N THE SUPREME COURT OF THE UNITED STATES OCTOBER TERM, 1995

CARRIE JAFFEE, as Special Administrator_for Ricky Allen Sr., Deceased,_Petitioner,

v.

MARYLU REDMOND and

Village of Hoffman Estates, Illinois,

Respondents,

On Writ of Certiorari to the United States_Court of Appeals for the Seventh Circuit

BRIEF FOR THE NATIONAL ASSOCIATION OF SOCIAL WORKERS,_THE ILLINOIS CHAPTER OF THE NATIONAL ASSOCIATION OF SOCIAL WORKERS,_THE NATIONAL FEDERATION OF SOCIETIES FOR CLINICAL SOCIAL WORK,_THE ILLINOIS SOCIETY FOR CLINICAL SOCIAL WORK,_AND THE AMERICAN BOARD OF EXAMINERS IN CLINICAL SOCIAL WORK_AS AMICI CURIAE IN SUPPORT OF RESPONDENTS

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INTEREST OF AMICI

The National Association of Social Workers (NASW) is a professional membership organization comprised of more than 155,000 social workers with chapters in every state, the District of Columbia, New York City, Puerto Rico and the Virgin Islands, and an international chapter in Europe. The Illinois Chapter of the NASW has over 8,500 members, one of whom is Karen Beyer, the licensed clinical social worker who provided treatment to Respondent Marylu Redmond. Created in 1955 by the merger of seven predecessor social work organizations, the NASW has as its purpose to develop and disseminate high standards of practice while strengthening and unifying the social work profession as a whole. In furtherance of its purposes, the NASW promulgates professional standards and criteria including Standards for the Practice of Clinical Social Work and Guidelines for Clinical Social Work Supervision, conducts research, publishes studies of interest to the profession, provides continuing education and enforces the NASW Code of Ethics. The NASW also sponsors a voluntary credentialing program to enhance the professional standing of social workers including the NASW Diplomate in Clinical Social Work and the Qualified Clinical Social Worker credentials.

Founded in 1973, the National Federation of Societies for Clinical Social Work (CSWF) is a federation of state societies whose members, numbering approximately 16,000, are all licensed or certified clinical social workers engaged in the diagnosis and treatment of mental and emotional disorders. The primary mission of CSWF and its member state societies is to enhance the quality and availability of clinical social work services throughout the United States by promulgating and enforcing its Standards of Practice for Clinical Social Work and its Code of Ethics, advocating the enactment of state and federal legislation to regulate the practice of clinical social work in order to protect the interests of patients, providing continuing education to members of the profession, encouraging educational institutions to provide the

highest level of clinical social work education and training, and advocating the inclusion of clinical social workers as reimbursable providers in public and private health insurance programs. The Illinois Society for Clinical Social Work is the CSWF member organization whose individual members are clinical social workers licensed and practicing in that state.

The American Board of Examiners in Clinical Social Work (ABE) is an independent, nonprofit, national credentialing board founded in 1987 to provide diplomate level board certification for advanced practitioners of clinical social work. Since its inception, ABE has certified approximately 21,500 clinical social workers as Board Certified Diplomates (BCDs). Criteria for diplomate status include a graduate degree in clinical social work, postgraduate clinical supervision, at least 7,500 hours of direct practice experience within a five-year period, fulfillment of requirements for state licensing, and successful completion of an advanced examination. All BCDs must be recertified annually to maintain currency of the credential.; recertification requires 20 hours of continuing social work education, maintenance -of the state's highest regulatory status for social workers, and 300 hours of direct clinical practice in the preceding 12 months. There are over 14,000 BCDs in the field, nearly 90 percent of whom have over a decade of clinical experience.

As the principal professional organizations involved with clinical social workers in the United States and in the State of Illinois, these amici have a strong interest in the issues presented in this case. Presently, the Codes of Ethics and Standards of Practice adopted and enforced by amici and the laws of nearly every state, including the State of Illinois, require clinical social workers to maintain the confidentiality of their communications with their patients, recognizing that such confidentiality is essential for the diagnosis and treatment of mental and emotional conditions. If the Court of Appeals' recognition of a privilege for such communications were not to stand, clinical social workers would face the dilemma of being ordered to violate state law and well established professional standards which they believe are crucial to their provision of effective mental health services.

