[J-79-2019]
IN THE SUPREME COURT OF PENNSYLVANIA
MIDDLE DISTRICT

SAYLOR, C.J., BAER, TODD, DONOHUE, DOUGHERTY, WECHT, MUNDY, JJ.

MELISSA DEAN, INDIVIDUALLY AND AS CO-ADMINISTRATOR OF THE ESTATE OF ANDREW E. JOHNSON AND CLIFTON EDWARD JOHNSON, INDIVIDUALLY AND AS CO-ADMINISTRATOR OF THE ESTATE OF ANDREW E. JOHNSON,	:	No. 26 MAP 2019
	:	Appeal from the Order of the Superior Court at No. 963 EDA 2017 dated July 2, 2018 (reconsideration denied September 10, 2018) Affirming in Part/Reversing in Part the Judgment of the Chester County Court of Common Pleas, Civil Division, at No. 2014-11603 dated March 22, 2017 and Remanding.
Appellants	:	
v.	:	
	:	ARGUED: September 11, 2019
BOWLING GREEN-BRANDYWINE, CRC HEALTH GROUP, INC. (AND/OR) D/B/A CRC HEALTH GROUP, MOHAMMAD ALI KHAN, M.D., ASIM KHURSHID RANA, M.D., JENNERSVILLE REGIONAL HOSPITAL, JAMES DUNCKLEE, M.D., SUSAN R. GILBERT, EXECUTRIX OF THE ESTATE OF JENNIFER M. PLUMB M.D., AND SOUTHERN CHESTER COUNTY EMERGENCY ROOM ASSOCIATES, P.C.,	:	
Appellees	:	

OPINION

JUSTICE DOUGHERTY **DECIDED: February 19, 2020**

In this discretionary appeal, we consider the scope and application of the qualified immunity provided under Section 114 of the Mental Health Procedures Act (MHPA), 50 P.S. §§7101-7503. We conclude the Superior Court erred in affirming entry of a compulsory nonsuit and hold immunity does not apply under circumstances where: (1)

the patient was admitted for and primarily received drug detoxification treatment; and (2) the patient did not receive treatment to facilitate recovery from a mental illness. Consequently, we reverse and remand for further proceedings.

I. Background

On November 20, 2012, twenty-three year-old Andrew Johnson (Andrew) voluntarily admitted himself to Bowling Green-Brandywine Addiction Treatment Center (Brandywine). Andrew sought drug rehabilitation treatment for his addiction to opiates (OxyContin) and benzodiazepines (Xanax), which were first prescribed to him two years earlier for pain and anxiety related to back injuries arising from an ATV accident. He was accompanied by his mother, appellant Melissa Dean, and reported his health history to Brandywine staff. Andrew's self-report was reflected in the "Mental Health History" section of a nursing assessment form as "Bipolar [and] ADHD" diagnoses from when he was a child. *See* Nursing Assessment at 4 and Rana Evaluation, November 30, 2012 at 1. At the same time, Andrew reported he was not currently receiving mental health treatment, was not under the care of a psychiatrist, and had never been prescribed any medications to treat any mental health issues. *See* Nursing Assessment at 4. The assessment form listed the reason for Andrew's admission as "To get off the pills." *Id.* at 1.

The next day, November 21, 2012, appellee Mohammad Ali Khan, M.D., a physician at Brandywine, took Andrew's medical history and performed a physical exam. Khan noted Andrew stated he previously had received diagnoses of "Bipolar and ADHD," but Khan recorded these diagnoses as "self-reported" and his indicated plan for treatment was "Benzo Detox Protocol [and] Methadone Taper." Medical History and Physical Examination. Khan then placed Andrew on Brandywine's "Alcohol/Benzodiazepine Detoxification Protocol." Detoxification Protocol. For purposes of detoxification, Khan

placed Andrew on a methadone taper for "complete withdrawal from all opioid/opiate medications." Consent to Treatment with Methadone. Andrew also underwent a psychosocial assessment on November 21, 2012, which noted under the Psychiatric/Mental Health section that Andrew was experiencing "anxiety" at the time of his admission. Residential Psychosocial Assessment at 2. On November 25, 2012, four days into his detoxification treatment, Andrew was sent to the emergency room at Jennersville Regional Hospital (Jennersville) for evaluation due to an elevated heart rate and his complaint that he was unable to see or move. Patient Record, dated 11/25. He was examined by emergency room physician James Duncklee, M.D. who diagnosed Andrew with drug withdrawal and returned him to Brandywine. Brandywine's nursing notes reflect Andrew appeared agitated and confused upon his return from Jennersville. *Id.*. On November 26, 2012, less than twelve hours after his discharge back to Brandywine from Jennersville, Andrew was found unresponsive in his room, and was again transferred to Jennersville via ambulance, where it was noted he was making rambling remarks. *See* Patient Record, dated 11/26/12. Andrew was evaluated by Jennifer Plumb, M.D. who diagnosed him with substance abuse and drug withdrawal, and discharged him back to Brandywine. *See id.*

