist/patient privilege patient/client communications "if the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous . . . and disclosure of the

communication is necessary to prevent the threatened danger" (Evid. Code §1024), found that the care provider had a duty to warn her or to otherwise act to enable her to protect herself. There is no case to be found imposing upon mental health care or social work professionals a duty to the public at large or to unidentified possible victims.

A. MENTAL HEALTH AND SOCIAL WORK PROFESSIONALS CANNOT MAKE ACCURATE LONG-TERM PREDICTIONS OF VIOLENCE.

Plaintiffs posit that by reason of Drabing's statement that he "intended to kill rich people," defendants knew or should have known that Drabing would commit a dangerous criminal act. Plaintiffs obviously misconceive the skills of mental health care and social casework professionals in assuming that these professionals are in some way more qualified than the general public to predict future violent behavior of their patients/clients. Would but that this were so; crime statistics would drop dramatically! It is true that under certain circumstances, a mental health or social casework provider can diagnose an individual patient/client's condition as imminently explosive. Myriad research studies have established, however, that the fond hope of a general capability to accurately predict future violence is simply unfounded.

The American Psychiatric Association Task Force on Clinical Aspects of the Violent Individual states:

> Neither psychiatrists nor anyone else have reliably demonstrated an ability to predict future violence or "dangerousness." Neither

> has any special psychiatric "expertise" in this area been established. American Psychiatric Association Task Force Report 8, CLINICAL ASPECTS OF THE VIOLENT INDIVIDUAL (July, 1974), 28.

To the same effect, it was recently stated:

> [B]ecause some ex-patients are involved in murders, rapes and other violent crimes, we call upon psychiatrists to predict which ones will become violent. Unfortunately, the assumption that psychiatrists can accurately predict such behavior . . . lacks any empirical support. Rappaport presents the problem: "There are no articles that would assist us to any great extent in determining who might be dangerous. If the psychiatrist or any other behavioral scientist were asked to show proof of his predictive skills, objective data could not be offered." Steadman & Cocozza, Stimulus/Response: We Can't Predict Who Is Dangerous, 8 PSYCHOLOGY TODAY 32, 35 (January, 1975); emphasis added.

Other recent research reinforces the conclusion that therapists have no special expertise in the prognosis of violence. From an in-depth study of 256 cases of incompetent, indicted felony defendants for whom psychiatric determinations of dangerousness were necessitated by New York law, H. J. Steadman concluded:

> A question that might be raised at this point is whether our data can address the issue of the abilities of psychiatrists to make these predictions as to dangerousness. This question rests on the assumption that there are bases in psychiatric training, perspective, and skills that give psychiatrists a special ability to make such predictions. In the 256 cases studied here we have examined how the psychiatric prediction of dangerousness is actually being done. . . . There seemed to be little in the way of special abilities evident in these cases. It is our opinion that our data, together with a lack of documentation in the literature for

> psychiatric abilities to accurately predict dangerousness, seriously question any assumption that there is such a special psychiatric expertise. Steadman, Some Evidence on the Inadequacy of the Concept and Determination of Dangerousness in Law and Psychology, 1 JOURNAL OF PSYCHIATRY AND LAW 409, 421-2 (1973); emphasis added.

What these studies and numerous similar ones[1] show is that absent a prior history of violence, no therapist can accurately predict whether his patient is in fact dangerous or not. Plaintiffs' contention that defendant should have predicted Drabing's violent acts and should have warned his family or physician thereof conflicts with this growing body

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1/ See Ennis & Litwack, Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom, 62 CAL. L. REV. 693, 711-716 (1974) and authorities cited therein; Steadman, Follow-up on Baxstrom Patients Return to Hospitals for the Criminally Insane, 130 AM. J. PSYCHIATRY 317 (1973); Steadman & Cocozza, The Criminally Insane Patient: Who Gets Out? 8 SOCIAL PSYCHIATRY 230 (1973); Steadman and Keveles, The Community Adjustment and Criminal Activity of the Baxstrom Patient, 1966-70, 129 AM. J. PSYCHIATRY 304 (1972); Steadman & Halion, The Baxtrom Patient: Background and Outcome, Three Seminars in Psychiatry 376 (1971); Halden, David & Steadman, The Baxstrom Woman: A Four Year Follow-up of Behavior Patterns, 45 PSYCHIATRY Q. 518 (1971); Wenk, et al., Can Violence Be Predicted, 18 CRIME AND DELINQUENCY, 393 (1972); McGarry, The Fate of Psychiatric Offenders Returned for Trial, 127 AM J. PSYCHIATRY, 1131 (1971); Shah, Crime and Mental Illness: Some Problems in Defining and Labelling Deviant Behavior, 53 MENTAL HYGIENE 21 (1969); von Hirsch, Prediction of Criminal Conduct and Preventive Confinement of Convicted Persons, 21 BUFFALO L. REV. 717 (1971); Livermore, Malmquist & Meehl, On Justification for Civil Commitment, 117 U. PA. L. REV. 75; Rosen, Detection of Suicidal Patients: An Example of Some Limitations and the Prediction of Infrequent Events, 13 J. CONSULTING PSYCHOLOGY 397; Steadman & Cocozza, Careers of the Criminally Insane (Lexington Books, 1974); Rappaport, The Clinical Evolution of the Dangerousness of the Mentally Ill (Charles C. Thomas, Springfield, Ill., 1967); Rubin, Prediction of Dangerousness in Mentally Ill Criminals, 27 ARCH. GEN. PSYCHIATRY 397 (1972).

of scientific evidence. In the first place, plaintiffs assume that a mental health care or social work professional will be able to predict violence. In fact, the above-cited studies show that the reasonable mental health or social work professional acting in conformity with the present standards of his profession cannot make any reliable prediction as to the possibility of his patients'/clients' future violence in the absence of a history of prior violent behavior.

