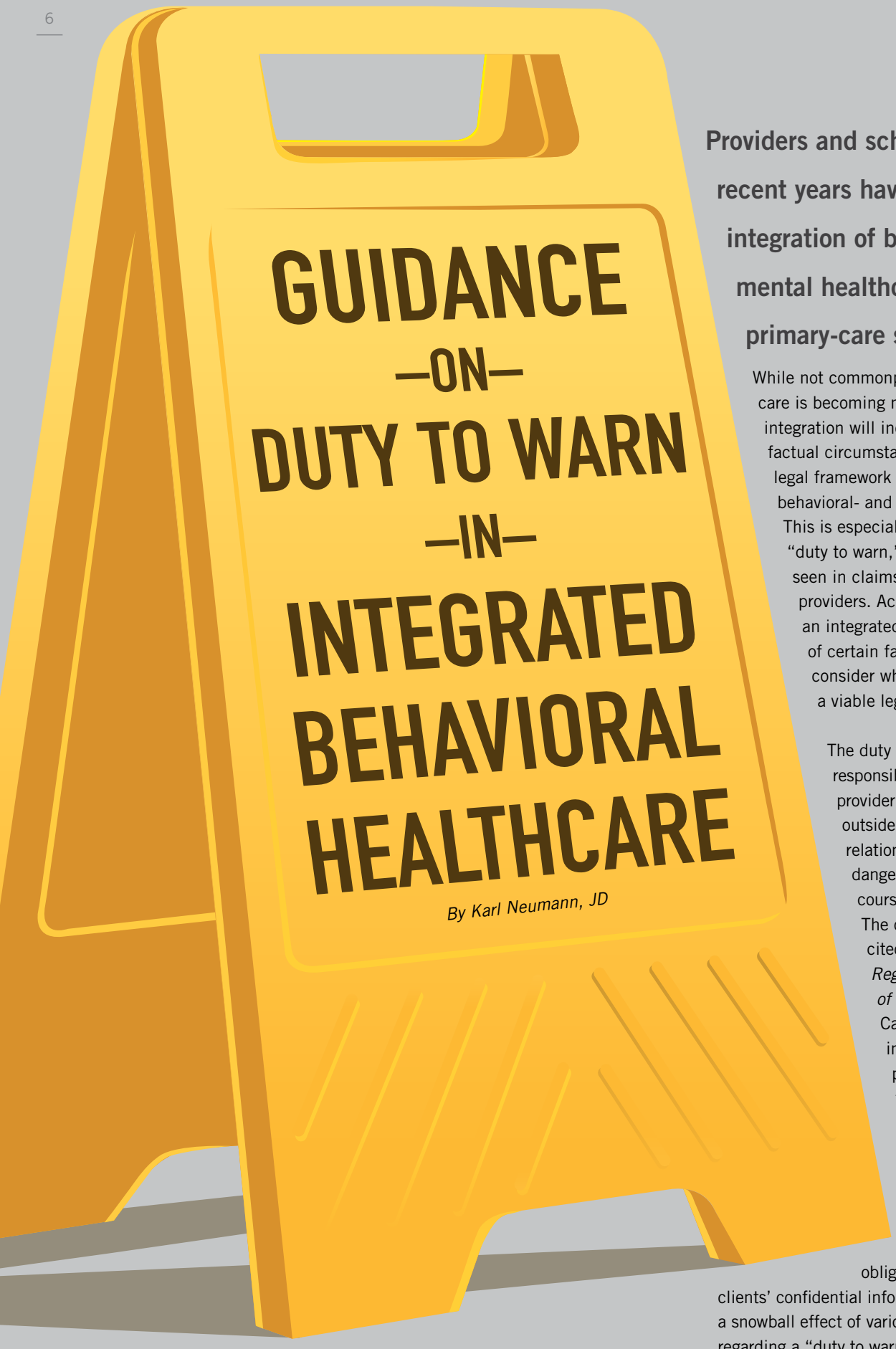

GUIDANCE —ON— DUTY TO WARN —IN— INTEGRATED BEHAVIORAL HEALTHCARE

By Karl Neumann, JD

Providers and scholars in recent years have advocated for integration of behavioral and mental healthcare into the primary-care system.

