A Brief Review of Some Duties and Requirements

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What are the various duties or obligations of a licensed mental health practitioner? Are there both legal duties and ethical duties, and what about moral duties? Do legal and ethical duties apply only to the relationship with patients, or are they broader? Do licensed mental health practitioners in your state ever have a "duty to warn" or a duty to protect persons who are not their patients? The discussion that follows is intended to serve the purposes of reminding practitioners of just some of their numerous professional obligations and raising questions for further consideration and research. For a more in depth discussion of any of the topics covered in this article, reference to prior issues of this Bulletin is suggested.

A "duty" is generally thought of as a legal obligation, the breach of which can result in liability. But there are also broader societal concepts of moral duty and professional concepts of ethical duty. The prudent mental health practitioner should not take too restrictive a view of the concept of duty or obligation – but rather – should view the concept as expansive and applicable to various aspects of their professional lives. For example, it might be wise to view the necessity of paying the state licensing fee and the malpractice insurance premium as duties owed to oneself. Neglect or disorganization with respect to such matters often leads to various unintended negative consequences for practitioners – such as being accused of practicing without a license and not being covered by professional liability insurance when an unexpected complaint or claim is asserted. Does a practitioner have a legal or ethical duty to disclose to the patient or to the patient's health insurer (who paid for psychotherapy services rendered by the practitioner) the fact of the temporary lack, lapse, or delinquency status of the license? Would the failure to do so constitute insurance fraud?

Confidentiality is both an ethical and a legal obligation or duty. A negligent or intentional breach of confidentiality is actionable civilly and administratively. Therapists and counselors should be aware of the many exceptions to confidentiality, some of which are mandatory and others of which are permissive. These many exceptions to confidentiality often result in disclosures to third parties without the signed authorization of the patient. Prudent practitioners typically inform patients at the outset of treatment of the major exceptions to the duty of confidentiality. Closely connected to the duty of confidentiality is the duty or obligation to assert the psychotherapist-patient privilege when information, records, or testimony is sought through the issuance and service of a subpoena for testimony at trial or deposition, or for treatment records. How and when that obligation is asserted and managed varies by state, but generally, resistance should be the initial instinct – not compliance. Once more information is obtained and the patient (and the patient's attorney) is consulted, appropriate action can be taken.

The topic of “duty to warn” (re: dangerous patients) has been discussed by me in multiple issues of this publication. As I have often written, the so-called “duty to warn” established by the famed Tarasoff decision by the California Supreme Court (1976), was not technically a duty to warn. The duty to warn was, and to some degree still is, a misconception. The duty created by the Court was simply, but importantly, a duty or obligation to use reasonable care to protect the intended victim against the threatened danger. Each state may treat the duty differently, both with respect to the precise obligation of the practitioner and the delineation of when the duty arises. It is important to know how the duty owed to the patient who is suicidal may differ from the duty owed to a person who the patient has threatened with imminent physical violence. It is also important to know if there is a duty to the general public when the patient presents a serious danger of physical violence without specification of an intended target. (See prior articles under the headings of “dangerous patient” or “duty to warn.”)

The primary duty owed to the patient is to render competent and reasonable mental health treatment. If the treatment provided is incompetent or negligent (the reasonably prudent practitioner under the same or similar circumstances test), this well accepted common law duty is breached and a civil action alleging negligence or malpractice could result in monetary damages. Another duty owed to patients (a requirement of law) is for practitioners to inform them of whatever the state requires in the way of disclosures (which I often differentiate from the doctrine of informed consent). In California, for example, the law requires the disclosure of the fee to be charged and the true name and license designation of the practitioner who conducts business under a fictitious business name. Additionally, ethical standards may provide guidance or impose ethical duties with respect to various aspects of the practitioner-patient relationship.

With respect to consent to treat and the doctrine of informed consent, practitioners must comply with state law, with professional association ethical standards, and with their understanding and view of the extent and nature of the information that should or must be disclosed or discussed at the outset of treatment and during the course of treatment. What are the risks or perils of mental health counseling or psychotherapy? Are those risks or perils remote or minimal? Could there be a problem if too much is disclosed and discussed at the outset of treatment regarding the risks, perils, or dangers of mental health treatment? Does or should state laws or regulations specify the risks or perils of marital therapy, individual psychotherapy, or mental health counseling? Are the potential risks variable and sometimes minimal based upon the nature of the treatment and the particular patient involved? (See prior articles under the heading of “informed consent” for an in-depth discussion of this sometimes vexing topic.)

What is the ethical or legal duty, if any, when the practitioner learns that his or her patient has had sexual contact with a prior therapist? Is there or should there be a duty for the practitioner to report such information to the licensing board? Could such a report ever be made in a manner that would protect the identity of the affected patient? With respect to the duty itself, state laws typically prohibit therapist-patient sexual contact. In California, the practitioner who learns from a patient that a prior therapist had sexual contact with the patient during the course of a prior treatment is obligated to give the patient a brochure promulgated by the state that delineates the rights of, and remedies for, patients who have been involved sexually with their psychotherapists. The law also requires the practitioner to

discuss the contents of the brochure with the patient.

As to whether there should be a duty to report this serious violation (a crime in many states) to the licensing board, that depends upon one's view of and commitment to the duty of confidentiality – and the respect that the practitioner believes must be shown for the wishes and welfare of the patient. As to whether a report could be made (if a state were to require a report) in a manner that protects the confidentiality of the patient, I think the best answer is "perhaps," but such a policy would be fraught with legal and practical issues. A credible and confidential report from a licensed mental health practitioner who is currently treating the patient who was exploited by a former therapist could, for example, trigger an undercover investigation of the named wrongdoer. But such an expensive and particularized investigation might be expected to render little meaningful results – for a variety of reasons. And, the accused practitioner would likely press to uncover the underlying reasons for the initiation of the investigation.

Therapists and counselors have multiple duties to report, and the reporting duties require reports to multiple agencies or entities within specified periods of time and by a variety of methods. Most notably, and I trust generally understood in considerable detail by most practitioners, are the duties to report known or reasonably suspected (or a similar standard) child abuse, elder abuse and dependent adult abuse. Violation of any of these duties may constitute a crime and can result in civil and administrative liability. Compliance with any of these duties generally results in some amount of immunity from liability. Whether or not such reporting duties must (or should) be disclosed to patients at the outset of treatment, and with what degree of granularity, is dependent upon state law, professional ethics, and the practitioner's professional judgment and philosophies/viewpoints.