

A Mental Health Professional's Guide to the Legal Obligation to Retain Client Confidences

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I. Introduction

A Mental Health Professional (MHP) is faced with the extraordinary and sometimes conflicting obligations of maintaining a client's confidences and protecting a client's emotional and mental health. (Throughout this article the phrase client will be used to identify the subject of both therapeutic and medical relationships.) This ambivalence is complicated when family relations are involved.

And while a client is typically entrusted with the task of facilitating his own therapeutic healing and development, MHPs are occasionally required to take affirmative steps to protect a client from himself, circumstances, or others.

Weighing options and alternatives when choosing to favor preservation of a client's well being over the preservation of a client's confidences is complicated by what can appear to be contradictory legal mandates. On the one hand, MHPs are ethically, professionally, and legally required to preserve the confidences with which they have been entrusted. On the other hand, MHPs may be ethically, professionally, and legally required to disclose confidences under certain circumstances. Understanding the relevant legal landscape will help MHPs when navigating this sometimes treacherous realm.

The first tool that should be applied when determining what should be disclosed and when is the treating professional's own sense of ethical and professional duty. Legal doctrines- especially where public health is concerned- typically emerge from a desire to protect the public interest. Where the provisioning of mental health services is concerned, this inquiry recognizes the fundamental value of the sanctity of the client-counselor relationship. As a noted legal publicist has recognized, "[confidences protect] interest and relationships which, rightly or wrongly, are regarded as, of [considerable] social

importance..." Charles McCormick, McCormick on Evidence, § 72 (3d. ed. 1984). In enacting laws requiring or protecting the confidences exchanged during the therapeutic process the legislature or judiciary have made a determination that, first the therapeutic process is of intrinsic social value, and second that this process is facilitated by mutual trust.

As any MHP can attest, the establishment and maintenance of trust through the creation of an environment that engenders mutual positive regard and respect is essential to the counseling relationship. It is in this setting that a client may identify and reconcile feelings that derive from highly personal experiences and anxieties. Like penitent parishioners, clients often disgorge long held secrets. Knowing that a counselor will hold these revelations in confidence empowers most clients toward the candor and authenticity often required for therapeutic growth. The need for confidence within the treatment setting was aptly described by a New York appellate court when it stated:

"[Within the therapeutic setting,] [t]he patient is called upon to discuss in a candid and frank manner personal material of the most intimate and disturbing nature. ... He is expected to bring up all manner of socially unacceptable instincts and urges, immature wishes, perverse sexual thoughts--in short, the unspeakable, the unthinkable, the repressed. To speak of such things to another human requires an atmosphere of unusual trust, confidence and tolerance. ... Patients will be helped only if they form a

trusting relationship with the psychiatrist.” MacDonald v. Clinger, 84 App Div 2d 482, 446 NYS2d 801, 804 (1982).

However, a client’s therapeutic development should not be permitted to dominate over all other considerations. Circumstances may require therapists to breach these confidences where the client presents a threat to themselves or another. Likewise confidences may be broken where circumstances threaten to exact a significant injury upon the unwitting client. There also may be circumstances where the disclosure of certain therapeutic interactions may be required to protect the sanctity of other valued relationships.

This article will examine the mandate and limits of retaining client confidences. This paper will first explore the various legally recognized family relations and the duty MHPs have to work within these familial bonds when providing therapeutic services. This paper will then explore the distinction between confidences and privilege, exploring the bounds and limits of each. Finally, this article will explore various regulatory schemes that touch on or affect MHPs’ ability or duty to preserve client confidences.

