

not dangerous to himself or others.”¹ The Court says that a duty is owed by a facility like Texas Home Management when a patient presents “an unreasonable risk to the safety of others,”² or it “takes charge of a person whom [it] knows or should know to be likely to cause bodily harm to others.”³ At the time Texas Home Management agreed to undertake Anthony Dixon’s treatment, all professionals who examined him agreed, and a court found, that he was not dangerous to others. Accordingly, the inquiry in this case should be what duty a facility owes to recognize that a mentally retarded patient has *become* dangerous to others. When the inquiry is properly focused, the second deficiency in the Court’s analysis becomes more apparent.

That deficiency is the Court’s failure to distinguish between the Peavys’ claims that implicate a duty owed by a mental health care provider to third parties for failure to diagnose or treat a patient properly, which we have consistently held that Texas law does not recognize, and issues of pure “control” that are unrelated to any professional diagnosis or treatment of a patient.

The third area in which the Court’s opinion is devoid of careful analysis is, what ability did Texas Home Management actually have to control Anthony Dixon and how should that ability to control have been exercised?

I would hold that the duty Texas Home Management owed to third parties such as Elizabeth Peavy was to report promptly to MHMR and appropriate law enforcement authorities all pertinent facts about

¹ Judgment, *In re Dixon*, No. 72,921 (314th Dist. Ct., Harris County, Tex.) (Jan. 31, 1991).

² __ S.W.3d at __.

³ *Id.* at n.4.

Anthony Dixon's violations of the law and any serious aggressive acts so that 1) MHMR could determine whether it should place Dixon elsewhere and 2) law enforcement officials could decide whether to pursue pending or additional criminal charges against him or to pursue further juvenile delinquency proceedings based on his criminal acts. If the Peavys could demonstrate that state actors would have taken actions that would have prevented their daughter's murder, then the Peavys would have established a cause of action. But to the extent that the Peavys' claims rest on the failure of Texas Home Management or its agents to diagnose and treat Anthony Dixon's violent proclivities properly, those claims cannot survive based on this Court's decisions in *Thapar v. Zezulka*,⁴ *Van Horn v. Chambers*,⁵ and *Bird v. W.C.W.*⁶

We squarely held in *Van Horn* that the ability to control a mental health patient does not give rise to a duty to third parties to properly diagnose and treat that patient.⁷ The allegation that Texas Home Management reasonably knew or should have known that Anthony Dixon presented an unreasonable risk of danger to third parties and failed to control him is indistinguishable from allegations in *Van Horn* that the health care provider "failed to see that [the patient] was transferred to a proper facility to handle his violent and disruptive behavior" and "permitted [the patient] to remain on an unsecured floor after he exhibited signs that he would erupt into violent and disruptive behavior."⁸ The allegations against Texas Home

⁴ 994 S.W.2d 635 (Tex. 1999).

⁵ 970 S.W.2d 542 (Tex. 1998).

⁶ 868 S.W.2d 767 (Tex. 1994).

⁷ 970 S.W.2d at 546-47.

⁸ *Id.* at 544.

Management are also indistinguishable from allegations in *Thapar* that the mental health care provider was negligent “in her diagnosis and treatment of [the patient’s] psychiatric problems,” “in releasing [the patient] from the hospital,” “in failing to have [the patient] involuntarily committed,” and “in failing to monitor [the patient] after his release to ensure that he was taking his medication.”⁹ In both *Thapar* and *Van Horn*, a patient brought about the death of someone while under the care of a health care provider.¹⁰

Instead of imposing a duty tailored to fit both the needs of the mentally retarded who have a history of behavioral problems and the general public’s need for safety, the Court imposes a broad duty of “control,” but there are internal inconsistencies in the Court’s opinion regarding “control.” A duty to “control” cannot exceed the *ability* to control. Because Anthony Dixon was violent over a long period of time in differing settings after MHMR placed him with Texas Home Management, the duty to “control” that the Court imposes today cannot logically be limited to simply preventing Dixon from visiting his mother in Houston. Yet that is the Court’s focus. Texas Home Management could not have allowed Dixon to attend public schools or to intermingle with others without close supervision and the ability to subdue him physically if necessary. That authority was not given to Texas Home Management by MHMR. Rather, MHMR chose Texas Home Management for Anthony Dixon precisely because the Lakewood Facility

⁹ *Thapar*, 994 S.W.2d at 637.

