NOTES

THIRD PARTY LIABILITY FOR THE NEGLIGENT RELEASE OF INVOLUNTARILY COMMITTED MENTAL PATIENTS

I. INTRODUCTION

*The modern concept of handling mental illness is one of treatment, not incarceration. The objective is to return the patient to society, which should be done as soon as . . . it is safe for others and helpful to the patient.*

The determination to release a mental patient confined in an institution involves a complex examination of competing policy concerns and psychiatric predictions and speculations. Difficult questions regarding the intertwining of duty and proximate cause must be resolved. Moreover, whether liability will attach to a psychiatrist, hospital administrator, or state agency depends in part on whether the individual or public entity enjoys statutory immunity.

It is not within the scope of this note to analyze the various procedures involved in the confinement of mental patients. Yet, when determining whether to release a patient, it is important to know whether

2. A mentally ill patient requiring involuntary treatment means:
   [A] person who is mentally ill and (1) who presents a substantial risk of imminent harm to himself or others as manifested by either recent overt acts or recent expressed threats of violence which presents a probability of physical injury to himself or to others, or (2) who is so unable to care for his own physical health and safety as to create an imminently life endangering crisis.
3. The release of mental patients from institutions involves the balancing of two competing interests. The protection of society from the premature release of mental patients is weighed against the realization that conditional release is an acceptable form of rehabilitation. Any decision to release must satisfactorily examine these competing policy interests on a case-by-case examination.
   4. See infra text accompanying notes 15-20.
   5. See infra text accompanying notes 114-16.
   6. See infra text accompanying notes 176-206.
the individual was confined voluntarily,\textsuperscript{7} involuntarily through civil proceedings,\textsuperscript{8} or involuntarily following a criminal acquittal based on insanity.\textsuperscript{9}

After a discussion of the considerations involved in the release decision and liability analysis, the focus will turn to an examination of a proposed release scheme and alternatives to a negligent cause of action against third parties.

II. RELEASING MENTAL PATIENTS

Once committed to a mental institution, patients find themselves trapped behind an intricate web of regulations, guidelines, and procedures that work against their attempts to leave the institution. On the national perspective, the problem of release is magnified by the diversity of release procedures among the jurisdictions.\textsuperscript{10} In some instances a statute specifically outlines the steps required and the different authorities necessary to certify the release. For example, a doctor's certification of recovery is sufficient to permit the release of a mental patient in some jurisdictions,\textsuperscript{11} but acts only as a condition precedent to a court's final authorization in another jurisdiction.\textsuperscript{12}

Hospital administrators, psychiatrists and judges look to whether the potential releasee is "dangerous to himself or others"\textsuperscript{13} when they eval-

\textsuperscript{7} See, e.g., MASS. GEN. LAWS ANN. ch. 123, § 10(a) (1980) which states in part: "Pursuant to departmental regulations on admission procedures, the superintendent may receive and retain on a voluntary basis any person providing the person is in need of care and treatment and providing the admitting facility is suitable for such care and treatment."

\textsuperscript{8} See, e.g., MINN. STAT. ANN. § 253A.02(3) (West 1977) which provides in part: "For the purpose of involuntary commitment of a person as mentally ill it is necessary for the court to find: (a) that the person is a mentally ill person, and (b) that involuntary hospitalization is necessary for the welfare of the person or the protection of society . . . ."

\textsuperscript{9} See, e.g., OHIO REV. CODE ANN. § 2945.40 (Page 1981) This section provides: "If a person is found not guilty by reason of insanity, the verdict shall state that finding, and the court shall cause an affidavit to be filed in the probate court . . . alleging that the person is a mentally ill person subject to hospitalization by court order . . . ."

\textsuperscript{10} See infra notes 29-31 and accompanying text.

\textsuperscript{11} See infra note 29 and accompanying text.

\textsuperscript{12} See, e.g., ARK. STAT. ANN. § 41-613(1) (1977); CAL. PENAL CODE § 1026.2 (West 1981); CAL. WELF. & INST. CODE § 1372 (West 1981); DEL. CODE ANN. tit. 16, § 5009 (1980); IDAHO CODE § 66-337(b) (1982); IOWA CODE ANN. § 226.27 (West 1981); MASS. GEN. LAWS ANN. ch. 123, § 16(e) (West 1982); N.Y. CRIM. PROC. LAW § 330.20 (McKinney 1981); OHIO REV. CODE ANN. § 2945.40 (Page 1981); OR. REV. STAT. § 426.300 (1981); and VA. CODE § 19.2-181 (1982).

\textsuperscript{13} "Dangerous to himself or others" has been defined as a "serious physical harm to himself or others." Matter of Torsney, 66 A.D.2d 281, 288, 412 N.Y.S.2d 914, 918 (1979). The Idaho legislature has defined "likely to injure himself or others" as:
uate their decision to release a mental patient. The Supreme Court has maintained a state cannot confine "a nondangerous individual who is capable of surviving safely in freedom by himself or with the help of willing and responsible family members or friends." Thus, if the proper releasing authority concludes a mental patient remains dangerous to himself or others, he may continue that individual's confinement. If they are unable to conclude that the patient is dangerous, however, then release becomes imperative.

A. Dangerousness

Central to the problem of predicting dangerousness is the lack of a "scientifically reliable method for predicting dangerous behavior." Failure to provide explicit legal standards of 'dangerousness' creates the unacceptable situation where, for example, one psychia-

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(1) A substantial risk that physical harm will be inflicted by patient upon his own person, as evidenced by threats or attempts to commit suicide or inflict harm on himself; or
(2) A substantial risk that physical harm will be inflicted by patient upon another as evidenced by behavior which has caused harm or which places another person or persons in reasonable threat of sustaining such harm.


14. O'Connor v. Donaldson, 422 U.S. 563, 576 (1974) (respondent was confined almost fifteen years for care and maintenance); Ellis v. United States, 484 F. Supp. 4, 9 (D. S.C. 1978). In Ellis, the patient had no record of suicidal or homicidal tendencies nor exhibited such during his confinement. Therefore, "it would have been constitutionally impermissable to have physically restrained Mr. Ellis to keep him in the Veterans Administration Hospital against his will." Id. at 9.

15. Diamond, The Psychiatric Prediction of Dangerousness, 123 U. Pa. L. Rev. 439, 452 (1974) [hereinafter cited as Psychiatric Prediction of Dangerousness]. Diamond states that there are no "well established clinical symptoms" which permit an accurate diagnosis of "potential danger" thus, one can not be certain that "persons who are not dangerous will not be labeled as such and unnecessarily confined." Id. at 440. See also Ennis & Litwack, Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom, 62 CALIF. L. Rsv. 693 (1974). Ennis and Litwack have found a number of factors interrelating to discount the efficiency of psychiatric predictions. Psychiatrists receive their training from various schools and "each school of psychiatry has a different view of what mental illness is, how it is caused, and how it should be treated." Id. at 721. The examination is tainted by the context in which it arises. Id. at 722-23. A psychiatrist's diagnosis can be influenced by a patient's socio-economic history. Id. at 724-26. "The largest sources of error derived from the inadequacies of the diagnostic system—the excessively fine distinctions required, the uncertain criteria for particular diagnoses, and the requirement of choosing a predominant diagnostic category when none was clearly evident." Id. at 729.

Some commentators have found that the attempt to accurately predict dangerousness is "inherently unreliable" because of the absence of a professional standard. Roth & Meisel, Dangerousness, Confidentiality, and the Duty to Warn, 134 AM. J. PSYCHIATRY 508 (1977).
trist can decide that only those mental patients who are likely to perpetrate violent crimes ought to be confined, while another psychiatrist, depending upon his personal philosophy, can employ the concept of 'dangerousness' to confine potential minor offenders, as well.  

Defining dangerousness so as to accommodate all psychiatrists and courts is a laudable goal to insure uniformity. Such an attempt, however, is a seemingly impossible chore in light of the divergent theories and studies conducted on dangerousness.  

Perhaps the most accepted form of predicting dangerousness is a retrospective look at the patient's prior conduct. As one court stated:

[T]o support a diagnosis of homicidal, suicidal, or dangerous, a patient must have a history of such behavior, . . . must have made verbal statements of homicide, suicide, or physical harm to himself or to others, or must have actually committed violent acts of a homicidal, suicidal, or injurious nature.

When determining liability, courts have relied on this type of "foreseeable" analysis. Some courts have also found liability where a psychiatrist or hospital "should have known" of a releasee's dangerous propensity.

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17. See generally Psychiatric Prediction of Dangerousness, supra note 15. Diamond takes the position that psychiatrists cannot accurately predict dangerous behavior and bases his opinion on the fact that there are a myriad of studies on the subject which are not based on the same criteria. The following are some of the theories on the subject.

Malmquist noted certain behavioral changes in his subjects prior to a homicidal act. Those changes are: use of drugs; object losses; threats to manhood; somatization, or a current medical problem; an emotional crescendo; and homosexual threats. Id. at 441 (citing Malmquist, Premonitory Signs of Homicidal Aggression in Juveniles, 128 AM. J. PSYCHIATRY 461, 462-65 (1971)).

"Hellman and Blackman have described a triad of symptoms—enuresis, firesetting, and cruelty to animals—which, if exhibited in childhood, are claimed to be predictive of aggressive violent crime in the adult. Id. at 441 (citing Hellman & Blackman, Enuresis, Firesetting and Cruelty to Animals: A Triad Predictive of Adult Crime, 122 AM. J. PSYCHIATRY 1431, 1432-34 (1966)).

Another expert claims that "'[l]ack of family interest, love, support, or acceptance' and '[c]onflict over basic identity are signs of potential violence." Id. at 443 (quoting Hartogs, Who Will Act Violently: The Predictive Criteria, in VIOLENCE: CAUSES AND SOLUTIONS 332 and 335 (R. Hartogs & E. Artzt eds. 1970)).

Goldstein claims that a childhood history of maternal deprivation, poor father identification, nocturnal enuresis, possible fire setting, violence towards animals, and brutalization by one or both parents are factors which lead one to murder another. Id. at 444 (citing Goldstein, Brain Research and Violent Behavior, 30 ARCH. NEURO. 1 (1974)).

18. Ellis v. United States, 484 F. Supp. 4, 10 (D. S.C. 1978) (patient displayed none of these symptoms, thus the label dangerousness was unwarranted).

The problems confronting releasing authorities in determining whether a mental patient will be a threat to society are significant. Since the medical profession cannot decisively determine whether an individual will perform a violent act upon another when released from a mental institution, those officials responsible for releasing patients must in certain cases rely upon speculative criteria. This, in turn, raises the chances of confining one who would never again inflict injury upon unsuspecting victims and releasing another who has learned to mimic docility in order to get released and continue his dangerous behavior outside the institution's walls. Thus, since psychiatric analysis is necessarily uncertain, and since the treatment of mental illness is not an exact science, any form of release involves some risk to the general public.

An important question is who shall determine whether the risk of release is too great for society's protection. Should it be the court, the psychiatrist, the hospital administrator, or a special legislative commission?

B. The Burden of the Release Determination

Underlying policy conflicts must be reconciled prior to a legislative enactment which delegates release authority to hospital administrators, courts, or special commissions.

A court determination of release is basically an allocation of social risk, while a psychiatric release is essentially a judgment within a rehabilitative framework. The judge decides whether or not the patient is potentially dangerous to society while the psychiatrist decides whether the patient's progress warrants release or will be furthered by his leaving the hospital.

Supporting the allegation that courts are ill suited to handle the release of mental patients and that hospital administrators are more qualified, one commentator noted:

[If a psychiatrist in charge of a patient . . . regards him, in his own best judgment, as ready to leave a hospital . . . how can he, in his professional conscience, let a court tell him that this he can not do . . .?] While the court has the right to order commitment, once a patient has been committed he comes under the jurisdiction of the hospital authorities. Hospital psychiatrists should be able to release the patient should they wish to do so.

20. See infra note 51.
One particular court opined that to place releasing authority under the hospital's jurisdiction was not an unconstitutional transfer of judicial powers to an administrative board.\textsuperscript{23} The decision to release "is far from being a judicial function. It does not involve any question of law or discretion. It is a question of fact."\textsuperscript{24} The court further reasoned:

\begin{quote}
[T]he public is to be protected by preventing the release and discharge of one not fully restored and who might put others in danger by his release. But no good reason has been suggested why the board of administration could not after a full hearing protect the public fully as well as a court, and possibly better by having a larger experience with such matters and better opportunity for observation of mentally abnormal persons.\textsuperscript{25}
\end{quote}

A justification as strong as that for permitting a hospital board to determine release eligibility has been advanced to support the court as the appropriate authority in making that decision. The underlying rationale is that the "situs of release authority . . . reflect[s] an allocation of social risk" and the court is better able to allocate that risk than psychiatrists who focus on the patient's immediate danger rather than the broader context of illegality.\textsuperscript{26} State legislatures consider it important for the judiciary to oversee the "often inaccurate predictions."\textsuperscript{27} Another justification for granting the judiciary this power centers on the economical fact that "[h]ospital authorities are often under pressure to release patients to relieve crowded conditions, and chances of releasing a dangerous individual are greatly enhanced."\textsuperscript{28}

\textsuperscript{25} 187 Kan. at 15, 353 P.2d at 811.
\textsuperscript{26} Release in New Jersey, supra note 21, at 168.
\textsuperscript{27} Id. at 166. See also Weihofen, Institutional Treatment of Persons Acquitted by Reason of Insanity, 38 Tex. L. Rsv. 849 (1960). Weihofen finds that psychiatrist's diagnosis of dangerousness is inaccurate in an absolute sense because of the psychiatrist's inclination to overpredict.

When a patient is released as recovered and later commits another crime, especially homicide or rape, there is almost certain to be loud public outcry (sic). Superintendents therefore may keep in custody patients whose condition is markedly improved who, were it not for the public danger involved, would be considered ready for a chance to reestablish themselves in free society. To be released, they will probably have to exhibit a good more sanity, self control, and strength of character than is possessed by many of us who have never been in a mental hospital.

\textit{Id.} at 864.
\textsuperscript{28} "Not Guilty By Reason of Insanity" . . . Mandatory v. Discretionary Commitment and Release Procedure For the Commitment of the Criminally Insane, 4 Wil-
Many jurisdictions resolve these basic underlying concepts by dividing the responsibility between the hospital administrators and the courts. The primary factor determining whether a statute permits the release of a mental patient by the court or hospital administrator is whether the patient was committed following an insanity acquittal, or following an involuntary civil commitment based upon probable cause. If the patient was released following an involuntary civil confinement, the typical statute permits the hospital director to release the patient without court approval.

An authorized staff physician of a hospital shall discharge an involuntary patient when he concludes that the patient no longer is mentally ill, no longer presents an immediate threat of danger to others, or when he believes that the patient can no longer reasonably benefit from treatment in the hospital.29

If the patient was released following an acquittal, the legislature vested the final release authority in the court.

