COMMENTS

NEW YORK'S IMMEDIATE NEED FOR A
PSYCHOTHERAPIST-PATIENT PRIVILEGE
ENCOMPASSING PSYCHIATRISTS, PSYCHOLOGISTS,
AND SOCIAL WORKERS

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INTRODUCTION

Accused of strangling his girlfriend Gloria to death, Robert Wilkins testified at trial that his girlfriend had attacked him first, causing him to suffer visible slashes on his left wrist and on his abdomen. Attempting to contradict Wilkins's allegations, the People sought to introduce the testimony of Dr. K.C. Sharma, a licensed psychologist, to reveal that Wilkins admitted to Dr. Sharma that such wounds were not the result of an attack by Gloria but instead were the remnants of a botched suicide attempt. Significantly, the New York Court of Appeals deemed such testimony inadmissible solely because of Dr. Sharma's status as a psychologist. Dismissing the Appellate Division's finding that the

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1 See People v. Wilkins, 480 N.E.2d 373, 374 (N.Y. 1985).

2 See id. at 375 (noting that Dr. Sharma had interviewed Wilkins at the hospital on the night of the incident).

3 Id. at 378, 377–78. The court reversed the Appellate Division’s finding that Dr. Sharma’s testimony was admissible because Wilkins had effectively waived any protection of the psychologist-patient privilege by placing his wounds at issue in the case. See id. at 375. The court concluded that because the psychologist-patient relationship is placed on the same basis in law as the attorney-client relationship under N.Y. C.P.L.R. 4507, the psychologist-patient privilege is waived only with the “express consent” of the client, and that by merely placing his wounds at issue in the case Wilkins made no such waiver. Id. at 377–78; see also discussion infra Part II.C (discussing the issue of waiver and its relationship to the respective
psychologist-patient privilege is “no broader” than the physician-patient privilege,\textsuperscript{4} the court implied that had Wilkins spoken with a psychiatrist, rather than a psychologist, such testimony would have been admitted and the entire outcome of the case completely different.\textsuperscript{5}

Increasing numbers of people are seeking treatment from physicians, psychologists and social workers for their mental health needs.\textsuperscript{6} Arguably, patients expect a certain level of confidentiality when they seek out such services\textsuperscript{7} and expect that such practitioners will not fully or even partially disclose any confidential communications.\textsuperscript{8} Confusingly, New York has three separate evidentiary privileges for, respectively, physicians, psychologists and social workers\textsuperscript{9} so that depending with whom the patient speaks, and what exactly is said, certain communications shared between a patient and a mental health provider may or may not be kept confidential. Limiting the patient’s evidentiary privilege in such a manner is unjust, unfair and, arguably, discriminatory. New York must replace these three evidentiary privileges with a single psychotherapist-patient privilege.

This Note focuses on New York’s treatment of the physician-patient privilege, the psychologist-patient privilege, and the social worker-patient privilege. While states such as Florida and California broadly define a psychotherapist to include psychologists, psychiatrists and social workers,\textsuperscript{10} New York offers no such

\textsuperscript{4} Wilkins, 480 N.E.2d at 377.

\textsuperscript{5} See id. at 376. The court explained that psychologists, unlike psychiatrists, are not authorized to practice medicine and are thus not categorized as physicians for the purposes of privileged communications. Id. Instead, psychologists are registered under the Education Law and are afforded protections different from those granted to psychiatrists. Id.

\textsuperscript{6} See Brief Amicus Curiae of The American Psychological Ass’n in Support of Respondents at 17, Jaffee v. Redmond, 518 U.S. 1 (1996) (No. 95-266) [hereinafter Am. Psychological Ass’n] (“Countless people seek professional help to cope with daily stress, family turbulence, and severe emotional trauma . . . .”).

\textsuperscript{7} See Kerry L. Morse, Note, A Uniform Testimonial Privilege for Mental Health Professionals, 51 Ohio St. L.J. 741, 741 (1990) (describing testimonial privileges generally and advocating for a uniform mental privilege to “provide more consistent protection . . . and more certainty for the individuals seeking help from these professionals”).

\textsuperscript{8} Am. Psychological Ass’n, supra note 6, at 10.


\textsuperscript{10} Florida law provides that a “psychotherapist” is:
guidance. Instead, New York defines the practice of psychotherapy as “the treatment of mental, nervous, emotional, behavioral and addictive disorders, and ailments by the use of both verbal and behavioral methods of intervention in interpersonal relationships with the intent of assisting the persons to modify attitudes, thinking, affect, and behavior which are intellectually, socially and emotionally maladaptive.”

Arguably, such a definition broadly applies to the services provided by psychologists, social workers, and certain physicians.

Regarding a psychotherapist-patient privilege, Justice Stevens of the U.S. Supreme Court wrote:

If the purpose of the privilege is to be served, the participants in the confidential conversation “must be able to predict with some degree of certainty whether particular discussions will be protected. An uncertain privilege, or one which purports to be certain but results in widely varying applications by the courts, is little better than no privilege at all.”

Anything less than complete consistency and concrete guidelines does little more than distort the intended purposes of the privileges.

Part I of this Note looks at the history and purpose of each privilege, while Part II explains three distinctions found amongst the evidentiary privileges. Part III examines options and alternatives to be considered by the legislature when creating a

(1) [a] person authorized to practice medicine . . . or reasonably believed by the patient so to be, who is engaged in the diagnosis or treatment of a mental or emotional condition, including alcoholism and other drug addiction; (2) [a] person licensed or certified as a psychologist . . . who is engaged primarily in the diagnosis or treatment of a mental or emotional condition, including alcoholism and other drug addiction; [and] (3) [a] person licensed or certified as a clinical social worker . . . who is engaged primarily in the diagnosis or treatment of a mental or emotional condition . . . .

FLA. STAT. ANN. § 90.503(1)(a)(1)-(3) (West 1999).

California defines a psychotherapist as

(a) [a] person authorized, or reasonably believed by the patient to be authorized, to practice medicine in any state or nation who devotes, or is reasonably believed by the patient to devote, a substantial portion of his or her time to the practice of psychiatry; (b) [a] person licensed as a psychologist . . . or (c) [a] person licensed as a clinical social worker . . . when he or she is engaged in applied psychotherapy of a nonmedical nature.

CAL. EVID. CODE § 1010 (West 1995) (emphasis added).