This brief focuses primarily on the second question presented by the Petition --- whether a psychotherapist patient privilege should apply to psychotherapy provided by clinical social workers to the same extent as psychotherapy provided by psychiatrists and psychologists. Other amici brief the issue of whether the Court should recognize a psychotherapist-patient privilege in general. The principal function of this brief is to inform the Court about the significant role clinical social workers play as psychotherapists and to demonstrate that, based on their training, education, professional standards and status under state law, the psychotherapy services provided by social workers deserve to be treated in the same manner as those provided by psychiatrists and psychologists for the purposes of Rule 501.

CONSENT OF PARTIES

This brief as amici curiae in support of Respond filed with the consent of all parties.

SUMMARY OF ARGUMENT

Clinical social workers are now the predominant providers of psychotherapy, as reflected in the broad acceptance of clinical social workers as compensable providers by federal and state health programs and private insurers. For the less economically advantaged and those living in many inner-city or rural areas, clinical social workers constitute an even higher percentage of mental health care providers. In the past twenty-five years, clinical social work has received widespread recognition as a distinct profession, inter alia through state licensing and certification regimes and the growth and development of specific standards of clinical practice and ethical rules. As an important aspect of this evolution, all but six states have recognized, with limited exceptions for particular circumstances, a psychotherapist-patient privilege protecting confidences imparted to clinical social workers by their therapy patients. Congress has also adopted certain confidentiality rules which encompass services by clinical social workers.

These important developments must guide this Court's application of Rule 501 of the Federal Rules of Evidence "in the light of reason and experience." Thus, this Court should not only recognize a general psychotherapist patient privilege, consistent with the rule proposed in 1972 for inclusion in the Federal Rules of Evidence, but also should acknowledge the application of that privilege to clinical social workers and their patients. Whatever exceptions may be appropriate in criminal cases and other evidentiary contexts, there should be none in this civil damages case, where testimony concerning what was said in therapy was not necessary to prove an essential element of Petitioner's cause of action.

ARGUMENT

CLINICAL SOCIAL WORKERS ARE, THE PREDOMINANT PROVIDERS OF PSYCHOTHERAPY TODAY, AND CONSTITUTE A FULLY DEVELOPED PROFESSION WHOSE PATIENT COMMUNICATIONS ARE WORTHY OF PROTECTION.

. 1. Clinical Social Workers Are The Major Providers Of Psychotherapeutic Services And Are Recognized As Authorized Providers Under Federal Health Programs, State Insurance Laws And Private Insurance Contracts.

Years ago, the delivery of psychotherapy to persons with mental illness and emotional disorders was the province of a small number of medical doctors, trained in the theories of Sigmund Freud, Karl Jung and their followers and successors. Today, psychotherapy employs a wide variety of modalities and theoretical orientations and is provided by a much greater number and broader range of mental health professionals.

The greatest proportion of psychotherapeutic services is now delivered by clinical social workers working in various settings including independent private practice. For example, a study of professional patient care staff in mental health organizations and general hospital psychiatric services in 1990 found that the number

of social workers providing mental health services in such facilities (53,375) was more than the combined number of psychiatrists (18,818) and psychologists (22,825). Clinical social workers are the predominant mental health professionals in facilities serving less privileged patients such as state and county mental hospitals, residential treatment centers for emotionally disturbed children, freestanding outpatient clinics, and freestanding partial care and multiservice organizations. Clinical social workers also are the predominant and often exclusive providers of mental health services in rural areas. One study found, for example, that in approximately one quarter of the counties in a six state area, social workers were the only licensed providers of mental health services. These counties tended to be rural and to have lower per-capita incomes than the state average.