If the court is satisfied by the application and report seeking the release or discharge of the committed person . . . , that the committed person is not insane or feebleminded and that his discharge or release will not be dangerous to the public peace and safety or himself, the court shall order his discharge or release. If the court is not satisfied, it shall promptly order a hearing. . . .30

A significant number of jurisdictions provide for both the release of civilly confined mental patients by hospital officials and the release of

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30. VA. CODE § 19.2-181 (West 1982). See also ARK. STAT. ANN. § 41-612 (1981); CAL. PENAL CODE § 1026.1(a) (West 1981); COLO. REV. STAT. § 16-8-115 (1963); DEL. CODE ANN. tit. 16, § 5009 (1980); FLA. STAT. ANN. § 394.463 (West 1973); GA. CODE ANN. § 505.6 (1982); ILL. ANN. STAT. ch. 91 1/2, § 3-906(a) (Smith-Hurd 1981); IOWA CODE ANN. § 226.29 (West 1981); MASS. GEN. LAWS ANN. ch. 123, § 16(e) (West 1981); MINN. STAT. ANN. § 253A.15 (West 1982); OHIO REV. CODE ANN. § 2945.40 (Page 1982); OR. REV. STAT. § 426.300 (1977).

But see VT. STAT. ANN. tit. 18, § 8009(b) (1982) which states in part:

The head of the hospital shall discharge a judicially hospitalized patient when the patient is no longer a patient in need of further treatment. When a judicially hospitalized patient is discharged, the head of the hospital shall notify the applicant, the certifying physician and the court and anyone who was notified at the time the patient was hospitalized.
insanity acquitees by the court. It is not infrequent to find as a condition precedent to release that hospital officials must submit to the court a certificate of recovery or a certificate that the patient no longer needs hospitalization. This procedure allows for a system of checks in the release decision. Also, it recognizes the court's jurisdiction over criminally insane acquitees and the safeguard of constitutional rights.

Under the statutes identified, the decision to release pertains to the unconditional release of a patient. In many instances, state legislatures provide exclusively for the temporary release of a mental patient. In allowing for the conditional release of a patient it is not necessary that the patient gain his sanity, but it is required that "such person will not in the reasonable future be dangerous to himself or others."

31. See, e.g., CAL. WELF. & INST. CODE § 7362 (West 1981) and CAL. PENAL CODE § 1026(a) (West 1981); FLA. STAT. ANN. § 394.469 (West 1973); ILL. ANN. STAT. ch. 91 ½, §§ 3-902(a), 3-906(a) (Smith-Hurd 1981); IOWA CODE §§ 226.27, 226.29 (West 1981); MASS. GEN. LAWS ANN. ch. 123, § 16(e) (West 1981); MINN. STAT. ANN. § 253A.15 (West 1982); OHIO REV. CODE ANN. § 2945.40 (Page 1982); and VA. CODE ANN. §§ 19.2-181, 37.1-99 (West 1982).

32. See supra note 12.

33. See Note, Procedure for the Release for the Criminally Insane—A Suggested Approach, WASH. U.L.Q. 120 (1962). “Apparently mandatory commitment without further inquiry into the individual’s then existing mental condition is not a denial of due process so long as ultimate judicial determination of sanity is provided for by statute.” Id. at 121.

34. See supra notes 29-31 and accompanying text.

35. IDAHO CODE § 66-338 (West 1982); MD. CTS. & JUD. PROC. ANN. § 10-806(a) (1982); and OR. REV. STAT. § 426.280 (1981).

36. The terms conditional release, temporary release, and open door are used interchangeably and shall mean any release which requires the patient to report back to the mental hospital or out-patient clinic program. The terms shall include, but are not limited to, work leave, home visits, day passes and rehabilitative leave. Release on convalescent leave status does not terminate the involuntary hospitalization order and shall include provisions for a continuing responsibility by the hospital, and will include a plan for treatment by the hospital.


One New Jersey court illustrated what factors must be considered before making a conditional release.

[T]he judge must conduct as broad an inquiry as possible, covering the patient's background, initial offense, available out-patient care, family life and potential job situation. He must hear and resolve conflicts in testimony from psychiatrists and, if not satisfied, call additional experts. Ultimately, he must make findings of facts as to the applicant's state of mental health and the conditions necessary to adequately assure his safe return to society. After evaluating this evidence the court must be persuaded by a clear and convincing standard before it will release the patient.
Since the focus falls exclusively on the patient's risk of harm to others, special scrutiny is given to the release decision.

C. Conditional Release

The conditional release, or "open door policy," is therapy itself and designed to aid a patient in his recovery.38 The custody pass, trial home visit, or work release are "recognized therapeutic device[s] used by psychiatrists in the care and treatment of patients to ascertain if there is going to be any reasonable probability that the patient will ever be able to mix peacefully and appropriately with his family and society."39 "Such a therapy program entails risks to the patient and to society as a whole, [and] it involves a balancing of interests which is most important in the psychiatric field."40

When balancing the needs of the patient to be rehabilitated against the protection of society from premature release, courts and legislatures will grant open door therapy when the risk factors tend to point that way.41


Modern psychiatry has recognized the importance of making every reasonable effort to return a patient to an active and productive life. Thus, the patient is encouraged to develop his self-confidence by adjusting to the demands of everyday existence ... [I]nstitutionalization is the exception, not the rule, and is called for only when a paramount therapeutic interest or the protection of society leaves no choice ... [M]odern psychiatric practice does not require a patient to be isolated from normal human activities until every possible danger has passed ... It has also been made clear to the Court that constant supervision and restriction will often tend to promote the very disorders they are designed to control. Id. at 192 (quoting Johnson v. United States, 409 F. Supp. 1283, 1293 (M.D. Fla. 1976), revd on other grounds, 576 F.2d 606 (5th Cir. 1978)). See also Grunenberg & Huxley, Implications of Rehabilitation, in REHABILITATION OF THE MENTALLY ILL 181 (M. Greenblatt & B. Simon eds. 1959).

39. Ellis v. United States, 484 F. Supp. 4, 8 (D. S.C. 1978) (since the patient showed no signs of homicidal or suicidal tendencies, he was a good choice for the open door).

40. Eanes v. United States, 407 F.2d 823, 824 (4th Cir. 1969) (quoting White v. United States, 244 F. Supp. 127, 131 (E.D. Va. 1965), aff'd per curiam, 359 F.2d 989 (4th Cir. 1966)) (calculated risks can be justified to treat the mentally ill intelligently).

41. In Higgins v. State, 24 A.D.2d 147, 265 N.Y. S.2d 254 (1965), the court commented that "nothing should unreasonably interfere with the rehabilitative processes and the obligation of the state to apply modern and generally accepted methods of controls in an effort to improve the mental condition of patients in state institutions." Id. at 149, 265 N.Y. S.2d at 256. See also Timmins v. State, 58 Misc. 2d 626, 296 N.Y. S.2d 429 (1968).
[I]t is incumbent upon the attendant experts who are in charge of the mentally ill to exercise that degree of care, in diagnosing the illness of a patient and in calculating the possibilities that his assaultive tendencies may assert themselves, which is commensurate with the risks involved in opening the doors of the hospital to him for leaves of absence during which he will be free of professional care, supervision or restraint.\(^4\)

It is during the diagnosis of the patient's illness and the determination of risk of harm to self or others that abuse or neglect of professional discretion can occur. When abuse does occur, a patient is released when all factors indicate that the initial risks involved outweighed any rational decision to release. In *Merchants National Bank & Trust Co. of Fargo v. United States*,\(^4\) the court found that "the Government's agents and employees not only did not exercise due care; in the view of this Court they exercised no care at all."\(^4\)

At the other extreme lies those cases where considerable due care is exercised, but some unforseeable act by the releasee occurs which causes injury to others. In *Hilscher v. State*,\(^4\) Robert Brown, a patient at a mental institution, was given permission to work at a neighboring farm.\(^4\) During one of these trips Brown went to the claimant's farm, which bordered the farm he worked on, and set fire to a building.\(^4\) The court found no liability because the patient's history had never indi-

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The court noted that home visits and passes conformed with accepted standards of medical practice; and that the objective is to return the patient to society as soon as, in the judgment of properly qualified doctors and psychiatrists, it is safe for others and helpful to the patient. 58 Misc. 2d at 631, 296 N.Y.S.2d at 434.

44. Id. at 417. The court based its conclusion on several factors. "Dr. Linnell believed almost everything Newgard (patient-murderer) told him without investigating or causing to be investigated any of Newgard's statements." Id. at 415. Dr. Craft had tested Newgard and found organic brain damage. Id. at 416. Apparently nothing came of this evaluation. Another factor the court found important was the fact that Mrs. Newgard, who was characterized as "a stable nurse," called Meade Hospital and talked to Dr. Rosenbaum, Meade's Chief of Staff, when she learned about the decision to release her husband. Id. at 413. During that conversation she became very upset and hung up on him. Id. Rosenbaum routinely "put a note of the conversation in Newgard's file, but at no time did he direct anyone at Meade to pursue the matter of Eloise Newgard's phone call further to determine what caused her to be upset. . . ." Id. at 418. Also, "Dr. Craft was negligent in not bringing to the attention of the appropriate Meade personnel a letter from Newgard while the latter was on the Davis ranch," which contained remarks that pointed to his "delusional" character. Id. These factors, and more, led the court to hold that the officials at Meade Hospital were negligent. Id.

45. 64 Misc. 2d 368, 314 N.Y.S.2d 904 (1970).
46. 64 Misc. 2d at 368-69, 314 N.Y.S.2d at 906.
47. 64 Misc. 2d at 369, 314 N.Y.S.2d at 906.
cated a proclivity to set fires and the hospital staff could in no way anticipate Brown's destructive act. Brown eloped and burned down a cottage belonging to Dr. Meyers of the mental institution. This time the court found the state liable because of negligence "in its failure to keep a close watch on Robert Brown, having been previously warned of his fire setting tendencies." The Hilscher scenario illustrates that a lack of care by hospital authorities in permitting Brown to continue to work outside greatly added to the risk society had to bear.

The problems inherent in deciding whether to open the doors of the mental institution for patient therapy are numerous and further complicated by the recognition that a certain degree of risk enters each decision. Not only must hospital authorities and the court determine what conditions they will impose upon the releasee, but also, the patient must want to help himself. Considering all the factors, the decision to temporarily release a patient for therapy involves greater risk than the decision to unconditionally release a patient who has regained his sanity.

48. 64 Misc. 2d at 372, 314 N.Y.S.2d at 909.
50. 64 Misc. 2d at 374, 314 N.Y.S.2d at 911.
51. Doctors must evaluate whether the patient is dangerous by determining whether he is homicidal, suicidal, or possesses the propensity toward violence. A patient's family life, social habits, and work experience are examined, as is any prior criminal offenses he may have and the nature of those offenses. In addition, the court must be certain that the patient has the "availability of adequate living" and the court must determine the "duration" which the patient will remain outside the institution's boundaries. For a general discussion of the latter two points, see Commitment—Conditional Release From Mental Institutions Made Available to Persons Confined Under Criminal Statutes, 6 SeTROn HALL L.R. 128, 142-43, 147-48 (1975).
52. The conditions imposed upon each patient released on a temporary basis is governed by the circumstances of each case. Restrictions on the time spent away from the institution; the avoidance of certain individuals; the daily attendance of outpatient clinics; the daily consumption of medication; and any conditions established by the releasing authority that he deems necessary. See generally Md. Code Ann. § 10-806(c)(3) (1982); Vt. STAT. ANN. tit. 18, § 8007(d) (Equity 1982).

Cf. Scheidt v. Meredith, 307 F. Supp. 63 (D. Colo. 1970). The petitioner was acquitted of criminal charges by reason of insanity, and thus was legally a convicted criminal. Id. at 66. When petitioner sought conditional release, however, the conditions imposed upon him were "as a matter of practice, the same conditions imposed upon a convicted criminal who (had) been placed on probation." Id. at 65-66. The court held that:

[J]t would be clearly proper to require that petitioner accept psychiatric out-patient care or supervision. However, terms which were designed to regulate the activities of convicted criminals and which are punitive in nature, cannot be imposed in a case as this.

Id. at 66.
D. Release Through Habeas Corpus Proceedings

Habeas corpus ad subjiciendum is a writ issued pursuant to a petition which commands an official to release or return to the court one who comes under his official authority. The writ's origins root back to common law and have the important purpose to aid those individuals illegally confined and to secure their release. In the mental health field the rationale behind the writ of habeas corpus is that the continued restraint of an individual who has been committed to an institution, yet has recovered, is illegal.

The procedural use of habeas corpus falls within several categories. The classic situation in which habeas corpus should be permitted is when there exists no statute which expressly governs the release procedure. In Richey v. Baur, the statute which authorized the commitment of one acquitted because insane did not establish guidelines for the release of such a person once his sanity returned. The patient was in the position either to petition the superintendent of the institution in which he was detained for a certification of recovery to sanity, or petition the court for a hearing on the issue of sanity. The court stated that in the absence of statutory guidelines, a superintendent's refusal to release a patient after his sanity has been restored is unjustified in light of authority which permits hospital officials to discharge recovered individuals without court authorization. The court found that habeas corpus was the proper procedure for the petitioner since the superintendent conceded that petitioner's sanity had been restored.

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53. BLACK'S LAW DICTIONARY 638 (Rev. 5th ed. 1979).
54. For a general discussion of the origins of habeas corpus, see 39 AM. JUR. 2D 143, Habeas Corpus (1968).
55. Not Guilty supra note 28, at 76. See also Soderquist v. Keller, 21 Wash. 2d 1, 8, 149 P.2d 528, 532 (1944) (where superintendent fails to exercise power to release the patient may seek judicial intervention).
56. 298 S.W.2d 445 (Mo. 1957).
57. Id. at 447.
58. Id.
59. Id. at 448. See also Northfoss v. Welch, 116 Minn. 62, 133 N.W. 82 (1911). In Welch, the petitioner had regained his sanity yet the superintendent refused to discharge him, not because he was insane, but because a statute which was passed subsequent to his commitment required the superintendent to guarantee petitioners future conduct. The court held that the statute could not be applied retroactively and common law permitted the petitioner habeas corpus proceedings where confinement became illegal because of restoration to sanity; Overholser v. Boddie, 184 F.2d 240 (D.C. Cir. 1950). In Boddie, a statute specifically described the procedures for discharging as "cured" one who had been released as "improved." The statute remained silent in regard to one confined who sought release from custody because of restoration to sanity. The court concluded that since the statute remained silent on this issue and that the remedy of habeas corpus had been available at common law and available prior to the enactment of the
In the Application of Perkins, a California court held that the petitioner was entitled to maintain a habeas corpus proceeding as his only remedy to show that his continual confinement was illegal. Under this type of proceeding a patient need not acquire a certification of recovery from hospital authorities. Several jurisdictions, however, have recognized that before a court may entertain a writ of habeas corpus to determine whether a patient has regained his sanity, a mandatory period of confinement must elapse.