On November 27, 2012, Andrew was again evaluated by Khan who noted he was suffering from hallucinations and reported seeing shadows. Khan ordered a psychiatric consultation to be conducted by appellee Asim Khurshid Rana, M.D., a staff psychiatrist at Brandywine. On November 28, 2012, Andrew was unable to stand on his own, and was not eating or drinking, so Rana performed the ordered psychiatric evaluation in Andrew's room. Rana took a history, and noted "[Andrew] told me that he has a long history of ADHD and was under treatment of a psychiatrist from age four and has been tried on Ritalin and Adderall in the past but has not been on any psychiatric medication

for many years. He hasn't seen a psychiatrist since age 11." Rana Evaluation dated November 30, 2012 at 1.[1] Rana's evaluation further stated:

> ***PSYCHIATRIC HISTORY***: as described previously [Andrew] has been seen by psychiatrist in the past and has been on stimulants in the past. No current psychiatric medications or psychiatric follow ups, no previous psychiatric admissions although there is mention that [Andrew] has history of bipolar illness but it is not clear who diagnosed him with that.
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> * * *
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> ***DIAGNOSES:***
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> Axis 1: Mood Disorder [Not Otherwise Specified]
> Anxiety Disorder [Not Otherwise Specified]
> Opioid and Benzodiazepine Dependence
> [Rule Out] Substance Induced Mood and Anxiety Disorder

Id. at 1-2. Rana's diagnoses did not include bipolar disorder or ADHD, and he prescribed the following "treatment plan":

> Considering [Andrew's] history of mood disorder and current symptoms of anxiety I will start him on Neurontin 200mg three times a day and adjust the dose as needed to help him both with his mood and anxiety symptoms and chronic back pain. I will continue to follow and adjust medication as needed. Try to obtain old records if possible. We will arrange follow up appointment with psychiatrist for once he leaves here. Re-consult me earlier if needed.

Id. at 3. Brandywine's admission forms and Detox Progress Notes indicate Andrew consistently complained of anxiety. *See* Detox Progress Notes dated: 11/21/12; 11/22/12; 11/23/12; 11/24/12.

[1] Rana's evaluation took place on November 28, 2012, but his notes were apparently not signed and dated until November 30, 2012 — two days after Andrew's death. Rana Evaluation dated November 30, 2012 at 3.

At approximately 8:15 in the evening of November 28, 2012, Andrew's blood pressure was recorded as elevated at 148 over 108 with a heart rate of 109. A short time later his blood pressure had risen to 154 over 115 and his heart rate was 103. Patient Record dated 11/28/12. The nursing staff informed Khan of these elevated vital signs, but Khan declined to examine Andrew, did not issue any new treatment orders, and instructed the nursing staff not to transfer Andrew to the emergency room. *See id.* The nursing staff again checked Andrew at 10:20 p.m. and noted he was unsteady, had a heart rate of 180 and blood pressure of 145 over 98. *See Id.* Staff administered Clonidine,[2] but no additional treatment. The nursing staff subsequently checked Andrew every two to three hours and noted he was "resting comfortably." *See id.* At approximately 7:50 a.m. the next morning, Andrew was found lying on the floor of his room, face down, without a pulse. *See id*. He was transferred to Jennersville where he was pronounced dead.

Andrew's parents, Melissa Dean and Clifton Edward Johnson, as administrators of Andrew's estate and in their individual capacities (appellants), filed a complaint in the Chester County Court of Common Pleas against appellees Brandywine, Drs. Kahn, Rana, Duncklee, and Plumb, and Jennersville, raising medical malpractice, wrongful death and survival claims.[3] Specifically, appellants alleged Andrew died of a cardiac arrhythmia due to the combination of medications prescribed during treatment at Brandywine, and that

[2] The record does not clearly indicate the reason for the prescription. It appears Clonidine may be used to treat high blood pressure, or to control symptoms of ADHD in children. Clonidine treats high blood pressure by "decreasing heart rate and relaxing blood vessels so that blood can flow more easily through the body." https://medlineplus.gov/druginfo/meds/a682243.html (retrieved January 3, 2020).

[3] Jennersville and appellants settled prior to trial.

his death was the result of medical negligence including the failure to properly examine, diagnose, appreciate, and treat his medical condition. Complaint at ¶¶ 41-58.

Khan, Rana and Plumb each filed new matter, asserting the affirmative defense of qualified immunity under the MHPA, which "establishes rights and procedures for all involuntary treatment of mentally ill persons, whether inpatient or outpatient, and for all voluntary inpatient treatment of mentally ill persons." 50 P.S. §7103. Section 114 of the MHPA insulates certain individuals from claims of ordinary negligence arising from treatment under the act:

> In the absence of willful misconduct or gross negligence, a county administrator, a director of a facility, a physician, a peace officer or any authorized person who participates in a decision that a person be examined or treated under this act, or that a person be discharged, or placed under partial hospitalization, outpatient care or leave of absence, or that the restraint upon such person be otherwise reduced, or a county administrator or other authorized person who denies an application for voluntary treatment or for involuntary emergency examination and treatment, shall not be civilly or criminally liable for such decision or any of its consequences.

