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Cover Page Footnote

I wish to thank Daniel Craine and Mariah Vogelgesang for their assistance.

IMMUNITY AND MENTAL HEALTH PROFESSIONALS

Mary Katherine Huffman[*]

I. INTRODUCTION

Should an inpatient in a mental health facility be afforded the right to seek tort damages as a result of the violence exacted by another in-patient, particularly when there is a statutory duty on the part of the hospital to protect the patient? Should the surviving family members of a mental health patient who takes his own life be permitted to seek damages from mental health professionals who violate a duty to that patient growing from their special relationship? These are but two queries that litigation attorneys and courts have considered in recent years. The answer to the concerns may, on its face, be rather simple, but legislative enactments in recent years, particularly in the form of enhanced immunity statutes, have served to afford little to no protection to those who are the victims of what would, more traditionally, be known as malpractice by mental health practitioners.

The roots of the common law right to recover for harm caused by the tortious acts of another, whether that conduct is intentional or unintentional, can be traced to social principles accepted over 2,000 years ago.[1] The concept is so imbedded in the Anglo-American system of civil justice that it bears little discussion as to its propriety or efficacy. It is often accepted, without debate, in modern legal systems that each citizen is responsible for his or her tortious conduct. At times, however, legislatures find it important, or perhaps politically expedient, to carve out exceptions to the ancient maxim of responsibility by insulating some, whether it is individuals, professions, or entities, from their tortious conduct. In enacting immunity statutes, legislatures defy the basic principle of our legal system—personal responsibility—leaving the victims of the professional acts or omissions of mental health professionals with little to no opportunity to recover. This suggests to the victims of those cloaked with immunity that their injuries are somehow not worthy of compensation, while a similar injury to another, exacted by one not so shielded with a legislative excuse for its conduct, goes compensated.

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[1] *See* John H. Wigmore, *Responsibility for Tortious Acts: Its History*, 7 Harv. L. Rev. 315 (1894); *see also* W. Page Keeton et al., *Prosser & Keeton on the Law of Torts* 160-61 (W. Page Keeton ed., 5th ed., West 1984) [hereinafter *Prosser & Keeton*].

This Article will briefly examine the historical application of the liability in Ohio of mental health professionals from the cases that followed the seminal decision in *Tarasoff v. Regents of the University of California*[2] through the Ohio Supreme Court's decision in *Estates of Morgan v. Fairfield Family Counseling Center*.[3] This Article will then consider the legislative response to *Morgan*, the Mental Health Services Providers Immunity Act, which sought to virtually eliminate the liability of mental health providers for any violation of the duty they owe to their patients or to the victims of violence by their patients. This Article will conclude that the legislative response to *Morgan* has been interpreted in such a manner as to virtually eliminate any remedy to mental health patients for the acts or omissions of their treatment providers, as well as any recourse for the victims of the patient's violence. However, this Article will also conclude that, because of the stated legislative purpose of the Mental Health Services Providers Immunity Act, the legislation does not serve to shield mental health professionals[4] from liability where the result of their violation of a duty to their patient results in the patient's suicide.

The Centers for Disease Control and Prevention reports that in 2004 suicide was the eleventh leading cause of death in the United States, accounting for 32,439 deaths.[5] Studies indicate that approximately one-third of those who commit suicide had contact with some mental health services provider within a year of their suicide, and about one in five had contact within the month of death.[6] Studies indicate that the risk factors for suicide include depression and other mental disorders; substance-abuse disorders; and[7] stress life events in combination with other risk factors, such as depression, prior suicide attempts, family history of mental disorders or substance abuse, family history of suicide, family violence, and firearms in the home.[8] It is also commonly reported in professional medical journals

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[2] 551 P.2d 334 (Cal. 1976).

[3] 673 N.E.2d 1311 (Ohio 1997).

[4] Various terms are employed in cases to describe the mental health professional at issue, including the terms therapist, psychologist, psychotherapist, or psychiatrist. Although the Ohio Revised Code defines a mental health professional as "an individual who is licensed, certified, or registered . . . to provide mental health services for compensation, remuneration, or other personal gain[,]" in this Article, so as not to limit the scope of application, I will utilize the same term, "mental health professionals," to describe the broad category of professionals who treat mental health patients. Ohio Rev. Code Ann. § 2305.51 (Lexis 2008).

[5] Dept. of Health & Human Servs. Ctrs. for Disease Control & Prevention, *WISQARS (Web-Based Injury Statistics Query and Reporting System)*, http://www.cdc.gov/ncipc/wisqars; *path* Leading Causes of Death Reports, *path* Data from 1999 and later, *search* Year(s) of Report 2004-2004, *search* Number of Causes Top 11 (last accessed May 27, 2008).

[6] Jason B. Luoma et al., *Contact with Mental Health and Primary Care Providers before Suicide: A Review of the Evidence*, 159 Am. J. Psych. 909, 909-16 (2002). This article also provides excellent references involving the assessment, management, and treatment of suicidal patients, as well as other empirical studies relating to suicide.

[7] Eve K. Moscicki, *Epidemiology of Completed and Attempted Suicide: Toward a Framework for Prevention*, 1 Clin. Neuroscience Res. 310, 310-23 (2001).

