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ISSUES OF SPECIAL IMPORTANCE TO MENTAL HEALTH PROFESSIONALS

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I.
INTRODUCTION

Mental health professionals ("MHP") face special legal challenges not usually encountered by the other health care professions. Unlike physical health care, mental health treatment frequently involves the disclosure of the patient's most intimate, secret and personal thoughts, fantasies and conduct. MHPs are also called upon to treat patients who, because of mental illness, may have the potential to injure themselves or others. MHPs also have the ability to involuntarily commit patients and to treat them without their consent. The law therefore imposes special obligations on MHPs as it relates to the confidentiality of patient information and the potential personal liability arising out of the conduct of their patients. Those obligations are receiving increased scrutiny as a result of the tragedies at Newtown, Connecticut and Aurora, Colorado. This paper addresses the challenges that MHPs face in dealing with the patient-therapist privilege, including responding to discovery and requests for information, and the potential liability arising out of the patient-therapist relationship.

II.
THE PATIENT-THERAPIST PRIVILEGE

Unique among the health care professions in Georgia, communications between a patient and a mental health professional are privileged as a matter of Georgia law. O.C.G.A. § 24-5-501, which provides for the attorney-client, spousal, grand jury and state secret privileges, also provides for privileged communications between patient and psychiatrist, psychologist, clinical social worker, clinical nurse specialist in psychiatric/mental health, licensed marriage and family therapist, and licensed

professional counselor.[1] As a result, neither the patient nor the MHP may be compelled to disclose privileged communications except in narrowly defined circumstances. Moreover, the MHP has an affirmative duty to assert the privilege on behalf of the patient. The obligations imposed by the privilege raise difficult and often conflicting duties for the MHP that are not applicable to other health care professionals.

Among the issues that MHP's must wrestle with are: determining when the privilege is applicable; determining when the privilege is deemed waived; determining if there are exceptions to the privilege; responding to requests for records that contain privileged communications or the product of privileged communications; complying with HIPAA's psychotherapy notes requirements; and resolving conflicting obligations that arise from the duty to maintain privileged communications with duties to the patient and to third parties.

A. Determining When The Privilege Applies

1. Is Treatment Given Or Contemplated

MHP's frequently act in different roles: treating therapist, retained expert or court appointed evaluator. However, the patient-MHP privilege applies only "'to the extent that treatment was given or contemplated.'" Mrozinski v. Pogue, 205 Ga. App. 731, 732, 423 S.E.2d 405, 407 (1992) (emphasis omitted) (quoting Massey v. State, 226 Ga. 703, 704, 177 S.E.2d 79, 81 (1970)). Thus, if an individual sees an MHP for a non-treatment related evaluation, such as fitness for duty, fitness for custody or emotional

[1] As part of the comprehensive revisions to the Georgia Evidence Code, the limitation of privileged communications between patient and licensed clinical social worker, clinical nurse specialist in psychiatric/mental health, licensed marriage and family therapist and licensed professional counselors to the "psychotherapeutic relationship" has been eliminated. The privilege now applies equally to all MHPs. The psychologist-patient privilege is also recognized in the Psychology Practice Act, O.C.G.A. § 43-39-16.

distress damages, no privilege attaches because the patient is not seeking treatment and treatment is not given or contemplated. Fulbright v. State, 194 Ga. App. 827, 392 S.E.2d 298 (1990); Rachals v. State, 184 Ga. App. 420, 361 S.E.2d 671 (1987), aff'd, 258 Ga. 48, 364 S.E.2d 867 (1988); Massey v. State, 226 Ga. 703, 177 S.E.2d 79 (1970). Thus, a criminal defendant who submits to a court-ordered evaluation for purposes of competency or criminal responsibility may not assert the privilege since no treatment is contemplated and no patient/therapist relationship exists. State v. Herendeen, 279 Ga. 323, 613 S.E.2d 647 (2005); Bobo v. State, 256 Ga. 357, 349 S.E.2d 690 (1986); Plummer v. State, 229 Ga. 749, 194 S.E.2d 419 (1972).

The confusion that can arise in distinguishing between treatment and evaluation is exemplified by the Supreme Court's decision in State v. Herendeen, 279 Ga. 323, 613 S.E.2d 647 (2005). Herendeen involved a subpoena served on two licensed psychologists who were treating two children pursuant to a Juvenile Court Order that the children receive therapy. The State sought the treatment records for use in a criminal prosecution against the childrens' parents. The State argued that since the treatment was not voluntarily sought, the privilege did not apply. The Court of Appeals, citing Lucas v. State, 274 Ga. 640, 645, 555 S.E.2d 440, 446 (2001), concluded that because treatment was given, the privilege applied regardless of whether the treatment was voluntarily sought. Herendeen v. State, 268 Ga. App. 113, 601 S.E.2d 372 (2004), aff'd, 279 Ga. 323, 613 S.E.2d 647 (2005).

The Georgia Supreme Court affirmed. State v. Herendeen, 279 Ga. 323, 613 S.E.2d 647 (2005). The trial court had held that the childrens' records were not subject to the privilege because the counseling "was done pursuant to court order with express contemplation of recommendations to the court based upon that therapy." Id. at 324,

613 S.E.2d at 649. Noting that Georgia, along with the other 49 States, the District of Columbia and all federal courts protect psychotherapist-patient communications, the Supreme Court held that where "the requisite relationship [between mental health provider] and patient" exists, the privilege applies. Id. at 326, 613 S.E.2d at 650. In contrast "[t]he requisite professional relationship does not exist when the mental health provider is appointed by the court to conduct a preliminary examination to evaluate a person's mental state because, in such a situation, mental health treatment is not given or contemplated." Id. In addition, "no professional relationship is formed because no mental health treatment is given or contemplated when a court . . . orders a plaintiff in a tort action to undergo a psychiatric examination . . . or . . . orders persons involved in a parental rights' termination action to undergo a mental evaluation." Id.

However, the Court rejected the argument that the privilege exists only when the patient voluntarily seeks treatment. Rather, the defining test for whether the privilege exists is whether treatment (as opposed to evaluation or assessment) was provided or contemplated. Because treatment was provided in Herendeen, the privilege applied and the communications between the children and the mental health professional were privileged. The Court remanded to the trial court for a determination of whether there was any material contained in the records that did not originate in communications between the children and their mental health providers and to determine whether a guardian ad litem should be appointed to decide whether the children should invoke the privilege.

The Herendeen decision was applied by the Court of Appeals in a contentious child custody dispute case. Gottschalk v. Gottschalk, 311 Ga. App. 304, 715 S.E.2d 715 (2011). The trial court ordered Mr. Gottschalk to enter therapy with a specified

psychologist. After six sessions the psychologist was directed to issue a report to the children's guardian ad litem with respect to continuation of supervised visitation. In issuing its order the trial court stated:

> There is to be no privilege with regard to this therapy as it is court-ordered and is ordered for the benefit of the minor children in this matter as well as the [appellant]. [The therapist] may share the results of this therapy with the guardian ad litem and the court, and the [appellant] is specifically required to follow the recommendations of [the therapist] as a condition of his visitation.

Id. at 315, 715 S.E.2d at 724. The Court of Appeals agreed with Mr. Gottschalk that the trial court erred when it concluded that the privilege did not apply because the treatment was court-ordered. Because the court-ordered relationship with the therapist involved or contemplated treatment, Mr. Gottschalk's communications with the therapist were privileged. However, the Court concluded that the error was harmless because the therapist was directed to only report her conclusions regarding visitation to the guardian ad litem and the court and not the communications themselves. The Court did not address the fact that the therapist's conclusions were necessarily the product of the privileged communications.

2. Does The Privilege Extend To Communications With A Physician

Another area of potential confusion is whether the privilege extends to a physician who does not practice the specialty of psychiatry. Georgia law does not contain a statutory definition of the term "psychiatrist," and there is no separate licensing designation for psychiatrists. The Georgia Supreme Court considered the issue in Wiles v. Wiles, 264 Ga. 594, 448 S.E.2d 681 (1994). Wiles was a child custody dispute. The wife, Dr. Wiles, was a physician. The husband sought the medical records

of one of Dr. Wiles's patients. Dr. Wiles was an internist who testified that she treated one-third of her patients for mental health problems, that providing counseling was part of her practice, and that she had treated the patient in question for a mental condition. The Court concluded that Dr. Wiles was a physician who spent a substantial portion of her time treating mental and emotional problems and that the privilege was therefore applicable. Id. at 598, 448 S.E.2d at 684. The difficulty with the Wiles test is that it is an after-the-fact assessment based upon the nature of the physician's practice and the amount of time that the physician devotes to mental health treatment during any particular time. Thus, a patient may confide in her physician only to learn after the fact that the communications are not privileged because of the nature of the physician's practice.

B. Determining When The Privilege Is Waived

Under Georgia law, the patient-MHP privilege is not waived when a plaintiff puts his/her mental state in issue, for example, by claiming damages for emotional distress or pain and suffering. Wilson v. Bonner, 166 Ga. App. 9, 303 S.E.2d 134 (1983); see also Aetna Cas. & Sur. Co. v. Ridgeview Inst., Inc., 194 Ga. App. 805, 392 S.E.2d 286 (1990); Plunkett v. Ginsburg, 217 Ga. App. 20, 456 S.E.2d 595 (1995); Dynin v. Hall, 207 Ga. App. 337, 428 S.E.2d 89 (1993). In contrast, some federal courts have reached a different result.[2]

However, when a party calls his or her mental health professional to testify when the party's mental status is at issue, this constitutes a clear intent to waive the privilege.

[2] In Jaffee v. Redmond, 518 U.S. 1 (1996), the Supreme Court resolved a conflict among the circuits by holding that confidential communications between a licensed psychotherapist and patient in the course of diagnosis and treatment are protected from compelled disclosure under Rule 501 of the Federal Rules of Evidence.