There is little, if anything, in the social work literature relating to prediction of dangerousness. The bulk of the research in the area is to be found in the psychiatric and psychology literature. All of the findings of scientific research are to the effect that no special professional ability or expertise has yet been demonstrated in the prognosis of dangerousness. Instead, the few studies which have been done "strongly suggest that psychiatrists are rather inaccurate predictors; inaccurate in an absolute sense, and even less accurate when compared with other professionals . . . and when compared to actuarial devices, such as prediction or experience tables." Dershowitz, The Law of Dangerousness, 23 J. LEGAL ED. 24, 46 (1970). See also Hakeem, Prediction of Parole Outcome from Summaries of Case Histories, 52 J. CRIM. L.C.&P.S. 145, 149-50 (1961); Morris, The Confusion of Confinement Syndrome, 17 BUFFALO L. REV. 651 (1968). As observed in Ennis & Litwack, Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom, 62 CAL. L.

REV. 693, 733 (1974):

> "Unlike the task of formulating a diagnosis psychiatrists are not even trained in the assessment or prediction of 'dangerousness'. . . . [T]raining and experience do not enable psychiatrists adequately to predict dangerous behavior."

B. THE NATURE OF PSYCHOTHERAPEUTIC COMMUNICATION IS SUCH THAT PATIENT/CLIENT STATEMENTS CONCERNING VIOLENT URGES OR WISHES RARELY INDICATE ANY ACTUAL DANGER OF VIOLENT ACTS: ACTION OUTSIDE THE THERAPY BY THE CARE PROVIDER BASED ON SUCH STATEMENTS WOULD BE CLINICALLY AND LEGALLY INAPPROPRIATE.

Plaintiffs state in their brief (at page 4) that "Drabing presented himself with symptoms of a serious mental illness and informed defendants that he 'intended to kill rich people.'" They conclude from this fact that "defendants recognized and accepted that Drabing . . . did intend to kill rich people" (page 5) and that plaintiffs' decedents (who fit the general description of "rich people") were therefore known by defendants to be in danger at Drabing's hands and that, to protect the decedents, they ought to have taken "action to require his hospitalization" and/or "relate the severity of the situation to his family physician" or his family (page 9).

Plaintiffs' contentions appear to be based on a concept that psychotherapeutic communication is composed of direct factual statements between the patient/client and his mental health or social casework professional upon which some prediction of future conduct might properly be based.

This notion in no way accurately describes the communications between psychotherapists and their patients/clients. As was observed by the California Supreme Court in In re Lifschutz (1970), 2 Cal.3d 415, 431, the psychotherapeutic relationship concerns itself at least as much with non-factual matters as with what may be termed "reality statements. Thus, the patient "lays bare his entire self, his dreams, his fantasies, his sins, and his shame."

While the ultimate aim of psychotherapy may, in some cases, be to enable the patient/client to better distinguish between fact and fantasy, the treatment itself, at least initially, accords equal and undifferentiated weight to each. To gain the patient/client's trust essential to treatment, the mental health care or social work professional must approach the patient/client's revelations as a form of communication, as an expression of trust or a testing of trust, not distinguishing between the factual and fantasy elements thereof. See Adler & Shapiro, Some Difficulties in the Treatment of Aggressive Acting-Out Patients, 27 Am. J. Psychotherapy 548 (1973); Halleck, PSYCHIATRY AND THE DILEMMA OF CRIME, 301-339 (Harper & Row , 1967).

The psychotherapeutic process requires a patient to disclose to his therapist his most intimate fears, emotions and fantasies. To enable the patient/client to discard the deep-seated conflicts which impair his functioning and limit his ability to work effectively and to enjoy fully satisfactory

relationships with other people, the patient/client is encouraged to abandon "rational thought," in a sense to regress to a state of what might be described as psychological infancy, and to express his most hidden, fearsome and embarrassing thoughts and feelings. Freud, The Interpretation of Dreams, in 4 STANDARD EDITION OF THE COMPLETE PSYCHOLOGICAL WORKS OF SIGMUND FREUD, (1958) 100-101. Frequently, these innermost thoughts are so painful, embarrassing, terrifying or shameful that the patient may never before have allowed himself to acknowledge them. Guttmacher and Werhofen, PSYCHIATRY AND THE LAW (1952).

The patient/client in treatment often expresses attitudes, wishes and intentions considered asocial in the community and totally at variance with his daily functioning personality. His free associations, fantasies as to what he has done or will do, and memories, are relevant to treatment but in the overwhelming majority of cases bear no relevance to actual reality. The material comes out of the unconscious layer of the mind, is often simply not germane to the patient/client's current activities, and has no predictive or evidentiary value whatever.

It would be grossly understating the case to say that a duty to hospitalize or to inform the family or physician of a patient/client who verbalizes anti-social ideas would impose upon mental health care and social work professionals a function disruptive to treatment. Murderous urges are

so frequently expressed in psychotherapy that any notion of hospitalizing or informing others when this phenomenon occurs is simply foolish. It would impose upon professionals an absurd requirement, irrelevant to treatment, to prematurely sort from numerous thoughts, feelings, fantasies and impulses revealed by very many patients/clients those very few on which a patient/client intended to act. See Ennis & Litwack, Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom, 62 CALIF. L. REV. 693, 733-4 n. 145 (1974).

Because psychotherapy does not and cannot properly involve such a fact-fantasy separation, action by a therapist based merely on such statements by a patient/client would be inappropriate in the psychotherapeutic context and would make proper treatment impossible. A duty on the mental health or social work professional to hospitalize or warn others of such communications by the patient/client would also interrupt the therapy by requiring the care provider to distance himself from the patient/client and the therapy. The most a care provider would be able to do under such a duty would be to make the statement that the patient/client has said he intended to perform a violent act. Such "tattling" behavior on the part of the care provider would be properly viewed by the patient/client as a rejection of him as a person and of the therapy, not to speak of a breach of the trust relationship on which it is based.

II.

THERE IS NO DUTY TO INVOLUNTARILY HOSPITALIZE A PATIENT/CLIENT.

Plaintiffs aver that defendants had a duty to "obtain the immediate hospitalization of Drabing" (brief, page 4) "pursuant to Ill. Rev. Stat., Chapter 91½, §6-1 et seq. and 7-1 et seq. The sections cited pertain to procedures prescribed by the Mental Health Code then in effect for admission of a patient to a mental hospital. Nowhere in these sections or elsewhere in the statutes or cases of this State is there articulated a duty on mental health care or social work professionals to hospitalize a patient/client.

