AAPL EXAMINER
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AAPL: Ask the Experts

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Neil S. Kaye, MD, DFAPA, Graham Glancy, MB, ChB, FRC Psych, FRCP (C), and Ryan Hall, MD will answer questions from members related to practical issues in the real world of Forensic Psychiatry. Please send questions to nskaye@aol.com.

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Q. Do mandated reporting laws apply to forensic evaluations?

Kaye:

Once again, our readers seek to stump us! This question should be analyzed from multiple perspectives: ethics, morals, and, of course, legal. While this is primarily a question seeking legal advice (and we are not lawyers-see disclaimer above), as forensic psychiatrists we are expected to have some familiarity with the law, especially as it pertains to the work we do as physicians. Generally, State law governs the practice of medicine, and so one must be familiar with your specific state's laws on this subject.

There are three broad yet common areas where mandatory reporting duties arise: duty to warn or protect a third party (Tarasoff [1] and progeny [2]) duty to report suspected elder abuse/exploitation, and duty to report child abuse/child sexual abuse (CSA.) While in most cases, the duty to warn requires a doctor-patient relationship, there are exceptions. The situation is analogous to when an evaluee reveals acute suicidality with a plan; one is duty-bound to take steps to intervene to save a life even if this violates the evaluator-evaluee relationship. Most States allow for involuntary detention for a fuller evaluation as part of

their civil commitment statutes. In the duty to warn scenario, however, the duty flows through the evaluee to a third party.

In the recent (2020) case of Maas v UPMC [3] the duty to warn/protect was extended to an identifiable class of people and the previous limitation of a clearly identified third party was vacated. The duty was extended to encompass *all persons who are members of a specific and identified group that is finite, homogenous, and united by common circumstance if one member of that group is threatened but not specifically identifiable*.

I practice in Delaware, where our mandatory reporting law is essentially all-encompassing and requires anyone and everyone (not just medical professionals, but all members of the public) to report any suspicion of possible abuse of a child, even if it occurred years ago so long as the possible victim was a minor at the time. Yes, that means if a 70-year-old evaluee sent for a testamentary capacity evaluation reveals they were abused by their deceased father, 65-years ago, when they were a child, this must be reported; mandatory reporting means mandatory. The police and CPS and the AG's office will investigate the case, and there are criminal penalties for a clinician's failure to report.

Our AG's office has gone so far as to assert that even if one simply learns or suspects this "abuse" may have occurred, even if only through a record review, the duty to report is triggered. From experience, this is overly burdensome, onerous, requires hours of time, and is not followed by most of the citizens (including professionals) in the State. Experience has shown that when a report has been made, unless there is significant identifying evidence available and a clear present risk or suggestion of ongoing abuse, nothing happens.

Glancy:

The Hippocratic Oath states, "Whatsoever things I see or hear concerning the life of men, in my attendance on the sick … I will keep silence thereon, counting such things to be as sacred secrets" [4]. From this central tenet of medical ethics, we have always considered privilege and confidentiality central to the physician-patient relationship. In most jurisdictions, this standard has been protected by regulation or legislation.

There has been a gradual development in circumstances where the breaching of confidentiality is considered less harmful and, on balance, beneficial to the interests of society. This has led to both discretionary and mandatory disclosure, which are defined and are specific to a situation. The concept of duty to protect and to warn is one of these

specific situations. The landmark cases that began this involution were the Tarasoff cases in 1974 and 1976 [1]. It has been noted that these cases have introduced a duty of care flowing through the patient to a third party, the third party being an identifiable victim. Tarasoff II amended the concept of the duty to warn an intended victim to a duty to protect.

It is, in my opinion, a good thing that Canada is often 20 years behind the United States in progressive legislation. It was not until 1999 that are Supreme Court ruled on this concept in the case of Smith v Jones. Dr. Roy O'Shaughnessy, former president of AAPL [5], assessed an evaluee who was referred by his lawyer for a presentence report. The evaluee had assaulted a sex worker and admitted to the doctor that he had fantasies of abducting and murdering other sex workers. Pertinently, he also described that he had the means and equipment to carry out his plans. Dr. O'Shaughnessy retained counsel and commenced an action to breach confidentiality in order to warn this group of victims.

The case was fast-tracked to the Supreme Court of Canada, who clearly articulated a duty to warn and protect an identifiable victim of a group of victims. This case clearly took into account not only the doctor-patient relationship, but also the highest privilege in the land, namely the solicitor-client relationship. Because of, and based on this case, similar to AAPL [6], the Canadian Psychiatric Association developed a guideline articulating the standard of care for Canadian psychiatrists [7].

This doctrine clearly sets out that all psychiatrists, including forensic psychiatrists, should warn patients and evaluees that the limits of confidentiality include, amongst other things, the duty to protect, warn, or inform in the event of a risk of severe bodily injury, death, or serious psychological harm to a clearly identifiable person or group of persons, when there is an element of imminence, creating a sense of urgency. The AAPL guideline for the forensic assessment [6] and the equivalent CAPL guideline [7] suggests that evaluees be informed of the limits to confidentiality at the beginning of any assessment and that this should include the duty to warn and protect should the situation arise [8,9].

