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COMPELLED TO TESTIFY: AN EVALUATION OF 32 M.R.S.A. § 7005 AND THE PRIVILEGE FOR MAINE LICENSED CLINICAL SOCIAL WORKERS

Juliana Kirkland O'Brien

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COMPELLED TO TESTIFY: AN EVALUATION OF 32 M.R.S.A. § 7005 AND THE PRIVILEGE FOR MAINE LICENSED CLINICAL SOCIAL WORKERS

*Juliana Kirkland O'Brien**

I. INTRODUCTION

The mental health industry is big business: the National Institute of Mental Health reports that in 2012, 43.7 million people ages eighteen and older (18.6% of U.S. adults) experienced issues associated with a mental illness.¹ In Maine, about 51,000 adults and approximately 13,000 children suffer from a serious mental illness.² According to the World Health Organization, mental illness “accounts for more disability in developed countries than any other group of illnesses, including cancer and heart disease”³ and in Maine, mental health issues coupled with substance abuse is the leading cause of disability and death for Mainers between ages fifteen and forty-four, and is the second leading cause of disability among all ages.⁴

While many people experience a mental health issue at some point in their lives, upwards of eighty percent can maintain “normal, productive lives” if they have access to effective treatment.⁵ However, unlike medical issues that can be diagnosed with a blood test or biopsy, mental health diagnosis and treatment depends largely on the patient’s disclosures to mental health professionals.

Psychotherapy is an example of an effective mental health treatment for anxiety disorders, mood disorders, addictions, eating disorders, and personality disorders.⁶ In addition, psychotherapy can be helpful for individuals looking to relieve stress, resolve conflict, and deal with other difficult life issues.⁷ In an attempt to help individuals manage or overcome their mental health issues, psychotherapists encourage patients to articulate their thoughts, urges, and

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1. *Any Mental Illness (AMI) among Adults*, NAT’L INST. OF MENTAL HEALTH, <http://www.nimh.nih.gov/health/statistics/prevalence/any-mental-illness-ami-among-adults.shtml> (last visited Nov. 2, 2014) (“As noted, these estimates of AMI do not include substance use disorders, such as drug- or alcohol-related disorders.”).

2. *State Statistics: Maine*, NAMI STATE ADVOCACY 2010, <https://www.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=93497> (last visited Nov. 2, 2014).

3. John M. Grohol, *CDC Statistics: Mental Illness in the US*, PSYCHCENTRAL (Sept. 4, 2011), <http://psychcentral.com/blog/archives/2011/09/03/cdc-statistics-mental-illness-in-the-us/>.

4. *The Tipping Point: Mental Health in Maine 2010*, NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI), [http://www.nami.org/Content/Microsites186/NAMI_Maine/Home174/Welcome_to_NAMI_Maine1/Updatedthetippingpoint-communitymentalhealthinmaine\(2\).pdf](http://www.nami.org/Content/Microsites186/NAMI_Maine/Home174/Welcome_to_NAMI_Maine1/Updatedthetippingpoint-communitymentalhealthinmaine(2).pdf) 5 (last visited Nov. 2, 2014).

5. *Substance Abuse and Mental Health Service: Message*, MAINE.GOV, <http://www.maine.gov/dhhs/samhs/mentalhealth/message.html> (last visited Nov. 2, 2014).

6. *Tests and Procedures: Psychotherapy*, MAYO CLINIC (Jan. 5, 2013), <http://www.mayoclinic.org/tests-procedures/psychotherapy/basics/why-its-done/prc-20013335>.

7. *Id.*

concerns in a safe, confidential therapeutic session.

Today, “psychotherapy” encompasses many professional subsets, including psychiatrists, psychologists, and licensed clinical social workers (LCSWs). Patients seeking mental health services can choose between a variety of professionals for similar mental health treatment, although LCSWs are usually more affordable than other licensed mental health workers.⁸ In addition, the professional outlook for social work is projected to increase by 19% between 2012 and 2022.⁹ Therefore LCSWs will have an amplified ability to impact society and the individual patient through their increased professional outreach.¹⁰

While LCSWs have not always been considered psychotherapists that require the same legal protections as the other classifications, the laws have adjusted to include LCSWs due to the fact the profession provides a “significant amount of mental health treatment.”¹¹ Given the important role that psychotherapy plays in society, there are several duties and laws in place that delicately balance between offering privacy to the patient, and protecting the public from dangerous situations.

In 1977, at a time where the Maine Rules of Evidence did not provide a privilege for social workers, the Maine State Legislature enacted 32 M.R.S.A. § 7005—a licensing statute that also gives a conditional privilege for social workers.¹² This provision is considered “conditional” because it exists unless an individual’s “physical or mental condition” is at issue, or a court decides the provision does not further the interest of justice.¹³

In 2008, the Maine Rules of Evidence expanded to include LCSWs into the full protections of the state psychotherapist-patient privilege.¹⁴ However, 32 M.R.S.A. § 7005, and its conditional exception remain and, due to the hierarchy of the laws, still governs. Therefore, while it appears that Maine LCSWs are protected under the Maine Rules of Evidence, an antiquated statute provides an exception to this protection.

In 2013, the Maine District Court (Biddeford, Douglas, J.) applied this statute in a Protection From Abuse (PFA) context, and held that, despite the Rules of Evidence, a clinical social worker could be compelled to testify at a PFA hearing in which a potential victim sought legal protection from a family member, based upon an alleged homicidal threat made in a psychotherapy session.¹⁵ The court relied on 32 M.R.S.A. § 7005 to compel the testimony. Such an exception has been termed “the dangerous-patient exception” because the enumerated privilege would give way in the event that the patient posed a danger to another individual.¹⁶

As it now stands, patients of Maine LCSWs are not as protected as the Maine

8. *Jaffee v. Redmond*, 518 U.S. 1, 15-16 (1996).

9. *Social Workers Job Outlook*, BUREAU OF LABOR STATISTICS OCCUPATIONAL OUTLOOK HANDBOOK (Jan. 8, 2014), <http://www.bls.gov/ooh/community-and-social-service/social-workers.htm#tab-6>.

10. *See Licensed Clinical Social Worker – LCSW*, HUMAN SERVICES EDU., <http://www.humanservicesedu.org/licensed-clinical-social-worker-lcsw.html> (last visited Nov. 20, 2014).

11. *Jaffee*, 518 U.S. at 15.

12. 32 M.R.S.A. § 7005 (1999 & Supp. 2013).

13. *Id.*

14. *State of Maine Supreme Judicial Court; Amendments to the Maine Rules of Evidence*, COURT RULES (July 7, 2008) <http://www.cleaves.org/2008Me.Rules10.pdf>.

15. *Donaldson v. Donaldson*, No. PA-13-287 (Me. Dist. Ct., Biddeford, Aug. 19, 2013).

16. *See, e.g., United States v. Hayes*, 227 F.3d 578, 583 (6th Cir. 2000).

Rules of Evidence would suggest, and 32 M.R.S.A. § 7005 threatens not only the legal protections afforded to these patients, but also the fundamental concepts that provide for effective mental health treatment. This article argues that 32 M.R.S.A. § 7005 must be amended to acknowledge and mirror the expanded protections given to LCSWs under the Maine Rules of Evidence, and recommends that, until the Statute is addressed, Maine courts limit their discretion under the Statute to only extreme circumstances, such as an imminent threat of harm against another individual.

Part II discusses the protections that are in place for psychotherapy patients designed to encourage individuals to seek and receive effective mental health treatment. This includes the ethical duty of confidentiality and the psychotherapist-patient privilege. Part III examines the exceptions in place to protect the public against dangerous patients. Part IV examines the issues that Maine LCSWs face due to the conflict of laws, and Part V provides the interim and long-term solution to this problem. Finally, Part VI concludes that, with the proper protections in place, patients of Maine LCSWs can feel comfortable to continue treatment without the fear of compelled disclosure.

II. PROTECTING THE PATIENT

“[C]onfidentiality is a sine qua non for successful psychiatric treatment[;]”¹⁷ the effectiveness of the psychotherapy experience depends on the level of trust that is built between a patient and her counselor.¹⁸ Based on this founding concept, confidentiality is seen as a necessary component for a patient to “receive the best medical care.”¹⁹ In order to facilitate the goal of a confidential exchange of information, there are layers of protections for the patient’s disclosed statements and information.²⁰

This Part will briefly look at the role and duty of confidentiality as well as the legal privilege that protects psychotherapy patients; the former prevents a mental health expert from volunteering the information obtained from the therapeutic sessions, and the latter prevents a therapist from being compelled to testify against his or her patient in a testimonial hearing. Each is a result of the recognition that individuals will be more open and honest in a therapeutic session if they are not concerned that their innermost thoughts might be made public.²¹

A. *The Role of Confidentiality in Psychotherapy*

Privacy in the medical field is founded on the principle that doctors should

17. *Jaffee*, 518 U.S. at 10 (quoting Advisory Committee’s Notes to Proposed Rules, 56 F.R.D. 183, 242 (1972)).

18. *Disclosures of information: Thought on a process*, AMERICAN PSYCHOLOGICAL ASSOCIATION (April 2007), <http://www.apa.org/monitor/apr07/ethics.aspx>.

19. Hindi T. Mermelstein & Joel J. Wallack, *Confidentiality in the Age of HIPAA: A Challenge for Psychosomatic Medicine*, PUBMED.GOV (Apr. 2008) 97 <http://www.ncbi.nlm.nih.gov/pubmed/18354061>.

20. *Adult Mental Health: Rights and Legal Issues*, MAINE.GOV, <http://www.maine.gov/dhhs/samhs/mentalhealth/rights-legal/confidentiality-statement.html> (last visited Sept. 12, 2014).

21. See Daniel W. Shuman & Myron S. Weiner, *The Privilege Study: An Empirical Examination of the Psychotherapist-Patient Privilege*, 60 N.C. L. REV. 893, 898 (1982).

have the most accurate information to render a proper diagnosis.²² Ensuring privacy in the medical field serves significant private and public interests by limiting individual suffering and reducing overall ailments in the society. The need for confidentiality is particularly acute with respect to mental health treatment, where the patient is verbally disclosing intimate details of their life, where, if revealed to the public may result in negative stigmas,²³ discrimination in employment,²⁴ and overall embarrassment and hesitation to continue seeking help.