A. HOSPITALIZATION IS BUT ONE OF MANY MODALITIES OF TREATMENT FOR MENTAL ILLNESS AND EMOTIONAL DISTURBANCE.

Even as there are many professional disciplines engaged in the delivery of care to persons who are mentally ill or emotionally disturbed, so are there myriad alternative modalities of treatment for those persons--all of which have their adherents and detractors, and none of which can offer any scientific claim that it is the one or only appropriate method. As stated by Miller, Dawson, Dix and Parnas in THE MENTAL HEALTH PROCESS (The Foundation Press, 1976), at page 49, "Full coverage of all or even most treatment techniques believed useful in dealing with mental illness would, in this context,

be both impossible and inappropriate." Among the modalities described and discussed are medication, pp. 50-60; electro-convulsive therapy, pp. 60-76; behavior modification programs, pp. 76-80; hospitalization, pp. 81-89; and treatment in the community as an alternative to hospitalization, pp. 89-98.

Sub-categories and combinations of these treatment alternatives abound. Choice of treatment alternative for a given patient-client will depend not only on clinical considerations relative to that individual but also on the educational and philosophical stance of the care provider. The condition of the patient/client at the moment will greatly influence treatment decisions. In describing treatment alternatives in its publication, CLINICAL ASPECTS OF THE VIOLENT INDIVIDUAL (July, 1974), the American Psychiatric Association Task Force considered the ramifications of acuteness:

> "Immediate Management
>
> "In the acutely agitated stage, the violent patient benefits from measures which restore a sense of mastery over impending loss of control of violent urges. . . . Verbal catharsis is important and medications such as phenothiazines or benzodiazepines may be offered the patient. [Lion, J. R., EVALUATION AND MANAGEMENT OF THE VIOLENT PATIENT. (Charles C. Thomas, 1972)] Hospitalization may also be offered certain patients who are afraid of becoming violent . . .
>
> "Continuing Treatment
>
> "In the non-acute stage, treatment is more diverse. A large literature exists on the various psychopathic, criminal and delinquent populations of patients. . . . Several reports have described individual psychotherapy with the violent patient or patients adjusted dangerous to society [Lion, The Role of Depression in the Treatment of Aggressive Personality Disorders,

> AM. J. of PSYCHIATRY 129:347-349 (1972); Tarachow, AN INTRODUCTION TO PSYCHOTHERAPY (International University Press, 1973) pp. 291-299; Carney, Three Important Factors in Psychotherapy with Criminal Patients, AM. J. of PSYCHOTHERAPY 27:220-231 (1973); Adler, Some Difficulties in the Treatment of the Aggressive Acting-Out Patient, AM. J. PSYCHOTHERAPY 27:548-556 (1973)], group psychotherapy with such patients [Lion & Bach-y-Rita, Group Psychotherapy with Violent Out-Patients, INT. J. OF GROUP PSYCHOTHERAPY 20: 185-191 (1970); Carney, Some Recurring Therapeutic Issues in Group Therapy with Criminal Patients, AM. J. of PSYCHOTHERAPY 26:34-41 (1972); Boriello, Patients with Acting Out Character Disorders, AM. J. of PSYCHOTHERAPY 27:4-14 (1973)], milieu approaches (Redl & Wineman, CONTROLS FROM WITHIN: TECHNIQUES FOR THE TREATMENT OF THE AGGRESSIVE CHILD (Free Press, 1952); Sturup, TREATING THE "UNTREATABLE," CHRONIC CRIMINALS AT HERSTEDVETER, [Johns Hopkins Press, 1968)], and behaviorally-oriented approaches designed to bring about more constructive and socially acceptable conduct [Mann & Moss, The Therapeutic Use of the Token Economy to Manage a Young and Assaultive Inpatient Population, J. of NERVOUS AND MENTAL DISEASE 157:1-9, 1973]."

While hospitalization of acutely ill mentally or emotionally disturbed patients/clients has been typical treatment in the past, that is no longer the case today. Hollingshead and Redlich, SOCIAL CLASS AND MENTAL ILLNESS (1958). It is suggested that any psychiatric hospitalization may have an adverse effect on a patient/client, Langsley & Kaplan, THE TREATMENT OF FAMILIES IN CRISIS (Grune & Stratton, 1968). Research indicates that a history of previous hospitalization heavily influences a subsequent decision to hospitalize, independent of the severity of an individual's current illness, and that, "[T]his observation is further evidence for the conclusion that to hospitalize a patient is a major

decision which forever after changes the attitude of both the patient and those who care for him." Mendel & Rapport, Determinants of the Decision for Psychiatric Hospitalization, ARCH. GEN. PSYCHIAT., 1969, 20, pp. 321-328, at p. 327. An excellent discussion of treatments alternative to hospitalization may be found in Stein & Test, ALTERNATIVES TO MENTAL HOSPITAL TREATMENT (Plenum Press, 1978).

B. WHERE THERE ARE RECOGNIZED ALTERNATIVE TREATMENT MODALITIES, A CLINICIAN MAY TREAT IN ACCORDANCE WITH ANY OF THESE

Plaintiffs base their claim against defendants on defendants' "failure" to utilize a specific treatment modality in treating Drabing. When clinical opinion is divided as to the proper treatment of a condition, where there are several alternative methods of treatment for a given problem, so long as treatment is in accord with a recognized system, it is not negligence to use it. Alternative Medical Procedures, 212 JAMA No. 2, p. 385, April 13, 1970. If a mental health care or social work professional can establish that the method of treatment he used is approved by at least a respectable minority of clinical opinion, no cause of action arises for failure to utilize some other modality. Bruce v. United States, 167 F. Supp. 579 (D. C. Cal., 1978); Kortus v. Jensen, 237 N.W.2d 845 (Neb., 1976). This is true even if hindsight would indicate that another method would have produced better results. Holder, MEDICAL MALPRACTICE LAW, 2d ed. (John

Wiley & Sons, 1978), p. 105. There simply is no cause of action for failure to use a specific treatment modality.

C. ONLY A VERY SMALL PERCENTAGE OF MENTAL PATIENTS (NOT TO SPEAK OF PERSONS NOT IN TREATMENT) COMMIT VIOLENT ACTS, ALTHOUGH MANY VERBALIZE THE DESIRE OR INTENT.

