

Parity at a Price: The Emerging Professional Liability of Mental Health Providers

THOMAS L. HAFEMEISTER*
LEAH G. MCLAUGHLIN**
JESSICA SMITH***

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* J.D., Ph.D., Associate Professor, School of Law; Associate Professor of Medical Education, School of Medicine; University of Virginia. The Authors would like to thank Shaun Boedicker, Patrick Mulligan, and Joshua Hinckley Porter for their valuable input.

** J.D., Associate, Cohen & Grigsby, P.C.

*** J.D., Associate, Macfarlane Ferguson & McMullen, P.A.

I wanted to tell her that if only something were wrong with my body it would be fine, I would rather have anything wrong with my body than something wrong with my head, but the idea seemed so involved and wearisome that I didn't say anything. I only burrowed down further in the bed.

—Sylvia Plath, *The Bell Jar*¹

I. INTRODUCTION

For much of human history, ailments of the body received far more attention than those of the mind.² Life was hard and survival virtually impossible without physical health. As more control was exerted over the environment, and enormous strides made in the ability to treat the body, greater attention could be given to mental health.³ But while the response to physical ills increasingly became a science,⁴ the treatment of mental illness remained more an art based on speculation and guesswork, and at times little more than quackery and chicanery.⁵

Because of the limited understanding of mental illness and how best to respond to it, few efforts were made to systematically treat it, with afflicted individuals fortunate to receive respite, asylum, and humane conditions.⁶ Further, most health care providers were unwilling to devote their careers to undertaking what typically was seen as a hopeless and unrewarding endeavor.⁷ With standards to guide treatment largely absent and a highly debilitated clientele with virtually no one willing to speak on their behalf, it is hardly surprising mental health providers have historically been effectively immune from professional liability claims.⁸

1. SYLVIA PLATH, *THE BELL JAR* 182 (25th anniversary ed. 1996).

2. See PAUL S. APPELBAUM, *ALMOST A REVOLUTION: MENTAL HEALTH LAW AND THE LIMITS OF CHANGE* 3 (1994). But see AM. PSYCHIATRIC ASS'N, *DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-IV-TR)*, at xxx (4th ed. 2000) (“[T]he term *mental disorder* unfortunately implies a distinction between ‘mental’ disorders and ‘physical’ disorders that is a reductionistic anachronism of mind/body dualism. A compelling literature documents that there is much ‘physical’ in ‘mental’ disorders and much ‘mental’ in ‘physical’ disorders.”).

3. See APPELBAUM, *supra* note 2, at 4.

4. See generally Mark A. Rothstein et al., *The Ghost in Our Genes: Legal and Ethical Implications of Epigenetics*, 19 *HEALTH MATRIX* 1 (2009). It should be recognized that physicians and allied health care providers readily acknowledge that the treatment of physical illness and injury remains as much an art as a science. ALAIN C. ENTHOVEN, *HEALTH PLAN: THE ONLY PRACTICAL SOLUTION TO THE SOARING COST OF MEDICAL CARE* 4 (1980).

5. See APPELBAUM, *supra* note 2, at 8.

6. See *id.* at 4, 8.

7. See *id.* at 4–5.

8. Paul S. Appelbaum, *Law & Psychiatry: Reforming Malpractice: The Prospects for Change*, 62 *PSYCHIATRIC SERVICES* 6, 6 (2011); Henry B. Rothblatt & David H. Leroy,

Recent developments, however, suggest the gap in the science-based understanding and treatment of mental health is closing.⁹ Examples include the emergence of purported biomarkers pertaining to mental illness,¹⁰ an expanding arsenal of treatments, including a host of newly

Avoiding Psychiatric Malpractice, 9 CAL. W. L. REV. 260, 260 (1973); Steven R. Smith, *Mental Health Malpractice in the 1990s*, 28 HOUS. L. REV. 209, 212–13 (1991). For purposes of this Article, the phrase *professional liability* will be limited to court claims focusing on the purported inadequate care delivered by a mental health provider. These providers could also face a parallel claim before their board of licensure. *See, e.g.*, Spitz v. Bd. of Exam'rs of Psychologists, 12 A.3d 1080, 1083 (Conn. App. Ct. 2011) (affirming decision to revoke psychologist's license for two years). Although an expansion of professional liability is likely to be accompanied by more disciplinary sanctions, the latter is beyond the scope of this Article. In addition, a professional liability claim can target the behavior of the care provider. For example, sexual interactions between a therapist and a client may be the subject of a liability suit and disciplinary action. *See* AM. PSYCHIATRIC ASS'N, THE PRINCIPLES OF MEDICAL ETHICS: WITH ANNOTATIONS ESPECIALLY APPLICABLE TO PSYCHIATRY § 2.1 (2010 ed. 2010) ("Sexual activity with a current or former patient is unethical."); C. Katherine Mann & John D. Winer, *Medical Negligence—Psychotherapist's Sexual Contact with Client*, in 14 AM. JUR. PROOF OF FACTS 3D 319 § 1 (1991) ("There is a] clear position taken by professional organizations and legal institutions against sexual contact between psychotherapists and their clients."). Further, greater attention has been given of late to the fiduciary duties of care providers, which also tend to focus on the provider's behavior rather than the treatment delivered per se. Thomas L. Hafemeister & Richard M. Gulbrandsen, Jr., *The Fiduciary Obligation of Physicians To "Just Say No" if an "Informed" Patient Demands Services That Are Not Medically Indicated*, 39 SETON HALL L. REV. 335, 375 n.200 (2009) ("[A] physician may have a fiduciary duty to keep medical records and information received in the course of the physician-patient relationship confidential and private, to not engage in a sexual relationship with a current patient, to avoid conflicts of interests that may compromise medical judgment, and to disclose to a patient adverse medical conditions of which the patient is unaware."). However, these claims are not addressed within this Article as it is focused instead on emerging treatment developments and their impact on liability.

9. It should be noted similar assertions have been made in the past. For instance, in the 1970s some psychiatrists felt various psychotropic medications were "miracle drugs." *See* Peter A. Parish, *What Influences Have Led to Increased Prescribing of Psychotropic Drugs?*, J. ROYAL C. GEN. PRAC., June 1973, at 49, 49. It was later shown they came with serious and potentially life-threatening side effects and were not universally effective. *See infra* Part IV.

10. *See* Daniel Z. Buchman & Judy Illes, *Imaging Genetics for Our Neurogenetic Future*, 11 MINN. J.L. SCI. & TECH. 79 (2010); Deborah W. Denno, *Courts' Increasing Consideration of Behavioral Genetics Evidence in Criminal Cases: Results of a Longitudinal Study*, 2011 MICH. ST. L. REV. 967, 997–1003; Jeffrey T.-J. Huang et al., *Disease Biomarkers in Cerebrospinal Fluid of Patients with First-Onset Psychosis*, 3 PLOS MED. 2145, 2145 (2006), <http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.0030428>; Thomas R. Insel, *Translating Scientific Opportunity into Public Health Impact: A Strategic Plan for Research on Mental Illness*, 66 ARCHIVES GEN. PSYCHIATRY 128, 128 (2009) (reporting efforts to close "the gap between the surge in basic biological knowledge and the state of mental health care"); Adam J. Kolber, *The Experiential Future of the Law*, 60 EMORY L.J. 585, 585 (2011); Mary L. Phillips & Eduard Vieta, *Identifying*

identified medications,¹¹ and increased emphasis on research-based diagnoses and treatment.¹²

At the same time, changes in the law and in social norms are eroding mental health providers' immunity from liability.¹³ These include a clearer delineation of the standard of care,¹⁴ a willingness to award damages for psychological harm,¹⁵ and a surge in the number of governmental actions brought against mental health providers.¹⁶

Functional Neuroimaging Biomarkers of Bipolar Disorder: Toward DSM-V, 33 SCHIZOPHRENIA BULL. 893, 893 (2007), available at <http://schizophreniabulletin.oxfordjournals.org/content/33/4/893.full.pdf+html>; Axel Steiger & Mayumi Kimura, *Wake and Sleep EEG Provide Biomarkers in Depression*, 44 J. PSYCHIATRIC RES. 242 (2010), available at <http://www.journalofpsychiatricresearch.com/article/S0022-3956%2809%2900189-7/abstract>; Melissa Healy, *Study Finds Telltale Signs of Depression: Biological Markers in the Bloodstream Offer Hope for Diagnostic Testing of the Disease*, L.A. TIMES, Apr. 18, 2012, at AA2; Natasha Allen, *New Blood Test May Help Detect Schizophrenia: First Test of Its Kind Looks for Biomarkers for the Mental Illness*, NBCNEWS.COM (Oct. 15, 2010, 3:18 PM), http://www.nbcnews.com/id/39686973/ns/health-mental_health/t/new-blood-test-may-help-detect-schizophrenia/#.UUTYLxycHYQ; see also *United States v. Kasim*, No. 2:07 CR 56, 2010 WL 339084, at *1 (N.D. Ind. Jan. 21, 2010) (“[When making a competency determination, when c]onfronted with an unreliable [psychiatric] history, other measures must be considered, specifically biological markers.”). *But see* Insel, *supra*, at 128 (“Despite high expectations, neither genomics nor imaging has yet impacted the diagnosis or treatment [of mental illness].”).

11. See Duff Wilson, *A Record Number of Drugs Are Being Tested To Treat Mental Illness*, N.Y. TIMES PRESCRIPTIONS BLOG (July 19, 2010, 3:48 PM), <http://prescriptions.blogs.nytimes.com/2010/07/19/a-record-number-of-drugs-are-being-tested-to-treat-mental-illness/>; see also *infra* Part IV.

12. See Phillips & Vieta, *supra* note 10, at 893 (“The recent research agenda for *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V)*, has emphasized a need to translate basic and clinical neuroscience research findings into a new classification system for all psychiatric disorders”); Darrel A. Regier et al., *The Conceptual Development of DSM-V*, 166 AM. J. PSYCHIATRY 645, 646 (2009); David Watson, *Rethinking the Mood and Anxiety Disorders: A Quantitative Hierarchical Model for DSM-V*, 114 J. ABNORMAL PSYCHOL. 522 (2005)

13. See Appelbaum, *supra* note 8, at 6 (“The rate of suits involving claims against psychiatrists has increased sharply since 1980, with some data suggesting that one in 12 psychiatrists is sued each year.” (citing Carol I. Tsao & Joseph B. Layde, *A Basic Review of Psychiatric Medical Malpractice Law in the United States*, 48 COMPREHENSIVE PSYCHIATRY 309 (2007))).

14. See Robert I. Simon, *Standard-of-Care Testimony: Best Practices or Reasonable Care?*, 33 J. AM. ACAD. PSYCHIATRY & L. 8, 9 (2005) (arguing that despite the multitude of treatment philosophies, “current research has established that certain treatments are more effective than others”).

15. Lars Noah, *Comfortably Numb: Medicalizing (and Mitigating) Pain-and-Suffering Damages*, 42 U. MICH. J.L. REFORM 431, 437–38 (2009) (“Previously, judges had declined to recognize emotional distress claims . . . out of a suspicion that such harms were too easily feigned. Growing acceptance of psychiatric testimony that the plaintiff suffered from a diagnosable mental illness provided some reassurance of legitimacy.”); John T. Nockleby & Shannon Curreri, *100 Years of Conflict: The Past and Future of Tort Retrenchment*, 38 LOY. L.A. L. REV. 1021, 1070–80 (2005).

16. See Tom Brown, *Miami Health Executive Gets Stiff Sentence for Fraud*, REUTERS (Dec. 9, 2011, 11:42 AM), <http://www.reuters.com/article/2011/12/09/us-usa-healthcare->

A greater number of advocates willing to assist individuals pursuing these suits is further fueling this change.¹⁷

However, arguably the most significant factor contributing to this increased liability exposure is the empowerment of the recipients of mental health care.¹⁸ This empowerment is in part the result of the lessened stigma associated with mental illness and claimants' increased willingness to acknowledge their condition in open court,¹⁹ as well as by improved treatments that, perhaps ironically, enhance their ability to pursue tort claims challenging the adequacy of the care they received.²⁰

This evolution creates a conundrum for the courts and society. The tort system awards damages to claimants to promote good conduct and deter undesired behavior,²¹ yet providing mental health treatment has never been very prestigious or financially rewarding, leaving its practitioners relatively unresponsive to tort-related incentives.²²

fraud-idUSTRE7B81DN20111209 (“[T]he owner of . . . a chain of mental health care centers . . . was convicted . . . on charges that she helped mastermind what prosecutors described . . . as ‘one of the largest and most brazen healthcare fraud conspiracies’ in U.S. history.”); Terri Langford, *3 Arrested in \$90 Million Medicare Fraud Scheme*, HOUS. CHRON. (Dec. 14, 2011), <http://www.chron.com/news/houston-texas/article/Three-arrested-in-90-million-Medicare-fraud-2403896.php>; *Mo. Psychologist Pleads to Health Care Fraud*, NEWSOK (Aug. 16, 2012), <http://newsok.com/mo.-psychologist-pleads-to-health-care-fraud/article/feed/420756> (describing guilty plea of psychologist “accused of claiming to see patients 364 days a year . . . [and] treat[ing] 19 patients almost daily” from 2008 to April 2012); David Pittman, *OIG: Mental Health Centers Need Scrutiny*, MEDPAGE TODAY (Aug. 22, 2012), <http://www.medpagetoday.com/publichealthpolicy/medicare/34322> (“Most community mental health centers employ at least one questionable billing practice, a government report has found.”); Jay Weaver, *Feds Spotlight South Florida’s Mental Health Clinics for “Questionable Billing” to Medicare*, MIAMI HERALD (Aug. 28, 2012), <http://www.miamiherald.com/2012/08/28/2972637/feds-spotlight-south-floridas.html>. Although beyond the scope of this Article, it can be argued that “[t]he connection between [the] quality of care, medical malpractice, and compliance [with federal and state operating requirements] is becoming more established in the health care system.” Richard E. Moses & D. Scott Jones, *Educating Physicians on Fraud and Abuse Compliance Issues*, CCH HEALTH CARE COMPLIANCE LETTER (CCH Inc., Riverwoods, Ill.), June 19, 2012, at 4, 4.

17. See *infra* Part III.

18. See *infra* Part III.

19. See *infra* Part III.

20. See *infra* Part IV.

21. See RESTATEMENT (SECOND) OF TORTS § 901 (1979); Alex Stein, *Toward a Theory of Medical Malpractice*, 97 IOWA L. REV. 1201, 1251 (2012) (“[T]he [medical malpractice] system . . . brings about an important social benefit by motivating care providers to deliver adequate treatment to patients.”).

22. See *supra* note 7 and accompanying text.

For example, the delivery of mental health care is often financed by the federal and state governments through Medicaid and Medicare.²³ Individuals with a mental illness, as a result of poverty or a disability,²⁴ frequently must rely on these programs for their health care coverage. However, because of the relatively low reimbursement levels associated with these programs, physicians are increasingly unwilling to accept these patients, to the point where prospective patients are finding it difficult to find physicians who will provide them with care.²⁵

To the extent that the costs of practicing a mental health specialty increase, whether it be the result of greater liability exposure, reduced payments, or a diminished sense of appreciation for the work done, it will become even more difficult to attract qualified individuals to this practice.²⁶ Further, although mental health professionals will welcome the progress made in the treatment of mental illness and the increased respect afforded individuals with a mental illness,²⁷ they will hardly appreciate second-guessing by the legal system of the oftentimes daunting

23. See CTRS. FOR MEDICARE & MEDICAID SERVS., *MEDICARE & YOUR MENTAL HEALTH BENEFITS* (2012), available at <http://www.medicare.gov/publications/pubs/pdf/10184.pdf>; Cynthia Shirk, *Medicaid and Mental Health Services* 3 (Nat'l Health Policy Forum, Background Paper No. 66, 2008), available at https://www.nhpf.org/library/background-papers/BP66_MedicaidMentalHealth_10-23-08.pdf (“Medicaid is the largest payer of mental health services in the United States . . .”).

24. See Thomas L. Hafemeister et al., *Forging Links and Renewing Ties: Applying the Principles of Restorative and Procedural Justice To Better Respond to Criminal Offenders with a Mental Disorder*, 60 *BUFF. L. REV.* 147, 157 (2012) (“[M]ental illness is the leading cause of disability in the United States for people between the ages of fifteen and forty-four.” (citing NAT'L ALLIANCE ON MENTAL ILLNESS, *MENTAL ILLNESSES: TREATMENT SAVES MONEY & MAKES SENSE* 1 (2007))); Esther Entin, *Poverty and Mental Health: Can the 2-Way Connection Be Broken?*, *ATLANTIC* (Oct. 26, 2011, 11:06 AM), <http://www.theatlantic.com/health/archive/2011/10/poverty-and-mental-health-can-the-2-way-connection-be-broken/247275/>; *Mental Health, Poverty and Development*, *WORLD HEALTH ORG.*, http://www.who.int/mental_health/policy/development/en/index.html (last visited Mar. 16, 2013).

25. See NAT'L ALLIANCE ON MENTAL ILLNESS, *STATE MENTAL HEALTH CUTS: A NATIONAL CRISIS* 1–10 (2011), available at <http://www.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=126233>; Juliette Cubanski & Patricia Neuman, *Medicare Doesn't Work As Well for Younger, Disabled Beneficiaries As It Does for Older Enrollees*, 29 *HEALTH AFF.* 1725 (2010); Sandra L. Decker, *In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, but Rising Fees May Help*, 31 *HEALTH AFF.* 1673 (2012); Julie Connelly, *More Doctors Are Opting Out of Medicare*, *N.Y. TIMES*, Apr. 2, 2009, at F9; Phil Galewitz, *Study: Nearly a Third of Doctors Won't See New Medicaid Patients*, *KAISER HEALTH NEWS* (Aug. 6, 2012), <http://www.kaiserhealthnews.org/Stories/2012/August/06/Third-Of-Medicaid-Doctors-Say-No-New-Patients.aspx>.

26. See Thomas Insel, *Psychiatry: Where Are We Going?*, *NAT'L INST. MENTAL HEALTH* (June 3, 2011), <http://www.nimh.nih.gov/about/director/2011/psychiatry-where-are-we-going.shtml> (explaining that only four percent of graduating medical seniors applied to a postgraduate training program in psychiatry, the lowest rate for all medical specialties).

27. See *infra* Parts III–IV.

treatment efforts they undertake.²⁸ Individuals with a mental illness, too, will likely be torn between applauding the enhanced acceptance of claims of inadequate mental health services and a fear that the already limited pool of qualified care providers will be further diminished.²⁹

With these tensions in mind, this Article considers the issues associated with emerging professional liability claims against mental health care providers. Part II supplies background information regarding this liability, including the elements of these claims. Part III details the decreasing stigma associated with obtaining mental health services and its impact on professional liability, while Part IV summarizes advancements in mental health treatment that have enhanced the functional capacities of potential litigants. The remaining Parts explore changes in the delivery of mental health care where litigation may be focused, including the increasing use of psychotropic medications (Part V), the expanding role of primary care physicians and other health care providers with limited training and experience pertaining to the treatment of mental illness (Part VI), the surge in pediatric psychotropic prescriptions (Part VII), the emergence of the informed consent doctrine and psychiatric advance directives (Part VIII), and the continuing development of *Tarasoff*-related liability (Part IX).

II. PRIMER ON PROFESSIONAL LIABILITY SUITS TARGETING MENTAL HEALTH CARE PROVIDERS

Although professional liability claims against mental health providers continue to be comparatively infrequent,³⁰ any increased exposure is significant because of the pervasiveness of mental disorders.³¹ It is estimated one in four adults suffer from a diagnosable mental disorder in

28. See Gardiner Harris, *Talk Doesn't Pay, So Psychiatry Turns Instead to Drug Therapy*, N.Y. TIMES, Mar. 6, 2011, at A1 (“[M]y office is like a bus station now . . .” (internal quotation marks omitted)).

29. See *id.*; *supra* note 22 and accompanying text.

30. See Ann H. Britton, *Psychotherapy Malpractice*, FORUM (Widener Law Health Law Inst., Wilmington, Del.), Oct. 2010, at 7, 7, available at <http://law.widener.edu/Academics/Institutes/HealthLawInstitute/%7E/media/Files/healthlawnewsletter/healthlawforum110810.ashx>; see also Anupam B. Jena et al., *Malpractice Risk According to Physician Specialty*, 365 NEW ENG. J. MED. 629, 629 (2011).

31. See Michael D. Brophy, *Emerging Medical-Legal Issues in the Prescriber-Patient Relationship*, MED. MALPRACTICE L. & STRATEGY, June 2001, at 4, 4 (“[F]our of the 10 leading causes of disability for persons aged 5 and older were mental disorders.”).

a given year, or approximately fifty-seven million Americans.³² Roughly half of all Americans will experience a mental illness during their lifetime,³³ and a serious mental disorder afflicts about one out of seventeen adults.³⁴ The prevalence rates for adolescents “closely approximate” those of adults,³⁵ as “about one in every three to four children” in the United States struggles with a mental disorder and around one in ten experiences “a serious emotional disturbance.”³⁶

Mental health treatment is provided by both physicians—of which psychiatrists are a subset—and other health care providers, which include psychologists, social workers, and a range of counselors,³⁷ any of whom can be the focus of a claim that inadequate mental health care was delivered.³⁸ Suits targeting nonphysicians are typically referred to as professional liability claims, while suits aimed at physicians are categorized as medical malpractice claims.³⁹ Their basic nature is similar,⁴⁰ although the terminology may differ somewhat. For example, those who receive

32. See *The Numbers Count: Mental Disorders in America*, NAT'L INST. MENTAL HEALTH, <http://www.nimh.nih.gov/health/publications/the-numbers-count-mental-disorders-in-america/index.shtml> (last visited Mar. 31, 2013) (citing Ronald C. Kessler et al., *Prevalence, Severity, and Comorbidity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication*, 62 ARCHIVES GEN. PSYCHIATRY 617 (2005)).

33. William C. Reeves et al., *Mental Illness Surveillance Among Adults in the United States*, MORBIDITY & MORTALITY WEEKLY REP., Sept. 2, 2011, at 1, 2, available at <http://www.cdc.gov/mmwr/pdf/other/su6003.pdf>.

34. NAT'L INST. MENTAL HEALTH, *supra* note 32 (citing Kessler et al., *supra* note 32).

35. Kathleen Ries Merikangas et al., *Lifetime Prevalence of Mental Disorders in U.S. Adolescents: Results from National Comorbidity Survey Replication—Adolescent Supplement (NCS-A)*, 49 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 980, 985 (2010).

36. *Id.* at 980.

37. See Stephen Hjelt, *Informed Consent and Psychotherapy: Apples and Oranges in the Garden of Doctrine*, 22 J. NAT'L ASS'N ADMIN. L. JUDGES 1, 21 (2002).

38. For an overview of mental health law and malpractice, see generally RONALD JAY COHEN & WILLIAM E. MARIANO, *LEGAL GUIDEBOOK IN MENTAL HEALTH* (1982); BARRY R. FURROW, *MALPRACTICE IN PSYCHOTHERAPY* (1980); THOMAS G. GUTHEIL & PAUL S. APPELBAUM, *CLINICAL HANDBOOK OF PSYCHIATRY AND THE LAW* (1982); JEFFERY D. ROBERTSON, *PSYCHIATRIC MALPRACTICE: LIABILITY OF MENTAL HEALTH PROFESSIONALS* (1988); and William W. Deardorff et al., *Malpractice Liability in Psychotherapy: Client and Practitioner Perspectives*, 15 PROF. PSYCHOL.: RES. & PRAC. 590 (1984). For a discussion of the related liability of pharmacists, see Andrew F. Spillane, Article, *Negligence Liability's Role in Changing Pharmacotherapy Responsibilities*, 12 MARQ. ELDER'S ADVISOR 453 (2011); church-related counseling services, see Constance Frisby Fain, *Minimizing Liability for Church-Related Counseling Services: Clergy Malpractice and First Amendment Religion Clauses*, 44 AKRON L. REV. 221 (2011); and institutions of higher education, see Helen H. de Haven, *The Academy and the Public Peril: Mental Illness, Student Rampage, and Institutional Duty*, 37 J. C. & UNIV. L. 267 (2011).