¹⁰ *Id.* at 636; *Van Horn*, 970 S.W.2d at 543-44.

offered what MHMR considered to be the “least restrictive alternative.”¹¹ The facts are undisputed that the Lakewood facility did not provide incarceration in any form and that the facility was not designed to contain and did not contain any security gates or locked doors. Any decision to place Dixon in an environment restrictive enough to prevent violent acts against others rested with MHMR, law enforcement officials, and ultimately the courts. Even after MHMR placed Dixon with Texas Home Management, he was arrested for aggravated assault during his spring vacation in 1993, more than a year before he murdered Elizabeth Peavy. He was taken into custody by law enforcement officials again in November of 1993, six months before the murder. Confining Dixon during that entire time and beyond would have been necessary to prevent what the Court says was a foreseeable homicide.¹² But the State did not choose confinement for Dixon.

In my view, Texas Home Management would be entitled to summary judgment in this case if it establishes as a matter of law either that 1) it promptly reported all facts about Anthony Dixon’s violations of the law and aggressive acts to MHMR and appropriate law enforcement authorities, or 2) had MHMR

¹¹ When Dixon was committed to MHMR’s custody, the Mentally Retarded Persons Act of 1977 governed his rights. Under section 15 of the Act, Dixon was entitled to the “least restrictive alternative”:

Right to Least Restrictive Alternative

Sec. 15. Each client shall have the right to live in the least restrictive habilitation setting appropriate to the individual’s needs and be treated and served in the least intrusive manner appropriate to the individual’s needs.

Act of May 12, 1977, 65th Leg., R.S., ch. 294, § 15, 1977 Tex. Gen. Laws 772, 776-77 (formerly TEX. REV. CIV. STAT. ANN. art. 5547-300, § 15), *repealed by* Act of Apr. 29, 1991, 72nd Leg., R.S., ch. 76, § 19, 1991 Tex. Gen. Laws 515, 647-48 (current version at TEX. HEALTH & SAFETY CODE § 592.032).

¹² ___ S.W.3d ____.

and law enforcement authorities known all the pertinent facts, they still would not have removed Dixon to a more confined setting that would have prevented the tragic death of Elizabeth Peavy. But the motion for summary judgment filed by Texas Home Management did not assert that it was entitled to summary judgment on either of these grounds. Accordingly, I concur in the Court's judgment remanding this case to the trial court for further proceedings but not in the Court's opinion.

I

When Anthony Dixon was born, his mother was thirteen. Within a few years after Anthony's birth, she had two other children, but was never married. Anthony Dixon's father died sometime before Anthony was committed to MHMR's custody. When MHMR placed Anthony at the Lakeside facility, he required not only mental health treatment but instruction in very basic skills such as eating with a knife, fork and spoon; chewing food with his mouth closed; not talking while chewing; how to brush his teeth; how and when to wash his hair; how to walk down grocery store aisles without being disruptive; toilet training to some degree; and many other basic hygiene and living skills.

Dixon's mental retardation had been diagnosed when he was in the third grade. Dixon thereafter displayed behavioral difficulties. Long before he was committed to MHMR's custody, he was referred to juvenile authorities for auto theft, for "mischief," for evading arrest, and as a chronic runaway. In 1988, about two or three years before he was civilly committed to MHMR's custody, Dixon was placed on juvenile probation. In 1990, when Dixon was thirteen, he was charged with burglary of a building. Instead of moving forward with juvenile delinquency proceedings, the State alleged that Anthony Dixon was mentally retarded and requested that the district court place him in a residential facility. The district court

ordered diagnostic evaluation, and it was determined that Dixon’s verbal IQ was 40 and his performance IQ was 61. He was diagnosed as “mildly mentally retarded.” Based on the experts’ evaluations, the district court found that Dixon was a mentally retarded person, but that he was not dangerous to himself or others. The district court committed Dixon to MHMR’s custody. Pursuant to former section 55.03 of the Juvenile Justice Code, the then-pending delinquency proceedings were stayed while Dixon received court-ordered mental health services that were ultimately provided by Texas Home Management.¹³