"Kill the umpire!" "I'm going to kill you a million times!" "You do that once more and I'll break your neck!" "Keep it up, and I swear, I'll kill you." "I hate him! I wish he were dead!" Indications of homicidal intent? These statements, and many in their genre, are uttered daily by persons more or less stable, healthy or mentally ill or emotionally disturbed. Whether such statements are to be considered genuine threats to individual or public safety will be determined by many factors, including the state of mind of the individual verbalizing them and the circumstances under which they were uttered. Should a witness to such an utterance be under a legal duty to "obtain immediate hospitalization" of the utterer, or to notify his family or physician of "the seriousness of his condition and the need for hospitalization?"

Statements of intent to kill, verbalizations of fantasies of mayhem, expressions of violent urges are the stuff of which psychotherapeutic communications are made. Many persons in treatment for mental illness or emotional problems produce such verbalizations in the context of the treatment session. Very, very few ever act on them. J. C. Nunnally, in POPULAR CONCEPTIONS OF MENTAL HEALTH (Holt,

Rinehart and Winston, 1961) points out that the public equates mental illness with dangerousness. Research concludes, however, that the base rate of violent behavior (except for suicide) by persons labeled mentally ill is no greater than that of the general public. Gulevich & Bourne, Mental Illness and Violence, in D. Daniels, M. Gilula, & F. Ochberg, VIOLENCE AND THE STRUGGLE FOR EXISTENCE (Little, Brown, 1970), p. 390.

Alan A. Stone, M.D., in his excellent volume, MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION (Jason Aronson, Inc., 1976), pp. 25-37, reviews the research on dangerousness of the mentally ill and conclusions to be drawn from it. There are few statistics as to what percentage of persons who threaten violence actually commit murder. One reported study of one hundred such persons who were followed for five to six years revealed that three of them actually murdered. Macdonald, HOMICIDAL THREATS (Charles C. Thomas, 1968). Mental health care and social work professionals must plan and choose treatment for their patients/clients based on clinical criteria. It is not in the interests of patients/clients or the community that artificial criteria based on unfounded prejudice and misconception determine the choice of treatment modality.

D. PUBLIC POLICY, STATUTORY AND CASE LAW FAVOR TREATMENT OF THE MENTALLY ILL AND EMOTIONALLY DISTURBED IN THE COMMUNITY, RATHER THAN IN A HOSPITAL.

During the early days of mental health care delivery,

the state of the art was such that a seriously mentally ill or emotionally disturbed person often could not be cared for at home or in the community. Treatment methods were primitive, at best, and in most instances of psychosis, little more than custodial care was available either for the benefit of the patient/client or the protection of the community. In the past two decades, however, a combination of elements has occurred which has wrought drastic change in the medical, legal and lay attitudes toward treatment of the mentally ill and emotionally disturbed.

Great technological advances in treatment have revolutionized the medical treatment of these patients/clients. The discovery of psychoactive medications has made possible the mitigation of psychosis so that persons who were formerly consigned to life in the back wards of asylums could be discharged from the hospital and maintained in the community. As the mental health and social work professions gained greater insight into the realities of human development and psychology, research has yielded ingenious and skillful systems of psychotherapy, making it possible to treat persons suffering from conditions formerly thought untreatable.

Meanwhile, as treatment possibilities outside of institutions have proliferated, disenchantment with mental institutions has increased. During the period following World War II, descriptive and empirical evidence of the possible debilitating effects of institutionalization indicated at least two areas

of concern: (1) an "institutional syndrome" whereby a patient/client who remains hospitalized for a long time acquires characteristics markedly unadaptive for future community living; and (2) the mere admission to a mental hospital appears to stigmatize the patient/client, adversely altering his opportunity for community adjustment (particularly as to employment opportunities), and his chances for a disposition other than hospitalization upon recurrence of serious problems. Stein & Test, ALTERNATIVES TO MENTAL HOSPITALIZATION (Plenum Press, 1978), pp. 3-4.

The decade of the sixties brought with it increased political and legal activity in the arena of individual rights. In this era was born the concept of mental health law, patients' rights, clients' rights, welfare rights--in fact an explosion in the field of constitutional law as questions as to the nature and limitations of the parens patriae and police power doctrines were explored. Cases dealing with the right of the state to involuntarily hospitalize, e.g. Lessard v. Schmidt, 349 F. Supp. 1078 (E. D. Wisc. 1972), vacated on other grounds, 414 U.S. 473 (1974), on remand, 379 F. Supp. 1376 (E. D. Wisc. 1974), vacated on other grounds, 44 L.Ed.2d 445 (1975); and the right to treatment, O'Connor v. Donaldson, 422 U.S. 563, 95 S. Ct. 2486, 24 L.Ed.2d 396 (1975), began to articulate policy to the effect that involuntary hospitalization is permissible only when a patient/client is mentally ill and dangerous to

himself or others, or mentally ill and unable therefore to provide for his basic needs. The involuntarily hospitalized patient cannot be kept in confinement without treatment, and has a right to the least restrictive conditions necessary to achieve the purposes of commitment. Wyatt v. Stickney, 344 F. Supp. 373, aff'd., 503 F.2d 1305 (5th Cir. 1974). In Lake v. Cameron, 124 U.S. App. D.C. 264, 364 F.2d 657, cert. den. 382 U.S. 863, 86 S. Ct. 126, 15 L.Ed.2d 100, the trial court was instructed to explore treatment alternatives which would impose "[d]eprivations of liberty . . . not . . . beyond what is necessary . . . ." The court in Dixon v. Weinberger, 405 F. Supp. 974 (D.D.C. 1975) ordered the District of Columbia to create a series of alternative treatment settings so that persons who required treatment in a setting less restrictive than a hospital could be appropriately served.