While not commonplace, integrated care is becoming more prevalent. This integration will inevitably present new factual circumstances that our current legal framework has not addressed, for behavioral- and mental-health providers. This is especially true with respect to the "duty to warn," a legal issue commonly seen in claims against mental-health providers. Accordingly, providers in an integrated setting should be aware of certain factors the courts may consider when deciding whether a viable legal claim exists.

The duty to warn refers to the responsibility of a mental-health provider to notify third parties—outside of the provider-patient relationship—of potential dangers revealed during the course of a patient's treatment. The duty arose from an often-cited 1976 case, *Tarasoff v. Regents of the University of California*, in which the California Supreme Court imposed a legal duty on psychotherapists to warn third parties of threats made to those parties by psychotherapists' patients. The case was significant because it cemented an exception to therapists' ethical obligations to maintain their clients' confidential information. That case led to a snowball effect of various states adopting laws regarding a "duty to warn" or "duty to protect."

THE SCOPE OF THE PROVIDER-PATIENT RELATIONSHIP

One factor courts often grapple with is whether there was a "special relationship" between the provider and patient. Many courts cite the Restatement (Second) of Torts § 315 for the prerequisite that a special relationship must exist before a duty to warn is implicated. In certain jurisdictions, the mental-health provider must have a "definite, established, and continuing relationship" with the patient. In others, the courts emphasize the degree of control the provider had over the patient.

But in an integrated, multi-provider system, does a mental-health provider have a sufficient special relationship to implicate the duty? Considering that integrated care can take many forms, questions will certainly arise as to whether a provider established the requisite relationship. On one end of the spectrum, a specialist in an integrated setting may simply provide recommendations to another provider and not have any direct contact with a patient. On the other end, a specialist may be jointly evaluating the patient and rendering mental-health treatment alongside a primary physician.

With varying approaches to an integrated model, providers will need to be cognizant of their precise role in treating a patient and/or assisting other providers. The scope and nature of their relationship with the patient should be clearly outlined in the records. The particular services being rendered should be documented—e.g., whether the service is a consultation, screening, or actual therapy. While courts are generally reluctant to have bright-line rules, at least one jurisdiction has held under particular facts that an initial assessment for subsequent counseling did not establish a special relationship that triggered a duty. It will also be important that the provider's exact role is conveyed to the patient and understood by all persons involved in the patient's care. Doing so will help remove any doubt as to what the relationship is between the provider and patient and, consequently, whether the relationship is sufficient to trigger a duty to warn.

FORESEEABILITY IN A COLLABORATIVE SETTING

In its most basic form, the duty to warn is called into question when it is asked whether it was reasonably foreseeable that the patient would commit a tort against a third party. The foreseeability factor is often the critical issue in determining whether a mental-health provider had a duty to a third party.

States have adopted various approaches regarding what knowledge is required before a duty will be imposed. Some courts may only impose liability where there is knowledge of a specific threat, as opposed to a vague, generalized one. Some courts require that there be knowledge that a particular person may be harmed, while others only require knowledge that a threat was made against a broader, identifiable class of persons.

The Washington Supreme Court case *Volk v. DeMeerleer*, 187 Wn.2d 241, 386 P.3d 254 (2016) is an instructive example of the foreseeability factor. In this case, a psychiatrist was treating a patient who had previously expressed suicidal and homicidal thoughts during treatment. Approximately three months after last being seen by the psychiatrist, the patient killed two individuals. The Washington Supreme Court held that the psychiatrist owed a duty of care to warn or protect potential victims of the patient. This decision came as a surprise to many in the medical-legal industry, considering that the patient had never specifically named the two individuals killed, or voiced any homicidal thoughts towards them—and it had been years since the patient's last documented hostile sentiment. The decision ultimately extended the scope of the duty to all individuals who may be "foreseeably" endangered by a patient, as opposed to just those who are "readily identifiable." The decision is a reminder of how broadly some jurisdictions interpret foreseeability in relation to persons who may be harmed.

In determining whether a threat was reasonably foreseeable, courts look to a number of different factors, such as whether the provider had knowledge of the patient's (i) homicidal thoughts, (ii) assaultive behavior, (iii) violent acts towards others, or (iv) non-compliance with medications.