The State could have sought to have Anthony Dixon confined in a juvenile detention facility. It did not. The State could have sought to have him committed to the Austin State Hospital or another facility in which he could be confined. It did not. Instead, the proper state authorities chose a residential facility that had no ability to confine Dixon and that was to send him to special education classes at a public school and to send him home to Houston for frequent visits with his mother and other family members. When Dixon was repeatedly involved in further criminal conduct for more than three years while a resident at Texas Home Management’s facility, state authorities still did not seek to reinstate the juvenile delinquency proceedings or to prosecute Dixon as an adult. Instead, they chose to leave Dixon at an intermediate care, residential treatment facility. The state authorities, including MHMR, are, of course, immune from liability to third parties for making these judgment calls because of the doctrine of sovereign immunity and the fact that the Texas Tort Claims Act does not waive sovereign immunity under the circumstances of this case.¹⁴

¹³ Act of May 24, 1973, 63rd Leg., R.S., § 1, ch. 544, 1973 Tex. Gen. Laws 1460, 1482 (formerly TEX. FAM. CODE § 55.03(d)), *repealed as amended by* Act of June 19, 1999, 76th Leg., R.S., ch. 1477, § 14, 1999 Tex. Gen. Laws 5067, 5075 (amending Acts omitted).

¹⁴ *See* TEX. CIV. PRAC. & REM. CODE § 101.021 (waiving governmental immunity from liability only for damages arising “from the operation or use of a motor-driven vehicle or motor-driven equipment” or the “condition or use of

Given this backdrop, the narrow issue before this Court should be what duty an intermediate care residential facility owes to third parties when the State has chosen that facility for a mentally retarded person who has had a history of behavioral problems including criminal conduct.

II

There is no question that Anthony Dixon was a mental health patient and that Texas Home Management provided mental health services and treatment to Anthony Dixon. A district court issued an order of civil commitment, finding that Dixon “is a mentally retarded person” and “requires special training, education, treatment, care or control for his own, or the community’s welfare.”¹⁵ That court committed Dixon “for an indefinite period to the custody of the Mental Health and Mental Retardation Authority of Harris County, Texas for placement.”¹⁶ MHMR chose the Lakewood facility owned and operated by Texas Home Management as the mental healthcare provider for Dixon. Lakewood had an interdisciplinary team, consisting of mental retardation professionals and paraprofessionals, who were to provide reports to MHMR at least quarterly regarding Dixon’s condition and the interdisciplinary team’s recommendations about mental health services for Dixon.

tangible personal or real property”); *Dallas County Mental Health & Mental Retardation v. Bossley*, 968 S.W.2d 339, 343 (Tex. 1998), *cert. denied*, 525 U.S. 1017 (Nov. 30, 1998) (holding that there was no waiver of the county mental health facility’s immunity under the Texas Tort Claims Act even though a patient committed suicide after escaping from the facility through unlocked doors).

¹⁵ Judgment, *In re Dixon*, No. 72,921 (314th Dist. Ct., Harris County, Tex.) (Jan. 31, 1991).

¹⁶ *Id.* (emphasis omitted).

All of the Peavys' allegations of negligence on the part of Texas Home Management are based on its failure to properly diagnose Dixon's violent proclivities and to treat or recommend to MHMR proper treatment for him. The specific allegations of negligence in the Peavys' petition are:

1. In the failure of the home, it's agents/servants or employees to control Dixon when they knew or should have known he was difficult to control and presented a danger to himself and members of the public.
2. In the failure of the home its employees and/or agents to refer Dixon for psychiatric [sic] treatment and counseling when they knew or should have known that he was a danger to himself and others.
3. In the failure of the home its employees and/or agents to provide a more structured environment for Dixon when they knew or should have known that he was a danger to himself and to others.
4. In failing to advise the Mental Health and Mental Retardation of Houston, Texas that Dixon was a danger to himself or others.
5. In the failure of Defendant to make sure Anthony Dixon took medication recommended by the physician.
6. In the failure of Defendant to more closely supervise Anthony Dixon.
7. In the failure of Defendant to refer Anthony Dixon for reassignment to a more secure facility.
8. In allowing Anthony Dixon to go to Houston in contradiction of Defendant's own employees' recommendation.
9. In allowing Anthony Dixon to continue to go on leave to Houston while experiencing increasing behavioral problems both while in Houston and upon his return.
10. In instituting and following a policy of rewarding good behavior while not punishing bad behavior.