Robert Reich, M.D., and Lloyd Siegel, M.D., in their article The Chronically Mentally Ill Shuffle to Oblivion, in PSYCHIATRISTS AND THE LEGAL PROCESS: DIAGNOSIS AND DEBATE, Bonnie, Ed. (Insight Communications, 1977), at pp. 264-265 describe the resulting trend to deinstitutionalization and treatment of the mentally ill and emotionally disturbed:

> " . . . Due to years of starvation financing, the state hospitals by and large were unable to provide their patients with currently acceptable or adequate standards of psychiatric care. . . .
>
> "The states, under court pressure to upgrade facilities, faced a dilemma. . . . At a time when state budgets were tightly squeezed

> and increased taxation was politically unpalatable, the millions of dollars necessary for improved psychiatric services to the chronically mentally ill and retarded were simply unavailable. Another means of caring for chronically mentally dysfunctional patients would have to be found.
>
> "Simultaneously, many in the psychiatric profession felt that the day of the large mental hospital, cold, impersonal and isolated, should be ended. . . ."

The notion of "least restrictive alternative" had become a by-word in Illinois by the early seventies. In 1973, the Governor's Commission to Revise the Mental Health Code was established. Meetings and hearings were held throughout the State for a period of some three years before its Report of the Commission was issued in 1976. The Report promulgated the concept as public policy in no uncertain terms. REPORT, GOVERNOR'S COMMISSION FOR REVISION OF THE MENTAL HEALTH CODE OF ILLINOIS, 1976, pp. 22-23 and 63. Mental Health care and social work professionals had been indoctrinated with this concept at least as early as 1974, when Wyatt v. Stickney, 344 F. Supp. 373, aff'd., 503 F.2d 1305 (5th Cir. 1974) was decided and much publicized. The hearings and meetings of the Commission did much to spread the word, so that the standard of practice in Illinois at the time of the occurrences complained of had already integrated the least restrictive alternative as a criterion for treatment planning. (The public policy was enacted into law in the new Mental Health Code of Illinois (Ch. 91½ Ill. Rev. Stat., 1978).)

Far from having a duty to hospitalize, mental health and social work professionals had and have a legal duty to treat in accordance with the least restrictive alternative, with treatment in the community favored.

III.

IT IS NOT POSSIBLE FOR MENTAL HEALTH CARE AND SOCIAL CASEWORK AGENCIES OR PROFESSIONALS TO CONTROL THE BEHAVIOR OF THEIR PATIENTS/CLIENTS; NEITHER THE RULE OF REASON NOR THE LAW IMPOSE UPON THEM ANY DUTY TO UNIDENTIFIED POTENTIAL THIRD-PARTY VICTIMS OF A PATIENT/CLIENT TO PREVENT DANGEROUS CRIMINAL ACTS.

Plaintiffs seek to impose on mental health care and social casework agencies and professionals who are the recipients of communications from a patient/client indicating dangerous or unwholesome fantasies, wishes or thoughts a duty to unidentified persons who might be in the class of possible victims of the patient/client to stop him from behaving dangerously. Plaintiffs suggest two means of accomplishing this control: (1) what would be essentially preventive detention, and (2) disclosure of the patient/client's communications to members of his family or his physician.

It may be fair to assume that detention of a patient/client in a secure setting from which it would be difficult to leave might accomplish this. Obtaining this detention

through law enforcement channels when the individual has not committed a crime is, of course, impossible! Obtaining involuntary hospitalization, on the other hand, is far from simple or routine. Commitment proceedings must be based on a diagnosis of mental illness plus dangerousness or helplessness, and the mental health care or social work professional who testifies to the need for hospitalization must present clear and convincing evidence to ~~do~~ this effect. (Indeed, many mental health professionals decry this position, asserting that dangerousness is irrelevant and involuntary hospitalization should be based solely on a need for treatment. See Treffert, The Practical Limit of Patients' Rights, PSYCHIATRISTS AND THE LEGAL PROCESS: DIAGNOSIS & DEBATE, Bonnie ed., 227-230 (Insight Communications) 1977, reprinted from 5 PSYCHIATRIC ANNALS 4 (April, 1975).) The responsible, honest mental health or social work professional is in no position to meet the mandated burden of proof in a case in which there has been no violent act by the patient/client nor other diagnostic indicators of an acute state of agitation and imminent loss of impulse control, but only communications which the clinician knows bear little or no relevance to the actual behavior of the patient/client in the overwhelming majority of cases.

To require of a mental health or social work professional that he vainly institute steps toward involuntary hospitalization which are highly unlikely of success by reason of the absence of legal and clinical criteria for such action

is manifestly untenable. Such an effort on the part of the professional would not only expose the professional to the possibility of a lawsuit by the patient/client but would also irretrievably rupture the therapeutic bond, rendering further therapeutic help to the patient/client impossible. A well recognized prerequisite for effective treatment of mentally ill or emotionally disturbed persons is a relationship of trust between the care provider and the patient/client. This trust is particularly crucial for patients/clients fantasizing about or threatening violence. Such persons generally exhibit paranoid tendencies (feelings of persecution), but wish, by revealing the threats of violence, to have the care provider help them master the violent urges they feel. If the care provider is not trusted, the violent potential will not be revealed, nor treatment proceed. Adler & Shapiro, Some Difficulties in the Treatment of the Aggressive Acting-Out Patient, 27 AM. J. PSYCHOTHERAPY 548 (1972); Halleck, PSYCHIATRY AND THE DILEMMA OF CRIME, 301-339 (Harper & Row), 1967.

Plaintiffs' suggestion that defendants owed a duty to the decedents to inform Drabing's family or physician of his condition must be met with the same argument. Even had they done so, by what logic can it be assumed that the family or physician would have instituted commitment proceedings, or that--if they had--the proceedings would have actually resulted in Drabing's hospitalization? The most likely result of such a disclosure would have been to cause Drabing to

terminate the treatment. Adler & Shapiro, supra. Further, there is strong support for the theory that such action on the part of the care provider might itself trigger the violent behavior by way of a self-fulfilling prophecy. When a mental health or social work professional is compelled to presume and act on a presumption that his patient/client will become violent, the professional's action will, of necessity, betray that presumption to the patient/client. Because of the nature of the psychotherapeutic relationship, a suggestion by the care provider that the patient/client is unable to control his violent impulses may alter the balance of the patient/client's psychological forces and remove the constraints which previously kept the patient/client from acting out his violent urges. See Lion, EVALUATION AND MANAGEMENT OF THE VIOLENT PATIENT (Charles C. Thomas) 1972.

