disability, any deviation from the mandated protocol, no matter how minor, may lead to the remanding of the case.

It is heartening to note that the court gave weight, not only to formal assessments by the treating psychiatrist, but also to information about clinical presentation and treatment by other clinicians involved, even when a clinician is not a treating source. Although these opinions may not carry "controlling weight" as they are not from the treating source, they usually carry significant weight and may even be entitled to more weight than the opinion of the treating source if that opinion does not meet certain specified criteria. The treating source in this case would be a licensed physician/psychiatrist, not an APRN. The court was unhappy with the ALJ for not giving adequate consideration to an assessment from a state agency psychologist and to progress notes from Ms. Kohler's psychiatric APRN. The ALJ's apparent dismissal of these reports gave an appearance of a biased view that led to denial of benefits.

The opinion of the treating psychiatrist carries controlling weight with regard to disability eligibility determinations. This fact may not be immediately apparent, given the high number of psychiatrically disabled individuals denied benefits. Those who are well enough to understand the system appeal the denial and subsequently fall into a large pool of individuals in limbo, waiting for the final determination of their applications. The sad reality of this case is how long it has dragged on; six years after the initial application, the case is still unresolved.

Duty to Warn Clarified

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The Kentucky Supreme Court Interprets When a Threat Is Communicated and the Meaning of an Actual Threat

In *DeVasier v. James*, 278 S.W.3d 625 (Kentucky 2009), the Supreme Court of Kentucky affirmed the court of appeals' decision concluding that the trial court should have directed a verdict in favor of Dr. William James, the psychiatrist defendant, because he owed no duty to warn or take precautions regarding a man he evaluated in an emergency department. In so doing, the court analyzed the statutory definitions of "communicated to a qualified mental health professional" and "an actual threat" contained in Ky. Rev. Stat. Ann. § 202A.400 (Michie 1995), both broadening and narrowing physician liability in duty-to-warn cases in Kentucky.

Facts of the Case

In July of 1995, Kenneitha Crady attempted to end an eight-year romantic relationship with her boyfriend Rene Cissell. Mr. Cissell had recently been violent with Ms. Crady on several occasions, including on July 12, when he crashed his car into a car carrying Ms. Crady, and on July 18, when he held a knife to her throat causing a small cut. At the time, Mr. Cissell was noted to be "depressed, irritable, abusing drugs, and increasingly angry" (*DeVasier*, p 628). After the knife incident, Mr. Cissell's sister, Georgia Yount, and Ms. Crady took Mr. Cissell for a crisis evaluation at a local outpatient psychiatric facility. Although he was given a follow-up counseling appointment for the next day, Ms. Crady and Ms. Yount were worried enough about his increasing anxiety that they took him instead to the psychiatric emergency department at the University of Louisville Hospital.

Mr. Cissell was first evaluated by an intake nurse, who was told about the recent violence. After that evaluation, the nurse charted that Mr. Cissell was a "man in crisis" and, based upon what Ms. Yount and Ms. Crady reported, the nurse charted that Mr. Cissell had "homicidal ideation." The nurse placed Mr. Cissell in the locked waiting room for further examination. His next evaluation was by a licensed clinical social worker, whom Mr. Cissell told that he "loved Crady, and that he did not want to harm her but was afraid that he could not control himself" (*Devasier*, p 633). The social worker then conferred with the attending psychiatrist, Dr. James, who performed the final evaluation. Dr. James decided against hospitalization by civil commitment for Mr. Cissell and allowed him to leave with his sister and Ms. Crady. Ms. Crady was present during all three evaluations.

After attending the counseling session, which had been scheduled the day before, Mr. Cissell and Ms. Crady got into another altercation. The police were

called but no arrests were made. The following day, Mr. Cissell stabbed Ms. Crady more than 40 times, killing her. He subsequently pleaded guilty to manslaughter in the first degree and was sentenced to 13 years in prison.