39. See, e.g., *Hare v. Wendler*, 949 P.2d 1141, 1142 (Kan. 1997) (referring to claim brought against psychiatrist as medical malpractice claim); *Figueiredo-Torres v. Nickel*, 584 A.2d 69, 71 (Md. 1991) (referring to claim brought against psychologist as professional negligence claim).

40. See 65 C.J.S. *Negligence* § 160 (2010).

services from a physician tend to be identified as patients, while the recipients of treatment from a nonphysician are usually designated as clients.⁴¹ Individuals may receive mental health services from both sets of professionals, although the services supplied tend to be different.⁴² Unless noted otherwise, the analyses in this Article are applicable to both sets of providers.

Rooted in English common law, medical malpractice claims generally fall within the broad sweep of tort law.⁴³ To pursue such a claim, the traditional elements of a tort—duty, breach of duty, harm, and proximate cause—must be satisfied to establish that a health care provider’s delivery of services to a client was negligent.⁴⁴ Plaintiffs must establish: (a) that a physician-patient or therapist-client relationship existed,⁴⁵ (b) that the mental health provider delivered services not meeting the applicable standard of care, (c) that the breach of the duty to supply the requisite level of care caused injury, and (d) that damages should be awarded to compensate the plaintiff for the harm incurred.⁴⁶

41. See, e.g., C. W. Ritchie et al., *Patient or Client? The Opinions of People Attending a Psychiatric Clinic*, 24 PSYCHIATRIST 447, 447 (2000), available at <http://pb.rcpsych.org/content/24/12/447.full>.

42. See Philip Knowles, *Collaborative Communication Between Psychologists and Primary Care Providers*, 16 J. CLINICAL PSYCHOL. MED. SETTINGS 72, 72 (2009); Richard M. Scheffler & Paul B. Kirby, *The Occupational Transformation of the Mental Health System*, 22 HEALTH AFF. 177, 185–86 (2003) (discussing how psychiatrists almost exclusively dispense medicine, while other mental health professionals are relied on for counseling).

43. See 1 BARRY R. FURROW ET AL., HEALTH LAW 264 (2d ed. 2000) (“[Suits] against physicians for medical failures can be found as early as 1375”); 4 STUART M. SPEISER ET AL., AMERICAN LAW OF TORTS § 15.10, at 526 (Monique C. M. Leahy ed., 2009). Breach of contract suits can also be filed, but are relatively rare. See, e.g., Owen v. Appelbaum, 613 N.Y.S.2d 504, 506 (App. Div. 1994) (holding that a plaintiff’s unsuccessfully filed breach of contract claim against psychiatrist, filed to take advantage of longer statute of limitations, to be essentially a medical malpractice claim).

44. See W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 30 (W. Page Keeton ed., 5th ed. 1984).

45. See, e.g., White v. Harris, 2011 VT 115, ¶ 4, 190 Vt. 647, 36 A.3d 203, 204–05. One emerging issue is whether the requisite relationship can be established when the only interaction was via electronic means. The Vermont Supreme Court recently held that a one-time, ninety-minute video-conference session as part of a telepsychiatry research study was sufficient to establish a psychiatrist-patient relationship. *Id.* ¶ 10, 190 Vt. at 650, 36 A.3d at 207.

46. Lawrence P. Hampton, Note, *Malpractice in Psychotherapy: Is There a Relevant Standard of Care?*, 35 CASE W. RES. L. REV. 251, 255–58 (1985); see also 1 THOMAS A. MOORE & KEVIN P. McMULLEN, MEDICAL MALPRACTICE: DISCOVERY AND TRIAL § 2:1.1.B.1 (7th ed. 2012) (“At the highest level of generalization, the physician has two obligations. The first is to possess the requisite learning and skill, and the second is to exercise the requisite care and diligence in using that learning and skill.”).

The standard of care for health care providers has traditionally been determined by what members of their profession would customarily do, rather than the reasonable and prudent person standard generally applied in negligence cases.⁴⁷ More specifically, they are under a legal duty to render their services “in a manner comporting with the skill and technical proficiency normally exercised by other professionals in the same field.”⁴⁸ Thus, the members of a given profession essentially set the standard of care.⁴⁹ Courts’ deference to these standards means that cases revolve around expert witness testimony “describing the actual pattern of . . . practice [within the profession], without any reference to the effectiveness of that practice.”⁵⁰ This approach means health care providers tend to be subject to liability only if they provide care that is out of step with what members of their profession are currently delivering, even if the customary approach could be expected to result in a poor outcome for a given client.⁵¹

However, there are indications that this manner of establishing the standard of care may be eroding. “In more than half the states, either through an explicit statutory change or through case law, malpractice law has moved away from a customary-practice standard, and toward a reasonably-prudent-physician standard.”⁵² This approach undercuts a

47. See, e.g., *Durflinger v. Artiles*, 673 P.2d 86, 92 (Kan. 1983) (quoting *Malone v. Univ. of Kan. Med. Ctr.*, 552 P.2d 885, 888–89 (Kan. 1976); *Chandler v. Neosho Mem’l Hosp.*, 574 P.2d 136, 138 (Kan. 1977)), *overruled on other grounds by Boulanger v. Pol*, 900 P.2d 823 (Kan. 1995); *Stepakoff v. Kantar*, 473 N.E.2d 1131, 1135 (Mass. 1985) (citing *Brune v. Belinkoff*, 235 N.E.2d 793, 798 (1968)); *Wofford v. E. State Hosp.*, 795 P.2d 516, 520 (Okla. 1990). *But see infra* notes 52–54 and accompanying text.

48. RALPH REISNER ET AL., *LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS* 125 (4th ed. 2004).

49. See FURROW ET AL., *supra* note 43, at 270.

50. BARRY R. FURROW ET AL., *LIABILITY AND QUALITY ISSUES IN HEALTH CARE* 144 (4th ed. 2001).

51. See *Lindsay v. N. Va. Mental Health Inst.*, 736 F. Supp. 1392, 1396 (E.D. Va. 1990) (determining a psychiatrist who followed established safety protocols was not liable for the death of an escaped patient). *But see Helling v. Carey*, 519 P.2d 981, 985 (Wash. 1974) (en banc) (finding that adherence to customary practice is not a shield if a relatively cost-effective alternative that enhances patient well-being is available); *infra* notes 52–54 and accompanying text.

52. James Knoll & Joan Gerbasi, *Psychiatric Malpractice Case Analysis: Striving for Objectivity*, 34 J. AM. ACAD. PSYCHIATRY & L. 215, 216 (2006); see also John Tucker, Comment, *A Novel Approach To Determining Best Medical Practices: Looking at the Evidence*, 10 HOUS. J. HEALTH L. & POL’Y 147, 179 (2010) (“[O]ver the past half century there has been a subtle erosion of the complete deference afforded the medical community in defining the medical standard of care.”); *id.* at 184–85 (reporting that “17 states have produced appellate decisions ‘explicitly rejecting the view that mere conformity to the usual custom and practice constitutes conclusive evidence’” that the standard of care was met and indicating a growing role for guidelines reflecting best practices supported by empirical evidence (quoting Ben A. Rich, *Medical Custom and Medical Ethics: Rethinking the Standard of Care*, 14 CAMBRIDGE Q. HEALTHCARE ETHICS 27, 32 (2005))).

“safety-in-numbers” approach that encouraged the status quo, and it has coincided with the rise of “evidence-based medicine,”⁵³ with testifying experts referring to such evidence when articulating the standard of care.⁵⁴ To the extent mental health providers can cite empirical support for the steps they have taken, they are far more likely to be shielded from liability. At the same time, an evidence-based approach may increasingly be viewed as necessary to satisfy the standard of care.⁵⁵

53. See David M. Eddy, *Evidence-Based Medicine: A Unified Approach*, 24 HEALTH AFF. 9, 9 (2005) (“The term ‘evidence-based medicine’ . . . has spread through medicine with amazing speed during the past fifteen years. The pace speaks to the attraction and fundamental soundness of the core idea: that what happens to patients should be based, to the greatest extent possible, on evidence.”); Rachel A. Lindor, *Advancing Evidence-Based Medicine by Expanding Coverage with Evidence Development*, 52 JURIMETRICS J. 209, 209 (2012) (arguing that Medicare’s “coverage with evidence development” policy that bases Medicare coverage for new products on evidence of effectiveness will make healthcare reform more successful); Jon-David R. Schwalm & Salim Yusuf, Commentary, *‘The End of Clinical Freedom’: Relevance in the Era of Evidence-Based Medicine*, 40 INT’L J. EPIDEMIOLOGY 855, 856 (2011); Tucker, *supra* note 52, at 149 (“As evidence based practice becomes the standard in the medical profession, the judiciary and state and federal legislators will fulfill their role and adapt the law to meet the requirements of changed circumstances.”); *id.* at 180 (“[I]t is likely that [advances in the medical evidence base] will permeate medical malpractice litigation in the same way they are permeating medical practice.”); Alex Stark, *From the Editor: Catching Up with Evidence-Based Medicine*, VIRTUAL MENTOR (Jan. 2011), <http://virtualmentor.ama-assn.org/2011/01/fred1-1101.html>.

54. See Tucker, *supra* note 52, at 188 (“In a classic battle of the experts, the one relying on high quality empirical data would be at an advantage in establishing her position as the true standard of care. As more jurisdictions adopt the position that customary care is not dispositive of the standard of care, and that reasonable prudence in reviewing and utilizing evolving [medical] evidence is a necessary factor in determining whether the standard was met, the reliance of testifying medical experts on [sources of information that reflect this evidence] will only increase.”).

55. See Peter A. Briss et al., *Closing the Gap Between Science and Law*, 35 J.L. MED. & ETHICS 92, 95 (Supp. 2007) (noting that in Washington State legislation was enacted directing mental health services to include evidence-based practices, and state contracts now require providers to use such practices); Mary C. Ruffolo & Jeff Capobianco, *Moving an Evidence-Based Intervention into Routine Mental Health Care: A Multifaceted Case Example*, 51 SOC. WORK HEALTH CARE 77, 77 (2012) (“[T]he movement to bring evidence-based mental health interventions into the public mental health system . . . has been a major thrust of federal and state efforts over the past 10 years.”); Gregory A. Aarons et al., *The Organizational Social Context of Mental Health Services and Clinician Attitudes Toward Evidence-Based Practice: A United States National Study*, IMPLEMENTATION SCI. 56 (June 22, 2012), <http://www.implementation-science.com/content/7/1/56> (“Clinicians who work in [mental health] clinics that expect them to place the well-being of each client first, to be competent and to have up-to-date knowledge are more likely to have more favorable views toward using [evidence-based practices] . . .”).

Nonetheless, courts continue to differentiate between care that falls below the professional standard and “a mere error of judgment.”⁵⁶ It has been determined that

[m]edical malpractice is *legal fault* by a physician or surgeon. It arises from the failure of a physician to provide the quality of care required by law. . . . A competent physician is not liable *per se* for a mere error of judgment, mistaken diagnosis or the occurrence of an undesirable result.⁵⁷

This deference to professional judgment has long existed, dating back at least to an 1898 decision by the high court of New York,⁵⁸ and has been specifically applied to mental health care.⁵⁹ Thus, the defining question in these cases is often whether the mental health provider, practicing in a field rife with uncertainty⁶⁰ but in which substantial empirical progress is being made,⁶¹ made an error that should incur liability.⁶²

Another defense in many jurisdictions is the “respectable minority doctrine.”⁶³ This doctrine has been explained as:

56. See, e.g., *Hall v. Hilbun*, 466 So. 2d 856, 866 (Miss. 1985). But see Joseph H. King, Jr., *Reconciling the Exercise of Judgment and the Objective Standard of Care in Medical Malpractice*, 52 OKLA. L. REV. 49, 62 (1999) (explaining that the “error of judgment” rule has been expressly recognized by only a minority of jurisdictions and many have stated that “only *non-negligent* judgments should be protected from liability”).

57. *Hall*, 466 So. 2d at 866 (emphasis added) (footnote omitted).

58. *Pike v. Honsinger*, 49 N.E. 760, 762 (N.Y. 1898) (“The rule . . . does not hold [a physician] liable for a mere error of judgment, provided he does what he thinks is best after careful examination.”).

59. See, e.g., *Soutear v. United States*, 646 F. Supp. 524, 536 (E.D. Mich. 1986) (“Psychiatry . . . is not an exact science. Medical doctors cannot predict with perfect accuracy whether or not an individual will do violence to himself or to someone else. . . . The concept of “due care” in appraising psychiatric problems, assuming proper procedures are followed, must take account of the difficulty often inevitable in definitive diagnosis.’ Thus, a psychiatrist will not be held liable for his patient’s violent behavior simply because he failed to predict it accurately.” (internal citations omitted) (quoting *Davis v. Lhim*, 335 N.W.2d 481, 487–88 (1983)); *Schrempf v. State*, 487 N.E.2d 883, 888–89 (N.Y. 1985) (“The treating physician . . . simply attached greater significance to those factors which seemed most promising and chose the course which appeared to offer the best opportunity for long-term rehabilitation. We know with hindsight that it was a mistaken impression. However, under the circumstances, it must be recognized as an exercise of professional judgment for which [liability will not be assigned.]”); *Littleton v. Good Samaritan Hosp. & Health Ctr.*, 529 N.E.2d 449, 457 (Ohio 1988).

60. See *supra* notes 5–7 and accompanying text.

61. See *supra* notes 9–12 and accompanying text.

62. It has also been noted that

[e]ach physician [is] expected to possess or have reasonable access to such medical knowledge as is commonly possessed or reasonably available to minimally competent physicians in the same specialty or general field of practice . . . , to have a realistic understanding of the limitations on his or her knowledge or competence, and, in general, to exercise minimally adequate medical judgment.

Hall, 466 So. 2d at 871.

63. See, e.g., *Jones v. Chidester*, 610 A.2d 964, 969 (Pa. 1992) (“[A] physician will not be held responsible if in the exercise of his judgment he followed a course of

Where two or more schools of thought exist among competent members of the medical profession concerning proper medical treatment for a given ailment, each of which is supported by responsible medical authority, it is not malpractice to be among the minority . . . who follow one of the accepted schools.⁶⁴

One criticism of this doctrine is that it allows practitioners to provide care that is not proven or even widely believed to be the most effective.⁶⁵ This tension is particularly evident in mental health care, where studies of the efficacy of various treatment alternatives are often lacking or highly contentious,⁶⁶ but it also frequently comes into play when traditional treatments are called into question by emerging approaches.

For example, in one case a patient underwent seven months of psychoanalysis for depression at a private facility without psychotropic medications being administered.⁶⁷ After his depression continued to worsen, he ultimately left the facility and was successfully treated at another facility with the aid of such medication.⁶⁸ The patient sued the first facility, alleging that it was malpractice to not provide the most widely employed means of caring for someone with his condition—pharmacotherapy.⁶⁹ This facility, however, was one of the leading psychoanalysis-oriented treatment centers in the country, and practitioners there tended to eschew the administration of psychotropic medications

treatment advocated by a considerable number of recognized and respected professionals in his given area of expertise.”).

64. *Chumbler v. McClure*, 505 F.2d 489, 492 (6th Cir. 1974).

65. See Glenn E. Bradford & David G. Meyers, *The Legal and Regulatory Climate in the State of Missouri for Complementary and Alternative Medicine—Honest Disagreement Among Competent Physicians or Medical McCarthyism?*, 70 UMKC L. REV. 55, 79 (2001) (citing *Hood v. Phillips*, 554 S.W.2d 160, 163–65 (Tex. 1977)).

66. See *Hicks v. United States*, 511 F.2d 407, 415 (D.C. Cir. 1975) (addressing difficulty of correctly diagnosing psychiatric problems); Larry E. Beutler, *David and Goliath: When Empirical and Clinical Standards of Practice Meet*, 55 AM. PSYCHOLOGIST 997, 999 (2000) (discussing contention over various treatment methods); Sarah Baldauf, *Brain Stimulation: Transcranial Magnetic Stimulation*, USNEWS.COM (July 15, 2009), <http://health.usnews.com/health-news/family-health/brain-and-behavior/articles/2009/07/15/brain-stimulation-transcranial-magnetic-stimulation> (describing research into new form of brain stimulation used to treat depression).

67. CHRISTOPHER SLOBOGIN ET AL., *LAW AND THE MENTAL HEALTH SYSTEM: CIVIL AND CRIMINAL ASPECTS* 141 (5th ed. 2009) (citing John G. Malcolm, *Treatment Choices and Informed Consent in Psychiatry: Implications of the Osheroff Case for the Profession*, 14 J. PSYCHIATRY & LAW 9, 16–18 (1986)) (discussing *Osheroff v. Chestnut Lodge, Inc.*, 490 A.2d 720 (Md. Ct. Spec. App. 1985)).

68. *Id.* at 142.

69. *Id.* at 140 (citing Gerald L. Klerman, *The Psychiatric Patient’s Right to Effective Treatment: Implications of Osheroff v. Chestnut Lodge*, 147 AM. J. PSYCHIATRY 409, 410 (1990)).

based on a belief that their use precluded exploration and resolution of underlying psychological problems.⁷⁰ This case demonstrates that the doctrinal orientation of a mental health practitioner can make a significant difference in the diagnosis and treatment techniques employed, but if that orientation falls out of style or is deemed inappropriate to address a client's condition, its practitioners may be subject to liability.⁷¹ As medications have become more widely used to treat mental disorders,⁷² some believe the standard of care may soon routinely require this type of treatment.⁷³ This controversial view,⁷⁴ if accepted, would enhance the risk of liability for practitioners who primarily use traditional, psychoanalytic methods of treatment or other nonpharmaceutical approaches.⁷⁵ However, it also suggests physicians may face liability for failing to refer to a nonmedical mental health practitioner a patient who might be better served by receiving a treatment modality that is not focused on pharmaceutical agents.⁷⁶

Nevertheless, although medical malpractice claims in general are relatively widespread,⁷⁷ this has not been the case with regard to mental health professional liability claims.⁷⁸ As one commentator wrote in 1991 about the traditionally low rate of mental health malpractice claims:

70. *Id.* at 141.

71. *See id.* at 140 (quoting Klerman, *supra* note 69, at 410–11) (noting that an arbitration panel ultimately awarded the patient \$250,000, which was upheld by a Maryland Special Appeals Court).

72. *See infra* Part V.

73. *See* Douglas Mossman, *Unbuckling the 'Chemical Straitjacket': The Legal Significance of Recent Advances in the Pharmacological Treatment of Psychosis*, 39 SAN DIEGO L. REV. 1033, 1093 (2002).

74. Controversy continues over whether forms of treatment other than psychotropic medications provide an equal or better alternative, whether these medications are safe and effective, and whether they are employed primarily because they are cheaper and enable third-party payors to avoid paying for long-term treatment. *See* Gardiner Harris, *Proof Is Scant on Psychiatric Drug Mix for Young*, N.Y. TIMES, Nov. 23, 2006, at A1; Jennifer Colangelo, *The Right To Refuse Treatment for Mental Illness*, 5 RUTGERS J.L. & PUB. POL'Y (Spring 2008), http://www.rutgerspolicyjournal.org/sites/rutgerspolicyjournal.org/files/issues/5_3/JLPP_5-3.pdf; *infra* Parts V–VII.

75. *See infra* Part V. One reading of the settlement discussed *supra* note 71 is that a practitioner may be liable for failing to refer a client to a provider who can prescribe psychopharmacological treatment, a reading that would have a very significant impact on the delivery of mental health care as nonphysicians—such as clinical psychologists—currently treat large numbers of individuals with a mental illness. *See* Phillip S. Wang et al., *Twelve-Month Use of Mental Health Services in the United States*, 62 ARCHIVES GEN. PSYCHIATRY 629, 630–31 (2005) (explaining that over thirty percent of all individuals seeking treatment for mental illness employ nonphysicians).

76. *See infra* Part V; *see also supra* note 74, *infra* notes 145, 165, 190, 196 and accompanying text.

77. Jena et al., *supra* note 30, at 629.

78. *See id.*; *see also supra* note 8 and accompanying text.

[D]uty, causation, and injury . . . are often difficult to prove; technical legal doctrines sometimes interfere with potential claims; former patients are reluctant to expose their mental health problems to the public . . . ; and the close relationship between patients and mental health professionals makes patients reluctant to file claims.⁷⁹

Proving these claims is still a daunting task today. Establishing the standard of care is challenging because of a lack of consensus regarding the diagnoses of mental disorders and the appropriate course of treatment for a given diagnosis, the absence of physical symptoms to guide these decisions, and the difficulty of predicting and preventing the exceptional behaviors—such as suicide or violence—that are often the critical event for a related claim.⁸⁰ Furthermore, the standard of care is typically established via expert witness testimony,⁸¹ but the ability of even forensic mental health professionals to approach liability cases competently and objectively has been questioned.⁸² Similarly, establishing causation is complicated by the fact that plaintiffs often have a history of mental illness before beginning treatment, clouding the already convoluted issue of proving that harm was caused by inadequate treatment.⁸³ There also must be a showing of damages before these claims can survive, with psychological or emotional harm frequently their primary focus,⁸⁴ but

79. Smith, *supra* note 8, at 213–14.

80. See *id.* at 214. But see Knoll & Gerbasi, *supra* note 52, at 216 (“[T]he applicable standard in [psychiatric] medical malpractice cases appears to be in the process of shifting and developing.” (citing Philip G. Peters, Jr., *The Reasonable Physician Standard: The New Malpractice Standard of Care?*, 34 J. HEALTH L. 105 (2001))); Maggie Murray, Note, *Determining a Psychiatrist’s Liability When a Patient Commits Suicide: Haar v. Ulwelling*, 39 N.M. L. REV. 641, 641 (2009) (“[F]ailure to prevent suicide is one of the leading causes for malpractice suits against mental health care providers.”).

81. See *supra* note 50 and accompanying text.

82. See Knoll & Gerbasi, *supra* note 52, at 216 (“Even among forensic psychiatrists, there may be considerable confusion about what standard of care to use when analyzing a psychiatric malpractice case.”).

83. See Smith, *supra* note 8, at 214–15; see also Knoll & Gerbasi, *supra* note 52, at 218 (“In cases of psychiatric malpractice, causation is perhaps the legal issue of greatest consequence.”); *id.* at 219 (“Two important concepts may support a defendant’s claim that her acts or omissions were not the proximate cause of a plaintiff’s damages: the presence of an intervening cause and the lack of foreseeability. Both . . . are elusive and complicated concepts.”).

84. For cases where such damages have been recognized, see *Accardo v. Cenac*, 722 So. 2d 302, 304, 312 (La. Ct. App. 1998), involving neurological conditions resulting from medication, *Noto v. St. Vincent’s Hospital & Medical Center*, 559 N.Y.S.2d 510, 511 (App. Div. 1990), involving aggravation of existing psychological debilities, and *Bramlette v. Charter-Medicine-Columbia*, 393 S.E.2d 914, 915–16 (S.C. 1990), involving suicide.

historically such harm has not been a sufficient basis for recovery.⁸⁵ Also, it is generally difficult for jurors and judges to understand and assess the impact of such harm in assigning damages.⁸⁶ Nevertheless, as follows, there are many reasons to expect the number of these cases to increase.