[8] M. Miller et al., *The Association between Changes in Household Firearm Ownership and Rates of Suicide in the United States, 1981-2002*, 12 Injury Prevention 178 (2006).

that violence by mental health patients is common in both the inpatient setting and post-discharge.[9]

II. FROM *TARASOFF* TO *MORGAN*

A. The Duty of Mental Health Professionals

It is blackletter law that in order for anyone to be liable to another in tort, there must first exist some duty between the parties. Any violations of such a duty, coexisting with proximate cause and damage, may render the tortfeasor liable to the victim. However, in the absence of a legally recognized duty, no liability will attach.[10] In the ever-evolving area of tort law involving mental health professionals and their potential liability to their patients or third parties, the troublesome concern for litigators and courts has been an element of negligence that often is taken for granted in other areas of professional negligence—that is, whether any duty may exist upon which liability could be predicated.

The nature and origin of a duty owed to another is a concept that is not readily defined. Professor Prosser recognized that "the problem of duty is as broad as the whole law of negligence, and . . . no universal test for it ever has been formulated."[11] Instead, as Professor Keeton noted, "'duty' is not sacrosanct in itself, but is only an expression of the sum total of those considerations of policy which lead the law to say that the plaintiff is entitled to protection."[12] An attempt has been made to clarify duty by defining the concept as "an obligation to which the law will give recognition and effect to conform to a particular standard of conduct toward another."[13]

Generally, the law does not impose a duty to take measures to protect another, even if it appears that precautionary action is necessary to protect the other from imminent danger.[14] However, where a special relationship exists between the defendant and a potential victim of a wrongdoer, or between the defendant and the wrongdoer himself, a duty may be imposed by law.

The Restatement (Second) of Torts suggests that a "special relationship" may exist in a variety of circumstances, including when an

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[9] *See* Christoph Abderhalden et al., *Predicting Impatient Violence Using an Extended Version of the BrØset-Violence-Checklist: Instrument Development and Clinical Application*, 6 BMC Psych. 17 (2006).

[10] *See Prosser & Keeton*, *supra* n. 1, at 30.

[11] William L. Prosser, *Handbook of the Law of Torts* 325 (4th ed., West 1971).

[12] *Prosser & Keeton*, *supra* n. 1, at 358; *see also Tarasoff*, 551 P.2d at 324; *Morgan*, 673 N.E.2d at 1322; *but see Restatement (Second) of Torts* § 314 (1965) ("The fact that the actor realizes or should realize that action on his part is necessary for another's aid or protection does not of itself impose upon him a duty to take such action.").

[13] *See* Thomas A. Goodman, *From* Tarasoff *to* Hopper*: The Evolution of the Therapist's Duty to Protect Third Parties*, 3 Behav. Sci. & L. 195, 207 (1985) (citing Prosser, *supra* n. 11, at 324).

[14] *See Restatement (Second) of Torts* § 314.

actor takes charge of a third person whom he knows or should know to be likely to cause bodily harm to others if the person's conduct is not controlled;[15] when the actor has created the risk of harm to others;[16] when the actor has intervened to increase a risk of harm;[17] or when the actor "has simply committed to rendering services relied on by others."[18]

Law students are often first introduced to the tort duty applicable to mental health professionals when reading the seminal case, *Tarasoff v. Regents of the University of California*,[19] wherein the California Supreme Court was the first to apply the concept of a special duty of a psychotherapist to protect a readily identifiable victim of his patient's violence.[20] In *Tarasoff*, an outpatient communicated to his therapist his homicidal ideations about a young woman with whom he had formed a fantasized relationship, and the patient later killed the young woman.[21] The therapist had failed to take any affirmative steps to warn the intended victim of any impending danger to her.[22] The *Tarasoff* Court recognized that a mental health professional has a duty to take actions to protect the potential victim from his patient.[23] In support of its decision, the California Supreme Court relied upon decisions finding that a physician's duty extends beyond his relationship with his patient to protect third parties from unreasonable risks of harm.[24] The *Tarasoff* Court opined:

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[15] *Restatement (Second) of Torts* § 319 (1965) ("One who takes charge of a third person whom he knows or should know to be likely to cause bodily harm to others if not controlled is under a duty to exercise reasonable care to control the third person to prevent him from doing such harm.").

[16] *Restatement (Second) of Torts* § 321 (1965) ("If the actor does an act, and subsequently realizes or should realize that it has created an unreasonable risk of causing physical harm to another, he is under a duty to exercise reasonable care to prevent the risk from taking effect.").

[17] *Restatement (Second) of Torts* § 324A (1965).

> One who undertakes, gratuitously or for consideration, to render services to another which he should recognize as necessary for the protection of a third person or his things, is subject to liability to the third person for physical harm resulting from his failure to exercise reasonable care to protect his undertaking, if
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> (a) his failure to exercise reasonable care increases the risk of such harm, or
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> (b) he has undertaken to perform a duty owed by the other to the third person, or
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> (c) the harm is suffered because of reliance of the other or the third person upon the undertaking.

Id.

[18] Todd Waller, Estates of Morgan v. Fairfield Family Counseling Center*: Application of Traditional Tort Law Post-*Tarasoff, 31 Akron L. Rev. 321, 324 (1997); *Restatement (Second) of Torts* §§ 314 cmt. a, 324A cmt. c (1965).

[19] 551 P.2d 334.

[20] *See* James P. Nolan, *Ohio Adopts the Professional Judgment Rule*, 15 U. Dayton L. Rev. 319 (1990).

