Preventing Gun & Other Violence…The Dangerous Patient

written by Richard Leslie | May 24, 2016

Avoiding Liability Bulletin – March 2013

With the President, Vice-President, and Congress focusing on the prevention of gun violence as a result of yet another horrifying shooting incident in Sandy Hook, Connecticut, my thoughts once again turn to the issue of confidentiality and the dangerous patient. I approach this article not as an advocate for a particular profession, but from the perspective of trying to fashion good, sensible, and fair public policy, were these issues to be publicly debated. I welcome your thoughts, comments and opinions – if you wish to weigh in on this subject – although I will not be able to respond to you individually. I realize, of course, that opinions will differ on these issues.

Suppose that mental health services are readily available to the poor and the middle class, as they are for the wealthy. While this supposition is far from current reality, the politicians are now talking about increased funding for mental health services as a result of recent events. The obvious thought is that if people can get needed and effective mental health treatment or counseling, this may lead to less violence generally. While it is hard to measure the amount of violence that may be prevented by universal access to quality mental health care, my belief is that any increases in funding for mental health programs, federal or state, will be minimal or marginal, at best. But for the purposes of this article, assume that all of those with significant mental health problems that are in need of treatment are able to access that treatment from qualified and competent practitioners.

I harbor no doubt that competent practitioners from all of the mental health professions will be able to deal with depression, anxiety, anger, and potential violence – and no doubt that much harm can and will be avoided as a result of competent care by psychiatrists, licensed counselors, LMFTs and LCSWs throughout the country. As mentioned above, the amount of prevention achieved will be hard to measure or quantify. I also have no doubt that there will come a time – in fact, many times –when a patient either communicates a serious threat of violence against another (or others) to his or her therapist or counselor or the mental health practitioner determines that the patient presents an imminent danger of violence to another (or others) based upon a number of factors, cues, or indicators that affect the practitioner’s judgment.

Two questions (there are others) that then arise are: Is the therapist or counselor under a duty to act in order to protect the intended victims? If so, what actions, if any, are or should be required?

With respect to the first question, there are two sub- questions – that is: is there a duty to protect the intended victim when there is a specific threat articulated by the patient to the practitioner, and is there

the same duty to protect when a specific threat is not articulated by the patient but the practitioner has nevertheless determined that physical violence by the patient is imminent? This article addresses only the latter two sub-questions – that is, when is (or should) the practitioner's duty to protect (an intended or reasonably identifiable victim or victims) be triggered?

Each state addresses these questions in their own unique ways. It might surprise some policy makers to learn that in some states there is no "duty to warn" or duty to protect, even if the intended victims are a classroom of first graders, and even if a credible threat has been communicated to a therapist. While mental health practitioners in such states may be permitted to take action, including breaking confidentiality to some degree, there may be no duty to do so – and no duty owed to an intended victim. In other states, the duty to protect the intended victim may only be triggered when the patient communicates a specific threat to the therapist, but not when the therapist "puts two and two together" – or determines, based upon his or her competence or expertise, that the patient poses a serious danger of violence to a reasonably identifiable other.

Confidentiality, like freedom of speech, is not absolute or without exceptions. The question then becomes whether it is good public policy for a duty to be imposed (e.g., a duty to protect intended victims) upon mental health practitioners running to someone other than the patient. It has long been my belief that the California Supreme Court decision in Tarasoff v. Regents University of California (1976) struck the right balance and tone. The Court created a duty to use reasonable care to protect the intended/foreseeable victim against the danger from the patient. The Court's balance and tone is best articulated in the following language from the Court:

"We realize that the open and confidential character of psychotherapeutic dialogue encourages patients to express threats of violence, few of which are ever executed. Certainly, a therapist should not be encouraged to routinely reveal such threats; such disclosures could seriously disrupt the patient's relationship with his therapist and with the persons threatened. To the contrary, the therapist's obligations to his patient require that he not disclose a confidence unless such disclosure is necessary to avert danger to others, and even then that he do so discreetly, and in a fashion that would preserve the privacy of his patient to the fullest extent compatible with the prevention of the threatened danger."

It is hard for me to see how one can today make a good public policy argument that says that even though the therapist is convinced that serious violence is about to be inflicted on a readily identifiable person or persons, the therapist could say that since he is under no "duty to warn" or duty to protect the intended victim, he or she can simply continue to treat the patient, albeit competently, and then be free from liability when the harm, possibly death, has been inflicted on others. Under the above-mentioned Tarasoff decision, the duty to protect the intended victim arises when the therapist determines that the patient poses a serious danger of violence to another. There is no requirement (as per the Tarasoff decision) that the patient has communicated a specific threat to the therapist, although that is often the case.

However, there is a statute in California that seemingly provides immunity from liability to

psychotherapists for failing to exercise the duty to protect where the patient has not communicated to his or her psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims. While I do not interpret the statute in that manner, others do. I am uncomfortable concluding that a therapist who determines that the patient is an imminent and serious danger of violence to others, and who does not act to protect the intended victim, should nevertheless be immune from liability because the patient had not communicated a specific threat to the therapist. The statute should be amended so that it is clear that the duty to protect arises not only when a threat is directly communicated to the therapist by the patient, but when the therapist determines that physical violence is imminent. Additionally, therapists should be immune from liability when they take the required actions after determining (as opposed to the uttered threat from patient to therapist) the patient's imminent physical violence against the intended victim(s).

If it is assumed that mental health services will become more available to those who are in need of such services, it then follows that there will be many more times when the therapist or counselor will be faced with these situations. I believe that if these issues were raised in the various states at this time, amendments would be made to state law that would impose a duty to protect intended victims. I do not believe that such an exception to confidentiality would generally or significantly affect the willingness of those who need therapy to obtain the help they need. That has not been the case in California, either with respect to the duty to protect in dangerous patient situations or the duties to report suspected child abuse, elder abuse, or dependent adult abuse.

The duties to report child, elder, and dependent adult abuse are imposed upon mandated reporters primarily for actions that have already occurred. In such cases, the damage has already been done and the duty to report (break confidentiality) is imposed for a past act. If confidentiality must be broken for the already completed acts of the patient (in the cases of child, elder, and dependent adult abuse reporting), does it really make sense to not impose a duty to protect an intended victim merely because the likely serious physical injury or death has not yet taken place?

It is believed by many practitioners that patients often know about the mental health practitioner's duty to report child abuse, and that they reveal such activity (including perpetrators) because they know intuitively or intellectually that the abuse will likely stop only once there is a report. Such thinking might also apply to someone who has the urge to physically harm or kill others. The last line of defense (and perhaps the most effective one) for society may be the mental health practitioner who has determined that a patient presents an imminent risk of harm to others or has been told by the patient of the serious physical harm that he or she intends to soon carry out.

Imagine if mental health care is readily available to those in need. How many cases of violence or mass murder might be avoided in the future if there is a duty to protect intended (and reasonably or readily identifiable) victims? Are the future deaths caused by dangerous patients a fair price to pay for the preservation of confidentiality under these circumstances? Is there not ever a greater duty of the mental health practitioner than to serve the individual patient? What are your thoughts?