III. THE IMPACT OF THE DECREASE IN STIGMA ASSOCIATED WITH MENTAL ILLNESS

In the past, recipients of mental health services were reluctant to file claims against treatment providers in part because doing so required them to discuss their condition publicly and expose themselves to the stigma routinely associated with mental illness.⁸⁷ Indeed, after professional liability insurance was first made available to psychologists by the American Psychological Association (APA) in 1961, zero claims were paid out for a decade.⁸⁸ Perhaps reflecting the growing understanding and acceptance of mental illness, clients have become more willing to pursue such claims as time has gone on,⁸⁹ with insurance payments rising accordingly.⁹⁰

Stigmatization of individuals with a mental illness has a lengthy history and has only recently begun to abate.⁹¹ “[This] [s]tigma . . . affects every aspect of their lives. It brings with it a multitude of problems, from insurance, to housing, to jobs; stigma stops patients from getting

85. See *supra* note 15 and accompanying text.

86. See Smith, *supra* note 8, at 215 (comparing emotional injuries to the sight of “[a] mangled limb or scarred body” in a traditional medical malpractice suit, which “presents to a jury dramatic evidence of injury” (quoting STEVEN R. SMITH & ROBERT G. MEYER, LAW, BEHAVIOR, AND MENTAL HEALTH: POLICY AND PRACTICE 9 (1987)) (internal quotation marks omitted)).

87. *Id.* at 213.

88. *Id.* at 212.

89. *Id.* at 212–13.

90. *Id.* at 212 (explaining that by 1980, the APA Insurance Trust paid over \$400,000 in claims in a four-year period (citing Paul Frederic Slawson & Frederick G. Guggenheim, *Psychiatric Malpractice: A Review of the National Loss Experience*, 141 AM. J. PSYCHIATRY 979, 980 (1984))); see also DAVID L. SHAPIRO & STEVEN R. SMITH, MALPRACTICE IN PSYCHOLOGY: A PRACTICAL RESOURCE FOR CLINICIANS 6 (2011) (explaining that APA payments reached \$750,000 for fiscal year 2005 (citing personal communication with Gerald Koocher in July 2009)).

91. William R. Dubin & Paul Jay Fink, *Effects of Stigma on Psychiatric Treatment*, in STIGMA AND MENTAL ILLNESS 1, 1 (Paul Jay Fink & Allan Tasman eds., 1992) (“Mental illness was once thought to be related to being possessed with demons. In more recent times, while such concepts are no longer prevalent, patients with mental illness continue to be viewed as constitutionally weak, dangerous, and responsible for their own plight.”).

the best treatment, or at times from getting any treatment at all.”⁹² Such stigmatized individuals were poorly positioned to initiate claims when they received questionable care.⁹³ However, in recent years there has been a concerted effort by many community leaders, consumer advocates, and mental health professionals to educate the public about mental illness and to free these individuals from blame for their condition.⁹⁴ Attempting to reverse the segregation induced by the extensive use of institutional care, and with a goal of treating individuals with a mental illness more humanely, legislation to establish community-based treatment centers and group homes has been enacted.⁹⁵ As a result, the idea that such individuals were a “menace” and “should be locked up and segregated from the rest of the community” began to recede.⁹⁶

Of particular note, the Americans with Disabilities Act (ADA) was passed in 1990 with the purpose of proscribing discrimination based on disability and “to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for . . . individuals [with disabilities].”⁹⁷ In 1999, the United States Supreme Court made it

92. *Id.*; see also GERALD N. GROB, *THE MAD AMONG US: A HISTORY OF THE CARE OF AMERICA’S MENTALLY ILL* 6 (1994) (discussing obstacles facing the mentally ill during the seventeenth and eighteenth centuries).

93. Smith, *supra* note 8, at 213–14.

94. See, e.g., RE-ENTRY POLICY COUNCIL, COUNCIL OF STATE GOV’TS, *REPORT OF THE RE-ENTRY POLICY COUNCIL: CHARTERING THE SAFE AND SUCCESSFUL RETURN OF PRISONERS TO THE COMMUNITY* 455 (2005), available at http://www.reentrypolicy.org/jc_publications/rpc_report_full/RPC_Report_Full.pdf (“[Recommendation] F: Educate the public to destigmatize mental illness and build support for people with mental illnesses.”); Glenna Riley, Note, *The Pursuit of Integrated Living: The Fair Housing Act as a Sword for Mentally Disabled Adults Residing in Group Homes*, 45 COLUM. J.L. & SOC. PROBS. 177, 178–79 (2011); John Dolores, *Psychotherapy: Not Just for Chronic Mental Illness*, WYO. LAW., June 2011, at 60; NAMI Public Service Announcements, NAT’L ALLIANCE ON MENTAL ILLNESS (July 2007), http://www.nami.org/Template.cfm?Section=About_NAMI&Template=/ContentManagement/ContentDisplay.cfm&ContentID=42493.

95. See Samantha A. DiPolito, Comment, *Olmstead v. L.C.—Deinstitutionalization and Community Integration: An Awakening of the Nation’s Conscience?*, 58 MERCER L. REV. 1381, 1385 (2007) (discussing the civil rights era and the Rehabilitation Act of 1973, which is called the “key legislative impetus behind” deinstitutionalization).

96. *Id.* at 1384–85; see also Shirley L. Klett et al., *Patient Evaluation of the Psychiatric Ward*, 19 J. CLINICAL PSYCHOL. 347, 351 (1963) (reporting results of a patient survey regarding perceptions of state hospital psychiatric wards).

97. 42 U.S.C. § 12101(a)(7) (Supp. IV 2011); see also Aviv Shamash, Note, *A Piecemeal, Step-by-Step Approach Toward Mental Health Parity*, 7 J. HEALTH & BIOMEDICAL L. 273, 280–82 (2011) (describing the passage of the Mental Health Parity Act of 1996, which limited differential treatment of mental health care costs by insurers).

clear in *Olmstead v. L.C.*⁹⁸ that “the unjustified segregation of individuals with mental disabilities in institutions constitutes discrimination under the ADA.”⁹⁹ Also in 1999, *Mental Health: A Report of the Surgeon General* was released, which encourages individuals with a mental illness to seek help, pointing to the many evidence-based interventions now available and stating that “[t]he health of the American people demands that we act with resolve and a sense of urgency to . . . address through research and education . . . the stigma attached to mental illness.”¹⁰⁰

Additionally, in 2008 Congress passed the Mental Health Parity and Addiction Equity Act (MHPAE),¹⁰¹ which “broadly prohibits group health plans from imposing disparate financial or coverage restrictions on mental health care.”¹⁰² Although the MHPAE does not mandate that insurers provide coverage for mental health care services,¹⁰³ most states enacted parity statutes that require “more significant mental health coverage than their federal counterpart.”¹⁰⁴ Subsequently, Congress enacted the Patient Protection and Affordable Care Act of 2010 (PPACA),¹⁰⁵ which “require[s] most insurance plans to offer essential health benefits, which include mental health, substance abuse, and behavioral health services.”¹⁰⁶

Community and online resources and support groups are also increasingly available to help individuals suffering from mental illness

98. *Olmstead v. L.C.*, 527 U.S. 581 (1999).

99. Dipolito, *supra* note 95, at 1392 (citing *Olmstead*, 527 U.S. at 607).

100. U.S. DEP’T OF HEALTH & HUMAN SERVS., MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 453–54 (1999), *available at* <http://profiles.nlm.nih.gov/ps/access/NNBBHS.pdf> (“Stigma assumes many forms, both subtle and overt. It appears as prejudice and discrimination, fear, distrust, and stereotyping. It prompts many people to avoid working, socializing, and living with people who have a mental disorder. Stigma impedes people from seeking help for fear that the confidentiality of their diagnosis or treatment will be breached. It gives insurers—in the public sector as well as the private—tacit permission to restrict coverage for mental health services in ways that would not be tolerated for other illnesses. . . . Powerful and pervasive, stigma prevents people from acknowledging their own mental health problems, much less disclosing them to others.”).

101. Pub. L. No. 110-343, 112 Stat. 3765 (codified as amended at 29 U.S.C. § 1185a (Supp. II 2009)).

102. *See* Shamash, *supra* note 97, at 284 (citing 29 U.S.C. § 1185a(a)(3)(A)).

103. *Id.* at 286.

104. *Id.* at 287.

105. Pub. L. No. 111-148, 124 Stat. 119 (codified as amended in scattered sections of 26 and 42 U.S.C.).

106. Shamash, *supra* note 97, at 296 (citing PPACA § 1302(b)(1)). The PPACA is more expansive in scope than the MHPAE in part because it is not limited to the large group health plans covered by the MHPAE. For a discussion of the PPACA relative to the MHPAE and its impact on the delivery of mental health care, see Colleen L. Barry & Haiden A. Huskamp, *Moving Beyond Parity—Mental Health and Addiction Care Under the ACA*, 365 NEW ENG. J. MED. 973 (2011), and Stacey A. Tovino, *A Proposal for Comprehensive and Specific Essential Mental Health and Substance Use Disorder Benefits*, 38 AM. J.L. & MED. 471 (2012).

obtain better services.¹⁰⁷ Direct-to-consumer advertising, including ads for antidepressants and anti-anxiety medications, are thought by some to be further reducing the stigma associated with mental illness by increasing awareness of these conditions and enhancing their “medicalization,”¹⁰⁸ thereby replacing the public perception that these are deviant social behaviors with a view that they are treatable medical conditions.¹⁰⁹ Although commentators have expressed concerns that these promotional efforts will result in the overdiagnosis of mental illness or a failure to employ equally effective alternative treatment modalities with fewer side effects,¹¹⁰ such information may encourage individuals to have meaningful conversations with their health care providers about their conditions and to scrutinize more closely related treatment decisions.¹¹¹

Although there is no denying that individuals affected by mental illness continue to face stigma,¹¹² efforts to dispel related myths, reduce discrimination, and educate citizens about the nature of mental illness and effective treatment options have lessened associated taboos.¹¹³ This

107. See, e.g., NAT’L ALLIANCE ON MENTAL ILLNESS, <http://www.nami.org/> (last visited Mar. 31, 2013) (providing informational resources, a legislative action center, and online communities for discussion and mutual support).

108. Andrew R. Payton & Peggy A. Thoits, *Medicalization, Direct-to-Consumer Advertising, and Mental Illness Stigma*, 1 SOC’Y & MENTAL HEALTH 55, 55 (2011) (“Medicalization occurs . . . when previously non-medical problems are defined and treated as medical problems” (quoting Peter Conrad & Valerie Leiter, *From Lydia Pinkham to Queen Levitra: Direct-to-Consumer Advertising and Medicalisation*, 30 SOC. HEALTH & ILLNESS 825, 825 (2008)) (internal quotation marks omitted)).

109. *Id.* at 56.

110. See Thomas L. Hafemeister & Sarah P. Bryan, *Beware Those Bearing Gifts: Physicians’ Fiduciary Duty To Avoid Pharmaceutical Marketing*, 57 U. KAN. L. REV. 491, 502–03 (2009); see also Katie Thomas, *J.&J. Unit Settles Cases with States on Risperdal*, N.Y. TIMES, Aug. 30, 2012, at B3 (“[A]uthorities have said that [Johnson & Johnson’s subsidiary] promoted the [antipsychotic] drug for uses it did not have approval for, including dementia in elderly patients, bipolar disorder in children and adolescents, depression and anxiety.”).

111. See W. John Thomas, *Direct-to-Consumer Pharmaceutical Advertising: Catalyst for a Change in the Therapeutic Model in Psychotherapy?*, 32 CONN. L. REV. 209, 212 (1999) (quoting Milt Freudenheim, *Psychiatric Drugs Are Now Promoted Directly to Patients*, N.Y. TIMES, Feb. 17, 1998, at A1); see also Hafemeister & Gulbrandsen, *supra* note 8, at 352–56 (describing proponents’ common arguments in defense of direct-to-consumer advertising).

112. See, e.g., Amanda M. Stone & Lisa J. Merlo, *Attitudes of College Students Toward Mental Illness Stigma and the Misuse of Psychiatric Medications*, 72 J. CLINICAL PSYCHIATRY 134, 138 (2011).

113. For a discussion of many of the methods being employed to lessen the social stigma of mental illness, see generally Patrick Corrigan & Betsy Gelb, *Three Programs That Use Mass Approaches To Challenge the Stigma of Mental Illness*, 57 PSYCHIATRIC

in turn has diminished the threat of public shaming, which previously discouraged pursuit of professional liability claims.

IV. THE IMPACT OF IMPROVED TREATMENT OUTCOMES

While efforts are being made to reduce the stigma associated with mental illness, another major shift has been occurring: treatment outcomes are improving, which is enhancing the functional ability of clients to express dissatisfaction. Treatment today consists primarily of psychopharmacology, psychotherapy, or various combinations of the two.¹¹⁴ Whereas past treatments, including many of the so-called first generation of psychotropic medications, were often either ineffective or induced debilitating side effects,¹¹⁵ newer treatments may be more effective and rehabilitative, albeit not without their own side effects, such as diabetes and rapid weight gain.¹¹⁶ The availability of improved treatment modalities means

SERVICES 393 (2006), available at <http://ps.psychiatryonline.org/data/Journals/PSS/3667/393.pdf>.

114. See SLOBOGIN ET AL., *supra* note 67, at 23; Johnathan Fish, *Overcrowding on the Ship of Fools: Health Care Reform, Psychiatry, and the Uncertain Future of Normality*, 11 HOUS. J. HEALTH L. & POL'Y 181, 183 (2011).

115. See, e.g., SLOBOGIN ET AL., *supra* note 67, at 29; John M. Kane & James M. Smith, *Tardive Dyskinesia: Prevalence and Risk Factors, 1959 to 1979*, 39 ARCHIVES GEN. PSYCHIATRY 473 (1982) (discussing the risks of developing tardive dyskinesia from using psychotropic medications); *Lobotomy: Surgery for the Insane*, 1 STAN. L. REV. 463, 463 (1949) (explaining that a prefrontal lobotomy "can so disintegrate a patient's personality as to leave a mere 'human vegetable'"); Theodore Van Putten et al., *Response to Antipsychotic Medication: The Doctor's and the Consumer's View*, 141 AM. J. PSYCHIATRY 16, 17 (1984) (acknowledging prescribed drugs severely incapacitated patients).

116. See, e.g., K.N.R. Chengappa et al., *Clozapine: Its Impact on Aggressive Behavior Among Patients in a State Psychiatric Hospital*, 53 SCHIZOPHRENIA RES. 1, 5–6 (2002) (finding clozapine to be effective at treating aggressive and violent behavior); Shitij Kapur et al., *Evidence for Onset of Antipsychotic Effects Within the First 24 Hours of Treatment*, 162 AM. J. PSYCHIATRY 939, 942–45 (2005) (describing early effectiveness of antipsychotic medicines); Stefan Leucht et al., *Antipsychotic Drugs Versus Placebo for Relapse Prevention in Schizophrenia: A Systematic Review and Meta-Analysis*, 379 LANCET 2063, 2063 (2012), available at [http://www.thelancet.com/journals/lancet/article/PIIS0140-6736\(12\)60239-6/fulltext](http://www.thelancet.com/journals/lancet/article/PIIS0140-6736(12)60239-6/fulltext) (summarizing data on how antipsychotic drugs benefit schizophrenia patients); Maura Kelly, *Hey, Let's Not Get Carried Away: Anti-Depressants Really Do Help People*, ATLANTIC (June 4, 2012, 6:57 AM), <http://www.theatlantic.com/health/archive/2012/06/hey-lets-not-get-carried-away-anti-depressants-really-do-help-people/257976/> (defending the benefits of antidepressants); Robert Preidt, *Antipsychotics Do Help Many with Schizophrenia, Study Finds*, HEALTHDAY (May 3, 2012), <http://consumer.healthday.com/Article.asp?AID=664331> (providing overview of multiple studies concluding antipsychotic drugs effectively treat schizophrenia). *But see* IRVING KIRSCH, *THE EMPEROR'S NEW DRUGS: EXPLODING THE ANTIDEPRESSANT MYTH* (2010) (arguing that antidepressant medications do not cure depression and can be harmful); ROBERT WHITAKER, *ANATOMY OF AN EPIDEMIC: MAGIC BULLETS, PSYCHIATRIC DRUGS, AND THE ASTONISHING RISE OF MENTAL ILLNESS IN AMERICA* (2010) (asserting that psychotropic drugs currently being used cause considerable harm); Michael B. Knable et al., *Extrapyramidal Side Effects with Risperidone and Haloperidol at Comparable D2 Receptor Occupancy Levels*, 75 PSYCHIATRY RES.: NEUROIMAGING

clients dissatisfied with their treatment, perhaps after a change in treatment or therapist, may now be better able to assert their rights and sustain litigation.

As noted, historically, few if any effective treatments were available for responding to mental illness.¹¹⁷ Following the revelation that lithium could be used as a treatment for bipolar affective disorders in 1949, the development of psychotropic medications accelerated dramatically.¹¹⁸ In the following decade, numerous antidepressant and antipsychotic drugs transformed the treatment of mental disorders in the United States.¹¹⁹ This made it possible to decrease the number of individuals living in state psychiatric facilities and return them to the community.¹²⁰ It has been said that the chance discovery of chlorpromazine's ability to reduce psychotic symptoms "ushered in the era of modern psychopharmacology,"¹²¹ although it would later be discovered that these first generation antipsychotics (FGAs) were also associated with a wide range of debilitating and even fatal side effects.¹²²

91, 98 (1997) (concluding that risperidone does not appear to prevent psychotic symptoms); Erica Goode, *3 Schizophrenia Drugs May Raise Diabetes Risk, Study Says*, N.Y. TIMES, Aug. 25, 2003, at A8 (describing how three commonly prescribed antipsychotic medicines increase patients' risk of developing diabetes); Denise Mann, *Older Antipsychotics May Work as Well as Newer Ones: Review; First-Generation Medications Are Also Much Cheaper, Researchers Note*, HEALTHDAY (Aug. 14, 2012), <http://consumer.healthday.com/Article.asp?AID=667642> (providing results of study concluding that second-generation antipsychotics are not significantly more effective than first-generation antipsychotics); Brian Vastag, *Hidden Data Show that Antipsychotic Drugs Are Less Effective than Advertised*, WASH. POST (Mar. 21, 2012, 6:05 AM), http://www.washingtonpost.com/blogs/the-checkup/post/hidden-data-show-that-antipsychotic-drugs-are-less-effective-than-advertised/2012/03/20/gIQAXX4IQS_blog.html (summarizing research on limited effectiveness of modern antipsychotic drugs); *infra* note 143 and accompanying text.

117. See Shamash, *supra* note 97, at 273 ("Even after the focus turned from incarceration to treatment, for centuries, many of the methods—including therapeutic asylums, electroshock therapy, and lobotomies—were at best ineffective and at worst inhumane."); *supra* notes 3–5, 115 and accompanying text.

118. SLOBOGIN ET AL., *supra* note 67, at 23; Joseph F. Goldberg & Leslie Citrome, *Latest Therapies for Bipolar Disorder: Looking Beyond Lithium*, POSTGRAD MED., Feb. 2005, at 25, 25–26.

119. SLOBOGIN ET AL., *supra* note 67, at 23.

120. *Id.* Other factors also contributed to this decrease, including a difficult fiscal climate for states that led them to reduce the availability of these beds as a cost-savings measure. See APPELBAUM, *supra* note 2, at 50.

121. Gerald J. Schaefer, *Drug-Induced Alteration of Psychotic Behavior: Who Benefits?*, 9 J.L. & HEALTH 43, 44 (1994–1995).

122. See Douglas Mossman & Jill L. Steinberg, *Promoting, Prescribing, and Pushing Pills: Understanding the Lessons of Antipsychotic Drug Litigation*, 13 MICH. ST. U. J. MED. & L. 263, 278–79 (2009) (explaining that "extrapyramidal symptoms" experienced

Antianxiety medications emerged in the 1970s and 1980s, and during the late 1980s and 1990s pharmaceuticals known as selective serotonin reuptake inhibitors (SSRIs) were developed to address depression.¹²³ In 1989, the Food and Drug Administration (FDA) approved clozapine, the first so-called second generation antipsychotic (SGA), or “atypical” antipsychotic, a class of drugs purported to “alleviate psychotic symptoms without inducing the extrapyramidal side effects” common with FGA use and with a much lower occurrence of damaging neuromotor syndromes such as tardive dyskinesia.¹²⁴ Over time, SGAs have become the predominant choice of physicians treating psychoses, although doubts as to their superiority and effectiveness and greater recognition of their own debilitating side effects have emerged.¹²⁵

As a result of the development of these medications and a considerable broadening in the scope of their usage, the number of related prescriptions has grown dramatically in recent years.¹²⁶ While spending on antidepressants more than doubled between 1997 and 2004, the sharpest increase was for drugs used to manage schizophrenia, bipolar disorder, and other psychoses, with spending on such drugs increasing from \$1.3 billion to \$4.1 billion during this period.¹²⁷ It was recently reported that “one in five adults [are] now taking at least one psychiatric drug . . . [and the o]verall use of psychiatric medications among adults grew 22% from 2001 to 2010.”¹²⁸ Although the increased use of medication

by patients taking FGAs included “stiffness, diminished facial expression, tremors, and restlessness[.] . . . permanent and sometimes disabling neuromotor syndromes such as tardive dyskinesia (TD), and . . . neuroleptic malignant syndrome, a severe and sometimes fatal reaction to the drugs” (internal quotation marks omitted).

123. SLOBOGIN ET AL., *supra* note 67, at 23.

124. Mossman & Steinberg, *supra* note 122, at 279–80.

125. See KIRSCH, *supra* note 116; WHITAKER, *supra* note 116; Knable et al., *supra* note 116, at 98; Mossman & Steinberg, *supra* note 122, at 284–93; Goode, *supra* note 116; Mann, *supra* note 116; Vastag, *supra* note 116.

126. See Shirley S. Wang, *Psychiatric Drug Use Spreads: Pharmacy Data Show a Big Rise in Antipsychotic and Adult ADHD Treatments*, WALL ST. J., Nov. 16, 2011, at A3; Sandra G. Boodman, *Antipsychotic Drugs Grow More Popular for Patients Without Mental Illness*, WASH. POST (Mar. 12, 2012), http://www.washingtonpost.com/national/health-science/antipsychotic-drugs-grow-more-popular-for-patients-without-mental-illness/2012/02/02/gIQAHIyz7R_story.html; Rick Nauert, *Cost/Use of Psych Meds Explode*, PSYCH CENT. (Apr. 25, 2007), <http://psychcentral.com/news/2007/04/25/spending-on-psychotherapeutic-drugs-explode>; Vastag, *supra* note 116.