50 P.S. §7114(a).

The matter was tried before a jury in November 2016, and after appellants presented their case through medical records and expert testimony, all defendants moved for nonsuit, claiming appellants failed to present evidence of willful misconduct or gross negligence, and defendants were therefore immune from suit under the MHPA.[4]

Appellants opposed the motion for nonsuit based on MHPA immunity by arguing Andrew admitted himself to Brandywine for drug detoxification treatment and was thus

[4] Duncklee and Brandywine did not initially plead the affirmative defense of qualified immunity under the MHPA in their answer or new matter, but the trial court granted them leave to amend to include the defense at the time the motions for nonsuit were filed.

not receiving treatment for "mental illness" from Brandywine or any of the physicians. Appellants claimed Andrew's treatment was therefore not within the scope of the MHPA. 50 P.S. §7103 ("act establishes rights and procedures for all . . . voluntary inpatient treatment of mentally ill persons"). Brief of Appellants at 27-28; N.T. 11/7/16, 26:17-23 Appellants submitted the MHPA is inapplicable in the absence of a mental health diagnosis, and the record did not support a finding that Andrew was diagnosed with a mental illness. Brief of Appellants at 30; N.T. 11/7/16, 26:24-27:17.

The trial court held the case was governed by the MHPA, the immunity provision applied, and nonsuit was warranted based on the following findings: (1) Andrew's history of psychiatric treatment for bipolar disorder and ADHD was noted in Brandywine's records; (2) Andrew had previously taken medication for anxiety;[5] (3) the psychiatric diagnoses were "carried" in his chart and, while not confirmed by a Brandywine physician, they were confirmed by Andrew's mother, and as a result, there was an actual mental illness diagnosis, and medications were ordered as needed; (4) Andrew's agitation and confusion displayed at Brandywine resulted in his transport to Jennersville for treatment; (5) the record at Brandywine reflected Andrew was experiencing hallucinations, as confirmed by Khan, resulting in an order for a consultation with Rana, a staff psychiatrist; and (6) Andrew's psychiatric evaluation resulted in a diagnosis of mood disorder, anxiety disorder and prescription of medication for those conditions. *See* Trial Court Pa.R.A.P. 1925(a) Opinion at 10-11.

[5] The trial court stated "[s]omewhere in the record there was a note that [Andrew] had tried Depakote and Lithium [which] didn't work for him, but that he was on Xanax." Trial Court Pa.R.A.P. 1925(a) Opinion at 10.

The trial court acknowledged the MHPA is intended to assure the availability of adequate treatment for the mentally ill, and applies only to "[p]ersons who are mentally retarded, senile, alcoholic, or drug dependent . . . if they are also diagnosed as mentally ill[.]" *Id.* at 11, *citing* 50 P.S. §7102. The trial court found Brandywine and its personnel provided psychiatric treatment to Andrew and thus qualified for the statutory immunity. The trial court further found Jennersville's emergency room physicians, Duncklee and Plumb, were also immune because they had access to Andrew's medical records at the time they examined him, and those records included a history of mental illness.

On appeal, a three-judge panel of the Superior Court affirmed the entry of nonsuit as to Brandywine and Khan and Rana, but reversed and remanded for further proceedings related to Duncklee and Plumb.[6] *Dean v. Bowling Green-Brandywine,* 192 A.3d 1177 (Pa. Super. 2018). The panel observed the qualified immunity provision of the MHPA applies to individuals and institutions that provide treatment to the mentally ill. *Id.* at 1180-81, *quoting* 50 P.S. §7114. The Superior Court noted that, although the MHPA does not contain a definition for "mentally ill person" or "mental illness," the Department of Human Services (DHS) has issued regulations stating "mental retardation, alcoholism, drug dependence and senility do not [by themselves] constitute mental illness. The presence of these conditions, however, does not preclude mental illness." *Id.* at 1181, *quoting* 55 Pa. Code. §5100.2. The panel additionally noted the term "treatment" as used in the MHPA is to be interpreted broadly and includes "medical care coincident to mental health care." *Id.*, *quoting Allen v. Montgomery Hospital*, 696 A.2d 1175, 1179 (Pa. 1997).

[6] The present appeal does not involve Drs. Duncklee and Plumb, who did not challenge the Superior Court's order.

The panel further determined the trial court did not err in entering nonsuit in favor of Rana, because appellants' evidence demonstrated he diagnosed Andrew with a "mood disorder, anxiety disorder . . . [and] opioid substance abuse induced mood[,]" and treated Andrew by prescribing medication for his anxiety and back pain. *Id.* at 1184. The panel thus concluded Rana was involved in the "diagnosis, evaluation, therapy, or rehabilitation" of mental illness and the MHPA's qualified immunity provision applied. *Id.*

Although the panel acknowledged "Brandywine did not view [Andrew] as suffering from mental illness for the first week after he was admitted" and "there is no evidence [Andrew] was being treated for mental illness prior to Dr. Rana's consult[,]" the panel found both Brandywine and Khan provided treatment after Andrew's psychiatric evaluation. *Id.* at 1185-86. Accordingly, as allegedly negligent acts by Brandywine and Khan occurred after the psychiatric consult, the panel concluded statutory immunity applied to them because Andrew was being treated for mental illness along with his drug addiction at the relevant times. The panel thus affirmed nonsuit in favor of Khan, Rana and Brandywine. *Id.* at 1187.

Appellants filed a petition for allowance of appeal and we granted review of the following issues:

> a. Whether the Superior Court, in reviewing a nonsuit, properly applied the provisions of the [MHPA] and the evidence in the light most favorable to the plaintiffs in granting limited immunity to a drug addiction treatment facility and its physicians where the individual who died while under the care of the facility was not mentally ill and did not seek voluntary inpatient treatment for a mental illness.
>
> b. Whether the Superior Court properly applied fundamental notions of due process and the [MHPA] to an individual who did not give consent to voluntary treatment under the MHPA.

