#K-300 11/1/79

Memorandum 79-63

Subject: Study K-300 - Evidence (Psychotherapist-Patient Privilege)

The Law Revision Commission submitted a recommendation relating to the psychotherapist-patient privilege to the 1978 session of the Legislature. The bill introduced to effectuate this recommendation passed the Legislature in amended form but was vetoed by the Governor. At the last meeting, the Commission indicated its desire to review this recommendation so that a decision could be made whether to resubmit the recommendation in 1980.

Attached is a copy of the recommendation revised (1) to include the change made to the recommended legislation after the bill was introduced in 1978 and (2) to reflect the enactment of a 1979 addition to the Evidence Code provisions relating to the psychotherapist-patient privilege. This draft is presented for review and approval for printing if the Commission desires to submit the revised recommendation to the 1980 session of the Legislature.

The bill introduced in 1978 was supported by:

California State Bar
California State Council of Agencies for Family Service
California Association of Marriage & Family Counselors
State Public Defender
National Association of Social Workers--California Chapter

The bill was opposed by:

California Peace Officers Association
California District Attorneys Association
California Attorney General

A copy of the Governor's veto message is attached as Exhibit 1 (yellow). The letter from the California District Attorneys Association (attached as Exhibit 2--pink) states the reason why the law enforcement groups opposed the bill. You may find the letter from Professor Kaplan (Exhibit 3--blue) of special interest. Also attached as Exhibit 4 (gold) is a copy of a law review article discussing the extension of the psychotherapist-patient privilege to patients of psychiatric social workers. A copy of the existing provisions of the Evidence Code is also attached (Exhibit 5--white).

Respectfully submitted,

John H. DeMoully
Executive Secretary

AB 2517

Memo 79-63

Exhibit 1

State of California

GOVERNOR'S OFFICE
SACRAMENTO 95814

EDMUND G. BROWN JR.
GOVERNOR

916 445-2841

September 30, 1978

To the Members of the California Assembly:

I am returning Assembly Bill Number 2517 without my signature.

The evidence before me does not support the wholesale expansion of the psychotherapist-patient privilege proposed by this bill, particularly as it relates to criminal proceedings.

Sincerely,

EDMUND G. BROWN JR.
Governor

CALIFORNIA DISTRICT ATTORNEYS ASSOCIATION

555 CAPITOL MALL, SUITE 1545, SACRAMENTO, CALIFORNIA 95814 Area Code (916) 443-2017

April 7, 1978 **Re: AB 2517**

The Honorable Charles Imbrecht
Member of the Assembly
California Legislature
State Capitol,Room 6009
Sacramento, CA 95814

Dear Assemblyman Imbrecht:

The California District Attorneys Association opposes the passage of your bill, Assembly Bill 2517.

Under the existing evidence code, confidential communications between either a psychotherapist or licensed psychologist is privileged. The privilege does not exist in criminal proceedings.

Assembly Bill 2517 would make several substantial changes to the existing law.

First, the definition of psychotherapist (Evidence Code 1010) would be expanded to include other types of counselors, i.e., social workers, educational counselors and educational psychologists.

Second, the definition of psychotherapist would be expanded to include individuals under Evidence Code 1010 operating as professional corporations.

Third, the definition of a confidential communication, Evidence Code section 1012, would be expanded to include communications between the patient and "any persons who are participating in the diagnosis and treatment under the direction of the psychotherapist, including members of the patients family."

The last major change would remove the limitation imposed by Evidence Code section 1028 which prevents the assertion of the psychotherapist-patient privilege in criminal proceedings.

Historically, the CDAA did not object to the creation of the psychotherapist-patient privilege when the legislature adopted the evidence code in 1965. The privilege was part of a package which contained offsetting benefits.

The rationale behind the privilege was to conform the existing broad privilege that the Business and Professions Code gave to licensed psychologists with the narrow privilege given to narrow physician-patient privilege which existed for psychiatrists prior to the evidence code. (See comment to Evidence Code 1014.)

The CDAA opposes AB 2517 for three reasons. First, if AB 2517 is adopted, an already broad privilege will be expanded beyond the necessity recognized at the time of adoption of the evidence code.

The passage of AB 2517 will result in the creation of a web of confidentiality. The web is spun three ways. First it is spun laterally by expanding the definition of psychotherapist. Second, it is spun horizontally by including communications between the patientand any persons involved in diagnosis and treatment including family members. Third, it is spun vertically by eliminating the section relating to use in criminal proceedings.

The creation of any privilege prevents the ascertainment of truth which is a primary goal of the criminal justice system. The creation of a new privilege, should be viewed with a great deal of caution since it will necessarily exclude relevant evidence from the trier of fact's consideration. In this context, weare notconvinced that the proponents of this rule have demonstrated a compelling need for the privilege sought to be created.

Therefore, CDAA opposes AB 2517.

Sincerely,

JOHN PRICE, Chairman
Legislative Committee

By: T.W. Condit
T.W. CONDIT
Legal Affairs Director

TWC:py

cc: Governor Edmund G. Brown Jr.
Michael S. Ullman
Michael V. Franchetti
Rod Blonien

April 14, 1978

California District Attorneys Association
Attn: T.W. Condit, Legal Affairs Director
555 Capitol Mall, Suite 1545
Sacramento, California 95814

Dear Mr. Condit: Re: AB 2517

The office of Assemblyman Imbrecht has provided me with a copy of your letter of April 7, 1978, opposing Assembly Bill 2517, and giving the reasons for this opposition.

The primary reason for Assembly Bill 2517 is to eliminate the existing discrimination against a patient who consults a therapist in a public mental health clinic as compared to a patient who consults a private psychiatrist or psychologist. The bill is described in detail in the enclosed recommendation of the California Law Revision Commission.

I personally doubt that the enactment of Assembly Bill 2517 would have any effect at all on obtaining convictions under the criminal justice system. (There is no privilege--and the testimony of the psychotherapist may be obtained--where the psychotherapist has reasonable cause to believe the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of others. See Evidence Code Section 1024. See also Evidence Code Section 1027.) On the other hand, I do believe that the enactment of the bill will encourage more persons to obtain mental health treatment at public mental health clinics. On balance, I believe that the overall effect of the bill will be to the benefit rather than the detriment of potential victims of crimes. I wish you would review your position on this bill with this point in mind and in light of the enclosed Recommendation of the Law Revision Commission.

Sincerely,

John H. DeMoully
Executive Secretary

JHD:kac
enc.

STANFORD LAW SCHOOL
STANFORD, CALIFORNIA 94305

May 23, 1975

Mr. John H. DeMoully
Law Revision Commission
Stanford Law School
Stanford, CA 94305

Dear John,

Here is a copy of the letter I sent to Otto Kaus. Secondly, I want to write you concerning Section 1028 of the Evidence Code. Essentially, that section says that in a criminal case the psychotherapist privilege is restricted solely to psychiatrists and psychologists and is denied to clinical social workers. To my mind this rule is not only indefensible, it is discriminatory in an especially unpleasant way. First of all, I think you can find no one to deny that the kind of psychotherapy performed by licensed clinical social workers is precisely the same as that performed by psychologists and psychiatrists short only of two differences which, though practically important, are irrelevant to our concern (psychiatrists can both prescribe drugs and commit to a mental institution).

More significant, perhaps, this difference in treatment between the clinical social worker on the one hand and the psychiatrist and psychologist on the other, operates to discriminate in two very important ways. First of all, although they perform basically the same types of psychotherapy, the clinical social worker is much more often working in either a mental health center, family service agency, or other agency. It is undeniable that these agencies tend to get those who simply cannot afford the more expensive therapy provided by the psychiatrist and to a lesser extent the psychologist. As a result, for the most part, the effect of the section in question is to deny the privilege to the poor and lower-middle class and allow it with respect to precisely the same kind of information to the upper-middle class and the rich.

I cannot also resist pointing out that there is another discrimination inherent in Section 1028. There is no doubt that the great majority of psychiatrists and psychologists practicing are men and the great majority of social workers are women. I admit that we have a caste system among our

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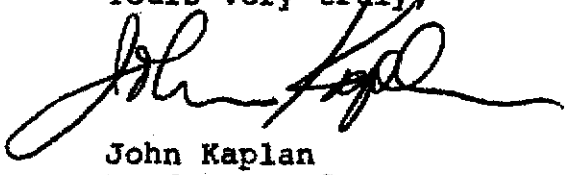
mental health professionals, but it strikes me as extremely unwise for the law to reinforce this through the use of the privilege area.

Of course, what I say with respect to the clinical social worker is applicable just as well to the school psychologist and the marriage family and child counselor--though, the inference of sexual discrimination is clearly not as great with respect to these latter two categories. In any event, the purposes of the psychotherapist privilege are not met if in the most important area of its application, it is simply denied to all but the most high status--and expensive--of the mental health professionals. I do hope that the Law Revision Commission will devote some time and energy to erasing this unfortunate inequality.

Yours very truly,



John Kaplan
Professor of Law

JK:rpt

Comments

UNDERPRIVILEGED COMMUNICATIONS: EXTENSION OF THE PSYCHOTHERAPIST-PATIENT PRIVILEGE TO PATIENTS OF PSYCHIATRIC SOCIAL WORKERS

The law of evidence in most jurisdictions contains a highly significant limitation: communications from a client who consults a private psychiatrist for treatment of mental or emotional illness are privileged, while similar communications from a client to a psychiatric social worker are not privileged. This state of affairs stems from the failure of most evidence codes to provide testimonial immunity for psychiatric social workers who, as the mainstay of the staffs of most public mental health facilities, are virtually the "poor man's psychiatrist."

This Comment analyzes some of the consequences that result from the failure to provide statutory privilege to psychiatric social workers and proposes a number of legal theories courts could use to create or extend the privilege. Section I discusses in detail some of the problems that denial of this privilege creates for both patients and psychiatric social workers. Section II examines the traditional test for determining whether a relationship merits the protection of privilege, and applies it to the psychiatric social worker-patient relationship. Section III advances an argument based on functional similarities between presently privileged professionals and psychiatric social workers. Section IV proposes an argument based on agency principles. Section V discusses the problem from an equal protection perspective, and Section VI proposes an argument based on equitable considerations.

I

THE NEED FOR A PRIVILEGE

The poor rely primarily upon public and charitable facilities for medical, dental, and psychiatric services.[1] Because of the severe shortage of psychologists and psychiatrists,[2] welfare departments and

1. Davidson, *Government's Role in the Economy: Implications for the Relief of Poverty*, 48 J. URBAN L. 1, 36 (1970).

2. COMMUNITY COLLEGE MENTAL HEALTH WORKER PROJECT, ROLES AND FUNCTIONS FOR DIFFERENT LEVELS OF MENTAL HEALTH WORKERS 1 (1969). Some figures will give an indication of the shortage. Over 500,000 school-age children suffer from serious mental illness; less than .5 percent receive adequate care. In a recent year, 40 percent of the qualified applicants of all ages who requested help at outpa-

most public mental health programs cannot provide a fully trained psychiatrist or clinical psychologist for every indigent patient requiring treatment for emotional or mental illness.[3] Yet the need for these services is acute. Mental illness ranks with heart disease and cancer as one of the nation's three greatest health problems.[4] And although the incidence of mental disorders is highest among low-income groups, they receive the least attention.[5]

In response to the great demand for services, mental health agencies have found it necessary to expand the size of their staffs. Since adequate numbers of psychiatrists and clinical psychologists are not available for such assignments, the new positions are frequently filled by psychiatric social workers,[6] particularly in government supported institutions, where the staffing problem is most severe.[7]

Psychiatric social workers are mental health professionals who have received advanced training in the behavioral sciences,[8] but who

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tient psychiatric clinics were put on waiting lists for a period exceeding one year. Weihofen, *Mental Health Services for the Poor*, 54 CALIF. L. REV. 920, 921 (1966) [hereinafter cited as Weihofen].

3. Wittman, *Utilization of Personnel with Various Levels of Training: Implications for Professional Development*, in TRENDS IN SOCIAL WORK 191 (Nat'l Ass'n of Soc. Workers 1966).

4. Weihofen, *supra* note 2, at 920.

5. B. BERELSON & G. STEINER, HUMAN BEHAVIOR: AN INVENTORY OF SCIENTIFIC FINDINGS 639 (1964).

6. By 1960 all states employed psychiatric social workers in mental health programs. U.S. DEP'T OF HEALTH EDUCATION AND WELFARE, HEALTH MANPOWER SOURCE BOOK—MEDICAL AND PSYCHIATRIC SOCIAL WORKERS 28 (1960). By 1967, psychiatric social workers in outpatient clinics were already working more hours per week than psychiatrists and clinical psychologists combined. NATIONAL INSTITUTE OF MENTAL HEALTH, DATA ON STAFF AND MAN-HOURS, OUTPATIENT PSYCHIATRIC CLINICS IN THE UNITED STATES 6-16 (1967).

7. More than 90 percent of all psychiatric social workers are employed by a state-supported facility. NATIONAL ASSOCIATION OF SOCIAL WORKERS, PSYCHIATRIC SOCIAL WORKERS AND MENTAL HEALTH 21 (1960) [hereinafter cited as NAT'L ASS'N OF SOCIAL WORKERS].

8. *Cf.* Calif. Personnel Bd., *Psychiatric Social Worker* 1 (1969) (job description) [hereinafter cited as Calif. Personnel Bd.]. The academic degree that most psychiatric social workers possess is a master's degree. Nationally, 80 percent of psychiatric social workers in public mental health programs have a master's degree or Ph.D. U.S. DEP'T OF HEALTH EDUCATION AND WELFARE, HEALTH MANPOWER SOURCE BOOK, MEDICAL AND PSYCHIATRIC SOCIAL WORKERS 42 (1960). A typical university curriculum for a student preparing for a career as a psychiatric social worker includes courses in the following subjects: developmental psychology; individual, family, and small group practice; psychodynamics and psychopathology; human development and pathology; medical and psychiatric casework; mental health and rehabilitation program planning. UNIVERSITY OF CALIFORNIA (BERKELEY), ANNOUNCEMENT OF THE SCHOOL OF SOCIAL WELFARE 19-22 (1972).

Although other social workers, such as intake workers or caseworkers, may at times deal with intimate and highly personal information, the need for a privilege for

lack the medical background of a psychiatrist. In many instances they perform the same functions as psychiatrists and psychologists.[9] Nevertheless, patients treated by psychiatric social workers do not enjoy the confidentiality privilege that applies to the psychiatrist-patient relationship.[10]

As almost all state legislatures have recognized in enacting statutory privileges for physicians and psychiatrists,[11] successful therapy

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such communications is not as acute as that for communications to psychiatric social workers who work directly with emotionally disturbed patients. These other categories of social worker are not dealt with in this Comment.