127. Nauert, *supra* note 126.

128. Wang, *supra* note 126 (“In 2010, Americans spent \$16.1 billion on antipsychotics to treat depression, bipolar disorder and schizophrenia, \$11.6 billion on antidepressants and \$7.2 billion on treatment for ADHD”); see also ERWIN BROWN, JR., MED. EXPENDITURE PANEL SURVEY, AGENCY FOR HEALTHCARE RESEARCH & QUALITY, STATISTICAL BRIEF 319: HEALTH CARE EXPENDITURES FOR ADULTS AGES 18–64 WITH A MENTAL HEALTH OR SUBSTANCE ABUSE RELATED EXPENSE: 2007 VERSUS 1997 (2011), available at http://meps.ahrq.gov/data_files/publications/st319/stat319.pdf (explaining that total mental health or

can be explained in part by scientific developments identifying new compounds and additional uses for existing medications, it can also be attributed to their expansive, albeit often unsubstantiated, use to treat a range of disorders¹²⁹ and the fact that many insurance companies will reimburse for the full cost of treatment that relies on medication but only part of the costs associated with psychotherapy.¹³⁰

While medications to treat the biological underpinnings of mental illness became increasingly available and popular, nonbiological treatments, which typically utilize verbal rather than physical interventions, also emerged and evolved.¹³¹ During World War II, psychiatrists found psychoanalysis to be an effective means of achieving relief for battle-worn soldiers and “implemented their new passion with zeal in post-war America.”¹³² Psychoanalysis was subsequently applied to help the average person overcome “problems of everyday life.”¹³³ In 1952, the first edition of the *Diagnostic and Statistical Manual of Mental Disorders* was published,¹³⁴ with a diagnostic scheme “built upon the theoretical framework of Freudian psychoanalysis.”¹³⁵ Moreover, other schools of psychotherapy were also emerging during this time with their practitioners bringing to bear their own expertise.¹³⁶ For example, “[t]he large-scale employment of clinical and counseling psychologists by the Veterans Administration during the World War II era is widely accepted as

substance abuse treatment expenditures for adults between the ages of 18 and 64 were \$36.5 billion in 2007, up \$13 billion from 1997).

129. See Mark Olfson et al., *National Trends in the Office-Based Treatment of Children, Adolescents, and Adults with Antipsychotics*, 69 ARCHIVES GEN. PSYCHIATRY 1247, 1252 (2012) (“Most of the . . . adult antipsychotic visits [to an office-based practice] did not include a diagnosis for which the antipsychotic had FDA approval The strength of evidence supporting efficacy for these ‘off-label’ conditions varies considerably . . .”).

130. See Boodman, *supra* note 126; Ellen Joan Pollock, *Managed Care’s Focus on Psychiatric Drugs Alarms Many Doctors: They Say Effort To Cut Costs Leads to Overuse, Misuse of Pills for Mental Illness; Talk Therapy Is Discouraged*, WALL ST. J., Dec. 1, 1995, at A1.

131. See SLOBOGIN ET AL., *supra* note 67, at 32–42.

132. Steven K. Erickson, *The Myth of Mental Disorder: Transsubstantive Behavior and Taxometric Psychiatry*, 41 AKRON L. REV. 67, 93–94 (2008).

133. *Id.* at 93.

134. *Id.* at 96 (citing AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL: MENTAL DISORDERS (1st ed. 1952)).

135. *Id.*

136. For an overview of the emergence of various schools of thought relating to psychotherapy, see Laurel Furumoto, *The New History of Psychology*, in 9 THE G. STANLEY HALL LECTURE SERIES 9, 11–12 (Ira S. Cohen ed., 1989).

providing a significant impetus to the emergence of psychologists as practitioners”¹³⁷

The 1999 Surgeon General’s report on mental health divided psychotherapy into three major categories: psychodynamic, behavioral, and humanistic,¹³⁸ while a contemporary estimate puts the number of related schools of thought at around 250.¹³⁹ The “school of thought” to which mental health providers belong can have considerable significance in a professional liability suit, as their actions will typically be judged against what a reasonable practitioner of that school of thought would have done under similar circumstances.¹⁴⁰ However, different orientations have grown and faded in popularity over the years, with some discredited and associated professionals found liable when their clients experienced harm.¹⁴¹ For example, “conversion therapy,” a school of thought that had a significant number of adherents at one time, subsequently fell out of favor, and its practitioners became the target of numerous professional liability claims.¹⁴²

137. *Introduction to PSYCHOLOGY AND PROFESSIONAL PRACTICE: THE INTERFACE OF PSYCHOLOGY AND THE LAW*, at x, xi (Francis R.J. Fields & Rudy J. Horwitz eds., 1982) (internal citation omitted); *see also* SLOBOGIN ET AL., *supra* note 67, at 53 (describing clinical psychology as a dominant force since 1950).

138. U.S. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 100, at 65–67.

139. SHAPIRO & SMITH, *supra* note 90, at 26–27.

140. *Id.*

141. *See, e.g.*, Jonathan Sacks, New Development, “*Pray Away the Gay?*”: *An Analysis of the Legality of Conversion Therapy by Homophobic Religious Organizations*, 13 RUTGERS J.L. & RELIGION 67, 72–78 (2011).

142. *Id.* Therapists employing “conversion therapy” attempted to “re-orient” someone with a homosexual orientation to a heterosexual preference. *Id.* at 67–68. Treatment centers were typically supported by organized religions opposed to homosexuality under the belief that it is morally wrong. *Id.* at 72 (“[A]ntigay views are ‘frequently rooted in sacred texts and codes of sexual conduct derived from those texts.’” (quoting John C. Green, *Antigay: Varieties of Opposition to Gay Rights*, in *THE POLITICS OF GAY RIGHTS* 121, 122 (Craig Rimmerman et al. eds., 2000), available at <https://www9.georgetown.edu/faculty/wilcox/green.pdf>)). These centers “utilized a variety of treatments . . . includ[ing] . . . psychoanalytic therapy, prayer and spiritual interventions, electric shock, nausea-inducing drugs, hormone therapy, surgery, and behavioral treatments, including masturbatory reconditioning, rest, visits to prostitutes, and excessive bicycle riding.” *Id.* at 70 (citing Douglas C. Haldeman, *The Practice and Ethics of Sexual Orientation Conversion Therapy*, 62 J. CONSULTING & CLINICAL PSYCHOL. 221, 221 (1994)). Conversion therapy is extremely controversial given the fact that, although once considered a mental disorder, homosexuality has been removed from the *Diagnostic and Statistical Manual of Mental Disorders* since 1973 and is increasingly viewed as a legitimate sexual orientation or behavior. *Id.* at 72–73 (citing Douglas C. Haldeman, *Sexual Orientation Conversion Therapy for Gay Men and Lesbians: A Scientific Examination*, in *HOMOSEXUALITY: RESEARCH IMPLICATIONS FOR PUBLIC POLICY* 149, 149 (John C. Gonsiorek & James D. Weinrich eds., 1991), available at <http://drdoughaldeman.com/doc/ScientificExamination.pdf>). Studies have also failed to show that these therapies are safe or effective, with “these forms of treatment hav[ing] resulted in patients suffering nervous breakdowns, experiencing feelings of guilt, committing suicide, self-mutilating their genitalia, exhibiting symptoms of

A raging debate continues over the relative efficacy and appropriateness of psychotherapy and psychopharmacology for addressing a range of disorders, with both camps citing research that ostensibly documents the value of their treatment approach.¹⁴³ Although some have asserted that psychotherapy and psychopharmacology should be viewed as alternative or complementary approaches rather than being seen as antithetical to one another,¹⁴⁴ this ongoing controversy suggests that mental health practitioners, regardless of their preferred treatment approach, need to remain aware of and be conversant regarding the potential benefits—and risks—of alternative treatment courses and refer their clients to other practitioners when these alternatives better meet their needs.¹⁴⁵ At a minimum, to avoid liability when there are several courses of treatment available and the most appropriate choice is not clear, mental health providers should obtain a consultation from someone with expertise

post-traumatic stress disorder, and experiencing other psychological traumas.” *Id.* at 75 (citing Karolyn Ann Hicks, “Reparative” Therapy: Whether Parental Attempts To Change a Child’s Sexual Orientation Can Legally Constitute Child Abuse, 49 AM. U. L. REV. 505, 515 & n.42 (1999)). Where clients are subjected to conversion therapy and suffer severe emotional harm as a result, the providing therapists may be subject to liability. *See id.* at 78.

143. Compare Marcia Angell, *The Epidemic of Mental Illness: Why?*, N.Y. REV. BOOKS, June 23, 2011, at 20, available at <http://www.nybooks.com/articles/archives/2011/jun/23/epidemic-mental-illness-why>, and Marcia Angell, *The Illusions of Psychiatry*, N.Y. REV. BOOKS, July 14, 2011, at 20, available at <http://www.nybooks.com/articles/archives/2011/jul/14/illusions-of-psychiatry/?pagination=false>, with Peter D. Kramer, Opinion, *In Defense of Antidepressants*, N.Y. TIMES, July 10, 2011, at SR1. *See also* KIRSCH, *supra* note 116, at 9–10 (finding that drugs and psychotherapy are equally effective at treating depression); WHITAKER, *supra* note 116, at 71 (disputing the serotonin theory of depression); Vastag, *supra* note 116 (discussing research indicating that SGAs are minimally effective). For better or for worse, the delivery of mental health treatment in recent years has parsed into that provided by medically trained professionals, who focus almost exclusively on the prescription and monitoring of pharmaceutical agents, and nonmedically trained professionals—such as clinical psychologists—who typically are not allowed to prescribe pharmaceutical agents and rely instead on psychotherapy and various cognitive-behavioral interventions. *See* Jonathan Alpert, Opinion, *In Therapy Forever? Enough Already*, N.Y. TIMES, Apr. 22, 2012, at SR5; Siddhartha Mukherjee, *Post-Prozac Nation: The Science and History of Treating Depression*, N.Y. TIMES MAG., Apr. 22, 2012, at 48; *infra* Part VI.

144. *See* Ripu D. Jindal & Michael E. Thase, *Integrating Psychotherapy and Pharmacotherapy To Improve Outcomes Among Patients with Mood Disorders*, 54 PSYCHIATRIC SERVICES 1484, 1484 (2003); Sandro Pampallona et al., *Combined Pharmacotherapy and Psychological Treatment for Depression*, 61 ARCHIVES GEN. PSYCHIATRY 714, 714 (2004).

145. *See supra* notes 75–76 and accompanying text.

regarding these alternatives.¹⁴⁶ A failure to obtain a needed referral or consult when treating a client can constitute a breach of the standard of care and result in liability for the provider.¹⁴⁷ Also, if a practitioner believes a client needs a treatment other than that approved by the client's healthcare payor, there may be a duty to challenge the insurance company's coverage refusal.¹⁴⁸

V. THE IMPACT OF THE INCREASED USE OF PSYCHOTROPIC MEDICATIONS

As described, the use of psychotropic medications now has a relatively lengthy history, and although initially used primarily to treat more serious conditions where psychotic symptoms were present, they are now prescribed for a broad range of less serious disorders as well.¹⁴⁹ Because of an oftentimes urgent need for a well-directed response, as well as various associated side effects, mental health providers must carefully prescribe these medications¹⁵⁰ and monitor their use, with

146. See Ryan C.W. Hall & Phillip J. Resnick, *Psychotherapy Malpractice: New Pitfalls*, 14 J. PSYCHIATRIC PRAC. 119, 121 (2008) ("If there is concern about which course of action is appropriate, obtain an official consultation from another colleague and/or a legal representative This shows deliberation and an attempt to act in good faith.").

147. See, e.g., *Pard v. United States*, 589 F. Supp. 518, 526 (D. Or. 1984) (finding that a psychiatrist avoided liability by acknowledging he was not capable of dealing with patient's problems and referring patient to another facility); *Klein v. Solomon*, 713 A.2d 764, 766 (R.I. 1998) (involving a university psychologist who treated a student with suicidal tendencies and was found liable when he failed to refer the student to someone qualified in suicide prevention or someone who could prescribe some form of medication to reduce his suicidal tendencies); see also Sally Clayton & Bruce Bongar, *The Use of Consultation in Psychological Practice: Ethical, Legal, and Clinical Considerations*, 4 ETHICS & BEHAV. 43, 43-44 (1994) (arguing that the importance of consulting in health care is well documented but psychologists often fail to do so); James M. Ellison, *Teaching Collaboration Between Pharmacotherapist and Psychotherapist*, 29 ACAD. PSYCHIATRY 195 (2005) (advocating that psychiatric residents be taught collaborative pharmacotherapy); *supra* notes 75-76, *infra* notes 165, 190, 196 and accompanying text.

148. See *Muse v. Charter Hosp. of Winston-Salem, Inc.*, 452 S.E.2d 589, 594 (N.C. Ct. App. 1995).

149. See Olfson et al., *supra* note 129, at 1247 (finding that from 2005 to 2008 antipsychotics were most commonly prescribed to children for disruptive behavior disorders and to adults for depression and bipolar disorder); Wang, *supra* note 126 (discussing overall increase in antipsychotic prescriptions and growing use for treating attention-deficit hyperactive disorder); Boodman, *supra* note 126 (describing shift in prescribing antipsychotics from primarily targeting schizophrenia and bipolar disorder to treating anxiety, attention-deficit disorder, and sleep and behavioral problems)

150. The privilege to prescribe medications is generally established as a matter of state law. Typically only physicians and various other medically trained providers are granted this privilege—as well as psychologists in New Mexico and Louisiana. See *infra* notes 191-201 and accompanying text. However, because medications have come to play such a significant role in the treatment of mental illness, all mental health providers must be aware of their impact and take appropriate steps pertaining to their use. See *supra* notes 145-47 and accompanying text.

modifications promptly made as needed.¹⁵¹ A failure to take appropriate steps when prescribing or monitoring psychotropic medications can establish a lack of due care, with recent associated malpractice claims falling into the following ten basic categories¹⁵²:

1. Failing to prescribe or continue needed medication or provide a sufficient level of medication to adequately address a patient's condition;¹⁵³
2. Issuing an unclear or illegible medication order;¹⁵⁴
3. Exceeding established recommended dosage without a justifying clinical indication, particularly when toxic levels were reached or adverse side effects induced;¹⁵⁵
4. Prescribing multiple drugs to a patient—"polypharmacy"—particularly when adverse interactions among the medications result;¹⁵⁶
5. Prescribing medications that have not been approved by the FDA,¹⁵⁷

151. See Elizabeth Williams, *Cause of Action for Negligence or Malpractice of Psychiatrist*, in 13 CAUSES OF ACTION 453, 492 (2d ed. 1999).

152. See Robert I. Simon, *The Law and Psychiatry*, 1 FOCUS 349, 352 (2003), available at <http://focus.psychiatryonline.org/article.aspx?articleid=49487>.

153. See, e.g., *Gowan v. United States*, 601 F. Supp. 1297, 1300 (D. Or. 1985) (holding doctor not liable after discontinuing drug treatment for psychiatric patient); *Paddock v. Chacko*, 522 So. 2d 410, 417 (Fla. Dist. Ct. App. 1988) (holding failure to prescribe proper amounts of antipsychotic drugs was not proximate cause of patient's injuries); Bill Rankin, *State High Court Lets Malpractice Suit Go Forward in Killing*, ATLANTA J.-CONST., Sept. 13, 2011, at 2B ("The Georgia Supreme Court is allowing a lawsuit filed on behalf of a mentally ill man who savagely killed his mother to proceed against the man's psychiatrist for discontinuing medications shortly before the homicide.").

154. See, e.g., Fred Charatan, *Compensation Awarded for Death After Illegible Prescription*, 172 W.J. MED. 80, 80 (2000).

155. See, e.g., *Moon v. United States*, 512 F. Supp. 140, 146 (D. Nev. 1981) (involving a psychiatrist sued for prescribing prolixin in daily dosages in excess of twenty milligrams when the recommended dosage is two to ten milligrams per day).

156. See, e.g., *Whittle v. United States*, 669 F. Supp. 501, 501 (D.D.C. 1987) (holding that "psychiatric resident's prescription of dangerous combination of antidepressant and barbiturates was direct and proximate cause of patient's death"); *Quigley v. Thai*, No. 2:09-CV-14221, 2011 WL 3027809, at *1-2 (E.D. Mich. July 25, 2011) (involving decedent's estate filing a wrongful death claim after healthy twenty-three-year-old decedent died following ingestion of two different antidepressants prescribed to him for use in combination).

157. See *Unapproved Drugs: Drugs Marketed in the United States That Do Not Have Required FDA Approval*, U.S. FOOD & DRUG ADMIN., <http://www.fda.gov/Drugs/GuidanceComplianceRegulatoryInformation/EnforcementActivitiesbyFDA/SelectedEnforcementActionsonUnapprovedDrugs/default.htm> (last updated Aug. 22, 2012).

6. Prescribing medication for a use other than that for which FDA approval was granted—“off-label” usage¹⁵⁸—particularly if an adverse reaction results and adequate justification for the usage is not supplied,¹⁵⁹ notwithstanding that this practice is common and can be appropriate when treating mental illness;¹⁶⁰
7. Failing to adequately disclose the risks associated with a given medication;¹⁶¹
8. Failing to monitor a patient’s compliance with a prescribed medication and dosage, which may entail under- or over-consumption of the prescription,¹⁶² or failing to properly wean a patient from a previously prescribed medication;¹⁶³

158. See BARRY R. FURROW ET AL., *LIABILITY AND QUALITY ISSUES IN HEALTH CARE* 80 (6th ed. 2008) (“Once a drug is approved for prescribing . . . the FDA does not have the authority to restrict physicians in their prescribing of the drug for particular purposes. . . . Prescribing drugs for a different purpose, in a higher or lower dose, or for a different population (e.g., children) than those for which the FDA approved the medication is called ‘off-label’ prescribing.”).

159. See Rebecca Dresser & Joel Frader, *Off-Label Prescribing: A Call for Heightened Professional and Government Oversight*, 37 J.L. MED. & ETHICS 476, 476 (2009) (“Responsible off-label prescribing requires physicians to: (1) evaluate whether there is sufficient evidence to justify an off-label use; (2) press for additional information and research when adequate evidence is lacking; and (3) inform patients about the uncertainties and potential costs associated with off-label prescribing.”); David C. Radley et al., *Off-Label Prescribing Among Office-Based Physicians*, 166 ARCHIVES INTERNAL MED. 1021, 1023 (2006) (“The greatest disparity between supported and unsupported off-label prescription occurred among psychiatric [therapies] (4% strong support vs 96% limited or no support)”); Boodman, *supra* note 126 (“[T]hese days atypical antipsychotics . . . are being prescribed by psychiatrists and primary-care doctors to treat a panoply of conditions for which they have not been approved, including anxiety, attention-deficit disorder, sleep difficulties, behavioral problems in toddlers and dementia.”).

160. See *supra* note 129 and accompanying text.

161. See, e.g., *Whittle*, 669 F. Supp. at 506 (holding doctor liable when he “fail[ed] to give [his patient] an explanation of the potential risks and benefits of the proposed course of treatment”; *Nail v. Georgia*, 686 S.E.2d 483, 485 (Ga. Ct. App. 2009) (involving a state mental health patient who claimed her physician failed to warn her that the drug Risperdal could cause Parkinson’s disease, which she developed); *White v. Lawrence*, 975 S.W.2d 525, 530 (Tenn. 1998) (holding doctor liable for directing patient’s wife to covertly administer Disulfiram—commonly known as Antabuse—to an alcoholic patient when doctor knew it reacted negatively with alcohol); see also *infra* Part VIII.

162. See, e.g., *Speer v. United States*, 512 F. Supp. 670, 676 (N.D. Tex. 1981) (holding psychiatrist not liable for failing to monitor patient’s use of medication after patient killed himself by overdosing on pills); *Davisson v. Nicholson*, 310 S.W.3d 543, 547 (Tex. App. 2010) (involving an action filed against a psychologist, physician, and the clinic that employed them alleging they were “negligent by continuing ‘to provide medical care and treatment’ to [the patient] and ‘by providing continued prescriptions for Adderall,’ despite collectively having seen [the patient] in the office only two or three times during that five-year period.”).

163. See, e.g., *Stormont-Vail Healthcare, Inc. v. Cutter*, 178 P.3d 35, 37–38 (Kan. Ct. App. 2007) (involving a suit filed against a doctor by a former patient alleging he breached “his duty of reasonable care by ‘abruptly taking [her] off Paxil, and by failing to place [her] on the proper taper-phase regimen for Paxil’ . . . , thus endangering her life”).

9. Failing to monitor the course of treatment and to treat side effects after they have been identified or should have been identified;¹⁶⁴ and
10. Failing to refer a patient for consultation or treatment by a specialist or another mental health provider when the needs of the patient exceed the expertise of the prescribing mental health provider.¹⁶⁵

Recently there has been a concerted effort to reduce psychiatric polypharmacy.¹⁶⁶ Individuals with a mental illness are often prescribed multiple psychiatric medications, sometimes from the same medication class—same-class polypharmacy—or sometimes from different medication classes—multiclass polypharmacy—to treat a given symptom cluster, usually with little scientific evidence as to the interactive effects of such combinations.¹⁶⁷ Although there are circumstances in which polypharmacy is an appropriate course of action, prescribers have been urged to “remain skeptical of polypharmacy approaches until proven,” “[c]onsider treatment alternatives, such as the use of psychosocial interventions, before prescribing an additional medication,” and anticipate and monitor for

164. See, e.g., *Freeman v. Lebedovych*, 186 Fed. App’x 943, 944–45 (11th Cir. 2006) (involving a prisoner suing psychiatrist, alleging deliberate indifference to prisoner’s condition after doctor continued prescribing medication that allegedly caused severe side effects). Because determining the appropriate medication for a given patient continues to involve a considerable degree of trial and error, modification of a prescription is often needed as greater understanding of the disorder, which may evolve over time, and the effectiveness and manifested side effects of the medication prescribed is gained. See Haiden A. Huskamp, *Managing Psychotropic Drug Costs: Will Formularies Work?*, 22 HEALTH AFF. 84, 89–90 (2003). In addition, as is generally the case for all medications, a healthcare provider is typically provided only a range of recommended dosages and must ascertain over time what is a safe and efficacious dosage level for the patient. *But see Vera v. Beth Israel Med. Hosp.*, 625 N.Y.S.2d 499, 500–01 (App. Div. 1995) (holding physician not liable for patient’s attempted suicide after prescribing dosage with limited information on patient’s health).

165. See *supra* notes 76, 145–47, *infra* notes 190, 196 and accompanying text.

166. See NAT’L ASS’N OF STATE MENTAL HEALTH PROGRAM DIRS., TECHNICAL REPORT ON PSYCHIATRIC POLYPHARMACY 5–6 (2001), available at <http://www.nasmhpd.org/docs/publications/archiveDocs/2001/Polypharmacy.pdf>; see also Steven J. Kingsbury & Megan Leahy Lotito, *Psychiatric Polypharmacy: The Good, the Bad, and the Ugly*, PSYCHIATRIC TIMES (Apr. 1, 2007), <http://www.psychiatrictimes.com/display/article/10168/53816>.

167. See NAT’L ASS’N OF STATE MENTAL HEALTH PROGRAM DIRS., *supra* note 166, at 5–7; Kingsbury & Lotito, *supra* note 166.

interactions.¹⁶⁸ Because of the ever-increasing number of largely unexplored possible combinations of psychiatric medications¹⁶⁹ and the idiosyncratic responses patients often have to them,¹⁷⁰ polypharmacy-focused litigation is particularly likely to continue to expand.

VI. THE EXPANDING ROLE OF PRIMARY CARE PHYSICIANS AND PRESCRIBING PRIVILEGES

A key component of the increased use of psychotropic medications is the enhanced role of primary care physicians in the delivery of mental health care, particularly with regard to the treatment of anxiety and depression.¹⁷¹ Primary care physicians play a predominant and expanding role in today's health care landscape,¹⁷² but this has especially been the case with regard to mental health care. This role is driven in part by the unavailability of psychiatrists and other mental health providers in many parts of the country.¹⁷³ However, it also reflects the fact that for most individuals, primary care physicians are the arbiters of their health care needs.¹⁷⁴ Patients' concerns about their health and health care are usually, and under most health plans must be, first directed to their primary care physician, including questions about their mental health and related treatment options.¹⁷⁵ "Primary care providers are the sole contacts for

168. NAT'L ASS'N OF STATE MENTAL HEALTH PROGRAM DIRS., *supra* note 166, at 9, 15–16.

169. Kingsbury & Lotito, *supra* note 166 ("Given the overwhelming number of possible combinations, it is unlikely that more than a few of these will be researched.").