The expanded role of clinical social workers in the provision of mental health care in the United States is in large part the result of federal and state government policies that recognize the valuable role of clinical social workers. Since their emergence in the 1960s, the major federal health care programs have all been expanded to include coverage of mental health services by independent clinical social workers. In 1980, for example, Congress directed the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) to conduct a two-year demonstration project in which licensed and certified clinical social workers would be reimbursed as mental health care providers without supervision by a physician. See Department of Defense Appropriation Act of 1981, Pub. L. No. 96-527 (1980). The Senate Report which reviewed the results of the demonstration project stated: "No quality of care problems have arisen, and reimbursement of clinical social workers costs less than the traditional physician gate-keeper approach." S. Rep. No. 580, 97th Cong., 2d Sess. 32 (1982). As a result of these findings, CHAMPUS has since recognized clinical social workers as independent providers of outpatient psychotherapy, and has mandated reimbursement for covered services provided by clinical social workers. See Department of Defense Appropriation Act of 1983, Pub. L. No. 97-377 (1983); 32 C.F.R. . _199.12(f), 49 Fed. Reg. 7562 (1984).

Similarly, in 1986 Congress amended the enabling legislation for

the Federal Employees Health Benefits Program (FEHBP) to require all participating insurance companies to include clinical social workers as reimbursable providers of mental health services without physician supervision. See Federal Employees Benefits Improvement Act of 1986, Pub. L. No. 99-251, _. 105(b), as amended by Pub. L. No. 100-202, . _101(m), codified at 5 U.S.C. . _8902(k)(1) (1986). Congress found that addition of this service "will contribute to cost containment and increased access to mental health services." H.R. Rep. No. 292, 99th Cong., 1st Sess. 6 (1985).

In 1987, Congress added clinical social work services provided pursuant to a contract with a Health Maintenance Organization (HMO) to the list of services reimbursable under the Medicare program. See Pub. L. No. 100-203, _. 4074(a)(1), as amended by Pub. L. No. 100-360, _. 411(h)(5)(A), codified at 42 U.S.C. _. 1395x(s)(2)(H)(ii). Two years later Medicare coverage was expanded to include all independent clinical social work services. See Pub. L. No. 101-239, _. 6113(b), codified at 42 U.S.C. .. __13951(a)(1)(F), 1395x(s)(2)(N). Coverage of clinical social work services also has been mandated in the Medicaid program for low income families and individuals. See 42 U.S.C. _. 1396d(a)(6). Recently, clinical social workers were added to the list of eligible direct providers of services under the Family and Medical Leave Act. See 29 C.F.R. _ . 825.118(b)(2).

Private health insurance plans have also contributed to the dramatic growth of clinical social work services. Under pressure from employers, unions and consumers, insurance contracts almost universally recognize clinical social workers as directly reimbursable providers of treatment for emotional and mental illness and substance abuse. Legislation in many jurisdictions requires that if health insurance provides mental health coverage, the beneficiary must be given freedom to choose any qualified mental health provider, including clinical social workers.

The role of clinical social workers has been greatly increased by the evolution of mental health care from in-patient to out-patient services, and by efforts at cost containment by the health care industry, employers and government. A national survey of mental

health, alcohol and drug abuse treatment in HMOs found, for example, that 30 percent of all HMO mental health staff are clinical social workers, as compared to 22 percent for psychologists, 22 percent for substance abuse counselors, 12 percent for psychiatric nurses, and 15 percent for psychiatrists. Since it is widely predicted that the end of this century will see 90 percent or more of all mental health services provided through managed care systems, the expansion of the clinical social worker role in the delivery of mental health treatment is certain to continue. Additionally, Employee Assistance Plans (EAPs), which are a relatively new employee benefit to help employees cope with such difficulties as substance abuse, mental illness, stress and family problems, tend to rely principally on clinical social workers for delivery of psychotherapy.

. 2. Clinical Social Work Is A Distinct Profession With Rigorous Education And Training Requirements, State Licensing Or Certification, Peer Controls And Ethical Rules.

Clinical social workers are legally recognized professionals educated and trained in the diagnosis and treatment of emotional and mental illness. The psychotherapy services which they provide are the same as those rendered by psychiatrists and clinical psychologists.

Social work education has evolved significantly from its earliest days. At present, 117 accredited master's level programs are offered by colleges and universities throughout the United States to prepare students for clinical social work practice and other career options. The typical clinical social worker has completed courses in cognitive, psychological and social development and major theoretical explanations of personality development, and has completed 900 hours of clinical training before graduating. While many of the 53 doctoral level programs are primarily oriented towards careers in research and teaching, there is a growing number of clinical doctorate programs that prepare post-master's degree students for advanced levels of clinical social work practice.