9. Many writers describe the work of psychiatric social workers as psychotherapy. *E.g.* R. GRINKER, H. MACGREGOR, K. SELAN, A. KLEIN, & J. KOHRMAN, PSYCHIATRIC SOCIAL WORK 112-32 (1961); J. ALVES, CONFIDENTIALITY IN SOCIAL WORK 97 (1959) [hereinafter cited as ALVES]; *cf.* Calif. Personnel Bd., *supra* note 8, at 1-2. Psychiatric social workers and supervisors of social worker training programs state that the services performed by psychiatric social workers and the techniques utilized by them are indistinguishable from those of psychiatrists and clinical psychologists. *E.g.*, interview with Professor Robert Wasser, School of Social Welfare, University of California, in Berkeley, California, March 1, 1973 [hereinafter cited as Wasser]. In many respects, the question is one of semantics; some would limit the use of the word "psychotherapy" to characterize the work of a medically trained psychiatrist or clinical psychologist. Questions of semantics aside, four propositions are relatively undisputed:

(1) Psychiatric social workers work directly with patients in solving their mental and emotional problems. *Id.*; *see* note 7 *supra*.
(2) In doing so they delve into intimate personal material in a way that requires confidence in order for success to be possible. *Id.*; *see* note 12-16 *infra*.
(3) Their academic training involves extensive study in psychological theory and clinical techniques. *See* note 8 *supra*.
(4) Numerically, they constitute the most significant professional class employed in mental health centers, devoting more hours per week to caring for patients than psychiatrists and psychologists, particularly in clinics that deal with indigents. *See* note 6 *supra*.

10. Many state agencies that provide social services for the poor have adopted confidentiality regulations, sometimes spurred by the requirements of federal funding. Generally, these have failed to command much respect from the courts, which have felt free to ignore or circumvent them when the occasion demanded. *E.g.*, Bell v. Bankers Life & Cas. Co., 327 Ill. App. 321, 64 N.E.2d 204 (1945). For a discussion of the devices used by courts to evade confidentiality requirements that fell short of being full-fledged privilege statutes, see ALVES, *supra* note 9, at 78 *et seq.*; Lo Gatto, *Privileged Communication and the Social Worker*, 8 CATH. LAW. 5 (1962).

11. Statutes providing privilege to the therapist-patient relationship are summarized in Comment, *Privileged Communications: A Case By Case Approach*, 23 MAINE L. REV. 443, 448-50 (1971). Of the 50 states and District of Columbia, 12 lack a privilege for physicians. Psychiatrists ordinarily receive protection under physician statutes, although five states have a separate psychiatrist privilege. (Four of these five are among the 12 states which do not have a privilege for physicians generally.)

All but 15 states and the District of Columbia have a psychologist privilege. Four have statutes conferring privilege upon marriage counselors. One state (New York) provides privilege for certified social workers. California provides privilege for licensed clinical social workers, but not for psychiatric social workers in general.

For a summary of states which have privilege for other relationships, such as clergyman-penitent, see 8 J. WIGMORE, EVIDENCE §§ 2285-2396. (McNaughton rev. 1961).

requires a strong bond of confidentiality.[12] "The psychiatric patient confides more utterly than anyone else in the world. He exposes to the therapist not only what his words directly express; he lays bare his entire self, his dreams . . . his sins, and his shame."[13] Thus, any intimation that information disclosed to the psychotherapist might not be held in confidence can gravely threaten the therapeutic value of the counseling relationship.

> Most patients who undergo psychiatry know that complete candor will be expected of them, and that they cannot get help except on that condition . . . . It would be too much to expect them to [comply with this requirement] if they knew that all they say . . . may be revealed to the whole world.[14]

The threat to the therapeutic value of this relationship is especially great in the treatment of patients from low income groups. These patients tend to be more distrustful of authority figures than their wealthier counterparts.[15] As a result, they generally are more likely to resist psychotherapy,[16] having learned from bitter experience to be wary of official figures who profess to be anxious to "help" them.[17]

The absence of privilege not only jeopardizes the possibility of effective treatment for the patient; it can also deter others from seeking attention.[18] Already there have been numerous cases in which a social worker's testimony has led to criminal sanctions against his client.[19]

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12. *E.g.*, the Legislative Comment accompanying CAL. EVID. CODE § 1014 (West 1968) states:

> Psychoanalysis and psychotherapy are dependent upon the fullest revelation of the most intimate and embarrassing details of the patient's life . . . . Unless a patient . . . is assured that such information can and will be held in utmost confidence, he will be reluctant to make the full disclosure upon which diagnosis and treatment . . . depend.

The Comment adds that the authors had heard reliable reports that patients had refused treatment because of doubts about confidentiality. The authors expressed concern that disturbed individuals, if untreated, might pose a threat to the safety of others. CAL. EVID. CODE § 1014, Legislative Comment (West 1968).

13. M. GUTTMACHER & H. WEIHOFEN, PSYCHIATRY AND THE LAW 272 (1952).

14. *Id.*

15. R. WALD, LAW AND POVERTY: 1965, 6-46 (1965); Rosenheim, *Privilege, Confidentiality, and Juvenile Offenders*, 11 WAYNE L. REV. 660, 669 (1965) [hereinafter cited as Rosenheim].

16. *E.g.*, Weihofen, *supra* note 2, at 925: "Psychiatr[ic care may be] a status symbol in Hollywood, but it [is] . . . a disgrace in Watts . . . ."

17. *Cf.* Gorman, *Psychiatry and Public Policy*, 122 AM. J. OF PSYCHIATRY 55, 58 (1965).

18. *Cf.* Goldstein & Katz, *Psychiatrist-Patient Privilege: The G.A.P. Proposal and the Connecticut Statute*, 118 AM. J. PSYCHIATRY 733, 734 (1961) [hereinafter cited as Goldstein & Katz]; Noble, *Protecting the Public's Privacy in Computerized Health and Welfare Information Systems*, 16 SOCIAL WORK 35, 37 (1971) [hereinafter cited as Noble]. This deterrence phenomenon has been noted in judicial opinions, *e.g.*, Taylor v. United States, 222 F.2d 398, 401 (D.C. Cir. 1955).

19. *See, e.g.*, State v. Plummer, 5 Conn. Cir. 35, 241 A.2d 198 (1967), a

As it becomes known that under certain circumstances the therapist can be compelled to divulge information revealed to him during therapy, prospective clients will become reluctant to seek professional help for mental and emotional problems.

A limitation on privileged communications also creates a significant strain for the psychotherapist who is called to the witness stand. The psychiatric social worker, like the psychiatrist and psychologist, owes allegiance to a professional code of ethics that stresses the importance of preserving the trust of his patients.[20] Requiring him publicly to breach a professional confidence places him in a cross-fire of conflicting demands. The courts demand disclosure while his professional values insist upon secrecy. As a result, when confidentiality has not been protected, mental health professionals called as witnesses have been known to refuse to testify,[21] to fabricate,[22] to have "memory lapses" on the witness stand,[23] or to keep two sets of records.[24]

The denial of privilege also affects the economics of national health care planning. In recent years, the soaring costs of health care have tended to place many forms of medical service beyond the reach

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prosecution for lascivious carriage brought on the basis of information provided by state welfare authorities to the police. Rappeport, *Psychiatrist-Patient Privilege*, 23 MD. L. REV. 39, 46 (1963), describes two unreported cases. In one, the court permitted out-of-state lawyers to view Maryland hospital records. As a result a mother lost custody of her children when the lawyer was able to produce a description in court of her deranged conduct, even though she was then well and saner than her husband, who got the children. In the other case, a minister had his confessions of a college-age love affair—thought to be at least in part fantasy—paraded before his parishioners.

These risks are duly noted by prospective patients. The California Law Revision Commission commented: "[We have] been advised that proper psychotherapy often is denied a patient solely because he will not talk freely to a psychotherapist for fear that the latter may be compelled in a criminal proceeding to reveal what he has been told." 1965 CAL. LAW REV. COMM'N. 195.

20. Mary Richmond, the founder of social work, wrote: "In the whole range of professional contacts there is no more confidential relation than that which exists between the social worker and the person or family receiving treatment." M. RICHMOND, WHAT IS SOCIAL CASE WORK 29 (1922). *See also* NATIONAL WELFARE ASSEMBLY, CONFIDENTIALITY IN SOCIAL SERVICE TO INDIVIDUALS 5, 40 (1958).

21. *In re* Lifschutz, 2 Cal. 3d 415, 467 P.2d 557, 85 Cal. Rptr. 829 (1970); Binder v. Ruvell, Civ. Docket No. 52C2535 (Circ. Ct. Cook County, Ill., June 24, 1952) (reprinted in 150 A.M.A.J. 1241 (1952)). *See* COMMSSIONERS ON REVISION OF THE STATUTES OF NEW YORK, 3 N.Y. REV. STAT. 737 (1836) (quoted in 8 J. WIGMORE, EVIDENCE § 2380 (a), at 829 (McNaughton rev. 1961) [hereinafter cited as 8 WIGMORE]; Slovenko, *Psychiatry and a Second Look at the Medical Privilege*, 6 WAYNE L. REV. 175, 196 (1960).

22. Fisher, *The Psychotherapeutic Professions and the Law of Privileged Communications*, 10 WAYNE L. REV. 609, 627-29 (1963). *See* note 23 *infra.*

23. Interview with psychiatric social worker section, Bayview Mental Health Center, San Francisco, California, on April 24, 1973.

24. *Id. Cf.* GROUP FOR THE ADVANCEMENT OF PSYCHIATRY, REPORT NO. 45 92, 96 (1960) [hereinafter cited as G.A.P.].

of growing numbers of middle- and low-income families.[25] To counter this trend, paramedical specialists, who perform limited functions formerly performed by physicians or psychiatrists, increasingly are being employed in many medical fields, including mental health.[26] Some of the nontherapeutic functions now performed by certain psychiatric social workers, such as preparation of preadmission diagnostic work-ups in a clinic or hospital,[27] are clearly paramedical in nature. Many of these paramedical functions require the psychiatric social worker to process information that should be held in confidence. Public acceptance of the psychiatric social worker will be imperiled, however, if a patient's communications with him cannot enjoy the same degree of legal protection as those with the psychiatrist or clinical psychologist. Without privilege, the psychiatric social worker will be regarded by his patients as a second-class practitioner, well-meaning and sincere, perhaps, but incapable of protecting their interests. Under such circumstances they will naturally be unable to place full confidence in him. To the extent that this results, the movement to make health care more widely available through utilization of paraprofessionals will be adversely affected.

A second, related development—the team approach to health care—is similarly jeopardized when psychiatric social workers are denied privilege. Mental health facilities, like those of other medical specialties, increasingly have been using an approach in which teams of specialists from many fields coordinate their expertise in the treatment of the patient.[28] This technique makes possible more efficient treatment and results in a higher standard of health care.[29] In many mental health clinics, these integrated teams include psychiatric social workers.[30] However, of all the team members—clinical psychologists, psy-

25. REPORT OF THE NAT'L ADVISORY COMM'N ON HEALTH MANPOWER 15-32 (1967); Gorman, *Psychiatry and Public Policy*, 122 AM. J. OF PSYCHIATRY 55, 57 (1965).

26. Forgotson, Roemer, and Newman, *Innovations in the Organization of Health Services: Inhibitive vs. Permissive Regulation*, 1967 WASH. U.L.Q. 400, 400-01 (1967). *See* U.S. DEP'T OF HEALTH, EDUCATION AND WELFARE, HEALTH MANPOWER SOURCE BOOK 21—ALLIED HEALTH MANPOWER SUPPLY AND REQUIREMENTS: 1950-1980 at 9 (1970); NAT'L COMM'N ON COMMUNITY HEALTH SERVICES, HEALTH IS A COMMUNITY AFFAIR 22 (1967).

27. *See* A. FINK, C. ANDERSON, & M. CONOVER, THE FIELD OF SOCIAL WORK 235-37 (1968) [hereinafter cited as A. FINK]; CALIF. DEP'T OF MENTAL HYGIENE, PROFESSIONAL SOCIAL WORKERS IN MENTAL HEALTH PROGRAMS 4-71 [hereinafter cited as CALIF. DEP'T OF MENTAL HYGIENE].

28. Goldstein & Katz, *supra* note 18, at 736.

29. Judicial notice of this practice, acknowledging its positive effect on efficiency, was taken in Wyatt v. Stickney, 325 F. Supp. 781, 783 (M.D. Ala. 1971).

30. "Psychiatric social workers are a key group participating in every phase of the department's program—treatment, rehabilitation, training, [and] research . . . ." CALIF. DEP'T OF MENTAL HYGIENE, *supra* note 27, at 1.

chiatrists, physicians, and psychiatric social workers—only the social worker lacks privilege. This omission creates a weak link that effectively neutralizes the protection afforded communications to the other professionals; the nonprivileged social worker can become a conduit through which otherwise privileged information can flow.[31] This leak threatens the successful application of team treatment techniques.

Thus, it is evident that the failure to provide a statutory privilege[32] for communications to psychiatric social workers creates serious problems. The remainder of this Comment reviews the various legal grounds that can be used by the courts to extend the privilege to psychiatric social workers.

II

THE TRADITIONAL TEST FOR EXTENDING PRIVILEGE

Privilege is typically a matter of statutory creation.[33] On appropriate occasions, however, courts have been willing to create privileges in the absence of a statute.[34] Wigmore developed the classic test for determining when a relationship merits the protection of confidentiality:[35]

(1) The communication must have been imparted in confidence that it would not be disclosed to others.

(2) The preservation of secrecy must be essential to the success of the relationship.

(3) The relationship must be one that society wishes to foster and protect.

(4) Any injury to the relationship caused by disclosure must out-

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"As an active contributor to diagnostic procedures, planning, and treatment [the psychiatric social worker is] a professional partner of other specialists—psychiatrists, nonpsychiatric physicians, psychologists . . . ." *Id.* at 2.

"Within the clinic, the psychiatric social worker maintains direct contact with the other team members to insure close interdisciplinary communication." NAT'L ASS'N OF SOCIAL WORKERS, *supra* note 7, at 17.

31. *See* material cited note 19 *supra*. *Cf.* Lewis, *Confidentiality in the Community Mental Health Center*, 37 AM. J. ORTHOPSYCHIATRY 946, 948 (1967).

32. The problem can be readily solved by legislative action, and in the long run this would be the best solution. This could be accomplished by simply adding "or psychiatric social worker" to the statute providing privilege to psychotherapists. If greater narrowness is desired, the qualification, "when performing psychotherapy of a nonmedical nature," could be added. *See* CAL. EVID. CODE § 1010(c) (West Supp. 1973).

33. *E.g.*, CAL. EVID. CODE § 911 (West 1968). *Cf.* 8 WIGMORE, *supra* note 21, § 2286(2), at 532.

34. *E.g.*, Binder v. Ruvell, Civ. Docket No. 52C2535 (Circ. Ct. Cook County, Ill., June 24, 1952) (reprinted in 150 A.M.A.J. 1241 (1952)); *Re* Kryschuk and Zulynik, 14 D.L.R.2d 676, 677 (Police Magis. Ct., Sask. 1958).

35. 8 WIGMORE, *supra* note 21, § 2285, at 527.

weigh the expected benefit to be derived from compelling disclosure.