170. *Id.* ("It should be realized that regardless of the rationale or quality of the research, the combination chosen might not be effective for a given patient.").

171. Tami L. Mark et al., *Psychotropic Drug Prescriptions by Medical Specialty*, 60 PSYCHIATRIC SERVICES 1167, 1167 (2009) ("[O]f the 472 million prescriptions for psychotropic medications, 59% were written by general practitioners, 23% by psychiatrists, and 19% by other physicians and non-physician providers."); Olfson et al., *supra* note 129, at 1254 ("The increase [in antipsychotic medications] . . . has been especially concentrated among . . . those treated by nonpsychiatrist physicians.").

172. The PPACA seeks to increase the quality of health care services and limit their costs by expanding the role of primary physicians in delivering health care. See Howard Dean, *The Evolving Role of Physicians in a Reformed American Health Care System*, 39 HOFSTRA L. REV. 9, 12 (2010).

173. See Kathleen C. Thomas et al., *County-Level Estimates of Mental Health Professional Shortage in the United States*, 60 PSYCHIATRIC SERVICES 1323, 1323 (2009) (detailing the "shortage of mental health professionals" that "has been a persistent concern for decades" and the "poor distribution of behavioral health professionals across the United States").

174. See Barry L. Carter, *Pharmacotherapy and the Primary Care Physician*, 17 PRIMARY CARE 469, 469 (1990) (explaining that the primary care physician is seen as the coordinator of health care services for the patient).

175. See *Primary Care Providers' Role in Mental Health*, BAZELON CENTER FOR MENTAL HEALTH L. 1–2, <http://www.bazelon.org/LinkClick.aspx?fileticket=CBTKUhxTivw%3D&tabid=220> (last visited Mar. 31, 2013).

more than 50% of patients with mental illness and have thus been described as the de facto system of treatment for mental health.”¹⁷⁶ Several factors make primary care providers likely, at least initially, to attempt to resolve their patients’ mental health problems by prescribing a treatment regime of psychotropic medications¹⁷⁷: their training and background consist primarily of a biological approach to treating mental illness,¹⁷⁸ the treatment options readily available to them are typically limited to medications,¹⁷⁹ their “gatekeeping” responsibilities restrict referrals to mental health specialists,¹⁸⁰ and they have a desire to personally assist their patients—which also typically reflects the expectations of their patients.¹⁸¹ They may even avoid assigning patients a mental disorder diagnosis “to

176. W. David Robinson et al., *Depression Treatment in Primary Care*, 18 J. AM. BOARD FAM. PRAC. 79, 79 (2005).

177. See BAZELON CENTER FOR MENTAL HEALTH L., *supra* note 175, at 1–2; Nahid M. Abed Faghri et al., *Understanding the Expanding Role of Primary Care Physicians (PCPs) to Primary Psychiatric Care Physicians (PPCPs): Enhancing the Assessment and Treatment of Psychiatric Conditions*, 7 MENTAL HEALTH FAM. MED. 17, 20 (2010).

178. The education of most primary care physicians includes a very limited “psych” rotation, where the treatment options explored are predominantly biological in nature—the use of psychopharmacological agents. See James A. Clardy et al., *The Junior-Year Psychiatric Clerkship and Medical Students’ Interest in Psychiatry*, 24 ACAD. PSYCHIATRY 35, 38 (2000).

179. The treatment options immediately available are generally restricted to medications falling within the healthcare payor’s formulary of approved medications. See Jürgen Unützer et al., *Transforming Mental Health Care at the Interface with General Medicine: Report for the President’s Commission*, 57 PSYCHIATRIC SERVICES 37, 38 (2006).

180. Under most health care plans, unless it is an emergency, patients are required to first seek out their primary care physician to address any emerging health care needs. See Peter J. Cunningham, *Beyond Parity: Primary Care Physicians’ Perspectives on Access to Mental Health Care*, 28 HEALTH AFF. W490, W491, W493 (2009). The primary care physician, in turn, serves as a “gatekeeper” for determining whether a patient should instead or in addition see a specialist, such as a mental health provider. *Id.* Under some health care plans, primary care physicians are “encouraged” by various means, including capitation, to minimize the number of these referrals, even though the primary care physician is typically an internist with limited expertise in mental health issues. Jerome P. Kassirer, *Access to Specialty Care*, 331 NEW ENG. J. MED. 1151, 1151 (1994). As a result, generally only if the primary care physician provides a referral to a specialist will the patient be able to see a mental health professional. See *What Do I Need To Know About My Insurance Benefits When Seeking Treatment?*, MENTAL HEALTH AM., <http://www.nmha.org/go/faqs/insurance> (last visited Mar. 31, 2013).

181. This devotion to their patients is driven by a number of factors, including their ethical obligation to provide care and treatment to their patients, the personal bond that is typically built up over the course of a series of visits that may span years, and the desire and need to retain their patients’ loyalty and thereby maintain their practice. See Sara Carmel & Seymour M. Glick, *Compassionate-Empathic Physicians: Personality Traits and Social-Organizational Factors That Enhance or Inhibit This Behavior Pattern*, 43 SOC. SCI. & MED. 1253, 1256–58 (1996).

minimize stigma, to prevent adverse legal or occupational consequences associated with seeking mental health treatment, or to capture more health plan benefits than would be available by providing *mental health treatment*.¹⁸²

With primary care physicians increasingly assuming the role of a mental health treatment provider, a role they may be only marginally qualified to fill, their care is likely to fuel a greater number of medical malpractice suits. Further, the fiscal pressures imposed by managed care and other third-party payors have increased the volume of patients seen by these physicians and decreased the amount of time spent with each one.¹⁸³ This, in turn, limits their ability to explore patients' problems, research and consider treatment options, and develop a working alliance that can enhance treatment success by encouraging trust, disclosures, and treatment compliance.¹⁸⁴ Also, whereas once the relationship between health care providers and patients created a bond that made patients reluctant to sue their health care provider, the reduction in the time spent together diminishes this protection from liability.¹⁸⁵

Given their modest expertise in the area of mental health, primary care providers must be especially mindful when treating patients for mental disorders. For example, it has been estimated that primary care physicians "recognize only half of [their] patients with major depression."¹⁸⁶ Other studies have found that patients treated with antidepressants in the primary care setting "did not always receive a dosage and/or a therapy duration in line with the recommendations included in international guidelines about depression treatment."¹⁸⁷ Further, close follow-up monitoring, which is generally absent in this setting,¹⁸⁸ is often prudent.¹⁸⁹

182. Olfson et al., *supra* note 129, at 1253 (emphasis added) (footnotes omitted).

183. See Debra S. Feldman et al., *Effects of Managed Care on Physician-Patient Relationships, Quality of Care, and the Ethical Practice of Medicine: A Physician Survey*, 158 ARCHIVES INTERNAL MED. 1626, 1629 (1998).

184. See *id.* at 1630.

185. See *id.*

186. Gregory E. Simon & Michel VonKorff, *Recognition, Management, and Outcomes of Depression in Primary Care*, 4 ARCHIVES FAM. MED. 99, 99 (1995).

187. Marco Menchetti et al., *Pharmacological Treatment of Depression in Primary Care: An Updated Literature Review (2000-2009)*, 8 CLINICAL NEUROPSYCHIATRY 234, 234 (2011) (citing Wayne Katon et al., *Adequacy and Duration of Antidepressant Treatment in Primary Care*, 30 MED. CARE 67 (1992)); see also Simon Gilbody et al., *Educational and Organizations Interventions To Improve the Management of Depression in Primary Care: A Systematic Review*, 289 JAMA 3145, 3145 (2003) ("Despite the frequency of presentation and the availability of effective interventions, the diagnosis and treatment of depression by nonspecialist practitioners often do not follow current guidelines" (footnotes omitted)).

188. Leif I. Solberg et al., *Follow-Up and Follow-Through of Depressed Patients in Primary Care: The Critical Missing Components of Quality Care*, 18 J. AM. BD. FAM. PRAC. 520, 521 (2005).

Thus, primary care physicians are exposing themselves to malpractice claims for a failure to adequately diagnose, treat, and monitor their patients once treatment—primarily a prescribed medication—commences. Referrals to and collaboration with a specialist in mental health care can help a primary care physician avoid or defeat such claims.¹⁹⁰

In addition, partially in response to a shortage of primary care physicians and a desire for cheaper health care alternatives, a number of states have extended prescribing privileges to physician assistants and other ancillary health care providers.¹⁹¹ Considering that they may have even less training and expertise in the diagnosis and treatment of psychiatric disorders than primary care physicians,¹⁹² their involvement in the delivery of mental health services is also ripe for litigation.

Similarly, in response to a need for the increased availability of mental health treatment in rural areas and a belief that “prescription authority is the next logical step in the professional development of clinical psychology,”¹⁹³ two states have enacted legislation enabling psychologists with specified training to obtain prescribing authority, with other states

189. For example, numerous metaanalyses “suggest a true short-term increase in suicidal behavior in young adults (aged 18 to 29 years) who receive antidepressants,” the population most likely to receive this medication. Elizabeth A. O’Connor et al., *Screening for Depression in Adult Patients in Primary Care Settings: A Systematic Evidence Review*, 151 ANNALS INTERNAL MED. 793, 800 (2009).

190. See Unützer et al., *supra* note 179, at 39. Historically, physicians were solo practitioners with total autonomy over patients’ well-being. JACALYN DUFFIN, HISTORY OF MEDICINE: A SCANDALOUSLY SHORT INTRODUCTION 137–38 (2d ed. 2010). Care is increasingly now provided by a team of providers, with specific health care needs addressed by various specialists. See Sara Michael, *The Future of Healthcare*, PHYSICIANS PRAC. (Apr. 1, 2010), <http://www.physicianspractice.com/future-healthcare>. Even when a team approach is not employed, health care providers are expected to consult with other specialists as needed and to refer patients to a specialist when a patient’s treatment needs exceed the provider’s expertise. 1 STEVEN E. PEGALIS & HARVEY F. WACHSMAN, AMERICAN LAW OF MEDICAL MALPRACTICE §§ 3:2, 3:10 (2d ed. 1992); see also *supra* notes 76, 145–47, *infra* note 196 and accompanying text.

191. See Roderick S. Hooker, *Prescribing by Physician Assistants and Nurse Practitioners*, AM. J. MANAGED CARE (Dec. 21, 2010), http://www.ajmc.com/articles/AJMC_10decHooker_Xcl_e356to7 (noting “an ever-widening sphere of prescribers”); Julia Johnson, Student Article, *Whether States Should Create Prescription Power for Psychologists*, 33 LAW & PSYCHOL. REV. 167, 167 (2009) (“[D]entists, optometrists, podiatrists, and nurses with various advanced degrees all have some prescription power in most states.”).

192. See *In re* Walter R., 2004 ME 77, ¶ 16, 850 A.2d 346, 351 (acknowledging that physician assistants are not as well-trained as psychiatrists).

193. James E. Long, Jr., Student Article, *Power To Prescribe: The Debate Over Prescription Privileges for Psychologists and the Legal Issues Implicated*, 29 LAW & PSYCHOL. REV. 243, 248–49 (2005).

considering this option.¹⁹⁴ Granting psychologists this power is controversial, and opponents argue that the training programs are not sufficient,¹⁹⁵ with a better solution being to “increase mental health training for general practitioners and encourage collaboration between the two professions.”¹⁹⁶

What is clear, however, is that psychologists who obtain prescribing power open themselves up to the increased liability associated with prescribing medications.¹⁹⁷ As for the governing standard of care, courts may hold them to the same standard as physicians or compare them to other prescribing nonphysicians with a similar level of training and education, with the latter resulting in the application of a more lenient standard.¹⁹⁸ Given that courts typically have not employed the physician standard in cases involving other nonphysician prescribers,¹⁹⁹ a similar approach may well be used with psychologists.²⁰⁰ Regardless, the increase in liability exposure accompanying prescribing power will most likely cause psychologists to increase their malpractice coverage and fees.²⁰¹

VII. PEDIATRIC PSYCHOTROPIC MEDICATIONS

The prescribing of psychotropic medications to children and adolescents is also rife with uncertainty and potential liability for mental health providers. It is estimated that roughly twenty percent of individuals eighteen years and younger meet the criteria for a psychiatric diagnosis,²⁰² with half of them suffering a significant functional impairment as a

194. See Johnson, *supra* note 191, at 167 (“With the relatively recent legislation in New Mexico and Louisiana, states are being forced, at the very least, to broach the subject within their respective governments.”); Long, *supra* note 193, at 244–45. Psychologists can also prescribe psychotropic medications in Guam. Nancy A. Melville, *Physicians Fight To Keep Psychologists from Prescribing*, MEDSCAPE (Mar. 27, 2013), <http://www.medscape.com/viewarticle/781519>.

195. Long, *supra* note 193, at 251–52.

196. *Id.* at 253; see also *supra* notes 75–76, 145, 165, 190 and accompanying text.

197. See Johnson, *supra* note 191, at 175.

198. *Id.*

199. See, e.g., *In re Abdo*, 2002-2513, p. 6–7 (La. App. 4 Cir. 7/9/03); 852 So. 2d 513, 518 (holding that the applicable standard for a nurse prescribing medication is the “nursing standard of care”); *Silves v. King*, 970 P.2d 790, 795 (Wash. Ct. App. 1999) (holding that nurse did not have a duty to warn patient of potentially harmful drug interactions because nurse is not qualified to assess risks as a physician is).

200. See Johnson, *supra* note 191, at 175.

201. See *id.* at 176.

202. See Myron L. Belfer, *Child and Adolescent Mental Disorders: The Magnitude of the Problem Across the Globe*, 49 J. CHILD PSYCHOL. & PSYCHIATRY 226, 226 (2008); see also *supra* notes 35–36 and accompanying text.

result of their mental disorder.²⁰³ Research also indicates that these disorders can have long-term effects, as mental illness can dramatically reduce life expectancy, life satisfaction, and lifetime income.²⁰⁴

A national study found that half of those who experience a mental illness begin to show symptoms by the age of fourteen, that these symptoms often go untreated, and that untreated mental disorders can lead to more severe and difficult-to-treat illnesses.²⁰⁵ A professor of health care policy at Harvard Medical School who conducted this study explained: “The pattern appears to be that the earlier in life the disorder begins, the slower an individual is to seek therapy, and the more persistent the illness.”²⁰⁶ The parties responsible for these children may miss or ignore these symptoms, hoping or believing they represent a “passing phase,” while the child may believe likewise or attempt to hide symptoms out of confusion, embarrassment, self-loathing, anger, distrust, or fear.²⁰⁷

203. Andrés Martin & Douglas Leslie, *Psychiatric Inpatient, Outpatient, and Medication Utilization and Costs Among Privately Insured Youths, 1997–2000*, 160 AM J. PSYCHIATRY 757, 757 (2003) (citing U.S. DEP’T OF HEALTH & HUMAN SERVS., *supra* note 100).

204. See Ronald C. Kessler et al., *Individual and Societal Effects of Mental Disorders on Earnings in the United States: Results from the National Comorbidity Survey Replication*, 165 AM. J. PSYCHIATRY 703, 709 fig.2 (2008) (finding serious mental illnesses have significant effects on earnings); Sami Pirkola et al., *General Health and Quality-Of-Life Measures in Active, Recent, and Comorbid Mental Disorders: A Population-Based Health 2000 Study*, 50 COMPREHENSIVE PSYCHIATRY 108, 108 (2009) (concluding that anxiety and depressive disorders lead to low health and quality of life); Dominic Hughes, *Mentally Ill Have Reduced Life Expectancy, Study Finds*, BBC NEWS (May 17, 2011, 8:59 PM), <http://www.bbc.co.uk/news/health-13414965> (“People suffering from serious mental illnesses . . . can have a life expectancy 10 to 15 years lower than the . . . average.”); Alan Mozes, *Kids’ Psychological Problems Have Long Term Effects*, U.S. NEWS: HEALTH (May 17, 2010), <http://health.usnews.com/health-news/family-health/brain-and-behavior/articles/2010/05/17/kids-psychological-problems-have-long-term-effects> (describing how mental illness diminishes lifetime income by as much as twenty percent and reduces the likelihood of marriage).

205. Press Release, Nat’l Inst. of Mental Health, *Mental Illness Exact Heavy Toll, Beginning in Youth* (June 6, 2005), <http://www.nimh.nih.gov/science-news/2005/mental-illness-exacts-heavy-toll-beginning-in-youth.shtml>; see also Ian Colman et al., *Forty-Year Psychiatric Outcomes Following Assessment for Internalizing Disorder in Adolescence*, 164 AM. J. PSYCHIATRY 126, 128 (2007) (finding that about seventy percent of adolescents who had an internalizing disorder at both ages thirteen and fifteen had a mental disorder at age thirty-six, forty-three, or fifty-three, compared with about twenty-five percent of mentally healthy adolescents).

206. Nat’l Inst. of Mental Health, *supra* note 205 (quoting Dr. Ronald Kessler, Professor of Health Care Policy, Harvard Medical School).

207. See Carolyn A. McCarty et al., *Adolescents with Suicidal Ideation: Health Care Use and Functioning*, 11 ACAD. PEDIATRICS 422, 424–25 (2011) (discussing the limited numbers of teens receiving the proper mental health care they need due to low detection rates). Victims of child abuse show particularly high rates of mental disorders. See Thomas

Even more so than the use of psychotropic medication prescriptions in general, their use with children and adolescents has exploded over the past two decades. A national study found that from 1993 to 2009 the percentage of visits to office-based physicians in which antipsychotic medications were provided increased over sevenfold for children, almost fivefold for adolescents, and slightly less than twofold for adults.²⁰⁸ There was “a particularly marked increase” in the use of these medications for youths with a mood disorder, as by the end of the study period almost one-third of office visits involving this diagnosis incorporated such medication.²⁰⁹ Similarly, the prescribing of medications for attention-deficit/hyperactivity disorder (ADHD) in children ages five through fourteen rose dramatically, while “treatment in preschoolers increased approximately 3-fold during the early 1990s.”²¹⁰ It has been noted that “[ADHD] and other disruptive disorders account for . . . 37.8%[] of antipsychotic use” in youth,²¹¹ with a 2007 national survey finding that “4.8% of all children aged 4–17 (2.7 million) were taking medication for ADHD.”²¹² In addition, over the course of a decade, the use of antipsychotic medication to treat youth with an anxiety disorder roughly doubled.²¹³

Proponents of these medications have identified several factors justifying their use, including increasing evidence of childhood psychiatric conditions, the public’s greater acceptance of biological interventions, and an increase in the number of pediatric clinical trials demonstrating

L. Hafemeister, *Castles Made of Sand? Rediscovering Child Abuse and Society’s Response*, 36 OHIO N.U. L. REV. 819, 824 (2010).

208. Olfson et al., *supra* note 129, at 1248–49, 1249 tbl.1 (concluding that office visits with a prescribed or supplied antipsychotic medication increased from 0.24% to 1.83% for patients zero to thirteen years of age, from 0.78% to 3.76% for patients fourteen to twenty years of age, and from 3.25% to 6.18% for adults). Another national survey determined that from 1994 to 2001 the rate of visits by an adolescent to a physician’s office resulting in a psychotropic prescription more than doubled from 3.4% in 1994–1995 to 8.3% in 2000–2001, with one out of ten office visits by adolescent males in 2001 resulting in such a prescription. Cindy Parks Thomas et al., *Trends in the Use of Psychotropic Medications Among Adolescents, 1994 to 2001*, 57 PSYCHIATRIC SERVICES 63, 65–66 (2006).

209. Olfson et al., *supra* note 129, at 1250.

210. Julie Mango Zito et al., *Trending in the Prescribing of Psychotropic Medications to Preschoolers*, 283 JAMA 1025, 1025, 1028 (2000).

211. Olfson et al., *supra* note 129, at 1247 (citing Mark Olfson et al., *National Trends in the Outpatient Treatment of Children and Adolescents with Antipsychotic Drugs*, 63 ARCHIVES GEN. PSYCHIATRY 679 (2006)).

212. S. N. Visser et al., *Increasing Prevalence of Parent-Reported Attention-Deficit/Hyperactivity Disorder Among Children—United States, 2003 and 2007*, 59 MORBIDITY & MORTALITY WKLY. REP. 1439, 1441 (2010).

213. Olfson et al., *supra* note 129, at 1247 (citing Jonathan S. Comer et al., *National Trends in the Antipsychotic Treatment of Psychiatric Outpatients with Anxiety Disorders*, 168 AM. J. PSYCHIATRY 1057 (2011)).

the safety and effectiveness of these medications for children.²¹⁴ In addition, this usage has been supported by third-party payors, as these medications are typically less costly than a series of sessions with a mental health therapist or inpatient hospitalization.²¹⁵

However, one report found that a sixfold rise in payments to Minnesota psychiatrists by drug makers for attending programs at which these medications were discussed coincided with a ninefold increase in the prescriptions of antipsychotics for children enrolled in the state's Medicaid program.²¹⁶ Further, psychiatrists receiving at least \$5000 in speaking fees from an antipsychotic drug's manufacturer wrote three times as many prescriptions for the drug.²¹⁷

In addition, even more so than for the general public,²¹⁸ off-label psychiatric medication prescriptions for youth are commonplace.²¹⁹ A conservative estimate is that fifty to seventy-five percent of these prescriptions are off-label, meaning the FDA has not specifically approved the drug for use in this context.²²⁰ Reasons given for the lack of clinical drug trials specifically targeting children include "relatively small market share, fear of legal liability, potential long-term adverse effects, the reluctance of parents to give permission to allow their children to be research subjects, and the lack of adequate research funding."²²¹

Despite its prevalence, safety concerns remain for youths prescribed psychotropic medications off-label.²²² In addition to the fact that the medications have not been directly proven safe or efficacious for this

214. Martin & Leslie, *supra* note 203, at 757–58.

215. *See id.* at 758.

216. Gardiner Harris et al., *Psychiatrists, Troubled Children and Drug Industry's Role*, N.Y. TIMES, May 10, 2007, at A1.

217. *Id.* *See generally* Hafemeister & Bryan, *supra* note 110.

218. *See supra* note 159 and accompanying text.

219. *See* Olfson et al., *supra* note 129, at 1251 ("Only a small proportion of child and adolescent antipsychotic [office-based physician] visits included an FDA clinical indication[.]").

220. Julie M. Zito et al., *Off-Label Psychopharmacologic Prescribing for Children: History Supports Close Clinical Monitoring*, CHILD & ADOLESCENT PSYCHIATRY & MENTAL HEALTH (Sept. 2008), <http://www.capmh.com/content/2/1/24> (citing Rosemary Roberts et al., *Pediatric Drug Labeling: Improving the Safety and Efficacy of Pediatric Therapies*, 290 JAMA 905 (2003)); *see also* Olfson et al., *supra* note 129, at 1252 tbl.4 (finding no FDA-approved indication for 94.0% of antipsychotic office-based physician visits involving children, 87.3% involving adolescents, and 71.6% involving adults).

221. Charles J. Coté et al., Commentary, *Is the "Therapeutic Orphan" About To Be Adopted?*, 98 PEDIATRICS 118, 120 (1996) (citing Carolyn H. Asbury, *The Orphan Drug Act: The First 7 Years*, 265 JAMA 893 (1991)).