Psychotherapy is a type of treatment where a patient speaks with a mental health provider, such as a LCSW, to identify the internal challenges that may be impacting their everyday life.²⁵ Sigmund Freud, the “father of psychoanalysis” believed that certain mental or emotional issues manifest because the patient is subconsciously trying to address repressed internal conflicts – if a patient keeps these thoughts in the unconscious, it would result in mental illness; however, if the patient discusses the memories, thoughts or urges, the symptoms would decrease.²⁶

Freud’s work focused on the relationship between the analyst and patient, where the analyst is limited to only the role of “listening and talking to the patient” in order to free the patient’s ego.²⁷ However, in order to create this psychotherapeutic relationship and provide effective treatment, Freud believed that confidentiality was necessary.²⁸ Observation changes behavior; a patient will be less likely to reveal their innermost thoughts and conflicts if they believe that an untrusted person is watching or listening, or that the information could be used against them at a later time.²⁹ It became understood that patients would resist disclosing these repressed thoughts and feelings *unless he or she has control over the information they reveal*.³⁰

Confidentiality helps build a strong therapeutic relationship because a patient will feel less inhibited to disclose their secret thoughts, and can establish a bond

22. JONATHAN I. EZOR, PRIVACY AND DATA PROTECTION IN BUSINESS: LAWS & PRACTICES 101 (2012).

23. Mayo Clinic Staff, *Mental Health: Overcoming the Stigma of Mental Illness*, MAYO CLINIC (May 17, 2014), <http://www.mayoclinic.org/diseases-conditions/mental-illness/in-depth/mental-health/art-20046477>.

24. EZOR, *supra* note 22, at 102.

25. MERRIAM WEBSTER DICTIONARY (3d ed. 1974).

26. See, e.g., Jim Haggerty, *History of Psychotherapy*, PSYCH CENTRAL, <http://psychcentral.com/lib/history-of-psychotherapy/000115> (last visited Sept. 13, 2014) (“While there were scattered references to the value of ‘talking’ in the treatment of emotional problems . . . Sigmund Freud developed psychoanalysis around the turn of the century, and made profound contributions to the field with his descriptions of the unconscious . . . and his model of the human mind.”).

27. JAN EHRENWALD, *THE HISTORY OF PSYCHOTHERAPY: FROM HEALING MAGIC TO ENCOUNTER* 647 (1991).

28. See, e.g., *id.*

29. Elisia Klinka, Note, *It’s Been A Privilege*, 78 *FORDHAM L. REV.* 863, 899-901, n.277 (citing a 1962 study completed by the Yale Law Journal where 71% of people surveyed indicated that they would be less likely to fully reveal their thoughts to the counselor without a protection of confidentiality).

30. Deborah Paruch, Comment, *From Trusted Confidant to Witness for the Prosecution: The Case Against the Recognition of A Dangerous-Patient Exception to the Psychotherapist-Patient Privilege*, 9 *U. N.H. L. REV.* 327, 392 (2011); see also Deirdre M. Smith, *An Uncertain Privilege: Implied Waiver and the Evisceration of the Psychotherapist-Patient Privilege in the Federal Courts*, 58 *DEPAUL L. REV.* 79, 90 (2008).

with the psychotherapist based on that trust.³¹ A patient's ability to "shield" himself from "public view" leaves open the possibility for the exchange of personal information.³²

While Freud's theories were just the beginning for the modern schools of psychotherapy,³³ the basic principles regarding the need for confidentiality have remained.³⁴ For example, the American Psychological Association notes that, "[c]onfidentiality is a respected part of psychology's code of ethics" and that additional laws exist to protect the patient's privacy.³⁵ In addition, the importance of confidentiality and privacy in psychotherapy is noted in case law: in *Jaffee v. Redmond*, the United States Supreme Court noted that psychotherapy relies on the patients' willingness to speak freely, and it would be "difficult, if not impossible for [a psychiatrist] to function without being able to assure . . . patients of confidentiality."³⁶ Understanding that privacy is paramount to the success of health treatment, federal,³⁷ state,³⁸ and professional guidelines³⁹ take certain measures to protect medical information.⁴⁰

For example, federal statutes such as the Health Insurance Portability and Accountability Act (HIPAA) provide protections for the information held by "covered entities" and give patients "an array of rights" concerning that information.⁴¹ "Ensuring strong privacy protections is critical to maintaining individuals' trust in their health care providers and willingness to obtain needed

31. Ellen McGrath, *Between Client and Therapist*, PSYCHOLOGY TODAY (Aug. 20, 2012), <http://www.psychologytoday.com/articles/200308/between-client-and-therapist>.

32. Gregg David Josephson, "Couching the Law of Privilege": Supreme Court Recognition of Psychotherapist-Patient Privilege in *Jaffee v. Redmond*, 19 WHITTIER L. REV. 533, 552 (1998).

33. Haggerty, *supra* note 26.

34. *Id.* (stating that for the next 50 years, psychotherapy relied on Freud's scholarship and in the 1950s, new methods were developed alongside the expansion of American psychology; however the need for confidentiality remained steadfast).

35. *Protecting your privacy: Understanding confidentiality*, AMERICAN PSYCHOLOGICAL ASSOCIATION, <http://www.apa.org/helpcenter/confidentiality.aspx> (last visited Nov. 19, 2014).

36. *Jaffee v. Redmond*, 501 US 1 (2006) (quoting Advisory Committee's Notes to Proposed Rules, 56 F.R.D. 183, 242 (1972)).

37. *See, e.g., Health Information Privacy*, U.S. DEP'T OF HEALTH & HUMAN SERV., <http://www.hhs.gov/ocr/privacy/> (last visited Sept. 13, 2014) (HHS published a final Privacy Rule in December 2000, which was later modified in August 2002. This Rule set national standards for the protection of individually identifiable health information by three types of covered entities: health plans, health care clearinghouses, and health care providers who conduct the standard health care transactions electronically. Compliance with the Privacy Rule was required as of April 14, 2003 (April 14, 2004, for small health plans)); 45 C.F.R. § 164.105 (2013); 42 C.F.R. § 51 (2013).

38. *See, e.g.,* 22 M.R.S.A. § 1711-C (2004 & Supp. 2013); 34-B M.R.S.A. § 1207 (2010); 34-B M.R.S.A. § 3608(1)(F) (2010).

39. Off. of Adult Mental Health, *Chapter 7: Rules Governing the Disclosure of Information Pertaining to Mentally Disabled Clients*, DEP'T OF HEALTH AND HUMAN SERV., <http://www.maine.gov/sos/cec/rules/10/chaps10.htm#193> (last visited Sept. 13, 2014); *Ethical Principles of Psychologists and Code of Conduct*, AM. PSYCHOL. ASS'N, <http://www.apa.org/ethics/code/index.aspx> (last visited Sept. 13, 2014) [hereinafter APA Duty of Confidentiality].

40. *Understanding Health Information Privacy*, U.S. DEP'T OF HEALTH AND HUMAN SERV., <http://www.hhs.gov/ocr/privacy/hipaa/understanding/> (last visited Sept. 13, 2014) (While HIPAA is an important part of medical privacy, this article will be focusing on protection for disclosed information in the course of treatment.).

41. *Id.*

health care services, and these protections are especially important where very sensitive information is concerned, such as mental health information.”⁴² By providing protection to these private conversations, patients can feel more comfortable addressing the real roots of their problems without fear of social or legal persecution.

B. *The Duty of Confidentiality*

Confidentiality is an ethical concept usually imposed upon psychotherapists through a professional or legal duty. For example, the American Psychological Association (APA) issues the Ethical Principles of Psychologists and Code of Conduct that consists of five general principals and specific ethical standards, including the “primary obligation” of maintaining confidentiality.⁴³ This duty prevents a psychotherapist from voluntarily disclosing the patient’s information.

In addition, according to the National Association of Social Workers, “[s]ocial workers should protect the confidentiality of clients . . . to the extent permitted by law.”⁴⁴ The Clinical Social Work Association promotes a duty to “maintain the privacy of both current and former clients, whether living or deceased, and to maintain the confidentiality of material that has been transmitted to them in any of their professional roles.”⁴⁵

Despite the value that absolute confidentiality might have on the therapeutic relationship, this duty must give way in certain circumstances. For example, the APA’s Ethical Standards rule 4.01 states that the duty of confidentiality exists, “recognizing that the extent and limits of confidentiality may be regulated by law.”⁴⁶ Similar conditions are in place for social workers: “[c]onfidentiality is a basic principle of social work intervention. It ensures the client that what is shared with the social worker will remain confidential, unless there is an ethical or legal

42. *HIPPA Privacy Rule And Sharing Info. Related to Mental Health*, U.S. DEP’T OF HEALTH AND HUMAN SERV., <http://www.hhs.gov/ocr/privacy/hipaa/understanding/special/mhguidance.html> (last visited Sept. 13, 2014).

43. APA Duty of Confidentiality, *supra* note 39. Psychologists have a primary obligation and take reasonable precautions to protect confidential information obtained through or stored in any medium, recognizing that the extent and limits of confidentiality may be regulated by law or established by institutional rules or professional or scientific relationship. 4.02 Discussing the Limits of Confidentiality: (a) Psychologists discuss with persons (including, to the extent feasible, persons who are legally incapable of giving informed consent and their legal representatives) and organizations with whom they establish a scientific or professional relationship (1) the relevant limits of confidentiality and (2) the foreseeable uses of the information generated through their psychological activities. (b) Unless it is not feasible or is contraindicated, the discussion of confidentiality occurs at the outset of the relationship and thereafter as new circumstances may warrant. (c) Psychologists who offer services, products, or information via electronic transmission inform clients/patients of the risks to privacy and limits of confidentiality.”)

44. *Ethics*, NATIONAL ASSOCIATION OF SOCIAL WORKERS, <https://www.socialworkers.org/nasw/ethics/default.asp> (last visited Sept. 18, 2014).

45. *Ethics Code*, CLINICAL SOCIAL WORKERS ASSOCIATION, <http://www.clinicalsocialworkassociation.org/about-us/ethics-code> (last visited Nov. 19, 2014).

46. APA Duty of Confidentiality, *supra* note 39.

exception.”⁴⁷

While these exceptions vary depending on the jurisdiction, psychotherapists generally need to disclose information when mandated by law, or to protect the patient, psychotherapist, or third party from harm, including cases of child abuse.⁴⁸ According to the Mayo Clinic, general situations where a psychotherapist may disclose otherwise confidential information include threatening to “harm yourself or commit suicide,” threatening to “harm or take the life of another person . . . abusing a child or a vulnerable adult,” or “being unable to safely care for yourself.”⁴⁹ As discussed below, the notable circumstances that may require a psychotherapist to disclose the confidential information center on protecting the patient or the public.

According to the APA, unless the situation falls within “client consent, legal mandate [or] legal permission” the psychotherapist may not disclose the protected information.⁵⁰ In the event that a psychotherapist discloses a patient’s confidential information in an unauthorized way, the psychotherapist faces legal and professional consequences.⁵¹ As such, psychotherapy patients can generally rely on their therapist to maintain a duty of confidentiality—to keep secret the confessed details of their lives—so long there is no intervening legal or ethical duty to disclose.