Habeas corpus petitions are frequent when hospital officials deny a patient a certificate of restoration to sanity and the patient subsequently seeks to secure his release. The weight of authority adheres to the general rule that a statute which requires certification of recovery by hospital authorities of persons committed to a mental institution after an insanity acquittal is a condition precedent to release. Though statute then it was a remedy "expressly" reserved to him by the statute. 184 F.2d at 243; and People v. McNelly, 83 Misc. 2d 262, 371 N.Y.S.2d 538 (1975) (defendant acquitted of charges on ground of insanity can always have his confinement reviewed on a writ of habeas corpus).

61. 165 Cal. App. 2d at 81, 331 P.2d at 717. After the lower court denied the patient's request for release, against conclusive evidence, the appeals court, in dismissing the action, maintained the action must lie in habeas corpus and not an appeal. Id.
62. See, e.g., In re Davis, 106 Cal. Rptr. 178, 505 P.2d 1018, cert. denied, 414 U.S. 870 (1973) (court could determine independently through habeas corpus if patient would recover his sanity); and Flores v. Lodge, 101 Idaho 533, 617 P.2d 837 (1980) (statute specifically authorizes the court to release a patient if he is no longer dangerous).
63. For cases denying a writ of habeas corpus on the ground that the expiration of one year from the date of commitment after the petitioner had been acquitted of murder by reason of insanity had not passed. See Re Slayback, 209 Cal. 480, 288 P. 769 (1930) (not an unconstitutional exercise of legislative power because confinement is not imprisonment for punishment); and Re Merwin, 209 Cal. 786, 288 P. 774 (1930) (Slayback upheld the power to confine for a mandatory period). In Commonwealth v. Vogt, 21 Pa. D. 38 (1911) the court upheld the constitutionality of a statute which provided that a petition for discharge could not be entertained until the petitioner was confined for at least three months.

But see Commonwealth v. Wilcox, 77 Pa. Super. 136 (1921). In Wilcox, the petitioner, acquitted of a murder because of insanity, petitioned the court to be released from custody on parole because she was no longer insane after only two months confinement. The court found that it possessed the power under the parole statute to release the petitioner at anytime and the power was distinct from the power to unconditionally release which required a minimum of three months confinement.

64. In Parker v. People, 108 Colo. 362, 117 P.2d 316 (1941) the petitioner's wife stated in an affidavit that the petitioner was not dangerous to himself or others and could be safely released. 108 Colo. at 364, 117 P.2d at 317. In addition, the petitioner attached a letter from the superintendent to petitioner's wife which stated that the patient's condition was improved but his immediate release was not advisable. 108 Colo. at 364, 117 P.2d at 317. Upon denying the habeas corpus proceeding the court found that the failure
few cases have permitted the release of a patient after denial by hospital authorities,\textsuperscript{65} nor recognized the right,\textsuperscript{66} the trend clearly dictates that a patient will not be released unless he shows that the superintendent acted arbitrarily or capriciously.\textsuperscript{67}

The writ of habeas corpus has also been denied in situations where other statutory remedies were available. One rationale advanced for the denial of habeas corpus focuses on the fact that the writ is discretionary and will not be issued when petitioner can secure the relief requested through other legal channels.\textsuperscript{68} Thus, in Hamilton v. Henderson,\textsuperscript{69} the court denied petitioner's writ of habeas corpus stating that she had to file in the probate court which adjudicated her incompetent.\textsuperscript{70} Another court has found that the proper procedure is to file a bill in equity on behalf of the petitioner and not proceed with a writ of habeas corpus.\textsuperscript{71} A third justification has found that the power to re-

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of the superintendent to make a favorable recommendation did not invoke the committing court's jurisdiction to hear the habeas corpus proceeding. 108 Colo. at 366, 117 P.2d at 318. See also In re Clark, 86 Kan. 539, 121 P. 492 (1912). The court concluded that since the superintendent's certificate of recovery was a necessary condition for release, the committing court could not investigate the question of sanity; 86 Kan. at 551, 121 P. at 496; and In re Ostatter, 103 Kan. 487, 175 P. 377 (1918). The court stated that until the superintendent certifies the petitioner as wholly recovered and not a danger to others he was not entitled to habeas corpus proceedings. 103 Kan. at 488, 175 P. at 378.

65. See Lawrence v. Barlow, 77 W. Va. 289, 87 S.E. 380 (1915). A friend of the patients furnished bond, as required by statute, in order to secure the patient's release. The hospital officials refused to release him even though his sanity had been restored. The court noted that habeas corpus was the proper remedy to secure his release.

66. See Ex parte Clark, 86 Kan. 539, 121 P. 492 (1912). In Clark, the court denied petitioner's release without first obtaining the superintendent's certificate of recovery. 86 Kan. at 553, 121 P. at 498. The court stated in dicta, however, that the court could hear the action under ordinary judicial procedures and the superintendent's certificate was not a prerequisite if the action were presented in an appropriate fashion so that the court could consider the request for release. 86 Kan. at 548, 121 P. at 496.

67. For cases holding that a petitioner can maintain a habeas corpus proceeding for his release by showing that he has maintained his sanity and by establishing that the superintendent acted arbitrarily or capriciously in refusing to certify petitioner, see Overholser v. Leach, 257 F.2d 667 (D.C. Cir. 1958) and O'Beirne v. Overholser, 180 F. Supp. 572 (D.D.C. 1960). For cases holding that mandatory commitment procedures for individuals acquitted of criminal offenses because of insanity as being valid, and a patient's subsequent failure to establish in the record of a habeas corpus proceeding for release from a mental institution that the superintendent acted arbitrarily and capriciously in refusing to certify that the petitioner had recovered and was eligible for release, see Overholser v. Russell, 283 F.2d 195 (D.C. Cir. 1960) and Foller v. Overholser, 292 F.2d 732 (D.C. Cir. 1961).

69. 232 Mo. App. 1234, 117 S.W.2d 379 (1938).
70. 232 Mo. App. at 1241, 117 S.W.2d at 384.
lease came under the purview of the state board of administrators.72 Once a petitioner can show that he has exhausted all his administrative or state remedies, however, a federal court will entertain a habeas corpus proceeding.73

E. Conclusion

A patient involuntarily confined in a mental institution faces a heavy burden to show a hospital administrator or a court that he no longer presents a danger to himself or others. Once the patient no longer poses a danger to society, he may be released or discharged conditionally or unconditionally. If a patient’s release becomes snagged at the hospital stage of the proceeding, the patient can seek the assistance of a court of law through a writ of habeas corpus. Unfortunately, no matter what form of release is used74 or who grants the release, mistakes are made and innocent parties are injured by released mental patients.

62.32 (West 1941)).
72. See In re Timm, 129 Kan. 126, 281 P. 863 (1929). In denying the writ of habeas corpus the court found that the statute providing for administrative relief was valid and the board’s function under the statute was not judicial, since it did not involve a question of law or discretion. The function involved only a question of fact. The fact is whether the petitioner had been restored to sanity. 129 Kan. at 129, 281 P. at 864.
73. See Scheidt v. Meredith, 307 F. Supp. 63 (D. Colo. 1970). Here petitioner filed a writ of habeas corpus in the United States District Court. Id. at 64. The court stated that if petitioner followed his state remedy and filed a petition with the state court to hear the issue of his restoration to sanity the court would address the issues of the “petitioner’s mental condition; whether the Superintendent of the hospital is arbitrarily refusing to certify the petitioner as sane; and whether petitioner is entitled to his release.” Id. at 65. The court went on to say that since “there is every probability that the state courts will stand by their previous ruling, and since the hearing is limited to sanity and arbitrary refusal to release, it would appear that petitioner has effectively exhausted his available state remedies” and may entertain a writ of habeas corpus before this court. Id.
74. Two other forms of release from mental hospitals that will not be discussed are suicide and escape. For a discussion of each, see generally Tort Liability of the Psychotherapist, 8 U.S.F.L. Rev. 405 (1973). The prediction of suicide, like the prediction of dangerousness, is not based upon accurate clinical evidence. “It is an accepted fact that sometimes no incidents precede the fatal act, that patients sometimes kill themselves no matter what restraints are used, and that many suicides are not even reported as such.” Id. at 423. Thus, a psychiatrist’s liability for a patient’s suicide generally relies on expert testimony indicating the acceptable standard of care. Id. at 423-25. See also Liability—Harm By Escaped Prisoner of Hospital or Sanitarium for Injury or Death of Patient as Result of His Escape or Attempted Escape, 70 A.L.R.2d 347 (1981). Under appropriate circumstances a public officer may be liable to a third person for harm done by a prisoner permitted to escape. Notwithstanding, public officers have generally not been held liable for the negligent or intentional harm done by an escaped prisoner, on the ground that the negligent or wrongful act of the official in permitting the escape was not the proximate cause of the harm which resulted. Id. at 350-55.
Thus, an inquiry must be made of a release authority’s liability for the negligent release of a mental patient.

III. LIABILITY FOR THE NEGLIGENCE RELEASE OF A MENTAL PATIENT

The increased public and judicial attention to victims of violent crime has resulted in the frequency of civil actions as a means of compensating the victims. Yet, since many perpetrators of crime are judgment proof, alternative ways of recovering compensation are necessary. One alternative is to hold a third party liable. When injury is caused by a mental patient recently released from a state institution, victims have brought charges of negligence against the United States under the Federal Tort Claims Act, against state governments under provisions of state law and against superintendents and directors of mental institutions. Case law illustrates that negligence claims can be

75. Carrington, Victims’ Rights Litigation: A Wave of the Future?, 11 U. Rich. L. Rev. 447, 450 (1977). Recognition is given to victim services promulgated by the prosecutors’ office, police departments, private organizations, victim compensation legislation, and restitution legislation. Yet, victims right litigation against third parties are important because it has the potential of preventing future victimization by giving “notice that the law works to aid victims” and if negligence is proven collectibility of judgment generally presents no problem. Id. at 454-469.

76. Id. at 456-59.

77. Id. at 457-58. See generally Note, But What About the Victim? The Foresaken Man in American Criminal Law, 22 U. Fla. L. Rev. 1, 10-20 (1969). In addition to citing restitution based upon a legislative mandate, other alternatives have been advanced. Repayment of injury based upon a plan of prison labor with wage garnishment has been suggested. Id. at 6. A system of civil claims in criminal proceedings has been advanced. Id. at 6-7. A victim may be compensated for their injury by taking a share of a “fine” levied against the criminal. Id. at 7. A citizen may also take out insurance which protects them from any unprovoked injury. Id. at 7-8; and Criminal Victim Compensation in Maryland, 30 Md. L. Rev. 266 (1970). Under the welfare theory of the Maryland Criminal Injuries Compensation Act, recovery for injuries is not available to all victims, only to “hardship victims.” Id. at 278-283.

78. See infra 176-206 and accompanying text.

79. See, e.g., Hernandez v. California, 11 Cal. App. 3d 895, 90 Cal. Rptr. 205 (1970) (legislative intent was to allow free release from confinement without the possibility of liability); Morgan v. County of Yuba, 230 Cal. App. 2d 938, 41 Cal. Rptr. 508 (1964) (sheriff’s failure to warn victim was proximate cause of death); Homere v. State, 48 A.D.2d 422, 370 N.Y.S.2d 246 (1975) (hospital doctors liable for not reevaluating patient after he became violent); Hilscher v. State, 64 Misc. 2d 368, 314 N.Y.S.2d 504 (1970) (knowledge of a dangerous propensity is the determining factor to liability); Pernetti v. State, 44 Misc. 2d 582, 254 N.Y.S.2d 332 (1964) (claimant must show he was within class sought to be protected); and Epting v. Utah, 546 P.2d 242 (1976) (the discretionary function exception is applicable for authorities releasing one on work leave).

80. See, e.g., Semeler v. Psychiatric Institute of Washington, D.C., 538 F.2d 121 (4th Cir. 1976) (failure of doctors to get court approval before releasing patient was proximate cause of victim’s death); Scheidt v. Meredith, 307 F. Supp. 63 (D. Colo. 1970) (conditions
maintained whether the release is conditional or unconditional.

A claim based on negligence of a third party has many barriers to overcome. To establish liability a plaintiff must prove:

[First] What the recognized and generally accepted standards, practices and procedures are in the community which would be exercised by competent physicians in the same specialty under similar circumstances.

[Second] The physician . . . or hospital personnel in question negligently deviated from the generally accepted standards, practices and procedures.

[Third] Such negligent deviation from the generally accepted standards, practices and procedures was a proximate cause of the plaintiff's injury.

[Fourth] The plaintiff was injured.81

A plaintiff must also address the problem of governmental immunity.82 Finally, in an action against the United States under the Federal Tort Claims Act, the applicable state law and state standard must be articulated.83

for release from mental hospital are not to be the same as those imposed on probation inmates); Meier v. Ross Gen. Hosp., 69 Cal. App. 2d 420, 445 P.2d 519, 71 Cal. Rptr. 903 (1968) (liability for not closely watching suicidal patient near open window); Bradley Center, Inc. v. Wessner, 161 Ga. App. 576, 287 S.E.2d 716 (1982) (hospital should have known patient was likely to cause bodily harm to others); Dimitrijevic v. Chicago Wesley Memorial Hosp., 92 Ill. App. 2d 251, 236 N.E.2d 309 (1968) (court required expert testimony to establish lack of ordinary care and skill).

81. Ellis v. United States, 484 F. Supp. 4, 10-11 (D. S.C. 1978) (physician must use reasonable care but only bound to possess and exercise that skill which is possessed by members of his profession).


83. The Federal Tort Claims Act was not intended to operate independently of state law, but "rather it was designed to build upon the legal relationships formulated and characterized by the States." Richards v. United States, 369 U.S. 1, 7 (1962). See, e.g., A & D International, Inc. v. United States, 665 F.2d 669 (5th Cir. 1982); Brock v. United States, 601 F.2d 976 (9th Cir. 1979); In re Silver Bridge Disaster Litigation, 381 F. Supp. 831 (S.D. W.Va. 1974).

The determination whether the complaint states a cause of action under the FTCA is governed by state law. See generally Builders Corp. v. United States, 259 F.2d 766 (9th Cir. 1958) (court reversed where the lower court concluded that the cause of action had to meet federal guidelines); and In re Bomb Disaster at Roseville, Cal., on April 28, 1973, 438 F. Supp. 769 (E.D. Cal. 1977) (elements of cause of action based on products liability under the FTCA must be based on state law).

State law establishes the duty of care in FTCA cases. See generally United States v. Schultz, 282 F.2d 628 (1st Cir. 1960). The Maine rule that a landowner owes no duty to a licensee except not to wantonly injure him or to set traps for him applied when plaintiff was injured on federal grounds. Chinca v. United States, 190 F. Supp. 643 (N.D. Cal. 1961) (duty owed by a landlord to a licensee under state law applied in a case involving the collapse of a bridge plank in a national park).
A. Standard of Care

A primary complication in a claim against a third party for the negligent release of a mental patient is the burden placed upon the victims to show that the psychiatrist failed to act as a "competent psychiatrist" under the same or similar circumstances. The standard of care represents a balancing of competing policies. In so doing, equal weight is not always given to both sides. Courts have observed that "a hospital cannot be charged with the responsibility of insuring the physical safety of the public from all harmful acts committed by patients who have been discharged."  