11 N.Y. EDUC. LAW § 8401(2) (McKinney Supp. 2006).
13 See Morse, supra note 7, at 746 (arguing that reliance on state legislatures to recognize and define evidentiary privileges has “led to the patchwork development of privilege law”).
psychotherapist-patient privilege, including the U.S. Supreme Court’s holding in *Jaffee v. Redmond*, other jurisdictions’ efforts in the field of privileged communications, and various N.Y. Proposed Codes of Evidence. Finally, Part IV proposes that New York recognize a psychotherapist-patient privilege protecting a patient’s privileged communications with psychiatrists, psychologists and social workers.

**I. BACKGROUND**

**A. Physician-Patient Privilege**

At the forefront of evidentiary privileges, New York codified a physician-patient privilege in 1828 when it declared that a physician may not “disclose any information which he may have acquired in attending any patient, in a professional character, and which information was necessary to enable him to prescribe for such patient as a physician, or to do any act for [such patient] . . . .”  

Applicable to pre-trial examinations, oral testimony, and certain documents, the privilege seeks to protect communications shared between the patient and the physician. While the physician-patient privilege purports to safeguard information obtained from

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15 See Williams v. Roosevelt Hosp., 488 N.E.2d 94, 97 (N.Y. 1985) (limiting the protection given to documents to those containing shared communications between the physician and the patient); see also Dillenbeck, 536 N.E.2d at 1133 (protecting information contained in medical files); Wheeler v. Comm’r of Soc. Servs., 662 N.Y.S.2d 550, 553 (App. Div. 1997) (labeling New York as a pioneer in the protection of the confidentiality of medical records); Edington v. Mut. Life Ins. Co. of N.Y., 67 N.Y. 185, 194 (1876) (indicating that communications “from the lips of the patient” and statements of third parties present at the time of revelation are also protected).

16 N.Y. C.P.L.R. 4504(a) (McKinney 1992). New York law provides:

(a) Confidential information privileged. Unless the patient waives the privilege, a person authorized to practice medicine, registered professional nursing, licensed practical nursing, dentistry, podiatry or chiropractic shall not be allowed to disclose any information which he acquired in attending a patient in a professional capacity, and which was necessary to enable him to act in that capacity.

Id.; see also Williams, 488 N.E.2d at 97 (explaining that the party asserting the privilege has the burden of justifying its necessity); People v. Sanders, 646 N.Y.S.2d 955, 959 (Sup. Ct. 1996) (listing three elements which must be established before the privilege is granted: “(1) there must be a relationship between the doctor and the patient; (2) the information in question must have been obtained during the course of treatment; and (3) the information obtained must have been necessary for diagnosis or treatment”).
the observation of a patient’s appearance and symptoms, no protection is granted to such appearances, symptoms, or incidents of a person’s medical history that would be obvious to a layman.\textsuperscript{17} Significantly, although psychiatrists are primarily sought out as mental health professionals, New York continues to classify psychiatrists as physicians so that psychiatrists’ evidentiary privileges are restricted to those shared by medical doctors concerned primarily with physical ailments.\textsuperscript{18}

\textbf{B. Psychologist-Patient Privilege and Social Worker-Patient Privilege}

One hundred and twenty-eight years after the codification of the physician-patient privilege, New York recognized the practice of psychology as a separate and unique profession\textsuperscript{19} and subsequently enacted an evidentiary privilege protecting communications shared between a psychologist and a patient.\textsuperscript{20} Interestingly, the legislative memorandum of the State Education Department pertaining to the psychologist-patient privilege explicitly states “this bill has no application whatsoever to any licensed physician or psychiatrist.”\textsuperscript{21} As early as 1956, the legislature set forth laws wrongly distinguishing between the two fields of mental health practice. Less than ten years after enacting the psychologist-patient privilege, New York enacted an evidentiary privilege for licensed social workers.\textsuperscript{22} Exemplifying what little concern was given to providing consistency amongst the privileges, the social worker-patient privilege seems little more than a messy mixture of the psychologist-patient and the physician-patient privileges. Similar to the physician-patient privilege, the social worker-patient

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\item \textsuperscript{17} Dillenbeck, 536 N.E.2d at 1130; see also Williams, 488 N.E.2d at 97.
\item \textsuperscript{18} Sanders, 646 N.Y.S.2d at 959 n.2.
\item \textsuperscript{19} Averell Harriman, Governor’s Memoranda on Bills Approved, 1956 N.Y. Sess. Laws 1684 (McKinney), reprinted in 1956 NEW YORK STATE LEGISLATIVE ANNUAL 479.
\item \textsuperscript{20} See 1956 N.Y. Laws 1632 (“The confidential relations and communications between a psychologist registered under provisions of this act and his client are placed on the same basis as those provided by law between attorney and client, and nothing in this article shall be construed to require any such privileged communications to be disclosed.”); see also N.Y. C.P.L.R. 4507 (McKinney 1992).
\item \textsuperscript{21} Memoranda of State Education Department, 1956 N.Y. Sess. Laws 1928 (McKinney), reprinted in 1956 NEW YORK STATE LEGISLATIVE ANNUAL 214 (emphasis added).
\item \textsuperscript{22} See 1968 N.Y. Laws 1043 (“A person duly registered as a certified social worker under the provisions of article [154] of the education law shall not be required to disclose a communication made by his client to him, or his advice given thereon, in the course of his professional employment . . . .”); see also N.Y. C.P.L.R. 4508(a) (McKinney Supp. 2006).
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privilege states simply that “[c]onfidential information [is] privileged;” communications shared between a social worker and the patient are not placed on the same level as an attorney-client relationship.\textsuperscript{23} Analogous to the psychologist-patient privilege, only a social worker who is “certified” will be granted protection under the privilege.\textsuperscript{24}

C. Intended Purposes of the Evidentiary Privileges

The existence of obvious distinctions amongst the three privileges is puzzling given their strikingly similar underlying purposes. In 1836, a New York Legislator stressed that unless communications between a physician and a patient remain privileged, patients may face “temptation to the perversion or concealment of truth, too strong for human resistance.”\textsuperscript{25} Nearly two hundred years later, the New York Court of Appeals listed three core objectives of the physician-patient privilege as (1) “[maximization of] unfettered patient communication with medical professionals;” (2) “candid . . . recording [of] confidential information” for medical professionals; and (3) protection of a “patients’ reasonable privacy expectations against disclosure of sensitive personal information.”\textsuperscript{26} Certainly, such objectives can easily be applied to any of the three evidentiary privileges.

