No. 89985

IN THE
SUPREME COURT OF ILLINOIS

MARSHA NORSKOG, individually and as administrator of the estate of HILLARY NORSKOG,	)	On Appeal from the Appellate Court of Illinois, First Judicial District
Plaintiff-Appellant	)	<u>No. 1-99-1829</u>
-vs.-	)	There Heard on Appeal from the Circuit Court of Cook County, Illinois, County Department, Law Division, Case Number 95 L 10905
ROGER PFIEL, GAYLE PRIEL and STEVEN PFIEL,	)	
Defendants-Appellees	)	Honorable Julia M. Norwick, Judge Presiding

Brief *Amici Curiae* in Support of Defendants-Appellees

Bazelon Center for Mental Health Law
Equip for Equality, Inc.
Illinois Psychological Association
National Alliance for the Mentally Ill – Illinois Chapter
National Depressive and Manic Depressive Association
National Mental Health Association

In Support of Affirmance

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STATEMENTS OF INTEREST

Bazelon Center for Mental Health Law

The Bazelon Center For Mental Health Law is a national public interest organization founded in 1972 to advocate for the rights of individuals with mental disabilities. The Center has engaged in litigation, administrative advocacy, and public education to protect the civil and human rights of individuals with mental disabilities. Central to this advocacy are efforts to ensure the availability of effective mental health treatment, including the privacy and confidentiality safeguards that are essential to effective treatment.

Equip for Equality, Inc.

Equip for Equality, Inc. founded in 1985, is a private, not-for-profit organization and is the protection and advocacy system for people with disabilities for the State of Illinois. Equip for Equality's mission is to advance the human and civil rights of people with physical and mental disabilities in Illinois, including individuals with psychiatric disabilities. Each year, Equip for Equality serves approximately 2,500 people with disabilities and has experience representing people with psychiatric disabilities to help them preserve confidential mental health information. Additionally, Equip for Equality's Public Policy Department has, over the years, successfully defended numerous efforts to expand the exceptions to the Illinois Mental Health and Developmental Disabilities Confidentiality Act.

Illinois Psychological Association (IPA)

The Illinois Psychological Association (IPA) is the largest association representing psychologists in Illinois. Its purpose is to advance psychology as a science and a profession and as a means of promoting human welfare by the encouragement of psychology in all its branches; by the continual improvement of the qualifications of psychologists through high standards of ethics, conduct, education and achievement; and by the increase and dissemination of psychological knowledge through meetings, professional contacts, reports, papers, discussion and publications.

While IPA is not addressing the issue of whether parents should be responsible for the acts of their children, nor is IPA condoning the heinous violence perpetrated in the extant case, IPA does strongly support the doctrine of privilege with respect to mental health records. As stated in the Mental Health and Developmental Disabilities Confidentiality Act, IPA believes that mental health records should never be released without the express consent of the recipient of these services or unless the recipient in a civil, criminal or administrative proceeding introduces his or her mental condition or any aspect of his services received for such condition as an element of his or her claim or defense. IPA especially opposes opening up the doctrine of privilege to a "fundamental fairness" rule that would result in the devastating annihilation of the entire doctrine.

National Alliance for the Mentally Ill – Illinois Chapter (NAMI Illinois)

NAMI Illinois is one of Illinois' largest mental health advocacy organizations. Made up of over 39 local affiliates, NAMI Illinois' mission is dedicated to eradicating mental illness and improving the lives of the mentally ill and their families. Through education and advocacy at the local and state level, NAMI Illinois provides support to

consumers and family members whose lives have been touched by mental illness. NAMI Illinois' membership of over 5,000 is made up of family members, consumers, professionals and those who believe in our mission.

National Depressive and Manic-Depressive Associations (National DMDA)

National DMDA is the nation's largest patient-directed, illness-specific organization. Founded in 1986 and based in Chicago, we represent the voices of more that 20 million American adults living with depression and the additional 2.5 million adults living with manic-depression, also known as bipolar disorder. National DMDA is a nonprofit organization, committed to our mission of educating the public that mood disorders are treatable medical illnesses. National DMDA has a prestigious 65-member Scientific Advisory Board composed of the leading researchers and clinicians in the field of mood disorders who join patients, family members and members of the mental health advocacy community at our annual conference to share the most current research and treatment information. National DMDA annually convenes a national conference for its constituents and it also produces high level scientific conferences. In addition, the association sponsors consumer surveys on issues of importance to those living with mood disorders.

National Mental Health Association

The National Mental Health Association, with its more than 340 affiliates, is dedicated to promoting mental health, preventing mental disorders, and achieving victory over mental illness through advocacy, education, research and services. NMHA envisions a just, humane and healthy society in which all people are accorded respect, dignity and the opportunity to achieve their full potential free from stigma and prejudice.

