Duty to Protect or Warn
Sebastian “Seb” Striefel, PhD
Department of Psychology, Utah State University, Logan, UT
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Violence is a fact of life. As such, virtually every state has laws specifying that health care professionals have a duty to protect or warn, and the specific legal requirements vary from state to state and discipline to discipline. Every biofeedback practitioner providing mental health care and related services should be familiar with the relevant laws of the state in which he or she practices and with the court precedents related to that law. Being able to deal appropriately with the relevant issues surrounding confidentiality and the ability to assess for, predict dangerousness to self and others, and deal with the same are expected standards of care that can vary in implementation from state to state. Consultation with colleagues and/or an attorney can be important.

Introduction
Violence is an ever increasing concern in our society. One need but read a newspaper to become aware of the prevalence of violence in our individual communities, the country, and the world. Violence is also a recurring problem encountered by health care professionals in the form of child abuse and neglect, client suicide or threat of suicide, client intent to kill another or actually doing so, and, of course, clients who kill or try to kill their health care provider. Health care professionals providing biofeedback services need to be familiar with the laws governing their activities in reference to actual or potential violence, how to assess the probability of violence, and their duty to their clients and others in reference to possible violence. These laws would include the following:

1. Involuntary commitment laws;
2. Child abuse and neglect reporting laws;
3. Abuse, neglect, or exploitation of disabled persons reporting laws;
4. Abuse, neglect, or exploitation of the aging reporting laws;
5. Duty to protect or warn laws; and

Health care professionals—by virtue of being professionals—are holding themselves out to the public as having special knowledge and skills in the form of services for which some clients and some third parties are willing to pay. Being a professional means that one has special obligations and responsibilities to those served and often to others as specified in ethical principles (Association for Applied Psychophysiology and Biofeedback, 2003), practice guidelines and standards (Striefel, 2004), and laws. This article will focus primarily on health care professionals’ responsibilities as specified in the duty to protect and/or warn laws.

History and Origin
The specific duty to warn and protect varies from state to state based on the actual duty to protect or warn law of that state (Smith, 1996). In addition, there are numerous court cases that have extended and/or limited the requirements of the duty to warn and protect laws. Although the findings of a court case are usually binding only in the state in which the court case was filed, such cases often serve as a precedent that is used in deliberating court cases in other states and in modifying the duty to warn and protect laws in other states. For example, the Tarasoff case in California in 1969 resulted in litigation that ended up in the California Supreme Court some 6½ years later. In that case, a patient (Prosenjit Poddar) informed his psychotherapist at the University of California in Berkeley that he intended to kill his girlfriend, Tatiana Tarasoff. Dr. Moore, the psychotherapist, contacted the police to have Poddar confined to an institution for observation. The police decided that Poddar was harmless, and Dr. Moore’s supervisor requested that all records of contact with the police be destroyed. Two months later, Poddar killed Ms. Tarasoff. The parents sued the university, arguing that at least a warning should have been issued to Ms. Tarasoff. Dr. Moore, the psychotherapist, contacted the police to have Poddar confined to an institution for observation. The police decided that Poddar was harmless, and Dr. Moore’s supervisor requested that all records of contact with the police be destroyed. Two months later, Poddar killed Ms. Tarasoff. The parents sued the university, arguing that at least a warning should have been issued to Ms. Tarasoff. The California Supreme Court agreed that the defendants had breached their duty to exert reasonable care. The court concluded that therapists have a duty to warn identifiable third parties of potential violence arising from a patient’s
threats. That court case resulted in a proliferation of duty to warn and protect laws in California and across the country, with each state creating its own version of duties and limitations. See Gellerman and Suddath (2005) or http://www.uky.edu/Classes/PHI/305.002/conf.htm for more information on the case.

Duty to Protect or Warn

Virtually every state has a duty to protect or warn law that specifies the duties of health care professionals from specific disciplines with regard to their duty in reference to potential violence perpetrated by their patients/clients. The duty to warn and protect laws generally apply to those from the mental health professions, including but not limited to psychology, psychiatry, social work, licensed professional counselors, marriage and family therapists, substance abuse counselors, and psychiatric nurses. It may well also apply to other physicians who treat mental health problems (e.g., the Utah Mental Health Professional Practice Act, 1994, also includes physicians, surgeons, and osteopathic physicians who provide mental health services). Child abuse and neglect laws apply to all health care professionals, as well as others, such as teachers. Usually the child abuse and neglect laws are separate from the duty to warn and neglect statutes but may well be referenced in both the specific discipline licensing law and in the state’s mental health practice act (Utah Mental Health Professional Practice Act, 1994).

The title of the law may refer to “duty to protect,” “duty to warn,” or “duty to warn and protect.” Regardless of title, the intent of the laws is to describe the duty of specific health care providers to take reasonable steps to protect potential victims from dangerous patients/clients (Smith, 1996). The steps may include a duty to warn potential victims, a duty to hospitalize or otherwise remove the patient so the intended violence is not possible, or it may take some other form specific to a specific state law (Smith, 1996).

General Requirements

The requirements of these laws change frequently, but some generalizations are possible. The core component of all these laws is that specific practitioners must take reasonable steps, which often includes warning the intended victim or the police if there is a significant risk of physical injury to an identifiable victim (Smith, 1996). All such laws raise confidentiality issues. Some of the laws try to limit therapists’ responsibilities to divulge confidential information. Yet it is not an uncommon expectation or requirement of law for confidentiality to be broken when the greater good of society will be served (e.g., preventing the death or injury of another person where information exists to indicate that such a possibility is likely). In any case, confidentiality issues are raised that should be considered by therapists in devising their limits of confidentiality and disclosure forms and in conducting the client informed consent process. Clients have a right to know that confidential information might be disclosed in certain situations and what those situations are (Striefel, 2003, 2004). Breaching confidentiality is acceptable in certain situations provided relevant rules are followed. Following the rules also helps protect the provider against sanctions. The harm from failing to disclose needs to outweigh the risk of breaching confidentiality (http://www.uky.edu/Classes/PHI/305.002/conf.htm). Knowing the laws and court precedents of the state in which one practices should help the practitioner develop a reasonable informed consent process including the limits of confidentiality.