Similar to the physician-patient privilege, the social worker-

\textsuperscript{23} N.Y. C.P.L.R. 4508(a) (“A person licensed as a licensed master social worker or a licensed clinical social worker . . . shall not be required to disclose a communication made by a client, or his or her advice given thereon, in the course of his or her professional employment . . . .”).

\textsuperscript{24} See N.Y. EDUC. LAW § 7701 (McKinney Supp. 2006) (defining social workers as those who engage in “the administration of tests and measures of psychosocial functioning, social work advocacy, case management, counseling, consultation, research, administration and management, and teaching”).

\textsuperscript{25} 3 N.Y. REV. STAT. pt. 3, ch. 7, tit. 3, art. 8, § 79 (1836); see Dillenbeck v. Hess, 536 N.E.2d 1126, 1130 (N.Y. 1989) (explaining that in the absence of such privileges, the threat existed that “physicians would alter or conceal the truth when forced . . . to choose between their legal duty to testify and their professional obligation to honor their patients’ confidences”); Williams v. Roosevelt Hosp., 488 N.E.2d 94, 96 (N.Y. 1985) (reasoning that the risk of humiliation and disgrace stemming from the public disclosure of certain shared communications with a physician may deter “adequate diagnosis and treatment” in certain situations); Wheeler v. Comm’r of Soc. Servs., 662 N.Y.S.2d 550, 553 (App. Div. 1997) (“The patient whose privacy and sensibilities are safeguarded will be the more likely to reveal information that will result in improvement or cure. This benefits the individual and, in turn, the community and, ultimately, the population.”).

\textsuperscript{26} In re Grand Jury Investigation, 779 N.E.2d 173, 175 (N.Y. 2002). But see Dillenbeck, 536 N.E.2d at 1135 (Bellacosa, J., dissenting) (arguing that the physician-patient privilege is seldom utilized to protect secret information, but rather is primarily used “as a tactical maneuver” to suppress injurious facts to the petitioning party) (internal citation omitted).
patient privilege seeks to encourage the client to speak freely and without fear,\(^{27}\) stressing that “uninhibited disclosure by the individual for the purpose of securing necessary assistance” is essential to the practice of a mental health professional.\(^{28}\) Additionally, the American Psychological Association explains that effective treatment may be obstructed if clients fear disclosure of confidential communications.\(^{29}\)

## II. DISTINCTIONS BETWEEN THE PRIVILEGES

### A. The Psychologist and the Psychiatrist

Historically, it makes little sense that the New York Legislature distinguished between psychology and psychiatry when enacting its evidentiary privileges. Because psychotherapy in the United States was originally practiced almost exclusively by psychiatrists, there was little need for rules governing other mental health professions.\(^{30}\) In 1951, Governor Dewey vetoed a bill that would establish psychology as an independent profession, reasoning that the boundary “between psychology and psychiatry . . . is . . . difficult to recognize in practice.”\(^{31}\) In 1954, the American Medical Association, the American Psychiatric Association, and the American Psychoanalytic Association jointly declared “that only [a] ‘psychiatrist[]’ could carry out ‘psychotherapy.’”\(^{32}\) Confusingly, both

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\(^{27}\) See Am. Psychological Ass’n, supra note 6, at 18 (explaining that the patient has a valid interest in retaining the privacy of “his intimate thoughts and feelings”).

\(^{28}\) In re Application to Quash a Subpoena Duces Tecum in Grand Jury Proceedings, 437 N.E.2d 1118, 1120 (N.Y. 1982); see also Am. Psychological Ass’n, supra note 6, at 17 (equating the importance of emotional survival to physical survival as society becomes more complex).

\(^{29}\) Am. Psychological Ass’n, supra note 6, at 2 (noting that psychologists have an ethical duty to ensure confidential communications with their patients).

\(^{30}\) Paul W. Mosher, Psychotherapist-Patient Privilege: The History & Significance of the United States Supreme Court’s Decision in the Case of Jaffee v. Redmond, in CONFIDENTIAL RELATIONSHIPS: PSYCHOANALYTIC, ETHICAL, AND LEGAL CONTEXTS 177, 183 (Christine M. Koggel et al. eds., 2003); see also Marrow, supra note 9 at 27 (arguing that the lack of distinction made between the varying types of practitioners (i.e., social worker, physician, psychologist) is due to the fact that the psychology “profession was at an early stage and . . . [was not yet] well established”).

\(^{31}\) Thomas E. Dewey, Memoranda on Legislative Bills Vetoed, in PUBLIC PAPERS OF THOMAS E. DEWEY: FIFTY-FIRST GOVERNOR OF THE STATE OF NEW YORK 1951, at 240–41 (1951) (noting that the bill’s “broad language create[d] uncertainty as to the fields of psychology and psychiatry” and citing objections of the Medical Society of the State of New York, the American Psychiatric Association, and the State Commissioners of Mental Hygiene and Health).

\(^{32}\) Mosher, supra note 30, at 185.
the Message of Governor Averell Harriman and the Legislative Memorandum of the State Department of Mental Hygiene fail to explicitly mention why the American Psychiatric Association, only two years after its above declaration, joined the Commissioner of Mental Hygiene in approving a bill to recognize the profession of psychology and afford psychologists separate privileges from psychiatrists.

Psychiatrists often treat emotional issues and mental disorders using similar techniques as psychologists. In *Jaffe v. Redmond*, the Supreme Court insinuated that it is just as imperative for a psychiatrist to maintain confidentiality (in order to ensure open and free discussion by his patients) as it is for a psychologist. The American Psychiatric Association, in its amicus brief for *Jaffee v. Redmond*, stated that there is “wide agreement that confidentiality is a sine qua non for successful psychiatric treatment” and that “[t]he relationship may well be likened to that of . . . the lawyer-client.” Interestingly, the New York Legislature chose to liken the attorney-client relationship only to the practice of psychology, communications shared between psychiatrists and patients are held to no such standard.

**B. Varying Levels of Confidentiality**

The court in *LeVien v. LaCorte* wrote “different privileged communications have varying weight in terms of legal importance

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34 Mosher, *supra* note 30, at 183–84 (explaining that the psychotherapist-patient privilege was originally named the psychiatrist-patient privilege due to the abundance of psychiatrists practicing psychotherapy in the 1950s).

35 Marrow, *supra* note 9, at 27 (noting that psychologists and psychiatrists might frequently work in the same setting, at the same time, serving “the same patient population” in a hospital setting). *But see* Mosher, *supra* note 30, at 186 (arguing that many psychiatrists fail to truly practice psychotherapy to the extent that they emphasize prescribing and adjusting dosages of psychotherapeutic drugs rather than listening or talking with patients).