Trammel v. Bradberry, 256 Ga. App. 412, 568 S.E.2d 715 (2002). Also see Griggs v. State, 241 Ga. 317, 245 S.E.2d 269 (1978) (defendant who called his psychiatrist to bolster his insanity defense waived the privilege); see also Armstead v. State, 293 Ga. 243, 744 S.E.2d 774 (2013) (defendant waived state constitutional right of privacy and statutory privilege in his mental health records when he filed notice of intent to pursue defense of not guilty by reason of insanity and put his mental capacity at issue).

In the absence of an express waiver of the privilege, one seeking the disclosure of privileged communications must establish a waiver by decisive, unequivocal conduct reasonably showing the intent to waive the privilege. Mincey v. Ga. Dep't of Cmty. Affairs, 308 Ga. App. 740, 708 S.E.2d 644 (2011). Mincey was a personal injury action against the Department of Community Affairs ("DCA"). Mincey failed to disclose her prior mental health treatment in response to various discovery requests. As a discovery sanction the court held that Mincey had waived her mental health privilege and ordered Mincey to execute a release authorizing the disclosure of her mental health records.

The Court of Appeals reversed, holding that Mincey's discovery conduct did not constitute a decisive and unequivocal waiver of the privilege. While the Court held that the trial court erred in concluding that Mincey had waived the privilege, the Court did find that DCA was entitled to discovery of information regarding whether and when Mincey was treated for mental health related issues. This finding was based on the well established rule that the privilege protects communications, not the fact of treatment or the dates of treatment.

It is also well established that the presence of a third party not necessary for the treatment process waives the privilege. However, the privilege extends to participants in joint therapy sessions, such as family therapy and marital therapy. There is no waiver

of the privilege where persons are being treated jointly or are participants in therapy which is primarily for the benefit of another. See Odom v. Odom, 291 Ga. 811, 814, 733 S.E.2d 741, 744 (2012) ("Communications between a treating psychologist and a patient are privileged . . . and do not lose their privileged status because patients may have been treated jointly or because they were referred by a guardian ad litem."); Mrozinski v. Pogue, 205 Ga. App. 731, 423 S.E.2d 405 (1992).

C. The Privilege Survives Death

The strength of the privilege is demonstrated by Sims v. State, 251 Ga. 877, 311 S.E.2d 161 (1984). In Sims the defendant wife was on trial for the murder of her husband and sought to introduce statements made by the deceased husband during joint counseling sessions which both she and her deceased husband had attended. The Court found that the defendant and her husband were jointly seeking counseling for marital problems and that the deceased husband was a necessary participant in the sessions. As a result, the husband's communications to the psychiatrist were entitled to protection. Id. at 881, 311 S.E.2d at 165-66. Since the privilege survives the death of the communicant, there was no one who could waive the privilege and the Court found that the trial court did not err in refusing to allow the psychiatrist to testify as to the deceased victim's communications during marital therapy. Id.

In Alvista Healthcare Center, Inc. v. Miller, 286 Ga. 122, 122, 686 S.E.2d 96, 97 (2009), a surviving spouse requested copies of her deceased husband's medical records because she was investigating a potential wrongful death action involving a nursing care facility owned and operated by Alvista. Alvista denied the surviving spouse's requests for records on the basis that HIPAA and its accompanying privacy regulations provided that the records could only be released to a permanent executor or administrator of the

deceased spouse's estate, which was not represented when the widow requested the decedent's medical records. [See Part II, Section E for a discussion of HIPAA requirements.]

The Georgia Supreme Court held that O.C.G.A. § 31-33-2(a)(2) authorizes a surviving spouse to act on behalf of the decedent or his estate in obtaining medical records only if an executor or an administrator has not been appointed and, therefore, the surviving spouse was entitled to access the decedent's protected health information under 45 C.F.R. § 164.502(g)(4) of the HIPAA Privacy Rule, which looks to the applicable state law to determine who has authority to act on behalf of the decedent or his estate.[3] Alvista Healthcare Center, 286 Ga. at 123-24, 686 S.E.2d at 97. However, the Court specifically stated that under O.C.G.A. § 31-33-4, mental health records are excepted from the provisions of the Health Records Act. Thus, under Georgia law there is no statutory mechanism by which an executor, administrator, or a surviving spouse can obtain the decedent's mental health records.

D. Responding To Discovery Requests

Another area that presents potential minefields to MHPs is responding to discovery requests. O.C.G.A. § 9-11-26(b)(1) provides that "[p]arties may obtain discovery regarding any matter, not privileged, which is relevant to the subject matter involved in the pending action." Therefore, the service of a subpoena, notice to produce discovery or deposition notice does not, by itself, constitute an exception to the privilege. The privilege must be affirmatively waived as a precondition of discovery.

[3] Section 164.502(g)(4) requires a covered entity like Alvista to treat a person who has authority to act on behalf of a deceased individual or his estate under an applicable law as a "personal representative . . . with respect to protected health information relevant to such personal representation." 45 C.F.R. § 164.502(g)(4).

Dynin v. Hall, 207 Ga. App. 337, 428 S.E.2d 89 (1993). See also Kennestone Hosp. v. Hopson, 273 Ga. 145, 538 S.E.2d 742 (2000). Unauthorized release of mental health records, even in response to a request for production of documents, may state a cause of action. Sletto v. Hosp. Auth., 239 Ga. App. 203, 205-06, 521 S.E.2d 199, 201-02 (1999). In addition, records maintained by mental health facilities under the Mental Health Code "shall be produced in response to a valid subpoena or order of any court of competent jurisdiction, except for matters privileged under the laws of this state." O.C.G.A. § 37-3-166(a)(8) (emphasis added); O.C.G.A. § 37-4-125(a)(8). See also O.C.G.A. § 37-7-166(a)(7) (relating to treatment records of alcoholics and drug dependent individuals).[4] Therefore, MHPs may not disclose privileged communications nor produce records containing privileged materials but must assert the patient-MHP privilege.

Breach of the duty to protect the patient's privacy and confidences can give rise to an action for damages. Mrozinski v. Pogue, 205 Ga. App. 731, 423 S.E.2d 405 (1992); Orr v. Sievert, 162 Ga. App. 677, 292 S.E.2d 548 (1982). MHPs should not produce privileged materials except in response to a court order or the express written authorization of the patient, even in the absence of an objection from the patient. See Jones v. Abel, 209 Ga. App. 889, 434 S.E.2d 822 (1993). In Jones, the Court of Appeals affirmed a jury verdict in favor of a psychiatrist who produced his patient's records in response to a third party request for production of documents on the fifteenth day after receipt of the request. With three justices vigorously dissenting, the Court affirmed the

[4] Absent the consent of the patient, records of a drug and alcohol abuse treatment facility can be disclosed only by court order based upon the determination that other ways of obtaining the information are not available and that the public interest and need for disclosure outweigh the harm to the patient. See 42 C.F.R. § 2.64; see also Carr v. Farmer, 213 Ga. App. 568, 445 S.E.2d 350 (1994).

jury verdict in favor of the psychiatrist on the basis of expert testimony that the standard of care required production of the records because no objection had been filed by the patient. Id. at 896, 434 S.E.2d at 828. The decision is questionable given the fact that the expert psychiatrist was not legally competent to render an opinion as to what the law required a mental health professional to do when confronted with an unobjected to request for production of documents. See also Bala v. Powers Ferry Psychological Assocs., 225 Ga. App. 843, 491 S.E.2d 380 (1997) (concluding that an expert affidavit opining that a psychologist had improperly disclosed information concerning the plaintiff to the plaintiff's former husband's attorney was sufficient to state a claim for malpractice); Jones v. Thornton, 172 Ga. App. 412, 323 S.E.2d 217 (1984) (patient sued a physician for invasion of privacy and libel on the basis of compliance with a discovery request prior to the expiration of the objection period provided in the Civil Practice Act). Accord Sletto v. Hosp. Auth., 239 Ga. App. 203, 521 S.E.2d 199 (1999).

E. HIPAA Protection For Psychotherapy Notes

1. HIPAA And Protected Health Information.

HIPAA's Privacy Standards, 45 C.F.R. § 164.500, et seq., generally prohibit "covered entities" from using or disclosing "protected health information" ("PHI"), unless a specific exception in the Privacy Standards applies.[5] Moreover, state laws that are more stringent than the Privacy Standards in protecting medical and health information are not preempted. Therefore, the strong protection that Georgia law affords to the patient-therapist privilege is not diluted by HIPAA.

[5] The Department of Health and Human Services issued a final rule on January 25, 2013 amending certain HIPAA regulations effective March 26, 2013. 78 Fed. Reg. 5566. The amendments primarily relate to the Health Information Technology for Economic and Clinical Health (HITECH) Act.

A "covered entity" generally may not use or disclose covered health information, except: (1) for treatment, payment, or health care operations; (2) upon the individual's agreement in certain limited circumstances (after an opportunity to agree or object); (3) to the individual; (4) pursuant to an authorization from an individual (unless the authorization is for the use or disclosure of genetic information for underwriting purposes); or (5) as permitted or required by HIPAA for governmental or other purposes. 45 C.F.R. § 164.502(a). Even when the use or disclosure of PHI is permitted, in most circumstances, a "minimum necessary" disclosure standard applies. 45 C.F.R. § 164.502(b).

HIPAA has an expansive definition of protected "health information." It applies to oral or recorded information that is created or received by a health care provider or plan and that relates to the past, present, or future health or condition of an individual, the provision of health treatment to an individual, or payments for health treatments. 42 U.S.C. § 1320d(4). Thus, even enrollment forms, claim forms, and bills for medical treatment include protected health information.