State law establishes whether a defendant's conduct was the proximate cause of plaintiff's injury when recovery is sought under the FTCA. See generally Arnhold v. United States, 284 F.2d 326 (9th Cir. 1960), reh'g denied, F.2d 924 (9th Cir.), cert. denied, 368 U.S. 876 (1961).

It is generally found that the defenses to a case are established by state law, even though the cause of action was brought under the FTCA. See generally Saunders v. United States, 150 F. Supp. 878 (D. Mass. 1957). The court applied state law requirements to filing in granting the United States summary judgment against a pedestrian who fell on ice on the State House sidewalk and who failed to comply with the state statute. Id. at 879.

Similarly, federal authority supports the proposition that the issue of burden of proof is governed by state law. See generally Alliance Assur. Co. v. United States, 252 F.2d 529 (2nd Cir. 1958). The court found that New York law applied on the question whether the United States as bailee had the burden of persuasion or merely the burden of coming forward with the evidence. Id. at 534-35.

In regard to the question of damages in an action under the FTCA the United States Supreme Court said damages were governed by the law of the state in which the government's tortious conduct took place. Richards v. United States, 369 U.S. 1, 16 (1962).

But see 28 U.S.C. § 2671 which defines "employee of the government" as found in 28 U.S.C. § 1346(b) as including officers or employees of any federal agency, members of any federal agency, members of the military or naval forces of the United States, and persons acting on behalf of a federal agency in an official capacity, temporarily or permanently in the service of the United States, whether without compensation. In Courtney v. United States, 230 F.2d 112, 114 (2d Cir. 1956) the court held that for purposes of the FTCA, the term employee was a federal question based on a federal statute.


85. Comment, Psychotherapists' Liability for the Release of Mentally Ill Offenders: A Proposed Expansion of the Theory of Strict Liability, 126 U. Pa. L. Rev. 204, 206-7 (1977) [hereinafter cited as A Proposed Expansion]. In release situations, the protection of society against violent assault must be measured next to the benefit of providing society with a rehabilitated and productive person. The release decision must account for the degree of calculated risk inherent in each decision. Even the exercise of the highest care will not obviate the risk of harm to society which arises after every release or "prevent the infliction of some harm by released patients." Id. at 207.


To require such responsibility suggests a form of strict liability against psychiatrist for
In light of the policies to rehabilitate mental patients through release programs, and to protect psychiatrists against liability, courts will not impose liability for an "honest error in judgment." To further protect the psychiatrist from liability for honest errors, the courts, while purporting to use an ordinary negligence standard, are applying a stricter standard and requiring plaintiffs to prove a higher degree of unreasonable conduct. "Courts have recognized the uncertainty of psychiatric analysis by refusing to second-guess psychiatric discretion and by requiring 'something more' than a 'mere error of professional judgment' to impose liability."

From a victim's view, a standard of care based upon reasonableness does not meet the risks of releasing patients who have the capability of causing serious bodily harm to third persons. Rather than imposing the release of mental patients. A steadfast reluctance to adopting strict liability principles appreciates that "exactitude is often impossible." Hicks v. United States, 511 F.2d 407, 415 (D.C. Cir. 1975) (error and uncertainty must be accepted without labeling them negligence). Accord Laird v. Nelms, 406 U.S. 797 (1972); Greenwood v. United States, 350 U.S. 366 (1956).

87. Williams v. United States, 450 F. Supp. 1040, 1044 (D. S.D. 1978). See also White v. United States, 244 F. Supp. 127 (E.D. Va. 1965) (failure of the doctor to remove outpatient privilege before patient stood in front of train was at most a mere error of judgment); Homere v. State, 48 A.D.2d 422, 370 N.Y.S.2d 246 (1975) (something more is where patient who had shown violent signs two days prior to release, yet was released any way); Taig v. State, 15 Misc. 2d 1098, 241 N.Y.S.2d 495 (1963) (psychiatrist cannot be liable for medical judgment which proves to be erroneous when a mental patient who was permanently released as cured assaulted young girl four or five months later); St. George v. State, 283 A.D. 245, 127 N.Y.S.2d 147 (1954) (the state could not be held liable for an honest error of professional judgment in releasing a mental patient, who stabbed and killed several people, on the basis that the state has the duty to treat patients, to improve their condition, and to release them when perceivably sane).

88. See Schwenk v. State, 205 Misc. 407, 414, 129 N.Y.S.2d 92, 98 (1953) (psychiatrist of state mental hospital must "possess that reasonable degree of learning and skill that is ordinarily possessed by psychiatrist in the locality" and "use reasonable care and diligence in the exercise of their skill"); Fischer v. City of Elmira, 75 Misc. 2d 510, 513, 347 N.Y.S.2d 770, 774 (1973) (state has duty to use reasonable care to protect person in state institution with suicidal tendencies against himself).

89. See Homere v. State, 79 Misc. 2d 972, 361 N.Y.S.2d 820, 824 (1974) (court found that the hospital's failure to reconvene the Commission after the releasee exhibited assaultive behavior was something more to establish liability); and Matter of Torsney, 420 N.Y.S.2d 192, 197, 394 N.E.2d 262, 267 (1979) (more is required to show dangerousness than an insanity acquittee's prior criminal record).

In general, applicable state statutes will be applied imposing a stricter standard than that of ordinary common-law negligence. Where the common law itself, and not a statute, imposes strict liability, it is still doubtful whether the courts would apply absolute liability.

duty of a "[psychiatrist] under similar circumstances" it has been suggested that a psychiatrist be under a duty to exercise "great care and caution" when making a determination to release a patient. Such a standard of care would place a psychiatrist on notice that his decision to release a patient is being scrutinized by hospital administrators, courts and legislatures. Hence, it is hoped that a psychiatrist will use more caution in formulating his methodology in determining whether a patient is ready for release and will recognize the seriousness of the court's or legislature's intent to reduce the number of injuries inflicted upon third parties by released mental patients.

B. Duty to Exercise Care Towards Third Parties

Psychiatrists are under a duty to follow the standard of care imposed by law and their failure to do so may make them liable for negligence. Courts have established different methods for deciding whether a duty exists between two parties. One approach looks to the competing policy considerations and observes that whether a duty exists depends ultimately on questions of fairness involving a weighing of the relationship of the parties, the nature of the risk involved, and the public interest in imposing the duty under the circumstances. This approach is, how-

91. Ellis v. United States, 484 F. Supp. 4, 10-11 (D. S.C. 1979)).
92. Eanes v. United States, 407 F.2d 823, 824 (4th Cir. 1969). See also Bush v. Director, Patuxent Inst., 22 Md. App. 353, 361, 324 A.2d 162, 168 (1974) (Secretary of Health and Mental Hygiene requires his hearing officers to ascertain by clear and convincing evidence). Accord Grimm v. Arizona Board of Pardons and Paroles, 115 Ariz. 260, 564 P.2d 1227 (1977). In the context of State Board of Pardons and Paroles releasing a prison inmate on parole and who has a history of violent and dangerous behavior, the court held that the "standard of care owed is that of avoiding grossly negligent or reckless release of a highly dangerous prisoner." 115 Ariz. at 267, 564 P.2d at 1234.
93. A viable argument to this approach would focus on the fact that the psychiatrist would be less inclined to release a patient because of the accentuated potential for liability. This consequence runs counter to a psychiatrist's goal to release a patient into society so that the patient can become a balanced and productive individual. As true as that assertion may be, however, if a psychiatrist takes all precautionary and prescribed steps in determining whether a mental patient should be certified for release, then they should not have any fears regarding liability.
95. 168 N.J. Super. at 482-83, 403 A.2d at 508. See also Rowland v. Christian, 69 Cal. 2d 108, 443 P.2d 561 (1968). The Rowland court enumerated several policy considerations:

[T]he foreseeability of harm to the plaintiff, the degree of certainty that the plaintiff suffered injury, the closeness of the connection between the defendant's conduct and the injury suffered, the moral blame attached to the defendant's conduct, the policy of preventing future harm, the extent of the burden to the defendant and consequences to the community of imposing a
ever, seldom adopted.96

In determining whether a duty arises courts most frequently discuss whether a special relationship exists between the two parties.97 Generally, in actions against a psychiatrist, hospital or government for the negligent release of mental patients, the psychiatrist and the third party have never met; thus, a professional working relationship does not exist between them. To overcome this deficiency, courts in some cases, have found a duty by virtue of a court order.98 Frequently, by finding that a psychiatrist knew or should have known that a patient would inflict injury to a particular person or to others, the courts have relied upon that situation to find that such knowledge gives rise to an obligation of the psychiatrist to warn or protect the third party.99

In Semler v. Psychiatric Institute of Washington, D.C.,100 the court of appeals suspended the defendant's twenty year sentence for abducting a young girl, and imposed as a condition of probation "that he continue to receive treatment at and remain confined in the Psychiatric Institute until released by the Court."101 The defendants, probation officer and psychiatrist, eventually allowed the patient to become an out-patient.102 While free as an out-patient, he killed the plaintiff's daugh-

69 Cal. 2d at 113, 443 P.2d at 564. Note, California's Approach to Third Party Liability for Criminal Violence, 13 Loy. L.A. L. Rev. 535 (1980). [hereinafter cited as Note, California's Approach]. "It appears that the majority of courts have used the duty balancing test in an incorporation-by-reference manner that allows them to make ad hoc policy decisions without due consideration of the conflicting values and competing interests that the courts themselves recognized originally in promulgating their balancing test." Id. at 549. Cf. Beuchene v. Synanon Foundation, Inc., 88 Cal. App. 3d 342, 347, 151 Cal. Rptr. 796, 798-99 (1979) (the safety of the public was outweighed by public policy favoring "innovative criminal offender release and rehabilitation programs"); Tarasoff v. Regents of University of California, 17 Cal. 3d 425, 551 P.2d 334 (1976) (Clark, J., dissenting) (to warn a potential victim gives no benefit to society but frustrates psychiatric treatment).

96. See, e.g., California's Approach, supra note 95, at 547-48. "Although a true balancing of various policy considerations would weigh such factors as the moral blameworthiness of defendant's conduct and closeness of the connection between the defendant's conduct and the injury suffered against each other, this has not been the practice. Rather, the courts rely almost exclusively upon foreseeability to determine duty." Id.

97. See infra notes 110-116 and accompanying text.


100. 538 F.2d 121 (4th Cir. 1976).

101. Id. at 121.

102. Id.
In finding the institution liable for negligence the court recognized the "special relationship created by the probation order . . . imposing a duty on the [defendant] to protect the public from the reasonably foreseeable risk of harm at [the patient's] hands." In finding a breach of duty the court relied on the facts that the outpatient "lived alone and attended only two therapy sessions a week. No one effectively monitored his medication, nor was he under constant observation. Moreover, he lacked the daily psychiatric supervision which . . . was available to him. . . ." Thus, the court concluded, "that the appellants breached the duty imposed on them by the order of probation when they failed to seek the trial judge's permission to transfer [the patient] to out-patient status." The duty imposed by the court in this situation seems harsh and has received criticism.

In Lipari v. Sears, Roebuck & Co., the Federal District Court for the District of Nebraska, faced the issue of whether "under Nebraska law the relationship between a psychotherapist and his patient is sufficient to justify the imposition of an affirmative duty on the therapist to control the conduct of his patient." In studying precedents, the court noted that a duty existed "to prevent the spread of a contagious disease." This duty was based on the rationale that because of a patient's malady the doctor may owe a duty "to the public and, in some cases, to other particular individuals." Applying that reasoning to the release of a mental patient, the court concluded:

[U]nder Nebraska law the relationship between a psychotherapist and his patient gives rise to an affirmative duty [which] requires that the therapist initiate whatever precautions are reasonably necessary to protect potential victims of his patient. This duty arises only when, in accordance with the standards of his profession, the therapist knows or should know that his patient's dangerous propensities present an unreasonable risk of harm to others.

103. Id.
104. Id. at 125.
105. Id.
106. Id. at 126.
107. See A Proposed Expansion, supra note 85, at 216-23.
109. Id. at 191.
110. Id.
111. Id.
112. Id. at 193. See also Tarasoff v. Regents of University of California, 17 Cal. 3d 425, 131 Cal. Rptr. 14 (1976). The court stated that a "defendant owes a duty of care to all persons who are foreseeably endangered by his conduct, with respect to all risks which make the conduct unreasonably dangerous." Id. at 435-36, 131 Cal. Rptr. at 23. In McIntosh v. Milano, 16 N.J. Super. 466, 403 A.2d 500 (1979), when a psychotherapist knew that his patient possessed hostile and jealous feelings toward his former girlfriend the
“Duty” described in this fashion poses some difficulty. If a therapist knew or should have known that his patient posed a risk of harm to another, that knowledge not only establishes the duty to act but also constitutes the basis of the therapist’s liability. The confusion originates because once the duty to a particular member “of the public is found, proximate cause in terms of duty to [that] particular plaintiff also exists if the individual is released and does injury.”¹³

This situation arises over the dual usage of “foreseeability,” as it pertains to the duty of a psychiatrist to a third party, is the foreseeability of risk in determining negligence.¹¹⁴ Conversely, “foreseeability” as used in determining proximate cause is the foreseeability of consequences in determining legal causation.¹¹⁵ Thus, when courts analyze third party negligence in mental release cases, there is little distinction between “foreseeability” as it relates to the risk that society must bear to aid patient’s therapy or the consequences of a determination to release.¹¹⁶ The confusion is not eliminated when examining the proximate cause element of negligence.

C. Proximate Cause and Foreseeability

In a cause of action based upon negligence, the plaintiff must establish the standard of care and prove the defendant owed a duty to the plaintiff and breached that duty.¹¹⁷ In addition, the plaintiff must show

court held that the therapist:

may have a duty to take whatever steps are reasonably necessary to protect an intended or potential victim of his patient when he determines or should determine, in the appropriate factual setting and in accordance with the standards of his profession established at trial, that the patient is or may present a probability of danger to that person.

16 N.J. Super. at 489, 403 A.2d at 511-12.


114. Id. at 617.

115. Id.

116. “[T]he question of what is proximate and that of duty are fundamentally the same: whether the interests of the plaintiff are to be protected against the particular invasion by the defendant’s conduct. (footnotes omitted.)” W. PROSSER, LAW OF TORTS, ch. 9, pp. 326 (4th ed. 1971). See also Semler v. Psychiatric Institution of Washington, D.C., 538 F.2d 121, 126 (4th Cir. 1976) (court stated that “the breach of this duty, followed by the foreseeable harm on which it was predicated, in itself demonstrates proximate cause”).

