Research Team

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Legislative Appropriation

- National Survey of legislative and case law
  - Comprehensive review of case law and statutes in the United States on duty to warn and duty to protect
  - Description of how Washington State's law compares to other states’ duties to third parties in context of mental health care
- Analysis of Impact of *Volk v. DeMeerleer*
  - In context of national law
  - In the context of existing Washington case law
  - To what extent, if any, the *Volk* decision changes the WA law
- Report on the likely impact of *Volk v. DeMeerleer* on mental health professionals, practice, facilities and resources
- Report on stakeholders’ views on liability and practice impact post-*Volk*
PRIMARY ISSUES RAISED BY VOLK
VARYING USE OF TERMS

> Duty to warn
> Duty to protect
> Duty to control
When does a mental health care provider have a duty to a third party who may be endangered by a patient?

Seminal case: Tarasoff v. University of California (1976) held that:

- when a patient threatens serious danger of violence to another, the therapist is obliged to use reasonable care to protect the foreseeable victim against such danger
- Earlier Tarasoff case used duty to warn
- This confusion of terms continues to be problematic in clarifying the law
Background—Washington interprets *Tarasoff* in 1983

> *Petersen v. State* (1983) held that psychiatrists have a duty to protect anyone foreseeable

- Patient had injured another in car accident shortly after release from Western Washington State Hospital
- No identifiable victim
- Still, court ruled psychiatrists had failed to protect universe of third parties by not petitioning for continued commitment
Background—A number of states narrow *Tarasoff* by statute, incl. WA

> 1987, the Washington State Legislature narrowed the *Petersen* holding

> (Now) RCW 71.05.120(3): mental health professionals do have a “duty to warn or to take reasonable precautions to provide protection from violent behavior where the patient has communicated an actual threat of physical violence against a reasonably identifiable victim or victims.”

– NOTE: codified in Involuntary Treatment Act (inpatient)
Facts: *Volk v. DeMeerleer*

> 2001—2009—DeMeerleer has intermittent outpatient clinic visits
  > Jan. 23, 2004—last homicidal thought in clinical record
  > June 2006-June 2009, no known visits with Dr. Ashby or information about clinic contact
  > June 2009, saw someone (unknown) at clinic who referred patient to outpatient clinic; unclear if patient followed up
  > Final appointment, April 16, 2010, makes no threat against girlfriend and her children

> July 16, 2010—Girlfriend ended their relationship. DeMeerleer did not attempt to contact Ashby or clinic.

> July 17, 2010—DeMeerleer kills girlfriend and one son, seriously harms other son
Primary issue in *Volk*—Which standard applies in the outpatient setting?

- **RCW 71.05.120(3) standard**: Does therapist owe a duty to warn or to take reasonable precautions to provide protection from violent behavior where the patient has communicated an actual threat of physical violence against a reasonably identifiable victim or victims?

- **Common law standard under *Petersen***: Does therapist owe duty to warn any foreseeable victims?
WA Supreme Court *Volk* decision

> Washington Supreme Court in December 2016
> *Volk v DeMeerleer* holds that outpatient providers have a duty to protect any foreseeable victim from dangers posed by a patient
  > - Thus duty to protect third parties is broader than that applied in the inpatient setting where the patient is more subject to control
  > - Case settled after remand
Two post-Volk cases filed

> Toone v. Pioneer Human Services, filed May 25, 2017 in Spokane County Superior Court
  – Mother files wrongful death suit after son’s suicide
  – Alleges providers failed to advise her of her son’s worsening condition and risk for suicide

> Desiree Douglass v. King County D/B/A UW Medicine/Harborview Medical Center, filed August 17, 2017 in King County Superior Court
  – Chronically mentally ill patient discharged from Harborview
  – A few hours later, patient stabs stranger on the street
NATIONAL SURVEY OF DUTY TO WARN/PROTECT CASES AND STATUTES
Volk Questions in Context of National Law

- How do other states address and define duty to third parties in the mental health care context?
- Which providers are covered by a duty to third parties and when does the provider accrue that duty?
- What is the standard determining when a duty to third parties arises?
- How is the class of beneficiaries defined?
- How is the duty to third parties discharged or extinguished?
Mental health providers who have duties to third parties