2. Consent vs. Authorization.

The Privacy Rules do not generally require that a covered entity obtain patient consent for use and disclosure of protected health information for specified purposes, including treatment, payment, and health care operations. See 45 C.F.R. § 164.502. (One notable exception is for psychotherapy notes, discussed below.) Nevertheless, the regulations permit and encourage health care providers to obtain consent for such purposes. The requirements for patient consent are set forth generally in Section 164.506.

By contrast, an "authorization" is required by the Privacy Rules for uses and disclosures of protected health information not otherwise permitted, even with consent. An authorization is a detailed document that gives covered entities permission to use protected health information for specified purposes other than treatment, payment, or health care operations, or to disclose protected health information to a third party specified by the individual. Where the Privacy Rules require patient authorization, voluntary consent is not sufficient to permit a use or disclosure of protected health information unless it meets the Privacy Rules' requirements for a valid authorization.

A valid authorization must specify a number of elements, including, but not limited to, (1) a specific description of the protected health information to be used and disclosed, (2) the person authorized to make the use or disclosure, (3) the person to whom the covered entity may make the disclosure, (4) the purpose of the disclosure, (5) an expiration date, (6) the right to revoke authorization (with certain limited exceptions); (7) a statement regarding the ability or inability to condition treatment, payment, enrollment or eligibility on the authorization; and (8) the potential for additional disclosure by the recipient. See 45 C.F.R. § 164.508.

In Allen v. Wright, 282 Ga. 9, 644 S.E.2d 814 (2007), the Georgia Supreme Court held that the medical release authorization requirement of O.C.G.A. § 9-11-9.2 is preempted by HIPAA. Section 9-11-9.2 requires that, in any action alleging medical malpractice, the plaintiff is required to file a medical authorization form which authorizes defendant's counsel to obtain and disclose protected health information and to discuss the plaintiff's case and treatment with his/her treating physicians. The Court concluded that the required authorization does not satisfy HIPAA requirements because it does not contain a sufficiently specific identification of the information to be

disclosed, does not provide for an expiration date, and does not contain a notice of the right to revoke the authorization. The 9-11-9.2 authorization was therefore preempted by HIPAA and not enforceable. See also Northlake Med. Ctr., LLC v. Queen, 280 Ga. App. 510, 634 S.E.2d 486 (2006).

3. Psychotherapy Notes.

In addition to the general protections for PHI, HIPAA's Privacy Rule extends special protection to psychotherapy notes. 45 C.F.R. § 164.508(a)(2) states that "[n]otwithstanding *any* provision of this subpart, . . . a covered entity must obtain an authorization for use or disclosure of psychotherapy notes . . ." (emphasis added).

"Psychotherapy notes" are defined as:

> [N]otes recorded (in any medium) by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session **and that are separated from the rest of the individual's medical record**. Psychotherapy notes excludes medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following items: Diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

45 C.F.R. § 164.501 (emphasis added). Therefore, psychotherapy notes should be maintained in a separate file from the rest of the patient's record.

The regulations provide that, with limited exceptions (which exceptions do not apply to psychotherapy notes), a covered entity "may not condition the provision to an individual of treatment, payment, enrollment in the health plan, or eligibility for benefits on the provision of an authorization." 45 C.F.R. § 164.508(b)(4).

The regulations recognize several exceptions to the authorization requirement for psychotherapy notes. See 45 CFR § 164.508(a)(2). Those exceptions include:

- Use by the originator of the psychotherapy notes for treatment;

- Use or disclosure by the covered entity in training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling;

- Use or disclosure by the covered entity to defend a legal action or other proceeding brought by the individual;

- Use with respect to the oversight of the originator of the psychotherapy notes, such as peer review;

- Disclosures required by law (45 C.F.R. § 164.512(a)) and certain disclosures about decedents (45 C.F.R. § 164.512(g)); and

- Disclosures required to avert a serious threat to health or safety. 45 C.F.R. § 164.512(j).

See 45 C.F.R. §§ 164.508(a)(2), 164.512.

In response to the tragedies at Newtown, Connecticut, and Aurora, Colorado, the Director of the Office for Civil Rights of the Department of Health and Human Services (DHHS) confirmed in a January 15, 2013 open letter to the nation's health care providers that HIPAA's privacy rules (45 C.F.R. § 164.512(j)) allow for the disclosure of "necessary information about a patient to law enforcement, family members of the patient, or other persons, when [the provider] believe[s] the patient presents a serious danger to himself or other people." Open Letter from Leon Rodriguez, Director of Office of Civil Rights for the Department of Health and Human Services, to United States Health Care Providers (January 15, 2013), http://www.hhs.gov/ocr/office/lettertonationhcp.pdf. The letter notes that disclosure is allowed to any "persons whom the provider believes are reasonably able to prevent or lessen the threat," including "the police, a parent or other family member, school administrators or campus police, and others who may be able to intervene to avert harm." See Section III, C. 3 regarding liability for warning.

Additionally, Section 164.512 specifically allows disclosures to "[a] public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect." 45 C.F.R. § 164.512(b)(1)(ii); see also 45 C.F.R. § 160.203(a)(iv) and (c) (HIPAA's confidentiality provisions do not preempt state laws that provide "for the reporting of disease or injury [or] child abuse"); O.C.G.A. § 19-7-5 (requiring MHPs to report child abuse). Section 512(c) allows a health provider to report other suspected abuse, but places limitations on such reporting. It states that:

> Except for reports of child abuse or neglect permitted by paragraph (b)(1)(ii) of this section, a covered entity may disclose protected health information about an individual whom the covered entity reasonably believes to be a victim of abuse, neglect, or domestic violence to a government authority, including a social service or protective services agency, authorized by law to receive reports of such abuse, neglect, or domestic violence:
>
> (i) To the extent the disclosure is required by law and the disclosure complies with and is limited to the relevant requirements of such law;
>
> (ii) If the individual agrees to the disclosure; or
>
> (iii) To the extent the disclosure is expressly authorized by statute or regulation and:
>
> (A) The covered entity, in the exercise of professional judgment, believes the disclosure is necessary to prevent serious harm to the individual or other potential victims; or
>
> (B) If the individual is unable to agree because of incapacity, a law enforcement or other public official authorized to receive the report represents that the protected health information for which disclosure is sought is not intended to be used against the individual and that an immediate enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure.
>
> (2) Informing the individual. A covered entity that makes a disclosure permitted by paragraph (c)(1) of this section must promptly inform the individual that such a report has been or will be made, except if:
>
> (i) The covered entity, in the exercise of professional judgment, believes informing the individual would place the individual at risk of serious harm; or

(ii) The covered entity would be informing a personal representative, and the covered entity reasonably believes the personal representative is responsible for the abuse, neglect, or other injury and that informing such person would not be in the best interests of the individual as determined by the covered entity, in the exercise of professional judgment.

45 C.F.R. 164.512(c).

4. Individuals' Rights To Access Protected Health Information.

HIPAA's Privacy Standards provide an individual with the right to inspect and obtain copies of his/her protected health information. That right, however, is not unqualified. A covered entity may refuse to disclose psychotherapy notes to the patient without any right of review under 45 C.F.R. § 164.524(a)(1). Moreover, access to other protected health information may be denied if the health care professional exercising his/her professional judgment determines that granting the patient "the access requested" would "reasonably likely" endanger the life or physical safety of the individual or another person. However, the patient has a right to have such a denial reviewed by a licensed health care professional who is designated by the covered entity as a reviewing official and who did not participate in the initial decision to deny. 45 C.F.R. § 164.524(a)(3)(i).

The Georgia Mental Health Code[6], on the other hand, grants patients access to their entire mental health record, including psychotherapy notes. Specifically, under the Mental Health Code, current patients may examine all their mental health records unless the Chief Medical Officer or the treating physician or psychologist determines that disclosure of the record would be detrimental to the patient's physical or mental health and a notation of that determination is included in the patient's record. O.C.G.A.

[6] O.C.G.A. § 37-3-101 et seq.

§§ 37-3-162(b) and 37-3-167(a); Ga. Comp. R. & Regs. § 290-4-6-.05(3)(a). Former patients, however, have unqualified access to their mental health records and the exception for withholding on the basis of potential harm is not applicable. Ga. Comp. R. & Regs. § 290-4-6-.05(3)(a).[7]

Georgia law has no similar statutory provisions for mental health professionals in the private practice setting to assist them in determining what rights patients have to access their mental health records. The Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists has adopted rules as part of the Code of Ethics which state, in part, that licensees must "provide information regarding a client's evaluation or treatment, in a timely fashion and to the extent deemed prudent and clinically appropriate by the licensee, when that information has been requested and released by the client." Ga. Comp. R. & Regs. § 135-7-.01(2)(m). Therefore, professional counselors, social workers, and marriage and family therapists follow a standard that is similar to the rules governing mental health facilities.

Georgia courts have not considered the question of whether mental health professionals must follow HIPAA or Georgia law when assessing patients' rights of access to their protected health information. HIPAA and its related regulations do not preempt any state law that provides more stringent requirements for the access of protected health information. Alvista Healthcare Ctr., 286 Ga. at 126, 686 S.E.2d at 99 (citing Moreland v. Austin, 284 Ga. 730, 733, 670 S.E.2d 68, 71-72 (2008)); Allen v. Wright, 282 Ga. 9, 12, 14, 644 S.E.2d 814, 816-18 (2007). According to 45 C.F.R. §

[7] Importantly, Georgia law does not address the question of whether a mental health professional may refuse a former patient access to mental health records if the mental health professional determined that releasing those records would be detrimental to the former patient's mental or physical health.