In an integrated setting, providers will need to be aware that this information could come from varying sources. The most obvious source is the patient him- or herself. But the challenge for courts will be when knowledge is conveyed to the broader integrated network. Integrated care will involve more communication among multiple providers. It will involve increased and shared access to electronic health records. Friends and family may also report pertinent information to some providers on a patient's healthcare team but not others. All of this will inescapably present difficulties in determining what a provider actually knew and if liability should exist. It is easy for someone to state in hindsight that a hazard was foreseeable, but the reality is that assessing potential threats can be incredibly difficult during behavioral- and mental-health treatment.

Therefore, providers should keep in mind the foreseeability factors and how certain information might be construed to impute knowledge of a potential hazard. It will be important for providers to document the nature and scope of what they learned during the course of treatment. If a threat is vague and

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should employ sound judgment and discretion to determine the level of contact needed on a patient-by-patient basis. By definition, telehealth does not permit in-person evaluations; telehealth practitioners should determine if circumstances require something more. Where in-person contact is considered necessary, telehealth practitioners can either engage surrogate examiners to be present with patients or recommend in-person appointments to those patients.

Knowing the limitations of care. Practitioners' responsibilities also include knowing the limitations of the care to be provided. Telehealth allows practitioners to provide any appropriate treatment for patients, including prescriptions. But just as in traditional settings, these practitioners must recognize situations that exceed their expertise or ability, or in which technological limitations frustrate treatment—and should refer these cases elsewhere for appropriate care. Notably, telehealth software prevents in-person examination of a patient's gestures and body language, and awareness of this potential source of miscommunication is critical to avoiding misdiagnoses and consequent malpractice liability.

Out-of-state licensing. Despite telehealth theoretically making it possible to treat patients anywhere in the country, practitioners should be aware that many states prohibit sustained practice with out-of-state licenses. Furthermore, mental-health professionals incur a practice-specific duty to take reasonable precautions to mitigate or prevent foreseeable injury to others caused by their patients (R3d (Torts) § 315), and telehealth practitioners should be especially aware of these signs, particularly in light of the technological limitations and physical separation from their patients that telehealth involves. It is a best practice, for example, to obtain each patient's emergency contact information so as to assist endangered patients.

Telehealth simplifies patient interactions, but it does not obviate practitioners' record-keeping practices. Practitioners must accurately and adequately document patient encounters so that records clearly, concisely, and correctly reflect treatment. Records must be permanent, confidential, and readily available to patients and their treatment providers in accordance with laws and regulations related to maintaining and transmitting such records. HIPAA and HITECH—medical privacy and security laws—require that telehealth software encrypt patient data; Skype, FaceTime and other commercially available communication services fail to meet this requirement. Practitioners must have telehealth-specific video-conferencing providers execute a business associate agreement to maintain patient confidences pursuant to HIPAA.

Telehealth prescriptions entail the same professional accountability as prescriptions penned during an in-person visit. Practitioners must evaluate the indications, appropriateness, and safety considerations for each telehealth prescription in accordance with current standards of practice; for example, practitioners should exercise special caution when prescribing DEA-controlled substances through telehealth. Integration with e-prescription services can help telehealth practitioners ensure accurate and error-free prescribing practices. PR

Sources

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ambiguous, and does not reasonably identify any class of persons, it should be noted as such. It will also be important that the provider document how he or she learned the information and through what source(s). Claims often live or die on the foreseeability factor, and having a documented history of what critical information was actually conveyed, if any, will assist in determining whether there is a viable claim.

CONCLUSION

The courts have not yet had meaningful opportunities to interpret the duty to warn in an integrated healthcare setting. Because the law is not uniform and integrated healthcare varies drastically, it is difficult to formulate definitive rules or guidelines that will broadly apply to all practices. However, foundational factors, such as whether there is a requisite special relationship and foreseeability of harm, should be kept in mind when rendering services in these integrated settings. And as integrated care becomes more prevalent, we can expect the courts to provide additional guidance on whether or not the duty is implicated under specific factual circumstances. In the meantime, providers should familiarize themselves with the current framework and how their particular jurisdictions apply the duty. PR

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