The Tarasoff Pendulum Swings Back: Expansion of Washington State Psychiatrists' Duties to Protect Third Parties

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In *Volk v. DeMeerleer*[1], in a 6-3 decision the Supreme Court of the State of Washington significantly expanded the duty of outpatient psychiatrists towards third parties whom their outpatients might harm, even if the outpatient made no threat to a specified potential victim. The APA's Committee on Judicial Action had helped draft an unsuccessful amicus brief written by the Washington State District Branch and other medical societies in support of limiting such a duty. This case essentially creates a strict liability standard for Washington State psychiatrists whose patients harm third parties

DeMeerleer had begun treatment with psychiatrist Dr. Howard Ashby in September 2001. At Dr. Ashby's initial evaluation he diagnosed DeMeerleer with bipolar disorder and prescribed Depakote. DeMeerleer provided a written list of bothersome experiences including "delusional and psychotic beliefs," as well as other beliefs indicating a lack of remorse for others. DeMeerleer's wife provided written documentation of DeMeerleer's dangerous rages as well as his dreams of going on killing sprees.

In 2003 DeMeerleer found out his wife was having an affair. She divorced him soon after. DeMeerleer reported suicidal ideations as well as homicidal thoughts towards his wife, but assured Dr. Ashby that he would not act on them, and he did not. DeMeerleer told Dr. Ashby about "revenge thoughts and fantasies," but did not report an identifiable victim. Dr. Ashby continued medication and psychotherapy.

In 2005 DeMeerleer began a new relationship with Rebecca Schiering, the mother of three sons. During that year DeMeerleer exhibited volatile behavior, and took firearms to the location of where his truck had been vandalized. DeMeerleer's family intervened, removed the guns from DeMeerleer's house and then informed Dr. Ashby the DeMeerleer's thoughts had "progressed from suicidal to homicidal."

DeMeerleer's relationship with Schiering progressed. In 2009 Schiering became pregnant with DeMeerleer's child. However during the pregnancy DeMeerleer lost his job and assaulted Schiering's nine year old autistic son. Schiering moved out and terminated the pregnancy. DeMeerleer contacted Dr. Ashby's clinic in "serious distress" and was referred to a community mental health clinic (the opinion does not make it clear whether DeMeerleer was in treatment with Dr. Ashby from 2005 until 2009, nor on what date DeMeerleer restarted treatment with Dr. Ashby.

In April 2010 DeMeerleer had his last visit with Dr. Ashby. According Dr. Ashby's note from that meeting:

> Jan indicates that his life is stable, he is reconstituting gradually with his fiance[e]. They are taking marriage classes, he can still cycle many weeks at a time. Right now he is in an expansive, hypomanic mood, but sleep is preserved. He has a bit more energy and on mental status, this shows through as he is a bit loquacious but logical, goal oriented and insight and judgment are intact. He states when depressed he can get intrusive suicidal ideation, not that he would act on it but it bothers him. At this point it's not a real clinical problem but we will keep an eye on it. Plan: We will continue Risperdal, Depakote and [bupropion].

Later DeMeerleer and Schiering mended their relationship when DeMeerleer's mental condition had improved. They ceased their relationship for good on July 16, 2010. There was no subsequent contact with Dr. Ashby.

On July 17, 2010 DeMeerleer entered the Schiering's home and killed Schiering and one of her sons. Another son escaped. DeMeerleer committed suicide.

Schiering's mother and surviving son sued Dr. Ashby, alleging failure to follow the standard of care. Ashby denied any failure of the standard of care and moved for summary judgment because DeMeerleer's behavior was not foreseeable, and because Dr. Ashby did not owe DeMeerleer's victims a duty of care. Ashby argued that there could be no foreseeability without actual threats by DeMeerleer towards the victims, and that no such threats had been made at any time during treatment. Ashby further argued that the only available actions that he might have taken were to seek civil commitment or warn any potential victims or the authorities of DeMeerleer's potential danger to others. Ashby claimed immunity for failure to hospitalize or to warn under a Washington State statute. Ashby filed supporting affidavits from DeMeerleer's family members and friends attesting that DeMeerleer had had no unusual behaviors and had made no threats around the time of the homicides/suicide. However Ashby did not provide an expert psychiatric report about the standard of care.

In response, the Plaintiffs argued that under *Petersen v. State*[2], once a special relationship existed between a mental health professional and his patient, the mental health professional owed a duty of reasonable care to any foreseeable victim of the patient. Plaintiffs argued that Dr. Ashby breached the duty owed by failing to perform a risk assessment on DeMeerleer and failing to provide

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intensive psychiatric treatment for DeMeerleer with more frequent clinic visits. Their theory was supported by an affidavit from a forensic psychiatrist, who also opined that Dr. Ashby's failures were a, "causal and substantial factor" in causing the harm to occur.

The trial court granted Dr. Ashby summary judgment, finding that there was no data indicating that DeMeerleer had made threats towards Schiering or her sons, and that therefore Ashby had no duty to warn Schiering.

Volk appealed to Washington's Appellate Court. Volk argued that Petersen did not require actual threats towards a specific victim before a duty could be imposed on a psychiatrist. Asbury argued in part that the Washington State legislature settled the public policy in 1987 when it adopted RCW 71.05.120(2) that limited the duty owed by mental health professionals to third parties only to those reasonably identifiable persons actually threatened by a patient. The Court of Appeals held that the legislative limits placed on the Petersen decision applied only when an involuntarily committed inpatient was released. The Appellate Court reversed the summary judgment opinion in part. Both sides appealed to the Washington State Supreme Court.