[21] *Tarasoff*, 551 P.2d at 339-40.

[22] *Id.*

[23] *Id.* at 345.

[24] *Id.* at 344.

> When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the therapist to take one or more of various steps, depending upon the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.[25]

It is generally acknowledged among scholars that the *Tarasoff* decision caused controversy, yet it has been widely accepted by courts and legislatures in the United States as a foundation for establishing the duties of mental health professionals to warn, control, and possibly protect the intended victims of their patient's expressed violent intentions.[26]

B. The Littleton *Decision*

Following the decision in *Tarasoff*, numerous courts accepted the existence of a duty similar to that outlined by the California Supreme Court,[27] while other courts chose to extend the decision so as to give a more expansive interpretation of the context in which the duty of mental health professionals is applicable.[28] Ohio courts had little reaction to the decision in the early years following *Tarasoff*. In 1978, one Ohio court of appeals found that a hospital may be liable for the negligent release of a mental patient when the hospital staff, in exercising its medical judgment, knows or should know that the patient would likely cause harm to himself or others.[29] In doing so, the court acknowledged that mental health professionals may, under appropriate circumstances, have a duty to protect third parties.[30] However, there was no reaction to the *Tarasoff* decision by the Ohio Supreme Court until its decision in *Littleton v. Good Samaritan Hospital & Health Center*[31] in 1988, some twelve years after the groundbreaking decision by the California Supreme Court.

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[25] *Id.* at 340.

[26] Peter F. Lake, *Revisiting* Tarasoff, 58 Alb. L. Rev. 97, 98 (1994); *see also Currie v. U.S.*, 644 F. Supp. 1074, 1078 (M.D.N.C. 1986) (noting that there has been "virtually universal judicial approval of the *Tarasoff* decision itself").

[27] *See* Nolan, *supra* n. 20, at 325 n. 73.

[28] *See e.g. Lipari v. Sears, Roebuck & Co.*, 497 F. Supp. 185, 194 (D. Neb. 1980) (holding that a therapist owes a duty to foreseeable victims, not simply to specifically or readily identifiable victims).

[29] *Leverett v. State*, 399 N.E.2d 106 (Ohio App. 10th Dist. 1978).

[30] *Id.* at 111.

[31] 529 N.E.2d 449 (Ohio 1988).

In *Littleton*, Theresa Pearson began exhibiting signs of depression shortly after giving birth to her second child, Carly.[32] She expressed feelings of rejection towards her infant and had impulses to harm the child.[33] After two hospitalizations, during the second of which she made an explicit threat to a nurse to harm her newborn, Theresa was discharged to her family with instructions that she was not to be left alone with Carly for long periods of time.[34] During a family meeting prior to discharge, it was agreed that for the year following discharge Carly would be primarily cared for by her grandparents.[35] At no time, either during the family meeting or upon discharge was the family told of Theresa's specific threat to kill Carly.[36] After discharge, Theresa did have contact with Carly but only in the presence of others.[37] Approximately fourteen days after she was discharged from the hospital, Carly's caregiver asked Theresa to watch Carly for a short period of time.[38] After the caregiver left the home, Theresa administered a fatal dose of aspirin to Carly.[39]

In its decision in *Littleton*, the Ohio Supreme Court adopted the so-called "professional judgment rule."[40] After determining that a special relationship existed within the meaning of the Restatement of Torts, the Court found that the psychologist had a duty to take reasonable precautions to protect Carly from his patient's violent propensities.[41] After examining the objective standard of care for medical specialists as articulated in the oft-cited ruling in *Bruni v. Tatsumi*,[42] and acknowledging the propriety of applying such a standard to traditional medical practitioners, the *Littleton* Court adopted a standard of care for mental health practitioners that encompasses a subjective element, known as the professional judgment rule.[43] In accepting the professional judgment rule as the appropriate standard of care applicable to mental health professionals, the Court acknowledged that

> [t]hough a psychiatrist's ability to predict violent behavior is probably better than a layperson's, and there does appear to be some consensus within the mental health community on the factors relevant to a diagnosis of violent propensities, diagnosing both the existence of violent propensities and their severity is still a highly subjective undertaking.

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[32] *Id.* at 451.
[33] *Id.*
[34] *Id.*
[35] *Id.* at 452.
[36] *Id.*
[37] *Id.*
[38] *Id.*
[39] *Id.*
[40] *Id.* at 459-60.
[41] *Id.* at 455.
[42] 346 N.E.2d 673 (Ohio 1976).
[43] *Littleton*, 529 N.E.2d at 459-60.

