TeleBehavioral Health 2025 Training Series

Behavioral Health Institute (BHI)
Harborview Medical Center
Website: https://bhinstitute.uw.edu
Email: bhinstitute@uw.edu

Northwest Regional
Telehealth Resource Center (NRTRC)
Website: https://nrtrc.org
Email: info@nrtrc.org

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Behavioral Health Institute (BHI)

Training, Workforce and Policy Innovation Center

The Behavioral Health Institute is a Center of Excellence where innovation, research and clinical practice come together to improve mental health and addiction treatment.

The BHI brings the expertise of Harborview Medical Center/University of Washington Medicine and other university partners together to address the challenges facing Washington's behavioral health system through:

- Clinical Innovation
- Research and Evaluation
- Workforce Development and Training
- Expanded Digital and Telehealth Services and Training

The BHI serves as a regional resource for the advancement of behavioral health outcomes and policy, and to support sustainable system change.

Northwest Regional Telehealth Resource Center (NRTRC)

Telehealth Technical Assistance Center

The NRTRC delivers telehealth technical assistance and shares expertise through individual consults, trainings, webinars, conference presentations and the web.

Their mission is to advance telehealth programs' development, implementation and integration in rural and medically underserved communities.

The NRTRC aims to assist healthcare providers, organizations and networks in implementing cost-effective telehealth programs to increase access and equity in rural and medically underserved areas and populations.

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Speaker Disclosures

None of the series speakers have any relevant conflicts of interest to disclose.

Planner disclosures

The following series planners and team have no relevant conflicts of interest to disclose:

Brad Felker MD
Cara Towle MSN RN
Topher Jerome
Mylinh Thao
Nicki Perisho RN
Jaleen Johnson

DISCLAIMER

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TeleBehavioral Health 2025

Clinicians' Duty to Protect in an Era of Telehealth: Legal and Clinical Considerations in Washington

JENNIFER PIEL, MD, JD

AUGUST 15,2025

Objectives

- Understand the legal basis for mental health professionals' duty to protect
- Review Washington law on the duty to protect
- Appreciate how to approach the duty from a clinical perspective

Question 1

You are required under Washington State law to warn identifiable victims of your patient's intended violence.

True or false?

a. True
b. False

Question 2

Breach of a patient's confidentiality may result in all of the following for a behavioral health clinician, ***EXCEPT***:

a. A tort suit
b. A criminal conviction
c. Sanction by state professional licensing board
d. Sanction by a professional organization (examples: American Medical Association, American Psychological Association)

Question 3

In *Volk v. DeMeerleer* (Wash. 2016), the treating psychiatrist was found liable for which of the following?

a. Failure to warn
b. Failure to seek involuntary hospitalization
c. Medical malpractice
d. The psychiatrist has not been found liable

Duty to Warn or Protect: Reactions to this term?

Balancing Act

- Protect patient confidentiality
- Protect therapeutic alliance
- Treat in least restrictive environment
- Protect others from patient's violence
- Difficulty with accurate violence prediction
- Liability concerns

Terms

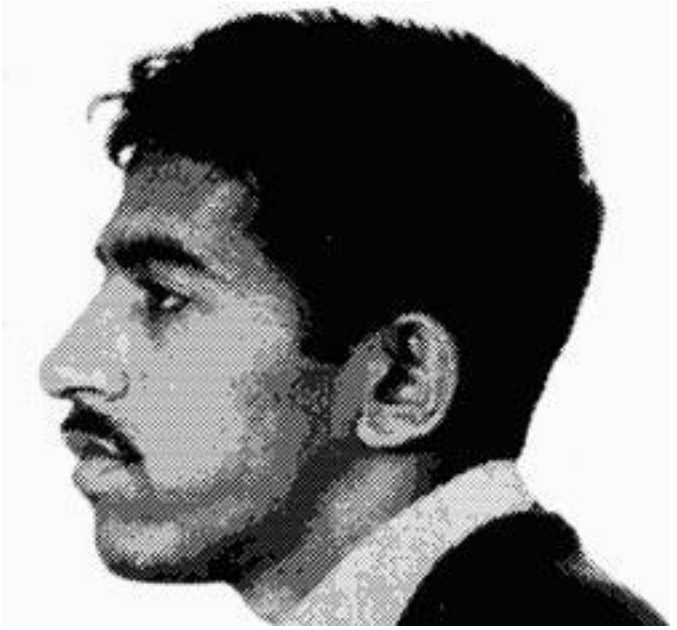
- Confidentiality
- Duty to warn
- Duty to protect
- Tarasoff-type duty
- Tarasoff-limiting law

Scenario

You are working on an outpatient mental health clinic. Your patient informs you that he has had violent fantasies toward his ex-girlfriend. She is currently out of the country.