The practical problems of imposing upon mental health care and social casework agencies and professionals a duty to protect unidentified potential victims of a patient/client defy description in terms of what may be implemented in the day-to-day practice of mental health care and social casework. Surely it cannot be reasonably suggested that a mental health care or social work professional divide his concentration while engaged in treatment of his patient/client to play probability games or engage in law enforcement activities. The rule of reason requires that the care provider, when confronted with a fragile patient/client

concentrate his efforts and skills in engaging that individual in the treatment process and sustaining him in it.

> "The importance of sustained professional contacts with such . . . persons even during periods of apparent conformity and adequacy is stressed as a means of helping the inadequate, oversensitive, and overdoubting individual to maintain at least one area of interpersonal relationship where there is sufficient freedom to express and share his doubts about his existence. . . .[T]he psychodynamic pattern of the kind of persons described in this study is such that without such efforts--they are very likely to end as "sudden murderers." Blackman, The Sudden Murderer, 8 ARCH. GEN. PSYCHIATRY 289 (1963).

IV.

MENTAL HEALTH CARE AND SOCIAL WORK PROFESSIONALS HAVE A LEGAL DUTY TO MAINTAIN THE CONFIDENTIALITY OF THEIR PATIENTS/CLIENTS.

The nature of the relationship between mental health and social worker professionals and their patients/clients is, in substance, one of the most profound fiduciary responsibility. It involves a mutual sharing of the deepest feeling and awareness, based in the assured trust of the patient/client in the care, skill and loyalty of the care provider to his emotional well being. Courts have found a fiduciary relationship where power or control has been vested in another and an expectation of trust and confidence induced or reposed as a function of the particular nature of the relationship. The essence of trust in the relationship of mental health

or social work professional and patient/client lies in the legal and ethical obligation of the professional to maintain the confidentiality of his patient/client. Dawidoff, THE MALPRACTICE OF PSYCHIATRISTS, 43-48 (Charles C. Thomas, 1973.

The court in Alexander v. Knight, 197 Pa. Super. 79, 177 A.2d 142 (1962), stated:

> "We are of the opinion that members of a profession, especially the medical profession, stand in a confidential or fiduciary capacity as to their patients. . . ."

(The court speaks to the relationship of physician to patient; it is inarguable that the concept applies to all mental health and social work professionals, whose relationships with their patients/clients are of the same care provider/care recipient essence and equally require trust as a basis.)

In Hammonds v. Aetna Casualty and Surety Company, 243 F. Supp. 793 (N.D. Ohio 1965), it was held:

> "[T]he physician-patient [relationship] is a confidential one which imposes fiduciary obligations upon the physician. . . . [T]he patient necessarily reposes a great deal of trust not only in the skill of the physician but in his discretion as well. The introduction into the relationship of this aura of trust, and the expectation of confidentiality which results therefrom, imposes the fiduciary obligations upon the doctor . . . ."

A. COMMON LAW IMPOSES ON MENTAL HEALTH AND SOCIAL WORK PROFESSIONALS A DUTY TO MAINTAIN CONFIDENTIALITY, BREACH OF WHICH WOULD EXPOSE THE PROFESSIONAL TO ACTION FOR BREACH OF CONFIDENTIALITY AND DEFAMATION.

The fiduciary nature of the care provider-patient/client

relationship imposes on the professional a duty to maintain confidentiality, breach of which is actionable. See Boyd v. Wynn, 150 S.W.2d 648 (Ky. 1941), and New York v. Leyra, 98 N.E.2d 553, rev'd. 347 U.S. 556 (1951). An example of the lengths to which courts have gone in enforcing the duty of confidentiality is Berry v. Maench, 331 P.2d 719 (Utah, 1973), in which a psychiatrist was held liable for libel by reason of his having inappropriately disclosed information about a patient. The court held that although truth is ordinarily a defense to a charge of libel, a care provider may be held liable for disclosure of confidential information about his patient/client even if it is true. See also Holder, MEDICAL MALPRACTICE LAW, 2d ed., 270-281 (John Wiley & Sons, Inc., 1978); Slovenko, PSYCHIATRY AND LAW, 434-456 (Little, Brown and Company, 1973); and Wilson, CONFIDENTIALITY IN SOCIAL WORK (The Free Press, 1978).

B. INHERENT IN THE CONTRACT BETWEEN CARE PROVIDER AND PATIENT/CLIENT FOR DELIVERY OF MENTAL HEALTH OR SOCIAL CASEWORK SERVICES IS AN IMPLIED WARRANTY OF CONFIDENTIALITY, BREACH OF WHICH WOULD EXPOSE THE PROFESSIONAL TO AN ACTION FOR BREACH OF CONTRACT.

The court in Doe v. Roe, 345 N.Y.S.2d 560, aff'd. 33 N.Y.2d 902, 352 N.Y.S.2d 626, 307 N.E.2d 823, 20 A.L.R.3d 1109, discussed the matter of the implied warranty of confidentiality in the psychotherapeutic relationship:

> "I, too, find that a physician who enters into an agreement with a patient to provide medical attention impliedly covenants to keep in confidence all disclosures made by the patient concerning the patient's physical and mental condition as well as all matters discovered by the physician in the course of examination or treatment. This is particularly true of the psychotherapeutic relationship for in the dynamics of psychotherapy '[t]he patient is called upon to discuss . . . all manner of socially unacceptable instincts and urges. . . .'"

As a fiduciary the mental health care or social work professional is required to "act in good faith for the utmost benefit of his patient." Dawidoff, THE MALPRACTICE OF PSYCHIATRISTS. (Charles C. Thomas, 1973). Pressure to choose between the potential risk of a lawsuit by some possible unknown third party victim and the actual breach of the contractual duty to maintain confidentiality (which is, of course, also actionable!) infringes grossly on the fiduciary capacity of the care provider. From any perspective, plaintiffs' position translates either to "Care provider; choose who is to sue you" or "Whose interests do you protect--the patient/client's (by following your clinical judgment) or your own (by acting not in response to the patient/client's clinical needs but to minimize the chances of a lawsuit against you)?"