SUMMARY OF ARGUMENT

It is widely recognized that effective mental health treatment is a significant benefit to society and that confidentiality is the *sina qua non* of such treatment. *Jaffee v. Redmond*, 518 U.S. 1, 10 (U.S. 1996). It is for this reason that fifty states, the District of Columbia and the federal courts recognize a psychotherapist-patient privilege. *Id.* at 12. In Illinois, the Mental Health and Developmental Disabilities Confidentiality Act, 740 ILCS 110/10 *et seq* ("Confidentiality Act" or "Act") guarantees the confidentiality of mental health records and communications except in specifically enumerated situations. *Mandziara v. Canulli*, 299 Ill. App. 3d 593, 599-600 (Ill. App. Ct. 1st Dist. 1998).

To be meaningful, confidentiality must be a certainty, because "the mere possibility of disclosure" will impede the development of the open and trusting patient-therapist relationship that is necessary for effective treatment. *Jaffee*, 518 U.S. at 10. Studies confirm that absent assurance of confidentiality, individuals will be less likely to seek and participate in needed treatment. *See e.g.*, David J. Miller & Mark Thelan, Knowledge and Beliefs about Confidentiality in Psychotherapy, 17 Prof. Psychol.: Res & Prac. 15 (1986).

Under Section 10(a)(1) of the Confidentiality Act, a recipient of mental health services has the privilege to refuse to disclose his records and communications unless the recipient introduces his mental health condition as an element of his claim or defense, and only then if the court finds that the evidence is "relevant, probative, not unduly prejudicial or inflammatory," that other evidence is unsatisfactory, and that the interest of substantive justice warrants disclosure. 740 ILCS 110/10(a) (2000).

In a "narrow" ruling, this Court in *D.C. v. S.A.*, 178 Ill. 2d 551 (Ill. 1997), recognized a limited *judicial* exception to the privilege provided by the Confidentiality Act. In that case, the Court held that "fundamental fairness" required that the privilege yield where a plaintiff in a personal injury action invoked the privilege to prevent the disclosure of information, not involving diagnosis or treatment, that could defeat the plaintiff's claim, and where all other factors warranted disclosure. *Id.* at 568-569.

Neither the Confidentiality Act nor this Court's decision in *D.C.* provides authority for the disclosure sought in this case, in which a defendant has invoked the privilege. The Appellate Court correctly concluded that the use of the privilege in this case was "as a shield", which is "the manner in which it was intended to be used." *Norskog v. Pfiel*, 314 Ill. App. 3d 877, 884 (Ill. App. Ct. 1st Dist. 2000). The court held that the narrow exception recognized in *D.C.* does not apply where the holder of the privilege is a defendant. *Id. See also, People v. Gemeny*, 313 Ill. App. 3d 902, 911 (Ill. App. Ct. 2d Dist. 2000).

Amici believe that the Court's decision in *D.C.* was incorrect because it failed to enforce the statute as written and because it introduced uncertainty into the confidentiality of mental health records in Illinois. *See Jaffee*, 518 U.S. at 17-18. The Court may wish to reconsider its ruling in that case.

In any event, the Court should make clear that the "narrow" exception of *D.C.* is limited to situations in which the holder of the privilege is one who has invoked the court's jurisdiction and who retains the ability to forgo his remedy in favor of the confidentiality of his records and communications. If the *D.C.* exception is extended to apply to the information sought in this case, i.e. from a defendant, the certainty of

confidentiality necessary for effective mental health treatment will be irreparably undermined. *See Jaffee*, 518 U.S. at 17-18.

ARGUMENT

I. Effective Mental Health Treatment, A Widely Recognized Benefit To Society, Requires The Certainty Of Confidentiality.

A. Certainty Makes The Disclosures Necessary For Mental Health Treatment Possible.

"The mental health of our citizenry, no less than its physical health, is a public good of transcendent importance." *Jaffee,* 518 U.S. at 11. Fifty states and the District of Columbia recognize, through statute and common law, a psychotherapist-patient privilege protecting communications between a patient and his therapist; federal common law also recognizes such a privilege, separate and in addition to constitutional privileges. *Id.* at 12-13. These laws represent a widespread consensus that mental health treatment bestows a critical benefit upon society and that a fundamental aspect of that treatment is confidentiality. In Illinois, the General Assembly has recognized, as have mental health professionals, that even the recipient's identity requires privacy, defining confidential communications to include information "which indicates that a person is a recipient" of mental health services. 740 ILCS 110/2 (2000). *See also,* Ellen S. Soffin, Note, *The Case for a Federal Psychotherapist-Patient Privilege that Protects Patient Identity*, 1985 Duke L.J. 1217, 1221 (1985).