11. In failing to refer anthony [sic] Anthony Dixon for reevaluation [sic] after he was found to be a danger to others by his school.¹⁷

As discussed above, when MHMR sent Dixon to Texas Home Management's facility, he was not a person who presented a danger to third parties. The question this Court should ask, therefore, is what duty a mental health care provider owes to third parties to recognize that a patient has become dangerous.

I submit that the Court has answered this question in at least three decisions, *Thapar v. Zezulka*,¹⁸ *Van Horn v. Chambers*,¹⁹ and *Bird v. W.C.W.*²⁰ In *Thapar*, a patient, while hospitalized, told his mental health care provider that he felt like killing his stepfather.²¹ Within a month after his release from the hospital, he did in fact kill his stepfather.²² The allegations in the suit that followed were that the physician was negligent in releasing the patient from the hospital, in failing to take steps to have him involuntarily committed, and in failing to monitor him after his release to ensure that he was taking his medication.²³ This Court held unequivocally that "*Bird* and our post-*Bird* writings answer definitively the first duty question presented by the facts before us: [the mental health care provider] owes no duty to Zezulka, a third party nonpatient, for negligent misdiagnosis or negligent treatment of [the patient]."²⁴ This holding did not depend

¹⁷ Plaintiffs' Second Amended Original Petition.

¹⁸ 994 S.W.2d 635 (Tex. 1999).

¹⁹ 970 S.W.2d 542 (Tex. 1998).

²⁰ 868 S.W.2d 767 (Tex. 1994).

²¹ 994 S.W.2d at 636.

²² *Id.*

²³ *Id.* at 637.

²⁴ *Id.* at 638.

on the degree of control that the mental health care provider had over the patient. The physician in *Thapar* certainly had the ability to refrain from releasing the patient when he or she did, had the ability to at least ask appropriate authorities to involuntarily commit the patient, and had the ability to monitor the patient to ensure that he was taking his medication.

The facts in *Van Horn* are even more analogous to the ones before us today. Van Horn treated a man who was admitted to a hospital displaying “combative” tendencies.²⁵ For the first two days, the patient was physically constrained with leather restraints.²⁶ Van Horn then determined that the patient no longer needed the restraints and could be moved to a private room.²⁷ The patient then attempted to leave the hospital, and hospital personnel attempted to prevent him from doing so.²⁸ In the chase and struggle that ensued, two hospital employees were killed and another was injured.²⁹ The subsequent negligence claims against Van Horn included allegations that he failed to diagnose properly the patient’s condition, failed to prevent the patient’s transfer to an unsecured floor with inadequate facilities to treat the patient’s violent behavior, failed to see that the patient was transferred to a proper facility to handle his violent behavior, and failed to order mandatory physical restraints.³⁰ We observed that “[t]he gravamen of the plaintiffs’ complaints is that Van Horn knew or should have known that [the patient] posed a danger to

²⁵ *Van Horn*, 970 S.W.2d at 543.

²⁶ *Id.*

²⁷ *Id.*

²⁸ *Id.*

²⁹ *Id.* at 543-44.

³⁰ *Id.* at 544.

others and should have treated him accordingly.”³¹ But once again, this Court’s decision about the duty that Van Horn owed to third parties did not turn on control. To the contrary, we clearly said that Van Horn “*may have had a basis for continuing physical restraint,*”³² and then said that his failure to order further physical restraint “could amount to medical negligence, but only against one to whom a duty is owed,” which we said was only the patient, not third parties.³³

I cannot square the Court’s decision today with *Van Horn*. The Court says that in balancing the traditional factors we consider in determining when a court will impose a duty, intermediate care facilities for the mentally retarded owe a duty to third parties to properly diagnose and respond to a patient’s violent behavior. But the balancing test came out just the opposite in *Van Horn* on very similar facts.³⁴ The only difference in the two cases is that in *Van Horn* the patient was voluntarily committed.³⁵

The Court attempts to distinguish *Van Horn*, saying “[h]ere, however, we are not concerned with a physician’s duty not to negligently misdiagnose a patient. Rather, we are concerned with the duty to control.”³⁶ But the Court’s opinion and the state and federal regulations it cites demonstrate beyond question that we *are* dealing with mental health care providers’ professional diagnoses.

