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IN THE SUPREME COURT OF THE STATE OF WASHINGTON

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BEVERLY VOLK, et al.,

Appellants,

v.

JAMES B. DEMEERLEER, et al.,

Respondents.

Filed *E*  
Washington State Supreme Court

OCT 13 2015

Ronald R. Carpenter  
Clerk *h/j*

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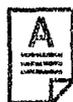
BRIEF OF AMICUS CURIAE

WASHINGTON STATE PSYCHOLOGICAL ASSOCIATION

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**TEXTS AND OTHER AUTHORITIES**

Appelbaum, P.S. (1982). Confidentiality in psychiatric treatment in  
*Psychiatry 1982: The American Psychiatric Association  
Annual Review*. Edited by Grinspoon, L. Washington,  
D.C.: American Psychiatric Press.

Appelbaum, P.S., Kapen, G., Walters, B., Lidz, C., and Roth, L.H.  
(1984). Confidentiality: An empirical test of the utilitarian

perspective. *Bulletin of the American Academy of Psychiatry and the Law*, 12(2), 109-116.

- Benjamin, G. A. H., Kent, L., & Sirikantraporn, S. (2009). A review of the duty to protect statutes, cases, and procedures for positive practice. In J. L. Werth, E. R. Welfel, & G. A. H. Benjamin (Eds.), *The duty to protect: Ethical, legal, and professional responsibilities of mental health professionals* (pp. 9 – 28). Washington, DC: APA Press.
- DeKraai, M. B., & Sales, B. D. (1982). Privileged communications of psychologists. *Professional Psychology: Research and Practice*, 13, 372-388.
- Garfield, S.L., Wolpin, M.P. (1963). Expectations regarding psychotherapy. *Journal of Nervous and Mental Disease*, 4, 353-362.
- Glossoff, H. L., Herlihy, S. B., Herlihy, B., & Spence, E. B. (1997). Privileged communication in the psychologist client relationship. *Professional Psychology: Research and Practice*, 28, 573-581.
- Harris, G. T., Rice, M. E., & Camilleri, J. A. (2004). Applying a forensic actuarial assessment (the violence risk appraisal guide to nonforensic patients). *Journal of Interpersonal Violence*, 19, 1063-1074.
- Kobocow, B., McGuire, J. M., & Blau, B.I. (1983). The influence of confidentiality conditions on self-disclosure of early adolescents. *Professional Psychology: Research and Practice*, 14(4), 435-443.
- Lens, V. (2000). Protecting the confidentiality of the therapeutic relationship: Jaffee v. Redmond. *Social Work*, 45(3), 273-276.
- Lindenthal, J.J., & Thomas, C.S. (1982). Psychiatrists, the public and confidentiality. *Journal of Nervous and Mental Disease*, 170, 319-323.

- Marsh, J.E. (2003). Empirical support for the United States Supreme Court's protection of the psychotherapist-patient privilege, *Ethics & Behavior, 13*, 385-397.
- MacKinnon, R.A., & Michaels, R. (1971). *The Psychiatric Interview in Clinical Practice*. Philadelphia: Saunders.
- McGuire, J.M., Toal, P. & Blau, B.I. (1985). The adult client's conception of confidentiality in the therapeutic relationship, *Professional Psychology: Research and Practice, 16*, 375-386. Meloy, J.R. (2000). Violence risk and threat assessment. San Diego, CA: Specialized Training Services.
- Miller, D.J., & Thelen, M.H. (1986). Knowledge and beliefs about confidentiality in psychotherapy. *Professional Psychology: Research and Practice, 17*(1), 15-19.
- Monahan, J. (1981). *The clinical prediction of violence*. Beverly Hills, CA: Sage.
- Monahan, J. (2006). Tarasoff at thirty: How developments in science and policy shape the common law. *University of Cincinnati Law Review, 75*, 497-521.
- Monahan, J., and Steadman, H.J. (Eds.) (1994). Violence and mental disorder: Developments in risk assessment. Chicago, IL: Univ. of Chicago Press.
- Mulvey, E. P., & Lidz, C. W. (1998). Clinical prediction of violence as a conditional judgment. *Social Psychiatry and Psychiatric Epidemiology, 33*, 107-113.
- Pabian, Y., & Welfel, E. R., & Beebe, R. S. (2009). Psychologists' knowledge of their state laws pertaining to Tarasoff-type situations. *Professional Psychology: Research and Practice, 40*, 8-14.
- Rogers, C.R. (1957). The necessary and sufficient conditions of therapeutic personality change. *Journal of Consulting Psychology, 21*, 95-103.