In 1972, only eleven states and Puerto Rico licensed or certified social workers. Today, all states, the District of Columbia, Puerto Rico and the U.S. Virgin Islands have some form of regulation of clinical social work practice. These laws mandate minimum levels of education, experience, and supervision and may require an examination before an applicant may be licensed or certified for clinical social work practice. In Illinois, for example, in order to become a licensed clinical social worker, as is the therapist in this case, an applicant must hold either a master's degree or a doctoral degree in social work from an approved academic program; must have completed either 3000 or 2000 hours, depending upon the level of academic degree, of post-degree supervised clinical professional experience; and must pass an examination. See 225 ILCS 20/9.

State laws uniformly require that social workers maintain the confidentiality of the information they receive from their patients. Federal laws applicable in various clinical practice settings, such as substance abuse treatment programs, also mandate confidentiality. Clinical social workers are also bound by rules of professional conduct which require confidentiality of patient-related information. These ethical codes require that patients be informed in advance of any limitations on confidentiality, and that informed and written consent be obtained before confidential information is revealed. Clinical social workers who violate these rules may be subject to both disciplinary action and liability for professional malpractice.

MOST STATES AND CONGRESS NOW RECOGNIZE A PRIVILEGE FOR CONFIDENTIAL COMMUNICATIONS BETWEEN PSYCHOTHERAPY PATIENTS AND CLINICAL SOCIAL WORKERS.

Confidentiality of communications between therapists and their patients has long been recognized as an essential ingredient in the relationship of trust which is the cornerstone of all successful psychotherapy:

. The psychiatric patient confides more utterly than anyone else in the world. He exposes to the therapist not only what his words directly express; he lays bare his entire self, his dreams, his fantasies, his sins and his shame. Most patients who undergo psychotherapy know that this is what will be expected of them, and that they cannot get help except on that condition. . . . .It would be too much to expect them to do so if they knew that all they say---and all that the psychiatrist learns from what they say---may be revealed to the whole world from a witness stand.

Guttmacher & Weihofen, Psychiatry and the Law 272 (1952); accord, Taylor v. United States, 222 F.2d 398, 401 (D.C. Cir. 1955). The evolution of the reality and understanding of psychotherapeutic roles over the past quarter century has made clear that this need for confidentiality applies regardless of the professional discipline of the therapist. With several professions engaged in the diagnosis and treatment of mental health and emotional problems, often as members of multi-disciplinary teams, patients 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.

Reflecting this evolution, state legislatures and Congress have increasingly recognized the need to include communications with clinical social workers in statutory provisions protecting psychotherapist-patient communications from disclosure. These legislative developments are highly significant given Congress' mandate, in Rule 501 of the Federal Rules of Evidence, that the Court fashion evidentiary privileges "in the light of reason and experience."

1. Prior to 1972, very few states recognized an evidentiary privilege for communications between patients and clinical social workers. Today, forty-four states and the District of Columbia have adopted such protections.

Petitioner wrongly attempts to minimize the importance of these statutory protections by noting that there are some differences among them and some states permit exceptions in special

circumstances. Amici do not dispute the need for careful delineation of the scope of the privilege and the inevitability of exceptions based on important public policies. But recognition of the need for some exceptions does not undermine the rationale of a psycho-therapist-patient privilege including clinical social workers, and no such exception is applicable in this case.

The exclusion of criminal actions from the scope of the privilege in some states reflects the fact that law enforcement interests have always been recognized as having special urgency in our society and that criminal cases pose unique constitutional issues. It does not, however, negate those states' recognition of the privilege in other contexts.

Statutory exceptions for court-ordered examinations merely recognize that communications in such cases are not made for the purpose of treatment and that patients have no reasonable basis for expecting confidentiality where an examination takes place for the very purpose of making a determination in connection with a legal proceeding. Similarly, patient-as-litigant exceptions merely illustrate the familiar principle, incorporated into virtually all recognized privileges, that a party who introduces an issue into litigation, such as his or her mental condition, may not prevent disclosure of all of the facts relevant to that issue.