36 See 518 U.S. 1, 10, 17 (1996) (noting that a psychotherapist privilege would encompass both psychiatrists and psychologists, the court consistently acknowledges the vital importance of confidential communications shared between the professional and the client and stating that “[e]ffective psychotherapy . . . depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts”).


and, therefore, insofar as concerns confidentiality, are entitled to varying degrees of protection.”

While the physician-patient and the social worker-patient privileges both state that confidential information is privileged, the broad language of the psychologist-patient privilege affords the psychologist-patient relationship the same level of confidentiality as the attorney-client relationship.

The Supreme Court notes in Jaffee that “the purpose of the attorney-client privilege is to ‘encourage full and frank communication between attorneys and their clients and thereby promote broader public interests in the observance of law and administration of justice.’” But this is essentially identical to the goal that each evidentiary privilege hopes to achieve; it makes little sense that the psychologist-patient privilege was afforded a greater level of confidentiality. Interestingly, there exists no legislative history specifying the exact reason why only the psychologist-patient privilege was related to the attorney-client privilege.

Expressing its dismay at the obvious inconsistencies existing amongst the privileges, the court in LeVien observed the contradiction: “a communication with a psychologist will remain protected, when the same communication with a psychiatrist . . . will be discoverable.” Different levels of confidentiality amongst the privileges ultimately disadvantage psychiatry, as psychiatrists stress the near “impossibility of ensuring the confidentiality of medical records.” Challenging the legislature’s unwillingness to differentiate psychiatrists from physicians, psychiatrists argue that the legislature fails to provide ample protection for certain types of psychotherapy.

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41 N.Y. C.P.L.R. 4507 (“The confidential relations and communications between a psychologist . . . and his client are placed on the same basis as those provided by law between attorney and client . . . .”); see also N.Y. C.P.L.R. 4503(a)(1) (McKinney Supp. 2006) (“Unless the client waives the privilege, an attorney . . . shall not disclose, or be allowed to disclose such communication . . . in any action, disciplinary trial or hearing, or administrative action . . . . Evidence of any such communication obtained by any such person, and evidence resulting therefrom, shall not be disclosed . . . .”).
43 See People v. Wilkins, 480 N.E.2d 373, 376–77 (N.Y. 1985) (stating that neither the memoranda accompanying the 1956 McKinney Sessions Laws of New York “nor the Governor’s message of approval” indicate the reason for the high standard).
45 Mosher, supra note 30, at 187 (internal citation omitted).
46 Id.
C. The Patient’s Right to Waive the Privilege

The right of a patient to waive his respective privilege ranges from the vague provisions of the psychologist-patient privilege to four specific instances listed in the social worker-patient privilege. While both the physician-patient privilege and the social worker-patient privilege allow for the express and implicit waiver of the privilege of confidentiality, it is unclear whether implied waiver of the psychologist-patient privilege is permitted. Because psychologists are afforded a heightened standard of confidentiality, it is generally thought that confidential communications should not be disclosed without the patient’s explicit consent. Regardless if a patient has expressly or impliedly waived his privilege, it is clear that a patient cannot exploit the privilege by using it “both as a sword and a shield,—to waive when it inures to her advantage, and to wield when it does not.” Additionally, a court will often waive the privilege when compelling policy reasons exist.

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47 See N.Y. C.P.L.R. 4507 (McKinney 1992) (“[N]othing in such article shall be construed to require any such privileged communications to be disclosed.”); see also Marrow, supra note 9, at 26.

48 N.Y. C.P.L.R. 4508(a)(1)–(4) (McKinney Supp. 2006) (including “such information as the client may authorize; . . . a communication . . . reveal[ing] the contemplation of a crime or harmful act”; information indicating that a child under the age of sixteen “has been the victim or subject of a crime”; and when the client brings charges against the certified social worker involving such confidential communications).

49 N.Y. C.P.L.R. 4504(a) (McKinney 1992 & Supp. 2006) (noting that the privilege remains “unless the patient waives the privilege”); N.Y. C.P.L.R. 4508(a)(1) (noting that a “social worker may disclose such information as the client may authorize”).

50 See Robert A. Barker & Vincent C. Alexander, Evidence in New York State and Federal Courts § 502.1(e) (1996) (stating that because "the psychologist-client privilege is 'placed on the same basis' as the attorney-client privilege . . . the doctrine of implied waiver [is restricted]" (footnote omitted) (quoting N.Y. C.P.L.R. 4507)); N.Y. C.P.L.R. 4507 (revealing that unlike the physician-patient privilege or social worker-patient privilege, the psychologist-patient privilege does not explicitly mention a client’s right of waiver, but instead states that “nothing in such article shall be construed to require any such privileged communications to be disclosed”). Courts generally construe such language to prohibit an implied waiver under the psychologist-patient privilege. See People v. Wilkins, 480 N.E.2d 373, 377–78 (N.Y. 1985) (refusing to imply a waiver of the attorney-client privilege when a client testifies on his or her own behalf); People v. Shapiro, 126 N.E.2d 559, 562 (N.Y. 1955) (explaining that “[a]ny other policy than strict inviolability, unless expressly waived, would seriously hamper the administration of justice" and that the rule against disclosure is so important that its waiver is prohibited without the express consent of the client).

51 McKinney v. Grand St., 10 N.E. 544, 544 (N.Y. 1887); see also Kump v. Smith, 250 N.E.2d 857, 859 (N.Y. 1969) (noting that “[d]isclosure is not a one-way street”); Mosher, supra note 30, at 181 (explaining that in the interest of fairness “one cannot selectively use favorable information from a protected relationship while [exploiting the privilege] to conceal unfavorable information”).