In jurisdictions lacking privilege statutes, courts have consistently referred to these criteria when deciding whether to grant or deny privilege in specific instances.[36] The test has been rigorously applied; in a majority of the cases, courts have held that the criteria, particularly the fourth, were not satisfied.[37] Of the handful of cases in which a privilege has been judicially extended in this manner, however, at least two involved members of the counseling and therapeutic professions.[38] And the commentators have concluded that therapy, when conducted by responsible, licensed professionals, is a relationship that satisfies Wigmore's criteria.[39]

In applying Wigmore's test to the relationship between a psychiatric social worker and his client, it is evident that all the requirements are met. Communications between a psychiatric social worker and his patients are imparted in the expectation of deepest confidence. The authorities agree that therapy requires complete candor of the patient, who must reveal compulsions, fantasies, fears, obsessions, and guilt feelings of such a private nature that he probably has never revealed them before, even to his closest friends.[40] No one would make revelations of this nature without the expectation that they would be held in confidence.

Also, preservation of confidentiality is essential to the success of the relationship. Without the security of a strong foundation of trust, the client will be unwilling, sometimes unable, to cooperate with his therapist in bringing to the surface painful repressed material, or in participating uninhibitedly in therapeutic measures designed to hasten his recovery.[41]

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36. *E.g.*, Falsone v. United States, 205 F.2d 734, 740 (5th Cir. 1953); State v. Smythe, 25 Wash. 2d 161, 168, 169 P.2d 706, 710 (1946).

37. *E.g.*, State v. Smythe, 25 Wash. 2d 161, 169-70, 169 P.2d 706, 711 (1946).

38. *See* cases cited note 34 *supra*.

39. *E.g.*, Louisell & Sinclair, *The Supreme Court of California 1969-1970, Foreword: Reflections on the Law of Privileged Communications—The Psychotherapist-Patient Privilege in Perspective*, 59 CALIF. L. REV. 30, 52 (1971) [hereinafter cited as Louisell & Sinclair]; Slovenko, *Psychiatry and a Second Look at the Medical Privilege*, 6 WAYNE L. REV. 175, 184-99 (1960).

40. In fact, the success of a psychiatric social worker is often measured by the extent to which he obtains a flow of private thoughts and feelings. *Cf.* Dembitz, *Ferment and Experiment in New York: Juvenile Cases in the New Family Court*, 48 CORNELL L.Q. 499, 521 (1963).

41. *E.g.*, Taylor v. United States, 222 F.2d 398, 401 (D.C. Cir. 1955): "In regard to mental patients, the policy behind such [privilege] statutes is particularly clear and strong. Many physical ailments might be treated with some degree of effectiveness by a doctor whom the patient did not trust, but a [psychotherapist] must have his patient's confidence or he cannot help him." *See also* notes 39 *supra* & 100 *infra*.

Moreover, successful therapy is so critically needed in our anxiety-ridden society that there can be little doubt that the injury that can result from disclosure outweighs the burden a privilege would impose on the courts' fact-finding machinery.[42] This conclusion has already been reached by the legislatures of a large majority of states which have granted the privilege to psychiatrists and psychologists.[43] When psychiatric social workers provide the same socially useful service as is now provided by these other professionals,[44] the state's failure to enact comparable legal protections for the benefit of their patients risks severe impairment of their ability to provide service.

One concern that might arise if the courts grant privilege to psychiatric social workers is that unqualified, self-appointed "therapists"—faith healers, meditators, and the like—might launch demands for recognition.[45] This does not present an insurmountable problem, however. In enacting privilege statutes legislatures have consistently distinguished between professions that have achieved some form of official state recognition or control,[46] such as through licensing laws or establishment of a state occupational category, and those that have not. Since most psychiatric social workers are employed in state facilities,[47] and are thus subject to state control and supervision, privilege could be provided for those psychiatric social workers but withheld from marginal groups which are not recognized or regulated by the state.

Consequently, on the basis of the four classic criteria, and with the understanding that privilege can be limited to recognized, licensed professionals, the courts should grant the privilege of confidentiality to psychiatric social workers.

III

Extension Based on Functional Similarities

Therapy is a clinical function. It can be performed by members of a number of professional groups—psychiatrists, clinical psycholo-

42. G.A.P. *supra* note 24, at 93, 95; *Louisell & Sinclair, supra* note 39, at 53. *See also* note 100 *infra*.

43. *See* note 11 *supra*.

44. *See* text accompanying note 9 *supra*.

45. Reportedly, the reason the drafters of the Uniform Rules of Evidence did not choose to extend privilege to "family counseling and that sort of thing" is that "we can not open the door . . . to uncontrolled groups." Comment, *Functional Overlap Between the Lawyer and Other Professionals*, 71 YALE L.J. 1226, 1241 n.99 (1962).

46. Geiser & Rheingold, *Psychology and the Legal Process: Testimonial Privileged Communications*, 19 AM. PSYCHOLOGIST, 831, 834-35 (1967) [hereinafter cited as Geiser & Rheingold]; 1964 CAL. LAW REV. COMM'N, 437-38; Louisell, *The Psychologist in Today's Legal World: Part II*, 41 MINN. L. REV. 731, 733-35 (1957).

47. *See* note 7 *supra*.

gists, and family physicians—who have the privilege of confidentiality in a majority of American jurisdictions.[48] Since it is the therapeutic function that the law of privilege is designed to protect, rather than any particular set of favored individuals, there is little justification for extending privileged status to these groups but not to psychiatric social workers, when the job specifications of the latter also include administering therapy to psychologically disturbed people.[49]

Functional considerations are not unknown to the law. Indeed, they figured prominently in the deliberations of at least one group charged with drafting legislation relating to medical privilege. When the revisers of the California Evidence Code extended the psychotherapist privilege, first to psychologists, then to licensed clinical social workers, they were influenced by the conviction that it would be illogical and invidious to provide privilege to one group but to deny it to another performing essentially the same function.[50]

A functional approach is not too technical to serve as a guide for judicial decision-making, nor need it burden the courts with a flood of litigation. On the contrary, courts have always been ready to look behind an individual's nominal title in order to determine whether the function he was actually performing warranted the protection of privilege. Courts have refused to permit a physician or attorney to invoke privilege when it was clear that he was not really performing medical or legal services. For example, courts have denied privilege to a lawyer who was in reality serving as a tax consultant or general business advisor.[51] On the other hand, courts have granted privilege when the function performed, while outside the normal range of a professional's duties, was nonetheless entitled to privilege on some other ground.[52]

An additional reason for extending privilege to patients of psychiatric social workers is the need, discussed earlier, to work toward a more rational system of manpower allocation in the field of public health.[53]

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48. *See* note 11 *supra*. Communications with clergymen, when acting as counselors, are also often privileged.

49. *See* notes 8, 9 *supra*.

50. Interview with Prof. Sho Sato, Professor of Law, University of California, past Vice Chairman, California Law Revision Commission, in Berkeley, California, Sept. 22, 1972.

51. Olender v. United States, 210 F.2d 795, 806 (9th Cir. 1954); R.C.A. v. Rowland Corp., 18 F.R.D. 440 (N.D. Ill. 1955); *In re* Fisher, 51 F.2d 424, 425 (S.D.N.Y. 1934).

52. Simrin v. Simrin, 233 Cal. App. 2d 90, 43 Cal. Rptr. 376 (2d Dist. 1965) involved a rabbi who performed marriage counseling. His work was held not to fall under the state's priest-penitent privilege statute, which limited coverage to confessions, but was nonetheless granted privileged status by virtue of its confidential nature as counseling. There was no statute providing privilege for counselors generally.

53. Recent thinking in this area urges that the health professions be viewed as a matrix in which duties and responsibilities are allocated on the basis of actual

Where psychiatric social workers are urgently needed to perform essential functions, courts should not hesitate to invoke the doctrine of functional identities in order to supply them with the legal safeguards necessary to perform those functions effectively. Failure to do so impedes the attainment of a rational delivery system for mental health care, one which maximizes the effectiveness of each practitioner by assigning duties in accordance with functional capacity rather than categorical title.

IV

AGENCY CONSIDERATIONS

Under conventional agency principles, communications directed to the assistant or agent of a physician are privileged to the extent they would have been had they been directed to the physician himself.[54] Thus, courts in many jurisdictions have expanded the privilege to encompass communications made to nurses and attendants when they work under the direction or supervision of a physician,[55] to medical interns when they take medical histories of patients,[56] and, in a slightly different context, to lay draft counselors when they perform counseling services in a center under the direction of a clergyman.[57]

Similarly, communications from patients to psychiatric social workers administering therapy under the direction of a supervisor covered by the privilege should also be privileged under this rule. Many psychiatric social workers interview patients and family members in order to help determine which patients are to be admitted to mental health facilities and which are ready to be discharged.[58] In doing so, they usually answer to the physician in charge of admitting and

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capacity for performing specific tasks—measured by training, experience, and demonstrated capacity—rather than by possession of a nominal title. Forgotson, Bradley, & Ballenger, *Health Services for the Poor—the Manpower Problem: Innovations and the Law*, 1970 WISC. L. REV. 756, 767 [hereinafter cited as Forgotson, Bradley & Ballenger.]

54. *See* cases cited notes 55-56 *infra*. This rule finds support in the treatises, *e.g.*, 8 WIGMORE, *supra* note 21, at § 2382; model codes, *see* UNIFORM RULES OF EVIDENCE rule 27 (1953); MODEL CODE OF EVIDENCE rule 221(c) ii (1942); and the evidence codes of many states, *e.g.*, CAL. EVID. CODE § 1012 (West Supp. 1973).

55. State v. Bryant, 5 N.C. App. 21, 167 S.E.2d 841 (1969); Ostrowski v. Mockridge, 242 Minn. 265, 65 N.W.2d 185 (1954); Mississippi Power & Light Co. v. Jordan, 164 Miss. 174, 143 So. 483 (1932). *Contra*, Weis v. Weis, 147 Ohio St. 416, 72 N.E.2d 245 (1947).

56. Franklin Life Ins. Co. v. William J. Champion & Co., 353 F.2d 919 (6th Cir. 1965).

57. *In re* Grand Jury Subpoena for Gordon Verplank, 329 F. Supp. 433 (C.D. Cal. 1971).

58. CALIF. DEPT. OF MENTAL HYGIENE, *supra* note 27, at 1-4; Rosenheim, *supra* note 15, at 666.

discharging patients. Other psychiatric social workers work directly with patients in outpatient clinics, in consultation with a director who is a psychiatrist.[59] In both cases, communications received by the social worker should be privileged under the agency principle.[60] Of course, psychiatric social workers who practice independently would not receive privilege under this rule, and some social workers might qualify for privilege in connection with some of their duties but not others.

V

EQUAL PROTECTION

Denial of privilege to patients of psychiatric social workers may even attain constitutional dimension under the guarantee of equal protection. In general, courts have gone to great lengths to ensure that citizens receive fair and even-handed treatment from the government.[61] Although the scope of equal protection review has been limited to some extent by certain decisions,[62] recent Supreme Court opinions have reaffirmed the vitality of this important constitutional principle.[63]

A. Compelling State Interest

Patients who use community and welfare services for treatment of mental or emotional problems do so primarily because they are poor.[64] At these facilities they ordinarily find themselves directed to the care of a psychiatric social worker,[65] with the consequent threat of com-

59. A. FINK, *supra* note 27, at 235. The increased flexibility and range afforded by agency principles is something on which the high-powered but overworked modern physician increasingly has come to rely. Today's highly trained medical specialist would feel enormously handicapped if, in order to protect the legal rights of his patients, he found it necessary personally to take charge of all aspects of their care. *E.g.*, Eureka-Maryland Assur. Co. v. Gray, 121 F.2d 104 (D.C. Cir.), *cert. denied*, 314 U.S. 613 (1941). As was discussed earlier, delegation and the team approach have proven effective and efficient means of dealing with community health problems. Where psychiatric social workers play a vital role in the treatment of patients, they too are entitled to this protection.

60. In similar circumstances, hospital records compiled by staff members for use by the hospital's physicians were held to be confidential. O'Donnell v. O'Donnell, 142 Neb. 706, 712, 7 N.W.2d 647, 650 (1943).

61. *See* cases cited notes 69-73 *infra*.

62. *E.g.*, Dandridge v. Williams, 397 U.S. 471 (1970).

63. San Antonio Independent School District v. Rodriguez, 93 S. Ct. 1278 (1973).

64. *See* note 1 *supra* & note 67 *infra*. Indeed, the great majority of these treatment facilities apply a financial test in screening prospective patients. An applicant who can afford private treatment is not accepted; or, a sliding fee scale is used which favors the destitute and encourages those who can afford private treatment to go elsewhere. Wasser, *supra* note 7.

65. *See* notes 6 & 7 *supra*.

pelled disclosure. A patient who can afford to engage the services of a private psychiatrist or clinical psychologist, however, does not run the risk that the confidences he reveals will be divulged.[66] Thus, the ability to pay is the major determinant of the extent to which a patient in therapy receives assurance of confidential treatment.[67] A significant form of protection is linked to the financial status of the patient.[68]

Classifications based on wealth occupy a disfavored place in equal protection law[69] and have been struck down in such contexts as criminal justice,[70] sentencing procedure,[71] and the right to vote.[72] Recent state court cases have even applied equal protection scrutiny to medical practices that imposed a greater burden upon indigents than others.[73]

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66. *See* note 11 *supra.*

67. The financial test that is frequently required at public treatment centers, [*see* note 64 *supra*] insures a very close correspondence between the class of all indigent mental patients and those who receive treatment from psychiatric social workers. For a recent discussion of the requirement of a close "fit" or correlation between the classes affected, see San Antonio Independent School District v. Rodriguez, 93 S. Ct. 1278, 1288-94 (1973).

In general, "[t]he kinds of care provided in psychiatric facilities is a function of the socio-economic level of the patient. The private psychiatrist is most likely to treat the most prosperous; state facilities, the working class." A. HOLLINGSHEAD & F. REDLICH, SOCIAL CLASS AND MENTAL ILLNESS: A COMPARATIVE STUDY 276-78 (1958). *See also* note 1 *supra.*

68. And, the loss of protection is absolute, rather than merely relative. *See* San Antonio Independent School District v. Rodriguez, 93 S. Ct. 1278, 1288-92 (1973). Patients who cannot afford a very expensive commodity—private psychiatry—are denied the benefit of privilege while those who can are accorded the full protection of the law.

69. *E.g.*, San Antonio Independent School District v. Rodriguez, 93 S. Ct. 1278 (1973) and cases cited notes 70-72 *infra.* For a broad discussion of this doctrine, *see generally Developments in the Law—Equal Protection*, 82 HARV. L. REV. 1065, 1121-24 (1969) [hereinafter cited as *Developments in the Law*]; *cf.* Michelson, *The Supreme Court, 1968 Term—Foreword*, 83 HARV. L. REV. 7, 17 (1969).