C. *The Legal Privilege*

Unlike the ethical duty of confidentiality, privileges prevent certain individuals from being *compelled* to disclose protected information in legal context. Therefore, even if a psychotherapist discloses information under an exception to the ethical duty, the information is still protected from disclosure in a testamentary hearing. Usually, privileges are covered by the rules of evidence governing that jurisdiction, and make this information inadmissible.⁵² However, states can impose governing statutes that regulate the admissibility of otherwise privileged information.⁵³

The rules of evidence are generally designed to increase the “reliability of the

47. *NASW Standards for Clinical Social Work in Social Work Practice*, National Association of Social Workers 15 (2005), <http://www.socialworkers.org/practice/standards/naswclinicalswstandards.pdf>.

48. Stephen Behnke, *Disclosing confidential information*, AMERICAN PSYCHOLOGICAL ASSOCIATION, <http://www.apa.org/monitor/2014/04/disclosing-information.aspx> (last visited Nov. 20 2014).

49. Mayo Clinic Staff, *Psychotherapy*, MAYO CLINIC (Jan. 5, 2013), <http://www.mayoclinic.org/tests-procedures/psychotherapy/basics/what-you-can-expect/prc-20013335>.

50. *Disclosing confidential information*, AMERICAN PSYCHOLOGICAL ASSOCIATION, <http://www.apa.org/monitor/2014/04/disclosing-information.aspx> (last visited Nov. 2, 2014).

51. Daniel Goleman, *What You Reveal To A Psychotherapist May Go Further*, N.Y. TIMES, April 14, 1993, <http://www.nytimes.com/1993/04/14/health/what-you-reveal-to-a-psychotherapist-may-go-further.html> (“Any licensed therapist who breaches confidentiality without a patient’s approval is open to a lawsuit and can lose his license for violating professional ethics.”).

52. *See, e.g.*, Fed. R. Evid. 501-502; M.R. Evid. 502-514.

53. *See, e.g.*, 32 M.R.S.A. § 7005.

fact-finding process” by allowing probative evidence to come into the record.⁵⁴ However, another role of the rules of evidence is to exclude unreliable or highly prejudicial evidence from the courtroom.⁵⁵ Privileges are a unique aspect of the law because the fact-finder is specifically blocked from relevant and perhaps even reliable information: “[e]videntiary privileges are the primary example of rules that exclude evidence for the purpose of promoting extrinsic substantive policies that exist outside of litigation.”⁵⁶ As a result, privileges are at variance with the ordinary evidentiary objectives, such as what Chief Justice Vinson called the public’s right to “every man’s evidence.”⁵⁷

The logic behind attaching a privilege to certain communications is that protecting the underlying relationships serves a greater purpose for society than does the need for the evidence.⁵⁸ Privileges have been acknowledged to protect communications between an attorney and his or her client, between spouses, and between the physician and his or her patient in an effort to encourage the open exchange of information.⁵⁹

On the whole, there are four fundamental conditions necessary for a communication to be covered by the evidentiary privilege:

- 1) The information must have been conveyed in “confidence that [it] will not be disclosed;”⁶⁰
- 2) Confidentiality must be necessary to maintain the relationship;⁶¹
- 3) The relationship supported by the privilege must be one that greater society recognizes as appropriate and necessary;⁶² and
- 4) The disclosure would cause more harm to the relationship than the benefit accomplished from the confidentiality.⁶³

While legal privileges protect a variety of relationships, the privilege protecting psychotherapists, like the attorney-client privilege, is born out of a professionally built relationship. In *Upjohn Co. v. U.S.*, the Court held that the purpose of the attorney-client privilege “[i]s to encourage full and frank communication between attorneys and their clients and thereby promote broader public interests in the observance of law and administration of justice.”⁶⁴ It is

54. Paruch, *supra* note 30 at 331. See also Deirdre M. Smith, *An Uncertain Privilege: Implied Waiver and the Evisceration of the Psychotherapist-Patient Privilege in the Federal Courts*, 58 DEPAUL L. REV. 79, 90 (2008) (“While other evidentiary rules aim to improve the reliability of evidence, leading to enhanced truth-seeking by fact finders and more efficient trials, privileges provide benefits outside adjudication, such as the preservation or protection of certain interpersonal relationships. Such purposes are central to many evidentiary privileges recognized today, including those shielding communications arising in marital, attorney-client, and clergy-believer relationships.”).

55. See Anthony Parsio, *The Psychotherapist-Patient Privilege: The Perils of Recognizing A “Dangerous Patient” Exception in Criminal Trials*, 41 NEW ENG. L. REV. 623 (2007).

56. *Id.* at 623.

57. *United States v. Bryan*, 339 U.S. 323, 331 (1950).

58. See Parsio, *supra* note 55 at 624.

59. CHRISTOPHER B. MUELLER & LAIRD C. KIRKPATRICK, EVIDENCE 285 (3d ed. 2012).

60. 8 JOHN H. WIGMORE, EVIDENCE IN TRIALS AT COMMON LAW 527 (1961).

61. *Id.*

62. *Id.*

63. *Id.*

64. *Upjohn Co. v. United States*, 449 U.S. 383, 389 (1981).

essential to the professional relationship that the lawyer be “fully informed by the client” in order to render the proper advice.⁶⁵

On a similar theory, the psychotherapist-patient privilege looks to protect the professional relationship between a mental health expert and her patient by encouraging full disclosure of information.⁶⁶ If a patient is fearful that the therapist may disclose these secrets to anyone outside the trusted space of therapy, the patient could be inhibited from revealing those innermost thoughts. The privilege is in place to protect that information and to encourage those who need the support of therapy to seek it without fear that their personal life will be made public; to further the right to privacy—what Warren and Brandeis termed the right to be “[l]et alone.”⁶⁷

The value of the therapeutic relationship has been affirmed time and time again in the psychotherapy profession, as well as federal and state courts. For example, the Court in *Jaffee*, when recognizing a federal privilege, focused primarily on the value of the therapeutic relationship,⁶⁸ and the benefit to society in protecting that relationship.⁶⁹

Like the spousal and attorney-client privileges, the psychotherapist-patient privilege is rooted in the imperative need for confidence and trust. . . . Effective psychotherapy, by contrast, depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears. Because of the sensitive nature of the problems for which individuals consult psychotherapists, disclosure of confidential communications made during counseling sessions may cause embarrassment or disgrace. For this reason, the mere possibility of disclosure may impede development of the confidential relationship necessary for successful treatment.⁷⁰

Privileges improve the medical relationship because the patient can “[f]eel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services.”⁷¹ Understanding that the conversations between a mental health expert and her patient are essential for treatment, both state and federal courts currently apply the psychotherapist-patient privilege.

D. Development of the Psychotherapist-Patient Privilege

The first reported decision of a court recognizing a psychotherapist-patient

65. *Id.*

66. *See, e.g., Jaffee v. Redmond*, 518 U.S. 1, 18 (1996).

67. Samuel D. Warren & Louis D. Brandeis, *The Right to Privacy*, 4 HARV. L. REV. 193, 193 (1890).

68. *Jaffee*, 518 U.S. at 6 (“Reason tells us that psychotherapists and patients share a unique relationship, in which the ability to communicate freely without the fear of public disclosure is the key to successful treatment.” (quoting *Jaffee v. Redmond*, 51 F.3d 1346, 1355-56 (7th Cir. 1995))).

69. *Jaffee*, 518 U.S. at 11 (“The mental health of our citizenry, no less than its physical health, is a public good of transcendent importance.”).

70. *Id.* at 10 (internal citations omitted)

71. Ralph Ruebner & Leslie Ann Reis, *Hippocrates to Hipaa: A Foundation for A Federal Physician-Patient Privilege*, 77 TEMP. L. REV. 505, 572 (2004) (quoting *Codes of Professional Responsibility: Ethics Standards in Business, Health, and Law* (Rena A. Gorlin ed., 4th ed. 1999)).

privilege was in 1952 in the Illinois Cook County Court.⁷² In that case, the plaintiff petitioned to have the defendant's medical records produced and to have the treating doctor testify.⁷³ The hospital witnesses claimed that the "[c]ommunications between the patient and the physician are privileged," and that this protection included psychiatric treatment.⁷⁴

The court held that the information resulting from psychiatric treatment *was* protected: "I am persuaded that the courts will guard the secrets which come to the psychiatrist and will not permit him to disclose them . . . the privilege ought to be granted and protected."⁷⁵

The Illinois Cook County Court held that the privilege protecting psychotherapy patients is different from the established physician-patient or attorney-client privileges because psychotherapy is "based on confidence" and if courts compelled the disclosure it would be an "abuse of that confidence."⁷⁶ Because the psychotherapy relationship is "unique and not at all similar to the relationship between a physician and patient" it requires a different privilege.⁷⁷

An "ordinary physician" looks for his or her patient to reveal the physical symptoms in order to try to identify the "particular malady" that ails the person.⁷⁸ In contrast, the psychotherapist is trying to identify the cause of the patient's mental and emotional distress.⁷⁹ In doing so, a psychotherapist investigates the patient's experiences during childhood and adolescence; "[i]n fact, what he seeks to do is to bring back to the conscious memory of the patient things forgotten but which lied dormant in the subconscious mind."⁸⁰ The particularity of this treatment requires the psychotherapist to "get that information out of the mouth of his patient."⁸¹

The court's analysis reflects the rationale supporting the ethical duty of confidentiality—the nature and importance of the mental health treatment requires serious professional and legal protections. Because psychological treatment requires both a more in-depth analysis into the patient's thoughts and more complete disclosure of these facts, the necessity for a separate privilege to protect the communications made in the course of treatment was necessary to the Illinois court.⁸²

In 1960, the Group for the Advancement of Psychiatry (GAP) stated in a report that, "[a]mong physicians, the psychiatrist has a special need to maintain confidentiality. His capacity to help his patients is completely dependent upon

72. *Binder v. Ruvell*, No. 52C2535 (Ill. Cir. Ct. June 24, 1952), available at <http://jaffee-redmond.org/cases/binder.htm>.

73. *Id.*

74. *Id.*

75. *Id.*

76. *Id.*

77. *Id.*

78. *Id.*

79. *Id.*

80. *Id.*

81. *Id.*

82. *Id.*

their willingness and ability to talk freely.”⁸³ Specifically, GAP was concerned that, without a psychotherapist-patient privilege, therapy would not be successful,⁸⁴ much like the concern that representation would not be effective without the attorney-client privilege.⁸⁵ The GAP report suggested that the psychotherapist-patient privilege mirror the attorney-client privilege in both intent and exceptions.⁸⁶

In 1961, the Connecticut legislature enacted a statute inspired by the GAP model for a psychotherapist privilege.⁸⁷ However, the Connecticut statute was more detailed and “did not tie the scope of the privilege to the attorney-client privilege.”⁸⁸ Soon after, Florida, Illinois, Kentucky and Maryland followed with statutes modeled after the Connecticut statute.⁸⁹

In 1969, the United States Supreme Court proposed the first Federal Rules of Evidence to Congress.⁹⁰ Initially, the proposal included nine federal privileges, including the psychotherapist-patient privilege.⁹¹ In 1973, the proposed rules came before Congress for approval.⁹² Due to political “crossfire,” Congress eliminated the proposed privileges for a single rule: Federal Rules of Evidence, Rule 501.⁹³

83. Paul W. Mosher, *Psychotherapist-Patient Privilege: The History and Significance of the U.S. Supreme Court's Decision in the Case of Jaffee v. Redmond* (1999) (unpublished manuscript) (emphasis omitted) (quoting Group for the Advancement of Psychiatry, *Confidentiality and Privileged Communication in the Practice of Psychiatry*, 92 (1960)), available at <http://jaffee-redmond.org/articles/mosher.htm>.