160.202, a state law is more stringent if it provides the patient greater rights of access to his/her protected health information. See Moreland v. Austin, 284 Ga. at 733, 644 S.E.2d at 71 ("'More stringent' means laws that afford patients more control over their medical records"); Tender Loving Health Care Serv. of Ga., LLC v. Ehrlich, 734 S.E.2d 276, 279 (Ga. Ct. App. 2012) (HIPAA preempts state law when it "affords patients more control over their medical records") overruled on other grounds by Wellstar Health Sys., Inc. v. Jordan, 293 Ga. 12, n. 6, 743 S.E.2d 375 (2013) (holding in part that HIPAA did not entitle an individual to access protected work product in the possession of a covered entity simply by virtue of the fact that it contained protected health information). Section 164.524(a)(1) of the HIPAA rules allows a covered entity to deny a patient complete access to psychotherapy notes without specifying a reason and without the requirement for review of the decision. However, under the Georgia Mental Health Code, current patients of a mental health facility have an absolute right of access to their entire mental health records, unless a mental health professional determines that disclosure of any portion of the records would harm the patient mentally or physically. O.C.G.A. §§ 37-3-162(b) and 37-3-167(a); Ga. Comp. R. & Regs. § 290-4-6-.05(3)(a). Therefore, when current patients request their mental health records, including psychotherapy notes, a Georgia facility may only withhold psychotherapy notes if there is a finding that disclosure would be detrimental to the patient.

In contrast, former patients have an unfettered right of access to their records maintained by the facility. Ga. Comp. R. & Regs. § 290-4-6-.05(3)(a). There is thus a potential conflict between the HIPAA provisions which provide no right of access to psychotherapy notes and the Mental Health Code, which clearly grants a right of access. Since the Mental Health Code provides the patient with greater rights than are provided

by HIPAA, the Mental Health Code would likely preempt HIPAA's provision permitting a facility to deny a patient right of access to psychotherapy notes. This conflict should not be an issue in the context of current patients, since access can be denied if it is determined that access would be detrimental to the patient. While the state regulations grant a former patient access without exception, the Code Section (O.C.G.A. § 37-3-162 (b)) provides for access subject to a finding of potential harm and makes no distinction between current and former patients. Since the primary duty imposed on any health care professional is to do no harm, the prudent course of action would be for a mental health professional in charge of patient records at a facility to review those records to determine whether disclosure to the patient would likely cause harm to the patient. If it is determined in good faith that disclosure would likely cause the patient harm, then the record should not be disclosed (and a notation to that effect should be made in the patient's record).

As to mental health professionals in private practice, other than licensed professional counselors, social workers and marriage and family therapists, there are no statutes or rules specifically governing a patient's right of access to their records. Since HIPAA explicitly provides that a mental health professional may refuse to disclose psychotherapy notes to the patient, the prudent course of action would be for the mental health professional to determine whether disclosure of psychotherapy notes to the patient or to any other entity that the patient requests would be detrimental to the patient. If so then those portions of the record which could cause the patient harm should be withheld. If there is no likelihood of harm then the mental health professional would have no reason not to provide the records to the patient.

5. No Private Right Of Action under HIPAA

HIPAA's penalty provisions authorize the Secretary of Health and Human Services to impose significant monetary penalties for any violation of the Act.[8] The civil monetary penalty escalates based on the provider's increasing level of culpability. Any person that violates HIPAA is liable for a penalty ranging from $100 to $50,000 per violation (where the covered entity did not know of the violation and would not have known of it with the exercise of due diligence) to a minimum of $50,000 per violation (where the violation was due to willful neglect and was not corrected in a timely fashion). The total amount imposed on the person for all violations of an identical requirement or prohibition during a calendar year may not exceed $1,500,000.

While the civil monetary penalties can be substantial, the federal courts have found that HIPAA does not create a private right of action. In Acara v. Banks, 470 F.3d 569 (5th Cir. 2006), the Fifth Circuit affirmed the dismissal on subject matter jurisdiction grounds of an action against a physician for the unconsented disclosure of medical information during a deposition. The Court found that HIPAA's delegation of enforcement authority to the Secretary of Health and Human Services was strong evidence of Congress's intent to preclude private enforcement. Every other Circuit Court that has analyzed the issue has come to the same conclusion. See Miller v. Nichols, 586 F.3d 53, 59 (1st Cir. 2009) ("No Private Right of Action under HIPAA"); Carpenter v. Phillips, 419 F. App'x 658, 659 (7th Cir. 2011) ("HIPAA does not furnish a private right of action"); Dodd v. Jones, 623 F.3d 563, 569 (8th Cir. 2010) ("HIPAA does not create a private right of action"); Seaton v. Mayberg, 610 F.3d 530, 533 (9th Cir.

[8] HIPAA's penalty provision now incorporates the increased and tiered civil money penalty structure provided by the Health Information Technology for Economic and Clinical Health (HITECH) Act.

2010) ("HIPAA itself provides no private right of action."); Wilkerson v. Shinseki, 606 F.3d 1256, 1267 (10th Cir. 2010) ("HIPAA does not create a private right of action for alleged disclosures of confidential medical information"); Bradley v. Pfizer, Inc., 440 F. App'x 805, 809 (11th Cir. 2011) ("there is no private right of action for a violation of HIPAA's confidentiality provisions"); see also Swift v. Lake Park High Sch. Dist. 108, No. 03-C-5003, 2003 WL 22388878, at *4 (N.D. Ill. Oct. 21, 2003) ("No federal court reviewing the matter has ever found that Congress intended HIPAA to create a private right of action."); Hudes v. Aetna Life Ins. Co., 806 F. Supp. 2d 180, 196 (D.D.C. 2011) (concluding that "[i]n light of the statutory language of [applicable enforcement provision 42 U.S.C. §] 1320d-5 and the apparent consensus among the courts that have considered the question, . . . Plaintiff has no private HIPAA right of action"), aff'd, No. 11-7109, 2012 WL 5894855 (D.C. Cir. Nov. 20, 2012).

F. Issues Related To Workers' Compensation

Although Section 164.508(a)(1) requires authorization before a covered entity may use or disclose protected health information, there is an exception for disclosure for use in a workers' compensation proceeding. Under Section 164.512, a covered entity may use or disclose protected health information without written authorization or an opportunity to object "as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs . . ." 45 C.F.R. § 164.512(l). Similarly, the regulations allow disclosures to an employer to evaluate whether an individual has a work-related illness, 45 C.F.R. § 164.512(b), or to determine eligibility for government benefits, 45 C.F.R. § 164.512(d). Thus, as a general matter, PHI may be disclosed to determine eligibility for benefits.

In addition, with respect to workers' compensation, O.C.G.A. § 34-9-207(a) provides that "[w]hen an employee has submitted a claim for workers' compensation benefits . . . , that employee shall be deemed to have waived any privilege or confidentiality concerning any communications related to the claim or history or treatment of injury . . . , including, but not limited to, communications with psychiatrists or psychologists." In other words, by submitting a claim for workers' compensation benefits, an employee waives any claim of privilege or confidentiality he may have with regard to his medical records under Georgia law to the extent that they relate to his claim. See Arby's Rest. Group, Inc. v. McRae, 734 S.E.2d 55, 56-57 (Ga. 2012) ("The occurrence of any one of [the] triggering events [in O.C.G.A. § 34-9-207] waives the employee's privilege in confidential health information"). Therefore, given the Privacy Rule's incorporation of state law when addressing workers' compensation, a covered entity is generally permitted to disclose an individual's protected health information related to a workers' compensation claim without prior authorization.

However, as previously noted, the Privacy Rule extends special protection to psychotherapy notes (45 C.F.R. § 164.508(a)(2)). Although several provisions of 45 C.F.R. § 164.512 are specifically exempt from the authorization requirement (§ 164.512(a), (d) as it relates to oversight of the health care provider, (g)(1) and (j)(1)(i)), Section 164.512(l)—addressing workers' compensation—is not among them. 45 C.F.R. § 164.508(a)(2)(ii). Moreover, although on its face the "disclosures required by law" provision might seem to apply, the specific discussion of disclosures allowed under this provision would not appear to cover workers' compensation proceedings, particularly in light of the specific workers' compensation provision contained in Section 512(l). Therefore, using basic rules of construction, it appears that psychotherapy notes may

not be disclosed without authorization in a workers' compensation proceeding because workers' compensation is not one of the listed exceptions under Section 508(a)(2)(ii).

III.
DAMAGES CLAIMS PARTICULARLY RELEVANT TO MENTAL HEALTH PROFESSIONALS

A. Involuntary Detention / False Imprisonment

The Georgia Code defines false imprisonment as "the unlawful detention of the person of another, for any length of time, whereby such person is deprived of his personal liberty." O.C.G.A. § 51-7-20. The Georgia Court of Appeals provided a good statement of the elements of the tort in Hampton v. Norred & Associates, Inc.:

> The essential elements of the cause of action for false imprisonment are a detention of the person of another for any length of time, and the unlawfulness of that detention. A detention need not consist of physical restraint, but may arise out of words, acts, gestures, or the like, which induce a reasonable apprehension that force will be used if plaintiff does not submit; and it is sufficient if they operate upon the will of the person threatened, and result in a reasonable fear of personal difficulty or personal injuries. . . . A person need not make an effort to escape or to resist until an application of open force results, thereby risking possible physical injury, before he can recover; however, an actual detention must have occurred whether caused by force or fear.

216 Ga. App. 367, 368, 454 S.E.2d 222, 223 (1995) (citations omitted). The tort thus has two central elements: (1) detention of the person (for any length of time), and (2) unlawfulness of the detention. Scott Hous. Sys., Inc. v. Hickox, 174 Ga. App. 23, 24, 329 S.E.2d 154, 155 (1985) ("In an action to recover damages for . . . false imprisonment the only essential elements are the arrest or detention and the unlawfulness thereof.") (citation omitted). Cases alleging false imprisonment by mental health professionals generally focus on the "unlawfulness" of the detention.