> Variably defined by states ranging from:
  – Generic: “mental health providers” (Arizona) or “therapists” (Utah); “health care providers” (Rhode Island)
  – More specific: “psychotherapists” or “a person that patient reasonably believes is a psychotherapist” (California)
  – Limited to categories of licensed providers:
    > Marriage and Family Counselors
    > Advanced Practice Registered Nurses trained in psychiatric care
    > Licensed Professional Counselors
  – Unspecified (South Carolina)
Role of the *Restatement (Second) of Torts*

> Most states recognizing a duty to warn or protect third parties ground the duty in Section 315 of the *Restatement*.

  - Section 315 is an exception to the general rule that no one owes a duty to protect a third party from harming another.

  - Section 315:
    > A person has a duty to control the conduct of a third person and thereby to prevent physical harm to another if:
    
    - A special relation exists between the actor and the third person which imposes a duty upon the actor to **control** the third person’s conduct, or
    
    - A special relation exists between the actor and the other which give to the other a right of protection

> Section 315 has been interpreted as requiring a relationship to be “definite, established, and continuing” and as containing some degree of control by the defendant over a third party.
Specifying the Duty to Third Parties

- States characterize duty differently
  - 9 states use the term “duty to warn”
    > Arizona, Arkansas, Georgia, Michigan, Mississippi, Missouri, Montana, South Carolina, and Wisconsin
  - 6 states use the term “duty to protect”
    > California, Delaware, Ohio, Pennsylvania, Vermont, and Virginia
    > Arguably this term provides for a broader set of actions on the part of the provider
  - 9 states provide for discretion to disclose to third parties, but not a duty to protect or to warn
  - 8 states have no duties to third parties in the context of mental health care
19 states use the terms “duty to warn” and “duty to protect” interchangeably or in tandem

<table>
<thead>
<tr>
<th>States</th>
<th>Description of Duties</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama, Colorado, Illinois,</td>
<td>Statutory duty to warn and protect; no distinction between terms made</td>
</tr>
<tr>
<td>Indiana**, Kentucky*,</td>
<td>* duty limited to inpatient context</td>
</tr>
<tr>
<td>Louisiana,</td>
<td>** statute uses both terms, case law refers only to duty to warn</td>
</tr>
<tr>
<td>Maryland, Nebraska, New</td>
<td></td>
</tr>
<tr>
<td>Hampshire**, New Jersey,</td>
<td></td>
</tr>
<tr>
<td>Oklahoma, Tennessee,</td>
<td></td>
</tr>
<tr>
<td>Washington</td>
<td></td>
</tr>
<tr>
<td>Idaho, Massachusetts,</td>
<td>Statutory and/or common law duty to warn and protect integrally tied to</td>
</tr>
<tr>
<td>Minnesota, New York, South</td>
<td>duty or capacity to control.</td>
</tr>
<tr>
<td>Dakota, Utah</td>
<td></td>
</tr>
</tbody>
</table>
When does a duty to third parties arise?

- All but two of the states with a duty to protect or warn characterize the threat triggering the duty to third parties as one which is a **serious, imminent, and explicit threat of physical harm or death**

- Georgia: duty to warn third parties of “generalized threats”

- Wisconsin: broad common law duty to warn when there is foreseeably or “harm”
# How are third party beneficiaries defined?

<table>
<thead>
<tr>
<th>States</th>
<th>Description of third party</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alabama, Arkansas, California, Delaware, Georgia, Idaho, Illinois, Indiana, Kentucky, Louisiana, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, Ohio, Oklahoma, Pennsylvania, South Dakota, Utah, Vermont, Virginia, <strong>Washington (pre-Volk and inpatient)</strong></td>
<td>Reasonably Identifiable Victim or Victims; clearly identifiable</td>
</tr>
<tr>
<td>Arizona</td>
<td>Persons within a “zone of risk” – ie parents or other in foreseeable area of danger (AZ); patient’s family members (RI)</td>
</tr>
<tr>
<td>Colorado, Maryland, Minnesota, New York, South Carolina, Tennessee</td>
<td><strong>Specific</strong> person or persons; specific clearly identified or identifiable potential victim, endangered person</td>
</tr>
</tbody>
</table>
How is the duty to third parties discharged or extinguished?