Confidentiality has been recognized as critical to both the willingness to seek treatment for oneself or one's child, and to the efficacy of treatment itself. Like the attorney-client privilege, the psychotherapist-patient privilege "serves private and public interests." *Hucko v. City of Oak Forest,* 1999 U.S. Dist. LEXIS 3316 *8 (N.D. Ill. 1999).

The privilege serves the public interest by facilitating the provision of appropriate treatment for individuals with mental or emotional problems. *See*, *In Re Subpoena served upon Jorge S. Zuniga,* 714 F.2d 632, 639 (6th Cir. 1983). This interest consists "not only in our altruistic concern for our neighbors' well-being, but in our more selfish interest in the effective treatment of those in the community who may pose a threat because of mental illness or drug addiction." *In Re Grand Jury Subpoena,* 710 F. Supp. 999, 1010 (D.N.J. 1989).

At the core of effective treatment, and the basis for the privilege, is "the imperative need for confidence and trust." *Jaffee,* 518 U.S. at 10. The Supreme Court in *Jaffee* took as a given that "effective psychotherapy depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears." *Id.* The Court went even further and observed that "[b]ecause of the sensitive nature of the problems for which individuals consult psychotherapists, disclosure of confidential communications made during counseling sessions may cause embarrassment or disgrace. For this reason, *the mere possibility of disclosure* may impede development." *Id.* (emphasis added).

The Supreme Court in *Jaffee* accepted as true the Judicial Conference Advisory Committee's finding that a therapist's ability to help her patients is completely dependent upon the patient's willingness and ability to talk freely, making it "difficult if not impossible for [a psychiatrist] to function without being able to assure …patients of confidentiality. While there may be exceptions to this general rule …, there is wide agreement that confidentially is the *sina qua non* for successful psychiatric treatment." *Id.* (emphasis added).

This Court confirmed that it shares the widespread belief in the importance of confidentiality in mental health treatment in *Doe v. McKay*, 183 Ill. 2d 272 (Ill. 1998). In that case, relying upon and quoting the United States Supreme Court's opinion in *Jaffee*, the Court rejected entirely a cause of action against a therapist based on a duty of care to third persons. *Id.* at 283-284. The Court held that the importance of the therapist-patient privilege to the public interest in Illinois required the barring of such a cause of action. *Id.* Allowing a non-patient's action against another person's therapist to go forward, the Court stated, "would seriously intrude on the relationship between therapist and patient, *jeopardizing the confidentiality necessary for the relationship to flourish.*" *Id.* (emphasis added).

The chilling effect that that the possibility of disclosure would have on the "open dialogue" necessary for effective treatment recently led the Sixth Circuit Court of Appeals to reject a "dangerous patient" exception to the privilege. *See U.S. v. Hayes*, 227 F.3d 578, 585 (6th Cir. 2000). In that case, the Court refused to allow a therapist to testify in a criminal prosecution about threatening statements made to a therapist, even though the statements themselves were unprivileged with respect to preventing harm to the person threatened. *Id.* The Court found that the "public end" of the prosecution was valid, but it did not justify the negative effect that such a ruling would have on the "improvement of our citizens' mental health, achieved, in part, by open dialogue in psychotherapy." *Id.*

Even more important than confidentiality itself is the patient's *belief* that his confidences will remain secret, for it is that belief that allows him to seek treatment, trust his therapist, and communicate freely. An individual who seeks treatment is asked to

"liberate" for the therapist's hearing and consideration the conscious and unconscious "ideas, memories, and feelings that contribute to his mental suffering and disturbed relations." Bollas & Sundelson, *The New Informants* 61 (1995). He must be able to discuss his fears and anxieties without concern that his most private thoughts, even fantasies, will be disclosed to others. Catherine J.H. Dubbleday, Comment, *The Psychotherapist-Client Testimonial Privilege: Defining the Professional Involved*, 34 Emory L.J. 777, 799 (1985) (quoting A. Anastasi, Fields of Applied Psychology, 346-47 (1979)).

A patient's disclosure to his therapist of his secrets is itself difficult, because the patient may fear the therapist's judgment or may be embarrassed by his own revelations. It is therefore important that there be "no further distress from the possibility of the analyst's exposure of the patient to anyone else." A. Watson, *Levels of Confidentiality in the Psychoanalytic Situation*, 20 J. Amer. Psychoanalytical Assn. 156, 157 (1972).