A mental health professional who in good faith executes a procedurally valid certificate authorizing involuntary detention under the Georgia Mental Health Code [9] does not act "unlawfully" and is insulated from a false imprisonment claim. Williams v. Smith, 179 Ga. App. 712, 715, 348 S.E.2d 50, 53 (1986). The Williams court, relying on the immunity provisions of the Mental Health Code for the admission and release of patients under O.C.G.A. § 37-3-4, applied a two-part test to determine a psychiatric clinic's immunity from a false imprisonment claim. First, so long as a patient's detention is predicated upon procedurally valid process, the detention is not "unlawful," and the remedy of false imprisonment is unavailable. Second, even if the detention is secured by procedurally void or defective process, false imprisonment is available only if the process was secured in bad faith. Id.

O.C.G.A. § 37-3-4 provides civil and criminal immunity to a person authorized to involuntarily commit patients so long as she "acts in good faith in compliance with the admission and discharge provisions of this chapter" and does not "fail[] to meet the applicable standard of care in the provision of treatment to [the] patient." This immunity provision provides an affirmative defense that the defendant has the burden of proving. Heath v. Emory Univ. Hosp., 208 Ga. App. 629, 631, 431 S.E.2d 427, 429 (1993).

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[9] O.C.G.A. § 37-3-41 allows any physician, psychologist, clinical social worker, or clinical nurse specialist in psychiatric/mental health within the state to execute a certificate stating that he has personally examined a person within the preceding forty-eight hours and found that the person appears to be a mentally ill person requiring involuntary treatment. O.C.G.A. § 37-3-81 allows for the involuntary detention of a patient beyond the evaluation period upon recommendation of the chief medical officer of an evaluating facility supported by the opinions of two physicians or a physician and a psychologist who have personally examined the patient within the preceding five days and who agree that the patient is a mentally ill person requiring involuntary treatment.

Heath reached the Court of Appeals twice. In its first review, the Court reversed summary judgment in the defendants' favor on the plaintiff's false imprisonment claim because the defendants produced no evidence that the plaintiff's three-day detention was pursuant to valid procedural process. Heath v. Peachtree Parkwood Hosp., Inc., 200 Ga. App. 118, 119, 407 S.E.2d 406, 407 (1991).

Upon remand, the plaintiff argued she was not a voluntary patient who could be lawfully detained against her volition. The patient testified that she believed she was checking herself into a weight loss clinic and that she was never notified of her statutory rights as a voluntary mental health patient and thus had no knowledge that she was, instead, checking into a mental health facility in which she could be held against her will. The jury returned a verdict of $25,000 on the false imprisonment claim in the plaintiff's favor.

On appeal, the defendants asserted as an affirmative defense that they were immune from liability, as provided by O.C.G.A. § 37-3-4, because they acted in good faith in compliance with the admission and discharge provisions of the statutes governing the admission of voluntary patients to a mental health facility. The Court held that, in order to assert the affirmative defense of immunity under O.C.G.A. § 37-3-4, the defendants first had to show the plaintiff was, in fact, a voluntary patient subject to the Mental Health Code. The Court held that the trial court did not err in instructing the jury that the defendants had the burden of proving these facts and upheld the jury verdict in the plaintiff's favor. Heath v. Emory Univ. Hosp., 208 Ga. App. at 631-32, 431 S.E.2d at 429-30.

The affirmative defense of immunity provided under O.C.G.A. § 37-3-4 does not extend to hospitals or other mental health facilities, but only to the employees of such

entities. Krachman v. Ridgeview Inst., Inc., 301 Ga. App. 361, 687 S.E.2d 627 (2009). In Krachman, the plaintiff conceded that she was lawfully admitted to Ridgeview as a voluntary patient, but she contended that she was unlawfully detained after Ridgeview staff members did not comply with the discharge procedures under O.C.G.A. § 37-3-22(a). Reversing the trial court's grant of summary judgment in favor of the mental health facility, the Court held that the plain language of O.C.G.A. § 37-3-4 extends immunity only to designated individuals and "does not evidence a legislative intent to confer immunity on hospitals or other mental health facilities." Id. at 364, 687 S.E.2d at 629. Furthermore, because the plaintiff sued Ridgeview under a respondeat superior theory of liability, Ridgeview had no defense based on its agent's immunity from civil liability for acts committed in the course of employment as "'[i]mmunities, unlike privileges, are not delegable and are available as a defense only to persons who have them.'" Id. at 364, 687 S.E.2d at 630 (quoting Gilbert v. Richardson, 264 Ga. 744, 754, 452 S.E.2d 476, 483-84 (1994) (citing Restatement (Second) of Agency § 217(b)(ii) (1958)). Finally, the Court found that material issues of fact existed as to plaintiff's false imprisonment claim. Because there was evidence that the plaintiff orally expressed her desire for discharge to Ridgeview staff members on numerous occasions, the Court concluded that jury questions remained regarding whether Ridgeview demonstrated its "objective compliance" with the discharge procedures set forth in O.C.G.A. § 37-3-22 (a) and Heath v. Peachtree Parkwood Hospital, Inc., 200 Ga. App. at 119(3), 407 S.E.2d at 407. Krachman, 310 Ga. App. at 366, 687 S.E.2d at 631.

In addition to compliance with procedural requirements, Georgia law provides a defense to a false imprisonment claim based on the existence of a medical emergency or the consent of a substituted decision maker. In Davis v. Charter-By-The-Sea, Inc., 183

Ga. App. 213, 358 S.E.2d 865 (1987), two adult children brought their intoxicated mother to the hospital. The mother had to be bodily carried by her children due to her condition, and two doctors who attended her determined she was "medically unstable" and should be admitted. One of the children also signed a consent form authorizing treatment of her mother.

The Court, distinguishing Williams because that case involved delivery of a patient to a facility by a peace officer pursuant to a valid certificate, found evidence of "other legal justification for receiving, examining, and treating [the mother]." 183 Ga. App. at 216, 358 S.E.2d at 868. The Court found sufficient evidence in the record to support a defense to the plaintiff's false imprisonment charge based on (1) the existence of a medical emergency and (2) valid consent given by a substituted decision maker or the implied consent of the incapacitated plaintiff. Id. at 216-17, 358 S.E.2d at 868.

B. Unauthorized Disclosure Of Privileged Records

Georgia law recognizes a cause of action for damages for the breach of the duty to protect a patient's privacy and confidentiality. See generally Mrozinski v. Pogue, 205 Ga. App. 731, 423 S.E.2d 405 (1992); Orr v. Sievert, 162 Ga. App. 677, 292 S.E.2d 548 (1982). In Mrozinski, a father participated in the psychiatric treatment of his minor daughter. The father contended that the treating psychiatrist provided privileged information to the attorney of his former wife for use in a custody suit. The information provided included a "discharge summary" and an affidavit. The information described the father's conduct and reactions during family therapy, contained the psychiatrist's observations and conclusions as to the interaction between the father and his daughter during family therapy, and expressed negative criticism of the father's conduct and

reactions during therapy. The affidavit recommended that custody of the child be returned to the former wife.

The father claimed (1) wrongful disclosure of privileged information, and (2) breach of confidential relations for both his and his daughter's records. The psychiatrist contended that the father was not a patient, and thus no privilege existed between himself and the father, and that any communications lost their privileged status when the psychiatrist treated the father and daughter jointly. The psychiatrist also argued that the father lacked standing to raise these claims on behalf of his minor daughter.

Referencing strong public policy interests, the Court held that if multiple persons participate in joint therapy, the psychiatrist-patient privilege extends to the communications of all participants. Mrozinski, 205 Ga. App. at 733, 423 S.E.2d at 408. The Court held that genuine issues of material fact existed, precluding summary judgment, on whether the psychiatrist gave or contemplated psychiatric assistance to the father so that the father would be a patient and the privilege would exist, and on whether the psychiatrist breached a confidential relationship during the custody dispute and disclosed the father's privileged information. Id. at 734, 423 S.E.2d at 409. The Court also held that the father had standing to file suit for unauthorized disclosure of his minor daughter's clinical records and for unauthorized release of privileged material regarding his minor daughter. Id. at 736-37, 423 S.E.2d at 411.

Georgia law also recognizes a claim for invasion of privacy for the unauthorized disclosure of privileged records. The right of privacy in Georgia is a "fundamental constitutional right." Cornelius v. Hutto, 252 Ga. App. 879, 883, 558 S.E.2d 36, 40 (2001) (citations omitted). To bring a successful invasion of privacy claim, a plaintiff must prove: (1) the defendant made a disclosure to the public; (2) the facts disclosed

were private, secluded or secret facts and not public ones; and (3) that the matter made public was offensive and objectionable to a reasonable man of ordinary sensibilities under the circumstances. Cabaniss v. Hipsley**,** 114 Ga. App. 367, 372, 151 S.E.2d 496, 501 (1966).

Cornelius is one of the few Georgia cases involving an invasion of privacy claim against a mental health professional. In Cornelius, a father brought a breach of confidentiality and invasion of privacy action against his former psychiatrist for giving an affidavit regarding custody of his son. Before the father divorced his ex-wife, the psychiatrist had treated them both. The allegedly offending affidavit did not expressly mention the psychiatrist's treatment of the father, but concluded that the son "would best be served by having limited contact with his father," and that "[the ex-wife] is the more psychologically fit and nurturing parent . . . ." Cornelius, 252 Ga. App. at 880-81, 558 S.E.2d at 39.

The Court found sufficient evidence in the record to send the question of breach of confidentiality to the jury, and thus upheld the denial of a directed verdict in the father's favor.[10] Id. at 882-83, 558 S.E.2d at 39-40. On the invasion of privacy claim, the Court rejected the defense that because the communications were revealed in an affidavit filed with the Court they were privileged under O.C.G.A. § 51-5-8 (providing a limited privilege in defamation cases). Citing "strong public policy against releasing mental health records," the Court refused to allow "circumvent[ion]" of the psychiatrist-

[10] The father contended that testimony by the psychiatrist at trial contradicted the psychiatrist's affidavit and should therefore have been excluded, entitling the father to a directed verdict. The Court held that the testimony did not necessarily contradict the affidavit, and, even if it did, additional evidence in the record supporting the psychiatrist's defense precluded granting a directed verdict in the father's favor. Id. at 882-83, 558 S.E.2d at 39-40.

patient privilege merely by filing an affidavit in a lawsuit. Id. at 883-84, 558 S.E.2d at 40-41. The Court thus held that the father's invasion of privacy claim presented a jury question, and reversed a directed verdict in the psychiatrist's favor. Id.