> Directly warning the readily identifiable third party victim and/or notifying law enforcement of the threat and/or commitment of the patient
  - This is the standard for most of the duty to warn, duty to protect and duty to warn and protect states

> A few states provide more guidance, albeit not necessary clear guidance
  - Alabama: “reasonable” steps
  - Indiana: prevent patient from using violence until law enforcement arrives
  - Ohio: commitment of the patient, notification to both law enforcement and the victim and creation of a treatment plan to thwart the threat and a second risk assessment
VOLK IN CONTEXT OF WA AND NATIONAL LAW
Volk in Context of Washington Law

> Between *Petersen* and *Volk*, series of duty to warn/protect cases

- Involving mental health providers, law enforcement, or both
- Those emerging from outpatient therapy scenario have all found that either the “special relationship” requirement was not met or the outpatient setting did not provide sufficient opportunity to control the patient.
- Cases finding an affirmative duty to protect were confined to those in which law enforcement (parole and probation officers) was supervising the perpetrator and had the capacity to control perpetrator and prevent harm to others.
Binchus v. State (2016) had both corrections and mental health personnel involved.

- Recently released county jail inmate with long history of mental illness killed and injured several people in a psychotic shooting spree
- Victims survivors sued arguing that State owed a duty to victims given the county had a “special relationship” giving rise to a duty to endangered third parties
- Court held that once patient was released and out of the control of the county, there was no duty to protect against foreseeable dangers
The duty to protect any foreseeable third party is broader than any other state except for Wisconsin.

- Wisconsin has addressed the issue in only one case (*Shuster v. Altenberg*) which explicitly embraced more extensive, broad liability.

In all but two jurisdictions, the duty is triggered by a *serious, imminent, and explicit threat of physical harm or death*.

- *Volk* did not have such clarity in terms of the threat.

Most states utilize Sec. 315 of the Restatement and link the duty to the capacity to control.

Some states limit the duty to protect or to warn third parties to situations emanating from an inpatient commitment, as opposed to outpatient treatment.
INPATIENT AND OUTPATIENT BED CAPACITY IN WA

<table>
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<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>Chemical Dependency Professional</td>
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<td>2874</td>
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<tr>
<td>Chemical Dependency Professional Trainee</td>
<td>1492</td>
<td>1542</td>
<td>1454</td>
<td>1546</td>
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<tr>
<td>Agency Affiliated Counselor</td>
<td>6529</td>
<td>7059</td>
<td>7990</td>
<td>8884</td>
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<tr>
<td>Certified Counselor</td>
<td>2</td>
<td>3</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Certified Advisor</td>
<td>691</td>
<td>675</td>
<td>598</td>
<td>560</td>
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<td>Hypnotherapist</td>
<td>710</td>
<td>736</td>
<td>764</td>
<td>747</td>
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<tr>
<td>Marriage and Family Therapist Associate</td>
<td>423</td>
<td>454</td>
<td>504</td>
<td>556</td>
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<td>Marriage and Family Therapist</td>
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<td>1408</td>
<td>1473</td>
<td>1572</td>
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<tr>
<td>Mental Health Counselor Associate</td>
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<td>1717</td>
<td>1763</td>
<td>1890</td>
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<td>Mental Health Counselor</td>
<td>5653</td>
<td>5912</td>
<td>6211</td>
<td>6577</td>
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<tr>
<td>Psychologist</td>
<td>2596</td>
<td>2707</td>
<td>2831</td>
<td>2925</td>
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<td>Sex Offender Treatment Provider Affiliate</td>
<td>34</td>
<td>32</td>
<td>27</td>
<td>24</td>
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<td>Sex Offender Treatment Provider</td>
<td>102</td>
<td>99</td>
<td>101</td>
<td>98</td>
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<tr>
<td>Advanced Social Worker (MSW)</td>
<td>110</td>
<td>120</td>
<td>117</td>
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<td>Associate Advanced Social Worker</td>
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<td>202</td>
<td>221</td>
<td>232</td>
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<tr>
<td>Associate Independent Clinical Social Worker</td>
<td>1084</td>
<td>1274</td>
<td>1483</td>
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<tr>
<td>Independent Clinical Social Worker</td>
<td>3659</td>
<td>3787</td>
<td>3966</td>
<td>4106</td>
</tr>
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</table>