84. *Id.* (“Psychiatrists not only explore the very depths of their patients' conscious, but their unconscious feelings and attitudes as well. Therapeutic effectiveness necessitates going beyond a patient's awareness and, in order to do this, it must be possible to communicate freely. A threat to secrecy blocks successful treatment.”); Smith, *supra* note 54, at 95 (“The psychiatrists argued, absent a guarantee that the words exchanged with their patients could not become evidence in a courtroom, patients could not fully enjoy the potential benefits of their treatment.”).

85. See *Upjohn Co. v. United States*, 449 U.S. 383, 385 (1981).

86. Abraham S. Goldstein & Jay Katz, *Psychiatrist-Patient Privilege: The GAP Proposal and the Connecticut Statute*, 118 AM. J. PSYCHOL. 733, 736 (1962), available at <http://journals.psychiatryonline.org/article.aspx?articleid=148487> (“The confidential relationship and communication between the psychiatrist and patient shall be placed on the same basis as regards privilege, as provided by law between attorney and client.”); Smith, *supra* note 54, at 95 (“Where exceptions or waivers applied to the attorney-client privilege, the same approach would be taken with the psychiatrist-patient privilege.”).

87. Goldstein & Katz, *supra* note 86, at 733.

88. Smith, *supra* note 54, at 95; Goldstein & Katz, *supra* note 86, at 736 (“The GAP statute suggested a host of problems which call into question the appropriateness of the attorney-client model.”).

89. Smith, *supra* note 54 at 96.

90. Deborah Paruch, *supra* note 30 at 340.

91. *Id.*; MODEL CODE EVID. R. 220-23; see MANFRED S. GUTTMACHER & HENRY WEIHOFEN, *PSYCHIATRY AND THE LAW* 269 (1st ed.1952).

92. Edward J. Imwinkelried, *An Hegelian Approach to Privileges Under Federal Rule of Evidence 501: The Restrictive Thesis, the Expansive Antithesis, and the Contextual Synthesis*, 73 NEB. L. REV. 511, 512 (1994).

93. FED. R. EVID. 501 (“Except as otherwise required by the Constitution of the United States or provided by Act of Congress or in rules prescribed by the Supreme Court pursuant to statutory authority, the privilege of a witness, person, government, State, or political subdivision thereof shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in light of reason and experience. However, in civil actions and proceedings, with respect to an element of a claim or defense as to which State law supplies the rule of decision, the privilege of a witness, person, government, State, or political subdivision thereof shall be determined in accordance with State law.”).

Instead of listing the federal privileges, Rule 501 directs the reader to the federal common law.⁹⁴ Therefore, while the psychotherapist-patient privilege was originally proposed in the 1973 Rules of Evidence, it was not until 1996 that the United States Supreme Court held that there is a federal privilege for psychotherapists.⁹⁵ By that year, all fifty states had adopted a psychotherapist-patient privilege through statute or rule.⁹⁶

In 1996, in *Jaffee v. Redmond*⁹⁷, the United States Supreme Court finally held that statements made to a licensed social worker in the course of psychotherapy treatment were protected from compelled disclosure.⁹⁸ This case is a result of a plaintiff trying to see the defendant's psychotherapist's records in a wrongful death action.⁹⁹

In this case, a police officer, Mary Lu Redmond, responded to a report of a fight at an apartment complex.¹⁰⁰ Believing that Ricky Allen was about to stab another man, Redmond shot and killed him.¹⁰¹ The administrator of Allen's estate, Jaffee, brought a claim in the United States District Court for the Northern District of Illinois alleging that Redmond violated Allen's constitutional rights by using excessive force.¹⁰²

During the discovery process, Jaffee learned that Redmond had been meeting with a clinical social worker, Karen Beyer.¹⁰³ Jaffee requested Beyer's notes.¹⁰⁴ Redmond opposed the request, claiming a psychotherapist-patient privilege protected the notes from disclosure.¹⁰⁵ The Court concluded "confidential communications between a psychotherapist and her patient 'promotes sufficiently important interests to outweigh the need for probative evidence.'" ¹⁰⁶ Despite the fact that the psychotherapist's notes and testimony may be relevant and useful for the plaintiff's case, the Court held that the interest in keeping the information private was more important than the interests served by disclosure. The Court held that the privilege serves important public ends and thus the psychotherapist-patient privilege covers the confidential information communicated to licensed psychologists and psychiatrists as well as communications to licensed social workers when there is intent for the conversation to be confidential and the communications occurred in the course of psychotherapy.¹⁰⁷

The Court created a "wall of protection against disclosures" of such

94. *Id.*

95. *Jaffee v. Redmond*, 518 U.S. 1, 2 (1996) ("[I]t is appropriate for the federal courts to recognize a psychotherapist privilege is confirmed by the fact that all 50 States and the District of Columbia have enacted into law some form of the privilege.").

96. *Id.*

97. *Id.*

98. *Id.*

99. *Id.*

100. *Id.*

101. *Id.*

102. *Id.*

103. *Id.*

104. *Id.*

105. *Id.*

106. Jerome S. Beigler, *Tarasoff v. Confidentiality*, 2 BEHAV. SCI. & L. 273, 283 (1984) (quoting *Trammel v. U.S.*, 445 U.S. 40 (1980)).

107. *Jaffee v. Redmond*, 518 U.S. 1, 15 (1996).

information at the discovery stage and through litigation.¹⁰⁸ In addition, the Court stated that Fed. R. Evid. 501 gives the courts the ability to “define new privileges” through common law, concluding that the private and public interests support the psychotherapist-patient privilege;¹⁰⁹ the privilege serves private interest by promoting effective therapy through trust and confidence in your therapist,¹¹⁰ and the privilege serves public interests by opening a path for successful treatment, which promotes people to seek mental and emotional health.¹¹¹

Following the Court’s holding in *Jaffee*, every jurisdiction had a statutory, evidentiary or common-law privilege protecting communications made during psychotherapy treatment¹¹² where a patient had the right to prevent the disclosure of confidential communication resulting from mental health treatment.¹¹³ While *Jaffee* is not binding to the states, the policy reasons behind *Jaffee* can be seen in the discussion of state privileges.

The psychotherapist-patient privilege protects arguably the most private information a person can convey: their innermost struggles. Built upon a relationship of trust, a psychotherapist can help an individual identify and confront these issues.

E. The Maine Privilege

As covered previously, LCSWs are considered psychotherapists under the current law of privileges due to the analogous role that LCSWs have in mental health treatment.¹¹⁴ However, Maine law has not always given equal protections to psychotherapists and social workers. The Maine Rules of Evidence have been protecting psychotherapy patients for decades, however the definition of a “psychotherapist” has evolved with the years. For example, in 1976, the Maine Rules of Evidence defined a psychotherapist as:

A person authorized to practice medicine in any state or nation, or reasonably believed by the patient so to be, while engaged in the diagnosis or treatment of a mental or emotional condition . . . [or] a person licensed or certified as a psychologist or psychological examiner.¹¹⁵

The commentary notes that the rule “combines a general physician-patient privilege with the statutory privileges for psychiatrists, psychologists and psychological examiners.” However, the rule did not incorporate all statutory privileges for mental health experts, and in 1977, the Maine Legislature further enacted a statute providing a conditional privilege for social workers.¹¹⁶ The statute is considered conditional because if it is necessary for the “proper administration of justice” to

108. Smith, *supra* note 54 at 79.

109. *Jaffee*, 518 U.S. at 2.

110. *Id.* at 11.

111. *Id.*

112. *Id.* at 12.

113. See B.W. Best, *Annotation, Privilege, in Judicial or Quasi-Judicial Proceedings, Arising from Relationship between Psychiatrist or Psychologist and Patient*, 44 A.L.R.3d. 24 (1972).

114. M.R. Evid. 503.

115. Richard Field & Peter Murray, *Maine Evidence* (1976).

116. 32 M.R.S.A. § 7005 (1999 & Supp. 2013).

disregard the privilege, the privilege will not be acknowledged, and disclosure may be compelled.¹¹⁷ This statute was most recently amended in 2001, and it currently states:

Except at the request of, or with the consent of, the client, no person licensed under this chapter may be required to testify in any civil or criminal action, suit or proceeding at law or in equity respecting any information which he may have acquired in providing social work services to the client in a professional and contractual capacity if that information was necessary to enable him to furnish professional social work services to the client. However, when the physical or mental condition of the client is an issue in that action, suit or proceeding or when a court in the exercise of sound discretion deems the disclosure necessary to the proper administration of justice, no information communicated to, or otherwise learned by, that licensed person in connection with the provision of social work services may be privileged and disclosure may be required.¹¹⁸

When this statute was enacted, it provided protection to a class of psychotherapy that would not otherwise be shielded from disclosure. This privilege came into being through the licensing provisions for the profession.¹¹⁹ The legislative history indicates that there was concern at the time of enactment that this privilege was only “illusory” because “[i]t seems to promise privileged communication to the person who is talking to a licensed social worker and yet the court can strip this away very easily, so it sort of exists but yet it doesn't exist.”¹²⁰ Nevertheless, the bill passed, and 32 M.R.S.A. § 7005 has been providing a qualified protection for patients of social work to this day.¹²¹

In 2008, the Maine Rules of Evidence expanded the privilege to include licensed clinical social workers, thus providing more protection than 32 M.R.S.A. § 7005.¹²² Citing *Jaffee v. Redmond*, the Maine advisory committee noted: “[o]f the various kinds of social workers covered by state licensing requirements, those designated and licensed as ‘clinical social workers’ seem best to fit the traditional role of psychotherapist as contemplated by the privilege.”¹²³ By including licensed clinical social workers under the privilege in the Maine Rules of Evidence, the Law Court seemed to indicate that the previously used “conditional” statutory privilege should be pushed aside for the more protective evidentiary privilege. However, the

117. *Id.*

118. *Id.* (emphasis added).

119. *Id.*

120. Legis. Rec. 442 (2d Reg. Sess. 1978).

121. 32 M.R.S.A. § 7005 (1999 & Supp. 2013).

122. M.R. Evid. 413 advisory committee's notes to 2008 amend., Me. Judicial Branch website/Rules (visited Oct. 4, 2014) (The privilege would also encompass licensed clinical social workers when treating emotional and mental conditions and four defined classes of licensed counseling professionals, “licensed professional counselors,” “licensed clinical professional counselors,” “licensed marriage and family therapists,” and “licensed pastoral counselors,” when performing their counseling functions.).