70. Douglas v. California, 372 U.S. 353 (1963); Griffin v. United States, 351 U.S. 12 (1956).

71. Tate v. Short, 401 U.S. 395 (1971); Williams v. Illinois, 399 U.S. 235 (1970).

72. Harper v. Virginia Bd. of Elections, 383 U.S. 663 (1966).

73. In New York City v. Wyman, 66 Misc. 2d 402, 321 N.Y.S.2d 695 (Sup. Ct. N.Y Co. 1971), the court struck down a regulation that required indigent women on Medicare who desired an abortion to first prove that an abortion was medically indicated; other women not on Medicare were not required to prove this. The court held the requirement discriminatory in that it tended to deprive low-income women of an opportunity freely available to others. Although this case was subsequently reversed, 30 N.Y.2d 537, 330 N.Y.S.2d 385, 281 N.E.2d 180 (1972), the decision is reported in a memorandum opinion and the grounds for reversal are uncertain. Schulman v. New York City Health and Hospital Corp., 70 Misc. 1093, 335 N.Y.S.2d 343 (Sup. Ct. 1972), another recent case, arose out of a requirement by the health department that abortion certificates bear the name of the patient. Finding that the city had no compelling reason for the requirement, the court struck down the regulation as an invasion of the patient's right to privacy, a violation of her patient-physician

The Supreme Court recently discussed poverty as a suspect classification in *San Antonio Independent School District v. Rodriguez.*[74] The Court had before it a claim that Texas' scheme for raising revenues for school districts unconstitutionally discriminated against residents of poor districts. Although after lengthy consideration the Court decided that the Texas plan did not discriminate against the poor, it seemed to leave intact the principle that wealth may be a suspect classification.[75] After reviewing past cases involving indigency, the Court developed a twofold test.[76] First, it must appear that the classification singles out a clearly defined group that by reason of its impecunity is unable to pay for a valuable benefit. Second, as a result of the classification, the group must sustain absolute deprivation of a meaningful opportunity to enjoy the benefit.

Both requirements are met in the case of indigent patients of psychiatric social workers. The poor have no realistic access to private psychiatry;[77] and those who receive care at the hands of psychiatric social workers are denied the benefit of privilege.[78] Other traditional indicia of a suspect classification are also very much in evidence in the case of poor persons who suffer from mental illness. They are "saddled with disabilities," "politically powerless," in need of protection from an unconcerned majority,[79] and subject to community stigma.[80] Thus, legislative action that allocates health care benefits in a manner which discriminates against this class should be constitutionally suspect.

Moreover, the interests invaded when privilege is denied—privacy,[81] the right to equal treatment at trial,[82] and, perhaps, access to

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privilege, and a violation of equal protection inasmuch as it placed an extra burden of stigma on single and married women who obtained the operation. Thus, courts have already begun to recognize the principle advanced here—that unequal medical regulations that encroach on important personal rights may violate equal protection.

74. 93 S. Ct. 1278 (1973).

75. *Id.* at 1288-94; *see also id.* at 1311 (Stewart, J., concurring).

76. *Id.* at 1290.

77. *See* notes 1, 67 & 68 *supra.*

78. *See* note 11 *supra.*

79. 93 S. Ct. 1278, at 1294.

80. *Id.* at 1333-36 (Marshall, J., dissenting).

81. Griswold v. Connecticut, 381 U.S. 479 (1965). In *In re* Lifschutz, 2 Cal. 3d 415, 431-32, 85 Cal. Rptr. 829, 839, 467 P.2d 557, 567 (1970) the California Supreme Court, citing *Griswold,* warned of the potential for encroachment upon constitutionally protected rights of privacy by the compelled disclosure of confidential communications between the patient and his psychotherapist.

Where a privilege statute exists, it provides evidence of a public policy in favor of confidentiality. This makes obtaining a civil remedy for invasion of privacy easier for patients injured by out-of-court disclosures and thus helps guarantee that such disclosures will occur less often. Goldstein & Katz, *supra* note 18, at 734 n.4. *Cf.* Racine v. Morris, 201 N.Y. 240, 94 N.E. 864 (1911). The principle of *Racine*—that legislatively created duties may give rise to a private cause of action—has been fol-

lowed in cases involving medical disclosures, *e.g.*, Munzer v. Blaisdell, 183 Misc. 773, 49 N.Y.S.2d 915 (Sup. Ct. 1944), *aff'd* 269 App. Div. [illegible], 58 N.Y.S.2d 359 (1945). Out-of-court disclosures by medical personnel are more [illegible]non than one might think. *See* Erickson & Gilbertson, *Case Records in the M[illegible] Hospital*, in ON RECORD 391, 408-09 (S. Wheeler ed. 1969).

82. *See* cases cited notes 70 & 71 *supra*. *Cf.* San Antonio Independent School District v. Rodriguez, 93 S. Ct. 1278, 1288 (1972). It is established that courts will not tolerate wealth-based classifications that impose unequal burdens on the rich and the poor at trial. Yet this is precisely what occurs when the law permits testimony from the therapist of the poor while forbidding it from the therapist of the well-to-do. Without privilege, of course, many patients will confide very little in their therapist. The therapeutic encounter becomes a guarded, defensive transaction in which the patient gains little (unless the therapist deceives the patient as to the degree of protection provided, *see* Section VI *infra*.). Patients who through naiveté or desperation reveal damaging material to the therapist lose the opportunity at trial to stand on an equal footing with those who can obtain private treatment. The testimony of a therapist can be utterly devastating. Even where a party is ultimately successful in court, permitting his therapist to testify against his wishes can do great damage:

(1) Revelation in a public trial that an individual has undergone psychotherapy can be harmful in itself; recall the Sen. Eagleton affair during the 1972 presidential campaign. Many employers hestitate to hire persons with a history of mental illness, and on a social level, loss of friendships and community esteem can follow public revelation that a person has suffered episodes of mental or emotional derangement.

(2) The range of psychiatric testimony, like that of psychiatric inquiry, can be extremely broad.

> Current . . . practice defines mental illness as something that can have its roots in the patient's earliest years, show its signs throughout the course of his life, and invade almost every sector of his current activity. No segment of his past or present [is] beyond the jurisdiction of psychiatric assessment . . . . While many kinds of organizations maintain records of their members, in almost all of these some . . . attributes can be included only indirectly, being officially irrelevant. But since [psychotherapists] have a legitimate claim to deal with the 'whole person,' they officially recognize no limits to what they consider relevant.

Ericson & Gilbertson, *supra* note 81 at 390. Thus the individual is subject to testimony that can range over great areas of his life.

(3) Not only does the psychiatric record consider the patient's whole life; it selects and chooses events in a way that ordinary records do not. Acts of deviancy challenge the observer to reassess the character of the people responsible for them. A friend is exposed as a homosexual; suddenly past events, chance remarks, and mannerisms begin to stand out; we begin to restructure our impression of the individual. A politician is shot; the next day the newspapers are full of accounts interpreting the background of the would-be assassin. A famous author commits suicide; in the public discussion that follows, a new person emerges. The psychiatric record essentially does the same thing—it "builds a case." The record "is not regularly used, however, to record occasions when the patient showed capacity to cope honorably and effectively with difficult life situations. Nor is the case record typically used to provide a rough average or sampling of [a patient's] past conduct. One of its purposes is to show the ways in which the patient is 'sick' . . . and this is done by extracting from his whole life course a list of those incidents that have or might have had symptomatic significance." *Id.* at 402-03. It is evident that the public revelation of this kind of selectively gathered and interpreted evidence, couched in impressive-sounding scientific terminology, has the capacity of causing the patient irremediable harm. That this risk is imposed on the indigent patients of public mental health facilities but not on the patients of private therapists constitutes an inequity of no small proportions.

medical care[83]—are fundamental.[84] This combination—discrimination on the basis of a suspect class, together with encroachment on fundamental personal interests—generally has failed to withstand constitutional scrutiny unless a compelling state interest can be shown.[85]

It is likely that whatever interests the state might advance to justify a privilege for communications to psychiatrists while withholding it from communications to psychiatric social workers would prove inadequate to support this differential treatment. State health and

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83. While the Supreme Court has never held that health care is a fundamental interest, it has implied that it would hold to be fundamental any commodity that is a prerequisite to the exercise of a fundamental interest, when denial means complete inability to exercise the interest, and when doing so would not open the floodgates. San Antonio Independent School District v. Rodriguez, 93 S. Ct. 1278, 1298-99 (1973). In *Rodriguez* the Court found the nexus between education and certain constitutionally protected liberties to be insufficiently close to warrant invoking strict scrutiny; and it is conceivable that it might come to the same conclusion with respect to health care. However, the case for education was weakened by the relative character of the benefit provided and the imperfect correlation between financial status and the amount of funding made available to "poor" districts, factors that are not present here. *Id.* at 1288-94.

Arguing along lines similar to those suggested by the "nexus" theory, commentators have urged that health care be recognized as a fundamental right. *See, e.g.*, Bendich, *Privacy, Poverty, and the Constitution*, 54 CALIF. L. REV. 407, 420 (1966). Similarly, mental health is a prerequisite to the full exercise of virtually all our most cherished liberties. The right to marry, to vote, to participate in the political process—hope of fully enjoying any of these is denied to emotionally ill patients who cannot secure effective care. Thus, a national commission has urged that medical care be accorded the status of a civil right. NAT'L COMM'N ON COMMUNITY HEALTH SERVICES, HEALTH IS A COMMUNITY AFFAIR 17-37 (1966). Other legal commentaries on medical subjects agree, *e.g.*, Forgotson, Bradley, & Ballenger, *supra* note 53, at 767.

Other authorities believe that effective health care, if not an absolute right, is at least a conditional one: where the state has undertaken to offer treatment, it must accept responsibility for supplying the minimal conditions necessary for making the treatment reasonably effective. Professor David Louisell, a widely respected authority on medical privilege and confidential communications, believes that psychotherapy and privilege are so inseparable that one necessarily implies the other: "The patient's right of confidential communication to his psychodiagnostician . . . is a function of his right to obtain such services. If he has a right to obtain such services, he has a correlative right to the essential confidentiality of communication." Louisell, *The Psychotherapist in Today's Legal World*, 41 MINN. L. REV. 731, 744 (1957). A recent decision by a federal circuit court announced a right to adequate rehabilitation for mentally ill patients housed in state facilities. It found that the state, having assumed the responsibility of providing services, could not maintain patients in a state of limbo for long periods of time without providing effective treatment. The opinion spoke of a constitutional right to receive "such individual habilitation as [would] give each of [the patients] a realistic opportunity to lead a more useful and meaningful life . . . ." Wyatt v. Stickney, 344 F. Supp. 387, 390 (M.D. Ala. 1972).

84. For a discussion of the fundamental-interest doctrine, *see, e.g.*, Dunn v. Blumstein, 405 U.S. 330, 336-42 (1972); Shapiro v. Thompson, 394 U.S. 618, 629-31 (1969). *Cf. Developments in the Law, supra* note 69, at 1120-21.

85. *See generally Developments in the Law, supra* note 69, at 1124.

welfare administrators might urge, for example, that they should be free to compile and circulate reports concerning patients without the trouble and expense of ensuring confidential handling of the records of those undergoing therapy. A mere saving in administrative efficiency, however, has been held not to constitute a compelling state interest when essential personal freedoms were at stake.[86] And, as a practical matter, this suggestion makes little sense since the relatively slight administrative gain is clearly outweighed by the potential damage to the entire therapeutic program that could result from one or two well-publicized exposures.[87]

Alternatively, the state might allege that it is necessary to treat as nonconfidential mental health data gathered from public treatment centers in order to facilitate research into the causes and conditions of mental illness, delinquency, and marital discord. This interest, however, could be served by a narrowly drawn research clause,[88] permitting the state to carry out research without forfeiting the substantial benefits of privilege, particularly that of protection against disclosure in court. In addition, most, if not all, legitimate research purposes can be served by supplying data in anonymous form, or, where individualized data are essential, by the use of coded records.[89]

Another possible state interest is protection of the state fisc. It could be argued that in order to remove violators from the welfare rolls, social workers must be able to report violations of eligibility rules when these come to their attention during therapy. Protection of the state fisc, however, has likewise failed to prevail in cases involving fundamental personal rights.[90] Moreover, withholding the confidentiality privilege is not necessary to protect the state's interest; other, more effective, means are available for discovering and verifying eligibility violations than depending on leads developed in the course of therapy.[91] Thus, while the interest might have some legitimacy when applied to ordinary caseworkers or intake workers,[92] its importance is

86. Shapiro v. Thompson, 394 U.S. 618 (1969). When deprivation of an important right is threatened, the state must be ready to bear the burden of a less onerous but higher-cost alternative. Carrington v. Rash, 380 U.S. 89, 95 (1965).

87. Goldstein & Katz, *supra* note 18, at 733; note 19 *supra*.

88. *See, e.g.*, CAL. EVID. CODE § 1011 (West 1968). *Cf.* Griffin v. Medical Soc'y, 7 Misc. 2d 549, 11 N.Y.S.2d 109 (Sup. Ct. 1939). For an exposition of the "less onerous alternative" doctrine, *see, e.g.*, Shelton v. Tucker, 364 U.S. 479 (1960).

89. A. MILLER, THE ASSAULT ON PRIVACY 239-57 (1971). California, for example, has instituted a number of such measures designed to protect the privacy of research subjects. *See* Noble, *supra* note 18, at 38-39.

90. Shapiro v. Thompson, 394 U.S. 618 (1969); Douglas v. California, 372 U.S. 353 (1963).

91. For example, home visits, periodic use of questionnaires, and cross-checking with the I.R.S. and other agencies are possible alternatives.

92. *See* note 8 *supra*.

outweighed by countervailing interests in the case of psychiatric social workers.

A further state interest, discussed earlier,[93] is the desire to discourage the practice of psychotherapy by charlatans and well-meaning but unqualified amateurs. It could be argued that extending privilege to an additional class makes it more difficult to resist subsequent claims by new groups for privileged status. As was observed, however, this purpose can be served by drawing the line to include only groups whose legitimacy has received state recognition through licensing statutes or the establishment of a state job category.[94] With state control and supervision the danger of quackery would be minimal, and a ready means for resisting premature claims by new groups would be available.

Given the impressive array of reasons favoring extension of the privilege to patients of psychiatric social workers, the relative insubstantiality of the interests the state seeks to protect, and the manner in which the statutory scheme discriminates against a suspect class, it is unlikely that the state will be able to satisfy the compelling interest standard required to justify the inequity currently perpetrated by most privilege statutes.

B. The Rationality Test

Even if the courts do not apply the compelling interest standard of equal protection review, however, withholding the privilege of confidentiality from patients of psychiatric social workers probably cannot survive under the less stringent rational basis test.[95]

Under the rational basis standard, legitimate reform measures need not solve every aspect of a problem.[96] Nor is a statute void if it might possibly fail to achieve its desired effect.[97] Nevertheless, a claim that a classification is rational may be defeated by showing that the classification cannot further the purpose underlying the legislation.[98]

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93. *See* text accompanying notes 45-47 *supra*.

94. *Id.*

95. *I.e.*, a reasonable relationship must exist between the purpose of the legislation and the classification provided by the statute. *E.g.*, Royster Guano Co. v. Virginia, 253 U.S. 412, 415 (1920).

96. San Antonio Independent School District v. Rodriguez, 93 S. Ct. 1278, 1299-1300 (1973); Dandridge v. Williams, 397 U.S. 471, 485-86 (1970).