Dean v. Bowling Green-Brandywine, 203 A.3d 973 (Pa. 2019) (per curiam). In considering whether the Superior Court erred in affirming nonsuit, we recognize nonsuit is proper "only if no liability exists based on the relevant facts and circumstances, with [plaintiffs] receiving 'the benefit of every reasonable inference and resolving all evidentiary conflicts in [plaintiffs'] favor.'" *Scampone v. Highland Park Care Ctr., LLC,* 57 A.3d 582, 595-96 (Pa. 2012), *quoting Agnew v. Dupler*, 717 A.2d 519, 523 (Pa. 1998). Our analysis hinges on whether appellees were entitled to statutory immunity pursuant to Section 114 of the MHPA and, to the extent this is a legal question, our standard of review is *de novo* and our scope of review is plenary and non-deferential. *Shinal v. Toms*, 162 A.3d 429, 441 (Pa. 2017). With these standards in mind, we proceed to the parties' arguments.

II. Arguments

Appellants argue the Superior Court erred in providing appellees with qualified immunity. Appellants assert the MHPA was narrowly tailored to apply to the treatment of mentally ill individuals at mental health facilities, and does not apply in this situation where Andrew was seeking rehabilitation and detoxification from a prescription drug addiction. Appellants acknowledge the MHPA can apply where medical treatment is incidental to "primary" treatment for mental illness, but that is not the case here because Andrew did not meet the threshold MHPA requirements of "suffering from a mental illness" or seeking "treatment for that mental illness at an approved facility." Brief of Appellants at 28, 30, *citing* 50 P.S. §7103.

Appellants further assert the decision below improperly expands the MHPA's narrowly tailored immunity provision beyond the intentions of the General Assembly. Appellants claim the statute's purpose is to facilitate care for the mentally ill, not to bar

claims of negligence by any patient in any setting where there is a vague allegation the patient had some form of psychiatric treatment or issue in the past. *Id.* at 31. Appellants claim immunity under the present circumstances is contrary to the language and purpose of the MHPA, and submit the Superior Court's decision is dangerous and unworkable precedent that conflicts with the text and intent of the MHPA. *Id.* at 32

Appellants further argue the Superior Court improperly extended the holding in *Allen* to apply to the present facts. Appellants note *Allen* involved a patient who was diagnosed as suffering from psychosis and mental retardation and seeking treatment for those "mental illnesses" when she suffered physical injuries during her mental health treatment. According to appellants, the *Allen* Court held a medical malpractice claim arising from those physical injuries was barred by MHPA immunity because the term "treatment" under the MPHA is interpreted to include "medical care coincident to mental health care." *Id.* at 35, *quoting Allen*, 696 A.2d at 1179. Appellants emphasize the *Allen* Court focused on the fact the plaintiff in that case was receiving treatment for mental illness when she was physically injured due to negligence at the defendant hospital. *Id.* at 35-36, *citing Allen*, 696 A.2d at 1176. Appellants distinguish *Allen* from this case by noting Andrew was seeking treatment for drug addiction only, and he did not receive treatment for mental illness.

Appellants argue the Superior Court misstated the holding in *Allen* when it concluded "once a patient is being treated for psychiatric issues, any contemporaneous medical treatment must be considered part and parcel of the psychiatric treatment." *Id.* at 36, *quoting Dean*, 192 A.3d at 1185. Appellants submit this interpretation of *Allen* is dangerously broad and will lead to absurd results; the Superior Court's decision

represents the first time MHPA immunity was held to apply where the injured patient sought treatment only for drug or alcohol addiction. According to appellants, the immunity previously applied only where the injured plaintiff was primarily seeking treatment for a serious mental illness. *Id.* at 38-41 (collecting cases). Appellants reject the panel's more expansive definition of "mental illness" to include alcoholism and drug dependency, and emphasize those particular conditions are actually excluded under the express terms of the MHPA. 50 P.S. §7102 ("Persons who are . . . . alcoholic[] or drug dependent shall receive mental health treatment only if they are also diagnosed as mentally ill, but these conditions of themselves shall not be deemed to constitute mental illness[.]"). Here, according to appellants, there was no diagnosis of mental illness when Andrew was admitted for drug detoxification, and there is no evidence that the results of Rana's psychiatric consultation was distributed to Khan or Brandywine to justify extension of immunity to them.

Appellants further argue the Superior Court's decision undermines "fundamental notions of due process" provided by the MHPA and common law. *Id.* at 45-54. Appellants note the MHPA specifically provides that before a person can be admitted to a facility for the voluntary treatment of mental illness, it must be clear the patient "'substantially understand[s] the nature of voluntary treatment' before he 'submit[s] himself to examination and treatment under the act.'" *Id.* at 46, *quoting* 50 P.S. §7201. Appellants assert the Superior Court's opinion transformed Andrew into a mental health patient in the absence of the requisite notice or consent. *Id.* at 48-49, *citing e.g.*, 50 P.S. §7203 (requiring explanation of treatment, consent and statement of rights under MHPA before voluntary inpatient treatment); §7205 (individualized treatment plan required; must be

provided to patient). Appellants claim failure to comply with these MHPA requirements means appellees may not benefit from the statute's immunity provision.