- Schmid, D., Appelbaum, P.S., Roth, L.H., & Lidz, C. (1983). Confidentiality in psychiatry: A study of the patient's view. *Hospital and Community Psychiatry, 34*, 353-355.
- Scott, C. L., & Resnick, P. J. (2006). Violence risk assessment in persons with mental illness. *Aggression and Violent Behavior, 11*, 598-611.
- Shuman, D.W., & Weiner, M.R. (1982). The privilege study: An empirical examination of the psychotherapist-patient privilege. *N.C.L. Review, 893-942*.
- Taube, D.O. & Elwork, A. (1990). Researching the effects of confidentiality law on patients' self-disclosures, *Professional Psychology: Research and Practice, 21*, 72-75
- Wilkins, M.A., McGuire, J.M., Abbott, D.W. and Blau, B.I. (1990). Willingness to apply understood ethical principles. *Journal of Clinical Psychology, 46* (4), 539-547.
- Woods, K.M., & McNamara, J.R. (1980). Confidentiality: Its effects on interviewee behavior. *Professional Psychology, 11*(5), 714-721.

## IDENTITY AND INTEREST OF *AMICI CURIAE*

The Washington State Psychological Association (WSPA) is a nonprofit scientific and professional organization founded in 1947. WSPA represents more than 600 members and affiliates, including the majority of psychologists holding doctoral degrees from accredited universities.

Wash. Rev. Code § 18.83.010(1) defines the "practice of psychology" to mean:

the observation, evaluation, interpretation, and modification of human behavior by the application of psychological principles, methods, and procedures for the purposes of preventing or eliminating symptomatic or maladaptive behavior and promoting mental and behavioral health. As a result, the mission of WSPA is to support, promote and advance the education, science and practice of psychology in the public interest.

Indeed, WSPA is recognized at the national level of psychology for its dedication to promoting the public interest.

Whenever WSPA attempts to promote the public interest, it relies upon the most recent scientific evidence to establish what actions would enhance the mental and behavioral health of Washington citizens. WSPA did so in 1985, as described below, when it led legislative change to narrow the breadth of the common law duty established by *Petersen v. State of Washington* (1983) and instead lobbied zealously to codify a more narrow standard, Wash. Rev. Code § 71.05.120. Since the legislative

changes in 1987, WSPA has reviewed the scientific evidence regarding the implementation of the duty to warn, and we found compelling evidence that demonstrates this specific law leads to better outcomes for patients and for the public. As a matter of public interest, WSPA is submitting an amicus brief to support Washington continuing to hold all mental health professionals, those who work in public or private settings, to the existing standard of care established by Wash. Rev. Code § 71.05.120. WSPA believes that Wash. Rev. Code § 71.05.120 contains the legislative decree on what the duty really is and that the statute abrogated *Petersen*. The placement of Wash. Rev. Code § 71.05.120 inside the commitment statutes was the only place the code reviser could place the legislative decree in 1987 as no other Chapters existed that covered all mental health professionals. WSPA and mental health professionals believed that the legislation in 1987 had ended the problem of a vague and ambiguous duty being imposed upon mental health professionals by *Petersen*.

## SUMMARY OF ARGUMENT

*Amici*, the state's leading association of psychology professionals and behavioral scientists, have prepared this brief to provide the Court with a comprehensive and balanced review of the scientific and professional literature pertinent to the issues before the Court. In preparing

this brief, *amici* have been guided solely by criteria related to scientific rigor and reliability of studies and literature, not by whether a given study supports or undermines a particular conclusion.