C. Patient Causes Harm To Third Parties

Georgia law creates seemingly conflicting duties on mental health professionals regarding the duty to warn identifiable third parties of foreseeable potential harm from a patient. On the one hand, Georgia law places a well-established duty on mental health professionals to maintain the confidentiality of patient communications. Mrozinski v. Pogue, 205 Ga. App. 731, 423 S.E.2d 405 (1992); Orr v. Sievert, 162 Ga. App. 677, 292 S.E.2d 548 (1982); see also supra, Part II, Section B. On the other hand, Georgia law imposes duties on mental health professionals both to their patients and to third parties that may require the disclosure of confidential and privileged communications. Under some circumstances, the duty to warn an identifiable third party of potential harm from a patient may outweigh the mental health professional's obligation to maintain the privileged and confidential nature of patient communications.

1. Duty To Control

Georgia courts have not explicitly adopted the classic duty to warn concept set forth in the seminal case of Tarasoff v. Regents of University of California, 551 P.2d 334 (Cal. 1976). Nevertheless, the Georgia courts have held that a duty to prevent harm to others may arise out of the special nature of the therapist/patient relationship. At the very least, mental health professionals in Georgia have a duty to exercise reasonable care to control a patient to prevent him from doing bodily harm to a third person. Bradley Ctr., Inc. v. Wesner, 161 Ga. App. 576, 287 S.E.2d 716, aff'd, 250 Ga. 199, 295 S.E.2d 693 (1982).

In Bradley Center, the patient of a mental health facility shot and killed his ex-wife and her lover while the patient was on an unrestricted weekend pass from the hospital. The hospital argued that it owed no duty to the ex-wife because she was outside the professional-client relationship. The Court disagreed, holding that where the course of treatment of a mental patient involves an exercise of control over him by a physician who knows or should know that the patient is likely to cause bodily harm to others, an independent duty arises, requiring the physician to exercise that control with such reasonable care as to prevent the patient from causing harm to others. Id. at 581, 287 S.E.2d at 721.

In 1992, the Georgia Court of Appeals described the Bradley Center decision as establishing a "two-part test" for determining under what circumstances a physician may be liable to a third party: "(1) the physician must have control over the mental patient; and (2) the physician must have known or reasonably should have known that the patient was likely to cause bodily harm to others." Ermutlu v. McCorkle, 203 Ga. App. 335, 336, 416 S.E.2d 792, 794 (1992). Thus, Bradley Center is expressly limited to cases in which the mental health professional has taken charge or otherwise assumed control of the patient. As such, if no right of control exists, a plaintiff cannot state a claim. See generally Ward v. Emmanuel Cnty. Bd. of Health, 218 Ga. App. 382, 461 S.E.2d 559 (1995); Ermutlu, 203 Ga. App. 335, 416 S.E.2d 792 (1992). For example, a mental health professional cannot be held liable for the release of a voluntary outpatient, since the professional does not exercise control over such a patient. Id. at 337, 416 S.E.2d at 794-95 (holding that patient must meet involuntary commitment standard before psychiatrist's duty arises).

2. Duty To Warn

The Georgia Court of Appeals recently focused on a second exception to the general rule that a doctor has no duty to prevent a third person from harming others. That exception "requires a special relationship between the doctor and the injured party which would confer a right to protection to the injured party." Bruscato v. Gwinnett-Rockdale-Newton Cmty. Serv. Bd., 290 Ga. App. 638, 640, 660 S.E.2d 440, 443 (2008) (citing Gilhuly v. Dockery, 273 Ga. App. 418, 419, 615 S.E.2d 237, 239 (2005); Restatement (Second) of Torts § 315(b)).[11]

Bruscato involved a psychiatric patient who was being cared for and monitored at home, at his parents' request and upon condition that the parents would provide 24-hour monitoring of the patient. The patient ultimately killed his mother, and the patient's father sued the patient's treating psychiatrist, alleging, in part, that the psychiatrist had a duty to the mother by virtue of the mother's special relationship with the psychiatrist. Id. at 641, 660 S.E.2d at 443. Relying on Swofford v. Cooper, 184 Ga. App. 50, 360 S.E.2d 624 (1987), aff'd, 258 Ga. 143, 368 S.E.2d 518 (1988),[12] the father contended that the mother "was conferred 'patient-like' status and had privity with [the

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[11] The comments to Section 315 indicate that such relationships would include, for example, common carriers, innkeepers, possessors of land, and individuals who are required by law or who voluntarily take custody of another. Bruscato, 290 Ga. App. at 642 n.7, 660 S.E.2d at 444 n.7. "[T]he comments to [Section 315] suggest that special relationships are based upon a duty to control." Id.

[12] Swofford presented the issue of whether a patient's caretakers became "patients" of the defendant physician by receiving advice as to how best to assist with the patient's care. Swofford, 184 Ga. App. at 53, 360 S.E.2d at 627. Citing Sims v. State, 251 Ga. 877, 881, 311 S.E.2d 161, 165 (1984), wherein the Supreme Court of Georgia held that when a third-party family member participates in joint therapy sessions, the third party is a "necessary or customary participant" and is deemed a patient to whom the privilege applies, the Court of Appeals concluded that the caretakers were not patients because they did not "necessarily or customarily participate[] in the consultation and treatment of [the patient]." Swofford, 184 Ga. App. at 53, 360 S.E.2d at 627.

treating psychiatrist] since she 'necessarily [and] customarily participated in the consultation and treatment of [the patient].'" Bruscato, 290 Ga. App. at 641, 660 S.E.2d at 443 (citation omitted). The Court of Appeals rejected both the "patient-like status" argument and the privity argument, concluding that no special relationship existed between the treating psychiatrist and the mother. Id. at 641-42, 660 S.E.2d at 443-44. The Court rejected the argument, as had the Swofford court, that the mere taking of advice regarding the treatment of a patient can convert a caretaker into a patient. Id.

The Bruscato court also rejected the argument that the mother had been in privity of contract with the psychiatrist by virtue of her agreement with the psychiatrist to provide 24-hour supervision and that this privity gave rise to a special relationship. Distinguishing cases in which decedent patients had sued physicians and hospitals based on duties to aid or protect arising from privity of contract, the Court refused to extend that privity to a "third party who was never the patient of the physician or hospital." Id. at 642, 660 S.E.2d at 444. The Court, accordingly, declined to extend the duties owed to third parties beyond that set forth in Bradley Center based on the facts of Bruscato, wherein the parents had supervised the patient at home for over three years prior to the attack. Id. at 643, 660 S.E.2d at 444. The Court stated further policy bases for its reticence, noting first that "[e]xtending a physician's duty of care to third parties beyond the provisions of the Bradley Center test mandating that the physician exercise control over the patient could discourage outpatient care to the detriment of the state's express policy of providing the 'least restrictive alternative,' 'least restrictive environment,' or 'least restrictive appropriate care and treatment' to mental patients." Id. The Court further noted that "the imposition of liability for an outpatient under these circumstances could discourage physicians from including the relative of any

mental health patient—or for that matter, the relative of a minor—in the treatment process out of concern that the physician would be exposed to greater liability." Id. Finally, the Court held that there was no duty to warn the mother of dangers and tendencies of which she was already fully aware by virtue of her care for the patient. Id. at 643-44, 660 S.E.2d at 445. Interestingly, Bruscato made a second appearance in the Court of Appeals in 2010. As discussed at page 37 below, the patient sued his psychiatrist for malpractice alleging claims for emotional distress. The Court reversed the dismissal of the case holding, in part, that the impact rule was not applicable to emotional distress claims in medial malpractice actions.

The Court of Appeals had addressed similar issues in Jacobs v. Taylor, 190 Ga. App. 520, 379 S.E.2d 563 (1989), a case in which the Court of Appeals appeared to assume that an assertion of breach of duty to warn identifiable parties of a patient's threats of violence stated an claim for relief. Jacobs involved a patient (Murray) who killed his ex-wife and two strangers five months after his release from a state hospital to the county jail. Following his acquittal on terroristic threat charges, Murray was released from custody and two months later murdered Taylor's decedents. The children of the decedents brought suit alleging, inter alia, that the defendants-physicians breached a duty to warn the decedents of their patient's murderous tendencies. The Court upheld summary judgment in favor of the physicians, finding that the ex-wife "was fully cognizant of the danger [the patient] presented," and that Georgia law imposes no duty to warn of that which the plaintiff already knew or should have known. Id. at 527, 379 S.E.2d at 568 (citations omitted). The Court found that the two strangers to the patient were not "foreseeable or readily identifiable targets." Id. The Court noted that it would not "impose a blanket liability on the doctors for failing to warn members

of the general public . . . of the risk posed by . . . a patient with a history of violence who made generalized threats . . . ." Id.

3. Liability For Warning

Since Georgia has yet to specifically adopt the duty to warn under Tarasoff, a mental health professional could potentially face liability to the patient for breach of the duty of privacy and confidentiality if she does warn a third party of harm. Furthermore, even if Georgia law imposes a duty to warn third parties on mental health professionals, many open issues concerning the application of the duty remain. For example, is an "express threat" required before the duty is triggered as it is in several other jurisdictions? Is "imminent danger" required?