> Psychiatric evaluations of any given fact pattern are bound to vary widely. And once a determination is made that a patient possesses a propensity for violent behavior, deciding upon a course of treatment poses difficult questions. The patient's right to good medical care, including freedom from unnecessary confinement and unwarranted breaches of confidentiality, must be balanced against the need to protect potential victims. Courts, with the benefit of hindsight, should not be allowed to second-guess a psychiatrist's professional judgment.[44]

In summarizing its decision, the *Littleton* Court held that a psychiatrist will not be held liable for the violent acts of a voluntarily hospitalized mental health patient subsequent to the patient's discharge if (1) the patient did not manifest violent propensities while being hospitalized and there was no reason to suspect the patient would become violent after discharge; (2) a thorough evaluation of the patient's propensity for violence was conducted, taking into account all relevant factors, and a good faith decision was made by the psychiatrist that the patient had no violent propensity; or (3) the patient was diagnosed with having violent propensities and, after a thorough evaluation of the severity of the propensities and a balancing of the patient's interests and the interests of potential victims, a treatment plan was formulated in good faith that included discharge of the patient.[45] By adopting a professional judgment rule, the Ohio Supreme Court afforded a somewhat higher degree of deference to mental health professionals in the decisions they make as to the care and treatment of their patients than is recognized for other medical professionals.[46]

C. The Morgan *Decision*

The *Littleton* decision does not appear to have been significantly noticed by the Ohio legislature, but eleven years later it was the springboard for the Ohio Supreme Court to expand the duties recognized in *Littleton* to an outpatient setting in its decision in *Estate of Morgan v. Fairfield Family Counseling Center*.[47] Before considering the *Morgan* decision itself, however, it is important to place the decision in context in terms of Ohio's mental health provider statutes as written at the time of the Court's ruling. Prior to the *Morgan* decision, Chapter 5122 of the Ohio Revised Code, which relates to the Hospitalization of Mentally Ill, read, in pertinent part:

> Persons, including, but not limited to, boards of alcohol, drug addiction, and mental health services and community

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[44] *Id.* (citations omitted).
[45] *Id.* at 460.
[46] *See* Nolan, *supra* n. 20, at 341.
[47] 673 N.E.2d 1311.

> mental health agencies, acting in good faith, either upon actual knowledge or information thought by them to be reliable, who procedurally or physically assist in the hospitalization or discharge, determination of appropriate placement, or in judicial proceedings of a person under this chapter, do not come within any criminal provisions, and are free from any liability to the person hospitalized or to any other person. . . . [N]o person shall be liable for any harm that results to any other person as a result of failing to disclose any confidential information about a mental health client or patient, or failing to otherwise attempt to protect such other person from harm by such client or patient.[48]

One Ohio court determined that the good faith standard as stated in the version of § 5122.34 enacted in 1989, and effective at the time of the *Morgan* decision, applied only to the admission, discharge, and judicial order of hospitalization of the patient and did not apply to other medical decisions made in the course of treatment.[49] Instead, the court found that the standard to be applied to decisions made in the course of treatment of a mentally ill person is the same as in other medical malpractice cases[50]—the objective standard of care test set forth by the Ohio Supreme Court in *Bruni v. Tatsumi*.[51]

The facts presented in *Morgan* are tragic.[52] Matt Morgan began experiencing difficulties at school, at work, and at home during his senior year of high school.[53] His grades and attendance at school had fallen, and he had difficulty keeping jobs.[54] Matt was disrespectful and verbally abusive to his parents; his parents grew afraid of him.[55] The problems continued after high school. In January 1990, Matt was removed from his parents' home by the police after attempting to fight with his father.[56] Matt drifted, homeless, for several months until he presented himself at the emergency room at a Philadelphia hospital in March 1990.[57] Matt was diagnosed as suffering from schizophreniform disorder[58] and was transported to a mental health

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[48] Ohio Rev. Code Ann. § 5122.34 (Lexis 1996).
[49] *Daniels v. State*, 1986 Ohio App. LEXIS 7780 (10th Dist. July 31, 1986).
[50] *Id.* at *4.
[51] 346 N.E.2d 673.
[52] For a thorough discussion of the *Morgan* decision and its implications, see Waller, *supra* note 18.
[53] *Morgan*, 673 N.E.2d at 1311.
[54] *Id.*
[55] *Id.* at 1314.
[56] *Id.*
[57] *Id.*
[58]

> The essential features of schizophreniform disorder are identical to those of schizophrenia, with the exception that the duration is less than six months. Once the signs and symptoms persist for a continuous period of six months, the diagnosis becomes schizophrenia. Schizophrenia is an inability to recognize

facility. The hospital noted various symptoms "suggestive of either schizophreniform disorder or schizophrenia,[59] including Matt's belief that the government was affecting his body and the air waves, such that he was unable to watch television or listen to tapes or the radio, delusions of persecution and ideas of reference and thought broadcasting."[60] Matt was hospitalized for twelve weeks, during which he was treated with intensive therapy and Navane, an antipsychotic or neuroleptic drug.[61] Over time, "Matt's paranoia regarding his family decreased and he developed improved insight into his mental illness."[62] The treating psychiatrist believed that his mental illness could be controlled by medication, and "Matt agreed that the medication was helping him and that his symptoms of mental illness may have contributed to his conflicts, especially with his father."[63] Matt made contact with his family who expressed a willingness to help him.[64] The treating psychiatrist was of the opinion that Matt could safely return to his parents' home but that his treatment and medications must continue.[65] Staff at the hospital contacted Fairfield Family Counseling Center for Matt's follow-up care.[66]

Matt Morgan first presented himself at Fairfield Family Counseling Center on July 16, 1990.[67] After an intake evaluation, Matt was referred to a psychiatrist.[68] The psychiatrist first saw Matt on July 19, 1990, for thirty minutes.[69] The psychiatrist saw Matt twice more over a three-month period of time.[70] Despite having received Matt's records from his hospitalization in Philadelphia, the doctor failed to review any of them and instead focused on his belief that Matt was malingering in order to obtain Social Security benefits.[71] The psychiatrist chose to wean Matt from his medications, but Matt did continue with psychotherapy and vocational counseling.[72] Matt's mother reported to the staff at the counseling center that her son's condition

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> reality in some way, marked by delusions and perceptual distortions. There is no cure for schizophrenia, but the symptoms can be controlled by medication . . . .