Source: WA Department of Health, 7/13/17
Psychiatrists licensed in WA

> 1,038 psychiatrists licensed in WA according to Medical Quality Assurance Commission data, July 6, 2017

Psychiatrists in WA by geographic area

- NW
- SW
- Central
- Eastern
Psychiatric Advanced Registered Nurse Practitioners (ARNPs) in WA

> 317 Psychiatric ARNPs in WA in 2016 Behavioral Health Workforce Assessment
  – Mean age: 61 years old

278 Nurses work in Accountable Community of Health Organizations
WA Funded Bed Capacity

> Since FY 2012, the numbers have generally stayed the same:
> Western State Hospital, Lakewood, WA
>   - Civil beds, 557
>   - Forensic beds, 285
> Eastern State Hospital, Medical Lake, WA
>   - Civil beds, 192
>   - Forensic beds, 95 until 2015, 125 for 2016 and 2017
> Child Study and Treatment Center, serves 5-17 year olds, Lakewood, WA
>   - Civil beds, 47
> Evaluation and Treatment capacity statewide, 937 beds
>   - 300 beds located in psychiatric units of inpatient acute care hospitals (Inpatient)
>   - 361 beds located in freestanding psychiatric hospitals (inpatient)
>   - 276 beds located in freestanding E&T centers licensed as residential treatment facilities (outpatient)
## Eastern State Hospital Occupancy Rate

**Date:** 10/23/2017

<table>
<thead>
<tr>
<th>Fiscal_Year</th>
<th>Patient_Days</th>
<th>Capacity</th>
<th>Percent_Occupancy</th>
</tr>
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<tbody>
<tr>
<td>2007</td>
<td>101755</td>
<td>115705</td>
<td>88%</td>
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<tr>
<td>2008</td>
<td>104982</td>
<td>116022</td>
<td>90%</td>
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<tr>
<td>2009</td>
<td>103946</td>
<td>110275</td>
<td>94%</td>
</tr>
<tr>
<td>2010</td>
<td>101801</td>
<td>104755</td>
<td>97%</td>
</tr>
<tr>
<td>2011</td>
<td>100630</td>
<td>104755</td>
<td>96%</td>
</tr>
<tr>
<td>2012</td>
<td>100194</td>
<td>105042</td>
<td>95%</td>
</tr>
<tr>
<td>2013</td>
<td>98364</td>
<td>104755</td>
<td>94%</td>
</tr>
<tr>
<td>2014</td>
<td>97736</td>
<td>104755</td>
<td>93%</td>
</tr>
<tr>
<td>2015</td>
<td>89597</td>
<td>104755</td>
<td>86%</td>
</tr>
<tr>
<td>2016</td>
<td>94515</td>
<td>110502</td>
<td>86%</td>
</tr>
<tr>
<td>2017</td>
<td>103258</td>
<td>115705</td>
<td>89%</td>
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</table>

**Source:** DSHS Behavioral Health Administration
### Western State Hospital Occupancy Rate

Date: October 24, 2017

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Capacity on Last Day of FY</th>
<th>Percent Occupancy on Last Day of FY</th>
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<tbody>
<tr>
<td>2007</td>
<td>897</td>
<td>94</td>
</tr>
<tr>
<td>2008</td>
<td>927</td>
<td>96</td>
</tr>
<tr>
<td>2009</td>
<td>867</td>
<td>90</td>
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<td>2010</td>
<td>837</td>
<td>93</td>
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<tr>
<td>2011</td>
<td>807</td>
<td>92</td>
</tr>
<tr>
<td>2012</td>
<td>827</td>
<td>93</td>
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<tr>
<td>2013</td>
<td>827</td>
<td>95</td>
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<tr>
<td>2014</td>
<td>827</td>
<td>99</td>
</tr>
<tr>
<td>2015</td>
<td>842</td>
<td>99</td>
</tr>
<tr>
<td>2016</td>
<td>842</td>
<td>94</td>
</tr>
<tr>
<td>2017</td>
<td>842</td>
<td>96</td>
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</tbody>
</table>