Finally, appellants claim the decision below means treatment may be included within the scope of MHPA immunity after only a brief psychiatric evaluation, when the provision does not even apply to all mental health care. Rather, appellants assert the MHPA should apply only when an individual has been involuntarily committed or consented to voluntary inpatient treatment for "mental illness." *Id.* at 47 & n.18, *citing* 50 P.S. §7103 (defining scope of MHPA). Appellants warn the holding below will incentivize hospitals, drug addiction treatment and other facilities to perform routine psychiatric evaluations at intake with vague diagnoses in order to bring a patient within the confines of the MHPA and insulate themselves from liability.[7]

Appellees Khan, Rana and Brandywine filed separate briefs in this Court but their arguments are similar; they argue the lower courts correctly held they are entitled to immunity under the MHPA. More specifically, appellees Khan and Rana argue the General Assembly intended the MHPA to cover as many treatment environments as possible to encourage open access to adequate mental health care. *See* Khan's Brief at 17-22, *citing DeJesus v. VA*, 479 F.3d 271 (3d Cir. 2007) (VA Domiciliary Program entitled to MHPA immunity from claims arising from veteran's murder-suicide after treatment for substance abuse problem, including psychiatric diagnosis of intermittent explosive

[7] The Pennsylvania Association for Justice filed an *amicus* brief in support of appellants, arguing outstanding questions of fact exist regarding what, if any, mental health treatment Andrew received. Amicus submits MHPA immunity should not apply because the mental health care provided here was incidental, at best, as Andrew was being treated only for prescription drug addiction. Amicus concludes the MHPA is not implicated where the minor diagnoses of Anxiety Disorder NOS and Mood Disorder NOS were unrelated to appellees' failure to monitor Andrew's blood pressure, the apparent cause of death.

disorder); Rana's Brief at 9, *citing Greater N.Y. Mut. Ins. Co. v. Bell Socialization Servs.,* 2009 WL 1743747 at *4 (M.D. Pa. June 18, 2009) (MHPA is intended "to provide adequate treatment to the mentally ill with the least restrictive physical restraints"). Rana also argues the *Allen* Court specifically rejected a narrow interpretation of Section 114 immunity when it held "treatment is given a broader meaning in the MHPA to include medical care coincident to the mental health care." Rana's Brief at 10, *quoting Allen*, 696 A.2d at 1179. Rana concludes Andrew was a resident at Brandywine and received counseling and assistance for "co-occurring" conditions of drug dependency and psychiatric issues. *Id.* at 18.

Brandywine argues it is also entitled to immunity because the evidence established it is a dual treatment facility that provided substance abuse/addiction treatment and mental health/psychiatric treatment to Andrew. Brandywine's Brief at 26 (Brandywine provides psychiatric care in addition to other types of care and can qualify as a "facility" under Section 105 of MHPA). Brandywine asserts it is entitled to immunity under the MHPA because it "participated in a decision that a person be examined or treated under this act." *Id.* at 27, quoting 50 P.S. §7114. Brandywine further argues immunity attaches because it was Khan and Rana's employer and it would undermine the statute's purpose if immunity applies to a facility's employees but not the facility itself, allowing plaintiffs to circumvent the limitation by seeking recovery against the facility only. *Id.* at 28

Appellees further argue the evidence presented at trial demonstrated Andrew suffered from longstanding mental health issues for which he was taking and abusing benzodiazepines (Xanax) and opioids (OxyContin), and recovery from addiction to these drugs was part of his treatment plan. *See* Brandywine's Brief at 30-31; Khan's Brief at

28. Brandywine further asserts Andrew's drug addiction treatment was related to his underlying mental health issues. Appellees Khan and Rana submit Andrew presented with a history of mental illness, as noted in his intake form, which Khan planned to evaluate at the time of admission, and for which Rana performed a psychiatric evaluation that referenced Andrew's mental health history. *See* Khan's Brief at 28, 34 n.13 (Detoxification Protocol form signed by Khan stated "plan for 'consult psychiatrist for bipolar and ADHD'"); Rana's Brief at 24. Khan further asserts his order for a psychiatric consult was a decision for mental health treatment under the MHPA, and he is therefore entitled to immunity. *Id.* at 30. Rana similarly argues he evaluated and diagnosed Andrew's mental health issues and prescribed "medication for the purpose of alleviating [Andrew's] pain and distress and facilitating his recovery" within the definition of treatment under the MHPA. *See* Rana's Brief at 26, *citing* 50 P.S. §7104 (defining "treatment" as including "diagnosis [or] evaluation . . . needed to alleviate pain and distress and to facilitate the recovery of a person from mental illness"). Appellees thus conclude *Allen* controls because Andrew's death was the result of acts occurring during detoxification from prescription drugs that were directly related to his mental health care.