123. *Id.* (The committee noted that the “licensed counseling professionals proposed to be covered by the privilege are now licensed under 32 M.R.S.A. §§ 13851 et seq. These licensed counselors provide different forms of psychotherapy in at least some circumstances. Such professionals are currently covered by a *conditional privilege* which permits disclosure of client communications ‘when a court in the exercise of sound discretion determines the disclosure necessary to the proper administration of justice.’”) (emphasis added) (quoting 32 M.R.S.A. § 13862).

conditional statute and its broad exceptions still remain.¹²⁴

Currently, the “Health Care Professional, Mental Health Professional, and Licensed Counseling Professional—Patient Privilege” (hereafter “psychotherapist-patient privilege”)¹²⁵ included in the Rules of Evidence states that “[a] patient has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications made for the purpose of diagnosis or treatment of the patient’s physical, mental or emotional condition”¹²⁶ The patient, the patient’s guardian, or the “personal representative of a deceased patient” may assert the privilege.¹²⁷

F. General Exceptions to the Privilege

While the psychotherapist-patient privilege serves important interests, there are still situations when the privilege must yield, and these exceptions vary by jurisdiction. In its recognition of the federal psychotherapist-patient privilege, the *Jaffee* Court did not provide any guidance as to the exceptions for the federal privilege.¹²⁸ However, years earlier in the 1969 proposed federal rules of evidence to Congress, the psychotherapist-patient privilege included three exceptions: 1) No privilege for communication in order to hospitalize the patient; 2) No privilege for court-ordered examinations; and 3) No privilege for proceedings where the patient’s mental condition is instrumental to the case.¹²⁹ Similar exceptions are found in the state-applied privileges as well.

For example, the Maine Rules of Evidence, like the proposed Federal Rules, provide three distinct exceptions to the privilege.¹³⁰ First, 503(e)(1) states that there is no privilege for communications “[r]elevant to an issue in proceedings to hospitalize the patient for mental illness” if the mental health professional determines that the “[p]atient is in need of hospitalization.”¹³¹ Next, 503(e)(2) states that there is no privilege for communications related to examinations by order of the court.¹³² This is when the court orders the patient to be examined for physical, mental or an emotional condition. Finally, in 503(e)(3), there is no privileged communication when the patient’s mental, physical, or emotional condition is an element of the patient’s claim or defense.¹³³ Given that the Rules of Evidence specifically lay out the privilege and the exceptions in the same rule, it suggests that an individual need not look further in the law to know the power and limitations of the privilege.¹³⁴

124. 32 M.R.S.A. § 7005 (1999 & Supp. 2013).

125. M.R. Evid. 503 (This provision amounts to a psychotherapist-patient privilege.).

126. M.R. Evid. 503(b).

127. M.R. Evid. 503(d).

128. Anne Bowen Poulin, *The Psychotherapist-Patient Privilege After Jaffee v. Redmond: Where Do We Go from Here?*, 76 WASH. U. L. REV. 1341, 1373 (1998).

129. Paruch, *supra* note 30 at 341.

130. See Goldstein & Katz, *supra* note 86 and accompanying text.

131. M.R. Evid. 503(e)(1).

132. M.R. Evid. 503(e)(2).

133. M.R. Evid. 503(e)(3).

134. M.R. Evid. 503.

III. PROTECTING THE PUBLIC

While the protections for psychotherapy patients may appear extensive, they are balanced with both professional and legal exceptions. Along with traditional public policy exceptions discussed above,¹³⁵ the duty of confidentiality and the psychotherapist-patient privilege must give way when the patient expresses the intent to harm another individual.

The duties and privileges protecting the patient exist because the Supreme Court has recognized that the psychotherapeutic relationship has more value on the whole when compared to the potentially probative evidence.¹³⁶ However, this value quickly dissipates when the patient is using the therapy session to process or plan for a dangerous event. This Part will look at the development of the legal duties in place to protect the public from potentially dangerous individuals as well as the issues that these exceptions have on the effectiveness of the psychotherapy treatment.

A. *Ethical Duty of Confidentiality: The Duty to Report*

A notable exception to the duty of confidentiality is for dangerous patients. “Although confidentiality is one of the major underpinnings of psychotherapy, the trend of cases clearly suggests that courts regard the safety of the public as superior to confidentiality in therapy when the two issues are in conflict.”¹³⁷ This issue was specifically addressed in the landmark case of *Tarasoff v. Regents of California*.¹³⁸

I. *Tarasoff v. Regents of California*

In 1976, the California Supreme Court held that a psychotherapist must disclose otherwise confidential information when the psychotherapists determine that his patient poses a serious threat of danger to a third party to protect potential victims.¹³⁹ The *Tarasoff* case began in August of 1969 when Prosenjit Poddar, a psychotherapy patient of Dr. Lawrence Moore, told his therapist that he intended to kill Tatiana Tarasoff.¹⁴⁰ Dr. Moore informed campus police who briefly detained Poddar, but neither Dr. Moore nor the campus police took any additional action.¹⁴¹ Two months later, in October of 1969, Poddar killed Tarasoff.¹⁴²

Tarasoff’s parents sued the Regents of California, Dr. Moore’s employer, claiming that Poddar had expressed his intention to kill their daughter to Dr. Moore, and therefore the Regents of California were responsible for their

135. See e.g. M.R. Evid. 503(e)(1-3).

136. Anthony Parsio, *The Psychotherapist-Patient Privilege: The Perils of Recognizing A “Dangerous Patient” Exception in Criminal Trials*, 41 NEW ENG. L. REV. 623, (2007).

137. Fillmore Buckner & Marvin Firestone, “Where the Public Peril Begins”: 25 Years After TARASOFF, 21 J. LEGAL MED. 187, 215 (2000), available at <http://cyber.law.harvard.edu/torts01/syllabus/readings/buckner.html>.

138. *Tarasoff v. Regents of Univ. of Cal.*, 551 P.2d 334 (1976).

139. *Id.* at 346.

140. *Id.*

141. *Id.* at 341.

142. *Id.* at 339.

daughter's death through the respondeat superior doctrine.¹⁴³ In response to Tarasoff's claim, the Regents of California maintained that they owed no duty to the victim.¹⁴⁴

In the Court's holding, the California Supreme Court created what has come to be known as the "Tarasoff duty"—a duty imposed on psychotherapists to protect third parties from reasonably foreseeable harm caused by their patients.¹⁴⁵ In this holding, the court recognized that, in some situations, only psychotherapists could avert imminent harm through their disclosure.¹⁴⁶ The Court recognized that psychotherapists would need to walk a fine line when assessing whether or not their patient might act in a dangerous or violent manner.¹⁴⁷ While the court does not "require that the therapist, in making that determination, render a perfect performance," the psychotherapist should implement a "reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of that professional specialty under similar circumstances."¹⁴⁸ The duty is only triggered when the mental health expert believes that the patient will act on his or her statement or threat.

In response to this holding, and in order to protect the therapeutic relationship, psychologists are expected to discuss the "relevant limits of confidentiality" with their patients.¹⁴⁹ This is important so that patients understand that, while their information is generally confidential, this is not a guarantee, and hopefully the psychotherapist and the patient can work through the disclosure and preserve the therapeutic relationship.

In Maine, mental health experts are held to a similar provision to disclose otherwise confidential information when their patients pose a threat of harm: "A licensed mental health professional shall disclose protected health information that the professional believes is necessary to avert a serious and imminent threat to health or safety when the disclosure is made in good faith to any person . . . who is reasonably able to prevent or minimize the threat."¹⁵⁰

The majority of states are now following the *Tarasoff* decision, either through

143. *Id.*

144. *Id.* at 340.

145. *Id.* at 342.

146. *Id.* at 345.

147. *Id.*

148. *Id.*

149. APA Duty of Confidentiality, *supra* note 39.

150. 34-B M.R.S.A. § 1207(6-A) (2010 & Supp. 2013); *see also* 22 M.R.S.A. § 1711-C (6)(D) (2004 & Supp. 2013) ("Disclosure may be made without authorization as follows: To appropriate persons when a health care practitioner or facility that is providing or has provided diagnosis, treatment or care to the individual in good faith believes that disclosure is made to avert a serious threat to health or safety."); 34-B M.R.S.A. § 1207(1)(I) (2013) ("A state-designated statewide health information exchange may disclose a client's health care information covered under this section even if the client has not chosen to opt in to allow the state-designated statewide health information exchange to disclose the individual's health care information when, in a health care provider's judgment, disclosure is necessary to: (1) Avert a serious threat to the health or safety of others, if the conditions, as applicable, described in 45 Code of Federal Regulations, Section 164.512(j)(2010) are met; or (2) Prevent or respond to imminent and serious harm to the client and disclosure is to a provider for diagnosis or treatment.").

statute or common law.¹⁵¹ However, *Tarasoff* does not address the evidentiary issues that lay tangent to the *Tarasoff* duty to disclose, namely its relationship with the psychotherapist-patient privilege.¹⁵²

B. The Evidentiary Privilege: The Dangerous Patient Exception

Similar to the duty of confidentiality, there are certain situations where a court may compel the unauthorized disclosure of a patient's information because the threat of harm is more serious than the need to protect the information. It is necessary to note, however, that disclosing information under an exception to the privilege is distinct from the *Tarasoff* disclosures.

Under *Tarasoff*, a psychotherapist is under a duty to protect potential victims by excusing the *ethical duty of confidentiality* to deliver this warning. However, the dangerous-patient exception requires the psychotherapist to push aside the *evidentiary psychotherapist-patient privilege and testify* as to confidential details in order to protect a third party. As the Ninth circuit noted, the *Tarasoff* duty to report and the testimonial privilege are distinct concepts, and the duty to report does not necessarily trigger a "an abrogation of the federal testimonial privilege."¹⁵³

While analogous, the harm from a dangerous-patient exception may surpass the harm from a *Tarasoff* disclosure because the patient's rights and liberties can be significantly impeded as a result of the psychotherapist's testimony. The fear that the psychotherapist might disclose confidential information may prevent a patient from being completely honest. However, this apprehension might intensify if there is a threat of prosecution in a courtroom, where the patient's most private and embarrassing thoughts might be forever codified in a court record.

Prior to the enactment of the Federal Rules of Evidence, the advisory committee for the 1969 proposed rules specifically noted that the rules did not include an exception for when a patient threatens harm against another:

Its members were persuaded that, as a class, patients willing to express to psychiatrists their intention to commit crime are not ordinarily likely to carry out that intention. Instead, they are making a plea for help. The very making of such pleas affords the psychiatrist his unique opportunity to work with patients in an attempt to resolve their problems. Such resolutions would be impeded if patients were unable to speak freely for fear of possible disclosure at a later date in a legal proceeding.¹⁵⁴

However, in the 1996 *Jaffee* decision, the United States Supreme Court alluded to the possibility of a dangerous-patient exception.¹⁵⁵ This exception permits the psychotherapist to testify as to otherwise privileged information without the patient's consent if there is reason to believe the patient poses a threat of imminent harm against a third party.¹⁵⁶

151. George C. Harris, *The Dangerous Patient Exception to the Psychotherapist-Patient Privilege: The Tarasoff Duty and the Jaffee Footnote*, 74 WASH. L. REV. 33, 45-48 (1999).