Scientific research has established that the duty to warn is better understood by mental health professionals and more likely to be applied accurately if the duty is defined clearly. The Washington statutes, Wash. Rev. Code § 71.05.120, impose a duty to warn upon treating mental health professionals when 1) an actual threat of violence has been made, and 2) the actual threat is made toward a reasonably identifiable victim(s). Mental health professionals would fail both the efficacious treatment of their patients and the protection of the public if a more ambiguous duty existed. Washington already has experienced the failure of the common law under *Petersen v. State of Washington* (1983) when a vaguely constructed duty was created. After that decision, mental health professionals believed that the *Petersen* duty called for them to protect anyone from their patients who might potentially harm some third party, by any type of violence or in some undefined manner. WSPA urges the Court to uphold the unambiguous standards of Wash. Rev. Code § 71.05.120 that have been applied to public and private mental health professionals, for all types of care, not just the care within the involuntary treatment system, since 1987.

## ARGUMENT

### I. THE NATURE OF SCIENTIFIC EVIDENCE AND ITS PRESENTATION IN THIS BRIEF

To assist the Court, we briefly explain the professional standards we have followed for selecting individual studies and literature for citation and for drawing conclusions from the research data and theory.

(1) We are ethically bound to be accurate and truthful in describing research findings and in characterizing the current state of scientific knowledge.

(2) We rely on the best empirical research available, focusing on general patterns rather than any single study. Whenever possible, we cite original empirical studies and literature reviews that have been peer reviewed and published in reputable academic journals or books. Not every published paper meets this standard because academic journals differ widely in their publication criteria and the rigor of their peer review. When journal articles report research, they employ rigorous methods, are authored by well established researchers, and accurately reflect professional consensus about the current state of knowledge. In assessing the scientific literature, we have been guided solely by criteria of scientific validity, and have neither included studies merely because they support,

nor excluded credible studies merely because they contradict, particular conclusions.

(3) Before citing any study, we critically evaluated its methodology, including the reliability and validity of the measures and tests it employed, and the quality of its data-collection procedures and statistical analyses. We also evaluated the adequacy of the study's sample, which must always be considered in terms of the specific research question posed by the study. In this brief, we note when a study's findings should be regarded as tentative because of a particularly small or selective sample, or because of possible limitations to the procedures used for measuring a key variable.

(4) No empirical study is perfect in its design and execution. All scientific studies can be constructively criticized, and scientists continually try to identify ways to improve and refine their own work and that of their colleagues. When a scientist identifies limitations or qualifications to a study's findings (whether the scientist's own research or that of a colleague), or when she or he notes areas in which additional research is needed, this should not necessarily be interpreted as dismissing or discounting of the research. Rather, critiques are part of the process by which science is advanced.

(5) Scientific research cannot prove that a particular phenomenon never occurs or that two variables are never related to each other. When repeated studies with different samples consistently fail to establish the existence of a phenomenon or a relationship between two variables, researchers become increasingly convinced that, in fact, the phenomenon does not exist or the variables are unrelated. In the absence of supporting data from prior studies, if a researcher wants to argue that two phenomena are correlated, the burden of proof is on that researcher to show that the relationship exists.

## II. WASHINGTON'S DUTY TO PROTECT

*Petersen v. State of Washington* (1983) involved a patient who had been stopped by hospital security for driving recklessly in the hospital's parking lot after returning from a day pass. Knowing this, the treating psychiatrist nonetheless discharged the patient the next morning. The case record showed the psychiatrist also knew the following data about the patient at the time of the discharge: The patient had an extensive history of drug abuse, the patient had partially castrated himself 16 days earlier while intoxicated on drugs, and the patient had entered the hospital after being adjudged gravely disabled (unable to take care of his basic life needs) and mentally ill "schizophrenic reaction, paranoid type with depressive features" (*Petersen v. State of Washington*, 1983, p. 423).

At the end of the 14-day involuntary hospitalization, despite his reckless driving of the night before, he was assessed on the day of release by the same psychiatrist who determined that the patient had recovered from the drug overdose and had regained “full contact with reality” (*Petersen v. State of Washington*, 1983, p. 427). Five days later, under the influence of drugs, the patient ran a red light in his vehicle and hit Ms. Petersen’s vehicle at 50 to 60 miles an hour.

