The majority concluded that such a nexus between imminent threat of injury and mental disorder had not been met. It noted that the state's case rested heavily on testimony that emphasized D.M.S.'s history of alcohol use and decompensation in the context of intoxication, but not a connection between his cognitive disorder and imminent threat of harm to self or others. Since the Montana statute did not recognize either substance use or personality disorder as a mental disorder, the link therefore must be specifically made to the cognitive disorder, NOS. A concurring opinion offered that had the case not been remanded secondary to the reasoning described above, it would have been remanded for the violation of D.M.S.'s right to remain silent; the jury had been informed of his refusal to participate in the second evaluation. Only one justice dissented, citing deference to the jury's observations of D.M.S.'s disruptive behavior during trial.

*Discussion*

Montana is not the only state that excludes alcohol, illicit substances, or personality disorders in the definition of mental disorder within its civil commitment statutes. *In re D.M.S.* illustrates the perils for testifying experts in these states who fail to make explicit the links (when they exist) between the relevant commitment criteria and the recognized mental illness. While such precise pronouncements about cause and effect may be artificial in a clinical milieu, such specificity may be necessary in legal proceedings where the statute limits grounds for commitment. As the majority opinion emphasized, inference or proximity to a mental disorder is not sufficient; criteria for commitment must be met "because of" the illness.

While the primary topic of interest to forensic psychiatrists in *In re D.M.S.* is causation, that aspect is only a subplot in this case; rather, the major story is the complex set of interactions between the criminal and civil procedures and standards. What began as a criminal matter became a civil one to remedy a deficiency in the criminal process—namely, the inability of the state to find criminal grounds on which to detain an individual who the state believed to be a menace. That the state offered to drop civil commitment proceedings if the court were willing to readjudicate competency and pursue the original DUI cases suggests strongly that the civil commitment petition was pursued solely to effect detention. This strategy ran aground at the point at which D.M.S. invoked the right to remain silent, a right more commonly associated with protections in a criminal proceeding. Because he availed himself of this right, the state could not meet the major elements of the civil procedure, causation. Ironically, this burden of proof was particularly high, since the standard of review in Montana for civil commitment proceedings is the same as in a criminal trial and could not be met without expert testimony as a matter of law rather than fact.

While the use of civil commitment statutes to engage in preventative detention is, of course, not unheard of in practice, as most civil commitment statutes are broadly drawn, this case demonstrates why it is preferable to use the criminal sanction to deal with dangerousness, where possible. Here, the overwhelming flavor is that the state had multiple bites of the apple to detain D.M.S. This seriously raises questions of due process as applied to him and potentially to others like him.

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# Duty to Control a Community Mental Health Outpatient via Emergency Civil Commitment

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### Rhode Island Supreme Court Declines to Impose on a Community Mental Health Center a Duty to Control a Voluntary Outpatient by Emergency Civil Commitment to Prevent a Violent Assault on a Coworker

In *Santana v. Rainbow Cleaners, Inc.*, 969 A.2d 653 (R.I. 2009), the Rhode Island Supreme Court considered an appeal of a summary judgment issued by the Providence County Superior Court in a case in which Zaida Santana, an assault victim, filed suit against a community mental health center for negligent supervision and failure to control a patient with

mental illness and a history of violent assaults. The main bases of the arguments on appeal were that a special relationship existed between the community mental health center and a voluntary outpatient; that relationship created a duty to supervise and control the patient by emergency civil commitment; and that the patient's unsupervised presence created an imminent likelihood of serious harm to others in the community.

*Facts of the Case*

In January 2004, the Providence Center, Inc., a community mental health center in Providence, Rhode Island, had its last treatment contact with David L. Kelly, a voluntary outpatient with mental illness, who lived next to and occasionally worked at Rainbow Cleaners.

In mid-May 2004, Mr. Kelly walked into Rainbow Cleaners, slammed his fist on the counter, and screamed at Ms. Santana. She expressed fear of Mr. Kelly's behavior, but a co-owner of Rainbow Cleaners told her that Mr. Kelly was harmless. On May 26, 2004, Mr. Kelly entered Rainbow Cleaners and struck Ms. Santana repeatedly on the head with a crowbar. She was hospitalized with severe brain injury, was unconscious for two weeks, and subsequently required 24-hour care. Mr. Kelly was detained by police and later was arraigned on three counts of felony assault. Mr. Kelly was admitted to Eleanor Slater Hospital, where he was found to be incompetent to stand trial.

After the assault, Ms. Santana named Rainbow Cleaners, the Providence Center, and "John Does I-X," the mental health providers who treated Mr. Kelly, in a lawsuit alleging negligent supervision of Mr. Kelly. Later, she settled her claim with Rainbow Cleaners. She removed Rainbow Cleaners and John Does I-X from her lawsuit.

The Providence Center moved on March 30, 2007, for summary judgment, arguing that no duty was owed to Ms. Santana. The center also argued that the violence risk posed by Mr. Kelly was not, nor should it have been, foreseeable and asserted that Ms. Santana had not produced any supporting evidence for her claim of negligent supervision of Mr. Kelly or for her claim that their patient could have met the conditions for emergency civil commitment (R.I. Gen. Laws § 40.1-5-7 (2004)). On June 30, 2008, the superior court found in favor of the Providence Center's motion for summary judgment.