152. *See id.*

153. *United States v. Chase*, 340 F.3d 978, 978 (9th Cir. 2003).

154. Goldstein & Katz, *supra* note 86 at 738-39.

155. *Jaffee v. Redmond*, 518 U.S. 1, 18 n.19 (1996).

156. *Id.*

Although it would be premature to speculate about most future developments in the federal psychotherapist privilege, we do not doubt that there are situations in which the privilege must give way, for example, if a serious threat of harm to the patient or to others can be averted only by means of a disclosure by the therapist.¹⁵⁷

Although the United States Supreme Court affirmed that psychotherapists couldn't be compelled to testify about a patient's confidential disclosures, the *Jaffee* footnote could be seen as suggesting a dangerous-patient exception when there is a serious threat of harm to the patient or another person.¹⁵⁸

The issue that the dangerous-patient exception seeks to address is that sometimes there are people who pose a serious threat of imminent harm against others, the only person who knows about this threat is the psychotherapist, and the only way to avert that harm is through the therapist's testimony.¹⁵⁹ Currently there is a federal circuit split as to whether a dangerous-patient exception should apply, and only some states have chosen to incorporate a dangerous-patient exception into that jurisdiction.¹⁶⁰

The conflict about whether to incorporate a dangerous-patient exception hinges on the patient's privacy interest compared to the protection of potential victims. For example, in *United States v. Chase*, the Court noted that "[i]f our Nation's mental health is indeed as valuable as the Supreme Court has indicated, and we think it is, the chilling effect that would result from the recognition of a 'dangerous patient' exception and its logical consequences is the first reason to reject it."¹⁶¹ The value of the psychotherapist-patient relationship resonated with the Court and led to the rejection of a dangerous-patient exception in the Ninth Circuit. However, not all jurisdictions agree. With the *Jaffee* footnote as the foundation, several federal jurisdictions have decided, one way or another, on whether to acknowledge a dangerous-patient exception.

In *United States v. Auster*, the Fifth Circuit recognized the dangerous-patient exception, but refused to apply it to the facts of this case because the defendant did not have any reasonable expectation of privacy in the threats he made.¹⁶² Therefore, if the dangerous-patient exception is to apply, it is necessary to ensure that the privilege has been established.

In *United States v. Glass*, the Tenth Circuit held that a dangerous-patient exception is appropriate if the threat is serious when the threat is made.¹⁶³ In its holding, the Court looked to *Jaffee*¹⁶⁴ and established that the federal psychotherapist-patient privilege does apply in this case.¹⁶⁵ However, depending on whether the threat conveyed during a psychotherapy session was "serious when it was uttered and whether its disclosure was the only means of averting harm," the

157. *Id.*

158. *Id.*

159. See *Donaldson v. Donaldson*, No. PA-13-287 (Me. Dist. Ct., Biddeford, Aug. 19, 2013).

160. Harris, *supra* note 151.

161. *Id.* at 978 (quoting *United States v. Hayes*, 227 F.3d 578, 584-585 (6th Cir. 2000)).

162. *United States v. Auster*, 517 F.3d 312 (5th Cir. 2008).

163. *United States v. Glass*, 133 F.3d 1356, 1360 (10th Cir. 1998).

164. *Id.* (citing *Jaffee v. Redmond*, 518 U.S. 1 (1996)).

165. *Glass*, 133 F.3d at 1360.

privilege may be excused under the dangerous-patient exception.¹⁶⁶ The Tenth Circuit remanded to inquire further into the seriousness of the threat and the available options.¹⁶⁷

The above referenced federal cases fell into line with the dangerous-patient exception foreshadowed and outlined in *Jaffee* footnote 19.¹⁶⁸ The dangerous-patient exception should only apply if the privilege has first been established,¹⁶⁹ the threat communicated was serious when said, and there is no other way to avert the harm than by excusing the privilege.¹⁷⁰

While federal courts sparked the nation-wide conversation, several states have independently addressed the issue. For example, California incorporated a dangerous patient exception to the psychotherapist-patient privilege in their Rules of Evidence: “There is no privilege under this article if the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger.”¹⁷¹ California is a state that has enacted legislation that provides that therapists may testify against their patients if they believe the patient would be dangerous to himself or another.¹⁷² The Law Revision Commission commented that:

Although the dangerous-patient exception might inhibit the relationship between the patient and his psychotherapist to a limited extent, it is essential that appropriate action be taken if the psychotherapist becomes convinced during the course of treatment that the patient is a menace to himself or others and the patient refuses to permit the psychotherapist to make the disclosure necessary to prevent the threatened danger.¹⁷³

Other than California, few states have statutes that clearly indicate whether or not a dangerous-patient exception exists.¹⁷⁴ For example, Illinois permits the psychotherapist-patient privilege to be abrogated in situations like “trials for homicide when the disclosure relates directly to the fact or immediate circumstances of the homicide.”¹⁷⁵ Wyoming law will excuse the privilege in situations where “an immediate threat of physical violence against a readily identifiable victim is disclosed to the psychologist.”¹⁷⁶ Likewise, Ohio law permits a court to compel the “testimony” of a psychotherapist if there is a “clear and

166. *Id.*

167. *Id.*

168. *Jaffee v. Redmond*, 518 U.S. 1, 18 n.19 (1996).

169. *Auster*, 517 F.3d at 315.

170. *Glass*, 133 F.3d at 1360.

171. CAL. EVID. CODE § 1024 (West 1967).

172. *Id.* (“There is no privilege under this article if the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger.”).

173. 7 Cal.L.Rev.Comm. Reports 1 (1965).

174. Harris, *supra* note 151.

175. ILL. COMP. STAT. ANN. § 15.5 (West, 2014).

176. WYO. STAT. ANN. § 33-27-123 (West, 2014).

present danger to the client or other persons.”¹⁷⁷

When considering the dangerous-patient exception, some commentators argue that an exception is appropriate because, due to the other enumerated exceptions,¹⁷⁸ the impact on the privilege would be minimal.¹⁷⁹ This argument is countered by the contention that another exception, especially an unpredictable exception, could lead to the evisceration of the privilege and destroy the relationships that the privilege aims to protect.¹⁸⁰

Given the current events and past holdings considering a dangerous-patient exception, it is fair to say that the psychotherapy-patient privilege might need to give way in extreme circumstances to protect the health and safety of the greater population. However, in order to keep the current benefits of psychotherapy while adding the benefits of the dangerous-patient exception, the situation must be specific, limited and extreme to properly co-exist with the psychotherapist-patient privilege.

IV. THE MAINE ISSUE: 32 M.R.S.A. § 7005 IS AN ANTIQUATED STATUTE THAT UNDERMINES THE PSYCHOTHERAPIST-PATIENT RELATIONSHIP AND THE INTENT OF THE MAINE RULES OF EVIDENCE

Arguably, “dangerous” individuals who make threatening statements in therapy are those who could benefit the most from continued mental health treatment. The privilege serves a public and private interest by promoting this mental health treatment, and an exception to the privilege, such as the dangerous-patient exception, could prove detrimental not only to the individual’s treatment, but for the safety and wellbeing of the greater population.¹⁸¹ Therefore, proceeding with a dangerous-patient exception, or any exception that uproots the protection of the privilege, should be done with careful regard for the intent of the privilege in the first place.

The issue facing Maine LCSW patients is that 32 M.R.S.A. § 7005 goes beyond the dangerous-patient exception to allow the court to set aside the privilege in any circumstance the court finds necessary.¹⁸² While the Maine Rules of Evidence incorporated LCSWs into the protection originally afforded to psychologists and psychotherapists, this effort is fruitless as long as this statute continues to conflict.¹⁸³ If the privilege is going to be effective, patients “[m]ust be

177. The Ohio statute specifically identifies testimony as opposed to other privileged situations. *See* OHIO REV. CODE ANN. § 2317.02 (West, 2014).

178. B. Joseph Wadsworth, Note, *Evidence-Recognition of a Federal Psychotherapist-Patient Privilege*, *Jaffee v. Redmond*, 116 S. Ct. 1923 (1996), 32 LAND & WATER L. REV. 873, 880-81 (1997).

179. *See* Swidler & Berlin v. United States, 524 U.S. 399, 409 (1998).

180. *Id.* at 410 (The Court stated that “A ‘no harm in one more exception’ rational could contribute to the general erosion of the privilege, without reference to common-law principles or ‘reason and experience.’”). This was supported two years later in *Jaffee v. Redmond*, 518 U.S. 1, 18 (1996) (discussing that “[a]n uncertain privilege, or one which purports to be certain but results in widely varying applications by the courts, is little better than no privilege at all.” (*quoting* *Upjohn Co. v. United States*, 449 U.S. 383, 393 (1981))).

181. Parsio, *supra* note 55 at 650-51.

182. 32 M.R.S.A. § 7005.

183. *Id.*; *see also* 32 M.R.S.A. § 13862 (1999) (“Privileged Communications: Except at the request or consent of the client, no person licensed under this chapter may be required to testify in any civil or

able to predict with some degree of certainty whether particular discussions will be protected.¹⁸⁴ This broad discretion afforded to the courts creates an uncertainty to the psychotherapist-patient privilege for LCSWs because the application of the protection would vary depending on the court's understanding of when justice requires the disclosure. This Maine statute leaves the fate of the psychotherapist-patient privilege to the unpredictable discretion of the court, and renders the 2008 amendment of the Rules of Evidence ineffective.¹⁸⁵

For example, when a daughter sought a protection from abuse order from the Maine District Court in Biddeford against her mother, the court held that the LCSW would be compelled to testify against her patient as to the threats the mother made against her daughter.¹⁸⁶

On June 18, 2013, a police officer arrived at the daughter's home to inform her that her mother made threats against her life during a counseling session with a LCSW.¹⁸⁷ The police were notified of this threat when the LCSW, based on her professional judgment, believed that the threat was credible, and that she had an ethical duty to inform and warn the potential victim.¹⁸⁸ Based on the LCSW's tip, the police notified the daughter of the threat, but did not take any additional action against the mother.¹⁸⁹

In fear for her life, the daughter turned to the Maine District Court in Biddeford, and was granted a temporary protection order under the Protection from Abuse statute, 19-A M.R.S.A. §4001, et seq. (PFA).¹⁹⁰ The matter was set for hearing on August 19, 2013.¹⁹¹ In the meantime, the daughter subpoenaed the LCSW to testify at the hearing.¹⁹² The LCSW filed a motion to quash the subpoena citing the psychotherapist-patient privilege.¹⁹³ The daughter filed an opposition to the motion to quash, and in addition she filed a motion to compel the counselor's testimony.¹⁹⁴ And finally, the mother objected to the motion to compel.¹⁹⁵

The court held a hearing on the pending motions.¹⁹⁶ The issue was whether or

criminal action, suit or proceeding at law or in equity respecting any information that the person licensed or registered may have acquired in providing counseling services or marriage and family therapy services to the client in a professional and contractual capacity if that information was necessary to enable the licensee to furnish professional counseling services to the client. When the physical or mental condition of the client is an issue in that action, suit or proceeding *or when a court in the exercise of sound discretion determines the disclosure necessary to the proper administration of justice, information communicated to or otherwise learned by that licensed or registered person in connection with the provision of counseling or marriage and family therapy services may not be privileged and disclosure may be required.*" (emphasis added).