Id.

[59] Common manifestations of schizophrenia include hallucinations, delusions, disorganized thoughts and behaviors, loose or illogical thoughts, agitation, flat or blunted affect, concrete thoughts, anhedonia (inability to experience pleasure) and poor motivation, spontaneity, and initiative. *See* David Satcher, *Mental Health: A Report of the Surgeon General*, http://www.surgeongeneral.gov/library/mentalhealth/home.html (last accessed Feb. 16, 2008).

[60] *Morgan*, 673 N.E.2d at 1314.

[61] *Id.* at 1315.

[62] *Id.*

[63] *Id.*

[64] *Id.*

[65] *Id.*

[66] *Id.*

[67] *Id.*

[68] *Id.*

[69] *Id.*

[70] *Id.*

[71] *Id.*

[72] *Id.*

was deteriorating; he was pacing, quiet, withdrawn, and moody; his eating habits had changed; his behavior was becoming similar to how it had been prior to his hospitalization; and Matt needed to go back on his medication.[73] She also reported to the staff that Matt had made a deposit on the purchase of a gun.[74] The counselor dismissed Mrs. Morgan's concerns as those of an overprotective mother.[75]

Matt's verbal abuse toward his parents began again, and he became aggressive toward his father.[76] His parents reported feeling threatened by him.[77] Mrs. Morgan again reported the symptoms to Matt's counselor and repeatedly contacted the counseling center seeking help for her son.[78] After an assessment, the hospital staff concluded that Matt could not be given medication or be hospitalized against his will.[79] However, one staff member did note in Matt's records that he was losing weight and decompensating and refusing medication and psychiatric care.[80] The same evening that the note was made in the record, Matt was playing cards with his parents and sister.[81] He excused himself from the table, went upstairs, obtained a gun, returned downstairs, and shot and killed his parents and seriously injured his sister.[82]

When considering the facts in *Morgan,* the Ohio Supreme Court was called upon to consider whether to extend its holding in *Littleton* to the outpatient setting. The Court, agreeing with the reasoning in *Tarasoff*, acknowledged that a physician is not liable for mere mistakes of judgment.[83] However, the Court did reason that "[a]s society changes, as our sciences develop and our activities become more interdependent, so our relations to one another change, and the law must adjust accordingly."[84] After reviewing special relationships and the duty to control the conduct of third parties under the Restatement (Second) of Torts, the *Morgan* Court concluded that "[a]lthough the outpatient setting affords the psychotherapist a lesser degree of control over the patient than does the hospital setting, it nevertheless embodies sufficient elements of control to warrant a corresponding duty to control."[85] In considering the role of mental health professionals, the *Morgan* Court acknowledged that

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[73] *Id.* at 1316.
[74] *Id.*
[75] *Id.*
[76] *Id.*
[77] *Id.*
[78] *Id.*
[79] *Id.* at 1316-17.
[80] *Id.* at 1317.
[81] *Id.* at 1314.
[82] *Id.*
[83] *Id.* at 1333.
[84] *Id.* at 1322.
[85] *Id.* at 1323.

> [s]ociety has a strong interest in protecting itself from those mentally ill patients who pose a substantial risk of harm. To this end, society looks to the mental health profession to play a significant role in identifying and containing such risks. The mental health community, therefore, has a broadly based responsibility to protect the community against danger associated with mental illness.[86]

The Court concluded that the professional judgment rule adopted in *Littleton* should be applicable to the outpatient setting, supporting the overriding concern to protect the public from assault by a violent mental health patient.[87] As the Court noted: "Fundamentally, the duty is imposed because the therapist is the best, if not the only, line of defense society has against the danger posed by the violent mental patient. Because of their special training, skill and contact with the patient, psychotherapists are especially equipped to thwart the danger."[88]

The Court then considered whether the provisions of Ohio Revised Code § 5122.34 served to immunize the defendants in the case from liability. The *Morgan* Court recognized that "*R.C. 5122.34* does not apply to immunize mental health professionals from liability in all contexts."[89] On its face, immunity under the statute was available only if the mental health professional acted in good faith. In order to satisfy the good faith requirement, the party claiming immunity must establish that they subjectively believed they were acting properly.[90] Because a finding of good faith would require the finder of fact to assess the credibility of the individual claiming immunity, such a determination could not be made as a matter of law.[91] However, the Court did not find it necessary to remand the matter on the issue of good faith, because, as the court concluded, the specific language of the aforementioned statute was applicable only in the area of civil commitment, and therefore immunity could not attach.[92]

One author, in summarizing the decision in *Morgan*, concluded that the Ohio Supreme Court "extended the reach of the psychotherapist's duty to protect others against a patient's violent propensities from an inpatient to an outpatient setting[,]"[93] and similar to the decision in *Tarasoff*, found

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[86] *Id.* at 1324 (citations omitted).
[87] *Id.* at 1328.
[88] *Id.*
[89] *Id.* at 1327.
[90] *Id.* at 1326.
[91] Geoffrey M. Wardle & Jeffrey L. Maloon, *The Strict Application of the Restatement, Ohio Law and the Rules of Civil Procedure:* Estates of Morgan v. Fairfield Family Counseling Center, 45 Clev. St. L. Rev. 649, 661 (1997).
[92] *Morgan*, 673 N.E.2d at 1327.
[93] Waller, *supra* n. 18, at 346.