II. Family Relationships

The relevant family relationships which touch on or concern the retention of confidences in the context of mental health services are those of marriage and paternity. It is therefore important for MHPs to

understand the legal parameters that characterize these relationships under Georgia law.

a. "Legal" Marital Status

In Georgia, marital relationships arise only through legally sanctioned unions. There exist no provisions under Georgia law for marriage between persons of the same sex. Additionally every party seeking to "contract for marriage" must be over 16 years of age (unless a live or expected child is involved), of sound mind, unmarried, and unrelated to their prospective spouse. See O.C.G.A. § 19-3-2. Additionally, there exist no current provisions under Georgia law for common law marriage. See O.C.G.A. § 19-3-1.1. However, if the requirements of common law marriage were satisfied prior to and maintained since July 1, 1997, a common law marriage retains all incidence of ceremonial union. Therefore, if a couple had lived together and held themselves out as husband and wife for eight years on July 1, 1997, then they would have formed a common law marital union. Field v. Massey, 232 Ga.App. 524, 502 S.E.2d 349 (1998).

a. Knowledge of the existence of a marital relationship may bear upon a health care provider's ability and willingness to disclose the existence of certain health conditions.

Under Georgia law a health provider is permitted, though not required, to disclose knowledge of a patient's infection with the HIV virus to the patient's spouse. O.C.G.A. § 24-9-47(g). While a health

care provider is permitted to also disclose knowledge of infection to a patient's known sexual partner, determining marital status is easier than determining possible sexual engagement. The reality is that health providers are far more likely to disclose knowledge of infection to a spouse than an assumed lover.

b. The presence of a marital relationship will bear upon the confidentiality of spousal communications.

The significance of the presence of the marital relationship bears upon the character of the confidentiality of communications between a husband and wife, in the presence of a MHP. Under Georgia law, a spouse may prohibit their partner from testifying about spousal communications. This privilege extends beyond the marital relationship. Because communications with a licensed MHP are also confidential, communication during marital counseling would presumptively retain its confidential character. See generally, Sims v. State, 251 Ga. 877, 881, 311 S.E.2d 161, 165 (Ga. 1984). However, this protection may be weakened as to couple's therapy, because of the absence of a privilege as between the therapeutic participants.

c. The presence of a marital relationship may influence a paternity determination and the rights and obligations attendant thereto.

Additionally, children born outside of the marital bounds are not presumed to be the child of the co-habitant putative father. However, this distinction is largely academic. Under Georgia law, a father who

signs a birth certificate or who holds the child out as his own is generally conclusively presumed to be the parent of a child born outside of the bonds of marriage. See O.C.G.A. § 19-7-46.1. Paternity can also be proven through judicial decree. See O.C.G.A. § 19-7-49. Additionally, a child born out of wedlock can be legitimated if the child's presumptive parents later marry. However, a co-habitant who has not been identified as the parent of a child is not authorized, absent express consent of a legally recognized parent, to consent to or direct the treatment of their co-habitant's child. Additionally, outside of the context of requesting emergency assistance, a non-adopting step parent may not, without the express consent of both custodial parents consent to or direct the treatment of their spouse's children.

All children born within the bounds of a marital relationship are presumed to be the children of the married couple. This presumption can be overcome, but only through judicial process. Under Georgia law, DNA testing has been recognized as a conclusive measure of paternity. For as long as the marital relationship lasts, both natural parents are authorized to consent to and direct the treatment of their minor children. Moreover, as minors are incompetent to contract it is unlikely that a child would be able to enter into a therapeutic relationship without parental approval or governmental intervention.

A minor child may however independently consent to treatment for venereal diseases and substance abuse that involves the use of illicit drugs. See O.C.G.A. § 31-17-7(a); O.C.G.A. § 37-7-8(b). However, this treatment must be overseen by a licensed physician. Additionally, while a MHP providing a child requested treatment is not required to disclose the nature and character of the treatment to the child's parents, they may inform the child's parents of the treatment even over the child's protest. See O.C.G.A. § 37-17-7(b).

II. THE EFFECT OF DIVORCE

Upon divorce or the dissolution of the marital relationship child custody is determined by agreement of the parties or judicial decree. Various factors, beyond the scope of this article, go into this determination. Additionally, parental rights may be terminated through judicial decree or transfer, by way of adoption.

a. Child custody may influence a parent's ability to consent to, direct, and participate in their child's medical care.

Categories of child custody include: joint legal custody, joint physical custody, concurrent joint legal and physical custody, and sole custody. Where the provisioning of mental health services are concerned the relevant custodial rights are legal custody and sole custody. Only parents with legal custody have an unfettered right to provision and direct the mental health treatment of their child.