Ms. Peterson was someone unknown to the patient. The court held that the psychiatrist had “incurred a duty to take reasonable precautions to protect anyone who might be foreseeably endangered by . . . the [patient’s] drug-related mental problems” (*Petersen v. State of Washington*, 1983, p. 428, emphasis added).

**A. A Lack of Clarity of the Common Law Duty Led to Poor Outcomes**

The decision created great uncertainty within Washington because the court emphasized the foreseeability of the dangerousness, no matter how intangible and overly broad, in defining a mental health professional’s duty to protect the public at large.<sup>1</sup> In addition, *Petersen* left

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<sup>1</sup> In later decisions, the Supreme Court narrowed the reach of *Petersen* by noting that it should only be applied to mental health patients under the institutional care (*Taggart v. State*, 118 Wn.2d 195, 822 P.2d 243 (1992); *Couch v. Dep’t of Corrs.*, 113 Wn.App. 556, 571, 54 P.3d 197 (2002); *Osborn v. State*, 157 Wn.2d 18, 24, 134 P.3d 197 (2006)).

Washington mental health professionals alarmed at their new common law duty because the case imposed a standard of foreseeability that was unsupported by any scientific basis. *Petersen* not only offered little clarity about how to meet the new duty, it forced mental health professionals into making invalid and unreliable clinical judgments in light of the poor research evidence about predicting violent behavior.

**B. The Legislature enacted a Duty to Warn based upon the Scientific Literature and Experience Data from Washington**

Psychologists<sup>2</sup> turned to the state legislature to enact a more reasonable duty, and cited the Monahan (1981) findings demonstrating that violent behavior is not consistently foreseeable. This seminal work by Monahan represented the first step in the development of psychological research to develop more accurate methods for predicting dangerousness. More recent psychological research has not led to better outcomes regarding the foreseeability of violence (e.g., Meloy, 2000; Monahan and Steadman, 1994). Monahan and Steadman (1994) explained that “civil and criminal courts throughout the world increasingly demand that psychiatrists, psychologists, and other mental health professionals offer

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<sup>2</sup> Eric Trupin, PhD and G. Andrew H. Benjamin, JD, PhD, WSPA psychologists, worked closely with the staff of Representative Seth Armstrong and Senator Phillip Talmadge to draft and shepherd through the legislature, Wash. Rev. Code § 71.05.120.

opinions about the “dangerousness” of mentally disordered persons.” They called attention to research from the 1970’s that “dramatically demonstrated the limits of professional expertise” in terms of violence prediction. “A limited amount of research conducted during the 1980’s attempted to improve on this unimpressive record but – with a few notable exceptions – achieved little success (Monahan and Steadman, 1994, p. vii).

In the intervening years, further research has helped to identify and organize risk assessment data collection designed to improve predictive accuracy (e.g., Meloy multifactorial violence risk model, 2000). The literature has suggested that mental health professionals engage in structured risk assessments designed to obtain actuarial and clinical assessments to reduce clinical judgment errors and increase the accuracy of violence assessments,<sup>3</sup> even though recent studies about predictions of violence have shown that such an approach only resulted in marginally lower rates of false-positive and false-negative errors.<sup>4</sup> Because of the

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<sup>3</sup> Monahan, J. (2006). Tarasoff at thirty: How developments in science and policy shape the common law. *University of Cincinnati Law Review*, 75, 497-521.