In at least one case, Garner v. Stone,[13] a jury returned a substantial damages award for a plaintiff who alleged the defendant-psychologist's decision to warn a third party of harm posed by the patient breached the psychologist's duty of care to the plaintiff. The psychologist made his decision to warn after consultation with an attorney, who informed him that he did have such a duty. The jury returned the verdict against the psychologist notwithstanding instructions informing the jury that a psychologist incurs an obligation to use reasonable care to protect the intended victim if the psychologist determines, pursuant to the standards of his profession, that the patient presents a "serious danger of violence." The case settled before appeal and therefore serves no precedential value in Georgia.

Given the tragedies of Newtown and Aurora, it is likely that, when squarely presented with the issue, the Georgia courts will find that a mental health professional has a duty to warn readily identifiable targets of her patient's threats of bodily harm

[13] Garner v. Stone, Civil Action File No. 97A30250-1 (DeKalb St. Ct. Filed Feb. 5, 1997).

even if the information was acquired in the course of a privileged communication. As discussed above, the Office of Civil Rights within HHS has recently affirmed in an open letter to the health community that the HIPPA privacy rules allow an MHP to warn of a readily identifiable threat, even if that warning discloses protected health information. While HIPPA does not preempt state law, it is persuasive public policy.[14] Mental health professionals must therefore make a judgment as to whether the risk to a third party outweighs the patient's right to privacy.

4. Liability For Emotional Distress

In 2010, the Georgia Court of Appeals carved out an exception in medical malpractice actions to the rule prohibiting recovery for emotional distress damages in negligence actions in the absence of physical injury. In Bruscato v. O'Brien, 307 Ga. App. 452, 705 S.E.2d 275 (2010), aff'd, 289 Ga. 739, 715 S.E.2d 120(2011), the Court of Appeals concluded that a plaintiff alleging medical malpractice no longer has to show physical injury to recover for emotional distress caused by the alleged malpractice. The Court also ruled that the plaintiff was not barred by public policy from pursuing a malpractice claim against his psychiatrist even though the alleged malpractice ultimately led to the plaintiff murdering his mother.

Bruscato v. O'Brien involved the same underlying facts as Bruscato v. Gwinnett-Rockdale-Newton Community Service Board, 290 Ga. App. 638, 660 S.E.2d 440 (2008), discussed at pages 32-34. Bruscato killed his mother after the defendant psychiatrist discontinued certain prescriptions, allegedly causing the patient to revert

[14] New York recently amended its mental hygiene law by providing that if a mental health professional determines that a patient is likely to engage in conduct that would result in serious harm to the patient or others, the professional shall make a report which can be used to revoke the patient's firearms license or make him ineligible for a license. §2230 (1-14-2013)

into a psychotic, homicidal state. Bruscato's father, as guardian, filed a malpractice action against the psychiatrist seeking damages for the emotional distress resulting from the alleged negligence in discontinuing his son's medication. The trial court granted summary judgment to the psychiatrist, concluding that 1) Georgia's Impact Rule barred the medical malpractice claim, and 2) that the patient could not recover damages due to Georgia's longstanding public policy of prohibiting wrongdoers from profiting from their misdeeds. On appeal, the Court of Appeals reversed.

The Court of Appeals outlined the origins of the Impact Rule, highlighting the concerns in emotional distress cases of frivolous litigation and the difficulties in proving causation between the negligence and the distress. The Court concluded that "[t]he above-stated policy concerns, however, are not present in medical malpractice cases." 307 Ga. App. at 457, 705 S.E.2d at 280. According to the Court, the requirements of medical malpractice claims, especially the presence of a physician-patient relationship and O.C.G.A. § 9-11-9.1's expert affidavit requirement, provide built-in safeguards to these policy concerns. Id.[15]

The fact that Bruscato was mentally incompetent to stand trial and had not yet been convicted of a crime was central to the Court's decision not to invoke Georgia's longstanding policy of prohibiting wrongdoers from benefiting from their wrongdoing. The Court concluded that Bruscato had not yet been found guilty of murder and, even if found competent to stand trial, could still be found not guilty by reason of insanity. Moreover, Bruscato claimed distress arising from the alleged malpractice—not the murder—so that "even if Bruscato is characterized as an intentional 'wrongdoer,' his

[15] The same rationale would apply to other mental health professionals.

status as such would not be a bar to his recovering for those damages that are not attributable to the alleged immoral or illegal act." Id. at 459, 705 S.E.2d at 281.

The Supreme Court granted certiorari to determine whether the Court of Appeals properly ruled that Bruscato's damages claims were not barred by public policy barring a wrongdoer from profiting from his wrongful acts. The Court affirmed, adopting the Court of Appeals analysis. O'Brien v. Bruscato, 289 Ga. 739, 715 S.E.2d 120 (2011). The Court concluded that while one who knowingly commits a wrongful act cannot use the act for personal gain, an individual's psychiatric condition may preclude him from knowingly committing a wrongful act. Because Bruscato had been found incompetent to stand trial, there had not been a finding that he knowingly committed a wrongful act. The Court also noted that Bruscato was not seeking to profit from the murder of his mother; rather, he was seeking damages for the suffering the alleged malpractice caused him.

In summary, Bruscato v. O'Brien effectively abrogates the Impact Rule in the medical malpractice context. Moreover, wrongful acts by the plaintiff do not necessarily provide an absolute bar to recovery where the Complaint alleges that the emotional distress arose from the malpractice and not from the wrongful act itself and/or the plaintiff did not knowingly commit the wrongful act.

D. Patient Suicide And Harm To Self

Unlike third-party-harm claims, which involve non-patients, suicide cases are based on a duty of care to the patient. Georgia first recognized liability for patient suicide in 1933. See Emory Univ. v. Shadburn, 47 Ga. App. 643, 643, 171 S.E. 192, 193 (1933) (holding that hospital has duty to "safeguard[] and protect[] the patient from any known or reasonably apprehended danger from himself . . . and to use ordinary and

reasonable care to prevent it"), aff'd, 180 Ga. 595, 180 S.E. 137 (1935). Until recently—and for the same reasons as articulated in the third-party cases—liability for suicide claims in Georgia was predicated on the mental health professional's right to "control" the conduct of his or her patient and thereby prevent the suicide. See Keppler v. Brunson, 205 Ga. App. 32, 33, 421 S.E.2d 306, 307 (1992) (citing Ermutlu, 203 Ga. App. 335, 336, 416 S.E.2d 792 (1992), for proposition that control required for liability in suicide claim). A 2012 decision by the Georgia Court of Appeals, however, casts doubt on the former "control" standard and suggests that an MHP can be liable for suicide claims under any circumstance, regardless of control, where the treatment of the patient "fell below the requisite standard of care, and this failure proximately caused [the] injury." Peterson v. Reeves, 315 Ga. App. 370, 375, 727 S.E.2d 171, 175 (2012) (citing O.C.G.A. § 51-1-27).

In Peterson, the patient, Reeves, brought a medical malpractice action against one of her treating psychiatrists for injuries sustained in a suicide attempt. Id. at 370, 727 S.E.2d at 172. During a tumultuous month of involuntary and voluntary treatments for psychotic behavior, Reeves was admitted for a second time to a voluntary treatment facility where Peterson, the psychiatrist, diagnosed her with several mental disorders and prescribed medication. Three days later, and without additional contact with Peterson, Reeves was discharged from the facility. Two days later she poured gasoline over herself and set herself on fire. Id. at 371-372, 727 S.E.2d at 173. Surviving the attempt, Reeves alleged that Peterson committed malpractice by failing to subject her to a suicide or self-injury risk assessment and for failing to involuntarily commit her. Id. at 372, 727 S.E.2d at 173. Peterson moved for summary judgment, asserting first that "Georgia law requires a psychiatrist to have control over a patient before he can be held

liable" and second that "no duty should be placed on a psychiatrist in a voluntary, outpatient facility to involuntarily commit any patient." Id. at 372-373, 727 S.E.2d at 173-174.

The trial court rejected Peterson's arguments and the Court of Appeals affirmed. The Court of Appeals dismissed the "control" line of cases as inapplicable to malpractice actions; i.e., a medical practitioner, regardless of whether the patient is under the practitioner's control, has a "long-recognized duty inherent in the doctor-patient relationship to exercise the applicable degree of care and skill in the treatment of [the] patient." Id. at 375, 727 S.E.2d at 175. And if the applicable degree of care and skill in the treatment of the patient requires the patient's involuntary commitment, then failing to commit the patient may amount to malpractice. The court stressed that it was "not creating[] a new 'duty to commit.' Rather, [it was] simply recognizing that, under some circumstances, the failure to commit may constitute a breach of the well-established duty of care physicians owe patients." Id. at 378, 727 S.E.2d at 177.

After Peterson, MHPs should be aware that failing to involuntarily commit a patient, or failing to properly assess whether a patient should be involuntarily committed, may constitute malpractice regardless of whether the patient is under the MHP's control. But MHPs must also be cognizant that involuntarily committing patients may "expose doctors to an increased risk of liability in suits for false imprisonment." Id. at 387, 727 S.E.2d at 181 (J. Andrews, dissenting).[16]

[16] The precedential value of Peterson is limited. Of the seven judges deciding the appeal, two joined the opinion, two concurred specially, and one concurred in the judgment only. Such a combination should be physical precedent only. Court of Appeals Rule 33(a). Nevertheless, the special concurrence mirrors the majority opinion, entirely agreeing with it in substance and only adding clarifications. While not binding precedent, Peterson is strong persuasive authority.