However, a custodial parent, who does not have legal custody of the child, may provision and direct medical treatment for a child during the child's sanctioned visitation periods. See, e.g., In re C.R., 257 Ga.App. 159, 159, 570 S.E.2d 609, 610 (Ga.App. 2002) (granting a third-party with temporary custody of a child who had been adjudged deprived the right to make medical decisions for the child). That being said, the parent granted legal custody is defined as the parent responsible for making determinations about the child's medical care. See O.C.G.A. § 15-11-13. Therefore, in the absence of a showing of deprivation, treatment decisions should generally be made by a parent having legal custody of the child.

It should also be noted that a non-custodial parent may have visitation rights, but lack any authority to request anything other than emergency care on the child's behalf. McCall v. McCall, 246 Ga.App. 770, 773, 542 S.E.2d 168, 170 (Ga.App. 2000). Also a parent without custodial rights may lack a right to view a child's medical records. See GAJUR FAMLAW § 9:1. A MHP is advised to request a court order directing their conduct in relation to the provisioning of mental health services or the examination of medical records where a dispute as to rights of access arises. It is also important to note that the character of parental rights are usually precisely defined within the relevant custody decree, a MHP would be well served to discuss the character

of the custody agreement with both parents before undertaking the treatment or diagnosis of a minor child of divorced parents.

b. Divorce may create ambiguity as to who has access to records relate to joint therapies.

Joint treatment received during the marital relationship also presents a problem upon dissolution of the marital bond. Typically, spouses embroiled in divorce will seek access to records of joint mental health treatment. The MHP may be forced into the status of an unwitting expert for either side where his mental impressions or treatment notes become litigation tools. However, in the absence of a judicial decree requiring production of specified documents this risk should not cause Georgia MHPs considerable distress.

1) Access to Mental Health Records Generally

Generally, medical records may be presumed to be the property of the MHP maintaining them. Unlike other medical records, under Georgia law, mental health records do not have to be delivered to the patient upon written request. In fact Georgia law expressly exempts mental health records from statutorily required disclosures. See O.C.G.A. § 31-33-2. However, where a facility is licensed by the Georgia Department of Human Resources to treat, receive, or evaluate recipients of state assistance, the Georgia Mental Health Code (MHC) requires that the records be maintained by the licensing entity and released under prescribed circumstances. O.C.G.A. § 37-3-166.

Additionally, under the MHC the client is afforded limited access to examine all records kept in his name by the treating facility or agency.

2) The Complication to Records Access Caused by Joint Therapies

However, the availability of patient access to mental health records is complicated where joint therapies are involved. Some states hold that where joint therapies are involved the model applicable to joint representation by an attorney should be followed.

See Samuel J. Knapp & Leon VandeCreek, *Privileged Communications to Psychotherapist in Pennsylvania: A Time For Statutory Reform*, 60 Temp. L.Q. 267, 287 (Spring 1987). Under the attorney-client model joint representation effectively vitiates certain confidences between the represented parties. Additionally, communications made in the presence of a third party generally serve to destroy the communications confidential character.

In spite of this, the Georgia Court of Appeals in *Mrozinski v. Pogue* made it clear that communications made during the course of joint therapies remain confidential, even as to a third-party participant. In *Mrozinski* a wife sought to compel the disclosure of therapeutic records relating to family therapy her ex-husband participated in with their daughter. The court emphatically held that participation in joint therapies does not act to waive the patient's right to insist upon confidentiality.

Perhaps nowhere is the patient more reluctant to reveal his true feelings and thoughts than in family therapy; for that very reason the viability of the privilege is essential. The privilege may be particularly important where the psychiatrist, in treating one person and knowing of another's deep concern for that person, encourages him to participate in therapy with the original patient. The strongest public policy considerations militate against allowing a psychiatrist to encourage a person to participate in joint therapy, to obtain his trust and extract all his confidences and place him in the most vulnerable position, and then abandon him on the trash heap of lost privilege. Mrozinski v. Pogue, 205 Ga.App. 731, 733, 423 S.E.2d 405, 408 (Ga.App.1992).