The patient's belief in confidentiality depends almost entirely upon evidence available to him regarding whether the confidences of *others* have been kept. Indeed, it is the evidence that one person's confidences have been kept—and protected from compelled disclosure—that makes another's belief in confidentiality possible:

> "There is no disagreement that effective psychotherapy requires a trusting relationship between the patient and therapist. The foundation of that trust is *the patient's belief* that the therapist will maintain the confidentiality of their communications. If the therapist is required by law to breach that confidentiality, therapy becomes difficult, if not impossible. *An enforced demand for breach of confidentiality with respect to one patient's communications may affect all patients, for the others may cease to believe—and rightly—that their confidences will be kept confidential."* Diamond, "Forensic Psychiatry," in Review of General Psychiatry 467 (3d Ed., H. Goldman ed. 1992) (emphasis added).

Studies confirm what common sense suggests: patients who are not assured of confidentiality are far less willing to make the disclosures necessary for treatment or to obtain or seek treatment in the first place. *See*, David Miller & Mark Thelan, Knowledge and Beliefs About Confidentiality in Psychotherapy, 17 Prof. Psychol.: Res. & Prac. 15 (1986). Jacob J. Lindenthal & Claudewell S. Thomas, Psychiatrists, the Public, and Confidentiality 170 J. of Nervous & Mental Disease, 319, 321 (1982). *See also*, Note, Toni Pryor Wise, *Where the Public Peril Begins: A Survey of Psychotherapists to Determine the Effects of Tarasoff*, 31 Stan. Law Rev. 165, 183 (1978). One study revealed that of 108 randomly selected potential patients, 42 percent reported that they would be less likely to be open in therapy if their communications could not be *absolutely* protected. Paul S. Applebaum et al., Confidentiality: *An Empirical Test of the Utilitarian Perspective*, 12 Bull. Am. Acad. Psychiatry & L. 109, 110 (1984) (citing Note, *Functional Overlap between the Lawyer and Other Professionals: Its Implications for the Privileged Communications Doctrine*, 71 Yale L.J. 1226, 1262 (1962)).

Despite the progress that has been made in the area of acceptance of mental illness and mental health treatment, widespread social stigma still attends both mental illness and treatment, thus necessitating that the fact of one's obtaining treatment be kept as confidential as the treatment itself. In one study, 55 percent of supervisors surveyed indicated that they would have a negative attitude towards an employee who had seen a psychiatrist. *See,* Psychiatric Peer Review: Preclude and Promise, 179 (J. Hamilton ed., 1985). In another survey, 83 per cent of teachers and administrators indicated that they did not want to reveal to state authorities whether they had ever sought mental health treatment. *Id.* (citing Rosen, Do Potential Community Mental Health Center Clients

Want Privacy?, Unpublished Manuscript in Noll &Rosen, Privacy, Confidentiality, and Informed Consent in Psychotherapy, in Psychiatric Patient Rights and Patient Advocacy: Issues and Evidence (1982)). Research has also revealed that some patients forego insurance coverage of their treatment rather than risk their employers finding out about it. See, *Statement of the American Psychiatric Association* (by Jerome S. Beigler, M.D.) *Before the Subcommittee on Government Information and Individual Rights of the Subcommittee on Government Operations* (April 9, 1979). Broad confidentiality reduces the fear of stigma, and, thus, promotes the social goal of a more mentally healthy society by encouraging those who want treatment to seek it.

Persons undergoing mental health treatment are not to be expected to view themselves as potential winners in a battle of future equities when they decide to bare their souls to a therapist. The very purpose of mental health treatment is to provide a safe and confidential place for the examination of guilt, shame, fear, and weakness. Certainly, a person sharing such information will be discouraged from doing so if he learns that a court has compelled disclosure of such information in a lawsuit against another person or his parents. *Jaffee*, 518 U.S. at 17-18. Any approach that reduces the certainty of confidentiality, such as one that balances the need for confidentiality against other interests in a situation in which the patient or mental health recipient has no choice regarding disclosure, will erode the patient's belief in confidentiality and will ultimately erode the mental health of our citizenry. *Id.*

B. A Parent's Role in Securing and Participating in Mental Health Treatment for Minor Children Requires Absolute Trust in the Confidentiality of the Treatment.

Today's generation of children is far more likely to have received mental health treatment than those of previous generations. This is not because they are more dangerous, or even more ill. It is because *some progress* has been made in destigmatizing mental illness and emotional problems, a great deal of progress has been made in successfully treating childhood mental problems, and because insurance has become more widely, although by no means universally, available for mental health treatment. That our children are more likely to receive treatment is a positive development about our society and it is that positive development that the privilege protects. *Jaffee*, 518 U.S. at 11.