³¹ *Id.* at 545.

³² *Id.* (emphasis added).

³³ *Id.*

³⁴ *Id.* at 543-45.

³⁵ *Id.* at 543.

³⁶ ___ S.W.3d at ___.

The Court recognizes that Dixon was treated by an interdisciplinary team provided by Texas Home Management that included mental retardation professionals.³⁷ The Court explains that “THM continuously assessed Dixon’s social, psychological, and educational progress in quarterly reports filed with MHMR. THM employed a Qualified Mental Retardation Professional (QMRP), to prepare reports tracking Dixon’s accomplishments and failures during the period.”³⁸ The Court also recognizes that Texas Home Management “provided Dixon not only with room and board, but also with a plan for his training and treatment. Professionals employed by THM continually monitored and reported on Dixon’s progress to the state.”³⁹ The record is thus clear that Texas Home Management’s function was to provide professional mental health services to Dixon. Texas Home Management’s decisions about Dixon’s interaction with members of the public and his family were a direct exercise of professional judgment about the treatment of a mental health client.

The Court refuses to address or even acknowledge the fact that state regulations required Texas Home Management’s interdisciplinary team to decide when Dixon would be permitted to have therapeutic visits to his home in Houston.⁴⁰ Those regulations provide that the “individual’s qualified mental retardation professional (QMRP) must authorize and document each therapeutic and extended therapeutic visit, subject

³⁷ *Id.* at ___ & n.1.

³⁸ *Id.* at ___.

³⁹ *Id.* at ___.

⁴⁰ 16 Tex. Reg. 3525, 3535 (1991) (formerly 40 TEX. ADMIN. CODE § 27.519(b)(2)).

to the approval of the physician.’⁴¹ In deciding whether and when Dixon could visit his mother, the interdisciplinary team necessarily exercised its professional judgment about Dixon’s mental health.

The undeniable fact that Texas Home Management’s decisions about the care and treatment of Dixon and what restrictions should be placed on him were professional mental health judgments is underscored by the fact that every 180 days other mental health professionals from the Texas Department of Health were to review the care provided to and the plan for treatment of each individual in a facility like the one Texas Home Management operated.⁴² The Texas Department of Health was to perform a “continued-stay review.”⁴³ The continued-stay review was to include a “certification of the individual’s continuing need for ICF-MR [intermediate care facility for the mentally retarded] services and an assessment of his continuing eligibility for a level of care under the criteria specified [for intermediate care for the mentally retarded].”⁴⁴ That continued-stay “review reestablishe[d] the individual’s level of care for the next 180 days.”⁴⁵

In addition, state regulations required an annual inspection of “patterns of care and services provided by an intermediate care facility for the mentally retarded (ICF-MR), including the provision of active treatment.”⁴⁶ In this annual review, called “utilization control,” state “[r]eviewers consider[ed]

⁴¹ *Id.*

⁴² 16 Tex. Reg. 714, 740 (1991) (formerly 40 TEX. ADMIN. CODE § 27.531(a)).

⁴³ *Id.*

⁴⁴ *Id.*

⁴⁵ *Id.*

⁴⁶ *Id.* at 739 (formerly 40 TEX. ADMIN. CODE § 27.523).

necessity, appropriateness, and availability of the facility's services.⁴⁷ The state regulations required that the utilization control review consist of "(1) inspection of care, that is, inspection of services provided by the facility," and "(2) a physician's certification or recertification of an individual's-resident's need for ICF-MR [intermediate care facility for the mentally retarded] care."⁴⁸

The regulations also required a "utilization review" to be performed by the Texas Department of Health's inspection-of-care teams for Title XIX clients in an intermediate care facility.⁴⁹ The objectives of utilization review plans were to:

- (1) promote quality care and to promote training that meets individual needs;
- (2) determine whether needed services are available and are provided on a continuing basis;
- (3) ensure that the services provided are necessary; and
- (4) review the individual program plan.⁵⁰

In addition to continued-stay reviews, utilization control reviews, and utilization review plans, the state regulations required an annual "inspection of care" by the Texas Department of Health for each individual in an intermediate care facility.⁵¹ An annual "inspection of care (IOC) includes, but is not limited to, a review of the level of services provided to a recipient to meet his individual care and training needs."⁵² And, the review team was required to include "appropriate health and social-services personnel," at least

⁴⁷ *Id.*

⁴⁸ *Id.* (formerly § 27.523(1), (2)).