3) The Influence of the Health Insurance Portability Access Act Upon a Clients Access to their Records

Additionally, under the Health Insurance Portability and Accountability Act (HIPAA) patients are permitted access to medical records, including their mental health records, upon written request. However, expressly exempted from this mandate are "psychotherapy notes" and records relating to communications made by a third party with an expectation of confidentiality. 45 CFR § 164.524 (a)(1)(i), 45 CFR § 164.524 (a)(2)(v).

Additionally, a MHP may refuse to provide records where the records include reference to a third-party who the MHP believes in their professional judgment would be "substantially harmed" by the disclosure. 45 CFR § 164.524 (a)(3)(ii). The meaning of "substantially harmed" within this context has not yet been determined, however, it is evident that "Department of Health and

Human Services” in enacting the legislation did not intend the anticipated harm to include the “endangerment of life or physical safety”. Compare 45 CFR § 164.524 (a)(3)(ii) to 45 CFR § 164.524 (a)(3)(i).

Should written request under HIPAA be made, a written response citing the reason for refusal must be provided within the require time period for response. If the reason for refusal is that the matter request constitutes a “psychotherapy note” or confidential third-party comment than the refusal must be accepted by the patient as legitimately asserted. If however the reason for refusal is that the disclosure would cause harm to a third-person, than the requesting patient has a right to request independent review by an unaffiliated MHP. This third-party will rule on the legitimacy of the objection, and both parties are bound by the determination.

The import of these various interlocking statutory schemes suggest that in the absence of express consent from all engaged parties, records relating to joint therapy should be disclosed to participants in a redacted form, excluding all references to the non-requesting participant. It is also apparently within MHPs rights to retain all privately maintained treatment notes, as opposed to treatment records, from a patient’s view. However, when dealing with current patients, licensed state service providers may do well to

include a notation indicating the certain notations have been withheld from patient review in order to protect the patient's mental health. See Ga. Comp. R. & Regs. r. 290-4-6-.05 (3)(a).

III. The Duties of Confidentiality and Privileged Communications

While these topics have been touched upon above, MHPs owe their patients two interrelated duties. The first is a duty to retain confidences and the second is a duty to withhold privileged communications from judicial consideration. Breach of either of these duties may subject MHPs to tort liability. It should be noted that an MHPs ethical duties may create a duty that the law does not recognize. Specifically, un-licensed MHPs may be required by the applicable professional standards to retain confidences that the law of Georgia does not protect. However, even unlicensed MHPs who engage a client in a relationship in which confidence and trust is imposed may owe that client an independent fiduciary duty of loyalty and confidence. O.C.G.A. § 23-2-58; But note Foster v. Swinney, 263 Ga.App. 510, 513, 588 S.E.2d 307, 310 (Ga.App. 2003) (refusing to address whether MHPs can rightly be viewed as a fiduciary).

a. It is important for a MHP to disclose the limits of confidentiality at the outset of the therapeutic relationship.

It is important for a MHP to cover the limits of confidentiality with the Plaintiff before treatment begins. See APA Ethical Guideline, § 5.01. A common practice of MHPs around the nation includes requesting that a client sign a recognition of these limits of confidentiality and a consent to receive treatment subject to the same. However, as noted by the court in Hicks v. Talbott Recovery System, Inc., 196 F.3d 1226, 1239 (11th Cir. 1999) disclosures that are not specifically authorized or required by other law will give rise to a tort cause of action. Therefore, blanket consent to disclosure of patient confidences is not likely to be effective.

In Hicks a physician who was directed to receive counseling in connection with discovered substance abuse, sought and received a battery of treatment interventions. Hicks requested that certain records be released to the Texas Medical Licensing Board, however, the facility who provided the treatment sought by Hicks forwarded records in which Hicks revealed a continuing sexual addiction and past incidence of sex with patients. These revelations occurred during psychotherapy that began on a date outside the scope of the consented release of records. As a result of learning of Hicks' sexual conduct, the Texas Medical Licensing Board significantly restrained his ability to practice medicine. The court held that the facility violated its fiduciary and professional duty by making the unauthorized disclosure.

b. It is important for a MHP to understand their obligations in connection with third-party request for the production of medical records.