184. *Upjohn Co. v. United States*, 449 U.S. 383, 393 (1981) (discussing the attorney-client privilege).

185. 32 M.R.S.A. § 7005.

186. *Donaldson v. Donaldson*, No. PA-13-287 (Me. Dist. Ct., Biddeford, Aug. 19, 2013).

187. *Id.*

188. *Id.*

189. *Id.*

190. *Id.*

191. *Id.*

192. *Id.*

193. *Id.*

194. *Id.*

195. *Id.*

196. *Id.*

not the court could compel the LCSW to testify as to potentially privileged information in a PFA hearing.¹⁹⁷

The mother argued that, while it is true that the court can compel a mental health expert to testify, the statements made would be inadmissible under the psychotherapist-patient privilege.¹⁹⁸ The daughter argued that the Maine Rules of Evidence list of exceptions to the psychotherapist-privilege was not exhaustive, and therefore the court could read in a dangerous-patient exception to compel the therapist to testify.¹⁹⁹

On the one hand is the daughter's safety; the alleged homicidal threats are the only evidence that the daughter has to get protection against her mother from the court. However, on the other hand is the mother's privacy and mental health; if the LCSW is forced to testify against her, the mother may not ever receive the mental health treatment she needs for fear that her most intimate thoughts will be revealed in a courtroom setting.

As to the admissibility of the LCSW's testimony, the court held that the psychotherapist-patient privilege was not "an absolute bar to testimony," and that, in this case, the court would hear from the psychotherapist.²⁰⁰ The court came to this holding because the LCSW had already disclosed the alleged threat to the police, and because the court had "express statutory authority to allow disclosure of confidential communications made to the social work[er] when 'necessary to the proper administration of justice.'"²⁰¹ The court found this protection hearing to be an appropriate situation to compel a psychotherapist's testimony.²⁰²

Without the therapist's testimony, the court could not properly assess if the daughter could obtain a PFA order to protect her against imminent harm because the only way for the daughter to obtain an order was to prove that her mother made a threat against her life, and the only admissible evidence of this fact was the LCSW's testimony.²⁰³

The court held that although the exceptions to Maine's psychotherapy-privilege do not apply in this case, the statutes permit the LCSW's limited disclosure.²⁰⁴ Therefore, the court looked to this statutory grant of authority, and held that the information was not privileged and the LCSW could testify as to the homicidal threats the mother made during treatment.²⁰⁵

In its holding, the court was mindful of the potential implications of this ruling—if the LCSW's testimony is not limited, the harm done to the mother's psychotherapy treatment would far exceed the benefit of the disclosure.²⁰⁶ In an effort to serve both parties' interests, the court limited the LCSW's testimony and disclosure.²⁰⁷ In the court's order on the Motion to Quash, the court said:

197. *Id.*

198. *Id.*

199. *Id.*

200. *Id.*

201. *Id.* (quoting 32 M.R.S.A § 7005 (1964 & Supp. 2013)).

202. *Id.*

203. *Id.*

204. *Id.*

205. *Id.*

206. *Id.*

207. *Id.*

- (1) [The LCSW] will be ordered to testify about the report she made to the Biddeford Police Department, namely what statements she made to the police in such report.
- (2) The court may further order [the LCSW] to testify about facts that gave rise to her decision to make that report, including statements made by Defendant, but reserves final ruling on this to trial.
- (3) Other statements made or information acquired in the course of the counseling relationship between [the mother] and the LCSW beyond the scope of items 1 and 2, above, are determined to be privileged and outside the scope of permitted testimony, unless Defendant opens the door through her examination of the LCSW.
- (4) The subpoena does not request production of any documents, and therefore the LCSW will not be required to produce any such documents, records or notes. To the extent the LCSW uses and documents or records to refresh her recollection, disclosure may be required in accordance with Rule 612.²⁰⁸

This ruling used the power granted to the court via statute, as well as the underlying social policy of the privilege to strike a balance between privacy and protection. In this situation, the only way for the potential victim to receive protection, absent an agreement, was through the clinical social worker's disclosure. There was no other evidence available.

However, the court's use of 32 M.R.S.A. § 7005 in this context opens the door not only for a dangerous-patient exception in Maine but for a total abrogation of the psychotherapist privilege permitted under the Maine Rules of Evidence for LCSWs, because the fate of the psychotherapist-patient privilege in regard to social workers is left to the discretion of the hearing judge. The conditions set forth in the statute run contrary to the goals of the current evidentiary privilege because it can cause a serious disruption in the therapist-patient relationship. Under 32 M.R.S.A. § 7005, the psychotherapist can be compelled to testify *against* their patient, an event that undoubtedly disrupts, if not forever severs, the psychotherapist-patient relationship that the Maine Rules of Evidence sought to protect.

As Justice Rehnquist wrote in *Upjohn Co. v. United States*, an "uncertain privilege, or one which purports to be certain but results in widely varying applications by the courts, is little better than no privilege at all."²⁰⁹ If Maine is to maintain an effective psychotherapist-patient privilege for LCSWs, the statute must be adjusted to limit its discretion under § 7005 to serious threats of harm when the patient has actual knowledge of the limits of confidentiality, and when there is no other reasonable means to avert the harm. In addition, the psychotherapist's testimony should be limited in scope to preserve as much of the relationship as possible. For the future of the Maine social workers, and the mental health treatment they provide, courts must limit their discretion under 32 M.R.S.A. § 7005.

V. THE SOLUTION

In order to properly protect LCSW patients, and to acknowledge the intent of

208. Parsio, *supra* note 55 at 650-51.

209. *Upjohn Co. v. United States*, 449 U.S. 383, 393 (1981).

the 2008 amendment to the Maine Rules of Evidence, the conditional privilege in 32 M.R.S.A. § 7005 needs to change. Therefore the Maine Legislature should look to amend § 7005 to reflect the 2008 incorporation of LCSWs into the Maine Rules of Evidence psychotherapist-patient privilege and associated protections and exceptions.

However, as long as 32 M.R.S.A. § 7005 remains in its current form, Maine courts should use their discretion to protect and preserve the Maine psychotherapist-patient privilege. The following recommendation provides a format to protect the integrity of the privilege, while still allowing a limited exception in the event of an imminent threat of bodily harm until the legislature can address the discrepancy.²¹⁰ Given that Maine does not have an enumerated dangerous-patient exception to the psychotherapist-patient privilege, this recommendation reflects upon the discussion and policy arguments concerning the benefits and downfalls of dangerous-patient exceptions from other jurisdictions.

*A. The Patient has Actual Knowledge of the Rights and Exceptions
Under the Privilege*

One of the fundamental aspects to creating a strong therapeutic relationship is the concept of trust; without trust, a patient is less likely to disclose the inner conflicts to receive the proper psychoanalysis and treatment.²¹¹ While the limits of confidentiality are often enumerated in publically available records, “confidentiality is a protection [that is] often assumed by patients to be total, but known by therapists to be severely limited.”²¹² Because of this assumption, it is important for therapists to inform their patients that the protections are not absolute because “disclosing information about a patient without knowledge or consent would be a breach of trust.”²¹³

Currently, neither Maine LCSWs nor patients can predict whether or not the information discussed will be protected by the privilege due to the statutory exception in § 7005. Because the protections and exceptions are unknown to both parties, it is difficult to establish a trusting therapeutic relationship, and whatever relationship is built can be easily shattered by the therapist’s compelled disclosure at a future testimonial hearing.

By understanding the protections and limits of the privilege, a patient (and the

210. While the Maine Rules of Evidence do not have a dangerous-patient exception, this recommendation is in the event that the court is inclined to use 32 M.R.S.A. § 7005 in a dangerous-patient situation. Ideally, Maine laws and rules will coexist at some point in a manner that acknowledges LCSWs as a prominent mental health service, and yet still offer protection to potential victims.

211. See *Tarasoff v. Regents of Univ. of Cal.*, 17 Cal. 3d 425, 459 (1976) (“Until a patient can trust his psychiatrist not to violate their confidential relationship, ‘the unconscious psychological control mechanism of repression will prevent the recall of past experiences.’”); *Jaffee v. Redmond*, 518 U.S. 1, 2 (1996) (“Effective psychotherapy depends upon an atmosphere of confidence and trust, and therefore the mere possibility of disclosure of confidential communications may impede development of the relationship necessary for successful treatment.”); *Scull v. Super. Ct.*, 206 Cal. App. 3d 784, 789 (Ct. App. 1988) (“The accurate diagnosis and effective treatment in psychotherapy are greatly dependent upon conditions of trust and confidentiality between patient and therapist.”).

212. RALPH SLOVENKO, *PSYCHOTHERAPY AND CONFIDENTIALITY: TESTIMONIAL PRIVILEGED COMMUNICATION, BREACH OF CONFIDENTIALITY, AND REPORTING DUTIES* 291 (1998).

213. *Id.* at 178.

psychotherapist) can more reasonably predict what will happen with the disclosed information, and build a stronger relationship on that mutual understanding. As the United States Supreme Court noted in regard to the attorney-client privilege, the purpose of the privilege is only fulfilled if “the attorney and client [can] predict with some degree of certainty whether particular discussions will be protected.”²¹⁴ Once this foundation is set, any compelled disclosures under one of the exceptions to the privilege is less likely to destroy the relationship because the patient was aware of the possibility of disclosure – there was no deception and therefore no violation of the trust.²¹⁵

Some scholars have suggested that the dangerous-patient exceptions should not apply unless the patient has been given explicit warning that the threats will not be kept confidential.²¹⁶ The ethical duty of confidentiality under the American Psychological Association includes the requirement for the psychotherapist to disclose “the relevant limitations on confidentiality” at the beginning of treatment.²¹⁷ Therefore, informing the patient about the rights (and the limits of those rights) under the evidentiary privilege would not put an unnecessary strain on the therapeutic relationship, and can help to preserve the relationship.