With respect to appellants' due process argument, appellees insist the evidence demonstrates Andrew provided consent for voluntary treatment of his mental illness when he admitted himself to Brandywine for in-patient treatment, and acknowledged he knew Brandywine was a dual-treatment facility such that he might be treated by psychiatrists as part of his treatment plan. *See* Brandywine's Brief at 39-40, Khan's Brief at 50; Rana's Brief at 22. Brandywine and Khan assert appellants failed to provide any authority to support their claims that technical compliance with the procedural requirements of the

MHPA is required for immunity to apply. *See* Khan's Brief at 49. Khan further argues consent and a treatment plan under the MHPA are required only "to the extent possible[.]" *Id.,* citing 50 P.S. §7107. According to Khan, the consent for treatment signed by Andrew provided the requisite due process. *Id.* at 53-54, *citing* 50 Pa. Code §5100.52.

III. Analysis

The questions before us require that we interpret statutory provisions of the MHPA. The goal of statutory interpretation is to ascertain and effectuate the intent of the General Assembly, and we are guided in this exercise by the Statutory Construction Act, 1 Pa.C.S. §§1501-1991. Wherever possible, a statute should be liberally construed to effectuate its object and promote justice. 1 Pa.C.S. §1928(c). Accordingly, we recognize the MHPA was enacted by the General Assembly for the express purpose of providing "procedures and treatment for the mentally ill." *Allen*, 696 A.2d 1178. Section 102 sets forth the guiding public policy:

> It is the policy of the Commonwealth of Pennsylvania to seek to assure the availability of adequate treatment to persons who are mentally ill, and it is the purpose of this act to establish procedures whereby this policy can be effected. The provisions of this act shall be interpreted in conformity with the principles of due process to make voluntary and involuntary treatment available where the need is great and its absence could result in serious harm to the mentally ill person or to others. Treatment on a voluntary basis shall be preferred to involuntary treatment; and in every case, the least restrictions consistent with adequate treatment shall be employed. Persons who are mentally retarded, senile, alcoholic, or drug dependent shall receive mental health treatment only if they are also diagnosed as mentally ill, but these conditions of themselves shall not be deemed to constitute mental illness.

50 P.S. §7102. Section 114 protects from civil and criminal liability those individuals and institutions that provide treatment to mentally ill patients, and thus promotes the statutory goal of ensuring such treatment remains available. *See Farago v. Sacred Heart General*

Hospital, 562 A.2d 300, 304 (Pa. 1989) (one purpose of MHPA "is to provide limited protection from civil and criminal liability to mental health personnel and their employers in rendering treatment in [the] unscientific and inexact [mental health] field").

Specifically, Section 114 states:

> In the absence of willful misconduct or gross negligence a county administrator, a director of a facility, a physician, a peace officer or any other authorized person who participates in a decision that a person be examined or treated under this act, or that a person be discharged, or placed under partial hospitalization, outpatient care or leave of absence, or that the restraint upon such person be otherwise reduced, or a county administrator or other authorized person who denies an application for voluntary treatment or for involuntary emergency examination and treatment, shall not be civilly or criminally liable for such decision or for any of its consequences.

50 P.S. §7114(a). Within this context, we first consider appellants' argument that Brandywine is not an "authorized person" participating in treatment decisions under the MHPA. We have broadly interpreted protected "persons" under Section 114 to include hospitals and other treatment facilities as well as their employees because denying such entities immunity would undermine the goals of the MHPA. *See Allen*, 696 A.2d at 1178 (hospital providing medical treatment for physical ailments coincident to mental health treatment was "person" within meaning of MHPA's immunity provision); *Farago*, 562 A.2d at 303 (hospital qualifies as person entitled to immunity under MHPA; mental health treatment facilities do not act independently from their employees). We therefore reject appellants' argument that Brandywine may not qualify for immunity under the MHPA.

We next consider whether Andrew was a "person [who was] examined or treated under" the MHPA. 50 P.S. §7114. Although Section 114 does not explain the meaning of "examined or treated" for purposes of the immunity provision, relevant definitions appear elsewhere in the MHPA. For example, Section 104 provides:

> Adequate treatment means a course of treatment designed and administered to alleviate a person's pain and distress and to maximize the probability of his **recovery from mental illness**. It shall be provided to all persons in treatment who are subject to this act. It may include inpatient treatment, partial hospitalization, or outpatient treatment. Adequate inpatient treatment shall include such accommodations, diet, heat, light, sanitary facilities, clothing recreation, education and medical care as are necessary to maintain decent, safe and healthful living conditions.
>
> Treatment shall include diagnosis, evaluation, therapy, or rehabilitation needed to alleviate pain and distress and **to facilitate the recovery of a person from mental illness** and shall also include care and other services that **supplement treatment and aid or promote such recovery.**

50 P.S. §7104 (emphasis added). Accordingly, we consider whether Andrew received treatment "to facilitate the recovery . . . from mental illness." Although the MHPA does not define "mental illness," we recognize DHS utilizes the following description:

> *Mental illness* — [t]hose disorders listed in the applicable APA Diagnostic and Statistical Manual; provided however, that mental retardation, alcoholism, drug dependence and senility **do not**, in and of themselves, constitute mental illness. The presence of these conditions however, does not preclude mental illness.

55 Pa. Code §5100.2 (emphasis added). Applying this definition to the terms of Section 114, it appears that in order to be entitled to immunity, appellees must have provided treatment for a mental illness, independent from and in addition to the treatment provided for Andrew's "drug dependence."