The physician-patient privilege seems to connote that nothing less than an affirmative assertion of a physical or mental condition by the patient, as part of his defense, will be deemed a waiver; therefore, a mere denial of an allegation in a complaint will not suffice as a waiver.\textsuperscript{53} In Dillenbeck, the New York Court of Appeals prohibited discovery of the defendant’s medical records even though the defendant’s intoxication at the time of the car accident was placed in controversy.\textsuperscript{54} Although agreeing that the defendant’s physical condition was indeed a controversial issue in the case, the court refused to recognize a waiver because the defendant himself had not affirmatively placed in controversy his intoxication at the time of the accident.\textsuperscript{55}

In contrast to Dillenbeck, the New York Supreme Court’s holding in LeVien v. LaCorte set forth different rules for the psychologist-patient privilege. In an allegation of defamation, the plaintiff in LeVien attempted to prove damages based on emotional stress by asserting that he required psychological visits.\textsuperscript{56} In response to plaintiff’s complaint, opposing counsel requested access to records concerning family therapy sessions as early as two years prior to the case and argued that the plaintiff placed his mental condition in issue by bringing suit.\textsuperscript{57} Although the court ultimately held that the defendants were entitled to redacted records of the psychological visits to the extent that “any information contained in the records [was] material and necessary to the defense of [the] action,”\textsuperscript{58} the court stated that the general rule concerning the psychologist-patient privilege is that “commencement of an action in which the mental condition of a party is placed in controversy is not sufficient to automatically permit the implying of a waiver of the psychologist-client privilege.”\textsuperscript{59} Instead, courts generally look to see if such

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privilege would have been waived under the attorney-client privilege and, most often, will limit the scope of a patient’s waiver to ensure protection of any other confidential information. Significantly, the court in LeVien acknowledged the possibility that such decisions lead to confusion and inconsistencies.

III. OPTIONS/ALTERNATIVES

A. Federal Recognition of a Psychotherapist Privilege

The Supreme Court has far surpassed any efforts of New York’s legislative bodies in establishing a psychotherapist-patient privilege. In Jaffe v. Redmond, Mary Lu Redmond, a police officer, was accused of shooting and killing Ricky Allen. During pretrial discovery, the administrator of Allen’s estate sought access to the records of more than fifty counseling sessions held between Redmond and a social worker. By denying access to such counseling sessions, the Court monumentally recognized a psychotherapist-patient privilege encompassing a psychiatrist-patient privilege, a psychologist-patient privilege, and a social worker-patient privilege for communications extended during therapy sessions.

that the patient effectively waived the psychologist-patient privilege by placing her medical condition in issue in a case seeking damages for defamation and intentional infliction of emotional distress).

LeVien, 640 N.Y.S.2d at 732.

See In re Farrow v. Allen, 608 N.Y.S.2d 1, 4 (App. Div. 1993) (prohibiting the waiver of the entire contents of a letter containing privileged information, even after such letter was released by the psychiatrist to a third party); see also People v. Bierenbaum, 748 N.Y.S.2d 563, 580 (App. Div. 2002) (affirming the admission of testimony pertaining to the contents of a letter upon learning that the patient had expressly consented to the waiver of confidentiality by allowing his psychiatrist to release the letter to warn the victim of the threat of harm, and by limiting the scope of the patient’s waiver, holding that the trial court correctly “allowed the jury to learn only of [the letter’s] existence and nature, but not of its specific contents beyond its warning”).

LeVien, 640 N.Y.S.2d at 731.

But see Barker & Alexander, supra note 50, § 502.2 (noting that a general physician-patient privilege has yet to be recognized by federal law); id. § 505.2 (stating that no social-worker privilege exists in federal law).


Id. at 5.

Id. at 15, 18 (citing Rule 501 of the Federal Rules of Evidence as prohibiting confidential communications shared between a psychotherapist and patient from disclosure); see also Faust F. Rossi, Evidence, 48 Syracuse L. Rev. 659, 698 (1998) (describing the federal psychotherapist privilege as broadly encompassing communications made to psychiatrists,
The Court stressed the need for an absolute and certain privilege because “[e]ffective psychotherapy . . . depends upon an atmosphere of confidence and trust in which the patient is willing to make a frank and complete disclosure of facts, emotions, memories, and fears.” Having “no hesitation” in extending the newly recognized psychotherapist privilege to include confidential communications made to both licensed psychiatrists and psychologists, the Court broadened the privilege to include clinical social workers. Furthermore, the Court rejected an analysis of admissibility and privileges on a case by case basis, but instead opted for a concrete guideline for future case law.

B. Patient Privileges in Other Jurisdictions

The respective evidentiary privileges found in the various jurisdictions throughout the United States evidence the inconsistent treatment of such privileges. While jurisdictions such as Florida, California, Georgia, and Kentucky have codified a single uniform privilege encompassing various mental health professionals, states such as New York retain separate evidentiary privileges depending on the profession. Such separate privileges themselves vary among professions and among states. For instance, Connecticut has enacted separate statutes for a psychologist-patient privilege, a psychiatrist-patient privilege, and a social worker-patient privilege, and Colorado has a separate evidentiary privilege for psychologists and physicians.

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67 Jaffee, 518 U.S. at 10.
68 Id. at 15–16 (citing reasons such as the abundance of mental health practitioners and the necessity of social workers for those who cannot afford the assistance of a psychologist or psychiatrist); see also Myrna S. Raeder, The Social Worker’s Privilege, Victim’s Rights, and Contextualized Truth, 49 HASTINGS L.J. 991, 993 (1998) (arguing that the social worker-patient privilege incorporated within Jaffee is “much more expansive” than most state laws).
69 See Jaffee, 518 U.S. at 17–18 (“Making the promise of confidentiality contingent upon a trial judge’s later evaluation of the relative importance of the patient’s interest in privacy and the evidentiary need for disclosure would eviscerate the effectiveness of the privilege.”).
70 See Raeder, supra note 68, at 992 (explaining that states vary greatly in defining their respective evidentiary privileges).
71 CAL. EVID. CODE § 1010, 1012 (West 1995); FLA. STAT. ANN. § 90.503 (West 1999); GA. CODE ANN. § 43-39-16 (2005); KY. R. EVID. 507 (2005).
73 CONN. GEN. STAT. ANN. §§ 52-146c, 52-146d, 52-146q (West 2005).
74 COLO. REV. STAT. § 13-90-107(1)(d), (g) (2004).
Only ten states continue to place the psychologist-patient privilege on the same level as that of the attorney-client privilege: Alabama, Arizona, Georgia, Idaho, Kansas, Montana, New Jersey, New York, Pennsylvania, and Washington. Of these states, only Alabama and Pennsylvania afford both psychologists and psychiatrists confidential relations similar to those of attorney and client. Interestingly, New Hampshire’s privileged communications statute is so broad as to place all mental health practitioners on the level of attorney-client.