<sup>4</sup> Harris, G. T., Rice, M. E., & Camilleri, J. A. (2004). Applying a forensic actuarial assessment (the violence risk appraisal guide to nonforensic patients). *Journal of Interpersonal Violence*, 19, 1063-1074; Scott, C. L., & Resnick, P. J. (2006). Violence risk assessment in persons with mental illness. *Aggression and Violent Behavior*, 11, 598-611.

variability of each client's disposition, history, contextual situation, and clinical issues, "only so much violence can ever be predicted using individually based characteristics, given the highly transactional nature of violence."<sup>5</sup> While the art and science of violence risk assessment has improved over the past several decades, there is a prevailing consensus opinion that any prediction can only be stated in probabilistic terms (high, moderate, mild, low risk) and that the duration of predictive accuracy is very fleeting at best.<sup>6</sup>

Other testimony documented unintended consequences of implementing such an ambiguously defined duty: After the *Petersen* decision, mental health professionals working in both public and private settings, in increasing numbers, obtained involuntary commitment evaluations from county designated mental health professionals for vague threats of violence uttered by their clients.<sup>7</sup> Data from the counties showed that mental health professionals were seeking evaluations at a significantly greater rate than before the common law decision. The increase in

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<sup>5</sup> Mulvey, E. P., & Lidz, C. W. (1998). Clinical prediction of violence as a conditional judgment. *Social Psychiatry and Psychiatric Epidemiology*, 33, 107, 107-113.

<sup>6</sup> Benjamin, G. A. H., Kent, L., & Sirikantraporn, S. (2009). A review of the duty to protect statutes, cases, and procedures for positive practice. In J. L. Werth, E. R. Welfel, & G. A. H. Benjamin (Eds.), *The duty to protect: Ethical, legal, and professional responsibilities of mental health professionals* (pp. 9 – 28). Washington, DC: APA Press.

<sup>7</sup> Testimony before the State of Washington Senate Judiciary, 1985.

evaluation requests overwhelmed the involuntary treatment systems of many counties and led to pervasive disclosures of confidential patient information, significantly greater county expenditures for the involuntary treatment evaluations, and no reductions in violence.<sup>8</sup>

The mobilization of Washington psychologists with other mental health professionals and consumer groups led to the enactment of a statute that defined the duty to warn specifically in order to more reasonably balance the need to maintain confidences of patients and protect the safety of the public. Chapter 71.05 applies to mental health mental health professionals in both public and private settings, and the legislature intended to accomplish the following in creating the laws of the chapter:<sup>9</sup>

- (1) To prevent inappropriate, indefinite commitment of mentally disordered persons and to eliminate legal disabilities that arise from such commitment;
- (2) To provide prompt evaluation and timely and appropriate treatment of persons with serious mental disorders;
- (3) To safeguard individual rights;

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<sup>8</sup> Testimony before the State of Washington Senate Judiciary, 1985.

<sup>9</sup> *See*, Wash. Rev. Code § 71.05.010; The law since the enactment of Wash. Rev. Code § 71.05.120 always contemplated continuity of care for persons with serious mental disorders that can be controlled or stabilized in a less restrictive alternative settings other than hospitalization. Outpatient treatment has never been precluded under the laws of this chapter.

- (4) To provide continuity of care for persons with serious mental disorders;
- (5) To encourage the full use of all existing agencies, professional personnel, and public funds to prevent duplication of services and unnecessary expenditures;
- (6) To encourage, whenever appropriate, that services be provided within the community;
- (7) To protect the public safety.

The Code Reviser recommended to the staffs of Representative Armstrong and Senator Talmadge that the new duty of warning and protecting third parties be placed within Chapter 71.05 RCW because, at the time, the laws relating to all mental health professionals existed within *just* this chapter. Wash. Rev. Code § 71.05.120 focused Washington's mental health professionals on assessing actual threats of physical violence against reasonably identifiable third parties.

### **III. CONCRETE STANDARDS OF CARE LEAD TO BETTER OUTCOMES**

The state of Washington has not been alone in enacting duty to warn/protect standards for mental health professionals to meet, although it was among the first States to enact a specific statute. Shortly after the *Tarasoff* ruling, only three states had implemented such a duty.<sup>10</sup> By the

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<sup>10</sup> DeKraai, M. B., & Sales, B. D. (1982). Privileged communications of psychologists. *Professional Psychology: Research and Practice*, 13, 372-388.

end of the last decade, Benjamin, Kent and Sirikantraporn (2009) found that a mandatory duty to warn/protect had been created by statute or rule in 24 states, and nine states operated under a common-law duty. In addition, 10 other state laws and eight provinces/territories had provided mental health professionals with a permissive duty to warn which means that the law allows, but does not require, a breach to patient confidentiality to protect third parties from a patient's threatened violence. The remaining 30 jurisdictions within North America have not developed law about the duty to warn/protect.