A context in which an action seeking recovery for unauthorized disclosure of medical records often arises is in the context of a third-party request for the production of documents. It is therefore important for MHP to understand the procedure that must be taken by a party requesting the production of documents relating to medical care.

Under Georgia law a party is permitted to request the production of documents that may have bearing upon the subject matter of a civil dispute. However, this right is not without limitation. Matters that are privileged or irrelevant may not be inquired into. The scope and character of the privilege applicable to communications between a MHP and his client will be later discussed; however inquiries into a party's mental health and treatment are generally irrelevant, even where the party's mental health is placed in dispute. In re Vincent, 240 Ga.App. 876, 879, 525 S.E.2d 409, 412 (Ga.App. 1999).

1) Patient Consent to the Release of Medical Records

Notwithstanding this fact, a patient may consent to the disclosure of medical records. Under O.C.G.A. § 9-11-34(c)(2) a party requesting the release of medical records must inform the person whose records are sought of the request and allow them ten (10) days

to object. Upon the patients failure to object the health professional may produce the requested documents. Jones v. Abel, 209 Ga.App. 889, 890, 434 S.E.2d 822, 824 (Ga.App. 1993).

2) Client Consent to the Release of Mental Health Records

However, where records relating to mental health treatment are requested failure to timely object will not amount to a waiver of a patient's right to object. Kennestone Hosp. v. Hopson, 273 Ga. 145, 149, 538 S.E.2d 742, 745 (Ga. 2000); Sletto v. Hospital Authority, 239 Ga.App. 203, 206, 521 S.E.2d 199 (1999). In Kennestone Hosptial a patient filed suit against a mental health care provider who produced the patient's records pursuant to a properly offered discovery request. In spite of apparently being notified of the request the patient failed to notify the care provider of her objection. Relying upon this silence as consent the provider provided the requested documents. The Georgia Supreme Court, noting the profoundly personal character of disclosure made during mental health counseling sessions held that waiver of the right to keep the subject matter of these exchanges confidential require the patient's "decisive, unequivocal conduct reasonably inferring the intent to waive." Kennestone Hosp. v. Hopson, 273 Ga. 145, 148, 538 S.E.2d 742, 745 (Ga. 2000).

Deriving instruction from the Kennestone court, it is advisably for a MHP to lodge an objection to all requests for the production of patient records, within 10 days of the request. In the same regard, a MHP is prohibited from offering testimony in the form of an oral account or a written affidavit disclosing the content or character of a patient's treatment. See Cornelius v. Hutto, 252 Ga.App. 879, 883, 558 S.E.2d 36, 40 (Ga.App.2001).

The reason for the distinction between the treatment of medical records and mental health records can be traced to the fact that exchanges between licensed MHPs and their clients are privileged while exchanges between other health care providers are not. Exchanges related to the provisioning of medical care are not privileged because a doctor's diagnosis ultimately derives from an empirical source, the patient's body. However, the provisioning of mental health care relies almost exclusively upon the patient's account of their own experience. Therefore, an assurance of patient candor is more important to a MHP than it is to a doctor dealing exclusively with somatic injuries. Because of this distinction, doctors -and not MHPs- are protected by what is known as the physician shield statute. This statute protects doctors from tort liability for disclosing details of medical treatment where the disclosure is issued pursuant to a request made in connection with pending litigation.

c. The duty of confidentiality and the client's right to privilege therapeutic communications are closely related.

The MHP's duties of confidentiality and privilege are so closely intertwined that it has been said that a MHP's duty to retain confidences is defined by the privilege that attaches to the therapeutic interaction. See Robert B. Remar & Richard N Hubert, Law & Mental Health Professionals, Georgia § 3.4 (American Psychology Association 1996). Therefore, determining the special duty of confidence owed by a MHP requires an examination of the limits of what we will refer to as the therapist-client privilege.