Twenty-seven states plus the District of Columbia have enacted some form of psychotherapist-patient evidentiary privilege. Notably, all twenty-seven states and the District of Columbia remove psychiatrists from a physician-patient classification by either classifying them as a separate profession or, in the case of California, designating them as persons “authorized . . . to practice medicine in any state . . . , or is reasonably believed by the patient to devote[] a substantial portion of his or her time to the practice of psychiatry.” While approximately half of these states place psychiatrists, psychologists, and social workers within a single

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76 ALA. CODE § 34-26-2 (“[T]he confidential relations and communications between licensed psychologists, licensed psychiatrists, or licensed psychological technicians and their clients are placed upon the same basis as those provided by law between attorney and client . . . .”); 42 PA. CONS. STAT. ANN. § 5944 (“The confidential relations and communications between a psychologist or psychiatrists and his client shall be on the same basis as those provided or prescribed by law between an attorney and client.”).

77 N.H. REV. STAT. ANN. § 330-A:32 (2004) (being the only state to include social worker on the same level as attorney-client relationship by stating, “[t]he confidential relations and communications between any person licensed under provisions of this chapter”); see id. § 330-A:18 (covering clinical social workers).


79 CAL. EVID. CODE § 1010; see sources cited supra note 78.
statute, only a few states group the three mental health professions under the label of “psychotherapist.”

For instance, Louisiana refers to protected communications made between patients and “[h]ealth care provider[s],” and Maryland refers to communications shared between patients and psychiatrists or psychologists. Thirteen states include only psychiatrists and psychologists in a psychotherapist privilege while excluding social workers.

New York must look to other jurisdictions when molding a psychotherapist-patient privilege. New York need not adopt an extremely broad version of the psychotherapist-patient privilege because the privileges found in Florida and California seem effective to provide an appropriate amount of protection. New York must address two critical issues when creating such a privilege. Most importantly, New York must ensure that a psychiatrist will be afforded protections that equate to Florida’s protections provided under its definition of a psychotherapist. Additionally, New York must decide if the communications shared between a psychologist and a patient are to be placed on the same basis in law as those occurring between an attorney and a client. Notably, neither Florida nor California mentions the attorney-client privilege in their

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81 CAL. EVID. CODE § 1010; FLA. STAT. ANN. § 90.503; KY. R. EVID. 507(a)(2); N.H. REV. STAT. ANN. § 330-A:2; OR. REV. STAT. § 40.230.

82 LA. REV. STAT. ANN. § 13:3734 (protecting communications made between a patient and a physician, a psychologist, a social worker, and other professionals).


85 See, e.g., Or. Rev. Stat. § 40.230(1)(c)(A) (protecting communications between anyone “[l]icensed, registered, certified or otherwise authorized under the laws of any state to engage in the diagnosis or treatment of a mental or emotional condition”).

86 See Fla. Stat. Ann. § 90.503(1)(a)(1) (West 1999) (defining a psychotherapist as “[a] person authorized to practice medicine in any state or nation, or reasonably believed by the patient so to be, who is engaged in the diagnosis or treatment of a mental or emotional condition, including alcoholism and other drug addiction”); Cal. Evid. Code § 1010(a) (West 1995) (defining a psychotherapist as “[a] person authorized . . . to practice medicine in any state or nation who devotes, or is reasonably believed by the patient to devote, a substantial portion of his or her time to the practice of psychiatry”).

C. The Failure of the New York Proposed Codes of Evidence

The three versions of the New York Proposed Code of Evidence submitted by the New York Law Revision Commission did little to unify the privileges. Arguably, the Commission’s 1978 proposed code of evidence was the closest that New York has come to a reasonable solution to the problem of having three distinct privileges. Among its successes, the Commission merged psychiatrists and psychologists into a single definition of “psychotherapist” and listed four exceptions, including “the condition as an element of a claim,” to the proposed psychotherapist-patient privilege. Additionally, the 1978 Proposed Code successfully removed the comparison between the attorney-client relationship and the psychologist-patient privilege.

Intended to clarify and change the law, the 1990 and 1991 proposals failed to link the privileges in such a manner as to make sense of their application. Arguably, the respective proposed codes represent a regression from the 1978 Proposed Code of Evidence as they do not even mention a psychotherapist-patient privilege. By separately identifying a physician-patient privilege, psychologist-patient privilege, and the social worker-client privilege, the 1990 and 1991 proposals support the belief that a patient is afforded specific rights depending on whom he speaks with.
sections 507, 508, and 509 of the 1990 and 1991 proposed codes, the only evident “conformation” of the privileges is the listing of explicit exceptions in each section and the importance the Committee placed on “condition in issue” as a proposed exception to all three privileges.

The three proposed sections do nothing more than add exceptions to each privilege. While the comments to section 508 of the 1991 proposals announce the addition of two key elements to the psychologist-patient privilege, the first “addition” merely makes section 508 aesthetically similar to its sections 507 and 509 counterparts by adding the title “Confidential communications privileged.” Such an addition to section 508 was wholly unnecessary and completely non-substantial because the provision continues to place the psychologist-patient privilege on the same level of attorney-client privilege and thereby keeps communications confidential.

The second addition proposed by section 508 of the 1991 proposals is the expansion of the definition of a psychologist to include “a person who is licensed or reasonably believed by the client to be licensed to practice psychology in this state or any other jurisdiction.” Arguably, the Commission’s efforts to broaden the definition of a psychologist are anything but ground-breaking, primarily because the respective psychotherapist evidentiary privileges in states such as Florida and California have contained similar language for at least twenty years. Perhaps the

96 See 1990 PROPOSED CODE, supra note 89, §§ 509(d), 510(d), 511(d); 1991 PROPOSED CODE, supra note 89, §§ 507(d), 508(b), 509(b).
98 1991 PROPOSED CODE, supra note 89, § 508(a) (reading “[c]onfidential communications privileged”); see also id. §§ 507, 509 (noting “[c]onfidential information privileged”).
99 Id. § 508(a) (reading “[c]onfidential communications privileged”).
100 1991 PROPOSED CODE, supra note 89, § 508(a) (“The confidential relations and communications between a psychologist . . . and a client are placed on the same basis as those provided by law between attorney and client”).
101 Id. (emphasis added).
102 See FLA. STAT. ANN. § 90.503 note (West 1999) (revealing that as far back as 1976, the Florida Law Revision Commission noted that the psychotherapist privilege applied to communications with “persons authorized to practice medicine in any state . . . or reasonably believed by the patient to be so, while engaged in the diagnosis or treatment of a mental or emotional condition”); CAL. EVID. CODE § 1010 cmt. (West 1995) (indicating that the Law Revision Commission commented as early as 1965 that a psychotherapist was defined to include “a person who is or who is reasonably believed to be a psychiatrist or who is a California certified psychologist”).
Commission hoped that a broader clause would mean that a patient who happens to speak with a psychiatrist, even when he is unaware of the psychiatrist’s profession and his right to practice medicine (example would be in a hospital shelter), would also remain protected under the statute.\textsuperscript{103} Interestingly, by placing “condition in issue” as an exception to the psychologist-patient privilege, section 508(b)(4) effectively contradicts the holding in \textit{People v. Wilkins}, as communications between a psychologist and a patient are no longer protected when the patient relies on such a condition as an element of defense.\textsuperscript{104} Borrowing from its 1978 Proposed Code of Evidence,\textsuperscript{105} and various other psychotherapist-patient privileges found in other jurisdictions,\textsuperscript{106} the Law Revision Commission could have easily conformed the proposed sections into a single provision encompassing all three privileges, yet failed to do so.