The custody, care and nurturing of a child resides with his parents. *Stanley v. Illinois*, 405 U.S. 645, 651 (U.S. 1972). The decision to seek mental health treatment for a child is thus a parent's decision. Like adults in need of treatment for themselves, parents of troubled children are well aware of the stigma that attends mental illness and treatment, and they depend upon the confidentiality of treatment when they make the difficult decision to seek treatment for a minor child. *Simpson v. Braider*, 104 F.R.D. 512 (D.D.C. 1985). Parents also often participate in a child's treatment. From the decision to seek treatment, through diagnosis and all phases of treatment, the parent can be a crucial part of the therapist-patient relationship. Thus, the certainty of confidentiality that makes mental health treatment possible generally is arguably even more important for a parent, who must make this decision on behalf of another whom he has the duty and the desire to protect. Exercise of that duty should not be influenced by a worry that the parent might later be sued for decisions he makes in regard to that

treatment, with the evidence against him being the diagnosis and open communications necessary for effective treatment.

The possibility that confidential communications may be later used against the parent in a civil action is destructive to the parent-child relationship itself and would have widespread adverse consequences for children. The "signs" that may alert a parent to seek treatment for a child may or may not signal, predict, or even relate to whether violence will be committed. But acting on those signs to seek treatment to prevent even the possibility of violence, as well as to treat other aspects of the individuals' problems, is highly responsible parental behavior. And it is that very behavior that will be chilled by allowing a fishing expedition into a therapist's communications to the parent and his diagnosis of the child for the purpose of finding evidence to hold those parents financially liable for the child's later actions. The parents may see their decision to seek treatment as acting to set up a case against their child, and against themselves, rather than as helping their child. They may also fear the rejection of their child if confidentiality is not assured.

This is not an idle fear. Our society has not only stigmatized mental illness, it has used mental health treatment as proof of illness, and proof of danger, so that those children who receive treatment are more readily believed to be a danger than those whose parents deny the problem, do not believe in treatment, or fear the stigmatization of treatment. *See, e.g., Blount v. city of City of* Tacoma, 720 7.2d 1126, 1129-1130 (9th Cir. 1983). Parents who may already be worried about their child's social adjustment must have no fear that their child will face even greater rejection if they seek help for him. *See, e.g.*, Gralnick & Duncan, *Problems of the Patient in Transit from Hospital to*

Community, in Mental Patients In Transition 27, 28 (M. Greenblatt, D. Levinson & G. Klerman eds. 1961) ("a patient may make every effort to deny his sickness, not because he does not want help, but because he does not want to be rejected.")

Compelled release of communications between a minor's therapist and his parents will ratify the worst fears parents have about seeking help for their children—their children will be presumed to be dangerous, they will be more likely to be held responsible for their actions, and confidential family information and diagnosis will be revealed if things do not work out as hoped. Parents might conclude that it is far better for them to turn inward, hide from professionals the concerns they have about their child, and hope that nothing bad ever happens. The inevitable result of such denial will lead to the deterioration of the mental health of both children and adult citizens, health which the Supreme Court has characterized as "a public good of transcendent importance." *Jaffee,* 518 U.S. at 11.

II. Expansion Of The *Judicial* Exception Adopted By This Court In *D.C. v. S.A.* To Include The Information Sought In This Case Would Undermine Illinois Public Policy Favoring The Confidentiality Of Mental Health Records.

A. By Its Terms, The Confidentiality Act Does Not Authorize Disclosure Of The Mental Health Records Or Communications Of A Recipient In A Negligent Entrustment Action Against The Recipient's Parent.

The Illinois General Assembly recognized the perils of disclosure of mental health records and communications, as discussed above, when it enacted the Confidentiality Act providing broad protections subject only to exceptions "specifically enumerated." *Mandziara*, 299 Ill. App. 3d at 599-600. Under that Act, a recipient's mental health records and communications may be disclosed in civil proceedings over his

objection only when "the recipient introduces his mental condition or any aspect of his services for such condition as an element of his claim or defense," and, only then, to the extent that such information is relevant, probative, not unduly prejudicial or inflammatory, and otherwise clearly admissible. 740 ILCS 110/1 (2000).

Under Section 10(a)(1) of the Act, a court does not begin to weigh admissibility, relevance, or the other enumerated other factors, unless and until the party asserting the privilege has "introduced his mental condition as an *element* of his claim or defense." 740 ILCS 110/1 (2000) (emphasis added). This Court has interpreted this provision strictly, holding that even where a plaintiff alleges a fact that makes his mental state relevant, disclosure is not authorized by the Act unless the alleged fact is a required element of plaintiff's cause of action. *D.C.*, 178 Ill. 2d at 570. In *D.C.*, this Court held that because a plaintiff's exercise of due care was not a required element of the plaintiff's claim in a personal injury action in Illinois (the issue if raised at all is raised by the defendant who also carries the burden), it could not form a statutory predicate for disclosure under the Act. *D.C.*, 178 Ill. 2d at 564. *See also Mandziara*, 299 Ill. App. 3d at 599-600; *Pritchard v. Swedish –American Hospital*, 191 Ill. App. 3d 388, 403 (Ill. App. Ct. 2d Dist. 1989).