The laws in the jurisdictions differ considerably in clarity about the standards for the assessment of a client's risk of committing violence, the target(s) of the threatened violence, and how to meet the duty to warn/protect.<sup>11</sup> In recent research involving psychologists in four states with varying legal requirements regarding the breach of confidentiality with dangerous clients,<sup>12</sup> the researchers found that most psychologists (76.4%) were misinformed about their state laws. In the two states where

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<sup>11</sup> Benjamin, G. A. H., Kent, L., & Sirikantraporn, S. (2009). A review of the duty to protect statutes, cases, and procedures for positive practice. In J. L. Werth, E. R. Welfel, & G. A. H. Benjamin (Eds.), *The duty to protect: Ethical, legal, and professional responsibilities of mental health professionals* (pp. 9 – 28). Washington, DC: APA Press.

<sup>12</sup> Pabian, Y., & Welfel, E. R., & Beebe, R. S. (2009). Psychologists' knowledge of their state laws pertaining to Tarasoff-type situations. *Professional Psychology: Research and Practice*, 40, 8-14.

no legal duty existed, many mistakenly believed that they were legally mandated to warn. In the two states where there were legal options other than warning the potential victim, most psychologists were confused about how to meet the duty. In other words, if the majority of these mental health professionals had confronted the circumstances described in the research and breached confidentiality without client permission, they would have been at risk for a civil suit from their clients for negligence or a disciplinary action by an ethics committee or licensing board for violating the confidentiality standards of their jurisdiction. Such findings are not surprising in light of long known evidence which has shown that concrete legal or ethical standards are better understood and executed more adequately by psychologists.<sup>13</sup> Washington's duty to warn, Wash. Rev. Code § 71.05.120, provides such precision.

**A. Washington's Duty to Warn Recognizes the Significance of Protecting Patient Confidences**

The *Peterson* decision often placed psychologists in an ethical bind: "Confidential communications between a client and a psychologist shall be privileged against compulsory disclosure to the same extent and subject to the same conditions as confidential communications between

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<sup>13</sup> Wilkins, M.A., McGuire, J.M., Abbott, D.W. and Blau, B.I. (1990). Willingness to apply understood ethical principles. *Journal of Clinical Psychology*, 46 (4), 539-547.

attorney and client” (Wash. Rev. Code § 18.83.110). During the *Peterson* period, many mental health professionals were insulating themselves from liability by having their patients evaluated for involuntary treatment by the county designated mental health professionals when their patients uttered vague threats. The situation improved with the clarity of Wash. Rev. Code § 71.05.120, which also appeared to have helped end such confidentiality breaches.

Later legislation prohibited all health care providers, not just mental health professionals, from disclosing "health care information about a patient to any other person without the patient's written authorization" except when the health care provider reasonably believes that the patient poses an "imminent danger" to the health and safety of an "individual" when the health care professional then “may” make the disclosures (Wash. Rev. Code § 70.02.050 (1)(c)).<sup>14</sup> This standard was further clarified by Wash. Rev. Code § 70.02.230 (2(i)(i)), which mandates that all information obtained in the course of providing mental health services must be confidential except for releases: “To appropriate corrections and law enforcement agencies all necessary and relevant information in the event of a crisis or emergent situation that poses a

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<sup>14</sup> “...however there is no obligation under this chapter on the part of the provider or facility to so disclose.”

significant and imminent risk to the public. The mental health service agency or its employees are not civilly liable for the decision to disclose or not so long as the decision was reached in good faith and without gross negligence.”