\textbf{IV. PROPOSAL}

The variation in the statutory language of New York’s evidentiary privileges undoubtedly leads to confusion among both patients and mental health providers. Some authorities have argued that the “privileges” are rendered “meaningless” due to “the large number of exceptions . . . [and] varying rules” among the respective provisions.\textsuperscript{107} New York must provide the patient with a level of certainty and assurance that their communications will remain confidential regardless of which mental health practitioner they choose to consult. It is highly unlikely that a patient will research exactly what information is privileged before they reveal such confidential information to their respected practitioner, especially in

\begin{itemize}
  \item \textsuperscript{103} See 1991 PROPOSED CODE, supra note 89, § 508 cmt. (a); see also id. §§ 507(a), 508(a), 509(a) (including protection of the privilege for anyone who “reasonably believe[s]” the person they are speaking with is a physician, psychologist, or social worker).
  \item \textsuperscript{104} See 1991 PROPOSED CODE, supra note 89, § 508(b)(4); id. cmt. (b)(4) (revealing that the exception would “nullify the decision” of \textit{People v. Wilkins}, where Wilkins sought to protect communications shared with a psychologist that revealed his stab wounds had been self-inflicted in order to maintain his justification that he had killed the victim in self-defense after being stabbed by her); supra notes 1–5 and accompanying text.
  \item \textsuperscript{105} See 1978 PROPOSED CODE, supra note 89, § 504(a)(2).
  \item \textsuperscript{106} See supra Part III.B.
  \item \textsuperscript{107} Mosher, supra note 30, at 182 (arguing that such variations open the gates to misuse by the patient); see also Brief for the National Ass’n of Social Workers et al. as Amici Curiae in Support of Respondents at 14, Jaffee v. Redmond, 518 U.S. 1 (1996) [hereinafter Nat’l Ass’n of Soc. Workers] (“[P]atients have no reason to focus on the particular credentials of the person whom they see, and have no basis for expecting that their communications with one category of therapists are protected from disclosure but those with another are not.”).
\end{itemize}
an emergency situation. A psychotherapist-patient privilege encompassing psychiatrists, psychologists, and social workers ensures open discussion by patients no longer fearful of forced disclosure of confidential communications. Psychiatrists must no longer be classified as physicians, but rather must become entitled to their own provision within the psychotherapist privilege. The court in LeVien stated, “Having recognized the possibility for inconsistencies in the protection of communications made to psychologists and psychiatrists and having recognized the tension between the broader psychologist-client privilege . . ., the [c]ourt observes that the removal of the possibility for inconsistency and a reconciliation of the tension is for the Legislature.” Additionally, the comments to section 508 of the New York Proposed Code of Evidence suggest that “it is impossible to justify the distinction between a physician and a psychiatrist on the one hand and a psychologist on the other.” Understandably, the Legislature may be reluctant to remove psychiatry from the classification of the physician-patient privilege solely because of a psychiatrist’s ability to practice medicine. However, in 2001, the U.S. Department of Health and Human Services reported that psychiatrists accounted for only three percent of total physician visits in the United States. Clearly, psychiatrists play a minor role in the category of physicians, regardless of their ability to practice medicine.

As early as 1978, the Law Review Commission suggested that psychiatrists be removed from their current status as physicians and be grouped instead, along with psychologists, under the heading “psychotherapist.” Twenty-seven states and the District of Colombia have already successfully separated psychiatrists from a physician classification, and some of those states have grouped them along with psychologists and social workers under the term

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108 See Morse, supra note 7, at 749.
109 See supra notes 27–28 and accompanying text.
112 See Mosher, supra note 30, at 187 (citing a 1952 Illinois case Binder v. Ruvell as the “first significant judicial recognition” that perhaps “different standards of confidentiality” should apply to those who practice psychotherapy and those who are primarily involved in medical care).
114 1978 PROPOSED CODE, supra note 89, § 504(a)(2).
“psychotherapist.” It is vital that psychiatrists be recognized as having closer similarities to psychologists than to medical doctors.

Any psychotherapist-patient privilege must include social workers. Thirteen states and the District of Colombia have effectively included social workers in their respective psychotherapist-patient privileges and there is no excuse for New York not to follow their lead. As of 1990, the number of social workers providing services in mental health organizations and general hospital psychiatric services was more than the combined number of psychiatrists and psychotherapists. This is the primary policy argument for incorporating all three privileges into one uniform privilege. Why should the upper-class individual be entitled to a higher level of protection solely because he has the financial ability to choose to speak with a psychologist? Is the working class individual who is forced to pick among a limited number of mental health professionals disadvantaged if only psychiatrists and social workers are offered under his medical plan? What about the lower income individual who can only afford the assistance of a social-worker at the local shelter or clinic? Why should New York punish the working class by not permitting them similar protection as it does for the upper-class individual who can pay a large hourly rate to speak with a psychologist?

Justice Stevens wrote in Jaffee of the importance of social workers today in the mental health profession:

115 See supra notes 78–84 and accompanying text.

116 See Nat’l Ass’n of Soc. Workers, supra note 107, at 10 (arguing that social workers provide essentially the same services as psychologists and psychiatrists); id. at 3 (indicating that effective “diagnosis and treatment of . . . emotional conditions” makes it necessary that social workers are granted a similar level of confidentiality as psychiatrists and psychologists).

117 See supra note 80 and accompanying text.

118 See Nat’l Ass’n of Soc. Workers, supra note 107, at 5 (revealing that “[t]he greatest proportion of psychotherapeutic services [are provided] by clinical social workers”).

119 See id. at 9 n.8 (indicating that “63% of all employees are enrolled in a managed care insurance plan” and that all of the major managed care companies offer the services of clinical social workers).