The Confidentiality Act clearly provides that disclosure of mental health records and information in civil cases is limited to those situations where it is the recipient who introduces the issue as part of his claim or defense and where the issue is one that is essential to the cause of action. *D.C.*, 178 Ill. at 564-565. In a negligent entrustment action, the issue of the defendant's negligence is, of course, for the plaintiff to prove. By denying facts relevant to that issue, the defendant simply puts the plaintiff to her proof.

This does not constitute the introduction by defendant of his mental state as an "element" of a claim or defense, and therefore cannot serve to invoke the exception provided by Section 110(1) of the Act. *D.C.*, 178 Ill. at 570.

B. In *D.C. v. S.A.*, This Court Adopted A Narrow Judicial Exception To Confidentiality.

Petitioner contends, and the trial court held, that disclosure in this case is governed not only by the Confidentiality Act, but also by a new "fundamental fairness" exception recognized by this Court in *D.C.* Under that exception, she argues, the records she seeks in discovery may be disclosed. The Appellate Court disagreed, holding that Respondents' use of the privilege in this case was "as a shield," and thus "in the manner in which it was meant to be used," and that the privilege could not therefore be overridden by Petitioner's need for the information. *Norskog,* 314 Ill. App. 3d at 884. The Court below observed that the critical fact in *D.C.* was that the holder of the privilege was a *plaintiff* who sought an economic advantage through use of the privilege, rather than a *defendant* who merely sought its protection. The Court below thus agreed with the Second District Appellate Court's decision in *Gemeny*, 313 Ill. App. 3d at 911, which also rejected any application of *D.C.* to defendants. This Court should similarly reject the broad "fundamental fairness" exception urged by Petitioner. It should either overrule *D.C.* or reaffirm the "narrow" applicability of *D.C.* to the rare situations for which it was intended. *D.C.,* 178 Ill. 2d at 570.

In *D.C.*, plaintiff, a pedestrian, was injured when an automobile owned by defendant hit him as he crossed the street. He later brought a suit against the defendant, claiming that defendant's negligence was the cause of his injuries, and alleging in his complaint that he had at all times exercised due care. In discovery, plaintiff provided his

medical records, but withheld his mental health records, citing the Confidentiality Act. Defendant, however, had come into possession of a letter, referring plaintiff for mental health treatment and suggesting that plaintiff may have been attempting suicide when he ran in front of the car. Defendant sought plaintiff's mental health records to show that plaintiff had attempted suicide and that in effect, his case was a sham. Defendant argued that plaintiff had introduced the issue of his mental condition in his complaint and that the material was thus disclosable under the authority of the Confidentiality Act.

The trial court conducted an *in camera* inspection of records and concluded that there were hospital records that could refute plaintiff's contention that defendant's negligence caused his injuries. This evidence, which did not include plaintiff's diagnosis, nor any information concerning treatment, was potentially dispositive of plaintiff's entire claim. The trial court held that these records were disclosable under the Act because, in addition to the other factors being met, plaintiff had introduced his mental condition by the filing of the lawsuit and ordered them disclosed. The court stayed its order, however, and certified and the issue for appeal. The Appellate Court reversed, and this Court granted defendant's petition for leave to appeal.

On appeal, this Court first concluded, as discussed above, that the defendant, not the plaintiff, had introduced the mental health condition of the plaintiff, and, agreeing with the Appellate Court, held that there was thus no statutory basis for requiring disclosure. The Court next considered whether the constitutional requirement of due process to the defendant required such disclosure, and concluded that it did not: "[W]e do not believe that the instant case presents a situation where due process rights are violated…." *Id.* at 568. Nevertheless, the Court held that "under the circumstances

presented [t]here, fundamental fairness command[ed] that the privilege yield." *Id.* The Court likened the situation to one involving the attorney client-privilege, which yields when the client engages the attorney's services to further a fraud. In its decision, the Court emphasized that the small amount of information at issue did *not* concern "psychiatric diagnosis, treatment, or progress," but related only to the plaintiff's "conduct and motivation." *Id.* at 569.[1] In its opinion, the Court implied that it believed that the use of the privilege in that case was tantamount to an attempt to use the judicial process to perpetrate a fraud. *Id.*

The decision of this Court in *D.C.* was "narrow." *Id.* at 570. In sum, the Court held that "under the facts of [that] case, the interests of justice demand[ed] that [the Court] tip the balance in favor of disclosure and truth," where a *plaintiff* sought to use the protections of the privilege "as a sword rather than a shield, to prevent disclosure of *relevant, probative, admissible,* and *not unduly prejudicial* evidence that has the potential to *fully negate* the claim plaintiff asserted against defendants...."*Id.*