C. COMMON LAW AND CONSTITUTIONAL PRINCIPLES GUARANTEE A RIGHT OF PRIVACY TO PATIENTS/ CLIENTS OF MENTAL HEALTH AND SOCIAL WORK PROFESSIONALS

It requires little argument to demonstrate the

proposition that the confidentiality of psychotherapeutic communications has constitutional underpinnings. A Constitutional "right of personal privacy, or a guarantee of certain areas or zones of privacy does exist" which protects intimate personal activities. Compelled disclosure of patient/client communications and care providers' speculations arising therefrom violates this constitutional right of personal privacy. Roe v. Wade, 410 U.S. 113, 153 (1973), and cases cited therein. As noted elsewhere herein, communications between a patient/client and his mental health care or social work professional commonly involve the most intimate personal facts. Indeed, the very fact of being in treatment is an intimate detail of one's life which patients/clients frequently are loath to disclose, even to their families and medical care providers.

In the case of In re Lifschutz, 467 P.2d 557 (1970) at 567, the California Supreme Court unanimously stated:

> "We believe that a patient's interest in keeping such confidential revelations [as are disclosed in psychotherapy] from public purview, in retaining this substantial privacy, has deeper roots than the California statute and draws sustenance from our constitutional heritage. In Griswold v. Connecticut, supra, 381 U.S. 479, 484, the United States Supreme Court declared that 'Various guarantees [of the Bill of Rights] create zones of privacy,' and we believe that the confidentiality of the psychotherapeutic session falls within one such zone. (CF. People v. Belous (1969) 71 Cal.2d 954, 963). Although Griswold itself involved only the marital relationship, the open-ended quality of that decision's rationale evidences its far-reaching dimension." 467 P.2d at 567.

In the case of Caesar v. Mountanos, 542 F.2d 1064 (1976), at 1066, a confidentiality case, the Court stated, "We have no doubt that the right of privacy relied on by Dr. Caesar is substantial." Likewise, the dissenting judge explicitly found that confidential psychotherapeutic communications "have the indicia to place those communications squarely within the constitutional right of privacy." 542 F.2d at 1071.

In Hague v. Williams, the Supreme Court of New Jersey held that "a patient should be entitled to fully disclose his symptoms and conditions to his doctor in order to receive proper treatment without fear that those facts may become public property." 37 N.J. 328, 181 A.2d 345, Sup. Ct. N.J. 1962, at 349.

The right to privacy belongs to every individual. It takes several forms, of which "the right to have one's private facts kept private" is one. Louis Brandeis and his law partner, Samuel Warren, in 1890, enunciated the general concept of an individual's right to privacy in the conduct and affairs of his life, free from unsolicited or unwarranted intrusion. Note, "Medical Jurisprudence - Privileged Communications between Physician and Patient - State Regulation and the Right to Privacy," 39 TENN. L. REV. 515 at 517 (1972); Warren and Brandeis, "The Right to Privacy," 4 HARV. L. REV. 195 (1890). Elucidating the concept as it relates to patients' rights, Perr states, "Release of or communication of confidential

information without permission involves unauthorized disclosure and is therefore a breach of the right to privacy." Perr, "Problems of Confidentiality and Privileged Communications in Psychiatry," 1971 LEGAL MED. ANL. 327 at 335 (C. Wecht, ed.).

Another aspect of the right to privacy is the right to be free of invasion of one's body by unwanted forms of clinical treatment. Winters v. Miller, 446 F.2d 65 (2d Cir. 1970), cert. den. 404 U.S. 985 (1971); Nelson v. Heyne, 491 F.2d 352 (7th Cir. 1974); Scott v. Plante, 44 L.W. 2430 (3rd Cir., March 29, 1976); Knecht v. Gillman, 488 F.2d 1136 (8th Cir. 1973). See also Schwartz, In the Name of Treatment: Autonomy, Civil Commitment and Right to Refuse Treatment, 50 NOTRE DAME LAWYER 803 (1975), and Wexler, Mental Health Law and the Movement Toward Voluntary Treatment, 62 CAL. L. REV. 671, 677 (1974).

The Supreme Court of this land has iterated and reiterated that the sensitive zone of personal privacy is protected as a "fundamental" constitutional right. E.G., Planned Parenthood Association v. Danforth, 428 U.S. 52 (1976); Roe v. Wade, 410 U.S. 113 at 156 (and cases cited therein), 163, 164. See also Friendship Medical Ctr. Ltd. v. Chicago Board of Health, 505 F.2d 1141 (7th Cir. 1974); Roe v. Ingraham, 403 F. Supp. 931 (S.D.N.Y. 1975); Whalen v. Roe, 429 U.S. 589, 97 S. Ct. 869 (1977); Doe v. Roe, N.Y.L. Jrl. November 25, 1977, at page 13; and Yoder v. Wisconsin, 406 U.S. 205 (1973).

As the Court said in Roe v. Wade, supra, in determining under what conditions personal privacy must take second place to other, more compelling interests, the appropriate test is not a simple balancing of the individual's right against the state's interest in regulation. Rather,

> "regulation limiting these rights may be justified only by a 'compelling state interest', [citations omitted] and . . . legislative enactments must be narrowly drawn to express only the legitimate state interests at stake." 410 U.S. at 156.

The state certainly has a compelling interest in protecting the public safety. The demands made by plaintiffs upon mental health care providers, although they would certainly result in invasion of privacy for innumerable patients/clients,can hardly be seen as likely of success in protecting the public safety. On the contrary, adherence to plaintiffs' demands would decrease the capability of the mental health and social work professions to contribute toward that compelling end.

Failure to guarantee and enforce strict protection for confidentiality of mental health or social casework treatment data would have two pernicious effects. First, it would deter patients who are in need of treatment from seeking it out in the first place, or from being sufficiently candid to allow for effective treatment. Second, disclosure would have a devastating effect on the course of treatment in progress for any patient/client whose care provider is compelled to make public one of his most intimate secrets--that he

receiving mental health or social casework services, much less the sensitive content of that treatment. See, e.g., Katz, Goldstein and Derschowitz, PSYCHOTHERAPY, PSYCHOANALYSIS AND THE LAW, 726-27 (1967). It should be specifically noted, in the context of this case, that patients/clients are often as or more sensitive about having their confidential communications disclosed to members of their family and close associates than they might be if the information was conveyed to strangers.