We approach this pivotal question by again acknowledging the General Assembly's explicit policy goal of promoting the availability of mental health treatment, while minimizing restrictions on that treatment. *See Allen* 696 A.2d at 1179 (noting MHPA seeks to impose least restrictive alternatives consistent with providing adequate treatment for mental illness); *Farago*, 562 A.2d at 304 (same). Pursuant to this public policy goal,

our courts have applied Section 114 immunity to doctors and hospitals that provide medical care for physical ailments associated with treatment for primary mental illness. *See Allen*, 696 A.2d at 1178-79 (hospital entitled to Section 114 immunity when providing acute medical care to mentally ill patient); *Downey v. Crozer-Chester Medical Ctr.*, 817 A.2d 517, 525 (Pa. Super 2003) ("[I]mmunity provided by the MHPA extends to institutions, as well as natural persons, that provide care to mentally ill patients.").

In *Allen*, the plaintiff-patient was admitted to Norristown State Hospital in August 1980 for long-term in-patient psychological treatment related to her diagnoses of psychosis and mental retardation. 696 A.2d at 1176. Over two years later, she was transferred from Norristown State Hospital to Montgomery Hospital for physical ailments of dehydration and fever, which were suspected to be a reaction to the medication prescribed at Norristown for her mental illness. *Id.* Allen's psychosis made her difficult to control, and hospital staff restrained her with a Posey vest tied to the bed to prevent her from falling. *See id.* at 1176, n.1. Allen was later found hanging from her bed with the restraint around her neck; she suffered brain damage and filed a medical malpractice action against her treating physician and the hospital. Ultimately, this Court held the physician and the hospital were entitled to Section 114 immunity because Allen was being treated for mental illness when her physical condition required acute medical care designed to "facilitate the recovery of a person from mental illness[.]" *Id.* at 1179, *quoting* 50 P.S. § 7104.

The Superior Court later applied *Allen* in *Downey v. Crozer-Chester.* Downey, who suffered from mental illness for years, was eventually diagnosed with organic mood disorder, bipolar type, and began receiving in-patient treatment for this condition after

being involuntarily committed to Crozer-Chester Medical Center. *Downey,* 817 A.2d at 522. Due to her mental illness, she was unable to care for herself and required direct supervision during all activities including bathing and showering, but she drowned at Crozer-Chester while bathing without supervision. The Superior Court ruled Section 114 immunity barred liability because the MHPA applies to daily "'care and other services that supplement treatment' in order to promote the recovery of the patient from mental illness." *Id.* at 525, *quoting Allen*, 696 A.2d at 1179.

Notwithstanding this holding from *Allen*, we observe application of the MHPA is limited by its own terms — it does not automatically apply in every situation involving a patient with a history of mental illness. For example, in *McNamara v. Schleifer Ambulance Serv.* 556 A.2d 448 (Pa. Super. 1989), the Superior Court held a defendant could not benefit from Section 114 protection where the injury suffered by the plaintiff did not result from treatment for a mental health diagnosis. McNamara suffered a skull fracture when he jumped out of a moving ambulance while being transported; the ambulance attendant had unfastened McNamara's seatbelt. The defendant ambulance company claimed it could not be held liable for its attendant's negligence because it was providing "treatment" to a mentally ill patient when he was injured. *Id.* The Superior Court rejected the argument, noting MHPA immunity is limited to decisions made "within the context of treatment, care, diagnosis or rehabilitation" of mentally ill patients, and the decision to unbuckle the seatbelt during transport did not qualify as such "treatment" warranting MHPA protection. *Id.* at 449-50.

It is clear, however, the MHPA applies to treatment decisions that "supplement" and "aid" or "promote" relief and recovery from "mental illness." *See* 50 P.S. §7104

("Treatment . . . shall also include care and other services that supplement [mental health] treatment and aid or promote such recovery."); *see also*, *Allen, supra; Downey, supra; McNamara, supra.* Consistent with this directive, Section 114 immunity might apply to treatment that does not specifically pertain to "mental illness" if the treatment "facilitates the recovery" from mental illness. *See Allen*, 696 A.2d at 1179, *citing* 50 P.S. §7104. We now apply this standard to the present case to determine whether the MHPA immunity insulates Brandywine, Khan, or Rana from civil liability for appellants' allegations of negligence.

We first consider whether appellees provided treatment to facilitate Andrew's recovery from mental illness. Appellees argue they treated Andrew's self-reported bipolar disorder and ADHD that was noted on his intake forms; the trial court found Andrew's mother confirmed this history, and Rana diagnosed Andrew's mood disorder and anxiety disorder, and prescribed him medication, the day before his death. The trial court noted "treatment" under the MHPA includes medical care that "supplement[s] treatment and aid[s] or promote[s] . . . recovery" from mental illness, and determined appellees' treatment of Andrew thus qualified for immunity pursuant to Section 114. Trial Court 1925(a) Opinion at 11-13.

However, the Superior Court determined Andrew was not being treated for mental illness during his drug detoxification at Brandywine. *See Dean*, 192 A.3d at 1186 (noting "absence of any evidence Brandywine was contemporaneously treating [Andrew] for mental health issues"). The panel also distinguished *Allen* in declining to apply MHPA immunity to Plumb and Duncklee because they did not provide treatment coincident to treatment for mental illness. *Id.* at 1185, *citing Allen,* 696 A.2d at 1179 (immunity applies

if patient's injuries arise from medical treatment that is "coincident" to psychiatric treatment). Nevertheless, the panel ultimately concluded the single brief psychiatric examination by Rana — over a week into Andrew's drug detoxification treatment — was "treatment of mental illness" that triggered Section 114 immunity for Rana, Khan and Brandywine. *Id* at 1184.