What do you do?

The Beginning



Facts: Tarasoff

1968				1969
• Tarasoff and Poddar meet at school • Friendly	• Relationship becomes distant • Tarasoff travels abroad for three months	• Poddar starts therapy • Reveals thoughts to kill Tarasoff • Tarasoff not specifically identified but reasonably identifiable	• Psychologists notifies campus police • No direct warning to Tarasoff • Clinic director orders destruction of documentation on breach of confidentiality	• Poddar stalks and kills Tarasoff

Tarasoff v. Regents of the Univ. of California

- Tarasoff I (1974) : Duty to warn
  - *The protective privilege ends where the public peril begin*

- Tarasoff II (1976): Duty to protect
  - *When a therapist determines, or should determine, that his patient presents a serious risk of danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim from danger*

Notable Points

- *Tarasoff* relates to California law
- Duty to protect after *Tarasoff* II
- "Tarasoff" now used to refer, generally, to concept of duty to warn/protect

Post-Tarasoff Concerns

- Patients will not be honest with providers
- Patients will not seek care
- Patients often vent thoughts that are fleeting
- Risk of overreaction of clinician (liability)
- How to discharge the duty

Trends Post-Tarasoff

- Period of extensions (1980s)
  - To unidentifiable victims
  - To foreseeable but not identified victims
  - For unintentional harm
  - To property

- Period of retractions (1990s)
  - Further define what triggers the duty
  - Specific steps to discharge duty

Tarasoff-Limiting Laws

- Most statutes require either a “serious” or “actual threat” against a clearly “identified” or “reasonably identifiable victim(s)”

- Statutes identify one or more options to discharge the duty. For example:
  - Notify intended victim(s)
  - Notify law enforcement
  - Initiate hospitalization (voluntary, involuntary)
  - Other reasonable steps

Current Legal Landscape

Volk Study – UW Law School (2017)

- Mandatory obligations
  - "Warn and/or protect" (or similar) language: 19 states
  - "Warn": 9 states
  - "Protect": 5 states
- Permissive breach of confidentiality: 9 states
- Not addressed or no duty: 8 states

Reporting Laws

Mandatory	Permissive
Require health professionals and others to take affirmative measures under certain conditions Failure to follow these laws could lead to civil liability or other problems (e.g., professional licensing boards)	***Allow, but do not compel,*** health professionals and others to report without fear of civil liability, but do not require reporting

What is the law in Washington State?

Petersen v. State (1983)

- Committed to WSH on basis of GD and DTS
- Schizophrenic reaction to PCP
- Apprehended by campus police for reckless driving in parking lot
- Planned discharge next day
- Collision occurs five days later

Petersen v. State (Wash. 1983)

A state hospital psychiatrist has a duty to take reasonable precautions to protect anyone who might foreseeably be endangered by his patient

RCW 71.05.120 (1987)