117. The plaintiff bears the burden to prove the elements of the negligence cause of action. See Merchants Nat’l Bank & Trust Co. of Fargo v. United States, 272 F. Supp. 409 (D. N.D. 1976). In Merchants, the court found that the plaintiff had “successfully borne” its burden by proving that the defendant’s negligence was the proximate cause of her husband’s death. Id. at 417.
the defendant's negligence was the proximate cause of the plaintiff's injury.\textsuperscript{118} "[I]t must appear that the injury was the natural and probable consequence of the negligence and wrongful act, and that it ought to have been foreseen in light of the attending circumstances."\textsuperscript{119} This "does not mean . . . that the precise events which occurred could themselves have been foreseen as they actually occurred; only that the events were within the scope of the foreseeable risk."\textsuperscript{120} Various factors aid the judge and jury in determining the proximate cause and foreseeability issue. Some factors are knowledge of the dangerous propensity, failure to transmit information, prior or recent violent acts, failure to investigate releasee's conduct and failure to follow established procedures.\textsuperscript{121}

As a basic tenet of law, a psychiatrist or hospital authority cannot be held liable to a third person for the negligent release of a mental patient without a showing that the releasing authority had some knowledge or notice of the releasee's potential for violence. In \textit{Hilscher v. State},\textsuperscript{122} a mental patient at a state school for the mentally retarded was released on work duty at which time he set fire to a farm building. In determining that the hospital authorities were not negligent in releasing the patient, and that no liability was imputed to the state, the court observed that the releasing authorities had "no previous knowledge or suspicion relative to any propensities [of the patient] for setting fires."\textsuperscript{123} Once hospital authorities have knowledge of a patient's

\begin{footnotes}
\item[118] The guidelines for determining proximate cause are no stricter now than when stated in \textit{Milwaukee & St. Paul Railway Co. v. Kellog}, 94 U.S. 469 (1876): The true rule is that what is the proximate cause of an injury is ordinarily a question for the jury. It is not a question of science or of legal knowledge. It is to be determined as a fact, in view of the circumstances of fact attending it. The primary cause may be the proximate cause of a disaster, though it may operate through successive instruments, as an article at the end of a claim may be moved by a force applied to the other end, that force being the proximate cause of the movement, or as in the oft-cited case of the squib thrown in the market-place. The question always is, Was there an unbroken connection between the wrongful act and the injury, a continuous operation? Did the facts constitute a continuous succession of events, so linked together as to make a natural whole, or was there some new and independent cause intervening between the wrong and the injury? \textit{Id.} at 474-75.
\item[119] \textit{Id.}
\item[120] Williams v. United States, 450 F. Supp. 1040, 1046 (D. S.D. 1978) (in light of the patient's past history of hostile behavior and alcoholism it was foreseeable that if he was released unsupervised he would cause injury).
\item[121] See \textit{infra} notes 121-160 and accompanying text.
\item[122] 64 Misc. 2d 368, 314 N.Y.S.2d 904 (1970).
\item[123] \textit{Id.} at 372, 314 N.Y.S.2d at 909. See also Seavy v. State, 21 A.D.2d 445, 250 N.Y.S.2d 877 (1964) (no liability because pyromania tendencies were in no way foresee-
potential for violence, however, failure to take adequate precautions can result in liability when the releasee inflicts injury to a third person.\textsuperscript{124}

The proximate cause issue has been resolved in other cases by a finding that a hospital authority failed to transmit information relative to the releasee's case or conduct. The case of \textit{Underwood v. United States}\textsuperscript{125} illustrates this proposition. The patient was admitted to the hospital emergency psychiatric clinic where the admitting physician learned the patient had a potential of inflicting harm on his wife.\textsuperscript{126} The attending physician promised to transmit this information to the next psychiatrist.\textsuperscript{127} This information was never transmitted and as a result, the patient was released and killed his wife.\textsuperscript{128} The Court of Appeals for the Fifth Circuit opined that the release of the patient did not amount to negligence because of the lack of foreseeable harm, but reasoned that it was negligent because of the physician's failure to transmit the information.\textsuperscript{129} More noteworthy is the case of \textit{Hicks v. United States}.\textsuperscript{130} A major shortcoming of the hospital's actions in \textit{Hicks} was its failure to transmit adequate information to the court in order for the court to make an intelligent decision on the release request.\textsuperscript{131} The court determined that a carefully drafted report would not have briefly mentioned that the patient was competent to stand trial, but would have referred to the patient's dangerousness to his wife and others.\textsuperscript{132} The \textit{Hicks} court stated: "The absence of a report of this or comparable character must be considered to have been a substantial factor leading to his release."\textsuperscript{133} Thus, the report was a "part of the continuing course of events which link the negligence of the Hospital to the death of the [patient's wife] as a proximate cause of it."\textsuperscript{134}

Another body of cases analyze the releasee's prior or recent acts of

\begin{itemize}
  \item See Hilscher v. State, 64 Misc. 2d 368, 314 N.Y.S.2d 904 (1970) (after the first fire incident the institution was placed on notice of the patient's propensity for fire setting);
  \item Leverett v. State, 61 Ohio App. 2d 35, 399 N.E.2d 106 (1978) (though patient was released three months before the incident, hospital authorities could be liable if they did not exercise good faith in the release decision).
  \item 356 F.2d 92 (5th Cir. 1966).
  \item Id. at 95-96.
  \item Id. at 96.
  \item Id.
  \item Id. at 98.
  \item 511 F.2d 407 (D.C. Cir. 1975).
  \item Id. at 419.
  \item Id. at 421.
  \item Id.
  \item Id.
\end{itemize}
violence to determine whether the releasing authority's decision was the proximate cause of a third person's injuries. A patient's prior history or recent act of assaultive behavior places custodial authorities on notice of potentially dangerous characteristics. In *Homere v. State*,\(^{135}\) the Hospital Commission made a determination on February 7, 1972 to release the patient.\(^{136}\) On February 23, 1972 the patient became violently disruptive and was placed in a camisole for over a day.\(^{137}\) Nevertheless, the patient was released on March 20, 1972 as originally planned.\(^{138}\) Though the New York court found that the hospital's negligence was based on its failure to reconvene the Commission,\(^{139}\) the court noted that the recent violent act was the basis of its decision.\(^{140}\) Thus, liability is predicated upon the hospital's failure to acquire a Commission's reevaluation "to determine if the assailant was still suitable for discharge after the violent events of February 23 and 24, 1972 and the resulting wrongful discharge of the assailant which was the proximate cause of the injuries to the claimants."\(^{141}\) Similarly, in *Bradley Center, Inc. v. Wessner*,\(^{142}\) the patient was diagnosed as possessing an immediate likelihood of harm to his wife and her lover.\(^{143}\) Nonetheless, the patient was permitted to leave the hospital grounds unsupervised, whereupon he killed both persons.\(^{144}\) The Georgia Court of Appeals found that the hospital was liable to the decedent's children because the decision to release the patient on the less restrictive pass was a proximate cause of the two murders.\(^{145}\)

Liability has been imposed in some situations where a patient is released from a mental hospital after an inadequate investigation or examination of the confined person. In *Fair v. United States*,\(^{146}\) the Court of Appeals for the Fifth Circuit noted that a "cursory examination was made" of the patient before he was released.\(^{147}\) Subsequent to his release, the patient killed three persons before taking his own

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136. 79 Misc. 2d at 974, 361 N.Y.S.2d 822.
137. 79 Misc. 2d at 975, 361 N.Y.S.2d at 823.
138. 79 Misc. 2d at 976, 361 N.Y.S.2d at 824.
139. 79 Misc. 2d at 976, 361 N.Y.S.2d at 824.
140. 79 Misc. 2d at 976, 361 N.Y.S.2d at 824.
141. 79 Misc. 2d at 976, 361 N.Y.S.2d at 824.
144. 161 Ga. App. at --, 287 S.E.2d at 719.
146. 234 F.2d 286 (5th Cir. 1956).
147. Id. at 290.
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life. Though the court rested its decision on the failure to warn the victim, the truth remains that an adequate examination been made by the psychiatrist the patient would not have been released.

Indeed, the most difficult claim to maintain rests upon the assumption that the psychiatrist or hospital authority failed to follow established principles or procedures in their diagnosis and release of a mental patient. Such a claim must prove that the releasing authority deviated from "recognized and generally accepted standards, practices and procedures in the community which could be exercised by competent physicians in the same specialty under similar circumstances." In Williams v. United States, the district court of South Dakota found "hospital procedures were ineffective to protect against that occasional negligence which is one of the ordinary incidents of human life." In Williams, even though the patient had recently attacked hospital personnel, the discharging psychiatrist released the patient. The court concluded that the incident which resulted in the death of Mr. Williams was foreseeable under the circumstances. Implicit in

148. Id.
149. See Homere v. State 79 Misc. 2d 972, 361 N.Y.S.2d 820 (N.Y. App. Term 1974). In that case, prior to release the patient exhibited overt acts of violence by destroying furniture and had to be restrained in a camisole. The court found that the institution's failure to reconvene the "Commission" to reevaluate the patient's release was negligent under the circumstances. 79 Misc. 2d at 976, 361 N.Y.S.2d 824. But see St. George v. State, 283 A.D. 245, 127 N.Y.S.2d 147 (1954) (where mental patient discharged for only five days as "improved" killed man while he was walking down the street, court held that the state could not be liable inasmuch it places an unfair burden upon the state if it were to be responsible for acts of every released patient).
150. See Hicks v. United States, 511 F.2d 407 (D.C. Cir. 1975). In Hicks, the court found "negligence in the failure of the Hospital to follow its own standards of care concerning the diagnosis of the patient." Id. at 420. This conclusion was based on the fact that the hospital failed to meet its obligation to the court by submitting an adequate report so that the court could render an intelligent decision concerning the patient's release. Id. at 419.
151. Ellis v. United States, 484 F. Supp. 4, 10-11 (D. S.C. 1978) (before liability can be imposed for deviation from medical standards expert testimony must be introduced to prove the deviation).
153. Id. at 1045.
154. Id. at 1042.
155. The evidence indicates that the procedure employed by the releasing authorities fell below accepted standards. The physician testified:

[H]e had seen Bush only twice—once at the initial screening for admission to the alcohol program and once at the discharge meeting. His decision to release Bush was based on these two meetings and a fifteen minute scan of Bush's current records. [The doctor] testified that he scanned the current records during the discharge staff meeting itself. He had never previously examined them. This discharge staff meeting lasted a total of approxi-
the court's decision is the fact that if proper and adequate discharging procedures were followed, the patient would not have been released without sufficient community safeguards.

Perhaps the most frustrating situation for a claimant occurs where the decision to release a mental patient was proper, yet, an incident takes place which gives rise to a cause of action. In Schwenk v. State, the decision to release was proper in terms of standard procedure, but the release involved a degree of societal risk due to the patient's psychiatric history. Another deterrent to a claim for injury arising out of a proper release of a mental patient is that psychiatrists and hospital authorities will not be held liable for honest errors in judgment.

When the release of a mental patient is founded upon proper release procedures and standards, other factors must be illuminated to sustain a cause of action. Typically, a claim can be sustained in situations where the police or hospital authorities promised to warn a specific person that a dangerous patient was to be released, but failed to give that warning. When the releasee subsequently injures the person to whom the promise was made, a claim for relief can be sustained.

Many factors aid the court and jury to decide the difficult question of proximate cause. In some circumstances the patient's conduct is foreseeable when considering his past and recent acts of violence and
psychiatric history. In these situations, the complications between the intertwining of duty and proximate cause mesh and the element of proximate cause will rarely be an issue. In other situations, the facts demonstrate that the psychiatrist either failed to transmit information, to adequately investigate the patient's condition or to follow established procedures. In these situations, not only must a duty be established between the psychiatrist and the third party, but the element of proximate cause becomes important in determining liability.

Perhaps the most difficult time a court has in balancing the objective to return the patient to society against society's need for protection arises in the context of determining whether a releasing authority is negligent for permitting a patient to be conditionally released. In these situations the element of risk is more substantial and the possible benefit to the patient is greatly increased.

D. Liability and the Open Door

When releasing a mental patient in an open door program the releasing authority must determine that the patient's mental health is such that he will not pose a danger to himself or others. Taking note that the patient has not completely regained his sanity under the therapeutic open door process, the decision to release must taken into account the patient's illness and whether his mental condition makes him capable of exhibiting assaultive or destructive acts.\[1\] Balancing these concerns with the general recognition by mental health experts that every reasonable effort should be made to return a patient to an active and productive life sets the standard of care for conditional release as distinguished from unconditional release.

Since an increased risk of harm to society exists when a mental patient gains release in an open door program, a court must give heightened attention to the psychiatrist's duty to third persons and the standard of care it imposes on releasing authorities. As a bare requirement,

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161. See Excelsior Ins. Co. v. State of New York, 296 N.Y. 40, 69 N.E.2d 553 (1946) where the court stated:

A balance must be struck between contending interests—(1) the State's duty to treat and care for its mental defective ward, with an eye toward returning them to society more useful citizens, and (2) the State's concern that the inmates of its institutions cause no injury or damages to the property of those in the vicinity. That balance may be hard to achieve. We keep within settled legal principles, however, if the State is held only to a duty of taking precautions against those risks 'reasonably to be perceived' . . . and if the community assumes the risk of accidental loss or damage to property by an inmate of an open institution. . . .

296 N.Y. at 46, 69 N.E.2d 556.
one court opined that "for the State to be liable, something more must be present than an honest error of professional judgment." A minority of courts recommend "that great care and caution should be taken to provide reasonable assurances that the risks involved will not ultimately prove to have been underestimated or miscalculated." In determining liability, courts are more inclined to grant a claim for relief when the injury is to a third party rather than to the patient himself. Justification for this approach is found in the fact that it is difficult for hospital staff to constantly supervise the movements of one determined to kill himself. An additional rationale is that through adequate diagnosis it should be easier to protect the community, and thus, any injury is viewed disfavorably.

When injury is sustained by a third party the question of liability may hinge upon a number of medical judgments in the release decision. In a recent case, an appeals court found that the hospital's failure to diagnose the patient as having an "explosive personality" before he committed murder "was the result of a serious error or mistake, not merely an error or mistake with serious consequences. . . ." In another instance, liability has been found when all the surrounding circumstances indicated that a patient in a psychiatric day care treatment program posed a serious threat of harm to society and the attending hospital staff failed to take affirmative precautions reasonably necessary to protect potential victims of the patient.

162. See supra note 87. In St. George v. State, 233 A.D. 245, 127 N.Y.S.2d 147 (1954), to allow a claim where a psychiatrist has allowed the release of a patient based upon lengthy observations and sound judgment in "its practical aspects it would mean that the State could release no one from any State mental institution without being under the risk of liability for whatever he did thereafter. . . ." 203 A.D. at 249, 127 N.Y.S.2d at 151.

163. See supra note 92 and accompanying text.

164. See White v. United States, 244 F. Supp. 127 (E.D. Va. 1965), aff'd per curiam, 369 F.2d 989 (4th Cir. 1966) (where recovery was denied when patient intentionally walked in front of a train); Baker v. United States, 226 F. Supp. 129 (S.D. Iowa 1964), aff'd, 343 F.2d 222 (8th Cir. 1965) (where recovery was denied when patient leaped over the fence into a window well); Finkel v. State, 37 Misc. 2d 757, 237 N.Y.S.2d 66 (Ct. Cl. 1962) (where recovery was granted when patient murdered neighboring resident). But see Eanes v. United States, 407 F.2d 823 (4th Cir. 1969) (where recovery was denied to a wife for injuries inflicted with a claw hammer by her husband while home on a temporary release from the mental institution).