1) Covered Professionals

As previously mentioned the therapist-client privilege extends only to licensed MHPs. Gore v. State, 251 Ga.App. 461, 463, 554 S.E.2d 598, 601 (Ga.App. 2001). However, this duty might extend to cover those that provide mental health services under the direct supervision of a licensed professional. Plunkett v. Ginsburg, 217 Ga.App. 20, 21, 456 S.E.2d 595, 597 (Ga.App. 1995). Direct supervision by a qualified licensed MHP is essential to the extension of the privilege to non-licensed health care provider. See Myers v. State, 251 Ga. 883, 310 S.E.2d 504 (1981) (holding that a nurse who was employed by a hospital where a psychiatrist was authorized to practice was not an agent of the treating psychiatrist).

The statute that creates the therapist-client privilege expressly enumerates those professionals covered to include: psychiatrists; licensed psychologists; licensed clinical social workers, clinical nurse specialist in psychiatric/mental health, licensed marriage and family therapists, and licensed professional counselors. O.C.G.A. § 24-9-21. Interestingly, because there are no special licensing requirements for a psychiatrist the definition of a covered psychiatrist has been left to judicial interpretation.

The Georgia Supreme Court therefore was required to define a psychiatrist as “a person licensed to practice medicine, or reasonably believed by the patient so to be, who devotes a substantial portion of his or her time engaged in the diagnosis and treatment of a mental or emotional condition, including alcohol or drug addiction.” Wiles v. Wiles, 264 Ga. 594, 597, 448 S.E.2d 681, 684 (Ga. 1994). Therefore, the assertion of the therapist-client privilege may require a threshold showing that the treating physician regularly provides assistance in connection with mental or emotional disorders.

2) Covered Interactions

Once the character of the treating MHP has been identified as within the ambit of the relevant statute’s protective scope it must next be determined whether the interaction was essentially therapeutic in character. Where a court or regulatory agency has compelled

examination of an individual by a MHP the privilege is not said to attach. Here the evaluation is not undertaken in connection with treatment, but in connection with a judicial or pseudo-judicial process. Trammel v. Bradberry, 256 Ga.App. 412, 423, 568 S.E.2d 715, 725 (Ga.App. 2002) (no privilege attaches to communications made in connection with a involuntary commitment proceeding). Likewise, no privilege attaches where an individual engages in conversation with a covered MHP for a private purpose not connected with that individual's treatment. See Fulbright v. State, 194 Ga.App. 827, 827, 392 S.E.2d 298, 299 (Ga.App. 1990) (where conversations related to a MHP's anticipated trial testimony were not viewed as privileged).

It should be noted that a privilege attaches only where the client voluntarily seeks treatment. In re L.H., 236 Ga.App. 132, 511 S.E.2d 253 (1999). However, the independent selection of a MHP will be sufficient to give rise to a therapeutic privilege, even where the initial desire for treatment is compelled.

3) Waiver of Privilege

An individual may also expressly or impliedly waive the therapist-client privilege. It first should be noted that the therapist-client privilege is intended to protect only the client, not the MHP or third-parties who may be mentioned during therapeutic sessions. See Johnson v. State, 254 Ga. 591, 331 S.E.2d 578 (1985). In light of this

the client may waive the privilege where they call a MHP professional to testify on their behalf. See Fields v. State, 221 Ga. 307, 144 S.E.2d 339 (1965).

Additionally, where the client's current mental health is placed into dispute by the client than the privilege may be said to be waived. Stevenson v. Stanley Bostitch, Inc., 201 F.R.D. 551, 557 (N.D.Ga. 2001). An assertion of a claim seeking recovery for intentional infliction of emotional distress may act to waive the therapist-client privilege, however, a request for damages incident to emotional distress does not. Id. Likewise an assertion of positive mental health will also act to impliedly waive the therapist-client privilege. See In re M.E., 265 Ga.App. 412, 421, 593 S.E.2d 924, 932 (Ga.App. 2004).

IV. Mandated Reporting

a. A MHP is required to report suspected incidence of child abuse.