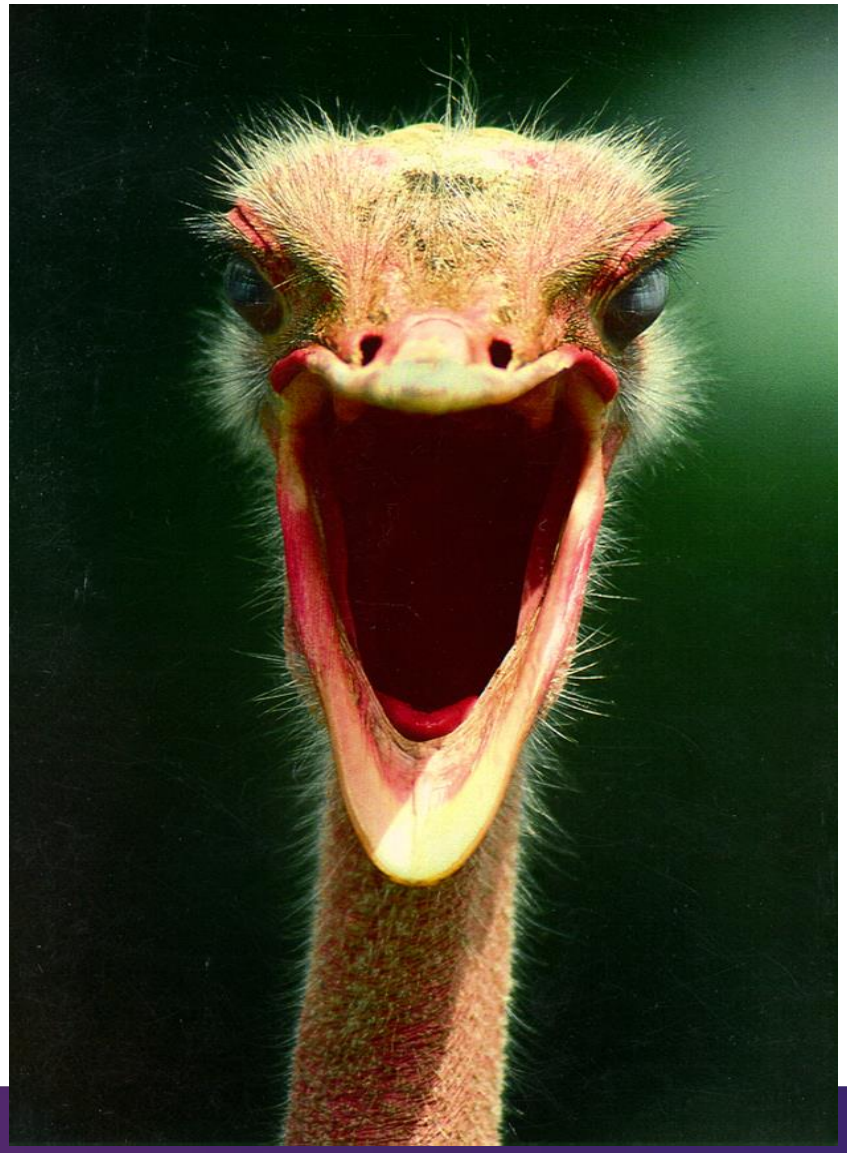
- This section does not relieve a person from . . . the duty to warn or to take reasonable precautions to provide protection from violent behavior where the patient has communicated an actual threat of physical violence against a reasonably identifiable victim or victims

- Discharge: warn victim and police

Volk v. DeMeerleer

- Familiar with *Volk v. DeMeerleer*?
- Read the legal decisions in *Volk v. DeMeerleer*?
- What is your reaction to the case decision?

This reaction?



Volk v. DeMeerleer

Volk v. DeMeerleer

Facts: Volk v. DeMeerleer

Facts from 2016 Case Opinion
Adapted from McDermott & Maher (2017)

2001	2003	2005	2009
• DeMeerleer begins treatment with Dr. Ashby	• Wife has affair • Divorce • Suicidal / homicidal • Would not act on thoughts • No identifiable target	• Relationship w/ Schiering • Volatile behavior • Family intervention • Mother contacts Ashby	• Schiering pregnant • Pregnancy ended • Conflict • Laid-off • Contacts clinic

Facts: Volk v. DeMeerleer

Adapted from McDermott & Maher (2017)

4/2010

- Last visit w/ Ashby
- Engaged to be married
- Marital counseling
- Suicidal / disavowed intent
- "Unstable"
- Cont. medications

3 months

7/16/2010

- Schiering ends relationship
- No contact w/ clinic

7/17/2010

- DeMeerleer kills Schiering, her son, and dies by suicide

Procedure: Volk v. DeMeerleer

- Suit filed by representatives of the victims
- Psychiatrist granted summary judgment
- Appellate court reversed (2014)
  - RCW 71.05.120(3) does not apply outside of involuntary commitment
- Washington Supreme Court upheld appellate court's reversal of summary judgment (2016)

Volk v. DeMeerleer (Wash. 2016)

Holding:

- Once there is a special relationship, a mental health professional is under a duty of reasonable care to act consistently with the standards of the mental health profession in order to protect the foreseeable victims from the dangerous propensities of his or her patient.