"'sufficient control' to establish a 'special relation' in the outpatient psychotherapeutic relationship."[94]

D. Immunity Post-Morgan

Following the decision in *Morgan* and prior to the legislature's action to broaden immunity to mental health providers, few courts had the opportunity to address the parameters of the high court's reasoning and the limited statutory immunity that may exist for mental health providers. However, one Ohio court found, when considering liability for the involuntary commitment of a patient, that, in order to invoke any statutory immunity, any statutory predicates to immunity must first be met.[95] Because the procedures mandated by statute for the hospitalization of the patient were not followed,[96] the mental health professionals could not shield themselves with immunity, even if they acted in good faith.[97]

In 1999, in direct response to the *Morgan* decision,[98] the Ohio General Assembly passed the Mental Health Services Providers Immunity Statutes, codified in Ohio Revised Code §§ 5122.34(B) and 2305.51(B).[99] It is significant to this Article's analysis that § 5122.34 is included in a chapter of the Code entitled "Hospitalization of Mentally Ill." The 1999 version of Ohio Revised Code § 5122.34, passed after the *Morgan* decision, is entitled "Immunity," and provides:

> (A) Persons, including, but not limited to, boards of alcohol, drug addiction, and mental health services and community mental health agencies, acting in good faith, either upon actual knowledge or information thought by them to be reliable, who procedurally or physically assist in the hospitalization or discharge, determination of appropriate placement, or in judicial proceedings of a person under this chapter, do not come within any criminal provisions, and are free from any liability to the person hospitalized or to any other person.
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> (B) Regardless of whether any affirmative action has been taken under this chapter with respect to a mental health client or patient and except as otherwise provided in *section 2305.51 of the Revised Code*, no person shall be liable for any harm that results to any other person as a result of

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[94] *Id.*

[95] *See Loughran v. Kettering Meml. Hosp.*, 710 N.E.2d 773, 776-78 (Ohio App. 2d Dist. 1998).

[96] The staff at the hospital failed to prepare a written statement explaining the basis for the detention as required by Ohio Revised Code § 5122.10 for the initiation of an emergency involuntary commitment.

[97] *Barker v. Netcare Corp.*, 768 N.E.2d 698, 708-09 (Ohio App. 10th Dist. 2001).

[98] 673 N.E.2d 1311.

[99] Ohio H. 71, 123d Gen. Assembly, 1999-2000 Reg. Sess. (Jan. 20, 1999).

> failing to disclose any confidential information about the mental health client or patient, or failing to otherwise attempt to protect such other person from harm by such client or patient.
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> . . .
>
> (D) The immunity from liability conferred by this section is in addition to and not in limitation of any immunity conferred by any other section of the Revised Code or by judicial precedent.[100]

If the immunity provided for in the aforementioned statute was not sufficient to satisfy the legislature's apparent angst over the *Morgan* decision, the lawmakers enacted an entirely new statute entitled "Liability of Mental Health Professionals and Organization for Violent Behavior of Mental Health Clients or Patients," codified in Ohio Revised Code § 2305.51. Pertinent sections of that statute provide:

> (B) A mental health professional or mental health organization may be held liable in damages in a civil action, or may be made subject to disciplinary action by an entity with licensing or other regulatory authority over the professional or organization, for serious physical harm or death resulting from failing to predict, warn of, or take precautions to provide protection from the violent behavior of a mental health client or patient, only if the client or patient or a knowledgeable person has communicated to the professional or organization an explicit threat of inflicting imminent and serious physical harm to or causing the death of one or more clearly identifiable potential victims, the professional or organization has reason to believe that the client or patient has the intent and ability to carry out the threat, and the professional or organization fails to take one or more of the following actions in a timely manner:
>
> (1) Exercise any authority the professional or organization possesses to hospitalize the client or patient on an emergency basis pursuant to section 5122.10 of the Revised Code;
>
> (2) Exercise any authority the professional or organization possesses to have the client or patient involuntarily or voluntarily hospitalized under Chapter 5122[ ] of the Revised Code;

[100] Ohio Rev. Code Ann. § 5122.34(A)-(B), (D) (Lexis 1999).

> (3) Establish and undertake a documented treatment plan that is reasonably calculated, according to appropriate standards of professional practice, to eliminate the possibility that the client or patient will carry out the threat, and, concurrent with establishing and undertaking the treatment plan, initiate arrangements for a second opinion risk assessment through a management consultation about the treatment plan with, in the case of a mental health organization, the clinical director of the organization, or, in the case of a mental health professional who is not acting as part of a mental health organization, any mental health professional who is licensed to engage in independent practice;
>
> (4) Communicate to a law enforcement agency with jurisdiction in the area where each potential victim resides, where a structure threatened by a mental health client or patient is located, or where the mental health client or patient resides, and if feasible, communicate to each potential victim or a potential victim's parent or guardian if the potential victim is a minor or has been adjudicated incompetent, all of the following information:
>
> (a) The nature of the threat;
>
> (b) The identity of the mental health client or patient making the threat;
>
> (c) The identity of each potential victim of the threat.[101]