Ms. Santana appealed the ruling to the Rhode Island Supreme Court. She argued that the Providence Center had a special relationship with Mr. Kelly, their patient, and that a duty to control Mr. Kelly arose from that relationship. She also argued that the duty imposed on the defendant was reasonable and consistent with public policy and that the assault by Mr. Kelly was foreseeable. The Providence Center reiterated its arguments as presented in superior court.

*Ruling and Reasoning*

The Rhode Island Supreme Court reviewed the case *de novo*. The court noted not having heard any previous cases that addressed the duty of a mental health provider to control a patient or a duty to protect a person other than the patient. The court also relied on *Tarasoff v. Regents of the University of California*, 551 P.2d 334 (Cal. 1976), a landmark California Supreme Court decision; the *Restatement* (*Second*) *of Torts* §§ 315-319 (1965); and case law from other state jurisdictions for guidance in its analysis of the case.

The supreme court ruled that there was no special relationship between the Providence Center and Mr. Kelly that would trigger a duty owed by the Center. The court found that the defendant did not owe a duty to control the conduct of Mr. Kelly, or a duty to protect Ms. Santana, which rendered null the issues of the Center's breach of those duties to Ms. Santana. The court also found no evidence provided by Ms. Santana to support her claim that the injury and damage she suffered were foreseeable or should have been foreseen by the Center.

The court cited two procedural bars to Ms. Santana's arguments. First, no medical documentation or affidavits were provided to support the plaintiff's appellate claim that Mr. Kelly met the criteria for emergency civil commitment when he was last ordered into mandatory treatment or at his last contact with the treatment provider. Second, the court barred Ms. Santana's claim of a duty to control and protect by seeking nonemergency civil commitment (R.I. Gen. Laws § 40.1-5-8 (2004)), because that claim was raised for the first time on appeal, which runs counter to appellate procedural rules.

*Discussion*

In addition to its findings specific to this case, the court provided future plaintiffs, defendants, and attorneys in the state of Rhode Island with an outline

of the factors to consider in a case analysis of a duty to control a mental health patient. These factors are the existence of a special relationship between the mental health provider and the voluntary outpatient; a duty to control a voluntary outpatient; breach of a duty to control a voluntary outpatient; foreseeability of harm or harm that should have been foreseen by the provider; serious damage or harm to the plaintiff, which has as a proximate cause the breach of a duty to control by the defendant mental health provider; extent of, consequences of, and liability for breach of a duty to control a voluntary outpatient; and public policy considerations (e.g., public safety, the therapeutic relationship between patient and mental health provider, and a patient's right to liberty and treatment in the least restrictive environment).

In the *Santana* decision, the court left the door open to finding a duty to control under different facts and circumstances involving a mental health provider and an outpatient. The court said, "[W]e do not say that an outpatient relationship *never* can give rise to an affirmative duty to control the patient's conduct" (*Santana*, p 665, emphasis in original).

The key implication of the *Santana* case is that in Rhode Island, future plaintiffs who bring claims against mental health providers for breach of duty to control a voluntary outpatient from seriously harming another person will have to prove that a special relationship existed between the mental health provider and the patient in which the provider had the opportunity, and therefore a potential duty, to control the patient. Supporting medical documentation or expert affidavits should be presented to support a plaintiff's claims that the provider had the authority, opportunity, and ability to control its outpatient. Plaintiffs will also bear the burden of proving that the outpatient would have met the stringent statutory criteria for involuntary emergency civil commitment and that the imminent risk of the likelihood of serious harm to others due to the patient's unsupervised presence in the community was either foreseeable or should have been foreseen according to the standard of care in their mental health profession.

While duty to control and duty to protect are well established in the legal vocabulary, these terms do not neatly correspond with mental health concepts. The facts of this case raise issues elsewhere described as problematic in *Tarasoff* cases: relative lack of control over outpatients, whether duty to protect can pass the "but for" test of legal causation, and the absence of a consensus on standard of care in "duty to protect" situations (Thomas M: Expanded liability for psychiatrists: Tarasoff gone crazy? *J Ment Health Law* 11:45–56, 2009).

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# Peer Review Privilege in Its Last Throes?

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### Protection and Advocacy Agency Seeks to Gain Access to Hospital Peer Review Records in Federal Courts

*In Virginia v. Reinhard*, 568 F.3d 110 (4th Cir. 2009), the United States Court of Appeals for the Fourth Circuit reversed a decision by the United States District Court for the Eastern District of Virginia that denied state officials' motion to dismiss a lawsuit filed by the Virginia Office for Protection and Advocacy (VOPA) for failure to release peer review records on the grounds (among others) that the state officials were not immune to suit under the Eleventh Amendment.

#### *Facts of the Case*

Congress encourages the states to establish entities such as VOPA to address disability-related matters, such as abuse, neglect, and discrimination. Federal funds are provided, under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (DD Act) (42 U.S.C. §§ 15001-15115 (2006)) and the Protection and Advocacy for Individuals with Mental Illness Act (PAIMI Act) (42 U.S.C. §§ 10801-10851 (2006)). The states, under these acts, establish their protection and advocacy entities to be either private or public entities, and Virginia chose the public option.

On July 18, 2008, VOPA filed a complaint before the United States District Court for the Eastern District of Virginia against James Reinhard, Commissioner of the Department of Mental Health, Mental