Source: DSHS Behavioral Health Administration
## Child Study and Treatment Center Occupancy Rate

**Date:** 10/23/2017

<table>
<thead>
<tr>
<th>Fiscal Year</th>
<th>Patient Days</th>
<th>Capacity</th>
<th>Percent Occupancy</th>
</tr>
</thead>
<tbody>
<tr>
<td>2007</td>
<td>16769</td>
<td>17155</td>
<td>98%</td>
</tr>
<tr>
<td>2008</td>
<td>16901</td>
<td>17202</td>
<td>98%</td>
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<tr>
<td>2009</td>
<td>16767</td>
<td>17155</td>
<td>98%</td>
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<tr>
<td>2010</td>
<td>16817</td>
<td>17155</td>
<td>98%</td>
</tr>
<tr>
<td>2011</td>
<td>16114</td>
<td>17155</td>
<td>94%</td>
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<tr>
<td>2012</td>
<td>16122</td>
<td>17202</td>
<td>94%</td>
</tr>
<tr>
<td>2013</td>
<td>16822</td>
<td>17155</td>
<td>98%</td>
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<td>2014</td>
<td>16570</td>
<td>17155</td>
<td>97%</td>
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<tr>
<td>2015</td>
<td>16406</td>
<td>17155</td>
<td>96%</td>
</tr>
<tr>
<td>2016</td>
<td>16660</td>
<td>17202</td>
<td>97%</td>
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<tr>
<td>2017</td>
<td>16239</td>
<td>17155</td>
<td>95%</td>
</tr>
</tbody>
</table>
Continuing Single Bed Certifications

Statewide SBC by Month

Source: DSE report and graph ran 7/20/17
Mandatory DMHP “No Bed” Reports

Statewide No Bed Reports by Month

Source DSE report ran 7/25/17 Line Graph by Robby Pellett
INSURANCE ISSUES RELATED TO VOLK
Insurance Claims, Policy Provisions, and Rates Related to Volk

> No insurance claims related to third-party duty to warn/duty to protect filed yet as a result of Volk

> To date, no insurer has made any changes to rates or policy provisions as a result of Volk

> Concern among providers, but too early to know what, if any, changes will occur
STAKEHOLDER SURVEYS
Stakeholders Listed in Appropriation

(1) Defense Attorneys;
(2) Washington State Association for Justice
(3) Department of Social and Health Services;
(4) Washington Academy of Family Physicians;
(5) Washington Association for Mental Health Treatment Protection;
(6) Office of the Insurance Commissioner;
(7) Washington Council for Behavioral Health;
(8) Washington State Hospital Association;
(9) Washington State Medical Association;
(10) Washington State Psychiatric Association;
Stakeholders Listed in Appropriation (con’t)

(11) Washington State Psychological Association;
(12) Washington State Society for Clinical Social Work;
(13) Washington Association of Sheriffs and Police Chiefs;
(14) Victim Support Services;
(15) NW Health Law Advocates;
(16) National Alliance on Mental Illness;
(17) American Civil Liberties Union; and,
(18) A sample of families who testified or presented evidence of their cases to the legislature.
**Additional stakeholders**

- Washington Association of Designated Mental Health Professionals;
- Andrew Benjamin; Clinical Professor of Psychology, Affiliate Professor of Law, University of Washington;
- Association of Advanced Practice Psychiatric Nurses; and,
Surveys

(1) National Association of Social Worker, WA Chapter;
(2) Northwestern Psychoanalytic Society & Institute;
(3) Seattle Psychoanalytic Society & Institute;
(4) UW Department of Psychiatry & Behavioral Sciences;
(5) Washington Mental Health Counselors Association;
(6) WA State Coalition of Mental Health Providers & Consumers;
(7) Washington State Psychiatric Association;
(8) Washington State Psychological Association; and,
Mental Health Providers Familiar with *Volk*

Mental Health Providers Who Knew of *Volk* Before Survey

- Knew: 89%
- Did Not Know: 11%
Mental Health Providers Considering Practice Changes Based on Volk