The "Background" information provided in the legislative history of Amended House Bill 71, the bill that enacted the 1999 versions of Ohio Revised Code §§ 5122.34 and 2305.51, proves to be particularly instructive when considering the intent of the legislation. The "Background" to the statute explains the explicit intention of the

> General Assembly to respectfully disagree with and supersede the statutory construction holdings of the Ohio Supreme Court relative to section 5122.34 of the Revised Code as set forth in *Estates of Morgan v. Fairfield Family Counseling Ctr.*, . . . and, thereby, to supersede the second, third, and fourth syllabus paragraph holdings of the Court in that case.[102]

The three syllabus paragraphs at issue from *Morgan* specifically state:

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[101] Ohio Rev. Code Ann. § 2305.51(B) (Lexis 1999).
[102] Ohio H. 71, 123d Gen. Assembly, 1999-2000 Reg. Sess. at § 3.

> 2. *R.C. 5122.34* does not preclude the finding that a special relation exists between the psychotherapist and the outpatient which imposes a common-law duty on the therapist to take affirmative steps to control the patient's violent conduct.
>
> 3. The relationship between the psychotherapist and the patient in the outpatient setting constitutes a special relationship justifying the imposing of a duty upon the psychotherapist to protect against and/or control the patient's violent propensities.
>
> 4. When a psychotherapist knows or should know that his or her outpatient represents a substantial risk of harm to others, the therapist is under a duty to exercise his or her best professional judgment to prevent such harm from occurring.[103]

Nothing in the aforementioned syllabus paragraphs relate to a patient's intent to cause physical harm to himself. Instead, the paragraphs clearly relate to a patient who represents a substantial risk of harm to another.

The good faith determination, as required by the aforementioned statutes, is certainly a vague and amorphous standard and obviously subject to interpretation. Ohio courts have found that such a determination "involves a weighing of a defendant's acts or omissions to determine whether the defendant acted on the basis of a judgment, honestly arrived at, that the subject should be committed or released."[104] An actor can make a prima facie showing of good faith by demonstrating such factors as

> the competence and training of the reviewing psychotherapists, whether the relevant documents and evidence were adequately, promptly and independently reviewed, whether the advice or opinion of another therapist was obtained, whether the evaluation was made in light of the proper legal standards for commitment, and whether other evidence of good faith exists.[105]

In order to rebut that showing, a plaintiff must establish that no reasonable, similar mental health professional would have acted as he did, under the circumstances.[106]

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[103] *Morgan*, 673 N.E.2d at 1317.

[104] *Yayathi v. Chittoprolu*, 2006 WL 3775859 (Ohio App. 10th Dist. Dec. 26, 2006) (citing *Loughran*, 710 N.E.2d at 776; *Griffin v. Twin Valley Psychiatric Sys.*, 2003 WL 22999355 at *27 (Ohio App. 10th Dist. Dec. 23, 2003)).

[105] *Id.* at *3 (citing *Littleton*, 529 N.E.2d at 458).

[106] *Id.*

Since the General Assembly's reaction to *Morgan*, the Ohio Supreme Court has had one occasion to contemplate the statutory immunity broadened by the legislature. In a 2006 case, *Campbell v. Ohio State University Medical Center*, the high court considered whether a hospital is liable to a patient for its failure to protect one patient from another.[107] The facts at issue in *Campbell* were fairly uncomplicated. In 1999, a patient at Harding Hospital, a mental health institution operated by the Ohio State University Medical Center, attacked and injured another patient.[108] The following day, the same patient physically attacked and severely injured a second patient at the hospital.[109] The plaintiff, the second patient injured at Harding Hospital, argued that Ohio Revised Code § 5122.29(B)(2) creates a duty on the part of the hospital to protect her from an assault and battery by another patient.[110] However, irrespective of such a duty, the Court considered whether that patient was required to meet the requirements of Ohio Revised Code § 2305.51 to maintain her action.[111] The plaintiff argued that the provisions of § 2305.51 are in conflict with the hospital's statutory duty to protect her from injury as a result of the actions of another patient.[112] Specifically, the patient argued that the hospital violated the statutorily mandated right of a hospitalized or committed patient "to be treated with consideration and respect for his privacy and dignity, including without limitation . . . reasonable protection from assault or battery by any other person."[113]

The *Campbell* Court acknowledged that a tension exists between the duty of an institution to protect its patients and the requirement that the elements set forth in § 2305.51(B) must be satisfied before an institution is liable for harm caused by a patient.[114] The Court resolved the tension, with little to no discussion, by relying solely on Ohio Revised Code § 5122.34(B), which provides that a mental health facility will not be liable for harm that results from a failure to protect a patient from another patient unless the injured patient establishes liability under § 2305.51.[115] In doing so, the Court essentially stripped mental health patients of any of the protections afforded to them elsewhere in the Code by applying the immunity statutes to conduct that certainly was not contemplated in the post-*Morgan* legislative expansion of immunity for mental health professionals. In its decision, the high court chose to give priority to the immunity afforded to mental health professionals, while ignoring the