⁴⁹ *Id.* (formerly 40 TEX. ADMIN. CODE §27.525(a), (b)).

⁵⁰ *Id.* at 739-40 (formerly § 27.525(d)).

⁵¹ *Id.* at 740 (formerly 40 TEX. ADMIN. CODE § 27.527).

⁵² *Id.* (formerly § 27.527(a)).

one of whom was required to be “a qualified mental retardation professional.”⁵³ The intermediate care facility was required to “cooperate with the professional review team” and to “provide pertinent information regarding individuals.”⁵⁴

The Court points out that Texas Home Management could have permanently released Dixon back to the Harris County MHMR if Texas Home Management concluded that Dixon had “maladaptive behavior(s) that the facility is unable to address successfully”⁵⁵ But that conclusion also involved the exercise of professional judgment by one or more mental health care professionals. State regulations required that “[t]he psychologist must participate in the release planning if the reason for release is the individual’s display of maladaptive behavior that the facility is unable to treat successfully.”⁵⁶ And, before a facility could release a client because of “maladaptive behavior(s) that [it] is unable to address successfully,” the facility was required to “provide evidence, in the individual’s record, of the interdisciplinary team’s attempts to manage the behavior(s). These attempts must include active participation of the facility’s psychologist or psychiatrist and review by the facility’s specially constituted committee.”⁵⁷

⁵³ *Id.* (formerly § 27.527(b)).

⁵⁴ *Id.* (formerly § 27.527(c)).

⁵⁵ ___ S.W.3d at ___ (citing 16 Tex. Reg. 3525, 3540 (1991) (formerly 40 TEX. ADMIN. CODE § 27.707(c)(3))).

⁵⁶ 16 Tex. Reg. 3525, 3540 (1991) (formerly 40 TEX. ADMIN. CODE § 27.707(c)(6)).

⁵⁷ *Id.* (formerly § 27.707(c)(3)).

All the decisions questioned by the Peavys in this suit are decisions made by Texas Home Management's mental health care professionals in the exercise of their professional judgment about the treatment and training of Dixon. These professional decisions were subject to continuing and extensive scrutiny by mental health care professionals employed or engaged by the state. Characterizing this case simply as one about "control" ignores the undisputed facts and controlling precedent from this Court.

The Court has not properly balanced the competing interests, which are admittedly in tension. The duty the Court has adopted today is far too broad to adequately protect the rights of the mentally retarded. It will result in unnecessary restriction of their rights in many cases by facilities who fear civil liability for their treatment decisions. The broad, ill-defined duty imposed by the Court will have the additional effect of punishing those who exercise their professional judgment in an attempt to care for the mentally retarded when, for whatever reason, the criminal justice system has affirmatively failed to prosecute and confine them for their criminal acts.

However, as will be discussed below in part IV, this does not mean that no duty at all should be imposed on intermediate care facilities like Texas Home Management. Intermediate care facilities for the mentally retarded owe a duty to third parties, but not for any failure to diagnose or treat a mental health client.

III

The Court indicates that Texas Home Management's duty to "control" Anthony Dixon required it to prevent him from visiting his mother, but did not require Texas Home Management to prevent Dixon

from interacting with members of the public in Nacogdoches.⁵⁸ The Court says that Dixon’s behavior “was more manageable in a structured environment”⁵⁹ and, therefore, that Texas Home Management only had a duty to eliminate Dixon’s unsupervised home visits.⁶⁰ But the evidence on which the Court relies to erect its duty of “control” would dictate a far broader duty of “control.”

If Dixon’s behavior before Elizabeth Peavy’s murder was such that it was reasonably foreseeable that he would murder someone in cold blood during a car jacking, then simply eliminating his trips home would not have been a reasonable response. Indeed, much of the violent behavior the Court says led to the foreseeability of Elizabeth Peavy’s murder, and therefore to the duty to “control” Dixon, occurred not in his hometown of Houston, but in the intermediate care facility in Nacogdoches where Dixon lived and the Nacogdoches public schools he attended each day of the week. Dixon stabbed or otherwise intentionally cut a student at his Nacogdoches public school with a piece of glass, and he was verbally and physically abusive to other students at his school. If this evidence indicates that Dixon was capable of murder or that he was dangerous to third parties, then his potential victims certainly included his classmates at school and residents of, as well as workers at, the intermediate care facility where he lived. Indeed, the classmate Dixon slashed at school was a third-party victim to whom Texas Home Management owed a broad duty of “control” under the Court’s writing.