Ignoring these limitations, Petitioner argues that *D.C.* created a general "fundamental fairness" exception, one that requires a balancing of the respective interests of the parties in every case in which it is raised. As contemplated by Petitioner, this exception would have only such limits as the wisdom and experience of the judge before whom it is plead may impose, and it would be potentially available each time the

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[1] Moreover, the Court noted that all of the other statutory criteria that would have been necessary for disclosure had the threshold statutory trigger of introduction of the condition been met were present: the evidence was "otherwise clearly admissible," it was relevant to the plaintiff's "conduct and actions at the time of the accident," and it was "probative" because it appeared to provide a possible explanation of how the accident occurred, (indeed that could be entirely dispositive of the defendant's liability), and it was "not obtainable elsewhere." *D.C. v. S.A.,* 178 Ill. 2d at 569.

privilege is asserted. This Court should reject Petitioner's argument and reaffirm the certainty of confidentiality of mental health records and communications in Illinois, either by overruling D.C. or reaffirming its narrow applicability.

C. This Court Should Reconsider Its Ruling In *D.C. v. S.A.*

We respectfully submit that this Court's decision in *D.C.* was both incorrect and unwise. First, it was incorrect because, through a detailed statutory scheme, the legislature had clearly indicated its intention to define all of the circumstances under which disclosure would be permitted. In *D.C.*, this Court contravened that scheme when it added exceptions to it. We thus agree with Justice Harrison's dissent in that case that the majority in *D.C.* "ignored the cardinal rule that a statute must be enforced as enacted by the Legislature," citing *Raintree Health Care Center v. Illinois Human Rights Commission*, 173 Ill. 2d 469, 490-91 (1996).

Second, the decision was an unwise change in policy. Although the majority believed, indeed announced, that its decision was "narrow," it nevertheless inserted a crack in the certainty of the privilege, which the Petitioner in this case is attempting, and other plaintiffs in future cases will attempt, to widen. The decision, has thus, in our view, planted the seed for the "mere possibility of disclosure" that the United States Supreme Court in *Jaffee* saw as destructive of the psychotherapist-patient relationship, and which caused that Court to reject a general balancing test altogether. *Jaffee,* 518 U.S. at 10. "We reject the balancing component of the privilege ... Making the promise of confidentiality contingent upon a trial judge's later evaluation of the relative importance of the patient's interest in privacy and the evidentiary need for disclosure ...would eviscerate the effectiveness of the privilege." *Id* at 17. Although as we show below, the

D.C. decision is narrow and most certainly does not embrace the circumstances presented in this case, in our view any exception to the privilege has the potential to erode it and must be justified by an overriding public benefit—such as preventing imminent harm. The civil action involved in *D.C.* did not involve such a benefit and should not have occasioned even a small crack in the wall of confidentiality.[2]

D. The Exception Recognized In *D.C.* Was Not Intended To Make The Privilege Subject To A "Fundamental Fairness" Balancing Test In Routine Discovery, Such As That Sought In This Case.

Although we believe that the decision in *D.C.* was incorrect, it is not necessary for this Court to overrule that decision in order to protect the evidence that Petitioner seeks to have disclosed in this case. To the contrary, permitting disclosure in the case would constitute a significant expansion of the ruling in *D.C.* Indeed, to extend *D.C.* to this case would be tantamount to eliminating the privilege whenever there exists an issue as to which the evidence sought could be relevant, and would thus undermine the privilege altogether.

D.C. created a judicial exception to the legislatively created privilege because the

[2]The *D.C.* exception is also questionable because depends upon what many in the psychiatric field have seen as a false premise—that the communications of a patient to his therapist necessarily contain an objective truth that will be useful in the judicial process. It is erroneous to assume that evidence shielded by the privilege is accurate, truthful evidence, whose consideration will necessarily aid the search for truth. The nature of statements made to psychoanalysts is quite often not "true" in the sense that we commonly understand the term. The object of psychotherapy is to allow the patient to work through his secrets and even unconscious feelings, by speaking them out loud in the intimate and nonjudgmental environment of a therapy session. It is not at all uncommon that the patient will express deeply buried socially unacceptable assertions to the therapist, which may sound like facts to an outside listener—e.g. "I am responsible for the death of my brother,"—but which the therapist understands may be expressions of fears, anxieties and other feelings, but not "true" in the fact-finding sense at all. *See e.g.*, American Psychiatric Association, 3 Treatments of Psychiatric Disorders 2078 (1989).

privilege appeared to be used by one who had invoked the court's jurisdiction to mislead the court so that the holder of the privilege could obtain a financial recovery from another. In this case, the Court is being asked to abrogate the privilege in a situation in which it has been invoked by a defendant, who has not initiated the judicial process but appears involuntarily, where fraud is not suggested, and where the purpose for disclosure is merely to pursue a *link in a chain* of evidence. The information that is sought includes the patient's diagnosis and the therapist's treatment recommendations, and is in support of a contention that ultimately depends, not upon a clearly refuted fact, but upon generalized associations between diagnosis and predictions of behavior.