120 See Raeder, supra note 68, at 994 (stating that “[s]ociety also recognizes that the victims are not only the rich who patronize psychiatrists, or the middle class who visit psychotherapists, but the masses who can barely afford any help or are sent with public funds to public as well as private social workers”).

121 See id. at 995 (reporting that at least two reasons social workers are in great demand are that insurance providers may prefer to “pay [only] the lower rate[] for social workers,” and that the middle class or poor may “only have access to treatment with social workers”); see also Nat’l Ass’n of Soc. Workers, supra note 107, at 6 (stating that clinical social workers provide vital services to the economically disadvantaged).
Their clients often include the poor and those of modest means who could not afford the assistance of a psychiatrist or psychologist, but whose counseling sessions serve the same public goals. We therefore agree with the Court of Appeals that “[d]rawing a distinction between the counseling provided by costly psychotherapists and the counseling provided by more readily accessible social workers serves no discernable public purpose.”

The policy reasons for unifying the three privileges into a single privilege extend beyond mere finances and into racial, ethnic, and even geographic discrimination arguments. Surely one who is near a major metropolitan area has a better choice of accessible professionals than an individual living in a remote or rural area who may seek the assistance of a social worker or psychiatrist simply out of convenience. Also, social workers are often the predominant mental health providers in inner-cities, frequently serving non-Caucasian populations. The prison system may also be an area affected by such a discrepancy in the protection afforded the various practitioners. It is no surprise that individuals are at a greater risk of conviction if damaging information is admitted into evidence. As mentioned above, those who lack the ability to speak with a psychologist face a higher risk of conviction. This may even explain some of the racial and ethnic disparities in incarceration rates.

The cornerstone of any psychotherapist-patient relationship is the element of trust.
relationship on an equal basis in law with the attorney-client privilege leads only to greater confusion concerning admissible evidence. Only eleven states continue to place the psychologist-patient relationship on the same basis of law as the attorney-client relationship.\(^{130}\) Perhaps the other thirty-nine states have recognized that a psychologist’s “primary concern is with treatment for an emotional issue or mental disorder” while the “lawyer is primarily concerned with the law,” with “the purpose of [the attorney-client] privilege [being] to facilitate the ability of the attorney to advise the client.”\(^{131}\) There is no reason for New York to insist on placing the psychologist-patient privilege on the same basis in law as that of the attorney-client relationship.

A provision expressly allowing waiver of the patient’s privilege is necessary in any psychotherapist-patient privilege to ensure reasonable certainty regarding admissible evidence.\(^{132}\) Additionally, clear and concise provisions concerning implied waiver must be found in the psychotherapist-patient privilege.\(^{133}\) While California lists no guidance whatsoever concerning waiver of the privilege,\(^{134}\) Kentucky states as a general rule that “[a] patient . . . has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications, made for the purpose of diagnosis or treatment of the patient’s mental condition, between the patient [and] the patient’s psychotherapist.”\(^{135}\) New York must aspire to establish a far more detailed statutory scheme than the one currently in place.

New York’s only option to ensure effective psychotherapy treatment for any patient, regardless of which mental health practitioner they choose, is to devise a psychotherapist-patient privilege covering psychiatrists, psychologists, and social workers. New York should mold its definition of psychotherapist to include:

\(^{130}\) See supra notes 75, 77 and accompanying text.

\(^{131}\) Marrow, supra note 9, at 26. “It is neither fair nor realistic to equate the concerns and actions of one profession with those of the other” because a lawyer does not provide the same services as a mental health provider. Id.

\(^{132}\) See generally supra Part II.C.

\(^{133}\) See generally supra notes 49–50 (discussing implied waivers).

\(^{134}\) See CAL. EVID. CODE § 1010 (West Supp. 2006) (defining who is a psychotherapist but not mentioning anything related to when a patient may waive his right to privileged communications).

\(^{135}\) KY. R. EVID. 507(b).
a person who is, or is reasonably believed by the patient to be: (a) A person authorized to practice medicine in any state or nation who devotes, or is reasonably believed by the person to devote, a substantial portion of his or her time to the practice of psychiatry[]; (b) A person licensed as a psychologist . . . []; or (c) A person licensed as a clinical social worker . . . .

New York must adopt a general definition of waiver, such as that found in Kentucky’s psychotherapist privilege: “[a] patient . . . [may] refuse to disclose [or] prevent any other person from disclosing confidential communications [or records], made for the purpose of diagnosis or treatment of the patient’s mental condition.” As far as exceptions to the privilege, New York should allow for the admissibility of communications relevant to an issue in proceedings to compel hospitalization of a patient for mental illness, and communications made in the course of a court-ordered examination of the mental or emotional condition of the patient. Additionally, communications should be allowed to be disclosed when the issue of breach of duty by the psychotherapist to the patient or by the patient to the psychotherapist arises, such as in a malpractice suit.

Most importantly, communications relevant to an issue of the mental or emotional condition of the patient should be disclosable in any proceeding in which the patient relies upon the condition as an element of his or her claim or defense. Under such a provision, communications should be disclosable in child custody cases where the mental state of a party is clearly an issue and where a proper resolution of the custody question requires disclosure. Similarly, disclosure should be allowed to protect the rights of the accused in a criminal case when the accused raises the defense of insanity. These latter provisions ensure that abuse of waiver will not become an issue.

In 1828, New York led the country in adopting a law that would
It is nonsensical that New York, a state that commonly hails itself as an innovator, could fall so far behind other states on this legal issue. If, hypothetically, Florida and California were the only two states to extend a psychotherapist-privilege to psychologist, psychiatrists and social workers, New York’s lack of response might be excusable. However, over half of the states have introduced legislation that encourages open communication with the three categories mental health providers and that provides a certain level of clarity for the mental health patient. The layperson seeking mental health treatment will not read, let alone understand, the provisions in New York state law outlining the various protections afforded to each category of mental health practitioner. To penalize such laypersons for their lack of knowledge and understanding is simply unjust and unfair and transforms “the therapeutic relationship . . . into a complicated guessing game where the psychotherapist tries to divine what the patient really intends, and the patient weighs the potential benefits of divulging a piece of information against the potential loss of privacy.”

The legislature must enact some form of evidentiary privilege providing uniform guidelines and rules for psychiatrists, psychologists, and social workers. Mental health providers and, more importantly, mental health patients deserve nothing less than absolute certainty that particular shared communications will not be admissible in a court of law regardless of what is said and with whom it is shared.

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143 See supra note 14 and accompanying text.
144 See supra note 86 and accompanying text.
145 See supra note 79 and accompanying text.