222. *See id.*; Olfson et al., *supra* note 129, at 1252–54.

use, as one commentator explains, “[t]he central nervous system and the neurotransmitters and receptors on which psychotropic agents act are in a period of substantial growth, development, and refinement through childhood and adolescence,” and animal studies have shown permanent changes in receptor systems following exposure to psychotropic drugs in developing mammalian brains, which warrants “great caution.”²²³ It has also been noted that “[y]oung people may be especially sensitive to the adverse metabolic effects of second-generation antipsychotics[,] . . . [as] children may be more vulnerable to antipsychotic-induced weight gain and perhaps even to antipsychotic-associated diabetes.”²²⁴ Thus, due to the physiological differences between adults and children, a showing of safety and efficacy when used with adults will not necessarily be replicated in children.²²⁵

In a 2004 case, the plaintiffs claimed their thirteen-year-old son committed suicide because he took the antidepressant Zoloft, which had not been approved by the FDA for the treatment of pediatric depression.²²⁶ Although the case was ultimately dismissed,²²⁷ the FDA subsequently recommended that Pfizer conduct studies testing Zoloft with children and adolescents.²²⁸ The outcome of these tests indicated a modest but measurable increase in the risk of suicide among pediatric patients being treated with antidepressants in general.²²⁹

Calls have been issued for more research on the safety of pediatric medications in general, and particularly with regard to psychotropic medications administered to juveniles.²³⁰ It has been argued that a

223. Peter S. Jensen, *Ethical and Pragmatic Issues in the Use of Psychotropic Agents in Young Children*, 43 CAN. J. PSYCHIATRY 585, 586 (1998).

224. Olfson et al., *supra* note 129, at 1248 (footnotes omitted).

225. See MINA K. DULCAN, *DULCAN’S TEXTBOOK OF CHILD AND ADOLESCENT PSYCHIATRY* 674 (2010).

226. *Miller v. Pfizer, Inc.*, 356 F.3d 1326, 1327 (10th Cir. 2004).

227. *Miller v. Pfizer Inc. (Roerig Div.)*, 196 F. Supp. 2d 1095, 1131 (D. Kan. 2002), *aff’d sub nom. Miller v. Pfizer, Inc.*, 356 F.3d 1326.

228. See Tarek A. Hammad et al., *Suicidality in Pediatric Patients Treated with Antidepressant Drugs*, 63 ARCHIVES GEN. PSYCHIATRY 332, 332 (2006).

229. *Id.*; see also David A. Brent et al., *Predictors of Spontaneous and Systematically Assessed Suicidal Adverse Events in the Treatment of SSRI-Resistant Depression in Adolescents (TORDIA) Study*, 166 AM. J. PSYCHIATRY 418, 418 (2009) (“The relationship of venlafaxine and benzodiazepines to [adverse] self-harm events [in treatment-resistant, depressed adolescents] requires further study and clinical caution.”).

230. DARCY E. GRUTTADARO & JOEL E. MILLER, NAMI POLICY RESEARCH INSTITUTE TASK FORCE REPORT: CHILDREN AND PSYCHOTROPIC MEDICATIONS 2 (2004), available at http://www.nami.org/Template.cfm?Section=Research_Services_and_Treatment&template=/ContentManagement/ContentDisplay.cfm&ContentID=36682; Brent et al., *supra* note 229, at 424; Alina Selyukh, *Advisers Urge FDA To Address Antipsychotics in Kids*, REUTERS (Sept. 22, 2011, 6:45 PM), <http://www.reuters.com/article/2011/09/22/us-usa-fda-antipsychotic-idUSTRE78L77L20110922> (sixteen of seventeen advisers urged the FDA to pay particular attention to potential problems for children during its newest phase of drug monitoring).

history of missteps in pediatric drug safety²³¹ requires “reassessing and updating the level of confidence” in prescribing medications for children, and that this need is “particularly true for the treatment of emotional and behavioral disorders” in children because of:

1) the rapid, expanded use of many drugs for psychotherapeutic purposes [in children], both singly and in combination; 2) the absence of current guidelines for prescribing of off-label psychotropic drugs . . . 3) the absence of objective markers of emotional and behavioral conditions which can limit solid decisionmaking on the [proper] use of psychotropic medications; and 4) the [absence of] close clinical monitoring and the engagement of parents and caregivers in such activities.²³²

As noted, complicating this issue is the fact that the scientific community and the American public are largely unwilling to expose children to experimental clinical trials to test the safety and efficacy of these drugs in this age group because of the possible risk to the participants in these studies.²³³ However, such trials are needed to detect side effects that may only appear when these medications are administered to children and which may only manifest themselves after an extended period of time.²³⁴ Because mental illness tends to be a chronic condition,

231. Zito et al., *supra* note 220 (explaining that history has shown that “elementary school age children can also be at increased risk of adverse events and can experience problems distinctly different from adults treated with the same drug,” citing the antibiotic tetracycline as an example, which after being “widely acclaimed and enthusiastically prescribed when it was introduced in 1955,” was later shown to be “responsible for hypoplasia and staining of enamel of primary and secondary teeth,” as well as the antiepileptic Phenobarbital, which has been shown to diminish intelligence and cause behavioral problems in children and adolescents following long-term use (footnotes omitted)).

232. *Id.* (footnotes omitted); see also A. Rachel Camp, *A Mistreated Epidemic: State and Federal Failure To Adequately Regulate Psychotropic Medications Prescribed to Children in Foster Care*, 83 TEMP. L. REV. 369, 373 (2011) (explaining that the majority of states do not regulate psychotropic medications administered to children placed in the state’s legal custody in any meaningful way).

233. See *supra* notes 220–21 and accompanying text; see also Jennifer Cheng-Shannon et al., *Second-Generation Antipsychotic Medications in Children and Adolescents*, 14 J. CHILD & ADOLESCENT PSYCHOPHARMACOLOGY 372, 372 (2004) (discussing how most studies are anecdotal or short-term studies); *Should Your Child Be in a Clinical Trial?*, U.S. FOOD & DRUG ADMIN., <http://www.fda.gov/forconsumers/consumerupdates/ucm048699.htm> (last updated Oct. 22, 2012) (“Up until the last decade, children were rarely included in studies of medical treatments. As a result, much is still unknown about how children respond to drugs . . .”).

234. Cheng-Shannon et al., *supra* note 233, at 372 (“[L]ong-term follow-up investigations and ongoing clinical monitoring are necessary to confirm [SGAs’] safety in [children].”); see also U.S. FOOD & DRUG ADMIN., *supra* note 233; *supra* notes 222–25 and accompanying text.

the lack of long-term clinical trials assessing the longitudinal impact of these medications is of particular concern.

Concerns have also been expressed that these medications are being prescribed primarily as a “quick-fix” behavioral-management tool by physicians without adequate mental health training, with needed psychosocial interventions being bypassed and insufficient attention being given to the potentially harmful effects of these drugs.²³⁵ Not surprisingly, insufficient attention to the prescribing of medications for children appears to occur most frequently among children who are least likely to have someone watching out for their needs and interests.²³⁶ Children in foster care are three to four times more likely to be on a psychotropic medication than other children who are the recipients of Medicaid-funded services.²³⁷ It has been postulated these medications are being used to “manage” rather than “treat” these children, thus unnecessarily exposing many of them to potential long-term detrimental side effects.²³⁸ A study of the Texas foster care system revealed that forty-one percent of the children prescribed psychotropic drugs received three or more different medications, raising polypharmacy concerns.²³⁹ A Government Accountability Office report highlighted that in each of five states examined, foster children were prescribed psychotropic medications much more frequently, and called for greater guidance to states on the prescribing of these medications to foster children.²⁴⁰

235. Steven Reinberg, *More Kids Taking Antipsychotics for ADHD: Study*, HEALTHDAY (Aug. 7, 2012), <http://consumer.healthday.com/Article.asp?AID=667425> (noting that researchers found that “controlling ‘disruptive behavior’ accounted for 63% of the reason antipsychotics were given to children,” while one psychiatrist asserted that these drugs “have ruined the brains of millions of children” (quoting Dr. Peter Breggin, Psychiatrist) (internal quotation marks omitted)).

236. See Camp, *supra* note 232, at 373 (explaining that the psychotropic medication prescription rate for foster children is up to fifty percent, while the prescription rate for children in the general population is approximately four percent).

237. David Sessions, *Psychotropic Drug Abuse in Foster Care Costs Government Billions*, POL. DAILY (June 17, 2010), <http://www.politicsdaily.com/2010/06/17/psychotropic-drug-abuse-in-foster-care-costs-government-billions/> (“[I]n 2003 a Florida Statewide Advocacy Council study found that 55 percent of Florida’s foster children were being administered psychotropic medications. Forty percent of them had no record of a psychiatric evaluation.”).

238. Camp, *supra* note 232, at 373.

239. *Id.* at 378 (citing *Prescription Psychotropic Drug Use Among Children in Foster Care: Hearing Before the Subcomm. on Income Sec. and Family Support of the H. Comm. on Ways and Means*, 110th Cong. 9 (2008) (statement of Dr. Julie M. Zito, Ph.D., Professor of Pharmacy and Psychiatry, Pharm. Health Servs. Research, Univ. of Md., Balt.)); see also *supra* notes 156, 166–70 and accompanying text.

240. *Introduction to U.S. GOV’T ACCOUNTABILITY OFFICE, FOSTER CHILDREN: HHS GUIDANCE COULD HELP STATES IMPROVE OVERSIGHT OF PSYCHOTROPIC PRESCRIPTIONS* (2011), available at <http://www.gao.gov/assets/590/586570.pdf> (finding that forty percent of foster children in Massachusetts receive psychotropic medication); see also Camp, *supra*

Given all the uncertainty surrounding the safety of pediatric psychotropic medications and the sympathetic nature of a child-plaintiff in a lawsuit alleging harm from an inappropriate prescription or monitoring of such a medication, there is considerable potential here as well for increased malpractice liability exposure for involved mental health professionals.

VIII. INFORMED CONSENT AND ADVANCE DIRECTIVES

The doctrine of informed consent has two components: a health care provider's duty to disclose relevant treatment-related information to the patient and an accompanying duty to obtain the patient's consent before commencing treatment.²⁴¹ Notwithstanding that the doctrine has longstanding roots in American jurisprudence as an outgrowth of the fundamental principle that a patient has a right to bodily autonomy,²⁴² legal recognition of a cause of action for a failure to obtain informed consent is a relatively recent phenomenon.²⁴³ The first articulation of the phrase "informed consent" did not appear in a published judicial opinion until 1957,²⁴⁴ and the first successful application of a related cause of action did not occur until 1972.²⁴⁵ Shortly thereafter, however, a sea change in judicial and societal views regarding patient decisionmaking

note 232, at 373–74 (discussing movement toward increased state regulation of psychotropic prescriptions for foster children); Michelle L. Mello, Note, *Psychotropic Medication and Foster Care Children: A Prescription for State Oversight*, 85 S. CAL. L. REV. 395, 418–19 (2012) (describing the Government Accountability Office's investigation and findings).

241. 1 STEVEN E. PEGALIS, AMERICAN LAW OF MEDICAL MALPRACTICE § 4:1 (3d ed. 2005).

242. *Schloendorff v. Soc'y of N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages."), *overruled on other grounds by* *Bing v. Thunig*, 143 N.E.2d 656 (N.Y. 1957).

243. See Thomas L. Hafemeister & Selina Spinos, *Lean on Me: A Physician's Fiduciary Duty To Disclose an Emergent Medical Risk to the Patient*, 86 WASH. U. L. REV. 1167, 1205 (2009). Dating back to Hippocrates, treatment decisions were regarded as the sole prerogative of physicians, who were entitled and even encouraged to deceive patients about the course of treatment if they concluded deception was in the patient's best interest. Lori B. Andrews, *The Right and Rite of Informed Consent*, 21 LAW & SOC'Y REV. 765, 766 (1988).

244. *Salgo v. Leland Stanford Jr. Univ. Bd. of Trs.*, 317 P.2d 170, 181 (Cal. Dist. Ct. App. 1957) (involving a patient who awoke from surgery paralyzed and a physician who admitted he failed to disclose the dangers of the surgical procedure beforehand).

245. *Canterbury v. Spence*, 464 F.2d 772, 786–87 (D.C. Cir. 1972) (holding that physician has a duty to disclose the material risks associated with a proposed procedure that a reasonable patient would need to receive to make an informed decision).

authority occurred and informed consent became the accepted law of the land, with causes of action for a failure to obtain consent now universally recognized.²⁴⁶

As a result of the high premium placed on informed consent, if a patient retains decisionmaking capacity and chooses not to undergo a recommended treatment, a physician generally cannot force or otherwise provide this treatment.²⁴⁷ Additionally, individuals can execute an “advance directive” that directs the treatment to be provided or withheld if the person later loses decisionmaking capacity.²⁴⁸ Although the use of advance directives is also a relatively recent phenomenon, there has been little opposition to them,²⁴⁹ largely because they have typically been limited to the forgoing of medical treatment when (1) a patient is terminally ill or continued treatment is futile and extremely painful, and (2) there is little controversy the patient lacks decisionmaking capacity at the time.²⁵⁰

Nevertheless, the law also recognizes exceptions to the informed consent requirement, particularly during a medical emergency.²⁵¹ For example, a federal district court ruled a county jail physician exercised reasonable professional judgment in forcibly injecting an inmate with an antipsychotic drug after being informed the inmate was banging her head against a cell door, as that constituted a medical emergency.²⁵² Another widely discussed exception involves the “therapeutic privilege,” which allows a physician to withhold information from a patient when disclosure

246. See Charity Scott, *Why Law Pervades Medicine: An Essay on Ethics in Health Care*, 14 NOTRE DAME J.L. ETHICS & PUB. POL'Y 245, 265–66 (2000).

247. See Samuel Jan Brakel & John M. Davis, *Overriding Mental Health Treatment Refusals: How Much Process Is “Due”?*, 52 ST. LOUIS U. L.J. 501, 525–26 (2008); see also *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 277, 279 (1990) (“[T]he common-law doctrine of informed consent is viewed as generally encompassing the right of a competent individual to refuse medical treatment. . . . [W]e assume that the United States Constitution would [also] grant a competent person a constitutionally protected right to refuse lifesaving hydration and nutrition.”).

248. Justine A. Dunlap, *Mental Health Advance Directives: Having One's Say?*, 89 KY. L.J. 327, 343–44 (2001).

249. See *Cruzan*, 497 U.S. at 290 (O'Connor, J., concurring) (“Delegating the authority to make medical decisions to a family member or friend is becoming a common method of planning for the future.”); Linda L. Emanuel et al., *Advance Directives for Medical Care—A Case for Greater Use*, 324 NEW ENG. J. MED. 889, 889 (1991); Sam J. Saad III, *Living Wills: Validity and Morality*, 30 VT. L. REV. 71, 89 (2005); Maria J. Silveira et al., *Advance Directives and Outcomes of Surrogate Decision Making Before Death*, 362 NEW ENG. J. MED. 1211, 1212 (2010).

250. See Norman L. Cantor, *Twenty-Five Years After Quinlan: A Review of the Jurisprudence of Death and Dying*, 29 J.L. MED. & ETHICS 182, 189 (2001).

251. See *Luka v. Lowrie*, 136 N.W. 1106, 1110 (Mich. 1912).

252. *Anglin v. City of Aspen*, 552 F. Supp. 2d 1205, 1218–22, 1224–25 (D. Colo. 2008).

might cause the patient harm.²⁵³ The rationale is that “patients may be upset by [the] disclosure of unpleasant information, and thereby rendered unable to make a rational treatment decision, or they may even [as a result of the disclosure] suffer psychological damage.”²⁵⁴ However, because what constitutes harm or damage to a patient can be defined quite broadly, it has been cautioned that “the therapeutic privilege exception threatens . . . to swallow the informed consent doctrine whole.”²⁵⁵ Thus, “[t]he privilege is rarely invoked to dismiss [an informed consent cause of action].”²⁵⁶ To the extent mental health providers misinterpret the applicability of either exception to a given case, they risk a professional liability claim.

It should also be noted that considerable concern has been expressed that advance directives will be abused when individuals with a disability are involved.²⁵⁷ The fear is that because their lives have traditionally been less valued or their early demise welcomed by caregivers weary of providing them with support, they will be pressured and coerced into executing advance directives forgoing life-sustaining treatment or that their directives will be prematurely implemented.²⁵⁸

A number of states have also enacted provisions extending the availability of advance directives to encompass directions for future mental health care.²⁵⁹ Often referred to as “psychiatric advance directives” (PADs), they have typically been promoted as a means by which persons with a mental illness, while they have decisionmaking capacity, can ensure that they receive psychiatric treatment should they later refuse treatment after losing decisionmaking capacity,²⁶⁰ which may be defined broadly.²⁶¹ A “Ulysses Clause” is often included establishing an irrevocable

253. FURROW ET AL., *supra* note 43, at 341 (citing *Canterbury v. Spence*, 464 F.2d 772, 789 (D.C. Cir. 1972)).

254. *Id.*

255. *Id.*

256. *Id.* at 342.

257. See Ruth F. Maron, Note, *Who Has a Will To Live? Why State Requirements for Advance Directives Should Be Uniform (ly Revised)*, 24 REGENT U. L. REV. 169, 173, 189 (2011).

258. See *id.* at 189 & n.137 (citing U.S. DEP’T OF HEALTH & HUMAN SERVS., ADVANCE DIRECTIVES AND ADVANCE CARE PLANNING: REPORT TO CONGRESS, at xii (2008)).

259. Dunlap, *supra* note 248, at 370–71.

260. See *id.* at 344.

261. *Id.* at 354 (“The [directive] springs into effect not upon the consumer’s incompetence, but rather, upon the consumer’s deterioration to the point where medication and treatment would be beneficial.”).

acceptance of certain treatments despite the individual's subsequent refusal of them during a mental health crisis.²⁶² Alternatively, the PAD can direct that the person *not* be subjected to specific psychiatric treatments, with the side effects of various antipsychotic medications generally providing the rationale for these refusals.²⁶³

Among the concerns expressed about PADs are that persons with a mental illness will be pressured or coerced into executing a PAD authorizing future psychiatric treatment as a condition for release from placement in a mental health facility, to avoid court-ordered treatment or restraint, or to appease family members or other individuals responsible for their support,²⁶⁴ or that PADs will later be implemented to facilitate treatment over objection even though the person retains decisionmaking capacity or to bypass an otherwise required procedure such as obtaining a court order.²⁶⁵ Additionally, the asymmetrical nature of PADs has been noted, as authorizing statutes typically enable a treating physician to override a PAD if the physician determines a given course of treatment is in the patient's best interests, while the patient remains bound to a previously expressed treatment directive.²⁶⁶ Finally, some argue against PADs because individuals executing them may demand treatment methods that do not conform to the standard of care or are difficult to readily access and employ.²⁶⁷

PADs have been cited as another potentially expanding area of liability for mental health providers.²⁶⁸ If a patient is harmed as a result of a provider's failure to comply with an advance directive, the patient may be able to recover damages under "a theory of negligence, battery,

262. *Id.* at 351–52. The directive may also authorize future hospitalization. *Id.* at 353–54.

263. *See id.* at 368.

264. *See* Jeffrey W. Swanson et al., *Psychiatric Advance Directives: An Alternative to Coercive Treatment?*, 63 *PSYCHIATRY: INTERPERSONAL & BIOLOGICAL PROCESSES* 160, 169 (2000).

265. *See* Breanne M. Sheetz, Note, *The Choice To Limit Choice: Using Psychiatric Advance Directives To Manage the Effects of Mental Illness and Support Self-Responsibility*, 40 *U. MICH. J.L. REFORM* 401, 411 (2007).

266. *See* Karl A. Menninger, II, *Advance Directives for Medical and Psychiatric Care*, in 102 *AM. JUR. PROOF OF FACTS* 3D 95 § 29 (2008); Elizabeth Ann Rosenfeld, Note, *Mental Health Advance Directives: A False Sense of Autonomy for the Nation's Aging Population*, 9 *ELDER L.J.* 53, 53–54 (2001) (arguing mental health advance directives do more to protect health care providers than patients).

267. *See Psychiatric Advance Directives: Issue Summary*, NAT'L MENTAL HEALTH ASS'N, <http://www.mentalhealthamerica.net/download.cfm?DownloadFile=44AD883D-1372-4D20-C8CE19A1830E1C8B> (last visited Mar. 31, 2012); John Petrilu & Jeffrey Swanson, *Mental Illness, Law, and a Public Health Law Research Agenda*, *PUB. HEALTH L. RES.* 34–35 (Dec. 2010), [http://publichealthlawresearch.org/sites/default/files/Petrilu%20%20Swanson%20TPE%20paper-%20Final%20Paginated%20\(1\).pdf](http://publichealthlawresearch.org/sites/default/files/Petrilu%20%20Swanson%20TPE%20paper-%20Final%20Paginated%20(1).pdf).

268. *See* Dunlap, *supra* note 248, at 364.

intentional infliction of emotional distress, or negligent infliction of emotional distress.”²⁶⁹ At the same time, if a provider implements a PAD when it is inapplicable—such as when the patient retains decisionmaking capacity—or has been improperly executed, and treats a competent patient over the patient’s objection or contrary to an otherwise binding directive from the patient or a surrogate, the provider may face a lawsuit for treating a patient without informed consent.²⁷⁰ However, many states authorizing the use of PADs afford physicians immunity if they have acted in good faith or permit a physician to override treatment objections following involuntary civil commitment of the patient.²⁷¹

With regard to civil commitment, the underlying rule was once that persons who met the applicable commitment criteria were presumed incapable, as a consequence of their mental disorder, of giving informed consent and thus could be treated over their objection during the ensuing hospitalization.²⁷² This position has now widely been rejected, with a separate determination of a lack of decisionmaking capacity required before treatment can be administered over objection.²⁷³ Nevertheless, the right and ability of institutionalized individuals to refuse treatment is an

269. Kathleen E. Werthey, *Cause of Action To Recover Damages for Health Care Provider’s Failure To Comply with Advance Directive*, 16 CAUSES OF ACTION 2D 83, 83 (2001); see also Leonard Berlin, *Malpractice Issues in Radiology: Do Not Resuscitate*, 175 AM. J. ROENTGENOLOGY 1513, 1513 (2000) (describing lawsuit against physician who violated a do-not-resuscitate order); Renee H. Martin, *Liability for Failing To Follow Advance Directives*, PHYSICIAN’S NEWS DIG. (Sept. 14, 1999), <http://www.physiciansnews.com/1999/09/14/liability-for-failing-to-follow-advance-directives/> (explaining potential liability resulting from failure to follow an advance directive). But see Dunlap, *supra* note 248, at 364 (“Following an advance directive, particularly in a state where there is immunity for good faith adherence to directives, is not likely to result in litigation—at least not successful litigation.”); Holly Fernandez Lynch et al., *Compliance with Advance Directives: Wrongful Living and Tort Law Incentives*, 29 J. LEGAL MED. 133, 139–42 (2008) (asserting that existing law provides inadequate remedies for failing to adhere to an advance directive).

270. See SLOBOGIN ET AL., *supra* note 67, at 291–92 (citing Conservatorship of Waltz, 227 Cal. Rptr. 436 (Ct. App. 1986)); Jaime Staples King & Benjamin W. Moulton, *Rethinking Informed Consent: The Case for Shared Medical Decision-Making*, 32 AM. J.L. & MED. 429, 429–30 (2006).

271. See Jeffrey W. Swanson et al., *Overriding Psychiatric Advance Directives: Factors Associated with Psychiatrists’ Decisions To Preempt Patients’ Advance Refusal of Hospitalization and Medication*, 31 LAW & HUM. BEHAV. 77, 78–79 (2007).

272. *Developments in the Law: Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1210–11 (1974).