Moreover, Petitioner seeks to obtain information that is at the essence of effective mental health treatment—diagnosis, treatment plan, and progress as reported to a minor's parents. These are precisely the things that this Court in *D.C.* emphasized at least twice were *not* to be disclosed in that case. Critical to the Court's decision was not only that the information sought was from a person who sought an unfair advantage, in a suit he had initiated, by maintaining its secrecy, but the fact that the information itself was simple and factual; it related to identifiable conduct and it was potentially dispositive, in and of itself, of the plaintiff's case. By contrast, the information sought here goes to the complexity of diagnosis and treatment, and it is of the ordinary discovery variety—information that may or may not ultimately even be admissible, that requires placement in a much larger context to have any relevance whatsoever, and that will at most bear upon, and certainly will not dispose of, an issue in the case.

This is surely not the sort of circumstance that we can expect to occur so rarely that no one need fear it. To permit discovery of the dates and times of treatment and

diagnosis, and the communications to parents involved in a child's treatment, whenever a person who may have been treated later commits an act of violence, and a victim or survivor seeks to impose civil liability, would make the rare now commonplace. In so doing, it would render confidentiality a mere possibility, not the guarantee that is needed to promote effective treatment. Such a result would "swallow the general rule of confidentiality." *Gemeny*, 313 Ill. App. 3d at 911.

The "exception" that Petitioner seeks to have recognized in this case goes to the heart of the privilege, and to the heart of the relationship between therapist and patient. We do not believe that when this Court urged the weighing of interests in *D.C.* it intended to extinguish the certainty that is central to the privilege, or that it intended that a balancing test should replace the statute in every case where the information sought might help resolve one of the issues in a case. A careful reading of *D.C.* in light of the policies of the Act, and the Court's favorable reference to *Jaffee* in that case, reveals that the exception it embraces must be limited to those cases in which a recipient initiates a *claim* for relief in court, and where the recipient seeks to suppress evidence that may refute entirely an essential element of his claim. This is the "sword" that the majority in *D.C.* was talking about. *See Gemeny*, 313 Ill. App. 3d at 911.

So limited, this judicial exception will preserve the essential certainty of the privilege, because *in all cases* the recipient would have the choice, difficult though it might be, of choosing confidentiality and forgoing his remedy. Every recipient may thus be confident that his confidences will forever remain secret, and his diagnosis forever confidential, unless and until he either introduces his condition in the manner set forth in the Act, or he invokes a court's jurisdiction as a plaintiff. Even then, he knows that his

information will remain confidential if he withdraws from that jurisdiction prior to the disclosure.

The impact of permitting disclosure without the clear limitation recognized by the Court below and that we urge here, will cut widely and cruelly across our society. *Everyone* can identify with being a potential defendant in this litigious society. Parents can especially identify, as the trend toward holding parents responsible for the actions of their children gains favor. The broad chilling effect of a rule that takes away the privilege regardless of whether the recipient or parent has invoked judicial process—that threatens to take it whenever psychiatric treatment of a minor child, initiated or participated in by the parents, is followed, even years later, by a violent act—is patent. This Court did not intend such a result when it issued its "narrow" ruling in *D.C.*, 178 Ill. at 570.

Stephen Pfiel's privilege constitutes a promise to the rest of us, and if the promise is kept in Pfiel's case, it may be believed in the next case. And the next child may be *prevented,* by early and confidential treatment sought by his parents in reliance on the promise, from harming another or himself, or, more likely, from living with unnecessary emotional pain for years to come. For this reason, this Court should make clear that *D.C.* has not taken away that promise, by squarely holding that the exception will apply only when the recipient of mental health services invokes the jurisdiction of the court and can withdraw from that jurisdiction if he concludes that he would rather protect his information than have his remedy. The rule may not be applied to defendants, who are in court involuntarily, and who have nothing to exchange for the privilege. Anything less

would be, in the words of the Supreme Court "little better than no privilege at all." *Jaffee*, 518 U.S. at 17.

CONCLUSION

For these reasons and those set forth in the briefs of Respondents and the other *Amici*, the decision of the Appellate Court should be affirmed.

RESPECTFULLY SUBMITTED,

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