Certainly, the fact that some states allow or require disclosures by social workers and other mental health professionals of confidential information concerning the contemplation of a crime or a harmful act, or concerning child abuse or custody issues, see Pet. Br. at 34-35, 32, is not a basis for refusing to recognize the existence of a psychotherapist-patient privilege in general and its applicability to this case. Statutes imposing a duty on mental health providers to disclose information concerning potentially dangerous patients affect only a small portion of the situations in which psychotherapy is provided. The existence of a similar limited exception in the rules governing attorney-client confidentiality has not led to abandonment of that privilege. And particular concerns about child welfare issues do not undermine the need for a psychotherapist-patient privilege in other contexts.

The relatively minor variations in, and exceptions from, these state laws do not support exclusion of clinical social workers from a psychotherapist-patient privilege; rather they indicate clearly the ability of the courts to fashion, under Rule 501, a workable privilege sensitive to the competing interests presented in particular situations.

2. Congress has also recognized the need for confidentiality in communications between clinical social workers and their patients. Section 333 of the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970, Pub. L. No. 91-616, and section 408 of the Drug Abuse, Prevention, Treatment, and Rehabilitation Act of 1972, Pub. L. No. 912255, established broad rules of confidentiality with respect to the identity, diagnosis, prognosis or treatment of patients in programs or activities for substance abuse treatment which are conducted, regulated, or directly or indirectly assisted by any department or agency of the United States. See 42 U.S.C. _. 290dd-2, superseding 42 U.S.C. __.. 290dd-3 and 290ee-3. Congress has enacted a similar provision with respect to treatment afforded by the Department of Veterans Affairs, see 38 U.S.C. _. 7332, and has directed that the same rules of confidentiality apply to programs for the treatment of alcohol abuse and alcoholism among employees of the federal government. See 5 U.S.C. _. 7362(b).

While these provisions allow disclosure of confidential information if authorized by an appropriate order of a court, courts are directed to weigh the "injury to the patient, to the physician-patient relationship, and to the treatment services" in determining whether disclosure should be ordered. See 42 U.S.C. _. 290dd-2 (b) (2) (C). Regulations make clear that any other disclosure is forbidden in any civil, criminal, administrative or legislative proceedings conducted by any federal, state or local authority, see 42 C.F.R. _. 2.13(a), and that confidentiality must be maintained regardless of the professional discipline to which the mental health provider belongs. See 42 C.F.R. _. 2.11 ("treatment" defined as "the management and care of a patient suffering from alcohol or drug abuse, a condition which is identified as having been caused by that abuse, or both, in order to reduce or eliminate the adverse effects upon the patient"). Courts have given these provisions a

broad reach consistent with their protective purpose. See United States v. Eide, 875 F.2d 1429, 1434-37 (9th Cir. 1989); United States v. Graham, 548 F.2d 1302, 1314 (8th Cir. 1977).

RECOGNITION OF A PRIVILEGE IN THIS CASE IS CONSISTENT WITH THE PHILOSOPHY OF RULE 501 AND THIS COURT'S PRIOR DECISIONS.

. 1. Recognition Of A Psychotherapist-Patient Privilege Including Clinical Social Workers Is Consistent With The Purpose And History Of Rule 501.

Rule 501 of the Federal Rules of Evidence requires courts to address the question of privilege "in the light of reason and experience." See Upjohn Co. v. United States, 449 U.S. 383 (1981). This Court has previously recognized that, in "the evolutionary development of testimonial privileges," Trammel v. United States, 445 U.S. 40, 47 (1980), courts should not "adhere . . . to doctrinal concepts long after the reasons which -gave them birth have disappeared and after experience suggests the need for change." Id. at 48.