166. Id.

167. Id.

168. In Lipari v. Sears Roebuck & Co., 497 F. Supp. 185, 193 (D. Neb. 1980) patient, Cribb, removed himself from psychiatric day care treatment against the advise of his doctor. Id. at 187. The court found that the doctor should have taken affirmative steps to
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Though the exercise of medical judgment tends to reflect a particular psychiatrist's own approach to rehabilitation, mere differences in diagnosis and release criteria does not necessitate a finding of liability. Particular facts of a case can make liability unwarranted. In Hilscher v. State, the claimant charged that the state was negligent in that it failed to properly supervise one of its mental patients involved in a work program outside the institution. The court held that the state was not liable for the damages caused by the fire set by the patient since there was no evidence to establish any previous knowledge or suspicion on the states behalf that the patient had a tendency to start fires.

In a more recent case, a custody pass was granted to a mental patient who had no history of suicidal or homicidal behavior. While free the patient threw his infant daughter from a second story porch killing her. Evidence established that the psychiatrist's diagnosis that the patient was "not homicidal, suicidal or dangerous to himself or to others . . . was clearly in compliance with generally accepted psychiatric standards, practices and procedures that are routinely and customarily practiced and followed by competent psychiatrists." The court stated that "for liability to attach for an error in medical judgment the physicians must have deviated from the generally accepted and recognized standards, practices, and procedures which have been exercised by competent physicians under the same or similar circumstances."

Apart from the burden of proving a negligence cause of action, the most frequent obstacle for a claimant to hurdle in his case against the federal or state government is to overcome a public employees tort immunity.

E. Federal and State Immunity

The federal government is protected by the Federal Tort Claims Act (FTCA). The FTCA grants immunity to governmental employees for prevent Cribb's release when he knew or should have known that his patient presented an unreasonable risk of harm to others. See also Hilscher v. State, 64 Misc. 2d 368, 374, 314 N.Y.S.2d 904, 911 (Ct. Cl. 1970).

169. 64 Misc. 2d 368, 314 N.Y.S.2d 904 (Ct. Cl. 1970).

170. 64 Misc. 2d at 371, 314 N.Y.S.2d at 908.

171. 64 Misc. 2d at 372, 314 N.Y.S.2d at 909.


173. Id. at 10.

174. Id.

175. Id. at 11. See also White v. United States, 244 F. Supp. 127, 132 (E.D. Va. 1965).

176. The Federal Tort Claims Act was originally enacted as Title IV of the Legislative
certain acts. A majority of states have adopted the immunity provi-

177. Section 2680 excludes the following types of claims from the coverage of the Act:
(a) Any claim based upon an act or omission of an employee of the Government, exercising due care, in the execution of a statute or regulation, whether or not such statute or regulation be valid, or based upon the exercise or performance or the failure to exercise or perform a discretionary function or duty on the part of a federal agency or an employee of the Government, whether or not the discretion involved be abused.
(b) Any claim arising out the loss, miscarriage, or negligent transmission of letters or postal matter.
(c) Any claim arising in respect of the assessment or collection of any tax or customs duty, or the detention of any goods or merchandise by any officer of customs or excise or any other law-enforcement officer.
(d) Any claim for which a remedy is provided by sections 741-752, 781-790 of Title 46, relating to claims or suits in admiralty against the United States.
(e) Any claim arising out of an act or omission of any employee of the Government in administering the provisions of sections 1-31 of Title 50, Appendix.
(f) Any claim for damages caused by the imposition or establishment of a quarantine by the United States.
(g) Repealed.
(h) Any claim arising out of assault, battery, false imprisonment, false arrest, malicious prosecution, abuse of process, libel, slander, misrepresentation, deceit or interference with contract rights. Provided: That, with regard to acts or omissions of investigative or law enforcement officers of the United States Government, the provisions of this chapter and section 1346(b) of this title shall apply to any claim arising, on or after the date of the enactment of this provision, out of assault, battery, false imprisonment, false arrest, abuse of process, or malicious prosecution. For the purpose of this subsection, "investigative or law enforcement officer" means any officer of the United States who is empowered by law to execute searches, to seize evidence, or to make arrests for violations of Federal law.
(i) Any claim for damages caused by the fiscal operations of the Treasury or by the regulation of the monetary system.
(j) Any claim arising out of the combatant activities of the military or naval forces, or the Coast Guard, during time of war.
(k) Any claim arising in a foreign country.
(l) Any claim arising from the activities of the Tennessee Valley Authority.
(m) Any claim arising from the activities of the Panama Canal Company.
(n) Any claim arising from the activities of a Federal land bank, a Federal intermediate credit bank, or a bank for cooperatives.


The doctrine of sovereign immunity dates back to Roman and common law and initially found credence in the notion that the "King can do no wrong." Russell v. Men of Devon, 2 T.R. 667, 100 Eng.Rep. R. 359 (1788). The first clear indication that the United States had a policy of sovereign immunity emanated from the case of Cohens v. Virginia, 19 U.S. (6 Wheat.) 264, 411-12 (1821). For a good discussion of the FTCA's historical
sions of the FTCA into their own legislation. A few states have abolished their immunity statutes and rely solely on legal principles of negligence. Some states specifically enumerate the conditions under which they will be immune from tort liability.

Like many of the state statutes, the FTCA is "a general waiver of governmental immunity in tort" and reflects an attitude that the government should assume the responsibility for the negligence of its employees. As a general waiver, Congress retained many excep-


The policy of sovereign immunity, however, did not leave a citizen completely without redress against the negligent conduct of governmental employees. An injured citizen could petition Congress for a private relief bill. See The Discretionary Function supra at 81. This procedure grew cumbersome as the number of petitions grew into the thousands. Dalehite v. United States, 346 U.S. 15, 25 n.9 (1953) gives a statistical breakdown of the number of private relief bills presented to Congress, the number of bills finally enacted by Congress, and the total appropriations outlaid from the Sixty-eighth Congress through the Seventy-eighth Congress.

Congress—responding to the burden posed by the influx of private relief bills, to the general jurisprudential change in attitude toward allocation of damages, and acceptance of responsibility by the tortfeasor—commenced congressional hearings to determine "a more equitable manner by which such claims could be adjudicated." The Discretionary Function supra at 81. The enactment of the FTCA in 1946 by the Seventy-ninth Congress grew out of these hearings.


182. Dalehite v. United States, 346 U.S. 15, 24 (1953). See Fair v. United States, 234 F.2d 288 (5th cir. 1956). The court stated that the broad and just purpose of the Act was to compensate victims of negligence in the conduct of governmental activities in circumstances "like those in which private persons would be liable." 234 F.2d at 294. Cf. Hargrove v. Town of Cocoa Beach, 96 So.2d 130 (Fla. 1957) where the Florida Supreme Court stated:

Immunization in the exercise of governmental functions has been traditionally put on the theory that "the King can do no wrong but his ministers can." In applying this theory the courts have transposed into our democratic system the concept that the sovereign is divine and that divinity is
tions to the Act to encompass both specific circumstances and general "discretionary" acts. It has been the "discretionary function" exception to the FTCA that has given rise to vociferous comment by many commentators and has led many courts to ponder upon the meaning of "discretionary function."

Beyond reproach. In preserving the theory they seem to have overlooked completely the wrongs that produced our Declaration of Independence and in the ultimate resulted in the Revolutionary War. We, therefore, feel that the time has arrived to declare this doctrine anachronistic not only to our system of justice but to our traditional concepts of democratic government.

The immunity theory has been further supported with the idea that it is better for an individual to suffer a grievous wrong than to impose liability on the people vicariously through their government. If there is anything more than a sham to our constitutional guarantee that the courts shall always be open to redress wrongs and to our sense of justice that there shall be a remedy for every wrong committed, then certainly this basis for the rule cannot be supported.

Id. at 132.

183. See supra note 174 for the list of exceptions.


186. The broadest reading of the "discretionary function" exception was pronounced in the Supreme Court case of Dalehite v. United States, 346 U.S. 15 (1953). The case arose out of the Texas City disaster of 1947. Appellants claimed that the federal government was negligent in adopting a fertilizer export plan, in manufacturing and handling the fertilizer, and in its efforts to contain and extinguish the blaze. Id. at 18. In denying the appellant's claim the Court noted that the "discretionary function":

includes more than the initiation of programs and activities. It also includes determinations made by executives or administrators in establishing plans, specifications or schedules of operations. Where there is room for policy judgment and decision there is discretion. It follows that acts of subordinates in carrying out the operations of government in accordance with official directions cannot be actionable. If it were not so, the protection of § 2680(a) would fail at the time it would be needed, that is, when a subordinate performs or fails to perform a casual step, each action or non-action being directed by the superior, exercising, perhaps abusing, discretion.

Id. at 35-36. Adopting this broad view, "permits the interpretation that any federal official vested with decision-making power is thereby invested with sufficient discretion for the government to withstand suit when those decisions go awry." Smith v. United States, 375 F.2d 243, 246 (5th Cir. 1967). This position came under strong criticism. See Note, Discretionary Exception Under Federal Tort Claims Act: Sovereign Immunity Dies A
The issue arising most frequently in the determination of whether

_Slow Death_, 4 _Duke L.J._ 34 (1954). The author objects to the Court's view that acts were discretionary if directed from a high, policy level, on the grounds that it focuses on the participants rather than the act itself. _Id._ at 38. _Texas City Disaster—Federal Tort Claims Act_, 22 U. Kan. City L. Rev. 176 (1954). The author believes that the Government should bear the same responsibility as private industries engaged in similar work. _Id._ at 177-78. _Comment, Federal Tort Claims Act: A More Liberal Approach Indicated_, 22 Mo. L. Rev. 48, 70-71 (1957) and _Torts—Federal Tort Claims Act—Expansion of the Discretionary Function Exception_, Tex. L. Rev. 474, 476 (1954) suggest that the task of defining "discretionary function" was too much for the Court, who simply took the easy way out by applying the exception to any employee exercising the slightest judgment.

A second approach expounded by the Supreme Court came two years after _Dalehite_. In _Indian Towing v. United States_, 350 U.S. 61 (1955), the Court refused to follow the broad definition of "discretion" as applied by _Dalehite_, and adopted the "good samaritan" rule prevalent in tort law.

[The Court held that although the Coast Guard was not obligated to operate a lighthouse, once it exercised its discretion, it was under a duty to use due care in its operation. If the Coast Guard failed in this duty, the Government was liable. Thus, the Court adopted the rule that if discretion is exercised and an activity undertaken, it must be performed with due care.]

_The Discretionary Function, supra_ note 177, at 99.

Significant to the _Indian Towing_ decision, the Court avoided the application of the planning-level operational-level analysis suggested by _Dalehite_, though the Court mentions that the negligence was at the operational level. 350 U.S. at 64. The _Indian Towing_ application of the "good samaritan" rule guided the Court's decision in a subsequent case.

In _Rayonier, Inc. v. United States_, 352 U.S. 315 (1957), the Court found negligence in a claim that the United States Forest Service negligently allowed a fire to be started on government land and failed to exercise due care to extinguish the fire before it spread on to appellant's property. 352 U.S. at 317.

In a planning-level and operational-level analysis, the initial policy level or planning decisions are considered ministerial and not exempt from liability. _See American Exchange Bank v. United States_, 257 F.2d 938 (7th Cir. 1958) (the decision to build a post office was discretionary, but the decision to not install a handrail leading up the post office stairs was operational); _Swanson v. United States_, 229 F. Supp. 217, 220 (N.D. Cal. 1964). "[T]he planning-level notion refers to decisions involving questions of policy, that is, the evaluation of factors such as the financial, political, economic, and social effects of a given plan or policy. . . . The operational level decision, on the other hand, involves decisions relating to the normal day-to-day operations of the Government."; _Wildwood Mild Ranch v. United States_, 218 F. Supp. 57, 77 (D. Minn. 1963) (court found that a pilot's choice of altitude and course did not involve a policy decision, but an operational decision to get to a particular destination). _But see_ _Dolphin Gardens, Inc. v. United States_, 243 F. Supp. 824 (D. Conn. 1965). The court found that the Secretary of Navy's choice to dump sludge from a river dredging operation in order to accommodate the movement of a nuclear submarine was "far removed from the operational level." 243 F. Supp. at 826.

_See also_ _Hendry v. United States_, 418 F.2d 774, 782 (2d Cir. 1969) (if granting or the refusal to grant a license is made without reliance upon any readily ascertainable rule or standard the court will hold the judgment to be discretionary); _United States v. Union Trust Co._, 221 F.2d 62 (D.C. Cir. 1955) (nearly every act or commission upon which a
certain conduct falls within the discretionary function exception is whether a plaintiff is alleging negligence in a choice of policy or in carrying out the specifics of the policy. In Lipari v. Sears, Roebuck & Co., the petitioner brought an action for the death of her husband by a mentally deficient individual who had fired a shotgun in a crowded dining room. The complaint did not allege that the V.A. hospital was negligent in its policy which permitted the patient to be released, but that the policy of release was negligently executed. On this issue the district court stated that "[a]lthough the development of an agency's rules and regulations is a discretionary function, it is generally recognized that the implementation of these rules does not involve policy judgments within the discretionary function exception." The court,
finding for the petitioner, held "that the therapist's decision not to detain [the patient] did not involve a balancing of policy considerations, and thus was not a discretionary function." 191

This "planning-operational" approach appears to be used most frequently in deciding whether conduct falls within the discretionary function exception. 192 Criticism tends to focus on semantics and suggests that there is seldom any neat separation between planning and operational decisions. 193 In addition to the planning-operational approach, the "good samaritan" 194 approach is available under certain circumstances.

Cases relying on the good samaritan rationale frequently involve situations where governmental officials have promised to perform a duty and have negligently carried out the obligation. In Fair v. United States, 195 the Provost Marshall promised the decedent, Miss Cooper, that he would inform her before patient Haywood was released in light of the threats on Cooper's life by Haywood. 196 Without notifying Cooper's guards, Haywood gained his release and killed Miss Cooper. 197 In finding the United States liable, the court held:

[If] the Government undertakes to perform certain acts or functions thus engendering reliance thereon, it must perform them with due care; that obligation of due care extends to the public and the individuals who compose it; the Government is liable for the actions of its employees dealing directly with the public in the application of established policies even if such employees are vested with a measure of discretion, and such liability of the Government for their acts and omissions in all of the respects mentioned is measured by the same rules as the local law applies to a private employer under like circumstances. 198

129, 135 (S.D. Iowa 1964), aff'd, 343 F.2d 222 (8th Cir. 1965).
192. See supra note 186. See also McDowell v. County of Alameda, 88 Cal. App. 3d 321, 151 Cal. Rptr. 779 (1979). The McDowell court stated: "Section 856 does not distinguish between the making of discretionary policy decisions and ministerial decisions, nor has it been construed as such." Id. at 328, 151 Cal. Rptr. at 783.
194. The "good samaritan doctrine" has been defined as: "One who sees a person in imminent and serious peril through negligence of another cannot be charged with contributory negligence, as a matter of law, in risking his own life or serious injury in attempting to effect a rescue, provided the attempt is not recklessly or rashly made." Jobst v. Butler Well Servicing, Inc., 190 Kan. 86, 90, 373 P.2d 55, 59 (1962).
195. 234 F.2d 288 (5th Cir. 1956).
196. Id. at 290-91.
197. Id.
198. Id. at 294.
Thus, "one who undertakes to warn the public of danger and thereby induces reliance must perform his 'good samaritan' task in a careful manner." The good samaritan rationale is generally limited by the circumstances of each case. For example, the good samaritan argument would not be applicable where there was no prior promise by a governmental agent to perform an act. When the promise is not there, the scope of the analysis is to determine if the discretionary act occurred at the planning level or the operational level.