Hall:

As always, my learned colleagues have made some excellent points regarding the ethics and case-law aspects of the question, which allows me to focus more on some of the practical concerns regarding the evaluation itself. Although most jurisdictions have an ethical and legal reporting statute for various situations (child abuse, elder abuse), it is not usually a continuous reporting statute. To put it simply, if abuse has already been reported and investigated, it is not usually the evaluators' obligation or duty to keep reporting it again and again. This is where documenting a thorough history, including if the appropriate authority (Child Protective Services, Elder Protection, or law enforcement) is already involved.

Often concerns or allegations of abuse have already been reported to the various legal authorities and court system by the time your forensic evaluation is occurring. In some instances, the abuse claimed by one party is being strongly denied by another. This may raise concern over the reasonable suspicion element for the evaluator. There is also the potential for exaggeration or outright malingering for many possible reasons (financial, retribution, avoidance of consequences, custody) [(10)]. Remember, most state laws require mandatory reporting based on only a suspicion or a claim. The actual fact finding and determination as to whether or not abuse occurs is not the purview of the forensic psychiatrist, rather it belongs to other authorities and arguably to the final trier of fact.

If the evaluator has reasons to suspect that abuse occurred, is still occurring, or that others are in danger, reporting the suspicion to outside authorities may raise concerns over the motivation for the report, but it is still required in some states. If there are legitimate concerns for current or ongoing harm during the legal process, consider discussing these concerns with the attorney who retained you. However, remember they are not your lawyer and do not necessarily have your protection as their interest. Checking with your own lawyer or with your medical malpractice insurance carrier may be a more worthwhile endeavor.

In these situations, emergency protective orders can be sought through the judge presiding over the case. This limits the chances of the evaluator being accused of being unduly biased or acting in bad faith. Although there is often immunity when mandatory reporting is done, this immunity only applies if the reporter is acting in good faith. It is also quite likely that if you do mandatory reporting, you will no longer be able to act as an expert in the case since your opinion will be "tainted" by your action.

A more difficult issue arises when someone has already reported abuse while in treatment or is noted to have had past treatment where abuse was identified. Since it is the standard of care to report, many practitioners may assume that a report was already made. Again, reporting an incident that has already been reported can be counterproductive and potentially harmful (e.g. clogs the system, takes resources away from new and active cases, and potentially stresses individuals who have already had the issue reported and theoretically investigated) but in some jurisdictions is still mandatory. The law tends to favor potential protection under the doctrine of *parens patriae* over facilitating treatment for those in need. This is why so many people will not disclose abuse, as they do not want themselves or the perpetrator to be investigated or exposed.

This raises the question of whether a forensic evaluator or new treater can reasonably assume a past treating therapist, who made a mandatory report has already addressed the issue. As noted by Dr. Kaye, depending on jurisdiction, the answer may be no. So, again it is important to know the laws that apply to the jurisdiction in which one is practicing and to take a history that includes whether it was an issue discussed in past therapy and, if possible, try to determine if an official investigation occurred or not.

Evaluators also need to be cognizant of their role and the type of evaluation they are doing and how that may affect the evaluee's presentation. For example, someone may overstate what occurred to them, as well as their symptoms (e.g. suicidal thoughts, flashbacks,) in an attempt to have a "stronger civil case" or to be relocated in a criminal case.

As noted in the AAPL Practice Resource for the Forensic Evaluation of Psychiatric Disability if there is concern about imminent harm to self or others, one of three approaches may be the best course of action:

1. Encourage the person to seek a higher level of treatment (seek voluntary evaluation or admission to a hospital, make an appointment with a current treater in close proximity to the evaluation)
2. Report the concern to the individual's attorney (either directly or through the attorney who retained the evaluator). The individual's attorney is also theoretically ethically bound to work for their client's best interest and can have additional assessments done without jeopardizing the expert's direct objectivity or raising questions regarding the motivation of the evaluator
3. Discuss or relate the concern to the evaluee's current treating doctor, if one exists, who has a stronger doctor-patient relationship, to further assess the imminent situation and to determine if a higher level of treatment is needed [(11)]. A fourth option, if the other three are not considered appropriate, would be to initiate a civil

commitment, but this is likely a last resort since the evaluator does not have the traditional doctor-patient treating relationship, and the nature of forensic work may raise the question of potential biases and motivation for the commitment. Again, there may be unique challenges and issues for any of the options discussed above, and each evaluator will need to use their best judgment at the time to meet legal and ethical standards.

Take-Home Points:

In most situations and jurisdictions, mandatory reporting may apply to a forensic assessment. Psychiatrists need to be aware of the laws for mandatory reporting in both their clinical and forensic work. Each state has its own laws, and while most do not, some require continuous re-reporting of suspected or alleged abuse. Making the mandatory reporting requirement part of your disclosure statement at the onset of an evaluation is the ethically correct thing to do. Letting the lawyer know of your responsibility is also advised. Retaining outside counsel may be necessary and self-protection is advised.

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