By analogy, some scholars were concerned that the *Tarasoff* disclosures would lead to more dangerous people because those individuals would be deterred from seeking mental health treatment.²¹⁸ However, through the proper warnings during treatment, it appears that patients and the mental health professionals can continue a relationship.²¹⁹ While testifying in a court on a public record is vastly different than a therapist disclosing the otherwise confidential information to an authorized person, there is hope that the Maine psychotherapist-patient privilege will remain strong, while still providing protection to potential victims if the patient is given adequate warning that any compelled disclosure is not meant as a sign of betrayal. In addition, any threat made against another person after this warning can be considered serious, permitting the psychotherapist to disclose under *Tarasoff*.

While notice is important, it is necessary to recognize that the warning will influence the future therapeutic relationship.²²⁰ While some professionals advise to give notice at the beginning of treatment, others suggest withholding the warning until a threat has been made.²²¹ In this scenario, the patient will have one bite of the apple, so to speak, before a therapist may need to testify against him. This benefits the psychotherapist relationship because the patient is not burdened with the idea of disclosure prior to revealing his violent intentions.

214. *Upjohn Co. v. United States*, 449 U.S. 383, 393 (1981).

215. Ralph Slovenko, Comment, *Psychotherapy and Confidentiality*, 24 CLEV. ST. L. REV. 375, 395 (1975) (“Trust--not absolute confidentiality--is the cornerstone of psychotherapy. Talking about a patient or writing about him without his knowledge or consent would be a breach of trust. But imposing control where self-control breaks down is not a breach of trust when it is not deceptive. And it is not necessary to be deceptive.”).

216. Brian P. McKeever, *Contours and Chaos: A Proposal for Courts to Apply the "Dangerous Patient" Exception to the Psychotherapist-Patient Privilege*, 34 N.M. L. REV. 109, 137 (2004).

217. APA Duty of Confidentiality, *supra* note 39.

218. *See id.*

219. *Id.*

220. *Id.* at 892-93.

221. Klinka, *supra* note 29 at 891-92.

However, this approach would require the psychotherapists to have a serious talk about the limits of confidentiality after the therapeutic relationship has been established. This conversation alone could impact the future of the relationship because the patient might believe the psychotherapist was not upfront with the patient from the beginning. In addition, if a dangerous patient were going to act after a single threat, it would be against public policy to disregard that serious comment because the psychotherapist waited to inform the patient of his rights.

B. No Other Reasonable Way to Avert the Harm

Even if the patient is adequately warned about the limits of the privilege, the psychotherapist-patient relationship should still be protected. Psychotherapy still serves important public and private interests, interests that should not be entirely set aside simply because patients appear dangerous. As the *Jaffee* footnote suggests, the court should not use the dangerous-patient exception unless there is no other reasonable way to avert the harm.²²² When applying the broad exception of § 7005, the value of the therapeutic relationship should be ever-present in the court's consideration. If the imminent harm can be averted by other means, those avenues should be explored before a therapist is compelled to testify.

One avenue that should always be explored before the application of a dangerous-patient exception is the *Tarasoff* duty to disclose. If speaking with the potential victim or the police quells the threatened harm, there is no need for the therapist to testify in court. Generally, if there is a threat of harm against a third party, the potential victim can find protection through realms other than compelling a psychotherapist to testify. Therefore, a § 7005 exception should only be used when disclosure is the only way to protect an individual from imminent harm.

If after trying to alleviate the potential harm through other means, the potential victim is still in need of protection, compelling a psychotherapist to testify at a hearing that can offer such protection is appropriate. For example, in the *Donaldson* case,²²³ the psychotherapist informed the police about the threat, and the potential victim was made aware of the threat, but even with this knowledge, the threat remained imminent. When the potential victim appealed to the court for relief via the PFA statute, the court appropriately used its discretion to offer her protection.²²⁴

C. A Psychotherapist Should Only be Compelled to Testify in a Hearing that can Reasonably Avert the Harm

The original intent of the dangerous-patient exception, as stated in the *Jaffee* footnote, is to compel otherwise confidential disclosures to avert imminent harm.²²⁵ Considering this intent, the only appropriate venue for a dangerous-patient exception in Maine is in testimonial hearings that can reasonably avert the threatened harm, such as Protection from Abuse and bail hearings.

222. *Jaffee v. Redmond*, 518 U.S. 1, 18 n.19 (1996).

223. *Donaldson v. Donaldson*, No. PA-13-287 (Me. Dist. Ct., Biddeford, Aug. 16, 2013) (Douglas, J.).

224. *Id.*

225. *Jaffee*, 518 U.S. at 18 n.19.

A Protection from Abuse (PFA) order is available to a person when a family or household member attempts or commits: 1) physical harm; 2) to force someone to do something from which they have a right to abstain; 3) put another in fear of physical harm through threats, harassment or tormenting behavior; 4) to force another to unlawfully restrict the movement of another person; or 5) to repeatedly follow or stalk another.²²⁶ One purpose for this court-authorized protection is “[t]o allow family and household members who are victims of domestic abuse to obtain expeditious and effective protection against further abuse so that the lives of the non-abusing family or household members are as secure and uninterrupted as possible.”²²⁷ But what happens when the only way to afford this protection is by peeking into the private communications between the defendant and his/her psychotherapist?

The dangerous-patient exception can play a critical role in the outcome of both the defendant’s mental health treatment and the plaintiff’s sense of security. With proper safeguards in place, the court should be able to compel limited disclosure to be able to offer the potential victim legal protection from the threatened harm.

The Maine PFA statute provides relief to victims of abuse, which includes threatened harm.²²⁸ The court can grant interim relief through an ex-parte hearing to provide protection from imminent harm, pending a full hearing.²²⁹ After a full hearing, or a consent agreement, the court can order protection for up to two years.²³⁰ Given that a PFA hearing provides protection against imminent harm, it is appropriate for a psychotherapist to testify as to the threatened harm in this situation.

Focusing specifically on Maine cases, the exception would be appropriate if the therapist’s testimony were the only way to offer legal protection. Compelled testimony in the case of restraining orders appears to be a “necessary outgrowth of the therapist’s ‘*Tarasoff*’ duty to protect potential victims from harm.”²³¹ This is because offering their knowledge in a court of law to secure protection is not an unreasonable approach when a life is on the line.

Another testimonial hearing that would be appropriate for a dangerous-patient exception is the bail hearing. If an incarcerated person poses an imminent threat to another, the court has the ability to immediately deter that harm by keeping the individual in jail. However, other than bail hearings, the dangerous-patient exception should not be used in criminal law.²³²

First, the dangerous-patient exception was born out of the idea of averting harm, and the purpose of a criminal trial is to punish; second, given the time delays

226. 19-A MRSA § 4002(1)(A-F) (2012 & Supp. 2013). (Another avenue for protection in Maine is Protection from Harassment, which extends beyond family or household members. 337-A M.R.S. § 4651. Looking beyond the scope of Maine’s rules, this theory could be applied to any protective hearing).

227. 19-A MRSA § 4001(2) (2012).

228. 19-A MRSA § 4002(1)(B) (2012 & Supp. 2013).

229. 19-A MRSA § 4006(2) (2012 & Supp. 2013).

230. 19-A MRSA § 4007(1), (2) (2012 & Supp. 2013).

231. Paruch, *supra* note 30 at 395 (quoting George C. Harris, *The Dangerous Patient Exception to the Psychotherapist-Patient Privilege: The “Tarasoff Duty” and the Jaffee Footnote*, 74 WASH. L. REV. 33, 47 (1999)).

232. *See* United States v. Hayes, 227 F.3d 578 (6th Cir. 2000).

between the incident and the trial, the harm has likely passed by the time the testimonial privilege can be waived by a dangerous-patient exception.²³³ Furthermore, a patient who made a threat against another during a psychotherapy session is “not likely to actually commit the act once court proceedings have begun.”²³⁴ With this in mind, civil protection order cases or bail hearings are the only appropriate context for the psychotherapist to prevent the harm from occurring.

However, even if the hearing has the power to prevent imminent harm, the exception should not be used if there is other evidence that would support a finding of abuse and reasonable fear. Therefore, the court should be awarded the discretion to conduct an in camera review of the information before it becomes public knowledge to assess if the confidential information is relevant and necessary to the issuance of protection.

D. The Psychotherapist’s Testimony Should be Limited to Only the Information Needed to Prevent the Imminent Harm

Finally, even if a psychotherapist is compelled to testify to offer protection in a limited situation, there are steps available to the court to limit and protect this information. Maine’s statute 32 M.R.S.A. § 7005 is particularly concerning because LCSW patients are exposed to an unrestricted exception that has the potential to go far beyond the intent of Maine’s lawmakers. For example, therapist’s testimony about threatened harm can easily spin out of control, and require disclosure of personal and irrelevant information, if the LCSW’s are required to give the reasons the therapist believed the threat to be credible in the first place. Therefore, a court should limit the testimony to only what is strictly necessary to offer protection.²³⁵

In most cases, the psychotherapist should only be permitted to testify to the threat conveyed in the psychotherapy session. This information is enough to satisfy the PFA statute as well as a judge in a bail hearing if the patient communicates a threat of violence against another and the potential victim is put in reasonable fear that the patient will follow through on that threat.²³⁶ Therefore, only the psychotherapist’s testimony to the statement made, the statement that would be necessary to report under a *Tarasoff* duty, would be permitted. However, testimony that explores the reasons why the psychotherapist reported under the *Tarasoff* duty would go too far.

If there is a debate as to whether the psychotherapist’s testimony is probative, the court should conduct an in camera review of the testimony to verify its necessity before the therapist is examined on the public record. This policy returns to the fact that the psychotherapist-patient relationship is one the court should look to protect if possible. The courtroom should not be a way for litigators to fish for evidence locked beneath the psychotherapist-patient privilege. This exception should only push the privilege aside when a threat of imminent harm is present, and

233. Paruch, *supra* note 30 at 393.

234. Parsio, *supra* note 55 at 650.

235. McKeever, *supra* note 216 at 147.

236. 19-A M.R.S. § 4002(1)(E) (2012 & Supp. 2013).

it should only be used to the extent necessary to provide protection.

VI. CONCLUSION

Maine LCSWs face an uncertain privilege; as long as 32 M.R.S.A. § 7005 provides a conditional privilege that conflicts with the Maine Rules of Evidence, the balance between protecting the patient and protecting the public is askew. As it stands, a LCSW patient is exposed—while the duty of confidentiality protects the patient to a certain extent, the court can compel a LCSW to disclose the patient's innermost thoughts, urges and conflicts on the public record at any time in any testimonial hearing. In response, the psychotherapist relationship may suffer, and the patient may not receive the best mental health treatment. Therefore, the statute needs to be amended to be clear about the protections offered under Maine law to LCSW patients.

Until the statute is amended, Maine courts should exercise their discretion to protect the intent and purpose of the psychotherapist-patient privilege. If a court is inclined to use the statute to provide protection to a potential victim, it should only be when the patient has actual knowledge of the rights and exceptions under the privilege, when there is no other reasonable way to avert the harm, when the LCSWs testimony would be in a hearing that can reasonably avert the harm, and when the LCSWs testimony is limited to only the information needed to prevent the harm.