Ruling

The Administratrix of Ms. Crady's estate, Lois DeVasier, filed suit against Dr. James and others in Jefferson Circuit Court, alleging liability stemming from failure of a duty to warn per Ky. Rev. Stat. Ann. § 202A.400 (Michie 1995). Claims against the other defendants were settled or dismissed, and at trial, a jury verdict was awarded to Dr. James. The plaintiff appealed to the Kentucky Court of Appeals and Dr. James cross-appealed. The appeals court affirmed the ruling in favor of Dr. James. Both parties appealed to the Kentucky Supreme Court, which affirmed the trial court decision.

Reasoning

According to Ky. Rev. Stat. Ann. § 202A.400 (Michie 1995), no duty to warn arises "unless the patient has communicated to the qualified mental health professional an actual threat of physical violence against a clearly identified or reasonably identifiable victim, or unless the patient has communicated to the qualified mental health professional an actual threat of some specific violent act." Two issues of law were considered by the Kentucky Supreme Court: the point at which a threat is communicated to a qualified mental health professional and what qualifies as an actual threat.

On the first issue, Dr. James argued that a threat was not communicated to him because Mr. Cissell did not directly express to him a threat against the deceased. The plaintiff argued that a threat was communicated indirectly to Dr. James through the other evaluators with whom Dr. James conferred. The court of appeals held that for a threat to be communicated, direct expression of it from the patient to the doctor was required. The supreme court disagreed, finding the ruling too narrow an interpretation of the statute and holding instead that a threat communicated to a mental health professional includes those conveyed by a patient "directly to a mental health professional" and those conveyed "indirectly through agents or ostensible agents of that professional who have a duty to relay the patient's information" (*DeVasier*, p 631).

The second issue was what constituted an actual threat: whether past violent actions were enough to create an actual threat or whether an active expression of violent intent was required. Dr. James argued that an actual threat was never communicated to him, either directly or indirectly. Ms. DeVasier argued that Mr. Cissell was a threat to Ms. Crady because his recent violent behavior showed he was an actual threat to her at the time of Dr. James' evaluation. The Kentucky Supreme Court agreed with Dr. James, holding that a duty to warn arises "only when the patient has communicated to the mental health professional, directly or indirectly, by words or gestures, that he will commit an act of physical violence," and "[s]imply *being* [emphasis in original] a threat of physical violence does not constitute communicating a threat of physical violence" (*Devasier*, p 632).

Discussion

The practice of psychiatry demands a difficult balance among providing effective and appropriate psychiatric treatment, complying with the applicable legal requirements, and adhering to the tenets of professional ethics. This case exemplifies the complexity of issues that providers often face, especially the difficulty involved in balancing relevant clinical concerns and outcomes with societal demands that public safety be ensured.

The Kentucky duty-to-warn statute affirmatively relieves any liability or legal action against the qualified mental health professional if he or she takes certain steps to protect potential victims where there is a reasonable prospect of violence by a patient. Further, the statute does not require holding the patient if hospitalization is not required for treatment in order to comply with those steps. The legislature appeared to want to protect the qualified mental health professional and the public, while infringing the least amount possible on the patient's freedom.

This case, however, muddied the waters in an already murky area. As noted, the court broadened how a threat can be communicated to a provider, now including the information gathered, not only by the provider, but also by all whom the provider supervises. On the other hand, the court narrowed what constitutes an actual threat of physical violence, saying that a history of past harm to the victim in the absence of a current threat does not meet the threshold of communicating an actual threat. And all this

resulted from a case in which the court found no duty to warn, yet the "potential victim" was killed.

So what is a law-abiding and ethical qualified mental health provider to do? Would there have been a difference in outcome if the provider had warned the possible victim and the police? The victim knew well her boyfriend's history of violence, as she had lived it for eight years. The police were involved with the couple after the hospital evaluation and before the killing, yet they made no arrest. Would there have been a difference in outcome had the provider civilly committed the patient? One may read this case as a clear example of the need to err on the side of safety, but care should be used when considering lowering the threshold for civil commitment to increase the safety of potential victims. It is not clear that such action would be effective or that it would appropriately safeguard the individuals' right to be treated with the least restrictive method. Until the legislature and the courts provide more coherent and comprehensive guidance, mental health providers must continue to rely on sound clinical judgment and experience, while tolerating the risk of uncertainty inherent in these cases.