Evolution in the delivery of mental health services was recognized in the pre-1972 development of proposed Rule 504 defining a psychotherapist-patient privilege. While the medical profession had historically taken the position that psychotherapy should only be provided by medical doctors, the Advisory Committee also included clinical psychologists within the proposed rule in recognition of their then-growing role in the delivery of psychotherapy. Moreover, while the Advisory Committee's first draft of Rule 504 applied only to medical doctors who devote "a substantial portion of [their] time to the practice of psychiatry," the final version of the proposed rule was expanded to include general practitioners who devote "all or a part" of their time to psychiatry, a change described by the Reporter for the Advisory Committee as reflecting the Committee's determination "to stress the particular activity of the psychotherapist at the time," rather than the credentials of the persons providing the psychotherapy. Extension of the psychotherapist-patient privilege to include clinical social

workers merely recognizes the continued evolution of psychotherapy and understanding of their roles as providers.

The absence of clinical social workers from the definition of "psychotherapist" in proposed Rule 504 reflected the undeveloped legal recognition of clinical social workers as providers of mental health services at the time of the Advisory Committee's deliberations. A majority of the states did not then provide for licensure or certification of clinical social workers, and there was statutory recognition of a privilege for communications between patients and social workers in only a handful of jurisdictions. The principal issue which occupied the Advisory Committee in its consideration of proposed Rule 504 was whether the Rules should include a broad doctor-patient privilege reaching all forms of medical treatment. See, e.g., Memorandum from Edward W. Cleary Re: Policy Aspects of Physician-Patient Privilege, reprinted in 1 House Hearings 557-59. After the Committee decided to limit the proposed privilege to the delivery of psychotherapy, it turned to whether the privilege should attach only to psychiatrists who practice psychotherapy on a fulltime basis, as was originally proposed in the Committee's 1969 draft, or whether the privilege should -apply to the treatment of mental and emotional problems by general medical practitioners, as in the final recommendation. See 25 Wright & Graham, Federal Practice and Procedure: Evidence _. 5521 (1989 ed.). There is no evidence that the Advisory Committee rejected the inclusion of clinical social workers on policy or any other grounds. See id. _. 5525 at 190.

The Advisory Committee's omission of social workers from its definition of psychotherapists was raised during the hearings in the House of Representatives on the Proposed Rules of Evidence. See, e.g., 1 House Hearings 174, 196-97, 452, 458-59, 460-63, 475-81; 2 House Hearings 215. After the House elected not to enumerate specific privileges of any kind in the Rules, the scope of proposed Rule 504 received little attention from witnesses in the Senate. See, e.g., Hearings on Federal Rules of Evidence Before the Senate Comm. on the Judiciary, 93d Cong., 2d Sess. 356-57 (1974) (Senate Judiciary Committee Staff Memorandum); but see id. at 280 (statement of American Psychiatric Association), 382 (letter from Council for the Advancement of Psychological Professions

and Services). The legislative history makes clear that Congress' substitution of Rule 501 for proposed Rule 504 was intended to permit, not to hamper, judicial development of a federal law of privilege, including a psychotherapist-patient privilege:

> . It should be clearly understood that, in approving this general rule as to privileges, the action of Congress should not be understood as disapproving any recognition of a psychiatrist-patient. . . . or any other of the enumerated privileges contained in the Supreme Court rules. Rather, our action should be understood as reflecting the view that the recognition of a privilege based on a confidential relationship and other privileges should be determined on a case-by-case basis.

S. Rep. No. 1277, 93d Cong., 2d Sess. 4 (1974). Thus, the legislative history fully supports adoption of a privilege for communications between clinical social workers and their patients in the light of reason and contemporary experience.

> . 2. Recognition Of A Privilege In This Case Is Consistent With The Court's Prior Decisions In That The Privilege Will Not Interfere With The Enforcement Of Federal Criminal Laws Or Significantly Impede The Truth-seeking Function Of The Courts In Civil Cases.

With only two exceptions, all of the cases in which this Court has refused to recognize testimonial privileges under Rule 501 or on other grounds have involved "the need for probative evidence in the administration of criminal justice." Trammel v. United States, 445 U.S. at 51. See also United States v. Arthur Young & Co., 465 U.S. 805 (1984); United States v. Gillock, 445 U.S. 360 (1980); United States v. Nixon, 418 U.S. 683 (1974); Couch v. United States, 409 U.S. 322 (1973); Gravel v. United States, 408 U.S. 606 (1972); Branzburg v. Hayes, 408 U.S. 665 (1972). In each of these cases, the societal interest in the enforcement of our criminal laws has overridden the competing interests in nondisclosure of information. As the Court stated in Gravel v. United States, "[w]e