D. STATUTES OF THE STATE OF ILLINOIS PROHIBIT DISCLOSURES BY MENTAL HEALTH AND SOCIAL WORK PROFESSIONALS OF CONFIDENTIAL COMMUNICATIONS PATIENTS/CLIENTS; THE STATUTES REFLECT THE PUBLIC POLICY OF THIS STATE.

A sophisticated and knowledgeable legislature in Illinois has expressed the long-standing public policy of this State that communications disclosed in the course of mental health or social work treatment are confidential. For two interesting and thoughtful commentaries on the Illinois view of psychotherapeutic confidentiality, see Beigler, The 1971 Amendment of the Illinois State on Confidentiality: A New Development in Privilege Law, 129:3 AM. J. PSYCHIATRY 87 (1972), and Foster, Illinois: A Pioneer in the Law of Mental Health Privileged Communication, 62 ILL. B. J. 668 (Aug., 1974). At the time this cause of action arose, there were several statutory strictures against disclosure. Section 5320 of the Social Worker's Registration Act (Ch. 111, §5320, Ill. Rev. Stat.) and Section 406 of the Psychologist's Registration Act (Ch. 111, §406, Ill. Rev. Stat.) both directly prohibited disclosures by these professionals of any information acquired from a patient/client with certain exceptions,

and contained criminal sactions for violation. Neither contained an exception to the prohibition to permit, much less direct, the professional to notify anyone as to statements by the patient/client relative to dangerous wishes or intentions.

Section 5.2 of the Evidence Code (Ch. 51, §5.2, Ill. Rev. Stat.) created a communications privilege for communications between a patient and psychiatrist. Although the act contained a limited patient-litigant exception to the privilege, no exception was provided for dangerous or criminal acts of the patient/client.

Mental health care and social work agencies and professionals had long been concerned about the limitations imposed upon them by these statutes in providing optional care of patients/clients and offering at least some effort toward protection of others in the few cases in which a patient/client was in a condition of acute agitation and the assistance of family or others was required. They were, in fact, instrumental in the passage of the Mental Health and Developmental Disabilities Confidentiality Act which took effect on January 1, 1979. The act permits (note: it does not mandate) a care provider, in his sole discretion, to disclose confidential information "to protect the recipient or other person against a clear, imminent risk of serious physical or mental injury or disease or death being inflicted upon the recipient, or by the recipient on himself or another. . . ." (Ch. 91½, §811, Ill. Rev. Stat. 1979). It may be deemed unfortunate that the defendants in this cause

did not have the statutory authority to breach Drabing's confidentiality at the time the cause arose. Whether they would have deemed it, in their discretion, appropriate is a moot point, as is any speculation as to whether such action would have averted the tragedy which occurred. The law at that time simply did not permit it. To charge defendants with negligence because they did not disobey the law is palpably absurd.

V.

IT IS THE PUBLIC POLICY OF THE STATE OF ILLIOIS TO ELIMINATE BARRIERS AND ENCOURAGE ACCESS TO AND UTILIZATION OF MENTAL HEALTH AND SOCIAL CASEWORK SERVICES IN THE INTERESTS OF PROTECTING THE INDIVIDUAL HUMAN RESOURCES AND COLLECTIVE SAFETY OF THE COMMUNITY.

Mental illness is a major social and economic problem in the United States. It has been estimated that at any one time, between 20 and 32 million Americans need some form of mental health services. "The current direct cost of providing mental health services is about $17 billion a year. The social cost, when measured in terms of lost wages and shortened life span, is estimated to be another $20 billion." PRELIMINARY REPORT TO THE PRESIDENT FROM THE PRESIDENT'S COMMISSION ON MENTAL HEALTH," September 1, 1977 at page 4. As a matter of public policy, as well as humanitarian desire,

it is urgent that mentally ill persons be encouraged to seek treatment they require to enable them to function in and contribute to society. This country cannot afford the economic and social cost of untreated mental illness. The President's Commission, at page 23, reports:

> " . . . The stigma of mental illness, however, is so pervasive in our society that many who need help do not seek it. The misunderstanding and fear surrounding mental and emotional problems are so great that there is insufficient public support for needed services and further research.
>
> "In many ways, this is surprising. Almost all Americans are touched by these problems, either themselves or in their families or among their neighbors and friends. Nevertheless, this stigma and the fears exist, and they are deeply engrained in our society. Unless we deal constructively with these problems, future progress will be slowed and those currently underserved are likely to remain underserved."

The stigma of mental illness carries with it grave and unfortunate consequences for its sufferers. "Mental patients appear to have taken the place of lepers as the targets of public dislike and rejection." Nunnally, POPULAR CONCEPTIONS OF MENTAL HEALTH, (Holt, Rinehart and Winston, 1961); Rabkin, Opinions about Mental Illness: A Review of the Literature, 77 PSYCHOL. BULL. 153 (1972). As a result, they are discriminated against to the degree that many who need treatment fear and avoid it.

Plaintiffs suggest a course of conduct for mental health and social work agencies which would require them to behave in a manner highly contraindicated clinically: to seek involuntary hospitalization for or divulge confidences

of any patients/clients who expressed dangerous urges. If plaintiffs' demands were met, patients/clients, who are already hesitant because of embarrassment and fear of the consequences of seeking treatment, would be further discouraged, to say the least.

There is a compelling state interest in encouraging persons needing mental health and social casework services to obtain these. For those few persons who <u>are</u> mentally ill and dangerous, access to treatment is probably the best protection on which the public may be able to count. It is the public policy of the State of Illinois to create a climiate in which access to mental health and social work care is enhanced. Patients/clients must be able to look to their care providers with confidence and hope, not uncertainty and fear of betrayal. The treatment plan is appropriately left to the treating professional, not prescribed by lay persons based on a panic response to an unfounded stereotype.

Public policy demands that the law enable the mental health and social work professional maximum opportunity to deliver services to mentally ill or emotionally disturbed persons. This requires a climate in which the patient/client may be assured of privacy and confidentiality and not subjected to fear of disclosure and stigmatization. It requires that treatment be provided in accordance with the patient/client's clinical needs, in the least restrictive manner consistent with patient/client care and the protection of the community.

CONCLUSION

For the reasons herein presented, amici curiae respectfully urge that the order of the trial court dismissing the plaintiffs' amended complaint, with prejudice, be affirmed.

Respectfully submitted,

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