97. Roschen v. Ward, 279 U.S. 337, 339 (1929).

98. *E.g.*, Police Dept. of the City of Chicago v. Mosley, 408 U.S. 92, 95 (1972); Weber v. Aetna Cas. & Ins. Co., 406 U.S. 164, 172 (1972); Eisenstadt v. Baird, 405 U.S. 438, 453-55 (1972); Morey v. Doud, 354 U.S. 457, 467-68 (1957). *See Developments in the Law—Equal Protection*, *supra* note 69, at 1083. *Cf.* Comment, *Legislative Purpose, Rationality, and Equal Protection*, 82 YALE L.J. 123, 151-54 (1972) for an excellent discussion of legislatively mandated goals.

Thus the limitation on the therapist-patient privilege could be found irrational, since the failure to recognize a psychiatric social worker-patient privilege is inconsistent with the policies behind the therapy privilege statutes[99] and legislation establishing mental health programs for the poor. The purpose of privilege statutes is to facilitate success in treatment.[100] Since medical authorities universally recognize that breaching a patient's confidence virtually eliminates any hope of improving his condition through therapy,[101] any measure that requires the disclosure of confidential communications for the sake of efficiency or some other extrinsic value jeopardizes the entire therapeutic program.

Moreover, extending a greater degree of protection to private patients than to indigents not only fails to achieve the legislative goals, it is invidious as well. One common definition of a rational classification is "one which includes all persons who are similarly situated with respect to the purpose of the law."[102] If privilege statutes exist in order to encourage the free flow of thoughts and feelings essential for the therapeutic relationship,[103] there is no rational justification for assuming that this need is less in the case of indigent patients. On the contrary, it is generally recognized that the need for trust and confidence is greatest in dealing with the poor.[104]

Thus, the classification suffers from lack of rationality in two key respects. It fails to promote its legislative objective and it draws a distinction between the wealthy and the poor that is arbitrary and counterproductive.

VI

EQUITABLE CONSIDERATIONS: REASONABLE BELIEF AND PRIVILEGE BY ESTOPPEL

The government owes a duty to those in its care to ensure that

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99. *See* text accompanying notes 12-14 *supra*.

100. *E.g.*, C. MCCORMICK, EVIDENCE 213 (2d ed. E. Cleary ed. 1972) states this as the rule with respect to physicians generally. As to psychotherapy:

> Although it is recognized that the granting of a privilege may operate in particular cases to withhold relevant information, the interests of society will be better served if psychiatrists are able to assure patients that their confidences will be protected.

CAL. EVID. CODE § 1014, at 232, *Legisl. Comment* (West 1968). Accordingly, many states have enacted statutes providing privilege to many professions whose members perform a similar function, *e.g.*, psychiatrists, psychologists, clergymen, and school counselors. *See* note 11 *supra*. The state's interest in providing effective mental health treatment is also evident from its huge investment in personnel and physical facilities. *See* notes 4-6 *supra* and accompanying text.

101. *See* notes 12-14 *supra*.

102. Tussman & tenBroek, *The Equal Protection of the Laws*, 37 CALIF. L. REV. 341, 346 (1949).

103. *See* text accompanying note 13 *supra*.

104. *See* notes 15-17 *supra*.

their constitutional rights are not violated as a result of the intimidating disparity between their own power and that of their governmental custodians.[105] The state must take particular care when it is dealing with persons who by reason of their poverty, lack of education, and unfamiliarity with bureaucratic structures cannot be expected effectively to understand and protect their own interests.

Poor people are ordinarily not familiar with the subtle differences among psychiatrists, clinical psychologists, licensed clinical social workers, and psychiatric social workers.[106]

The state job specifications of psychiatric social workers set out duties[107] that cannot be carried out successfully without first establishing a confidential relationship with the client. Indeed, psychiatric social workers are required by their professional code to provide an atmosphere of trust.[108] Thus, it is inevitable that many patients of state-employed psychiatric social workers will receive the impression, from nonverbal clues and suggestions if not from overt assurances,[109] that their communications will be held in confidence. When state agencies hire psychiatric social workers knowing of their professional commitment to confidentiality, and when they assign them duties which require such confidentiality to be performed successfully,[110] the state must assume a share of responsibility for fostering in the minds of many unsophisticated patients the belief that communications to the therapist will remain private.

Given the state's responsibility for creating this impression, it would be inconsistent and inequitable for the state to assert, in a criminal proceeding, for example, that privilege does not exist.[111] Accordingly, even if patients of psychiatric social workers cannot claim privilege as a matter of right, courts should invoke their broad equitable powers and refuse to countenance such assertions.[112]

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105. *E.g.*, Miranda v. Arizona, 384 U.S. 436, 457-72 (1966).

106. These categories may be meaningful to the well-educated clientele of private psychotherapists, but their implications are not readily perceived and appreciated by the poor and the ill-educated. Consequently, they are frequently unaware of the differences these distinctions entail with respect to their rights under the law of evidence. Interview with Bernard Diamond, Psychiatrist, Professor of Law and Criminology, University of California, in Berkeley, California, January 4, 1973.

107. *See* notes 8, 9 *supra*.

108. *See* note 20 *supra*.

109. The social worker often expressly assures the patient that his communications will be held in confidence. J. ALVES, *supra* note 9, at 92. Even without overt assurances, many patients will assume that their communications will be held confidential. Geiser & Rheingold, *supra* note 46, at 836.

110. *See* text accompanying notes 12-17 *supra*.

111. *Cf.* Smart v. Kansas City, 208 Mo. 162, 105 S.W. 709 (1907).

112. At one time, it was widely believed that the government could not be estopped by acts of its agents. *See, e.g.*, Federal Crop Insurance Corp. v. Merrill, 332

The importance of protecting patients' legitimate expectations of privacy has been acknowledged by a number of jurisdictions. In these states, statutory provisions afford privilege to persons who, though technically not entitled to privilege, reasonably believed they were consulting an authorized medical practitioner. For example, the California Evidence Code provides for protection of persons who consult an individual reasonably believed to be a psychiatrist or physician.[113] Voluminous case law from many jurisdictions supports this rule,[114] as do many of the model codes.[115] Thus, whenever patients are led to believe that the person with whom they are dealing is a psychiatrist, they should be able to claim privilege when their mistake is a reasonable inference from the circumstances or manner in which they are treated.[116]

CONCLUSION

Many writers oppose the creation of new privileges on the ground that they inhibit the ability of courts to ascertain the truth.[117] Truth,

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U.S. 380 (1947). In all likelihood the former reluctance of courts to consider estoppel against the government rested on an unstated belief that the state treasury should not be bled in order to redeem an erroneous promise extended by a public official. In the present situation, though, financial considerations are not especially prominent; the government suffers little financial harm if it should decide to honor the expectations of privacy developed by indigent patients as a result of the therapeutic encounter. A further ground of distinction lies in the fact that in *Merrill* the government's agent acted "wrongly" toward both the government, in misrepresenting its position, and toward the farmer, in inducing him to rely on nonexistent forms of protection. Here, however, it is the government that has acted wrongly toward both parties. It has furnished a situation in which the patient is deluded into believing that he will be dealt with confidentially. And it has placed the social worker in the position of having to represent that he can provide the patient with a security that in actuality he cannot guarantee. Thus the equities in both respects—financial cost and fair play—lie more strongly in favor of estoppel here than they did in *Merrill*. In similar situations, modern courts have upheld claims of estoppel when the necessary elements of deception and detriment were present. They have been particularly sympathetic to claims in which public officers have acted, as they have here, in the exercise of a power or duty expressly conferred upon them by statute. *E.g.*, United States v. Certain Parcels of Land, 131 F. Supp. 65, 74 (S.D. Cal. 1955) and cases cited therein.

113. CAL. EVID. CODE § 1010 (West Supp. 1973). Other states have similar provisions, *e.g.*, ILL. REV. STAT. ch. 51 § 5.2 (West Supp. 1973).

114. *E.g.*, People v. Decina, 2 N.Y.2d 133, 138 N.E.2d 799, 157 N.Y.S.2d 558 (1956); Ballard v. Yellow Cab Co., 20 Wash. 2d 67, 145 P.2d 1019 (1944); People v. Barker, 60 Mich. 277, 27 N.W. 539 (1886).

115. UNIFORM RULES OF EVIDENCE rule 27 (1953); MODEL CODE OF EVIDENCE rule 220(b) (1942).

116. Seemingly, these statutes would only protect a patient who believed that his therapist was a psychiatrist, *i.e.*, cases where the patient's error is a mistake of fact. Mistakes of law, where the patient knows his therapist is a psychiatric social worker but thinks psychiatric social workers have privilege, would fall outside this rule, although there seems to be no reason in logic or policy for this distinction.

117. *E.g.*, C. MCCORMICK, EVIDENCE 159 (2d ed. E. Cleary ed. 1972).

however, may be pursued at too great a cost.[118] The recent growth in the number of legislatively created privileges reflects society's belief that certain relationships are so important that they must remain inviolate even in the face of demands by the judicial system.

The relationship between a psychiatric social worker and his patient, while currently unprotected by legislation, is such a relationship. It is in the best interest of society that it be protected. Legislatures should act in this critical area. Until they do, existing legal doctrines may be used to provide remedies where they are needed.

Richard Delgado

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118. Pearse v. Morse, 1 De G. & Sm. 28-29, 16 L.J. Ch. 153 (1846).

Memo 79-63 Exhibit5

Article 7

PSYCHOTHERAPIST-PATIENT PRIVILEGE

Section

1010. "Psychotherapist."
1011. "Patient."
1012. "Confidential communication between patient and psychotherapist."
1013. "Holder of the privilege."
1014. Psychotherapist-patient privilege.
1014.5. Privilege of professional person rendering treatment to minor under Section 25.9 of Civil Code
1015. When psychotherapist required to claim privilege.
1016. Exception: Patient-litigant exception.
1017. Exception: Court-appointed psychotherapist.
1018. Exception: Crime or tort.
1019. Exception: Parties claiming through deceased patient.
1020. Exception: Breach of duty arising out of psychotherapist-patient relationship.
1021. Exception: Intention of deceased patient concerning writing affecting property interest.
1022. Exception: Validity of writing affecting property interest.
1023. Exception: Proceeding to determine sanity of criminal defendant.
1024. Exception: Patient dangerous to himself or others.
1025. Exception: Proceeding to establish competence.
1026. Exception: Required report.
1027. Privilege nonexistent; patient child under 16 or victim of crime [New].
1028. Criminal proceedings [New].

§ 1010. "Psychotherapist"

As used in this article, "psychotherapist" means:

(a) A person authorized, or reasonably believed by the patient to be authorized, to practice medicine in any state or nation who devotes, or is reasonably believed by the patient to devote, a substantial portion of his time to the practice of psychiatry;

(b) A person licensed as a psychologist under Chapter 6.6 (commencing with Section 2900) of Division 2 of the Business and Professions Code;

(c) A person licensed as a clinical social worker under Article 4 (commencing with Section 9040) of Chapter 17 of Division 3 of the Business and Professions Code, when he is engaged in applied psychotherapy of a nonmedical nature.

(d) A person who is serving as a school psychologist and holds a credential authorizing such service issued by the state.

(e) A person licensed as a marriage, family and child counselor under Chapter 4 (commencing with Section 17800) of Part 3, Division 5 of the Business and Professions Code.

(Amended by Stats.1967, c. 1677, p. 4211, § 3; Stats.1970, c. 1396, p. 2624, § 1.5; Stats.1970, c. 1397, p. 2620, § 1.5; Stats.1972, c. 888, p. 1584, § 1; Stats.1974, c. 545, p. 1359, § 16.)

Comment—Law Revision Commission

1965 Enactment

A "psychotherapist" is defined to include only a person who is or who is reasonably believed to be a psychiatrist or who is a California certified psychologist (see Bus. & Prof. Code § 2900 et seq.). See the Comment to Section 990.

§ 1011. "Patient". As used in this article, "patient" means a person who consults a psychotherapist or submits to an examination by a psychotherapist for the purpose of securing a diagnosis or preventive, palliative, or curative treatment of his mental or emotional condition or who submits to an examination of his mental or emotional condition for the purpose of scientific research on mental or emotional problems. (Stats.1965, c. 299, § 1011.)

Comment—Assembly Committee on Judiciary

See the Comment to Section 991. Section 1011 is comparable to Section 991 (physician-patient privilege) except that the definition of "patient" in Section 1011 includes not only persons seeking diagnosis or treatment of a mental or emotional condition but also persons who submit to examination for purposes of psychiatric or psychological research. See the Comment to Section 1014.

§ 1012. "Confidential communication between patient and psychotherapist"

As used in this article, "confidential communication between patient and psychotherapist" means information, including information obtained by an examination of the patient, transmitted between a patient and his psychotherapist in the course of that relationship and in confidence by a means which, so far as the patient is aware, discloses the information to no third persons other than those who are present to further the interest of the patient in the consultation * * *, or those to whom disclosure is reasonably necessary for the transmission of the information or the accomplishment of the purpose * * * for which the psychotherapist is consulted, and includes a diagnosis made and the advice given by the psychotherapist in the course of that relationship.

(Amended by Stats.1967, c. 650, p. 2006, § 5; Stats.1970, c. 1396, p. 2625, § 2; Stats. 1970, c. 1397, p. 2627, § 2.)

Comment—Law Revision Commission

1965 Enactment

See the Comment to Section 992.

1967 Amendment

The express inclusion of "a diagnosis" in the last clause will preclude a possible construction of this section that would leave an uncommunicated diagnosis unprotected by the privilege. Such a construction would virtually destroy the privilege.

§ 1013. "Holder of the privilege". As used in this article, "holder of the privilege" means:

(a) The patient when he has no guardian or conservator.

(b) A guardian or conservator of the patient when the patient has a guardian or conservator.

(c) The personal representative of the patient if the patient is dead. (Stats.1965, c. 299, § 1013.)

Comment—Law Revision Commission

See the Comment to Section 993.

§ 1014. Psychotherapist-patient privilege; application to individuals and entities

Subject to Section 912 and except as otherwise provided in this article, the patient, whether or not a party, has a privilege to refuse to disclose, and to prevent another from disclosing, a confidential communication between patient and psychotherapist if the privilege is claimed by:

(a) The holder of the privilege;

(b) A person who is authorized to claim the privilege by the holder of the privilege; or

(c) The person who was the psychotherapist at the time of the confidential communication, but such person may not claim the privilege if there is no holder of the privilege in existence or if he is otherwise instructed by a person authorized to permit disclosure.

The relationship of a psychotherapist and patient shall exist between a psychological corporation as defined in Article 9 (commencing with Section 2995) of Chapter 6.6 of Division 2 of the Business and Professions Code or a licensed clinical social workers corporation as defined in Article 5 (commencing with Section 9070) of Chapter 17 of Division 3 of the Business and Professions Code, and the patient to whom it renders professional services, as well as between such patients and psychotherapists employed by such corporations to render services to such patients. The word "persons" as used in this subdivision includes partnerships, corporations, associations * * * and other groups and entities.