cannot carry a judicially fashioned privilege so far as to immunize criminal conduct proscribed by an Act of Congress or to frustrate the grand jury's inquiry into whether publication of these classified documents violated a federal criminal statute." 408 U.S. at 627. Also, in criminal cases, societal interests in nondisclosure of confidential information may compete with defendants' rights to a fair trial, including the Sixth Amendment right of confrontation. And when the privilege issue arises in the context of a criminal investigation, the veil of secrecy surrounding grand jury proceedings offers protection against abuse of the information. See In re Zuniga, 714 F.2d 632, 642 (6th Cir.), cert. denied, 464 U.S. 983 (1983). This case does not involve a criminal investigation or prosecution; nor is the issue of a psychotherapist patient privilege likely to arise primarily in the context of criminal actions.

It is true, as Petitioner contends, Pet. Br. at 38, that cases involving civil enforcement of the civil rights laws also involve issues of national importance. But this Court has distinguished section 1983 cases from cases involving federal criminal laws when it comes to balancing competing societal interests. E.g., United States v. Gillock, 445 U.S. at 371-73. This Court has often ruled that state and local officials are entitled to absolute or qualified immunity from liability in civil suits brought under section 1983, see, e.g., Imbler v. Pachtman, 424 U.S. 409, 429 (1976); Wood v. Strickland, 420 U.S. 308 (1975); Scheuer v. Rhodes, 416 U.S. 232 (1974); Pierson v. Ra.v, 386 U.S. 547 (1967); Tenney v. Brandhove, 341 U.S. 367 (1951), while acknowledging that these officials are not immune from federal criminal liability for the same conduct. E.g., Scheuer v. Rhodes, 416 U.S. at 237. The Court has also made clear that the policies underlying section 1983 do not require the admission of unreliable hearsay evidence, see Mayor of City of Philadelphia v. Educational Equality League, 415 U.S. 605, 616-17 (1974), and it is beyond doubt that the attorney client and other recognized privileges apply fully in section 1983 actions notwithstanding the strong federal interest in enforcing the civil rights laws.

In most instances, as here, recognition of a privilege for communications with clinical social workers will not interfere with the truth-seeking function of the federal courts in civil rights or

other civil cases. Nondisclosure of such communications will ordinarily not "plac[c] beyond the plaintiff's reach a range of direct evidence relevant to proving ... elements that are critical to [the plaintiff's case]," Herbert v. Lando, 441. U.S. at 169, because information disclosed by a patient to a therapist regarding external events rarely will be the only available evidence of those events. If a "smoking gun" exists, it is most unlikely to be found in such cointhunicatiotts. See University of Pennsylvania v. EEOC, 493 U.S. ,at 193. Even where the issue is the patient's prior state of mind, other testimony will frequently be available; and, if the patient herself puts her state of mind in issue, she cannot complain if the court allows An exception to the Privilege as necessary for a full and fair hearing. See Dixon v. City of Lawton, Oklahoma, 898 F.2d 1443, 1450-51 (10th Cir. 1990) (relying on proposed Rule 504 (d) (3)).

Information covered by the privilege may also be unreliable in many cases, especially where therapy has fc)llowed immediately after a traumatic episode. Therapists inquire into external events for the purpose of uncovering the emotional effects of those events, not to obtain a complete report of what actually transpired. These emotions may color what the patient recalls or does not recall, as well as how the events are reported and recorded. Furthermore, it is an unfortunate fact that the need for mental health care services carries considerable social stigma. Thus, testimony concerning communications made in therapy may often be unduly prejudicial as well as unreliable.

Under a qualified psychotherapist-patient privilege such as amici urge, the limited value of testimony concerning communications made in therapy would cause it to be excluded in most cases. However, such evidence could still be admitted in special categories of cases where there is an exceptional need. As the Court of Appeals correctly found, this is not such a case.

CONCLUSION

For the foregoing reasons, the Court should affirm the decision of the Court of Appeals recognizing, under Rule 501, a testimonial

privilege for confidential communications between individuals and their clinical social workers during the course of psychotherapy.

. Respectfully submitted,

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