- The foreseeability of DeMeerleer's victims is a question of fact.

Key Considerations

- Terms left for clarification
  - Special relationship (conceded by Dr. Ashby)
  - Dangerous propensities
  - Foreseeable victim

- Applicability to various types of clinicians
  - Act consistently with the standards of the profession

How do you meet your legal and professional responsibilities under Washington law?

Approach

1. What triggers the duty?

2. Who needs protection?

3. How can the duty be discharged?

Comparison

	RCW 71.05.120	Volk
When triggered?	Actual threat of physical violence	Special relationship Dangerous propensities
Whom is duty owed? Or, who needs protection?	Reasonably identifiable victim	Foreseeable victim
How is duty discharged?	Warn (clean discharge) or protect	Measure to protect, which can include warning

Additional Comparison

	RCW 71.05.120	Volk
Type of violence protected by law	Intentional harm of violence	Broader, may include patient's negligent behavior
Dangerousness	Make a threat	Pose a threat

Technology-Perpetrated Abuse

- Cyber-stalking
- Cyber-monitoring (spyware)
- Online harassment
- Depletion of shared accounts (banking)

What are some ways you can protect a third party from your patient's acts of violence?

Practice Pointer: Means to "Protect"

Volk v. DeMeerleer (2016), n. 12

Court

- Closer monitoring of medication compliance
- Closer monitoring patient's mental state
- Increase family involvement
- Warning others of the risk posed by the patient
- Involuntarily hospitalization

Other

- Voluntary hospitalization
- Increase frequency of appointments
- Removal of weapons
- Refer to alcohol/substance abuse programs
- Address anger management (therapy)

Considering the "Foreseeable Victim"

Zone of danger

- Based on recent communications/behavior
- Historic acts of violence/threats of violence
- Types of violence
- Setting (bar, work, home)

Scenario

You are working in an outpatient mental health clinic. You have an appointment with a patient via video-based technology.

What are some considerations for cases involving the duty to protect when care is delivered over telehealth?

Responding to Duty-to-Protect Scenario

- Largely similar to face-to-face encounters
- Confirm the location of the patient
  - Emergency response/issue warning
  - Legal standard and resources
- Confirm alternate way to reach patient (phone)
- Gain familiarity with patient's surroundings
  - Items that could be used as weapons
  - Firearm at the location
- Understand who else might be present (caution IPV)
- Procedure for intoxication
- Procedure for driving
- Intentional disconnect as elopement

Limiting Liability

- BREATHE!
- Assess violence risk: A clinician is more likely to be found liable if they made a clinical judgment *without sufficient information* (e.g., fail to gather reasonable information) than when an informed clinical decision was made in good faith but turned out to be incorrect
- Apply clinical knowledge to the relevant legal standard
- Seek consultation
- Document

Return to Question 1

You are required under Washington State law to warn identifiable victims of your patient's intended violence.

True or false?

a. True
b. False

Take Home Points

- Washington State has statutory law and case law on the duty to protect
- The *Volk* standard is a ***duty to protect***, not a duty to warn
- Understanding the language of the law is instructive, but don't forget to gather sufficient information.
- Know the location of the patient.

Contact Information

Jennifer Piel, MD, JD

piel@uw.edu

Jennifer.Piel@va.gov

Center for Mental Health, Policy, and the Law (CMHPL)

cmhpl@uw.edu

After today's session:

Slides & resources will be posted after the session

https://bhinstitute.uw.edu/

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- LINK will be shared in the chat box and emailed
- Helps the presenters plan future sessions
- Required for:
  - Certificate of Completion – no cost.
    - May be able to use Certificate of Completion to meet CE requirements.
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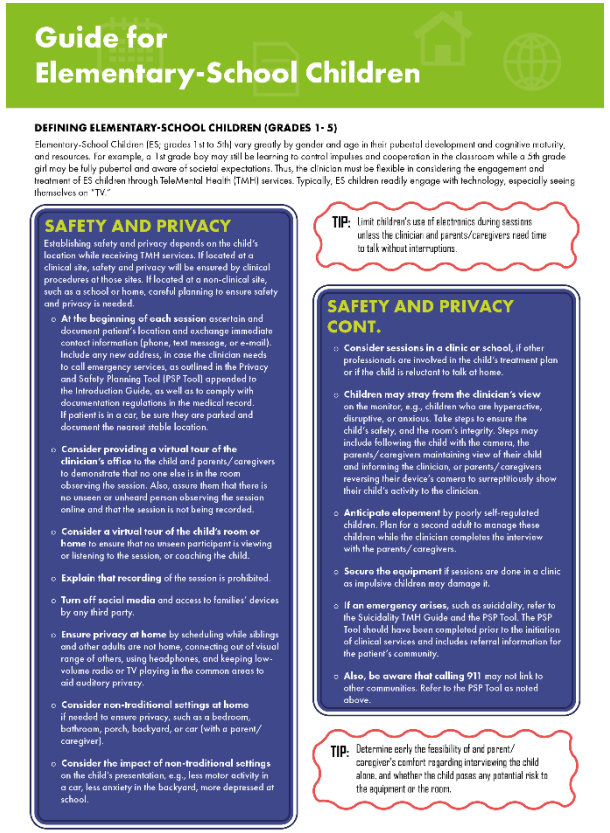
TeleMental Health Guides for Infancy to Young Adults

Guides (8)

- Infancy and Toddlers
- Pre-schoolers
- Elementary School Children
- Middle School Youth
- High School Teens
- Young Adults
- Neuropsychological Testing
- Suicidality



Guide for Elementary-School Children

DEFINING ELEMENTARY-SCHOOL CHILDREN (GRADES 1- 5)

Elementary-School Children (ES; grades 1st to 5th) vary greatly by gender and age in their pubertal development and cognitive maturity, and resources. For example, a 1st grade boy may still be learning to control impulses and cooperation in the classroom while a 5th grade girl may be fully pubertal and aware of societal expectations. Thus, the clinician must be flexible in considering the engagement and treatment of ES children through TeleMental Health (TMH) services. Typically, ES children readily engage with technology, especially seeing themselves on "TV."

SAFETY AND PRIVACY

Establishing safety and privacy depends on the child's location while receiving TMH services. If located at a clinical site, safety and privacy will be ensured by clinical procedures at those sites. If located at a non-clinical site, such as a school or home, careful planning to ensure safety and privacy is needed.

- **At the beginning of each session** ascertain and document patient's location and exchange immediate contact information (phone, text message, or e-mail). Include any new address, in case the clinician needs to call emergency services, as outlined in the Privacy and Safety Planning Tool (PSP Tool) appended to the Introduction Guide, as well as to comply with documentation regulations in the medical record. If patient is in a car, be sure they are parked and document the nearest stable location.
- **Consider providing a virtual tour of the clinician's office** to the child and parents/caregivers to demonstrate that no one else is in the room observing the session. Also, ensure them that there is no unseen or unheard person observing the session online and that the session is not being recorded.
- **Consider a virtual tour of the child's room or home** to ensure that no unseen participant is viewing or listening to the session, or coaching the child.
- **Explain that recording** of the session is prohibited.
- **Turn off social media** and access to families' devices by any third party.
- **Ensure privacy at home** by scheduling while siblings and other adults are not home, connecting out of visual range of others, using headphones, and keeping low-volume radio or TV playing in the common areas to aid auditory privacy.
- **Consider non-traditional settings at home** if needed to ensure privacy, such as a bedroom, bathroom, porch, backyard, or car (with a parent/caregiver).
- **Consider the impact of non-traditional settings** on the child's presentation, e.g., less motor activity in a car, less anxiety in the backyard, more depressed at school.

TIP: Limit children's use of electronics during sessions unless the clinician and parents/caregivers need time to talk without interruptions.

SAFETY AND PRIVACY CONT.

- **Consider sessions in a clinic or school,** if other professionals are involved in the child's treatment plan or if the child is reluctant to talk at home.
- **Children may stray from the clinician's view** on the monitor, e.g., children who are hyperactive, disruptive, or anxious. Take steps to ensure the child's safety, and the room's integrity. Steps may include following the child with the camera, the parents/caregivers maintaining view of their child and informing the clinician, or parents/caregivers reversing their device's camera to surreptitiously show their child's activity to the clinician.
- **Anticipate elopement** by poorly self-regulated children. Plan for a second adult to manage these children while the clinician completes the interview with the parents/caregivers.
- **Secure the equipment** if sessions are done in a clinic as impulsive children may damage it.
- **If an emergency arises,** such as suicidality, refer to the Suicidality TMH Guide and the PSP Tool. The PSP Tool should have been completed prior to the initiation of clinical services and includes referral information for the patient's community.
- **Also, be aware that calling 911** may not link to other communities. Refer to the PSP Tool as noted above.