⁵⁸ ___ S.W.3d at ___.

⁵⁹ *Id.* at ___.

⁶⁰ *Id.* at ___.

The duty to “control” imposed by the Court amounts to full-time confinement. That is not the care the State chose to provide to Anthony Dixon. It was MHMR who made the decision to place Dixon in a residential facility that had no ability to physically confine him to the extent necessary to prevent his violent acts. While it is true that Elizabeth Peavy might not have been killed if Texas Home Management had prevented Dixon from going home the particular weekend that he did, the duty imposed by the Court would require Texas Home Management to confine Dixon virtually at all times, even precluding him from attending school, in order to protect third parties from his violent acts. It was the State, not Texas Home Management, that made the decision about whether Anthony Dixon would be allowed to live among and interact with the public.

We know from the summary judgment record before us that law enforcement officials and MHMR were aware of at least some of Anthony Dixon’s criminal acts while he resided at Texas Home Management’s facility. Yet these state actors did not remove Dixon from that intermediate care facility and place him in a more restrictive environment. Why was Anthony Dixon allowed by juvenile justice authorities to remain among the civilian population after he was arrested for aggravated assault for brandishing a gun while trespassing? When Dixon was again taken into custody on other occasions for breaking and entering, theft of a vehicle, and participation in a high-speed chase, why did law enforcement authorities fail to act? Why did the juvenile authorities and prosecutors fail to ask the district court that had civilly committed Dixon to an intermediate care facility to revoke that commitment and order him confined in a secure facility where he would have no contact with the public? We do not know the answers to these questions. We do know, however, that the decision and ability to confine Anthony Dixon to the degree

necessary to prevent harm to third parties rested with the State, not with the intermediate care facility that the State chose to provide mental health services to Anthony Dixon.

IV

The duty that should be imposed on facilities such as Texas Home Management is a duty to notify MHMR and appropriate law enforcement officials of patients' criminal or violent behavior, not an amorphous, open-ended duty to "control" all mentally retarded persons who have exhibited some criminal or violent behavior. The State, including MHMR, and appropriate law enforcement officials cannot make an informed decision about a mentally retarded person's liberty without all the facts regarding his or her behavior. In this case, the State could not make an informed judgment about whether Anthony Dixon should be confined in the State Hospital, whether juvenile delinquency proceedings should go forward, or whether Dixon should be tried as an adult under criminal law without knowing all the facts.

Imposing such a duty is not inconsistent with our holding in *Thapar v. Zezulka* that a mental health care provider has no duty to warn third parties.⁶¹ Our decision in that case was based on the public policy established by the Legislature in a statute that permits but does not require a mental health care provider to disclose information to law enforcement officials if there is a probability of imminent harm.⁶² We concluded that imposing a mandatory duty to warn would conflict with the legislative scheme and would place mental health professionals in the "Catch-22" of either incurring liability to a patient for disclosing confidential communications that proved to be an idle threat or incurring liability to third parties for failing

⁶¹ 994 S.W.2d 635, 638-40 (Tex. 1999).

⁶² *Id.* at 639.

to disclose.⁶³ But in the case before us today, MHMR has legal custody of the patient, and MHMR has access to all confidential communications made during the course of treatment.

Texas Home Management has not established in its summary judgment motion that it has discharged its duty to report to MHMR and to report non-confidential information about Dixon's violent behavior to law enforcement officials. While there is evidence that many of Anthony Dixon's actions were known to MHMR and law enforcement officials, Texas Home Management did not assert or establish that it gave all the pertinent facts to the appropriate state actors. Texas Home Management thus failed to meet its summary judgment burden.

Accordingly, I agree with the Court that the claims against Texas Home Management must be remanded to the trial court. However, I disagree with the ill-defined and overly broad duty imposed by the Court today on intermediate care facilities who provide mental health services to the mentally retarded.

Priscilla R. Owen
Justice

OPINION DELIVERED: October 31, 2002

⁶³ *Id.* at 639-40.