The Washington Psychiatric Association argued in their amicus brief to the Washington Supreme Court that the 1987 legislation should apply to both in both inpatient and outpatient settings, and that the broader duty imposed by the Court of Appeals, which created a strict liability standard, was both inconsistent with the legislative mandate of 1987 and contrary to common sense.

The Washington State Supreme Court ultimately held that under Petersen this is a medical negligence case and not a medical malpractice case under Washington law. The Court noted under medical malpractice the psychiatrist owes a duty to his patient and that Washington does not recognize a cause of action for medical malpractice without a physician patient relationship. The Supreme Court affirmed the trial court's summary judgment decision with regards to any claim of medical malpractice.

However the Supreme Court went on to explain that Washington law imposes an alternative duty, that of medical negligence, which occurs when there is a special relationship between the mental health professional and patient. Citing *Petersen, Tarasoff II*[3] and *Lipari v. Sears*[4], the Court explained that once a mental health professional and a patient establish a treatment relationship, either outpatient or inpatient, the professional "incurs[s] a duty to take reasonable precautions to protect *anyone* who might foreseeably be endangered by the patient's condition" [emphasis in original].[5] The Court noted that the psychiatrist is not necessarily required to control the patient's future actions, but was under a duty to "take reasonable precautions" to lessen the dangerous propensities of the patient. These precautions are to be informed by "professional mental health standards." The Court also noted that it explicitly rejected California's post *Tarasoff* approach that had limited that victims must be readily identifiable before liability can be imposed on treating psychiatrists.

Based on the facts of this case, as well as Dr. Ashby's concession that a special relationship existed between himself and DeMeerleer, the Court held that the special relationship requirements were met. Once the theoretical duty was found to exist, the question remained whether the injury was reasonably foreseeable and this is a question of fact to be decided by the jury. The Court held that the plaintiff's forensic psychiatrist's affidavit "created a genuine issue of material fact as to whether, based on the standards of the mental health profession, the harms experienced by Schiering and her family were foreseeable." The majority relied in part on a misreading of Douglas Mossman's paper, *The Imperfection of Protection through Detection and Intervention*.[6] The majority wrote that the paper stood for the ability of psychiatrists to accurately predict future violence. However Dr. Mossman actually wrote that while violence risk assessment had advanced since the *Tarasoff* decision, predictions about whether a specific patient would be violent or not in the future could not be made accurately, because of the low base rate of violence. The case was returned the trial court to resolve the medical negligence claim.

The dissent pointed out that *Petersen* was a case where psychiatrists had the ability to control their patient because the patient in *Petersen* had been involuntarily hospitalized, and that the psychiatrists in *Petersen* had an ability to exercise continued control of their inpatient. This was not the case here as DeMeerleer was never an inpatient under Asher's control. The dissent noted that the majority imposed duty on psychiatrists without regard for this "control principle" which was novel and incorrect under Washington State Law. The dissent further noted that the majority was essentially adopting new language from Sec. 41 of the Third Restatement of Torts that, rather than requiring a controlling relationship before imposing a duty to exercise control, explicitly state that control is not necessary in mental health contexts.[7] The dissent pointed out that this language has not been adopted by any State that has considered it.

There is no Federal issue here so current Washington Law now imposes what I believe is an unworkable strict liability duty on psychiatrists to somehow protect society in general from potential harm, even when no specific threat was made towards anyone. To correct this problem the Washington State Psychiatric Society could ask for a re-hearing, and failing that could lobby the legislature to pass another limiting statue, explicitly rejecting the holding in this case.

In Maryland, in response to such potential expansion of psychiatrists' duty to third parties, the Maryland Psychiatric Society successfully lobbied for legislation that created a duty

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Primary Prevention

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munity forensic mental health.[6] A recent encouraging development has been the creation of a forensic hospital version of START NOW (available in the public domain[7]) from Robert Trestman and colleagues at the University of Connecticut Health Center, in collaboration with members of the Forensic Division of the National Association of State Mental Health Program Directors (NASMHPD). START NOW uses a cognitive-behavioral and motivation interviewing-focused treatment approach to offenders with behavioral disorders and has demonstrated positive outcomes in several correctional studies.[8] The hope is that forensic clinicians in hospital settings will be interested in employing the program and conducting evaluation or research on its effectiveness with that population. START NOW has already been used with good effectiveness in Connecticut in a community program at the fifth intercept, involving specialty probation/parole, case management and clinical supports.[9]

What we need next is to develop the capacity to utilize the programs cited by Rotter & Carr and by Trestman with clients in the community who are not yet (or at least not currently) involved in the criminal justice system. I am encouraged by the current enthusiasm for collaboration among the AAPL committees devoted to community, hospital and correctional forensic practice. I am also encouraged at the potential for development of a forensic recovery committee within AAPL, under the leadership of Sandy Simpson.[10] I am particularly intrigued at the notion Simpson cites of the "moral agenda" of recovery for forensic patients – learning to live better so as not to re-offend.[11]

Perhaps members of these committees can continue to help develop programs and training for public mental health systems to encourage primary prevention of CJSI. This is an area ripe for AAPL members' leadership in education and implementation, with the potential for tremendous public health advances in the mental health and justice systems.

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to point out that many of the words I used in this article, not the highlighted ones, were once new and different.

Finally, many thanks to the printer of the Newsletter, whom I know is going crazy with all my quotes and ellipses.

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to third parties under very limited circumstances, gave explicit instructions on how to discharge that duty, and created immunity for mental health professionals who act in good faith.[8] California[9] and Nebraska[10] have adopted similar limiting statutes and Washington State could do the same.

References:

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