Unresolved are several possible defenses to patient suicide claims. Among the least developed are defenses based on contributory or comparative negligence and lack of proximate causation.[17] Georgia's contributory negligence statute reduces a claimant's recovery by the degree of his negligence, and bars a claimant from any recovery if the claimant bears fifty percent or more of the responsibility for the negligent act. O.C.G.A. § 51-11-7. The Georgia Court of Appeals has rejected the theory that suicide bars recovery as a matter of law as an act of contributory negligence. Brandvain v. Ridgeview Inst., Inc., 188 Ga. App. 106, 119, 372 S.E.2d 265, 275 (1988) (holding that defenses of contributory or comparative negligence are matters for jury consideration and are not determinable as matter of law), aff'd, 259 Ga. 376, 382 S.E.2d 597 (1989); see also Peterson, 315 Ga. App. At 376, 727 S.E.2d at 176 ("proximate cause is undeniably a jury question and is always to be determined on the facts of each case upon mixed considerations of logic, common sense, justice, policy, and precedent" (citation omitted)). The Court in Brandvain also rejected the theory that suicide acts as an intervening cause, cutting off proximate causation. Id. at 116, 372 S.E.2d at 273 (suicide not an intervening cause if reasonably foreseeable to the defendant). However, in Miranda v. Fulton DeKalb Hospital Authority, 284 Ga. App. 203, 664 S.E.2d 164 (2007), the Court of Appeals found that the alleged failure to properly monitor a suicidal patient was not the proximate cause of the patient's suicide. The patient was placed in restraints with an order that he be monitored every 15 minutes. He managed to escape and committed suicide 15 hours later. Plaintiff's expert witness testified that had the patient been continually monitored his escape would have been much more difficult.

[17] Lack of proximate cause is not truly a defense, as proximate causation is part of a plaintiff's prima facie case for negligence.

The Court concluded as a matter of law that this testimony failed to establish proximate cause.

Finally, Georgia law provides qualified statutory immunity to mental health professionals' decisions to admit or discharge. O.C.G.A. § 37-3-4.[18] This immunity can insulate these professionals if a patient is discharged and subsequently commits suicide, so long as the professional acted in good faith. See generally Poss v. Ga. Reg'l Hosp., 676 F. Supp. 258, 262 (S.D. Ga. 1987), aff'd sub nom., Poss v. Azar, 874 F.2d 820 (11th Cir. 1989). But that immunity is unavailable if the health professional "fail[ed] to meet the applicable standard of care in the provision of treatment to a patient." O.C.G.A. § 37-3-4.

E. Sexual Relations With A Patient

As a general rule, licensing board rules and ethical principles governing mental health professionals impose an absolute ban on sexual relations between mental health professionals and their current patients. In Georgia, such conduct can expose the professional to criminal prosecution and disciplinary sanctions by the appropriate licensing board,[19] as well as substantial civil liability. These rules also generally prohibit a practitioner from entering into a professional relationship with a patient with whom the practitioner has had a sexual relationship.

Under Georgia law, a psychotherapist who engages in sexual relations with a patient is deemed to have committed the felony of sexual assault, regardless of whether

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[18] See also supra, Part II, Section A.

[19] Virtually all the licensing boards in Georgia governing mental health professionals now have disciplinary rules prohibiting sexual relations between the professional and a patient or client, as do the ethical codes of most national medical and mental health professional organizations.

the patient consented to the relationship. O.C.G.A. § 16-6-5.1(c). The rationale for the Code section appears to be that a person under the care of a therapist is deemed to be in the "custody" of the therapist such that the patient cannot legally and knowingly consent to a sexual relationship with the therapist. Cf. Howard v. State, 272 Ga. 242, 243, 527 S.E.2d 194, 195 (2000) ("We observed that, to fulfill its role, the State can protect the public by enacting legislation which criminalizes various forms of sexual conduct, including sexual conduct which can be said to take place in private, between consenting adults: e.g., sexual contact with prisoners, the institutionalized, and the patients of psychotherapists (O.C.G.A. § 16-6-5.1); incest (O.C.G.A. § 16-6-22); and solicitation of sodomy (O.C.G.A. § 16-6-15)."). Apparently no Georgia appellate court has interpreted this Code section as it applies to mental health professionals, although there have been prosecutions of mental health professionals under the statute. See Demetrios v. State, 246 Ga. App. 506, 541 S.E.2d 83 (2000) (prosecution for rape, sexual assault and violation of § 16-6-5.1(c)). The Code may also allow for a private right of action. Cf. Am. Home Assurance Co. v. Smith, 218 Ga. App. 536, 538, 462 S.E.2d 441, 444 (1995) ("A civil remedy may also be available [under § 16-6-5.1], although Georgia's criminal statute does not directly contemplate one") (dictum).

A mental health professional who ignores § 16-6-5.1 and the many ethical and professional rules proscribing sexual relationships with a patient likely faces a cause of action for medical malpractice, fraud, assault, battery, and intentional infliction of emotional distress. See, e.g., Hickey v. Askren, 198 Ga. App. 718, 403 S.E.2d 225 (1991) (decided on statute of limitation grounds). Furthermore, most insurers now expressly exclude such claims from coverage or limit the amount of coverage. Even absent such an exclusion, an insurer may take the position that such claims are not covered or are

excluded by a general fraudulent or intentional acts exclusion. See Am. Home Assurance Co., 218 Ga. App. at 536, 462 S.E.2d at 444 (upholding provision in malpractice liability insurance policy limiting coverage to $25,000 in lawsuits involving sexual misconduct by the insured).

F. Child Abuse Reporting

The Georgia Child Abuse Reporting Act requires that healthcare professionals, including psychologists, nurses, professional counselors, social workers and marriage and family therapists, report suspected child abuse. Such a report is required notwithstanding "that the reasonable cause to believe such abuse has occurred or is occurring is based in whole or in part upon any communication to that person which is otherwise made privileged or confidential by law." O.C.G.A. § 19-7-5(g). No private right of action exists against healthcare professionals who fail to report. The Georgia courts have also held that healthcare professionals enjoy good faith immunity for incorrect reports of child abuse.

1. No Private Right Of Action For Failure To Report

The Georgia courts have held that there is no private cause of action against a healthcare professional who fails to report suspected child abuse in violation of O.C.G.A. § 19-7-5(g). See Cechman v. Travis, 202 Ga. App. 255, 414 S.E.2d 282 (1991) (O.C.G.A. § 19-7-5 does not create private right of action against a physician who failed to identify and/or report abuse); Vance v. TRC, 229 Ga. App. 608, 494 S.E.2d 714 (1997) (reaffirming Cechman and holding that O.C.G.A. § 19-7-5(g) does not create a private right of action even where a physician failed to report possible sex abuse of a minor); Fulton-DeKalb Hosp. Auth. v. Reliance Trust Co., 270 Ga. App. 822, 608 S.E.2d 272 (2004) (O.C.G.A. § 19-7-5(g) does not create private right of action against a hospital for

failing to identify and/or report evidence of suspected child abuse); see also, e.g., Anthony v. Am. Gen. Fin. Servs., 287 Ga. 448, 456, 697 S.E.2d 166, 172 (2010) (citing favorably to Cechman and Vance for the proposition that "the public policy advanced by a penal statute, no matter how strong, cannot support the implication of a private civil cause of action that is not based on the actual provisions of the relevant statute" (emphasis in original)).

In 2006, the Georgia Court of Appeals reaffirmed that mental health providers have no duty to the victim to report suspected child abuse. McGarrah v. Posig, 280 Ga. App. 808, 635 S.E.2d 219 (2006). In McGarrah, a mother and guardian of a minor child brought an action against a licensed psychologist, who provided therapy and treatment to the plaintiff's son, and the psychologist's practice, alleging that the psychologist breached a professional standard of care by her failure to detect and report alleged sexual abuse. The mother attempted to distinguish Chechman, Vance, and Fulton-DeKalb Hospital on the grounds that in those decisions the plaintiffs' common-law claims failed, not because no cause of action at common law existed, but because the injury to the plaintiff was not the proximate result of the breach of any legal duty owed by the defendants. Id. at 809-810, 635 S.E.2d at 221. The Court disagreed, reaffirming that the legal duty to report child abuse is imposed by Georgia statute, which does not give rise to a private cause of action for damages.[20] Id. at 810, 635 S.E.2d at 222.

[20] The Court acknowledged that, at least in Fulton-DeKalb Hosp., lack of proximate causation was an additional ground for denying the plaintiff's recovery for damages resulting from failure to report suspected child abuse. McGarrah, 280 Ga. App. at 810, 635 S.E.2d at 222.

2. Good Faith Immunity For Reports

The Georgia Child Abuse Reporting Act provides broad immunity for anyone who reports suspected child abuse. Under the Act, any person who participates in the making of a report of suspected child abuse is immune from civil or criminal liability that would otherwise be incurred, "provided such participation . . . is made in good faith." O.C.G.A. § 19-7-5(f). In 2003, the Supreme Court of Georgia clarified the immunity provision of the Act in O'Heron v. Blaney, 276 Ga. 871, 583 S.E.2d 834 (2003).

The Court in O'Heron held that the Act's immunity provision allows immunity to attach in two ways, either by showing that "reasonable cause" exists, or by showing "good faith." Id. at 873, 583 S.E.2d at 836. The Court explained that the Act requires a reporter who has reasonable cause to suspect child abuse to report to avoid facing criminal penalties. The trigger for the duty to report is a "reasonable cause to believe," which requires an objective analysis. Id. at 872, 583 S.E.2d at 836. The relevant question, therefore, is "whether the information available at the time would lead a reasonable person in the position of the reporter to suspect abuse." Id. at 873, 583 S.E.2d at 836. If an objective analysis supports the reporter's conclusion that child abuse has occurred, then immunity attaches and there is no need to further examine the reporter's good faith. Id.

If, on the other hand, the information would not lead a reasonable person to suspect child abuse under an objective standard, then the reporter may still enjoy immunity if she made the report in good faith. The Court described the Act's good faith statute as a subjective one. It described the relevant question as "whether the reporter honestly believed she had a duty to report." Id. A reporter acting in good faith enjoys

immunity under the Act even if she is negligent or exercises bad judgment. Id. at 873-74, 583 S.E.2d at 836-37.