273. See Christyne E. Ferris, Note, *The Search for Due Process in Civil Commitment Hearings: How Procedural Realities Have Altered Substantive Standards*, 61 VAND. L. REV. 959, 963–64 (2008).

ongoing issue.²⁷⁴ Compounding concerns are recent changes to various related mental health laws, such as broadening the criteria for civil commitment and enhancing the availability of outpatient civil commitment, which expand the circumstances under which a state can exercise control over persons with a mental disorder, ostensibly to provide for the safety and well-being of the individual and society, but which also facilitate the state's ability to encourage or impose treatment without informed consent.²⁷⁵ Again, predicting incorrectly when treatment over objection can be administered can expose mental health providers to liability.

Further complicating matters, imposing mental health treatment over the objection of an individual can be countertherapeutic.²⁷⁶ Particularly if the patient is not given an opportunity to express opposition, imposing treatment can exacerbate the patient's mental health problems.²⁷⁷ To enhance mental health care and reduce the risk of a professional liability suit, any bypassing of the normal informed consent process should occur

274. See Nathan T. Sidley, *The Right of Involuntary Patients in Mental Institutions To Refuse Drug Treatment*, J. PSYCHIATRY & L. 231 (1984); see also MICHAEL L. PERLIN, *THE HIDDEN PREJUDICE: MENTAL DISABILITY ON TRIAL* 125 (2000) ("The question of the right to refuse antipsychotic medication remains the most important and volatile aspect of the legal regulation of mental health practice."); Kurt M. Hartman & Bryan A. Liang, *Exceptions to Informed Consent in Emergency Medicine*, HOSP. PHYSICIAN, Mar. 1999, at 53, 55–57 (explaining circumstances in which doctors should be allowed to, or perhaps even should, treat resisting patients, and circumstances in which doctors should not be allowed to treat resisting patients).

275. See Michael Allen & Vicki Fox Smith, *Opening Pandora's Box: The Practical and Legal Dangers of Involuntary Outpatient Commitment*, 52 PSYCHIATRIC SERVICES 342, 342–43 (2001); John Monahan, *Tarasoff at Thirty: How Developments in Science and Policy Shape the Common Law*, 75 U. CIN. L. REV. 497, 515 (2006) ("Mandating adherence to mental health treatment in the community through outpatient commitment has become the most contested issue in mental health law. . . . With the 1999 enactment in New York State of 'Kendra's Law,' . . . nationwide interest in outpatient commitment has greatly increased."); *Outpatient and Civil Commitment*, BAZELON CENTER FOR MENTAL HEALTH L., <http://www.bazelon.org/Where-We-Stand/Self-Determination/Forced-Treatment/Outpatient-and-Civil-Commitment.aspx> (last visited Mar. 31, 2013); Scott C. Fears & Ann Hackman, *Commentary, Outpatient Commitment: A Treatment Tool for the Mentally Ill?*, VIRTUAL MENTOR (Jan. 2009), <http://virtualmentor.ama-assn.org/2009/01/pdf/ccas2-0901.pdf>.

276. For a review of the empirical research on the therapeutic jurisprudence value of a right to refuse treatment, see PERLIN, *supra* note 274, at 279–85.

277. See *id.* at 278–79 (arguing that in psychiatry the right to refuse treatment and informed consent are particularly important for maintaining a therapeutic doctor-patient relationship); see also Norman G. Poythress et al., *Perceived Coercion and Procedural Justice in the Broward Mental Health Court*, 25 INT'L J.L. & PSYCHIATRY 517, 520, 530–31 (2002) (finding that when offenders with a mental disorder participating in a mental health court perceived the proceedings to be fair, which included being treated with respect and dignity and being permitted to present their position to the decisionmaker, their acceptance of and compliance with the outcome of the proceedings were enhanced, even when an adverse ruling was issued).

only under very limited circumstances.²⁷⁸ From a pragmatic perspective, a client's satisfaction with and trust in a mental health provider diminishes the likelihood that a suit will be brought.²⁷⁹ It follows that proceeding with treatment without first obtaining a client's informed consent, particularly if forcibly administered over objection, increases the likelihood a client will pursue a professional liability claim.

IX. TARASOFF-RELATED LIABILITY

No discussion of emerging professional liability would be complete without a discussion of the impact of the landmark case of *Tarasoff v. Regents of the University of California*,²⁸⁰ the first case to establish that mental health providers have a duty to take steps to protect reasonably foreseeable victims of their patients.²⁸¹ *Tarasoff* has been characterized as “one of the single most celebrated cases in the recent history of American tort law,”²⁸² with “no court ruling ha[ving] had a broader or more enduring impact on day-to-day mental health practice.”²⁸³

278. PERLIN, *supra* note 274, at 155.

279. See Henry Thomas Stelfox et al., *The Relation of Patient Satisfaction with Complaints Against Physicians and Malpractice Lawsuits*, 118 AM. J. MED. 1126, 1126 (2005); see also *supra* notes 184–85 and accompanying text.

280. 551 P.2d 334 (Cal. 1976) (en banc).

281. *Id.* at 340. It should be noted that a failure to predict and prevent suicidal behavior by a client may raise many of the same issues discussed in this subpart. See L. D. Hankoff, *Assessment and Prediction of Suicide*, 268 JAMA 3257, 3275 (1992) (reviewing ASSESSMENT AND PREDICTION OF SUICIDE (Ronald W. Maris et al. eds., 1992)); Jacqueline M. Melonas, *Patients at Risk for Suicide: Risk Management and Patient Safety Considerations To Protect the Patient and the Physician*, INNOVATIONS CLINICAL NEUROSCIENCE, Mar. 2011, at 45, 45; L. Sher, Commentary, *Preventing Suicide*, 97 Q.J. MED. 677, 677 (2004); April R. Smith et al., *Revisiting Impulsivity in Suicide: Implications for Civil Liability of Third Parties*, 26 BEHAV. SCI. & L. 779, 779 (2008); Murray, *supra* note 80, at 641–42. For representative cases, see *Patton v. Thompson*, 958 So. 2d 303, 313 (Ala. 2006), *Kockelman v. Segal*, 71 Cal. Rptr. 2d 552, 553–54 (Ct. App. 1998), and *Almonte v. Kurl*, 46 A.3d 1, 8 (R.I. 2012).

282. Peter F. Lake, *Revisiting Tarasoff*, 58 ALB. L. REV. 97, 97 (1994); see also Thomas G. Gutheil, *Moral Justification for Tarasoff-Type Warnings and Breach of Confidentiality: A Clinician's Perspective*, 19 BEHAV. SCI. & L. 345, 345 (2001) (calling *Tarasoff* “one of the most significant developments in medico-legal jurisprudence of the past century” (citations omitted)).

283. Douglas Mossman, *Critique of Pure Risk Assessment or, Kant Meets Tarasoff*, 75 U. CIN. L. REV. 523, 526 (2006); see also Patrick K. Fox, Commentary, *So the Pendulum Swings—Making Sense of the Duty To Protect*, 38 J. AM. ACAD. PSYCHIATRY & L. 474, 477 (2010) (“The decision’s impact on the practice of psychiatry was immediate and profound . . .”); Mossman, *supra*, at 524 (“[T]hirty years after its promulgation,

Lawmakers and commentators, however, “remain divided on the wisdom and proper application of *Tarasoff*,”²⁸⁴ with “the medical, scientific and policy judgments that undergird *Tarasoff* decisions need[ing] to be revisited regularly to reflect . . . new developments . . . in violence risk assessment, violence prevention, mental health services, and theories and developments in tort liability.”²⁸⁵

In *Tarasoff*, a young man, Prosenjit Podder, stalked and murdered a young woman, Tatiana Tarasoff, with whom he was infatuated, after indicating to his treating psychologist his intention to do so.²⁸⁶ According to the California Supreme Court, when a therapist determines or reasonably should have determined under the applicable professional standard that a patient poses “a serious danger of violence” to a third party, the therapist has a duty to take reasonable steps to protect that third party from the danger posed by the patient.²⁸⁷

The court’s decision generated considerable criticism,²⁸⁸ accompanied by prophecies of the demise of mental health care.²⁸⁹ Among the criticisms

Tarasoff remains, to mental health professionals, the most influential ruling in mental disability law.”).

284. Ann Hubbard, Symposium Introduction, *The Future of “The Legal Duty To Protect”: Scientific and Legal Perspectives on Tarasoff’s Thirtieth Anniversary*, 75 U. CIN. L. REV. 429, 429 (2006) (“Courts and legislatures have embraced, restricted or rejected *Tarasoff*’s basic premise that mental health professionals have a duty to predict which of their patients will commit acts of violence and to protect third parties from that violence.” (footnote omitted)).

285. *Id.* at 430.

286. *Tarasoff*, 551 P.2d at 341. As one commentator described the key facts of the case:

Poddar told the psychologist of his intent to kill someone (readily identifiable as Tatiana) when she returned from Brazil. The psychologist and two psychiatrist colleagues agreed that Poddar should be committed for observation in a mental hospital. The psychologist notified the campus police orally and by letter. Three police officers took Poddar into custody, but, satisfied that Poddar was rational, released him on his promise to stay away from Tatiana. . . . [A supervising] psychiatrist . . . then asked the police to return the psychologist’s letter and ordered that no further action be taken to hospitalize Poddar.

Poddar stopped seeing his psychologist after the police detained him. He continued to follow Tatiana, however. . . . [Ultimately,] Poddar went to Tatiana’s home to speak with her. Tatiana was not there, and her mother told Poddar to leave. He returned later that day . . . armed with a pellet gun and a kitchen knife, and found Tatiana alone. When she refused to speak with him and ran from the house, Poddar caught up with her and stabbed her to death.

Mossman, *supra* note 283, at 533 (footnotes omitted).

287. *Tarasoff*, 551 P.2d at 345 (“While the discharge of this duty of due care will necessarily vary with the facts of each case, in each instance the adequacy of the therapist’s conduct must be measured against the traditional negligence standard of the rendition of reasonable care under the circumstances.” (footnote omitted)).

288. See Robert B. Kaplan, Comment, *Tarasoff v. Regents of the University of California: Psychotherapists, Policemen and the Duty To Warn—An Unreasonable Extension of the Common Law?*, 6 GOLDEN GATE U. L. REV. 229, 229 (1975); see also Michael L. Perlin, *Tarasoff and the Dilemma of the Dangerous Patient: New Directions for the 1990’s*,

lodged were that it (1) incorrectly assumed mental health providers could accurately predict future violence;²⁹⁰ (2) compromised confidentiality, an essential element for the success of mental health services, “by decreasing [clients’] trust in their [treatment providers], by discouraging [them] from communicating sensitive information [for] fear of subsequent disclosure, and by causing [them] to prematurely terminate therapy [because of] potential (or actual) breach[es] of confidentiality;”²⁹¹ (3) would result in “a net increase in violence” as fewer people would seek treatment, or treatment, when sought, would be less effective as clients would be more guarded in their disclosures;²⁹² (4) unfairly and inappropriately branded persons with a mental disorder as dangerous;²⁹³ (5) forced clinicians to violate a “central . . . ethical precept,” namely, attending first and foremost to the needs of their clients, with priority instead given to the safety of the community;²⁹⁴ (6) would harm clients as it would often lead to unnecessary and countertherapeutic involuntary hospitalizations;²⁹⁵ (7) required warnings that might cause putative victims unnecessary emotional distress or lead to preemptive retaliatory violence;²⁹⁶ and (8) would lead therapists to refuse to see potentially violent clients.²⁹⁷

In addition, there was considerable confusion among clinicians as to the duty being imposed, triggered in part by the fact that the California Supreme Court issued two *Tarasoff* rulings, with the first imposing a

16 LAW & PSYCHOL. REV. 29, 35 (1992) (noting “an ‘avalanche’ of largely critical academic commentary” followed the ruling).

289. See Perlin, *supra* note 288, at 29 (citing Robert N. Cohen, Note, *Tarasoff v. Regents of the University of California: The Duty To Warn: Common Law & Statutory Problems for California Psychotherapists*, 14 CAL. W. L. REV. 153, 153 (1978)); Kaplan, *supra* note 288, at 230.

290. See Mossman, *supra* note 283, at 554; Perlin, *supra* note 288, at 36 (citing Daniel J. Givelber et al., *The Tarasoff Controversy: A Summary of Findings from an Empirical Study of Legal, Ethical, and Clinical Issues*, in *THE POTENTIALLY VIOLENT PATIENT AND THE TARASOFF DECISION IN PSYCHIATRIC PRACTICE* 35, 37 (James C. Beck ed., 1985)).

291. Perlin, *supra* note 288, at 36; see also Mossman, *supra* note 283, at 554; Kaplan, *supra* note 288, at 237.

292. Kaplan, *supra* note 288, at 238.

293. Mossman, *supra* note 283, at 554.

294. Perlin, *supra* note 288, at 36 (quoting Givelber et al., *supra* note 290, at 37) (internal quotation marks omitted).

295. *Id.*

296. *Id.* at 36–37.

297. *Id.* at 37.

“duty to warn”²⁹⁸ and the second establishing a “duty to protect” prospective victims.²⁹⁹ Although the second ruling superseded the first and provided mental health providers with a range of options to meet the requisite duty “to use reasonable care to protect the intended victim,”³⁰⁰ the duty to warn language, with its more challenging and unsettling requirement to track down and personally warn threatened third parties, became part of the popular lexicon. Indeed, this confusion continues relatively unabated.³⁰¹

Clinicians were further alarmed by a series of subsequent rulings³⁰² that they found “perplexing because of their inconsistency and unpredictability,”³⁰³ appeared “to make little or no clinical sense,”³⁰⁴ and not only interpreted *Tarasoff* more broadly, but also resulted in a lack of

298. *Tarasoff v. Regents of the Univ. of Cal.*, 529 P.2d 553, 555 (Cal. 1974), *vacated en banc*, *Tarasoff v. Regents of the Univ. of Cal.*, 551 P.2d 334 (Cal. 1976).

299. *Tarasoff*, 551 P.2d at 346; *see also* Karen Tapp & Darrell Payne, *Guidelines for Practitioners: A Social Work Perspective on Discharging the Duty To Protect*, 8 J. SOC. WORK VALUES & ETHICS 2-1, 2-2 to -3 (2011) (citing *Tarasoff*, 551 P.2d 334).

300. *Tarasoff*, 551 P.2d at 340. The court stated that clinicians could, alternatively, provide warning to “others likely to apprise the victim of the danger, to notify the police, or take whatever other steps are reasonably necessary under the circumstances.” *Id.* The latter has widely been construed to encompass seeking a client’s involuntary hospitalization via a civil commitment petition. *See* Monahan, *supra* note 275, at 498. Although controversial, *see supra* notes 274–75 and accompanying text, it has been suggested that seeking outpatient civil commitment, where it is authorized, may provide another means for a mental health provider to satisfy a *Tarasoff* duty. *See* Monahan, *supra* note 275, at 518.

301. *See* Yvona L. Pabian et al., *Psychologists’ Knowledge of Their States’ Laws Pertaining to Tarasoff-Type Situations*, 40 PROF. PSYCHOL.: RES. & PRAC. 8, 8 (2009) (polling psychologists from four states on their knowledge of *Tarasoff*-related laws in their states, and finding that most—76.4%—were misinformed about their state laws because they believed they had a legal duty to warn when they did not or believed that a warning was their only option when other protective actions less harmful to client privacy were permissible).

302. Mossman, *supra* note 283, at 545 (“As troublesome as *Tarasoff* was, its legal progeny were even more unsettling for therapists.”).

303. Tapp & Payne, *supra* note 299, at 2-3 (discussing a Michigan case where liability was initially imposed even though there was no past record of violence and “[t]he plaintiff’s sole piece of tangible proof was a notation made in a hospital record [two years previously] documenting that the patient had made threats towards his mother” (citing *Davis v. Lhim*, 335 N.W.2d 481 (Mich. Ct. App. 1983))).

304. Matthew F. Soulier et al., *Status of the Psychiatric Duty To Protect, Circa 2006*, 38 J. AM. ACAD. PSYCHIATRY & L. 457, 457–58 (2010) (discussing five cases in which, respectively, a victim was “well aware of the risk she ran by her behavior,” *Jablonski v. United States*, 712 F.2d 391 (9th Cir. 1983); an auto accident was caused by a patient, *Petersen v. State*, 671 P.2d 230 (Wash. 1983) (*en banc*); random victims were shot in a crowded nightclub, *Lipari v. Sears, Roebuck & Co.*, 497 F. Supp. 185 (D. Neb. 1980); an aunt was attacked by a patient who had never been violent or threatened his aunt, *Davis*, 335 N.W.2d 481; and an auto accident occurred five-and-a-half months after discharge and 500 miles away, *Naidu v. Laird*, 539 A.2d 1064 (Del. 1988)).

national uniformity regarding the requisite duty.³⁰⁵ Ultimately, *Tarasoff* “influenced the legal requirements governing therapists’ duty to protect third parties in nearly every state in the US.”³⁰⁶

With its seemingly broad mandate to protect third parties, encountering a *Tarasoff*-like scenario has tended to strike fear in the hearts of mental health providers,³⁰⁷ leading them to lobby for statutory protection from such suits or at least guidelines on how to fulfill the duty to protect.³⁰⁸ The enactment of these statutes, now in place in at least thirty-seven states, is also viewed as reflecting “a heightened appreciation . . . that clinicians face an exceptional dilemma when confronted with patients who make threats toward others,”³⁰⁹ although disagreement exists over whether these statutes have provided “hoped-for clarity in defining [and limiting] the duty to protect.”³¹⁰

It is, however, now widely acknowledged that for a number of reasons, *Tarasoff*-like rules were not ruinous to clinical practice.³¹¹ Among the reasons given are that (1) mental health providers should be dedicated to assisting all who are in need, including the potential victims of client

305. James L. Knoll IV, *The Duty To Protect: When Has It Been Discharged?*, PSYCHIATRIC TIMES (July 2, 2012), <http://www.psychiatrictimes.com/forensic-psych/content/article/10168/2087528> (“The broadest interpretation occurred in the 1980 case of *Lipari v Sears, Roebuck & Co.* The case involved a VA patient who shot strangers in a crowded nightclub, without ever threatening a specific person and a month after terminating psychiatric treatment. The court rejected the *Tarasoff* limitation to an identified victim, imposing not only a duty on therapists to predict dangerousness, but also a duty to protect unidentified but ‘reasonably foreseeable victims’ in the general public.” (footnote omitted) (citing *Lipari*, 497 F. Supp. 185)).

306. *Id.*

307. Perlin, *supra* note 288, at 29–30 (“[T]he legend of the *Tarasoff* case has grown to mythic proportions. . . . [E]mpirical surveyors have found that it has had a profound impact on mental health practice even in jurisdictions where it is inapplicable. . . . [I]t is the subject of the most common questions directed to the American Psychiatric Association’s legal consultation service.” (footnotes omitted) (citing Givelber et al., *supra* note 290, at 39–54; James C. Beck, *The Psychotherapist’s Duty To Protect Third Parties from Harm*, 11 MENTAL & PHYSICAL DISABILITY L. REP. 141, 147 (1987))).

308. Soulier et al., *supra* note 304, at 458; *see, e.g.*, COLO. REV. STAT. § 13-21-117 (2011); N.J. STAT. ANN. § 2A:62A-16 (West Supp. 2011); VA. CODE ANN. § 54.1-2.400.1 (2009).

309. Soulier et al., *supra* note 304, at 458; *see also* Knoll, *supra* note 305 (discussing states’ duty to protect and “permission to warn” statutes).

310. Soulier et al., *supra* note 304, at 458; *see also* Tapp & Payne, *supra* note 299, at 2–3 (“[O]nly in a few cases did courts construe the statutes to limit the duties owed to third parties” (citation omitted)).

311. *See* Mossman, *supra* note 283, at 542; Soulier et al., *supra* note 304, at 460; Knoll, *supra* note 305.

threats,³¹² with most therapists having already embraced such a duty;³¹³ (2) these duties resulted in a needed closer examination of clients' potential for such behavior,³¹⁴ which can enhance their treatment and rehabilitation and help them avoid criminal and civil sanctions that might otherwise ensue;³¹⁵ (3) taking protective steps can actually "further the therapeutic alliance and contribute[] to a [client's therapeutic] progress;"³¹⁶ and (4) the scope of the duty was not as broad as commonly believed.³¹⁷

It has even been asserted that the *Tarasoff* duty "has [now] become a central aspect of patient care," with "practitioners . . . view[ing] the duty . . . as they would other essential elements of care."³¹⁸ Practitioners were also reassured when "courts began to reflect ambivalence about the extension of the duty to protect" and typically "required that the threat be clearly foreseeable and [established] that the duty extended only to 'reasonably foreseeable victims' and not to the general public."³¹⁹ Additionally,

312. See Soulier et al., *supra* note 304, at 460.

313. See Knoll, *supra* note 305.

314. See *id.* (quoting Fillmore Buckner & Marvin Firestone, "Where the Public Peril Begins": 25 Years After Tarasoff, 21 J. LEGAL MED. 187, 214 (2000)).

315. Perlin, *supra* note 288, at 39.

316. *Id.*; see also Mossman, *supra* note 283, at 542 ("[I]n most cases issuing the warning had a minimal or a positive effect on the psychotherapeutic relationship." (quoting Renee L. Binder & Dale E. McNiel, *Application of the Tarasoff Ruling and Its Effect on the Victim and the Therapeutic Relationship*, 47 PSYCHIATRIC SERVICES 1212, 1212 (1996)) (internal quotation marks omitted)).

317. See Pabian et al., *supra* note 301, at 10–12.

318. Fox, *supra* note 283, at 475 ("I can scarcely conceive of a psychiatric interview in which the patient's risk to self or others is not addressed.").

319. Knoll, *supra* note 305. See also Soulier et al., *supra* note 304, which surveyed all *Tarasoff*-related appellate cases decided from 1985 through 2006 and found that forty-seven cases were decided in favor of the defendants, with only six for the plaintiffs—two of which explicitly rejected *Tarasoff* as a basis for the verdict—and that the most common reason given in ruling for the defendant was "the patient had not previously communicated to the therapist a threat targeting an identified victim." *Id.* at 461–69. In such cases, "the courts almost always found that defendants owed no duty to the public at large." *Id.* at 470. See, e.g., *Brady v. Hopper*, 751 F.2d 329, 330 (10th Cir. 1984) (finding that psychiatrist who treated John Hinckley Jr., who seriously injured the appellant in his attempt to assassinate President Reagan, was correctly held not liable because Hinckley never conveyed to the psychiatrist "specific threats against specific . . . victims"); *Thompson v. Cnty. of Alameda*, 614 P.2d 728, 737–38 (Cal. 1980) (en banc) (holding a therapist was not liable where his patient named a "large amorphous public group of potential targets" rather than a readily identifiable individual); *Tedrick v. Cmty. Res. Ctr.*, 920 N.E.2d 220, 228 (Ill. 2009) (holding that care providers did not have an obligation to warn a patient's wife and noting "this court has rejected the rationale of the *Tarasoff* case"); *Eckhardt v. Kirts*, 534 N.E.2d 1339, 1344 (Ill. Ct. App. 1989) (requiring the plaintiff to establish the patient made "specific threat(s) of violence . . . directed at a specific and identified victim"); *Adams v. Bd. of Sedgwick Cnty. Comm'rs*, 214 P.3d 1173, 1174 (Kan. 2009) (holding that mental health providers did not owe a duty to those injured by an outpatient who became violent nine months after treatment order expired); *Santana v. Rainbow Cleaners, Inc.*, 969 A.2d 653, 654, 666–67 (R.I. 2009) (holding mental health provider not liable to the

a recent line of cases is viewed as establishing that the “*Tarasoff* duty” does not extend to persons who were aware of their danger.³²⁰ Thus, while the *Tarasoff* duty remains a professional liability concern for mental health providers, it is generally not seen to be as great a threat as was once widely believed.³²¹

Others, however, remain unconvinced,³²² and have expressed concerns that (1) confusion remains over the governing criteria, with the governing duty remaining “in a persistent state of flux;”³²³ (2) the duty is difficult or even virtually impossible to meet;³²⁴ (3) the obligation dominates and corrupts clinical practice;³²⁵ (4) the requirement is unfair and unjust to those in need of mental health services;³²⁶ (5) public safety has not been

victim of an assault by a voluntary outpatient last seen five months earlier as there was no evidence the attack was foreseeable); *Boren v. Texoma Med. Ctr., Inc.*, 258 S.W.3d 224, 230 (Tex. Ct. App. 2008) (holding duty not incurred when an emergency room patient left and killed his ex-wife and two children the next morning but did not exhibit or indicate behavior dangerous to others or make “any specific threat to injure his family or his wife’s family”).