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[107] 843 N.E.2d 1194 (Ohio 2006).
[108] *Id.* at 1195.
[109] *Id.*
[110] *Id.* at 1196.
[111] *Id.*
[112] *Id.*
[113] *Id.* at 1195 (quoting Ohio Rev. Code Ann. § 5122.29(B)(2) (Lexis 2006)).
[114] *Id.* at 1196.
[115] *Id.*

mandates of the explicit statutory duty of a facility to protect its patients from the violent actions of another patient. Additionally, Ohio Revised Code § 2305.51 has been interpreted by one Ohio court of appeals as requiring a patient's explicit threat to harm another as a predicate to liability.[116]

Immunity conferred by statute has long been recognized as an exception to the general principle that all persons as well as entities are liable for the harm caused to others by their tortious acts.[117] Because statutes that confer immunity are in derogation of the common law, Ohio courts have found that such immunizing statutes must be narrowly construed by courts and should be applied only to the class of persons or things that is the object of legislative attention.[118]

An initial reading of §§ 5122.34 and 2305.51 of Ohio Revised Code might suggest a broad application of the immunity afforded to mental health professionals in those statutes. In spite of the stated purpose of the legislation, the Ohio Supreme Court, in *Campbell,* chose to give an expansive reading to those statutes. However, a careful reading of the post-*Morgan* immunity legislation, and an analysis of the legislative intent in enacting the statutes, suggests limited applicability of those statutes.

While several Ohio courts have applied the provisions of §§ 2305.51 and 5122.34 to effectively immunize mental health professionals from liability for the violent acts of their patients towards third parties,[119] a review of the authority suggests that no court of appeals has yet addressed the application of those statutes to the liability of a mental health professional when a patient commits suicide. However, it is clear from the legislative history, the *Morgan* decision, and the three syllabus paragraphs that Amended House Bill 71 was intended to supersede, the intent of §§ 5122.34 and 2305.51 was to limit the liability of mental health professionals where their outpatients cause harm to third persons. Nothing in the legislative history, the language of the statutes, or the authority suggests that the intent of the statutes was to provide immunity to mental health professionals where their outpatients commit suicide. The language of the statutes clearly speak to harm inflicted on third persons by the mental health patient. Moreover, because immunity statutes are in derogation of the common law, any statutory immunity granted by the legislature must be strictly construed. As such, the immunity suggested in the Mental Health

[116] *Stewart v. N. Coast Ctr.*, 2006 WL 1313098 (Ohio App. 11th Dist. May 12, 2006).

[117] *See Ramos v. Madera*, 484 P.2d 93, 98 (Cal. 1971); *Muskopf v. Corning Hosp. Dist.*, 359 P.2d 457, 462 (Cal. 1961).

[118] *See Nobles v. Wolf*, 562 N.E.2d 144, 148-49 (Ohio 1990); *Assn. for Def. of the Washington Loc. Sch. Dist. v. Kiger*, 537 N.E.2d 1292, 1293 (Ohio 1989); *State ex rel. Natl. Broad. Co. v. Cleveland*, 526 N.E.2d 786, 790 (Ohio 1988); *Faith Fellowship Ministries, Inc. v. Limbach*, 513 N.E.2d 1340, 1342 (Ohio 1987).

[119] *See generally Stewart*, 2006 WL 1313098 at *7.

Services Providers Immunity Statutes is inapplicable to claims of violation of a duty by mental health professionals where their patient commits suicide.

Finally, one must conclude that it is a tragic circumstance that the legislature chose to provide very little protection for the mentally ill from the acts or omissions of their mental health providers. Enacting immunity statutes that provide sweeping protection for the actions or inactions of mental health professionals is to suggest that safeguarding the interests of the mentally ill is somehow unimportant, while other segments of society, including other practitioners in the medical profession, are held responsible for their conduct. For over 2,000 years it has been recognized in Western society that each citizen is responsible for his own conduct. Apparently not so for those who care for the mentally ill.

III. CONCLUSION

The immunity statutes enacted by the Ohio legislature post-*Morgan* are inapplicable to the liability of mental health providers when the claimed negligent conduct of the professional results in the suicide of the patient, as such an interpretation does not fit within the intent of those immunity statutes. Subsection (B)(4) of Ohio Revised Code § 2305.51 can only be read to apply to a patient's threat of violence toward another. Additionally, when considering the stated legislative purpose of the statutes, which is to supersede and overrule three specific syllabus paragraphs of the Ohio Supreme Court's holding in *Morgan*, all of which relate to a patient's violence towards third-party victims, any interpretation of the so-called Mental Health Services Providers Immunity Statutes that would extend immunity to a mental health professional's potential liability relating to a patient's suicide would be to reach a conclusion not contemplated by the stated purpose of the legislature in enacting the immunity statutes.

Since the Ohio Supreme Court, in *Morgan,* already expressly found that the immunity statute, albeit a prior version of the statute, must only be applicable as specifically provided in the legislation, the immunity statutes cannot be read to protect mental health providers where their patients commit suicide. Instead, courts should consider the duties detailed in *Littleton* and *Morgan* as the applicable standard when considering a mental health professional's conduct relating to the suicide of a patient. The Ohio legislature should also be encouraged to reconsider the immunity provided for in the current statutes so as to afford protection to those patients and their victims for violations of any duty to them by mental health professionals. A modification of the immunity statutes would balance the interests of patients, as well as the victims of violence by mental health

patients, while still recognizing the highly subjective undertaking of practicing in the mental health profession.