Mental Health Providers Considering Practice Changes Based on Volk

- Currently Considering Making Changes: 70%
- Not Yet Considering Changes: 30%
Mental Health Providers Reporting Changes Made to Practice Based on *Volk*

- 50% Have Made Changes
- 50% Have Not Yet Made Changes
9 THEMES FROM CHANGES MADE TO PRACTICE
9 Themes From Changes Made to Practice

> 1) Increased screening/Less likely to accept high-risk patients

  “I’m reluctant to take on new patients with a history or risk of violence, self-harm, anger problems and psychotic disorders. These are patients that are already very hard to find resources for outside of community mental health which is woefully underfunded and relies primarily on medications, with little to no talk therapy available. I worry that the most seriously mentally ill will have an even harder time accessing treatment.”
9 Themes From Changes Made to Practice

> 2) Increased screening/Will not accept high-risk patients

  – “[I]f a potential client seems to be deeply depressed, has a history of suicide, or is particularly volatile, I will refuse to see them. In the past, I accepted such clients. (And I had no bad experiences doing so.)”

> 3) Increased documentation

  – “Ask about and document additional specific questions of clients.”
9 Themes From Changes Made to Practice

> 4) Modified disclosure form

  – “Modified my disclosure statement – added Volk language to list of mandated reporting requirements.”

> 5) Increased calls, or plans to increase calls, to law enforcement

  – “[C]alling law enforcement even when I don’t think a patient is an immediate threat so that I can document that I did so.”
9 Themes From Changes Made to Practice

> 6) Not practicing or considering not practicing
   - “I am quitting psychiatric practice in Washington due to the unreasonable level of risk this decision puts me under.”

> 7) Focusing on potential victims/harms more than patient care
   - “Consider a broader range of potential victims and broader range of potential types of harm that a patient can inflict. Given vagueness of court ruling, forced to think about types of harm besides physical violence. Some of my patients have been very put off by my inquiry into these other areas, especially because they really aren’t relevant to my work and there is no way that we can identify all the possible types of harms and then all of the possible victims. It is distracting from our meaningful work together, which for some patients, is focused on risk reduction for physical harm. I am just alienating them.”
9 Themes From Changes Made to Practice

> 8) Increased referrals, or plans to increase referrals, for involuntary detainment

  – “Lower threshold for referring for hospitalization.”

> 9) Peer consultations

  – “Feel like I need to consult more but this is not realistic for many patient encounters and I am doing this for liability reasons, not that my management would change.”
PERCEPTIONS OF DUTY OWED PRE- AND POST- VOLK
Perceptions of Duty Owed Pre- and Post- *Volk*

> Pre- *Volk*

- Duty owed was defined in RCW 71.05.120
- Duty owed applied in all treatment settings
- Clinical judgment was used in satisfying duty
- Warning was generally recognized as necessary when an actual threat against a reasonably identifiable victim was communicated; otherwise, other actions were possible
Perceptions of Duty Owed Pre- and Post- *Volk*

> **Post- *Volk***
> - Lack of clarity regarding duty owed, when it begins, how to discharge, when it ends
> - Any threat
>   > Notify potential victim
>   > Notify law enforcement
>   > Call DMHP and request ITA
> - On the other hand – the duty didn’t substantively change
>   > It remains the duty to protect by exercising reasonable precautions, and the duty to warn
>   > Prior to *Volk*, providers may not have thought that a vague threat was actionable
Additional Concerns Raised by Stakeholders

> Mental health services are not sufficiently funded;
> Many providers are concerned that to satisfy *Volk* they will be less able to use their clinical judgment;
> Providers cannot accurately predict dangerousness;
> Confidentiality and privacy remain a concern;
> Potential implications to mental health workforce; and,
> One uniform standard needed in Washington State.
CONCLUSIONS

> *Volk* substantially changed the duty to protect and warn in Washington with respect to outpatient mental health care
  > Duty is broader for outpatient providers than for inpatient providers who have more power to control
> Washington is now an outlier
  > No other state but Wisconsin has such a broad duty for outpatient care
> Providers are uncertain how to practice under *Volk*
> Little to no additional inpatient capacity
  > Washington still relying on single bed certifications to fill gaps in access to inpatient mental health care