The Superior Court erred in so holding. Notwithstanding Rana's psychiatric evaluation, we conclude appellees did not provide Andrew with treatment to facilitate his "recovery from mental illness" such that MHPA immunity applies. *See* 50 P.S. §7103 (MHPA "establishes rights and procedures for all involuntary treatment of mentally ill persons, whether inpatient or outpatient, and for all voluntary inpatient treatment of mentally ill persons"); 50 P.S. §7114 (providing immunity from suit to certain individuals providing treatment "under the act"). Moreover, *Allen* does not direct that immunity applies here. In *Allen*, it was clear the plaintiff-patient had a psychiatric diagnosis of psychosis when she received "coincident" medical treatment for the physical ailment of dehydration. Our holding in *Allen* that the physician-defendants were entitled to MHPA immunity reflects the reality such protection serves the policy goals of the statute, that is, it supports — rather than endangers — the continued availability of treatment for **mental illness**. *Allen*, 696 A.2d at 1179 ("Policy reasons . . . support [our] interpretation of the immunity provision in Section 114 of the MHPA. If the provision were interpreted narrowly . . . so that it only applied to treatment specifically directed at a mental illness, it could reduce or eliminate the willingness of doctors or hospitals to provide needed medical care to a mentally ill patient who is referred by a mental hospital for medical treatment.").

The present factual scenario, however, does not similarly warrant MHPA coverage, and applying the immunity under these circumstances would not further the policy goals articulated by the General Assembly. The record is clear Andrew admitted himself to Brandywine for detoxification from drug dependency, and he was placed on the facility's Alcohol/Benzodiazepine Detoxification Protocol, which included a methadone taper as his treatment. Although Andrew self-reported a decades-old history of bipolar disorder and ADHD, the record is devoid of evidence he received treatment for those diagnoses at Brandywine. Likewise, his transfer to Jennersville arose out of his drug withdrawal symptoms only; he was not being treated for "mental illness." Even appellee Rana, who noted Andrew's self-reported history of "Mood Disorder NOS" and "Anxiety Disorder NOS," did not independently confirm those past, self-reported diagnoses; instead, Rana's evaluation concluded there was no clear diagnostic history of bipolar disorder or ADHD, and that Andrew was not currently receiving treatment for mental illness. *See* Rana Evaluation dated November 30, 2012 at 1 ("No current psychiatric medications or psychiatric follow ups, no previous psychiatric admissions although there is mention that the patient has history of bipolar illness but it is not clear who diagnosed him with that."). In fact, Rana prescribed medication for anxiety and back pain arising from drug detoxification treatment. *Id.* at 3 (R.R. 221a). And, importantly, treatment for drug dependency is expressly excluded from the relevant Code provisions describing "mental illness." 55 Pa. Code §5100.2 ("Alcoholism, drug dependence . . . do not, in and of themselves, constitute mental illness").

Accordingly, our review of the record in the light most favorable to appellants does not support the lower courts' determination that appellees fall under the protection of

MHPA immunity. The undisputed cause of Andrew's death was cardiac arrhythmia. N.T. 11/3/12 at 22:1-23:18 (cause of death was cardiac arrhythmia due to combination of medications). There is no indication the medical care for the physical condition of elevated heart rate and blood pressure "was coincident to" any treatment for "mental illness." *Cf. Allen*, 696 A.2d at 1179 (applying MHPA's immunity to defendant doctors who treated mentally ill patient in acute need of treatment for physical ailments). Instead, Andrew's dangerously elevated blood pressure and heart rate allegedly arose from his drug detoxification treatment, which does not fall within MHPA coverage.

IV. Conclusion

We therefore hold the Superior Court erred when it affirmed nonsuit in favor of appellees on the basis of Section 114 immunity. In so holding, we are mindful that applying MHPA protection under the present circumstances would expand immunity to all physicians and facilities that treat patients with any history of mental illness, however remote or unrelated to the current treatment. The Superior Court's more expansive application would essentially immunize all providers that adopt a routine practice of ordering a "psychiatric consult" for every patient, regardless of presentation, and is not supported by our review of the relevant provisions of the MHPA. *See* 50 P.S. §7104 (defining treatment as diagnosis, evaluation, therapy, or rehabilitation to "facilitate the recovery . . . from mental illness"); *see also* 1 Pa.C.S. §1921(b) (letter of statute is not to be disregarded under pretext of pursuing its spirit). We are particularly disinclined to apply immunity here given that drug dependency is expressly excluded from relevant definitions of the MHPA-targeted condition of "mental illness." 55 Pa. Code §5100.2.

Accordingly, we reverse the decision of the Superior Court and remand to the trial court for further proceedings.[8]

Jurisdiction relinquished.

Chief Justice Saylor and Justices Baer, Todd, Donohue, Wecht and Mundy join the opinion.

[8] Given our holding on the first question presented by appellants, we need not reach the second question relating to due process.