The California Supreme Court imposed a duty on mental health professionals “to take reasonable steps to prevent a patient whom they knew or should have known was mentally disturbed and dangerous from harming anyone” (La Fond, 1996, p. 224). Thus, a second concern is raised having to do with mental health professionals’ being able to correctly diagnose mental disturbance and to assess whether, and the degree to which, a specific individual is dangerous to self or others. Only by so doing can others be protected because violence by the patient is prevented, at least to the degree reasonable for qualified professionals. Failure to prevent harm to others when “one should have known” can result in a negligence lawsuit and all that goes with that: stress, financial burden, loss of reputation, and so forth. Some state laws have immunity clauses that protect professionals against some kinds of liability for failing to predict and prevent harm (La Fond, 1996). There is little empirical evidence that mental health professionals can accurately predict dangerousness.

Civil commitment laws in many states are an outgrowth of the Tarasoff decision and were designed to remove dangerous people so they cannot harm even unidentifiable members of the public (La Fond, 1996). Involuntary hospitalization also raises liability issues if the involuntarily hospitalized patient is not provided with adequate treatment to promote reasonable chances of recovery. Wrongful commitment lawsuits are also becoming more common. Thankfully, most state laws have immunity clauses protecting professionals against such lawsuits except for extreme cases of negligence or abuse.

Evaluation of homicidal ideation is a routine part of a mental status examination (Gellerman & Suddath, 2005). One could even argue that it is a part of the expected
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standard of care. An evaluation of dangerousness includes not only asking about violent fantasies but also asking about physical and sexual content (Gellerman & Suddath, 2005). In like manner, suicidal risk is also an expected part of a mental health examination. Such evaluations may well serve as the trigger for a duty to warn and protect identifiable others (Gellerman & Suddath, 2005) or even the responsibility to have the individual client/patient hospitalized voluntarily or involuntarily.

It must be remembered that violent fantasies are not always an indication that violent behavior will follow (Gellerman & Suddath, 2005). After all, many normal people have violent fantasies that are never acted out. Better predictors than fantasies alone are the quality of the fantasies, the preoccupation with them, the level of planning and detail, and a history of past violent behavior (Gellerman & Suddath, 2005). Other factors to consider include loss of relationships, mood disorders, substance abuse, level of distress, and compulsiveness toward actions (Gellerman & Suddath, 2005). Do you assess and/or treat mental or emotional disorders? If so, you should know how to conduct an appropriate mental status assessment including factors such as violence fantasies, dangerousness, risk of suicide, and so on. The courts expect mental health professionals to be able to predict the potential harmfulness/dangerousness of their clients/patients (Lenihan, 1999).

Communicable diseases also trigger the duty to warn and protect in many states if there is an identifiable person at risk (e.g., the partner of an AIDS client; Lenihan, 1999).

The issues surrounding confidentiality, its limitations, its breaching, the mental status exam, issues of dangerousness to self or others, and duty to warn and protect should all be very carefully documented so that, if the need arises, one can clearly demonstrate to a court or others what was and was not done and why. Seeking consultation and/or supervision in difficult situations or when unsure of how to proceed should be a routine part of practice, as should the documentation of such activities. Sometimes the consultation should be with another mental health practitioner and sometimes with an attorney who specializes in the activities of concern.

Court Actions

A few court findings should help readers understand how different courts have ruled concerning issues related to duty to warn and protect.

1. The Missouri Supreme Court ruled that physicians have no duty to warn the general public (http://www.mobar.org/mobarforms/courtsDetail.aspx?item+100).

2. The Alaska Supreme Court ruled that a health care provider’s special relationship with his or her patients creates a duty to protect the patient from unreasonable risk of harm, including the foreseeability of danger posed by other patients (http://www.state.ak.us/courts/sp.htm).

3. The Kansas Appellate Court ruled that therapists need not render a perfect performance in predicting dangerousness but must exercise a reasonable degree of skill, knowledge, and care equivalent to that ordinarily possessed and exercised by members of the discipline under similar circumstances(http://www.ksbsrb.org/dutytowarn.html). Note that the key in Kansas is consultation to ensure that one is as competent in carrying out the duty to warn and protect as are one’s colleagues.

4. The Texas courts have declined to impose a common law duty on mental health professionals to warn third parties of their patients’ threats (http://alpha.fdu.edu/psychology/guy_duty_to_warn.htm).

5. A Washington court has ruled that a practitioner has a duty to extend involuntary commitment for involuntarily committed patients if dangerousness still exists (http://www.ksbsrb.org/dutytowarn.html).

6. The 4th Circuit Court in North Carolina ruled that a psychologist or psychiatrist is not required to seek involuntary commitment for a patient who refuses voluntary commitment (http://www.apa.org/psyclaw/currie.html).

It is important to note that the courts in different states seem to take directly opposite positions in cases involving the duty to warn and protect. It is important to remember that the specific circumstances in each case can influence decisions about the duty to warn and protect.

References


Utah Mental Health Professional Practice Act, Laws of Utah, 63-55-258 and 78-14-3 (1994).

Correspondence: Sebastian Striefel, PhD, 1564 E 1260 N, Logan, UT 84341-2847, email: Sebst@msn.com.

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