In Buford v. State, after the California appeals court determined that there was a special relationship between the claimant and the state, the court addressed the issue of whether the state was immunized from liability. The plaintiff's complaint alleged that the state was negligent in its ministerial actions by failing to adequately give follow-up supervision of an out-patient. The court partially agreed by finding that the state employees were not immune under the state tort claims act. The court noted, however, that a specific statute provided that "a public entity is not liable for: ... an injury proximately caused by a patient of a mental institution." The court concluded that the immunity statute applies to a mental institution inmate who is granted a leave of absence, and therefore, the "[p]laintiffs could not state a cause of action against [the] State."

199. Morgan v. County of Yuba, 230 Cal. App. 2d 938, 945, 41 Cal. Rptr. 506, 512 (1964) (quoting Indian Towing Co. v. United States, 350 U.S. 61, 64 (1955)). Morgan involved a wrongful death action by three minors due to the untimely death of their mother. 230 Cal. App. 2d at 941, 41 Cal. Rptr. at 509. One Avel Ashby was arrested in Yuba County and the Sheriff's Department guaranteed Mrs. Morgan that they would inform her when Ashby was released on bail. 230 Cal. App. 2d at 941, 41 Cal. Rptr. at 510. The Sheriff's Department failed to do so and Ashby killed Mrs. Morgan. 230 Cal. App. 2d at 941, 41 Cal. Rptr. at 510. But see Hicks v. United States, 511 F.2d 407 (D.C. Cir. 1975). Here the hospital wrote Mrs. Morgan that her husband had been released from their custody. Even though, the court found liability based upon a strict negligence—foreseeability argument. 511 F.2d at 421-22.

200. In Indian Towing, the government conceded that discretion was being exercised at the operational level but contended that since the function there being performed was strictly "governmental" in character—one which private persons do not perform—and the FTCA intends only to fix liability if it would be imposed upon a private individual under the same circumstances, no liability against the government could be imposed. 350 U.S. at 65. The court denied this contention. Id.

202. Id. 164 Cal. Rptr. at 272.
203. Id. 164 Cal. Rptr. at 273.
204. Id. 164 Cal. Rptr. at 273.
205. Id. 164 Cal. Rptr. at 273. See also Note, Victims' Suits Against Government Entities And Officials For Reckless Release, 29 Am. U. L. Rev. 595, 604-08 (1980) (official immunity is distinguished from sovereign immunity).
206. 104 Cal. App. 3d at 829, 164 Cal. Rptr. at 273.
Once the determination is made that the act occurred at the operational-level, the question of whether the employee acted negligently can be addressed in a traditional manner.

**E. Conclusion**

The growing number of cases involving the negligent release of mental patients reaching the courts every year indicates an uncertainty in the law. This situation is due in part to several factors. Concern has been raised over the standard of care to which a court will hold releasing authorities. Considerable debate has risen in regard to the fact that the question of duty and proximate cause are now one element of a negligence claim rather than two. In regard to claims brought under the FTCA, a determination must be made whether the official's conduct was at the planning level or operational level. Litigation arose over the meaning of "dangerousness" since it lacks a universally accepted definition and different psychiatrists attach different meanings to the word. Finally, conditions of overcrowding at mental institutions might justify the release of a patient whose risk to society is still questionable, and hence, questions of policy will have to be resolved.

In an attempt to meet the deficiencies in a claim against a third party for the negligent release of a mental patient and to compensate victims of unprovoked injuries for a lengthy trial which may result in a decision against them, steps must be taken at the release stage to increase the likelihood that those patients released will not subsequently cause harm to others. Furthermore, steps should be taken to find other methods of compensating victims injured by negligently released mental patients. This note will now explore a viable plan for releasing mental patients and some possible alternatives to a cause of action based on negligence.

207. See supra notes 84-93 and accompanying text.
209. This question must be resolved to determine whether a governmental entity will be immune from liability. If immunity does not apply, then the negligence claim can go forward.
210. See supra note 17 and accompanying text.
211. See supra note 28 and accompanying text.
IV. A Proposed Plan For Release

The intent behind adopting a plan for the controlled release of involuntarily confined patients from a mental institution shall be to increase the likelihood that the patient's release from custody will not create a threat of harm to himself or any third party. Such a plan will apply to both the patient who was committed due to a finding of insanity in a criminal trial and to the patient who was committed in an involuntary civil confinement proceeding.

Any statutory plan for the release of an involuntarily committed mental patient must include a provision for release by a writ of habeas corpus. The writ of habeas corpus may be filed at any time in a court of competent jurisdiction to determine the legality of the detention. Additionally, the plan will permit the director of a mental facility to "make an application for a writ of habeas corpus to determine whether a facility properly admitted or properly holds an individual."212

The conditional release of an involuntarily committed patient and one committed after an insanity acquittal will read the same. Though the circumstances surrounding the commitment may vary, the situation remains that under either form of commitment the underlying factor is that both patients exhibited some form of dangerousness to themselves or others. Typically, a mental patient can be conditionally released by the director of the hospital without court notification.213 A plan for conditional release shall require court approval. The primary concern for requiring court approval is twofold. First, it establishes a second form of protection, thereby creating a system where the psychiatrist must evaluate his methodology for accuracy. Secondly, it permits the court, who may have some inside information regarding a particular subject, to reevaluate the patient's progress since committed.


The Virginia Code states in part:
The director of a State hospital may discharge any patient under the preparation of a predischarge plan formulated in cooperation with the community services board where the patient resided prior to hospitalization . . . except one held under an order of a court or judge for a criminal proceeding, as follows:
1. Any patient who, in his judgment, is recovered.
2. Any patient who, in his opinion, is not mentally ill.
3. Any patient who is impaired or not recovered and whose discharge, in the judgment of the director will not be detrimental to the public welfare or injurious to the patient.
4. Any patient who is not a proper case for treatment within the purview of this chapter.
To insure public safety, a secondary check system is warranted. Thus, the plan will provide that when in the opinion of the superintendent of the state hospital a patient will not in the reasonable future be dangerous to himself or to others or their property, and is not in need of supervision, he shall make application for the conditional release on such conditions the superintendent deems necessary in a report to the court which committed the patient. 214 After being notified, the court will have ten days to determine whether to hold a hearing to approve or disapprove the plan. If no action is taken, the plan will be considered approved. 215 The term “conditional release” shall include, but is not limited to, work leave, temporary home visits or one day passes.

When formulating a plan for unconditional release a distinction will have to be made between civil involuntary commitment and commitment following an insanity acquittal. In regard to a patient who has been committed following an acquittal, a mandatory period of confinement of one year must be met. Once the mandatory period of confinement has been met, the procedure for release can commence. Thus, when the superintendent of the state hospital determines that the patient’s sanity has been restored, 216 that the patient may be discharged without danger to the public peace and safety or to himself, and that such person has been involved in a judicially approved out-patient treatment for a period of not less than ninety days, the superintendent shall make an application for the discharge of such person in a report to the court which committed him. 217 Upon receipt of the application

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The Arkansas Code states in part:
If the Director of the State Hospital is of the opinion that the person committed to his custody . . . is no longer affected by mental disease or defect, or, if so affected, that he no longer presents a danger to himself or to the person or property of others and is not in need of care, supervision, or treatment, he shall make application for the discharge or conditional release of such person in a report to the court by which such person was committed. . . .

215. See, e.g., Ohio Rev. Code Ann. § 2945.40 (1981) which states in part: “Within five days after receiving the notice, the court may request a full hearing on the person’s continued commitment by so informing the head of the hospital. If the court does not request a hearing within the five-day period, the head of the hospital . . . may discharge the person.”

216. See, e.g., Cal. Penal Code § 1026.1(a) (West 1982) which states in part: “A person committed to a state hospital or other facility under the provisions of Section 1026 shall be released therefrom only:
(a) Upon determination that sanity has been restored . . . .”

217. See, e.g., Cal. Penal Code § 1026.2 (West 1982) which states in part: “No hearing upon such application shall be allowed until the person committed shall have been con-
for discharge, the court will appoint at least three psychiatrists who have never before examined the patient for the purpose of examining the “person and to report within sixty days their opinion as to his mental condition.”218 If the court is satisfied with the report that the patient has been restored to sanity or that the patient no longer poses a danger to the public peace and safety or to himself, then the court will order his discharge or release. If the court is not satisfied with the report, or the report concludes that the patient has not been restored to sanity or still poses a danger to the public peace and safety or to himself, then the court shall order a hearing. At the hearing, the patient may request to be heard before a jury, and the patient bears the burden to prove that he has regained his sanity and that his discharge or release would not be dangerous to the public peace and safety or to himself. According to the determination of the court or jury upon such a hearing, the committed person will either be discharged or released, or recommitted under the authority of the superintendent of hospitals.

In regard to a patient involuntarily committed, a mandatory period of confinement of sixty days must be met. Once the mandatory period of confinement has been met the procedure for release can commence. Thus, the patient, a guardian, a friend or a relative may make an application to the court for the patient’s discharge on the ground of restoration of sanity or that the patient’s release will not endanger the public peace and safety or himself. The superintendent of the state hospital may make an application for the discharge of such patient when he has determined that the patient’s sanity has been restored and the patient may be discharged without danger to the public peace and safety or to himself. The remaining procedure for release is the same as in the case of a patient committed after an insanity acquittal. Three impartial psychiatrists examine the patient, make a recommendation to the court and the court discharges the patient or conducts a hearing.

V. ALTERNATIVE MODES OF COMPENSATION

Several means of compensating victims of violent crimes have been formulated. This note has discussed civil liability against a third party who owed a duty to the plaintiff either premised on policy or found to exist because of a special relationship.219 Another method of recovery, briefly alluded to, seeks civil liability directly against the mental pa-

219. See supra notes 110-16 and accompanying text.
tient. Yet, most mental patients are judgment proof, because they are either incarcerated and deprived of their earning capacity, or are indigent. Apart from these two methods of recovery a victim may attempt to seek recovery under a theory of negligence per se, restitution or may apply for compensation with a state victim compensation program.

A. Negligence per se

Negligence per se is a special form of recovery premised upon a duty imposed by statute. In order for a statute to impose a specific duty of care for civil negligence, the statute must be clear, unambiguous and drafted with the purpose of preventing the type of injury actually suffered and protecting a particular class of persons of which the plaintiff is a member. The effect of the statutory duty enables the plaintiff to show that the statute was violated. This would automatically establish both duty and breach in a civil negligence action.

If a statute is enacted which requires hospital directors to seek the court's permission before a patient can be released conditionally or unconditionally, or transferred, then any time a patient is released without proper permission, liability can be attached if the patient subsequently harms another. More practically, however, a court order may have the same legitimacy as a statute and thus could be the basis of a negligence per se argument.

220. See supra notes 75-76.
221. See supra note 76.
222. See BLACK'S LAW DICTIONARY 933 (rev. 5th ed. 1979) which states:
   Conduct, whether of action or omission, which may be declared and treated as negligence without any argument or proof as to the particular surrounding circumstances, either because it is in violation of a statute or valid municipal ordinance, or because it is so palpably opposed to the dictates of common prudence that it can be said without hesitation or doubt that no careful person would have been guilty of it. As a general rule, the violation of a public duty, enjoined by law for the protection of person or property, so constitutes.
223. See Griekson v. Kongsli, 40 Wash. 2d 79, 240 P.2d 1209 (1952). Motor vehicle statute governing the right of way was “designed only for the protection of users of the roadway and a violation of them as to persons within that class may be negligence per se. Appellants, as owners of a building on land abutting the highway, are not within that class.” Id. at 81, 240 P.2d at 1210.
225. See A Proposed Expansion, supra note 85.
In *Semler v. Psychiatric Institute of Washington, D.C.*, the court ordered the defendant's twenty year sentence suspended for probation on the condition "that he continue to receive treatment at and remain confined in the Psychiatric Institute until released by the Court." The court held that a special relationship was "created by the probation order [and] imposed a duty on the appellants to protect the public from the reasonably foreseeable harm at [the patient's] hands. . . ." Thus, when the patient killed Miss Semler, the "breach of [that] duty followed by the foreseeable harm on which it was predicated, in itself demonstrate[d] proximate cause" and liability.

Though the court in *Semler* did not justify its decision on the theory of negligence per se, its opinion treats the violation of the court order as if it were a negligence per se analysis. Significant to a negligence per se case is the standard of care established by the statute or court order. Typically, the psychiatrist would have been held to a standard of care of a competent psychiatrist in a similar circumstance. Under that standard, the psychiatrist might not have been liable. Yet, the court order imposed a higher standard of care upon the psychiatrist and removed most of the psychiatrist's discretion. Thus, when the court found that the psychiatrist failed to adhere to the court order, it literally closed the door to any discussion of the psychiatrist's conduct. Further testimony established that the court's order had the purpose to prevent the type of injury which occurred against the class of persons of which the victim was a member.

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Courts traditionally make decisions concerning what is reasonable under the law of torts, and these decisions have the broad effect of proscribing certain kinds of behavior that have been deemed negligent. By definition, the standard of the ordinarily prudent man must reflect a community's experience; judges are presumably well versed in ascertaining and applying such a standard. A court order arguably has sufficient legitimacy to justify a finding of negligence *per se* if it is breached.

*Id.* at 217.
226. 538 F.2d 121 (4th Cir. 1976).
227. *Id.* at 124.
228. *Id.* at 125.
229. *Id.* at 126.
231. 538 F.2d at 125.
232. *Id.* at 125-26.
233. *Id.* at 124. The doctor testified:
Yes, [the judge] was very interested in the case. He seemed to have a thorough knowledge of John's situation, his past, his problems. He was concerned for the citizens of Fairfax County. He was concerned for John. I felt that he gave me a very complete dissertation on his feelings about what was important and how serious the situation was.
The use of negligence per se has a limited use in actions against mental institutions or psychiatrists for the release of patients. Yet, after Semler, "psychiatrists who are under a statutory or judicial obligation to seek court approval for the release of a mentally ill offenders are not likely to free the patient until they have submitted their plans to the court." Yet, after Semler, "psychiatrists who are under a statutory or judicial obligation to seek court approval for the release of a mentally ill offenders are not likely to free the patient until they have submitted their plans to the court."

B. Restitution

Unlike civil liability, restitution depends upon criminal liability and thus requires a heavier burden of proof. Restitution is premised upon the theory that "retribution is a primary function of punishment and the punishment should fit the crime." It can have the effect of "restoring the criminal's sense of social and personal responsibility."