During the creation of Chapter 70.02, the legislature did not amend the specificity Wash. Rev. Code § 71.05.120 as it clearly called for disclosures from mental health professionals when an actual threat of violence was made toward a reasonably identifiable victim. This standard still applies to all mental health professionals, including psychologists and psychiatrists, regardless of practicing in a public or private setting. As mentioned above, some unintended confusion arose since the code reviser forced the new law into Chapter 71.05 RCW as Chapter 70.02 RCW was not created until much later. Wash. Rev. Code § 71.05.120 has curbed the overly broad standards created by Peterson.

**B. Recognition of the Importance of Confidentiality in Mental Health Settings**

The clinical literature on the practice of mental health assessment and counseling has placed a heavy emphasis on the development of an effective patient-therapist relationship (e.g., McKinnon & Michaels, 1971; Rogers, 1957). Elements such as empathy, genuineness, trustworthiness, and confidentiality have long been recognized as essential to such

therapeutic contacts. Empirical support for this viewpoint has included research with both inpatient and outpatient subjects who have expressed the importance of confidentiality to their forming an effective relationship in counseling and to increasing their willingness to disclose issues and concerns which might otherwise be embarrassing, sensitive, or distressing (Appelbaum, 1982; Appelbaum et al., 1984; Kobocow et al., 1983; Schmid et al., 1983; Woods & McNamara, 1980).

Statements made in the course of assessment and counseling sessions are made with the expectation that they will be held in confidence (McGuire et al., 1985; Miller & Thelen, 1986). Patients rely on mental health professionals' ethical duty to maintain confidentiality (Shuman & Weiner, 1982) and tend to benefit from a clear explanation at the outset of any limits or exceptions to the expectation that all therapeutic information will remain confidential and protected from discovery. A majority of subjects (both patients and non-patients) report that breaches of confidentiality would adversely affect the therapeutic relationship and limit their willingness to disclose potentially negative information about themselves, their thoughts, and their behaviors (Appelbaum et al., 1984).

The laws promoting confidentiality have deepened psychotherapeutic evaluation and treatment. The value of full disclosure between mental health professionals and their clients outweighs the

potential benefit that might occur if testimony or the release of confidential information is required under most clinical circumstances.<sup>15</sup> Empirical research has demonstrated that if mental health patients were assured of broad confidentiality, they were more willing to respond to clinician inquires about personal information, with greater disclosures, and were more honest in their responses.<sup>16</sup> As a society we want our mental health professionals to protect the confidences of our clients unless a few, very specific types of disclosures would protect the public. Blurring confidentiality communication protections among mental health professionals and patients would prevent effective therapeutic intervention from occurring in many cases.

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<sup>15</sup> *Jaffee v. Redmond*, 116 S.Ct. 1923 (1996).

<sup>16</sup> Marsh, J.E. (2003). Empirical support for the United States Supreme Court's protection of the psychotherapist-patient privilege, *Ethics & Behavior*, 13, 385-397; McGuire, J.M., Toal, P. & Blau, B.I. (1985). The adult client's conception of confidentiality in the therapeutic relationship, *Professional Psychology: Research and Practice*, 16, 375-386; Taube, D.O. & Elwork, A. (1990). Researching the effects of confidentiality law on patients' self-disclosures, *Professional Psychology: Research and Practice*, 21, 72-75.

## CONCLUSION

As the research studies and experience data from Washington have shown, the existing statute provides protections to third persons should a patient express an actual threat of harm against a reasonably identifiable victim. Both public and private mental health professionals have assimilated into their practices the standards of Wash. Rev. Code § 71.05.120 without needless intrusions on the privacy and the confidences of their patients. WSPA urges the Supreme Court to uphold the clarity of the existing law.

RESPECTFULLY SUBMITTED, this 2 day of October, 2015.

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## CERTIFICATE OF SERVICE

I, Paul A. Bastine, hereby certify under the laws of the State of Washington that on the 2d day of October 2015, a true and accurate copy of the *Brief of Amicus Curiae WSPA* was filed with the Washington Supreme Court via email to this address: [Supreme@courts.wa.gov](mailto:Supreme@courts.wa.gov). I further certify under the laws of the State of Washington that true and accurate copies of the same document were served on all parties of record by e-mail:

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Done this 2 day of October 2015



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Paul A. Bastine