TIP: Determine early the feasibility of and parent/caregiver's comfort regarding interviewing the child alone, and whether the child poses any potential risk to the equipment or the room.

TELEMENTAL HEALTH GUIDE FOR ELEMENTARY-SCHOOL CHILDREN

Case Example

Abdul is a 10 y/o Afghani refugee boy who presented with his mother due to the school's concern with his inattention and distractibility in class, restlessness and difficulty staying seated, yelling out answers impulsively, and falling behind academically. The Mother noted similar difficulties in the home, especially regarding homework. Both parents worked and lived in an urban neighborhood with poor transportation options, so they agreed to home-based TMH. The family used their smartphone for the sessions, with adequate, but not optimal, cell reception. Sessions were held in the parent's bedroom, for privacy. An older sister watched the siblings in another room or took them for a walk.

Abdul was readily engaged over the smartphone and told of his favorite videogame, his love of Legos, and his best friend at school, as well as the injustices of his siblings. The clinician conducted the interview by alternating between the mother's history and the child's input.

Even with the spotty connectivity, the clinician appreciated Abdul's good verbal skills, intellect, charming personality, as well his impulsive intrusiveness and mild mid-facial and guttural tic. To assess his gross motor skills, the clinician asked Abdul to do some movements, including some dance movements. He was awkward and had difficulty cooling down once wound up. To assess his fine motor skills, and to keep him occupied in order to obtain the mother's history, Abdul was asked to draw a picture of his favorite animal. He impulsively scribbled something and quickly returned to the smartphone to show his artwork: not an animal, but he enthusiastically told of its meaning, demonstrating his creativity and knowledge.

The clinician then asked Abdul to play with his Hot Wheels in front of his mother, allowing more time with the mother while monitoring Abdul. He did so, fairly quietly for a while, then became increasingly louder, and then disruptive. At various times, Abdul's mother quietly flipped the smartphone's camera to allow observation of Abdul's play without his knowledge. He did show symbolic play, although somewhat aggressive with the Hot Wheels breaking off some wheels.

Then, the clinician sent an ADHD rating scale and an anxiety rating scale to the older daughter's tablet so that the mother could complete these behavior reports in another room while the clinician spent some individual time with Abdul. The mother also logged into the school's website to check Abdul's grades, missing assignments, and the teacher's recent comments. Meanwhile, the clinician observed Abdul's play and engaged him verbally regarding his Hot Wheels. The clinician asked Abdul to trace his favorite Hot Wheel car and write the name of it along with his name on top of the paper. He showed some difficulties with tracing and penmanship but had correct spelling. He showed increased tic movements while engaged in this task.

The clinician made a diagnosis of ADHD with a concern about a fine motor disability and tics. They wrote a treatment plan on the "White Board" that included: a) the clinician requesting completion of behavior rating scales from selected teachers, to be uploaded into the clinician's website portal; b) making the child a "Focus of Concern" under Public Law 94-142 for further school evaluation and possibly special education services, and c) developing a structured plan for homework including turning it in reliably; and d) the mother reviewing the treatment plan on the website and reading information about ADHD treatment, including using behavior charts. As the family did not have a printer, the clinician also sent a hard copy of the treatment plan and readings. They made a plan for the mother to meet alone with the clinician in a week to set up a behavior program and discuss the relevance of a medication trial, consistent with evidence-based treatment for ADHD.

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Additional Free Resources for Washington State Behavioral Health Providers

EDUCATIONAL SERIES: 12.00pm to 1.30pm PST

- UW Traumatic Brain Injury – Behavioral Health ECHO (Fridays) → → →
- UW Psychiatry & Addictions Case Conference ECHO (Thursdays)
- **UW TelePain series (Wednesdays)**

PROVIDER CONSULTATION LINES

- **UW Pain & Opioid Provider Consultation Hotline**
- Psychiatry Consultation Line
- Partnership Access Line (pediatric psychiatry)
- Perinatal Psychiatry Consultation Line

Sitting with Grief – Julia Framm

TODAY
12-1.30pm

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