The benefit to the victim, however, is that the state prosecutes the action in a swift criminal trial. A victim will know in a relatively short period of time whether restitution will be granted whereas civil litigation takes a number of years before a judgment is rendered and payment is received. An immediate set back to restitution centers on the fact that for a victim to receive restitution compensation the defendant must be free to acquire adequate funds to pay the restitution. Most frequently, restitution becomes a condition of probation. In terms of mental patients as defendants, the chances are paramount that the defendant will be placed into a mental hospital until he is restored to sanity or no longer poses a danger to society. Thus, like negligence per se, restitution has a limited use in situations involving injury caused by mental patients.

Id. at 125 n.2.

234. Unless a committing court specifically imposes upon hospital authorities the duty to report to the court before releasing a mental patient the negligence per se argument as advanced in Semler will not be permitted. Until legislators statutorily impose an affirmative duty upon hospital authorities to seek judicial verification for a release decision, negligence per se will not be applicable.

235. See A Proposed Expansion, supra note 85, at 220.


238. California's Approach, supra note 95 at 542.

239. See U.S. CONST. amend. VI, which states in part: "In all criminal prosecutions, the accused shall enjoy the right to a speedy and public trial. . . ."


241. See California's Approach, supra note 95, at 541.
C. Victim of Violent Crime Programs

Perhaps the most effective alternative to a civil claim against a psychiatrist, hospital or government for the negligent release of a mental patient is the state funded victim of violent crime program.\(^{242}\) The purpose of these programs is to indemnify and rehabilitate\(^{243}\) victims by compensating them for their medical expenses, lost wages, loss of financial sources of a family member and burial expenses, but not property damages.\(^{244}\)

Several justifications for the state funded program have emerged. Some advocates stress that the state has failed in its duty to protect its citizenry, therefore, it is obligated to compensate the victims for their injuries.\(^{245}\) State statutes characterize the program as a "matter of grace," not a legal right and view the compensation as a humanitarian duty.\(^{246}\) A third justification for the program remarks that the "government should insure citizens against the 'shared risks' that are part of life in society."\(^{247}\)

The victim compensation plans are not applicable to everyone because of the eligibility requirements. Before individuals can benefit from such a program they must have sustained a minimum loss,\(^{248}\) have met the financial hardship test,\(^{249}\) have been a resident of the state to which they apply\(^{250}\) and not have been a member of the offender's family or household.\(^{251}\) If the victim meets the eligibility requirement then he can collect an award established by statute.\(^{252}\) Since the programs are meant to compensate victims for their out-of-pocket

\(\text{\cite{242}}\) See generally Note, Compensation for Victims of Crime: Evolving Concept or Dying Theory, 82 W. VA. L. REV. 89 (1979). See also Appendix chart 1.

\(\text{\cite{243}}\) See CAL. GOV’T CODE § 13959 (West 1979). This section provides: "It is in the public interest to indemnify and assist in the rehabilitation of those residents of the State of California who as the direct result of a crime suffer a pecuniary loss which they are unable to recoup without suffering serious financial hardship."

\(\text{\cite{244}}\) See Garofalo and McDermott, National Crime Victim Compensation: Its Cost and Coverage, 1 LAW AND POLICY Q. 439, 440 (1979).


\(\text{\cite{246}}\) See Survey supra note 245, at 421.

\(\text{\cite{247}}\) Id. (quoting Carrow, CRIME VICTIM COMPENSATION PROGRAM MODELS, 5-7 (1980)).

\(\text{\cite{248}}\) See Appendix chart 2.

\(\text{\cite{249}}\) CAL. GOV’T CODE § 13960(e) (West 1980). This section provides: "... Said loss shall be in an amount of more than one hundred dollars or shall be equal to 20 percent or more of the victim's net monthly income, whichever is less."

\(\text{\cite{250}}\) See Survey supra note 245, at 492.

\(\text{\cite{251}}\) Id. at 489. This requirement "was designed to prevent the 'unjust enrichment' of the offender. . . ." Id.

\(\text{\cite{252}}\) See Appendix chart 2.
expenses, the "states deduct from every claim the amount that the vic-
tim received from 'collateral sources.'"\textsuperscript{253}

Victim of Violent Crime Programs are gaining more recognition
across the country, yet the federal government remains reluctant to
help sponsor these programs.\textsuperscript{254} Nonetheless, it offers a viable alterna-
tive to a negligence claim against a hospital for the release of a mental
patient, so long as the damages are not substantial, nor the personal
injury too serious.

VI. Conclusion

Important issues have been raised regarding the release of mental
patients from state institutions. The focal point centers on the need to
guarantee public safety and the shouldering of liability.

The public safety concern becomes seriously attenuated in recogni-
tion of accepted procedures. Hospital administrators and staff psychia-
trists have adopted a course which permits the early release of mental
patients. This approach finds credence in two salient factors. First,
with the increase of mental commitments and the lack of new facilities,
mental institutions are unable to adequately handle the overcrowded
conditions.\textsuperscript{255} As a result, a propensity exists to release patients who
appear to be a safe risk but who could use more daily hospital observa-
tion.\textsuperscript{256} Second, the underlying psychiatric practice to release patients
through the institution's open doors, as a method of rehabilitation, en-
hances the potential for societal injury.

These two pertinent recognitions must be examined in conjunction
with two more viable concerns. Numerous judicial scholars, legal com-
mentators and psychiatrists have remarked on the inability to ade-
quately predict dangerousness.\textsuperscript{257} So long as dangerousness remains the
determining criteria in release decisions, considerable measures must
be advanced to safely assure that the releasing authorities decision was
substantiated. In addition, the realization that some release decisions
may be protected by state or federal immunity statutes,\textsuperscript{258} warrants the
creation of a check system to verify the soundness of the conditional or
unconditional release.

Totalling these major factors together, strong support can be gath-
ered for approving the judiciary as the necessary body to oversee re-

\textsuperscript{253} See Survey, supra note 245, at 488.
\textsuperscript{254} Id. at 493.
\textsuperscript{255} See supra note 28 and accompanying text.
\textsuperscript{256} Id.
\textsuperscript{257} See supra notes 15-20 and accompanying text.
\textsuperscript{258} See supra notes 176-206 and accompanying text.
lease decisions. Psychiatrists and hospital administrators have the expertise to determine whether out-patient status will effectively assist a mental patient to overcome his mental condition. Similarly, psychiatrists and hospital staff are best suited to examine a patient’s daily progress and determine whether dangerous propensities have waned or have remained apparent. Yet, with the inadequacy of predicting “dangerousness,” the inclination to rehabilitate patients through the hospital’s open doors, the effect overcrowding has on release decisions and the possibility of immunity, the court system is the best alternative to impartially oversee the release decision.

DAVID NELSON SHAFER
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<td>New AA</td>
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<td>General revenue</td>
</tr>
<tr>
<td>North Dakota</td>
<td>1975</td>
<td>Workmen's Comp. Bureau (two years)</td>
<td>$205,000</td>
<td>General revenue</td>
</tr>
<tr>
<td>Ohio</td>
<td>1976</td>
<td>Ct. of Claims (w/Atty. Gen.)</td>
<td>$4,484,000</td>
<td>Reparations Special Acct. ($3 costs, any offense)</td>
</tr>
<tr>
<td>Oregon</td>
<td>1977</td>
<td>Dept. of Justice (w/Work. Comp. Bd.) (two years)</td>
<td>$711,000</td>
<td>General revenue</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>1976</td>
<td>New AA</td>
<td>$942,000</td>
<td>General revenue</td>
</tr>
<tr>
<td>Tennessee</td>
<td>1976</td>
<td>Circuit Courts (DAs + Bd. of Claims) (9 mos.)</td>
<td>$144,000</td>
<td>Crim. Injuries Comp. Fund ($21 tax, serious crimes)</td>
</tr>
<tr>
<td>Texas</td>
<td>1979</td>
<td>Industrial Accident Bd. Began 1/1/80</td>
<td>$144,000</td>
<td>Crime Victim Comp. Fund ($15 costs felony/$10 misdem.)</td>
</tr>
<tr>
<td>Virginia</td>
<td>1976</td>
<td>Industrial Commission</td>
<td>$261,000</td>
<td>Crim. Injuries Comp. Fund ($10 costs, serious crimes)</td>
</tr>
<tr>
<td>State</td>
<td>Year</td>
<td>Department</td>
<td>Max. award</td>
<td>Min. loss</td>
</tr>
<tr>
<td>------------</td>
<td>------</td>
<td>------------------------------------------------</td>
<td>------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>1975</td>
<td>Dept. of Industry, Labor + Human Rltns. New AA</td>
<td>$999,000</td>
<td></td>
</tr>
<tr>
<td>Virgin Islands</td>
<td>1968</td>
<td>Dept. of Industry, Labor + Human Rltns. New AA</td>
<td>$149,000</td>
<td></td>
</tr>
</tbody>
</table>


**CHART 2**

Victim compensation programs: operation

<table>
<thead>
<tr>
<th>State</th>
<th>Max. award</th>
<th>Min. loss</th>
<th>Excludes Financial need</th>
<th>Report to police</th>
<th>File w/ comm'n.</th>
<th>Emergency award</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska</td>
<td>$25,000</td>
<td>None</td>
<td>x</td>
<td>5 days</td>
<td>2 yrs.</td>
<td>$1500</td>
</tr>
<tr>
<td>California</td>
<td>$23,000</td>
<td>$100</td>
<td>x</td>
<td>Yes</td>
<td>1 yr.</td>
<td></td>
</tr>
<tr>
<td>Connecticut</td>
<td>$10,000</td>
<td>$100</td>
<td></td>
<td>5 days</td>
<td>2 yrs.</td>
<td></td>
</tr>
<tr>
<td>Delaware</td>
<td>$10,000</td>
<td>$25</td>
<td></td>
<td>&quot;cooperate&quot;</td>
<td>1 yr.</td>
<td>No set limit (NSL)</td>
</tr>
<tr>
<td>Florida</td>
<td>$10,000</td>
<td>None</td>
<td>x</td>
<td>72 hrs.</td>
<td>1 yr.</td>
<td>$500</td>
</tr>
<tr>
<td>Hawaii</td>
<td>$10,000</td>
<td>None</td>
<td>x</td>
<td>Yes</td>
<td>18 mos.</td>
<td></td>
</tr>
<tr>
<td>Illinois</td>
<td>$10,000</td>
<td>$200</td>
<td>x</td>
<td>ASAP</td>
<td>2 yrs.</td>
<td></td>
</tr>
<tr>
<td>Indiana</td>
<td>$10,000</td>
<td>$100</td>
<td>x</td>
<td>48 hrs.</td>
<td>90 days</td>
<td>$500</td>
</tr>
<tr>
<td>Kansas</td>
<td>$10,000</td>
<td>$100</td>
<td>x</td>
<td>72 hrs.</td>
<td>1 yr.</td>
<td>NSL</td>
</tr>
<tr>
<td>Kentucky</td>
<td>$15,000</td>
<td>$100</td>
<td>x</td>
<td>48 hrs.</td>
<td>6 mos.</td>
<td></td>
</tr>
<tr>
<td>Maryland</td>
<td>$45,000</td>
<td>$100</td>
<td>x</td>
<td>48 hrs.</td>
<td>180 days</td>
<td>$1000</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>$10,000</td>
<td>$100</td>
<td>x</td>
<td>48 hrs.</td>
<td>1 yr.</td>
<td></td>
</tr>
<tr>
<td>Michigan</td>
<td>$15,000</td>
<td>$100</td>
<td></td>
<td>48 hrs.</td>
<td>30 days</td>
<td>$500</td>
</tr>
<tr>
<td>Minnesota</td>
<td>$25,000</td>
<td>$100</td>
<td>x</td>
<td>5 days</td>
<td>1 yr.</td>
<td>NSL</td>
</tr>
<tr>
<td>Montana</td>
<td>$25,000</td>
<td>None</td>
<td>x</td>
<td>72 hrs.</td>
<td>1 yr.</td>
<td>NSL</td>
</tr>
<tr>
<td>Nebraska</td>
<td>$10,000</td>
<td>None</td>
<td>x</td>
<td>3 days</td>
<td>2 yrs.</td>
<td>$500</td>
</tr>
<tr>
<td>New Jersey</td>
<td>$10,000</td>
<td>$100</td>
<td>x</td>
<td>3 mos.</td>
<td>1 yr.</td>
<td></td>
</tr>
<tr>
<td>New York</td>
<td>Unlim. med.</td>
<td>None</td>
<td>x</td>
<td>1 wk.</td>
<td>1 yr.</td>
<td>$1500</td>
</tr>
<tr>
<td></td>
<td>$20,000 wages</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>North Dakota</td>
<td>$25,000</td>
<td>$100</td>
<td>x</td>
<td>72 hrs.</td>
<td>1 yr.</td>
<td>NSL</td>
</tr>
<tr>
<td>Ohio</td>
<td>$50,000</td>
<td>None</td>
<td>x</td>
<td>72 hrs.</td>
<td>1 yr.</td>
<td>NSL</td>
</tr>
<tr>
<td>Oregon</td>
<td>$23,000</td>
<td>$250</td>
<td>x</td>
<td>72 hrs.</td>
<td>6 mos.</td>
<td>$1000</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>$25,000</td>
<td>$100</td>
<td>x</td>
<td>72 hrs.</td>
<td>1 yr.</td>
<td>$1000</td>
</tr>
<tr>
<td>Tennessee</td>
<td>$10,000</td>
<td>$100</td>
<td>x</td>
<td>48 hrs.</td>
<td>1 yr.</td>
<td>$500</td>
</tr>
<tr>
<td>Texas</td>
<td>$50,000</td>
<td>None</td>
<td>x</td>
<td>72 hrs.</td>
<td>180 days</td>
<td>$1500</td>
</tr>
<tr>
<td></td>
<td>Amount</td>
<td>Deduct.</td>
<td>Min.</td>
<td>Max.</td>
<td>Duration</td>
<td>(2 yrs. GC)</td>
</tr>
<tr>
<td>----------------</td>
<td>--------</td>
<td>---------</td>
<td>------</td>
<td>------</td>
<td>----------</td>
<td>-------------</td>
</tr>
<tr>
<td>Virginia</td>
<td>$10,000</td>
<td>$100</td>
<td>x</td>
<td>x</td>
<td>48 hrs.</td>
<td>180 days</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(deduct.)</td>
<td></td>
<td></td>
<td></td>
<td>(2 yrs. GC)</td>
</tr>
<tr>
<td>Washington</td>
<td>-</td>
<td>None</td>
<td>x</td>
<td></td>
<td>72 hrs.</td>
<td>1 yr.</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>$10,000</td>
<td>$200</td>
<td>-</td>
<td>x</td>
<td>5 days</td>
<td>2 yrs.</td>
</tr>
<tr>
<td>Virgin Islands</td>
<td>$15,000</td>
<td>None</td>
<td>x</td>
<td></td>
<td>24 hrs.</td>
<td>2 yrs.</td>
</tr>
</tbody>
</table>