The therapist-client privilege also does not protect against disclosures required under other positive law. Under Georgia law a licensed MHP is required to report suspicions of child abuse. See O.C.G.A. § 19-7-5. In addition to licensed MHPs child welfare agency personnel, child-counseling personnel, child service organization personnel, school employees including teachers, school counselors, and school administrators, and other are required to report suspected incidence of child abuse. However, mere training or expertise in psychology or human development will not compel an individual to report suspected abuse. Gladson v. State, 258 Ga. 885, 376 S.E.2d 362 (1989). The failure to report known incidents of abuse may result in criminal penalties for the non-disclosing individual. Reporting should be made immediately either to a designated supervisor or an identified designee of the Department of Human Resources. Assuming that the report is made in good faith a mandated reporter can not be held criminally or civilly liable for the report.

b. A MHP is permitted to report HIV infection and a minor's drug use to a limited class of people.

Additionally, while reporting is not required licensed medical MHPs are authorized to report knowledge of client's infection with HIV

to either a minor child's parents or those he reasonably believes are at risk of being infected, including other health professionals. See O.C.G.A. § 24-9-47(g); O.C.G.A. § 31-22-9.1(g). A similar right exist in connection with known drug usage.

- c. A MHP is permitted, and possibly required, to disclose certain otherwise privileged communications when a patient threatens to injure themselves or others.**

Finally MHPs are required to warn third parties of a specific threat made by a patient under their care. In Bradley Center, Inc. v. Wessner, 250 Ga. 199, 201, 296 S.E.2d 693, 695 (Ga. 1982) a defendant-physician was found to be potentially liable for the death of an individual killed by a mental patient whose temporary release from confinement had been authorized by the physician. The court held that where, in the course of treatment, a physician exercises control over the freedom of a mental patient, and where it is reasonably foreseeable that the patient will cause bodily harm to others if released from confinement, a person so injured may maintain a cause of action against the physician, regardless of privity. However, where the treating facility or MHP is not authorized to exert physical control over an individual who eventually causes harm to another liability for the intervening criminal act can not flow to the MHP of treating facility. See Baldwin v. Hospital Authority of Fulton County, 191 Ga.App. 787, 790, 383 S.E.2d 154, 157 (Ga.App. 1989).

The controlling rule apparently requires a right of control in order for liability to injured third-parties to follow. However these is authority indicating that a MHP with knowledge of a specific threat of harm may be obliged to warn a foreseeable victim of that threatened

harm. In Jacobs v. Taylor, 190 Ga.App. 520, 527, 379 S.E.2d 563, 568 (Ga.App. 1989), the court tacitly held that while there is no duty to warn the public at large of a patient's violent predisposition, a MHP may have a duty to warn unwitting potential victims of an announced threat to do the victim harm. See also, Anneewakee, Inc. v. Hall 196 Ga.App. 365, 367, 396 S.E.2d 9, 10 (Ga.App. 1990).

Additionally, a MHP is obliged to protect a client who has articulated a desire to harm themselves. This duty is especially pronounced because of the fact that the client presumptively contracts with the treating therapist to protect against the very injury suffered. Purcell v. Breese, 250 Ga.App. 472, 476, 552 S.E.2d 865, 868 (Ga.App. 2001). Therefore, if within the exercise of appropriate professional care the treating MHP could have come to be aware of the threat the client posed to himself than failure to take affirmative steps, including disclosure of confidences, to provide for the clients well being will give rise to an action alleging professional neglect. See, e.g., Brandvain v. Ridgeview Institute, Inc. 188 Ga.App. 106, 113, 372 S.E.2d 265, 271 (Ga.App. 1988).

V. Conclusion

As discussed above a MHP has a unique obligation to his or her clients. While a MHP is required to preserve client confidences, circumstances may require the disclosure of information that was

communicated solely because of the client's expectation of non-disclosure. In addition to navigating the impact the decision to break trust may have upon the therapeutic relationship a MHP must also consider to the legal implications of a decision to retain or disclose a confidence.

While when to retain confidence is not precisely defined the principals discussed above, supplemented by your own discretion, will ensure that you safely navigate potentially treacherous terrain. It must be remembered that professional supervision, ethical hotlines maintained by the relevant licensing board, and legal counsel are all available to help you reach an informed and fully considered decision when faced with the complex legal and ethical obligations implicated by your duty to preserve client confidences.

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