CONFIDENTIALITY – High Risk Behavior of Patient

written by Richard Leslie | October 3, 2022

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A CPH-insured mental health practitioner requested that I comment on a situation with a patient that raised questions about the duty of confidentiality and the exceptions to that duty. Several preliminary comments are necessary before addressing the scenario presented. First, and as I have often cautioned, the law in each state varies, sometimes in fine nuance, so readers must determine whether the law in their state of practice conforms with or differs from the legal principles and opinions discussed below. Also, it is important to remember that any change in the facts or circumstances of a particular scenario may raise different legal questions and different answers.

The duty of confidentiality is the cornerstone of the mental health professions. A wrongful breach of confidentiality can lead to civil liability for the practitioner and a licensing board enforcement action against the practitioner. In rare cases, a criminal prosecution may be possible – of course, depending upon state law. Typically, the laws pertaining to the duty of confidentiality provide various exceptions to confidentiality, which may be numerous. Some of these exceptions to confidentiality are mandatory (e.g., child abuse reporting, elder abuse reporting) and some are permissive (e.g., communications with other licensed health care practitioners or licensed health facilities for purposes of diagnosis or treatment of the patient).

The duty of confidentiality may not only be established by statute, but may also be affected by case law (e.g., a decision of the highest court in the state – like the famed *Tarasoff* decision of the California Supreme Court decades ago). This decision created, for California practitioners, the "so-called duty to warn" in cases where the patient presents an imminent and serious danger of violence to another. I have written about this "so-called duty" in previous issues of the *Avoiding Liability Bulletin* and described the actual duty created. Other states may have similar high court cases affecting the duty of confidentiality and, like California, may have enacted statutes that provide immunity from liability for practitioners who comply with the dictates of the statute in specified dangerous patient situations.

The scenario presented by the CPH-insured reader describes a patient who informs the practitioner of her interest in a high risk behavior that could lead to harm. The practitioner describes the behavior of the patient as "in the category of (something like) buying drugs, selling sexual favors, or smuggling contraband." The practitioner discouraged the patient from moving forward with what sounded like a bad idea, but did not stand in the way of the patient's autonomy. Since the practitioner did not know if harm had befallen the patient as a result of the patient's possible behavior following the session, the practitioner sent a "safety check-in" to the patient and the patient confirmed her safety. Once safety

was confirmed by the patient, the situation for the practitioner ended at that point.

The practitioner wondered what she would have done if the patient had not responded to the safety check-in within the time period that the practitioner considered necessary. The practitioner wondered if she should have contacted the patient's family in the event of no confirmation from the patient. Without confirmation from the patient, the practitioner would have no knowledge of whether the patient followed through with the risky behavior described in session or whether the patient was harmed. The practitioner imagines that the patient did follow through with the behavior, but she did not know. If the practitioner had informed family members that there was not a timely response, what would be the content and purpose of such a disclosure? Would the patient's contemplated behavior be disclosed?

Without knowing what the specific law is in the state where this occurred, it is my impression (and bias) that the patient was entitled to confidentiality. The behaviors described are in my view not particularly unique or different from the behaviors of many patients throughout the country. The behaviors involved are crimes, and likely dangerous – depending upon the circumstances. But mental health practitioners have long treated patients who may be involved in criminal or dangerous behaviors – whether they are drug users, prostitutes, sex workers, or a variety of other "dangerous" behaviors (including driving under the influence). Those patients are generally entitled to confidentiality, just like other patients with other problems.

Practitioners must be familiar with the exceptions to confidentiality, whatever state this scenario might occur in. There may be states where certain criminal behavior of a patient might have to be reported, but generally, the past crimes of the patient are confidential. In the scenario presented, the patient informed the practitioner of intended behavior, but the intended behavior was not a situation where the patient was threatening violence against others or herself. The patient was not suicidal and was not threatening self-harm. In this case, the patient was expressing her interest in a high risk behavior. Merely because the behavior contemplated was risky (and might constitute a crime) is not enough, in my view, to warrant a breach of the duty of confidentiality.

The behaviors described, while risky from a personal safety standpoint, are also risky in terms of a possible arrest for the particular behavior involved. These realities present grist for the mill of effective mental health care and counseling. I trust that there are mental health practitioners throughout the country who treat patients who engage in all kinds and degrees of risky behaviors, whether they constitute crimes or not. It seems unwarranted to break confidentiality so that a friend or family member may be informed of the behavior or the harm even if they may be able and willing to help (assuming they are not in family therapy).

Moreover, unless there is written authorization from the patient, or unless a specific law or regulation allows or mandates disclosure in such circumstances, informing others would in my view be a breach of confidentiality – which could result in a complaint to the licensing authority or a claim or lawsuit for damages. Simply because the patient may engage in risky behavior (or talk about doing so) does not, in my view, warrant breaking confidentiality and likely the trust of the patient. The practitioner would be

best served to provide excellent treatment, and possibly, with the consent of the patient, and if clinically appropriate, involve family members or others in the treatment.

One may ask what would have happened if the response was timely but the patient reported that she was physically harmed. The patient could of course inform others as she desired. The practitioner would have done nothing wrong. During therapy, the practitioner had discouraged the patient from moving forward with the behavior but did not (and should not) stand in the way of the patient's autonomy. Those who engage in risky or criminal behavior are responsible for the consequences of their actions. Hopefully, they go to mental health practitioners to get help. The practitioner's role is to treat the patient in a clinically sound and ethical manner.

Based upon the limited information provided, it seems to me (a non-health care practitioner) that the safety check-in could have created unnecessary problems for the practitioner had the response from the patient not occurred in a timely way – possibly leading to a breach of confidentiality. Was there a prior understanding (in writing) between the patient and the practitioner regarding the expected response time and the consequences of no timely response from the patient? Are practitioners responsible for tracking patient safety between sessions, and if so, under what circumstances and how frequently should this be done?