(Amended by Stats.1969, c. 1436, p. 2943, § 1; Stats.1972, c. 1286, p. 2569, § 6.)

Comment—Senate Committee on Judiciary

This article creates a psychotherapist-patient privilege that provides much broader protection than the physician-patient privilege.

Psychiatrists now have only the physician-patient privilege which is enjoyed by physicians generally. On the other hand, persons who consult certified psychologists have a much broader privilege under Business and Professions Code Section 2904 (superseded by the Evidence Code). There is no rational basis for this distinction.

A broad privilege should apply to both psychiatrists and certified psychologists. Psychoanalysis and psychotherapy are dependent upon the fullest revelation of the most intimate and embarrassing details of the patient's life. Research on mental or emotional problems requires similar disclosure. Unless a patient or research subject is assured that such information can and will be held in utmost confidence, he will be reluctant to make the full disclosure upon which diagnosis and treatment or complete and accurate research depends.

The Law Revision Commission has received several reliable reports that persons in need of treatment sometimes refuse such treatment from psychiatrists because the confidentiality of their communications cannot be assured under existing law. Many of these persons are seriously disturbed and constitute threats to other persons in the community. Accordingly, this article establishes a new privilege that grants to patients of psychiatrists a privilege much broader in scope than the ordinary physician-patient privilege. Although it is recognized that the granting of the privilege may operate in particular cases to withhold relevant information, the interests of society will be better served if psychiatrists are able to assure patients that their confidences will be protected.

The Commission has also been informed that adequate research cannot be carried on in this field unless persons examined in connection therewith can be guaranteed that their disclosures will be kept confidential.

The privilege also applies to psychologists and supersedes the psychologist-patient privilege provided in Section 2904 of the Business and Professions Code. The new privilege is one for psychotherapists generally.

Generally, the privilege provided by this article follows the physician-patient privilege, and the Comments to Sections 990 through 1007 are pertinent. The following differences, however, should be noted:

(1) The psychotherapist-patient privilege applies in all proceedings. The physician-patient privilege does not apply in criminal proceedings. This difference in the scope of the two privileges is based on the fact that the Law Revision Commission has been advised that proper psychotherapy often is denied a patient

solely because he will not talk freely to a psychotherapist for fear that the latter may be compelled in a criminal proceeding to reveal what he has been told. The Commission has also been advised that research in this field will be unduly hampered unless the privilege is available in criminal proceedings.

Although the psychotherapist-patient privilege applies in a criminal proceeding, the privilege is not available to a defendant who puts his mental or emotional condition in issue, as, for example, by a plea of insanity or a claim of diminished responsibility. See Evidence Code §§ 1016 and 1023. In such a proceeding, the trier of fact should have available to it all information that can be obtained in regard to the defendant's mental or emotional condition. That evidence can often be furnished by the psychotherapist who examined or treated the patient-defendant.

(2) There is an exception in the physician-patient privilege for commitment or guardianship proceedings for the patient. Evidence Code § 1004. Section 1024 provides a considerably narrower exception in the psychotherapist-patient privilege.

(3) The physician-patient privilege does not apply in civil actions for damages arising out of the patient's criminal conduct. Evidence Code § 999. Nor does it apply in certain administrative proceedings. Evidence Code § 1007. No similar exceptions are provided in the psychotherapist-patient privilege. These exceptions appear in the physician-patient privilege because that privilege does not apply in criminal proceedings. See Evidence Code § 998. Therefore, an exception is also created for comparable civil and administrative cases. The psychotherapist-patient privilege, however, does apply in criminal cases; hence, there is no similar exception in administrative proceedings or civil actions involving the patient's criminal conduct.

§ 1014.5. Privilege of professional person rendering treatment to minor under Section 25.9 of Civil Code

1014.5. Notwithstanding any other provision of law, with respect to situations in which a minor has requested and been given mental health treatment or counseling pursuant to Section 25.9 of the Civil Code, the professional person rendering such mental health treatment or counseling has the psychotherapist-patient privilege.
(Enacted by Stats. 1979, Ch. 832, § 2)

Note. Section 25.9 of the Civil Code reads:

25.9. (a) Notwithstanding any other provision of law, a minor who has attained the age of 12 years who, in the opinion of the attending professional person, is mature enough to participate intelligently in mental health treatment or counseling on an outpatient basis, and (1) would present a danger of serious physical or mental harm to himself or herself or to others without such mental health treatment or counseling, or (2) has been the alleged victim of incest or child abuse, may give consent to the furnishing of such outpatient services. Such consent shall not be subject to disaffirmance because of minority. The consent of the parent, parents, or the legal guardian of the minor shall not be necessary to authorize the provision of such services. Mental health treatment or counseling of a minor as authorized by this section shall include the involvement of the minor's parent, parents, or legal guardian, unless in the opinion of the professional person who is treating or counseling the minor, such involvement would be inappropriate. Such person shall state in the client record whether and when he or she attempted to contact the parent, parents, or legal guardian of the minor, and whether such attempt to contact was successful or

unsuccessful, or the reason why, in his or her opinion, it would be inappropriate to contact the parent, parents, or legal guardian of the minor.

(b) The parent, parents, or legal guardian of a minor shall not be liable for payment for any such mental health treatment or counseling services, as provided in subdivision (a), unless such parent, parents, or legal guardian participates in the mental health treatment or counseling and then only for the services rendered with such participation.

(c) As used in this section "mental health treatment or counseling services" means the provision of mental health treatment or counseling on an outpatient basis by any governmental agency, by a person or agency having a contract with a governmental agency to provide such services, by any agency which receives funding from community united funds, by runaway houses and crisis resolution centers, or by any private mental health professional, as defined in subdivision (d).

(d) As used in this section "professional person" means a person designated as a mental health professional in Sections 622 to 626, inclusive, of Article 8 of Subchapter 3 of Chapter 1 of Title 9 of the California Administrative Code; marriage, family, and child counselors as defined in Chapter 4 (commencing with Section 17800) of Part 3 of Division 7 of the Business and Professions Code; licensed educational psychologists as defined in Article 5 (commencing with Section 17860) of Chapter 4 of Part 3 of Division 7 of the Business and Professions Code; credentialed school psychologists as defined in Section 49424 of the Education Code; clinical psychologists, as defined in Section 1316.5 of the Health and Safety Code; and the chief administrators of any agency referred to in subdivision (c).

(e) The provisions of this section shall not be construed to authorize a minor to receive convulsive therapy or psychosurgery as defined in subdivisions (f) and (g) of Section 5325 of the Welfare and Institutions Code, or psychotropic drugs without the consent of his or her parent or guardian.

§ 1015. When psychotherapist required to claim privilege. The psychotherapist who received or made a communication subject to the privilege under this article shall claim the privilege whenever he is present when the communication is sought to be disclosed and is authorized to claim the privilege under subdivision (c) of Section 1014. (Stats.1965, c. 299, § 1015.)

Comment—Law Revision Commission

See the Comment to Section 995.

§ 1016. Exception: Patient-litigant exception. There is no privilege under this article as to a communication relevant to an issue concerning the mental or emotional condition of the patient if such issue has been tendered by:

(a) The patient;

(b) Any party claiming through or under the patient;

(c) Any party claiming as a beneficiary of the patient through a contract to which the patient is or was a party; or

(d) The plaintiff in an action brought under Section 376 or 377 of the Code of Civil Procedure for damages for the injury or death of the patient. (Stats.1965, c. 299, § 1016.)

Comment—Law Revision Commission

See the Comment to Section 996.

§ 1017. Exception: Court-appointed psychotherapist

There is no privilege under this article if the psychotherapist is appointed by order of a court to examine the patient, but this exception does not apply where the psychotherapist is appointed by order of the court upon the request of the lawyer for the defendant in a criminal proceeding in order to provide the lawyer with information needed so that he may advise the defendant whether to enter or withdraw a plea based on insanity or to present a defense based on his mental or emotional condition.

(As amended Stats.1967, c. 650, p. 2007, § 8.)

Comment—Law Revision Commission

1965 Enactment

Section 1017 provides an exception to the psychotherapist-patient privilege if the psychotherapist is appointed by order of a court to examine the patient. Generally, where the relationship of psychotherapist and patient is created by court order, there is not a sufficiently confidential relationship to warrant extending the privilege to communications made in the course of that relationship. Moreover, when the psychotherapist is appointed by the court, it is most often for the purpose of having the psychotherapist testify concerning his conclusions as to the patient's condition. It would be inappropriate to have the privilege apply in this situation. See generally 35 Ops.Cal.Atty.Gen. 226 (1960), regarding the unavailability of the present physician-patient privilege under these circumstances.

On the other hand, it is essential that the privilege apply where the psychotherapist is appointed by order of the court to provide the defendant's lawyer with information needed so that he may advise the defendant whether to enter a plea based on insanity or to present a defense based on his mental or emotional condition. If the defendant determines not to tender the issue of his mental or emotional condition, the privilege will protect the confidentiality of the communication between him and his court-appointed psychotherapist. If, however, the defendant determines to tender this issue—by a plea of not guilty by reason of insanity, by presenting a defense based on his mental or emotional condition, or by raising the question of his sanity at the time of the trial—the exceptions provided in Sections 1016 and 1023 make the privilege unavailable to prevent disclosure of the communications between the defendant and the psychotherapist.

1967 Amendment

The words "or withdraw" are added to Section 1017 to make it clear that the psychotherapist-patient privilege applies in a case where the defendant in a criminal proceeding enters a plea based on insanity, submits to an examination by a court-appointed psychotherapist, and later withdraws the plea based on insanity prior to the trial on that issue. In such case, since the defendant does not tender an issue based on his mental or emotional condition at the trial, the privilege should remain applicable. Of course, if the defendant determines to go to trial on the plea based on insanity, the psychotherapist-patient privilege will not be applicable. See Section 1016.

It should be noted that violation of the constitutional right to counsel may require the exclusion of evidence that is not privileged under this article; and, even in cases where this constitutional right is not violated, the protection that this right affords may require certain procedural safeguards in the examination procedure and a limiting instruction if the psychotherapist's testimony is admitted. See In re

Spencer, 63 Cal.2d 400, 46 Cal.Rptr. 753, 406 P.2d 33 (1965).

It is important to recognize that the attorney-client privilege may provide protection in some cases where an exception to the psychotherapist-patient privilege is applicable. See Section 952 and the *Comment* thereto. See also Sections 912(d) and 954 and the *Comments* thereto.

§ 1018. Exception: Crime or tort. There is no privilege under this article if the services of the psychotherapist were sought or obtained to enable or aid anyone to commit or plan to commit a crime or a tort or to escape detection or apprehension after the commission of a crime or a tort. (Stats.1965, c. 299, § 1018.)

Comment—Law Revision Commission

See the Comment to Section 997.

§ 1019. Exception: Parties claiming through deceased patient. There is no privilege under this article as to a communication relevant to an issue between parties all of whom claim through a deceased patient, regardless of whether the claims are by testate or intestate succession or by inter vivos transaction. (Stats.1965, c. 299, § 1019.)

Comment—Law Revision Commission

See the Comment to Section 957.

§ 1020. Exception: Breach of duty arising out of psychotherapist-patient relationship. There is no privilege under this article as to a communication relevant to an issue of breach, by the psychotherapist or by the patient, of a duty arising out of the psychotherapist-patient relationship. (Stats.1965, c. 299, § 1020.)

Comment—Law Revision Commission

See the Comment to Section 958.

§ 1021. Exception: Intention of deceased patient concerning writing affecting property interest. There is no privilege under this article as to a communication relevant to an issue concerning the intention of a patient, now deceased, with respect to a deed of conveyance, will, or other writing, executed by the patient, purporting to affect an interest in property. (Stats.1965, c. 299, § 1021.)

Comment—Law Revision Commission

See the Comment to Section 1002.

§ 1022. Exception: Validity of writing affecting property interest. There is no privilege under this article as to a communication relevant to an issue concerning the validity of a deed of conveyance, will, or other writing, executed by a patient, now deceased, purporting to affect an interest in property. (Stats.1965, c. 299, § 1022.)

Comment—Law Revision Commission

See the Comment to Section 1002.

§ 1023. Exception: Proceeding to determine sanity of criminal defendant. There is no privilege under this article in a proceeding under Chapter 6 (commencing with Section 1367) of Title 10 of Part 2 of the Penal Code initiated at the request of the defendant in a criminal action to determine his sanity. (Stats.1965, c. 299, § 1023.)

Comment—Law Revision Commission

Section 1023 is included to make it clear that the psychotherapist-patient privilege does not apply when the defendant raises the issue of his sanity at the time of trial. The section probably is unnecessary because the exception provided by Section 1016 is broad enough to cover this situation.

§ 1024. Exception: Patient dangerous to himself or others. 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. (Stats.1965, c. 299, § 1024.)

Comment—Law Revision Commission

This section provides a narrower exception to the psychotherapist-patient privilege than the comparable exceptions provided by Section 982 (privilege for confidential marital communications) and Section 1004 (physician-patient privilege). Although this 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.

§ 1025. Exception: Proceeding to establish competence. There is no privilege under this article in a proceeding brought by or on behalf of the patient to establish his competence. (Stats.1965, c. 299, § 1025.)

Comment—Law Revision Commission

See the Comment to Section 1005.

§ 1026. Exception: Required report. There is no privilege under this article as to information that the psychotherapist or the patient is required to report to a public employee or as to information required to be recorded in a public office, if such report or record is open to public inspection. (Stats.1965, c. 299, § 1026.)

Comment—Law Revision Commission

See the Comment to Section 1006.

§ 1027. Privilege nonexistent; patient child under 16 or victim of crime

There is no privilege under this article if all of the following circumstances exist:

(a) The patient is a child under the age of 16.

(b) The psychotherapist has reasonable cause to believe that the patient has been the victim of a crime and that disclosure of the communication is in the best interest of the child.

(Added by Stats.1970, c. 1396, p. 2625, § 3; Stats.1970, c. 1397, p. 2627, § 3.)

Law Revision Commission Comment

1970 Addition

Section 1027 provides an exception to the psychotherapist-patient privilege that is analogous to the exception provided by Section 1024 (patient dangerous to himself or others). The exception provided by Section 1027 is necessary to permit court disclosure of communications to a psychotherapist by a child who has been the victim of a crime (such as child abuse) in a proceeding in which the commission of such crime is a subject of inquiry. Although the exception provided by Section 1027 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 the victim of a crime and that disclosure of the communication would be in the best interest of the child.

§ 1028. Criminal proceedings

Unless the psychotherapist is a person described in subdivision (a) or (b) of Section 1010, there is no privilege under this article in a criminal proceeding.

(Added by Stats.1970, c. 1396, p. 2625, § 4; Stats.1970, c. 1397, p. 2627, § 4.)

STATE OF CALIFORNIA

CALIFORNIA LAW REVISION COMMISSION

REVISED

RECOMMENDATION

relating to

Psychotherapist-Patient Privilege

November 1979

CALIFORNIA LAW REVISION COMMISSION
Stanford Law School
Stanford, California 94305

To: THE HONORABLE EDMUND G. BROWN JR.
Governor of California and
THE LEGISLATURE OF CALIFORNIA

The Evidence Code was enacted in 1965 upon recommendation of the California Law Revision Commission. Pursuant to legislative authority of Resolution Chapter 130 of the Statutes of 1965, the Commission has maintained a continuing review of the Evidence Code to determine whether any technical or substantive changes are necessary.