320. Brian Ginsberg, *Tarasoff at Thirty: Victim’s Knowledge Shrinks the Psychotherapist’s Duty To Warn and Protect*, 21 J. CONTEMP. HEALTH L. & POL’Y 1, 2 (2004); see, e.g., *In re Estate of Votteler*, 327 N.W.2d 759, 762 (Iowa 1982) (holding that plaintiff cannot recover damages if “the evidence has sufficient force to charge the victim with knowledge of the danger”); *Hinkelman v. Borgess Med. Ctr.*, 403 N.W.2d 547, 549, 551 (Mich. Ct. App. 1987) (holding psychotherapist’s duty to protect did not arise because “the victim herself was aware of the danger” as a result of repeated incidents in which the patient had threatened and even raped the victim before shooting her to death at a later date).

321. Indeed, two high courts have explicitly rejected arguments that a *Tarasoff* duty exists as a matter of common law in their states. *Thapar v. Zezulka*, 994 S.W.2d 635, 638 (Tex. 1999); *Nasser v. Parker*, 455 S.E.2d 502, 506 (Va. 1995).

322. Soulier et al., *supra* note 304, at 460 (“[C]ommentators have been deeply divided on whether the legal duty the courts have articulated is good social policy or is mistaken.”).

323. Fox, *supra* note 283, at 474.

324. See *id.* at 476 (“[T]he clinician is forced to walk a razor-thin line”); Mossman, *supra* note 283, at 602 (“The problem with the *Tarasoff* rule is that it presupposes that assessments of dangerousness are yes-or-no predictions, whereas what mental health clinicians have is the ability to assign persons to different levels of risk. To take action . . . requires, in turn, a judgment about what level of risk is sufficient to justify the action. But no court has provided guidance as to what this level of risk is . . .”).

325. See Fox, *supra* note 283, at 476 (“Psychiatrists may resolve this tension by limiting their assessment of threat. . . . [T]he psychiatrist may adopt a see-no-evil, hear-no-evil, speak-no-evil approach.”); Mossman, *supra* note 283, at 527 (“[T]he implicit obligation to protect the public is present in every clinical contact . . .”).

326. See Mossman, *supra* note 283, at 602 (“*Tarasoff* is troubling in its willingness to sacrifice the interests of patients for the sake of society. The same notions of fairness and justice that prevent us from imposing confinement on people because they might commit future crimes also tell us that undeserving patients should not suffer adverse consequences for things they only have a probability of doing.”).

enhanced as the required breach of confidentiality tends to end the therapeutic relationship and prevents future clinical efforts that might have defused the danger posed by the client;³²⁷ (6) these duties have expanded the preventive detention and social control of individuals with a mental disorder, including increased and improper use of psychiatric hospital admissions;³²⁸ and (7) therapists' cultural biases inappropriately shape when protective efforts are undertaken.³²⁹

Furthermore, others assert that the *Tarasoff* duty and associated litigation continue to expand,³³⁰ and even if a *Tarasoff* claim is rejected, clinicians may be subject to a parallel lawsuit claiming they provided negligent care to their client³³¹ or face related disciplinary sanctions from their licensure board.³³² Recent cases causing clinicians renewed concern have been issued in Colorado,³³³ Louisiana,³³⁴ and Michigan.³³⁵

327. See *id.* at 542–43 (citing Gutheil, *supra* note 282, at 353).

328. See Perlin, *supra* note 288, at 38–39.

329. See *id.* at 38.

330. See Tapp & Payne, *supra* note 299, at 2–5 (“Trends show an increase in the number of lawsuits filed against social workers in the past 25 years.” (citation omitted)); Michael Thomas, *Expanded Liability for Psychiatrists: Tarasoff Gone Crazy?*, J. MENTAL HEALTH L., Spring 2009, at 45, 45 (“[M]any clinicians will be troubled to learn the extent to which *Tarasoff* liability has extended in some jurisdictions.”); see also Hubbard, *supra* note 284, at 445 (“As neuroscience develops or discovers new avenues for exploring the human brain, or ‘reading our minds,’ will the law demand even more intrusive or restrictive measures to detect ‘unacceptable’ thoughts, impulses or inclinations?”).

331. Fox, *supra* note 283, at 475.

332. See *id.* (“[A *Tarasoff*-like case may impose an] ethics-based obligation to protect third parties from patients who pose a risk. This duty can be viewed as an extension of the principle of nonmaleficence, in which the psychiatrist [should] take[] reasonable steps to protect the patient from the adverse consequences that can result from acting on his violent impulses.”); Mossman, *supra* note 283, at 578 (“What is good for the [client] must be sacrificed for the (greater) good of society. . . . [This] should be a source of ethical discomfort In traditional medical ethics, doctors serve individual patients and have fiduciary obligations to them, not to those around them.”).

333. See *Fredericks v. Jonsson*, 609 F.3d 1096, 1103–04, 1106 (10th Cir. 2010) (affirming that the defendant, a psychologist who had completed an evaluation at the request of the Colorado probation department, was shielded from liability by the Colorado mental health professional liability statute, but extending the range of mental health providers who owe a *Tarasoff* duty beyond those who have provided treatment to those who have merely provided a mental health evaluation); see also John J. Maxey et al., *Duty To Warn or Protect*, 39 J. AM. ACAD. PSYCHIATRY & L. 430 (2011) (discussing this ruling).

334. See *Barbarin v. Dudley*, 2000-0249 (La. App. 4 Cir. 12/20/00), p. 5–6; 775 So. 2d 657, 660 (reading statute limiting liability to third parties narrowly to only protect those mental health providers specifically listed by the statute); see also Soulier et al., *supra* note 304, at 471–72 (“[The case] that appeared troubling was *Barbarin*, in which a non-mental health clinician warned a home nurse regarding a patient on the day of the attack about a violent act that had occurred four years ago. The patient had not communicated a threat since, but the [court] decided that the physician may still have had a common law duty to protect the nurse, even though he had fulfilled the statutory duty to warn.” (footnote omitted)).

But arguably the recent case that has caused the greatest consternation among mental health providers is a 2004 California Court of Appeal ruling that determined that the communication of the client's threat triggering the duty to protect could come from someone other than just the client. In *Ewing v. Goldstein*, a patient's father had informed his son's therapist that his son had threatened to harm his ex-girlfriend's new boyfriend.³³⁶ The patient subsequently killed the boyfriend, and the court ruled that this indirect communication of the patient's threat could suffice to impose on the therapist the duty to protect.³³⁷ The court stated that "[a] communication from a patient's family member to the patient's therapist, made for the purpose of advancing the patient's therapy, is a 'patient communication.'"³³⁸ One commentator wrote that this ruling "expanded the criteria that trigger the duty to warn . . . and in its wake has left confusion in the mental-health community about when and how the duty arises."³³⁹

In addition, "[b]y the late 1990s, . . . mental health professionals had developed new views about the accuracy of violence predictions, which led [some] to conclude that, contrary to what had [been asserted previously], 'clinicians are able to distinguish violent from nonviolent patients with a modest, better-than-chance level of accuracy.'"³⁴⁰ These

335. See *Dawe v. Dr. Reuven Bar-Levav & Assocs.*, 780 N.W.2d 272, 273 (Mich. 2010) (holding statute limiting liability to third parties for a failure to protect is not applicable where a former patient entered the psychiatrist's office and shot the plaintiff, a current patient of the psychiatrist, and others participating in a group therapy session). In addition, two older cases continue to cause mental health providers alarm. See *Jablonski v. United States*, 712 F.2d 391, 398 (9th Cir. 1983) (imposing duty notwithstanding that there were "no specific threats concerning any specific individuals," with the client's psychological profile and prior history of violence sufficient to trigger the duty to protect); *Lipari v. Sears, Roebuck & Co.*, 497 F. Supp. 185, 187–88 (D. Neb. 1980) (permitting a suit after a patient shot strangers in a crowded nightclub without making any specific threats and a month after terminating psychiatric treatment).

336. *Ewing v. Goldstein*, 15 Cal. Rptr. 3d 864, 867 (Ct. App. 2004).

337. *Id.* at 867–68.

338. *Id.* at 868.

339. Gwynneth F. Smith, Note, *Ewing v. Goldstein and the Therapist's Duty To Warn in California*, 36 GOLDEN GATE U. L. REV. 293, 293–94 (2006); see also Donald A. Eisner, *From Tarasoff to Ewing: Expansion of the Duty To Warn*, 24 AM. J. FORENSIC PSYCHOL. 45, 45 (2006) (characterizing *Ewing* as a "significant expansion of the duty to warn"); Soulier et al., *supra* note 304, at 459 (describing critical responses to the *Ewing* decision); Smith, *supra*, at 319 ("The business of violence prediction is simply too fraught with ambiguity to expect therapists to maintain client confidentiality while attempting to navigate the murky waters of a hasty expansion of the duty to warn.").

340. Mossman, *supra* note 283, at 555 (quoting John Monahan, *Clinical and Actuarial Predictions of Violence*, in 1 MODERN SCIENTIFIC EVIDENCE: THE LAW AND SCIENCE OF

predictions were further enhanced as “[t]he 1990s also witnessed the beginnings and dissemination of a new approach to, or ‘technology’ for, making violence risk assessments.”³⁴¹ Although significant concerns remain about a clinician’s ability to adequately assess risk and prevent harm in a given case,³⁴² these developments suggest that more may be

EXPERT TESTIMONY § 7-2.2 (David L. Faigman et al. eds., 1997)); *see also* Monahan, *supra* note 275, at 497 (“[T]he field of violence risk assessment has burgeoned and is now a vast and vibrant area of interdisciplinary scholarship.”); Lisa J. Warren et al., *A Clinical Study of Those Who Utter Threats To Kill*, 29 BEHAV. SCI. & L. 141, 141, 147–49 (2011) (finding that among 144 adults referred to a community-based forensic mental health service for assessment following an explicit threat to kill someone that created a fear of future violence in the person to whom the threat was made, 41.7% within twelve months of their assessment committed an offense, including 22.9% who committed a violent offense—including one homicide—and 12.5% assaulted the initial threat target, including the one fatality; factors found to significantly increase the risk of subsequent violence were a history of substance abuse, a history of violence, limited education, and the absence of any mental health treatment during the study period; the combination of these four factors predicted violence with a specificity of 87.4%).

341. Mossman, *supra* note 283, at 564; *see id.* at 565–66 (“Before 1990, most studies of psychiatric violence prediction examined efforts in which mental health professionals had used their ‘clinical judgment’ to gauge violence and make decisions relevant to patients. . . . In the 1990s, mental health literature witnessed the publication of several studies that described the capacities of actuarial ‘technology’ in assessing the risk of future violence. . . . By now, the social science literature contains scores of studies of actuarial prediction methods yielding results that imply well-above-chance levels of predictive accuracy.”); *see also* Monahan, *supra* note 275, at 498–99 (“There are two basic approaches to assessing the risk of violence. One approach, called unstructured risk assessment, relies on the subjective judgment of people experienced at making predictive judgments. . . . [R]isk factors are selected and measured based on the mental health professional’s theoretical orientation and prior clinical experience. What these risk factors are, or how they are measured, might vary from case to case, depending on which seem most relevant to the expert doing the assessment. At the conclusion of the assessment, risk factors are combined in an intuitive manner to generate an overall professional opinion about an individual’s level of violence risk. The other approach, termed structured risk assessment, relies . . . more on objective rules. Those rules specify in advance *at least* which risk factors are to be measured in making a prediction and how they are to be measured. In some forms of structured risk assessment, rules also govern how the measured risk factors are to be combined to yield an overall estimate of violence risk. In the most structured form of risk assessment, these actuarial estimates . . . are offered as the final products of the risk assessment process: they are meant to replace, and not to inform, professional judgment.” (footnotes omitted)).

342. *See* Monahan, *supra* note 275, at 500 (“Little has transpired in the intervening decades to increase confidence in the ability of mental health professionals, using their unstructured clinical judgment, to accurately assess violence risk.”); Mossman, *supra* note 283, at 566 (“The available research also shows that actuarial measures are far from perfect at distinguishing those individuals who will be violent from those who will not.”). Furthermore, it has been pointed out that even if mental health providers have an enhanced ability to predict violence, these predictions are only estimates of the likelihood of violence and do not answer the basic question of when confidentiality should be breached and what steps should be taken. *See* Hubbard, *supra* note 284, at 436 (“[A]nswering the science question does not answer the policy question: what is the threshold of risk that we as a society are willing to accept in order to avoid institutionalizing non-dangerous people? . . . Therapists have little direction from courts or legislatures as to the level of

expected of clinicians in preventing harm to third parties threatened by their clients and that they will be expected to be aware of and proficient in utilizing this new knowledge and these tools.³⁴³ Although it has been suggested that clinicians may be afforded some protection by the fact that few clinicians currently employ this more advanced approach, commentators have also argued that this shield from liability may and should be diminishing.³⁴⁴ In any case, consistent with other treatment-

risk that justifies—indeed requires—a particular protective measure, such as a warning.” (footnotes omitted)); *see also* Mossman, *supra* note 283, at 567 (“*Tarasoff* fails to recognize that therapists do not have yes-or-no advance knowledge about whether a threat (or other behavior) implies that a disclosure is necessary At best, therapists know about probabilities or (more often) degrees of relative risk.”); *id.* at 577 (“[S]ociety cannot agree upon what level of risk is ‘serious’ enough to trigger a *Tarasoff*-type response to future danger. Moreover, it appears that there is no agreement about risk levels even among judges.”); Michael R. Quattrocchi & Robert F. Schopp, *Tarasaurus Rex: A Standard of Care That Could Not Adapt*, 11 PSYCHOL. PUB. POL’Y & L. 109, 133 (2005) (“There is no reasonable evidence that warnings are effective in preventing harm. There is reasonable evidence, however, to suggest that treatment prevents violence . . .”).

343. *See* Hubbard, *supra* note 284, at 435 (“[B]reakthrough techniques in violence risk assessment, if widely implemented, could alleviate many, but certainly not all, objections to obligating mental health professionals to make violence predictions under *Tarasoff*.”); Monahan, *supra* note 275, at 511 (“The post-*Tarasoff* scientific literature is clear that structured risk assessment is superior to unstructured risk assessment in accurately predicting violent behavior. . . . [But t]he literature on the incorporation of structured risk assessment into the clinical practice of predicting violence . . . suggests that only a minority of mental health professionals routinely employ structured risk assessment.”); *id.* at 502 (“Courts as well as legislatures have become remarkably receptive to the introduction of structured risk assessment tools” (footnotes omitted)); Mossman, *supra* note 283, at 566 (“[C]linicians who perform ‘risk assessments have a professional responsibility to be aware of the advantages and limitations of using [these] tools.” (quoting Thomas R. Litwack, *Actuarial Versus Clinical Assessments of Dangerousness*, 7 PSYCHOL. PUB. POL’Y & L. 409, 438 (2001))).

344. *See* Monahan, *supra* note 275, at 514. Professor Monahan acknowledges that mental health providers may be shielded from liability because only a small minority employ structured violence risk assessment when predicting violence and “[i]n most states . . . proving the standard of care [in a malpractice suit] means proving only what . . . mental health professionals ‘customarily do under similar circumstances.’” *Id.* (footnotes omitted) (quoting Philip G. Peters, Jr., *Empirical Evidence and Malpractice Litigation*, 37 WAKE FOREST L. REV. 757, 758 (2002)). Nonetheless, he points out that “[t]his situation may be changing . . . [as] a growing minority of states have abandoned the custom-based standard of care” and are employing “a reasonable physician standard . . . [that] provides . . . less shelter for those adhering to antiquated customs.” *Id.* (quoting Peters, *supra*, at 758; Phillip G. Peters, Jr., *The Role of the Jury in Modern Malpractice Law*, 87 IOWA L. REV. 909, 967 (2002)) (internal quotation marks omitted). In Professor Monahan’s view, “more *Tarasoff* protection for clinical ‘innovators’ who use evidence-based structured violence risk assessment, and less protection for clinicians adhering to the ‘antiquated custom’ of using unstructured risk assessment, is exactly what the future should portend for *Tarasoff* liability.” *Id.*; *see also infra* notes 52–55 and accompanying text.

related decisions, it has been suggested that mental health providers may be able to minimize their liability exposure by seeking a related consult.³⁴⁵

Finally, more may be expected of mental health providers following widely publicized tragedies such as the recent mass shootings in Connecticut, Colorado, Arizona, and Virginia. In each of the postmortems following these events, considerable attention has been given to indications that the individuals responsible for these shootings suffered from a mental illness and had previously received at least some mental health services,³⁴⁶ with questions raised whether more effective mental health interventions or additional steps taken by involved mental health providers could have prevented these events.³⁴⁷ For example, subsequent to the shootings in Newtown, Connecticut, a law was passed in New York that “requir[es] physicians, social workers and other therapists to report

345. See Solomon M. Fulero, *Tarasoff: 10 Years Later*, 19 PROF. PSYCHOL.: RES. & PRAC. 184, 186 (1988) (“Consultation provides evidence of professional consensus about the action taken. A therapist is not liable for a negative outcome unless his or her actions fall below the expected standard of care.”); Tapp & Payne, *supra* note 299, at 2–9 (advising that social workers facing a *Tarasoff*-like scenario should obtain “contemporaneous consultation”); Kaplan, *supra* note 288, at 242 (“[I]t seems prudent to suggest that a therapist should always obtain a consulting opinion from another qualified psychiatric specialist before deciding to warn a person who has been threatened by his patient.”); Knoll, *supra* note 305 (“[P]ast therapists and referral sources should be queried where appropriate, and consultations may be sought. If this type of careful, reasonable approach is taken . . . then reasonable professional judgment has been demonstrated and clinician liability becomes very unlikely . . .” (footnote omitted)); see also *supra* notes 146–47, 165, 190 and accompanying text.

346. See Colleen L. Barry et al., *After Newtown—Public Opinion on Gun Policy and Mental Illness*, 368 NEW ENG. J. MED. 1077, 1077 (2013), available at <http://www.nejm.org/doi/pdf/10.1056/NEJMp1300512> (discussing the highly publicized mass shootings at Sandy Hook Elementary in Newtown, Connecticut, the movie theatre in Aurora, Colorado, the political meet-and-greet in Tucson, Arizona, and the campus of Virginia Tech University, and noting these four events shared the common characteristic that “all four shooters were apparently mentally ill”).

347. See, e.g., John Cloud, *The Troubled Life of Jared Loughner*, TIME (Jan. 15, 2011), <http://www.time.com/time/magazine/article/0,9171,2042358,00.html#ixzz1We16V5Sq> (“[S]omeone at Pima Community College should have responded more directly to Loughner’s warning signs The Loughner case is similar to that of Seung Hui Cho, who in 2007 shot and killed 32 people at Virginia Tech. . . . Schools should devote more resources to students with obvious problems.”); Adam Clark Estes, *Revelations About Adam Lanza’s Mental Health Still Don’t Explain the Violence*, ATLANTIC WIRE (Feb. 19, 2013), <http://www.theatlanticwire.com/national/2013/02/revelations-about-adam-lanzas-mental-health-still-dont-explain-violence/62317/> (“Almost as long as we’ve known his name, we’ve known that Adam Lanza struggled with some sort of mental illness.”); Erica Goode et al., *Before Gunfire, Hints of ‘Bad News’: In Colorado, Tracing the Trial of a Loner Coming Apart*, N.Y. TIMES, Aug. 27, 2012, at A1 (discussing missed clues that “paint a disturbing portrait of a young man struggling with a severe mental illness who more than once hinted to others that he was losing his footing,” including that at one point, “his psychiatrist . . . grew concerned enough that she alerted at least one member of the university’s threat assessment team that he might be dangerous”).

potentially dangerous patients to local health officials.”³⁴⁸ At the same time, one positive aspect that may result is enhanced funding and support for mental health services.³⁴⁹

X. CONCLUSION

This Article has examined a number of areas in which professional liability claims pertaining to mental health care can be expected to increase. Whereas practitioners were once insulated from litigation for various reasons, these barriers are rapidly breaking down. As treatment has vastly improved, the standard of care and the expectations of patients and society have evolved. Injuries experienced due to the negligent delivery of mental health care services are now increasingly likely to generate a legal claim.

Mental health providers, clients, and society will likely have mixed feelings about this evolution. On the one hand, it represents a triumph. It indicates that clients are sufficiently recovered, empowered, and supported that they can pursue claims against mental health providers for inadequate care. In addition, these suits also suggest that mental health care and its providers are gaining greater parity with their physical health counterparts. However, mental health care in this country continues to be underfunded, undersupported, and underappreciated. To the extent that providers feel that the delivery of this care has become too onerous, it may drive them from the field and make critically needed services less available.

348. Brady Dennis & Lena H. Sun, *After Newtown, Support for Mental-Health Spending Grows*, WASH. POST (Feb. 23, 2013), http://www.washingtonpost.com/national/health-science/after-newtown-support-for-mental-health-spending-grows/2013/02/23/0d8d75ca-7495-11e2-aa12-e6cf1d31106b_story.html.

349. *Id.* (“Mental-health advocates from coast to coast are seizing upon a rare and unexpected chance to stem the years-long tide of budget cuts and plug gaps in the nation’s patchwork mental-health-care system. In the wake of the massacre in Newton, Conn., lawmakers from both parties, along with notoriously tight-belted governors, are pushing to restore some of the estimated \$4.3 billion in mental-health spending that was slashed from state budgets between 2009 and 2012.”); see also Brady Dennis & Paul Kane, *Measure Would Strengthen Mental Health-Care System*, WASH. POST (Feb. 7, 2013), http://www.washingtonpost.com/national/health-science/measure-would-strengthen-mental-health-care-system/2013/02/07/dd64db44-714d-11e2-ac36-3d8d9dcaa2e2_story.html (“A bipartisan group of senators, citing renewed urgency after the shooting massacre at Sandy Hook Elementary School, introduced legislation Thursday aimed at strengthening the nation’s fragmented mental health-care system and improving access at the community level.”).

It should be noted that the debate over the impact of medical malpractice liability on the practice of medicine and whether it improves or impedes the quality of health care has raged for over a century and a half in this country and continues to rage today.³⁵⁰ Although the full impact of increased professional liability on mental health providers and mental health care remains to be seen, greater attention must be given to its emergence in light of the wide demand for and vital nature of these services.

350. See Thomas L. Hafemeister & Joshua Hinckley Porter, *The Health Care Reform Act of 2010 and Medical Malpractice Liability: Worlds in Collision or Ships Passing in the Night?*, 64 SMU L. REV. 735, 738–42 (2011).