As a result of this continuing review, the Commission submitted a recommendation to the 1978 Legislature relating to the psychotherapist-patient privilege. See Recommendation Relating to Psychotherapist-Patient Privilege, 14 Cal. L. Revision Comm'n Reports 127 (1978). The recommendation proposed to expand the scope of the privilege to cover patients of certain psychotherapists who are not now covered by the privilege, to make clear that family and group therapy are included within the privilege, to repeal the exception for "criminal proceedings" (the application of which under existing law depends on the type of psychotherapist making or receiving the confidential communication), and to make technical revisions in the provisions relating to professional corporations.

Assembly Bill No. 2517 was introduced by Assemblyman Imbrecht at the 1978 legislative session to effectuate the recommendation. The bill passed the Legislature but was vetoed by the Governor.

In preparing this new recommendation, the Commission has considered the Governor's veto message and other communications the Commission received concerning Assembly Bill No. 2517. The Commission has also reviewed the provisions of Chapter 832 of the Statutes of 1979. Chapter 832 made significant and important improvements in the protection provided minors under the psychotherapist-patient privilege. Although these improvements deal to some extent with the problems dealt with in the Commission's earlier recommendation, the Commission has concluded that legislation is still required to remedy deficiencies in the existing psychotherapist-patient provisions of the Evidence Code.

The proposed legislation contained in this new recommendation is the same as Assembly Bill No. 2517 as it passed the Legislature in 1978. This recommendation is the same as the earlier recommendation except that this recommendation adds a provision to codify the rule that the psychotherapist-patient privilege protects a parent or other third party who provides confidential information to a psychotherapist which is necessary for the diagnosis or treatment of a patient. This provision was included in Assembly Bill No. 2517 in the form in which it passed the Legislature in 1978.

Respectfully submitted,

Beatrice P. Lawson
Chairperson

RECOMMENDATION

relating to

PSYCHOTHERAPIST–PATIENT PRIVILEGE

The Evidence Code provisions relating to the psychotherapist–patient privilege were enacted in 1965[1] upon recommendation of the California Law Revision Commission.[2] These provisions have been the subject of several subsequent Commission recommendations, with the result that they have been amended and supplemented a number of times.[3] In the course of its continuing study of the law relating to evidence, the Commission has reviewed the psychotherapist–patient privilege in the light of recent law review articles,[4] monographs and other communications received by the Commission,[5] and the

[1] 1965 Cal. Stats., Ch. 299. As originally enacted, the psychotherapist–patient privilege was contained in Sections 1010–1026 of the Evidence Code. Sections 1027 and 1028 were added by legislation enacted in 1970. Unless otherwise noted, all section references herein are to the Evidence Code.

[2] See *Recommendation Proposing an Evidence Code*, 7 Cal. L. Revision Comm'n Reports 1 (1965). For the Commission's background study on the psychotherapist–patient privilege, see *A Privilege Not Covered by the Uniform Rules—Psychotherapist–Patient Privilege*, 6 Cal. L. Revision Comm'n Reports 417 (1964).

[3] See *Recommendation Relating to the Evidence Code: Number 1—Evidence Code Revisions*, 8 Cal. L. Revision Comm'n Reports 101 (1967); *Recommendation Relating to the Evidence Code: Number 4—Revision of the Privileges Article*, 9 Cal. L. Revision Comm'n Reports 501 (1969); *Recommendation Relating to the Evidence Code: Number 5—Revisions of the Evidence Code*, 9 Cal. L. Revision Comm'n Reports 137 (1969). See also 1967 Cal. Stats., Ch. 650; 1970 Cal. Stats., Chs. 1396, 1397. A number of other amendments have been made in these provisions to conform to other recent enactments.

[4] See, *e.g.*, Louisell & Sinclair, *Reflections on the Law of Privileged Communications—The Psychotherapist–Patient Privilege in Perspective*, 59 Calif. L. Rev. 30 (1971); Comment, *Underprivileged Communications: Extension of the Psychotherapist–Patient Privilege to Patients of Psychiatric Social Workers*, 61 Calif. L. Rev. 1050 (1973); *Supreme Court of California 1972–1973, Psychotherapist–Patient Privilege*, 62 Calif. L. Rev. 406, 604 (1974); Comment, *California Evidence Code Section 771: Conflict with Privileged Communications*, 6 Pac. L.J. 612 (1975); Comment, *Tarasoff v. Regents of the University of California: Psychotherapists, Policemen and the Duty to Warn—An Unreasonable Extention of the Common Law?* 6 Golden Gate L. Rev. 229 (1975); (131) Note, Untangling Tarasoff: Tarasoff v. Regents of The University of California, 29 Hast. L. J. 179, 194-96 (1977); Comment, Discovery of Psychotherapist-Patient Communications After Tarasoff, 15 San Diego L. Rev. 265 (1978).

[5] See, *e.g.*, Letter, dated May 23, 1975, from Professor John Kaplan, Stanford Law School, on file in the Commission's offices. Professor Jack Friedenthal prepared a background study for the Commission. The coverage of the study includes the psychotherapist–patient privilege. See Friedenthal, Analysis of Differences Between the Federal Rules of Evidence and the California Evidence Code (mimeo 1976). The Commission has also had the benefit of an unpublished paper by Robert Plattner, The California Psychotherapist–Patient Privilege (Stanford Law School 1975).

Section 1014.5 was added by legislation enacted in 1979.

1979 Cal. Stats., Ch 832.

and letter, dated February 16, 1978, from Justice Robert Kingsley, Court of Appeal, Second District, both letters

The Commission has also reviewed the provisions of Chapter 832 of the Statutes of 1979, which gives the protection of the psychotherapist-patient privilege to various professionals who provide mental health treatment or counseling to a minor.

Federal Rules of Evidence.[6] As a result of this review, the Commission has determined that a number of revisions in the scope of the psychotherapist–patient privilege are desirable.

The Commission recognizes that any extension of the scope of protection afforded confidential communications necessarily handicaps the court or jury in its effort to make a correct determination of the facts. Hence, the social utility of any new privilege or of any extension of an existing privilege must be weighed against the social detriment inherent in the calculated suppression of relevant evidence. Applying this criterion to the psychotherapist–patient privilege, the Commission is persuaded that protection afforded by the psychotherapist–patient privilege is unduly limited and therefore makes the following recommendations.

Psychologists Licensed in Other Jurisdictions

Section 1010(b) of the Evidence Code includes within the psychotherapist–patient privilege psychologists licensed in California.[7] However, a psychologist licensed or certified in another state or nation may give treatment in California.[8] For this reason, Section 1010(b) should be broadened to include the patient of a psychologist licensed or certified in another state or nation.[9] This expansion will conform subdivision (b) to subdivision (a) which covers a patient of a psychiatrist authorized to practice in "any state or nation."

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[6] The Federal Rules of Evidence do not contain a statutory psychotherapist–patient privilege. See Rule 501. However, the Supreme Court Advisory Committee's proposed rules included a statutory privilege with notes thereon. See Proposed Federal Rules of Evidence, Rule 504 (J. Schmertz ed. 1974). The Commission has consulted the proposed rules and notes in preparing this recommendation.

[7] Section 1010(b) requires licensure under Chapter 6.6 (commencing with Section 2900) of Division 2 of the Business and Professions Code (psychologists).

[8] Business and Professions Code Section 2912 provides:

2912. Nothing in this chapter shall be construed to restrict or prevent a person who is licensed or certified as a psychologist in another state or territory of the United States or in a foreign country or province from offering psychological services in this state for a period not to exceed 30 days in any calendar year.

[9] For a comparable recommendation, see Supreme Court Advisory Committee's Note to Section 504 of the Proposed Federal Rules of Evidence (J. Schmertz ed. 1974).

Psychologists Employed by Nonprofit Community Agencies

Subdivision (d) of Section 2909 of the Business and Professions Code authorizes a nonprofit community agency which receives a minimum of 25 percent of its financial support from federal, state, and local governmental sources to employ unlicensed psychologists to provide psychological services to patients served by the agency. These psychologists must be registered with the Psychology Examining Committee at the time of employment[10] and must possess an earned doctorate degree in psychology or in educational psychology or a doctorate degree deemed equivalent by regulation adopted by the committee.[11] In addition, they must have one year or more of professional experience of a type which the committee determines will competently and safely permit them to engage in rendering psychological services. In view of these stringent requirements and the need to provide protection to patients who utilize the services of nonprofit community agencies for psychotherapeutic treatment, the scope of the psychotherapist–patient privilege should be extended to include patients of the psychologists described above.

Licensed Educational Psychologists

Legislation enacted in 1970 provides for the licensure of educational psychologists.[12] A licensed educational psychologist may engage in private practice and provide substantially the same services as school psychologists who are already included within the psychotherapist–patient privilege.[13] The qualifications for a licensed educational psychologist are more stringent than for a school psychologist, the licensed educational psychologist being required to have three years of full–time experience as a

[10] The exemption from the licensing requirement is for a maximum of two years from the date of registration.

[11] The degree must be obtained from the University of California, Stanford University, the University of Southern California, or from another educational institution approved by the committee as offering a comparable program.

[12] See Article 5 (commencing with Section 17860) of Chapter 4 of Part 3 of Division 7 of the Business and Professions Code (licensed educational psychologists), enacted by 1970 Cal. Stats., Ch. 1305, § 5.

[13] See Evid. Code § 1010(d).

credentialed school psychologist in the public schools or experience which the examining board deems equivalent.[14] For these reasons, the psychotherapist–patient privilege should be broadened to include the licensed educational psychologist. This would be consistent with Evidence Code Section 1014.5, which was enacted in 1979[14a] and extends the psychotherapist-patient privilege to a licensed educational psychologist who provides mental health treatment or counseling to a minor under Civil Code Section 25.9.[14b]

Psychiatric Social Workers

Section 1014.5 of the Evidence Code extends the psychotherapist-patient privilege to social workers having not less than two years of post-Masters experience in a mental health setting[14c] when providing mental health treatment or counseling to a minor under Civil Code Section 25.9. Except to this limited extent, the psychotherapist–patient privilege does not now apply to psychiatric social workers.[15] The psychiatric social worker is an important source of applied psychotherapy of a nonmedical nature in public health facilities.[16] By excluding psychiatric social workers, the existing privilege statute denies the protection of the privilege to those who rely on psychiatric social workers for psychotherapeutic aid. To provide equality of treatment, the Commission recommends expansion of the psychotherapist–patient privilege to include all patients receiving psychotherapy from psychiatric social workers. This would expand the existing privilege to cover not only all minors (covered to some extent under existing Section 1014.5) but also adults and family members treated by a psychiatric social worker. To assure adequate qualifications for the psychiatric social worker, the expanded privilege should be limited to (1) those psychiatric social workers who are employed by the state and (2) those psychiatric social workers who have not less than the minimum qualifications required of a state psychiatric social worker[17] and work in a city, county, or other local mental health facility that is operated as a part of the approved county Short–Doyle Plan.[18]

[14] Bus. & Prof. Code § 17862.

14a. 1979 Cal. Stats., Ch. 832.

14b. See Civil Code § 25.9(d).

14c. See Civil Code § 25.9(d)(adopting by reference Section 625 of Article 8 of Subchapter 3 of Chapter 1 of Title 9 of the California Administrative Code, defining "social worker").

[15] Belmont v. State Personnel Bd., 36 Cal. App.3d 518, 111 Cal. Rptr. 607 (1974).

[16] See Comment, *Underprivileged Communications: Extension of the Psychotherapist–Patient Privilege to Patients of Psychiatric Social Workers*, 61 Calif. L. Rev. 1050 (1973).

[17] See California State Personnel Board, Specification, Psychiatric Social Worker (rev. 1973).

[18] See Welf. & Inst. Code § 5601. This limitation would not apply to professionals covered by Section 1014.5.

Professional Corporations

Conforming amendments to the Moscone–Knox Professional Corporation Act made clear that the relation of physician and patient exists between a medical corporation and the patient to whom it renders services,[19] but failed to make clear that the relationship of psychotherapist and patient also exists between a medical corporation and the patient to whom it renders services.[20] Likewise, provisions authorizing the formation of a marriage, family, or child counseling corporation neglected to make clear that the relationship of psychotherapist and patient exists between such a corporation and its patient.[21] The application of the psychotherapist–patient privilege to a medical corporation and to a marriage, family, or child counseling corporation should be made clear and the provision located in an appropriate place in the psychotherapist–patient statute.

Group and Family Therapy

There is a question whether the psychotherapist–patient privilege applies in group and family therapy situations. Section 1012 of the Evidence Code defines a confidential communication between patient and psychotherapist to include information transmitted between a patient and psychotherapist "in confidence" and by a means which, so far as the patient is aware, discloses the information to no third persons "other than those who are present to further the interest of the patient in the consultation, or those to whom disclosure is reasonably necessary for . . . the accomplishment of the purpose for which the psychotherapist is consulted." Although these statutory exceptions would seem to include other patients present at group or family therapy treatment,[22] the language might be narrowly construed to make information disclosed at a group or family therapy session not privileged.

In light of the frequent use of group and family therapy, it is important that these forms of treatment be covered by the psychotherapist–patient privilege. Group and family therapy are now used more and more in such important areas as marriage and family problems, juvenile delinquency, and alcoholism. It is a growing and promising

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[19] See 1968 Cal. Stats., Ch. 1375, § 3.

[20] Evidence Code Section 1014 was amended in 1969 to make clear that a psychological corporation is covered and again in 1972 to cover a licensed clinical social workers corporation.

[21] See Article 6 (commencing with Section 17875) of Chapter 4 of Part 3 of Division 7 of the Business and Professions Code, enacted by 1972 Cal. Stats., Ch. 1318, § 1.

[22] *Cf.* Grosslight v. Superior Court, 72 Cal. App.3d 502, 140 Cal. Rptr. 278 (1977) (privilege covers all relevant communications by intimate family members of patient to psychotherapist and to psychiatric personnel, including secretaries, who take histories for the purpose of recording statements for the use of psychotherapist).

form of psychotherapeutic aid and should be encouraged and protected by the privilege.[23] The policy considerations underlying the privilege dictate that it encompass communications made in the course of group and family therapy. Psychotherapy, including group and family therapy, requires the candid revelation of matters that may be not only intimate and embarrassing but also possibly harmful or prejudicial to the patient's interests. The Commission has been advised that persons in need of treatment sometimes refuse group or family therapy because the psychotherapist cannot assure the patient that the confidentiality of his communications will be preserved.[24]

The Commission, therefore, recommends that Section 1012 be amended to make clear that the psychotherapist–patient privilege protects against disclosure of communications made during group and family therapy. It should be noted that, if Section 1012 were so amended, the general restrictions embodied in Section 1012 would apply to group and family therapy. Thus, communications made in the course of group or family therapy would be within the privilege only if they are made in confidence and by a means which discloses the information to no other third persons.

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[23] See, *e.g.*, Note, *Group Therapy and Privileged Communications*, 43 Ind. L.J. 93 (1967); Fisher, *The Psychotherapeutic Professions and the Law of Privileged Communications*, 10 Wayne L. Rev. 609 (1964).

[24] See also Meyer & Smith, A Crisis in Group Therapy, 32 American Psychologist 638 (1977).

Information Provided in Confidence by Third Person

The patient's parents or relatives or other persons may have information the psychotherapist needs in order to diagnose the patient's condition or to provide treatment. The needed information may be information concerning the behavior of the patient,[25] information concerning the person providing the information, or another kind of information. In some cases, further disclosure of the needed information would be detrimental to the person having the information, and the person may be unwilling to disclose the needed information to the psychotherapist unless the person can be protected against further disclosure.

Section 1012 of the Evidence Code should be amended to make clear that the psychotherapist-patient privilege covers information reasonably necessary to the diagnosis or treatment of the patient that is disclosed by another person to the psychotherapist in confidence. This rule is consistent with existing law.[26] To protect against further disclosure of the information, the person disclosing the information should be made a joint holder of the privilege.[27] The right of the person making the disclosure to claim the privilege is, of course, subject to the various exceptions to the privilege[28] and to the Evidence Code provision relating to waiver of the privilege.[29]

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25. See Grosslight v. Superior Court, 72 Cal. App.3d 502, ___ Cal. Rptr. ___ (1977) (communications to psychotherapist by parents concerning their daughter's behavior).

26. See Grosslight v. Superior Court, 72 Cal. App.3d 502, ___ Cal. Rptr. ___ (1977) (communications to psychotherapist by parents concerning their daughter's behavior were within purview of psychotherapist-patient privilege and therefore privileged). No judicial decision has been found indicating whether the privilege extends to nonfamily communications. See Grosslight v. Superior Court, supra, 72 Cal. App.3d at 508, ___ Cal. Rptr. at ___ ("We do not here determine whether the Section 1014 privilege extends to nonfamily communications").

27. See Evid. Code § 912(b) (waiver of the right of one joint holder to claim the privilege does not affect the right of another joint holder to claim the privilege).

28. See Evid. Code §§ 1016 (patient-litigant exemption), 1017 (court-appointed psychotherapist), 1018 (crime or tort exception), 1019 (parties claiming through deceased patient), 1020 (breach of duty arising out of psychotherapist-patient relationship), 1021 (intention of deceased patient concerning writing affecting property interest), 1022 (validity of writing affecting property interest), 1023 (proceeding to determine sanity of criminal defendant), 1024 (patient dangerous to himself or others), 1025 (proceeding to establish competence), 1026 (required report), 1027 (patient child under 16 who is victim of crime).

29. See Evid. Code § 912.

Application of Privilege in Criminal Proceedings

Section 1028 of the Evidence Code makes the psychotherapist–patient privilege applicable in criminal proceedings where the psychotherapist is a psychiatrist or psychologist but inapplicable in criminal proceedings where the psychotherapist is a clinical social worker, school psychologist, or marriage, family, and child counselor.[25] (30) The basis for this distinction is not clear. A patient consulting a psychotherapist expects to receive the benefit of the privilege regardless of the type of psychotherapist consulted; Section 1028 frustrates this expectation in the case of criminal proceedings.

The major effect of Section 1028 is to deny the privilege to patients who consult clinical social workers and marriage, family, and child counselors while preserving the privilege for precisely the same types of communications by patients who consult psychiatrists and psychologists. Section 1028 may also discourage potential patients from seeking treatment for mental and emotional disorders for fear of disclosure of communications in criminal proceedings. This is particularly important in drug addiction cases, but it is important in other cases as well.

Society has an interest in protecting innocent victims from injury by criminal activity, but Section 1028 is not essential to protect this interest; it is adequately protected by two other exceptions to the privilege. Evidence Code Section 1027 denies the privilege where a child under 16 is the victim of a crime and disclosure would be in the best interests of the child. Evidence Code Section 1024 denies the privilege where the patient is dangerous to himself or herself or to others. In addition, the psychotherapist may be personally liable for failure to exercise due care to disclose the communication where disclosure is essential to avert danger to others.[26] (31)

The Commission believes that the harm caused by Section 1028 far outweighs any benefits to society that it provides. The provision should be repealed.

Proposed Legislation

The Commission's recommendations would be effectuated by enactment of the following measure:

An act to amend Sections 1010, 1012, and 1014 of, to add Section 1010.5 to, and to repeal Section 1028 of, the Evidence Code, relating to the psychotherapist–patient privilege.

The people of the State of California do enact as follows:

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(30) Section 1028 provides that, "[u]nless the psychotherapist is a person described in subdivision (a) or (b) of Section 1010, there is no privilege under this article in a criminal proceeding."

(31) Tarasoff v. Regents of University of California, 17 Cal.3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

Evidence Code § 1010 (amended)

SECTION 1. Section 1010 of the Evidence Code is amended to read:

1010. As used in this article, "psychotherapist" means:

(a) A person authorized, or reasonably believed by the patient to be authorized, to practice medicine in any state or nation who devotes, or is reasonably believed by the patient to devote, a substantial portion of ~~his~~ time to the practice of ~~psychiatry;~~ *psychiatry.*

(b) A person licensed as a psychologist under Chapter 6.6 (commencing with Section 2900) of Division 2 of the Business and Professions ~~Code;~~ *Code, or a person employed by a nonprofit community agency who is authorized to practice psychology under the provisions of subdivision (d) of Section 2909 of the Business and Professions Code, or a person licensed or certified as a psychologist under the laws of another state or nation.*

(c) A person licensed as a clinical social worker under Article 4 (commencing with Section 9040) of Chapter 17 of Division 3 of the Business and Professions Code, ~~when he is~~ *while* engaged in applied psychotherapy of a nonmedical nature.

(d) A person who is serving as a school psychologist and holds a credential authorizing such service issued by the state.

(e) A person licensed as a marriage, family and child counselor under Chapter 4 (commencing with Section 17800) of Part 3, Division ~~5~~ *7* of the Business and Professions Code.

(f) A person licensed as a licensed educational psychologist under Article 5 (commencing with Section 17860) of Chapter 4 of Part 3 of Division 7 of the Business and Professions Code.

(g) A state employee serving as a psychiatric social worker in a mental health facility of the State of California, while engaged in applied psychotherapy of a nonmedical nature.

(h) A public employee having not less than the minimum qualifications required of a state psychiatric social worker who is serving as a psychiatric social worker in a city or county mental health facility operated as a part

of the approved county Short-Doyle Plan (as defined in Section 5601 of the Welfare and Institutions Code), while engaged in applied psychotherapy of a nonmedical nature.

(i) A person having not less than the minimum qualifications required of a state psychiatric social worker who is serving as a psychiatric social worker in a mental health facility operated under contract with a city or county as part of the approved county Short-Doyle Plan (as defined in Section 5601 of the Welfare and Institutions Code), while engaged in applied psychotherapy of a nonmedical nature.

Comment. Subdivision (b) of Section 1010 is amended to recognize the possibility of treatment of a patient by a psychologist employed by a nonprofit community agency (see subdivision (d) of Section 2909 of the Business and Professions Code) or a psychologist licensed or certified in another state or nation. Where the psychologist is licensed or certified in another state or nation, the treatment may take place in California (see Section 2912 of the Business and Professions Code) or in the other state or nation.

Subdivision (f) is added to include a licensed educational psychologist as a psychotherapist for the purpose of the privilege. This addition complements subdivision (d) (school psychologist). For the qualifications for a licensed educational psychologist, see Bus. & Prof. Code § 17862. See also Section 1014.5 and Civil Code Section 2.5.9(d).

Subdivisions (g)-(i) are added to include a psychiatric social worker as a psychotherapist for the purpose of the privilege. The prior law had been construed in *Belmont v. State Personnel Board,* 36 Cal. App.3d 518, 111 Cal. Rptr. 607 (1974), as not including a confidential communication by a patient to a psychiatric social worker within the protection of the psychotherapist-patient privilege. The addition of subdivisions (g)-(i) is based on functional similarities between presently privileged professionals and psychiatric social workers. See generally Comment, *Underprivileged Communications: Extension of the Psychotherapist-Patient Privilege to Patients of Psychiatric Social Workers,* 61 Calif. L. Rev. 1050 (1973). See also Section 1014.5. Subdivisions (h) and (i) bring within the privilege patients of those psychiatric social workers who work in mental health facilities that have been approved as a part of the county Short-Doyle Plan and by the State Department of Health for funding under the Short-Doyle program. See Welf. & Inst. Code §§ 5703.1, 5705. See also Welf. & Inst. Code § 5751 (Director of Health to establish standards of education and experience for

professional, administrative, and technical personnel employed in mental health services). See also Section 1014.5 and Civil Code Section 2112(d).

Evidence Code § 1010.5 (added)

SEC. 2. Section 1010.5 is added to the Evidence Code, to read:

1010.5. The relationship of a psychotherapist and patient shall exist between the following corporations and the patients to whom they render professional services, as well as between such patients and psychotherapists employed by such corporations to render services to such patients:

(a) A medical corporation as defined in Article 17 (commencing with Section 2500) of Chapter 5 of Division 2 of the Business and Professions Code.

(b) A psychological corporation as defined in Article 9 (commencing with Section 2995) of Chapter 6.6 of Division 2 of the Business and Professions Code.

(c) A licensed clinical social workers corporation as defined in Article 5 (commencing with Section 9070) of Chapter 17 of Division 3 of the Business and Professions Code.

(d) A marriage, family or child counseling corporation as defined in Article 6 (commencing with Section 17875) of Chapter 4 of Part 3 of Division 7 of the Business and Professions Code.

Comment. Section 1010.5 is added to continue the second paragraph of Section 1014(c) with the exception of the definition of "persons" which is not continued. See Section 1014 and Comment thereto. Subdivisions (a) and (d) are new; they make clear the application of the psychotherapist–patient privilege to types of professional corporations not previously covered.

Evidence Code § 1012 (amended)

SEC. 3. Section 1012 of the Evidence Code is amended to read:

1012. (a) As used in this article, "confidential communication between patient and psychotherapist" means information, including information obtained by an examination of the patient, transmitted between a patient and ~~his~~ *the* psychotherapist in the course of that relationship and in confidence by a means which, so far as

the patient is aware, discloses the information to no third persons other than those who are present to further the interest of the patient in the consultation, or those to whom disclosure is reasonably necessary for the transmission of the information or the accomplishment of the purpose for which the psychotherapist is consulted, *or persons who are participating in the diagnosis and treatment under the direction of the psychotherapist, including members of the patient's family,* and includes a diagnosis made and the advice given by the psychotherapist in the course of that relationship.

(b) As used in this article, "confidential communication between patient and psychotherapist" includes information reasonably necessary for the diagnosis or treatment of the patient by the psychotherapist that is disclosed by another person to the psychotherapist in confidence by a means which, so far as the person is aware, discloses the information to no third persons other than those described in subdivision (a).. With respect to information so disclosed, the person disclosing the information is a joint holder of the privilege under this article.

Comment. Section 1012 is amended to make clear that the scope of the section embraces marriage counseling, family counseling, and other forms of group or family therapy. However, it should be noted that communications made in the course of joint therapy are within the privilege only if they are made in confidence and by a means which discloses the information to no other third persons. The making of a communication that meets these two requirements in the course of joint therapy would not amount to a waiver of the privilege. See Evid. Code § 912(c) and (d). The waiver of the privilege by one of the patients as to that patient's communications does not affect the right of any other patient in group or family therapy to claim the privilege with respect to such other patient's own confidential communications. See Evid. Code § 912(b).

Subdivision (b) is a new provision that makes clear that the psychotherapist-patient privilege protects disclosures made by parents or other third persons to the psychotherapist where made in confidence and reasonably necessary for the diagnosis or treatment of the patient by the psychotherapist. The subdivision is consistent with prior law. See Grosslight v. Superior Court, 72 Cal. App.3d 502, ___ Cal. Rptr. ___ (1977) (communications to psychotherapist by parents concerning their

daughter's behavior were within purview of psychotherapist-patient privilege and therefore privileged). There was no judicial decision under prior law whether the privilege extended to nonfamily communications. See Grosslight v. Superior Court, supra, 72 Cal. App.3d at 508, ___ Cal. Rptr. at ___ ("We do no here determine whether the Section 1014 privilege extends to nonfamily communications"). The communication protected by subdivision (b) may concern the behavior of the patient as in Grosslight, may be information concerning the person making the communication, or may be any other relevant information. The protection provided by subdivision (b) is necessary because disclosure of the confidential communication might be detrimental to the person called upon to make the disclosure, and full disclosure might not be made absent this protection. For this reason, the person disclosing the information is made a joint holder of the privilege. See Section 912(b) (waiver of the right of one joint holder to claim the privilege does not affect the right of another joint holder to claim the privilege). The right of the person making the disclosure to claim the privilege is, of course, subject to the exceptions provided in this article and to subdivisions (c) and (d) of Section 912. It should be noted that protection is provided under subdivision (a) of Section 1012 for disclosures by the psychotherapist to the person making the communication described in subdivision (b). Moreover, disclosure to persons to whom disclosure is permitted under subdivision (a) of Section 1012 without loss of the privilege does not cause loss of the privilege provided under subdivision (b).

Evidence Code § 1014 (amended)

SEC. 4. Section 1014 of the Evidence Code is amended to read:

1014. Subject to Section 912 and except as otherwise provided in this article, the patient, whether or not a party, has a privilege to refuse to disclose, and to prevent another from disclosing, a confidential communication between patient and psychotherapist if the privilege is claimed by:

(a) The holder of the privilege;

(b) A person who is authorized to claim the privilege by the holder of the privilege; or

(c) The person who was the psychotherapist at the time of the confidential communication, but such person may not claim the privilege if there is no holder of the privilege in existence or if ~~he~~ *such person* is otherwise instructed by a person authorized to permit disclosure.

~~The relationship of a psychotherapist and patient shall exist between a psychological corporation as defined in Article 9 (commencing with Section 2995) of Chapter 6.6 of Division 2 of the Business and Professions Code or a licensed clinical social workers corporation as defined in Article 5 (commencing with Section 9070) of Chapter 17 of Division 3 of the Business and Professions Code, and the patient to whom it renders professional services, as well as between such patients and psychotherapists employed by such corporations to render services to such patients. The word "persons" as used in this subdivision includes partnerships, corporations, associations and other groups and entities.~~

Comment. The last paragraph of Section 1014(a), with the exception of the definition of "persons," is continued in Section 1010.5. "Person" is defined in Section 175 to include a partnership, corporation, association, and other organizations.

Evidence Code § 1028 (repealed)

SEC. 5. Section 1028 of the Evidence Code is repealed.

~~1028. Unless the psychotherapist is a person described in subdivision (a) or (b) of Section 1010, there is no privilege under this article in a criminal proceeding.~~

Comment. Former Section 1028 is not continued.