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DANGEROUS CLIENTS & THE THREAT OF VIOLENCE

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A Wisconsin Case

In their 4 PM appointment, an experienced psychologist was listening to his client escalate into angrier and angrier talk. He was sounding violent. The man had a history of violence, but had been on medications for years. Once his family took on the duty of monitoring his medication compliance, there had been no more trouble with angry outbursts. But something had changed. The psychologist began thinking about the "duty to warn" standards.

This was a major mistake. The man suddenly arose, taking the psychologist by surprise, and began to strangle him. After a terrible fight, both were knocked out. The psychologist awoke first, called 911, and the police came. Finding that the client was dead, they held the traumatized psychologist at gunpoint and transferred him under guard to a hospital to get care for his 37 stab wounds (from a letter opener which was on the desk). The prosecutor then spent months whether to charge the psychologist with murder.

In the meantime, the psychologist was further traumatized when his life was threatened by the deceased client's sons who vowed to kill him. Things shifted when the autopsy revealed no trace of medications in the blood stream of the client. Apparently, the medication monitoring had either stopped or been ineffective. The psychologist has severe PTSD and is disabled in terms of any work with clients. He moved to another state. His advice is:

Remember that in such a situation knowing the legal standards for "duty to warn" is far less important than self - protection. You are the closest potential victim. Worry about yourself – not "third parties."

Following this advice, let us start with the issue as to your own safety or that of any supervisees. First rule is to not worry about legal standards for third-party warnings or other secondary issues. **Focus on your vulnerability and your safety first**. **Start by protecting yourself.**

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(1) Have a policy in your office about signaling emergencies;
(2) Staff should be authorized to call into an office during a session or to interrupt with a knock on the door if they hear anything which is worrisome in terms of safety;
(3) Remember that you can break the client's angry "set" any number of ways. For example, you can suddenly say something like, *"Oh, my goodness, I forgot to tell my receptionist that…."* and pick up the phone and call someone.
(4) You can exit the office under a similar pretext or with *"I'm terribly sorry, but I have to run to the bathroom …I'll be right back … please excuse me but nature calls…"*
(5) Try to not have potential weapons in sight – scissors, letter openers, etc. should be in drawers;
(6) The best seating arrangement allows access to the door without you or the client tripping over each other

WHEN YOU ARE THE TARGET OF STALKING OR ASSAULT BY A CLIENT

Survey of a random sample of university counseling centers in the U.S. found that 64% of the staff had experienced harassment from a current or former client. (Romans, Hays & White, 1996). Other studies have found high numbers of professionals who have been threatened or attacked, with physical assaults more likely in hospitals and clinics than in private practices.

A literature review regarding studies of psychiatrists found that more than 1/3 had been assaulted at least once, and that 72 to 96% of psychiatric residents have been verbally threatened while 36 to 56% had experienced physical assaults. (Anonius et. al., 2010).

A study of psychiatric residents received 570 responses – 349 women and 221 men. This group reported 327 face-to-face verbal assaults, 113 incidents of physical assault, 106 harassing phone calls, and three sexual assaults by patients. Respondents were asked if they reported the incident, and 68.1% reported it to the immediate attending physician, 51% to another resident, and/or to other staff at the site (50.7%). (Moran, 2009)

A study of randomly selected family physicians in Canada reported that of the 774 (of 3,802 surveyed) who responded, 98% reported that they had experienced at least one incident of "minor" abuse and 75% reported "major" abuse (sexually harassed or physically threatened). Nearly 40% reported having had at least one incident of "severe" abuse such as a physical attack with injury, sexual assault, or stalking. (Miedema et. al., 2010)

In March of 2010 the U.S. Dept. of Justice, Bureau of Justice Statistics, released a Special Report entitled **Workplace Violence, 1993 – 2009.** It revealed heartening statistics showing that from 2002 to 2009 the rate of nonfatal workplace violence declined by 35%, which followed a 62% decline between 1993 and 2002. Workplace homicides declined by 51% from 1993 to 2009. They are rare for psychologists (Robiner & Li, 2021). While bartenders and law enforcement officers top the list, mental health is nearly double the rate for transportation workers (bus, cab drivers). Mental health professionals have a rate of 17 per 1,000, with a rate of 20.5 across all mental health workers. Medical workers, by contrast, are at 6.5 per 1,000, with physicians at 10.1 and nurses at 8.1. A number of studies have been done on this issue (Phillips, 2016).

An archival study of former hospital inpatients who engage in post-discharge stalking found that the duration was short-term, generally only a few weeks. Such patients were more likely to have a history of fear-inducing or assaultive behavior pre-admission, and were more likely to have personality disorders or a paranoid disorder with erotomanic features. They are more likely male. (Sandberg, McNeil, Binder, 1998) Other research has shown that assaultiveness by certain groups such as schizophrenics is no higher than the general population if you control for alcohol & drug use. **Drinkers are far more likely to actually assault.**

There are some excellent resources on the internet – Psychologist Ken Pope's website has a section devoted to this issue – **http://kspope.com/stalking.php** I would highly recommend Mullen, Pathe, & Purcell (2008) -- **Stalkers and Their Victims.** Forensic psychiatrist Robert Simon (2011) has done a good summary of this issue entitled "Patient violence against health care professionals (**Psychiatric Times,** 3 March 2011) which can be found on the internet.

When counseling professionals seek police assistance, 100% report it is helpful. When they talk with colleagues, only 60% do. Q: What do we do wrong when a colleague tells us about stalking or harassment by a client? A: We focus on how it started, a product of our own anxiety, in effect blaming the victim (our colleague) rather than focusing on solutions.

A study of the stalking of psychologists by their clients (Gentile et. al., 2002) found that **there is no specific profile for those who had been stalked; But afterwards they did employ more safety measures**

For drug abuse evaluation or treatment programs, there is an authorization [section 2.12(c) (5) of the federal rules] to **contact a law enforcement agency when a client has committed or threatened a crime on program premises or against program personnel**. However, disclosure is limited to: (1) suspect's name & address; (2) last known whereabouts; (3) the fact that he/she is a client of the program. Otherwise, in general, remember these key rules:

(1) Stalking and harassment are generally not confidential -- only how you know the identity of the client & the fact that they are a client are confidential;
(2) Obtain consultation & document it;
(3) Document all incidents in an administrative file – the client file should only contain a note that stalking or harassment have occurred;
(4) With consultative help, attempt to get the behavior to stop via:

- **(a) Direct request by the supervisee;**
- **(b) Administrative demand by supervisor or agency director;**
- **(c) Cease & Desist Letter from an attorney or prosecutor;**
- **(d) Police intervention.**

(5) Follow directions of law enforcement & other experts;

(6) Get help and support – being a victim can have very troubling consequences including PTSD, wanting to leave the field, etc.

DUTIES TO THIRD PARTIES WHO ARE AT RISK OF VIOLENCE

As professionals, as colleagues of other professionals, and as consultants and supervisors we

may encounter all sorts of situations in which there is a question of dangerousness of a client towards others. In examining the list below, you will note what a wide variety of situations exist in which the dangerousness of the client is an issue:

(1) Ongoing dangerous situations, such as ones involving family violence;
(2) Clients who are antisocial and involved in criminal acts or a violent lifestyle;
(3) Clients who talk violently but have no history of violent actions;
(4) Situations in which the client is talking violently and may be going psychotic;
(5) Situations in which the client is talking about engaging in reckless conduct which could endanger others, or where a murder/suicide seems possible;
(6) Situations in which the client is not handling stress well and is in a job, such as that of a police officer, where violence could easily occur;
(7) Situations in which the client threatens to harm a class or group of people (e.g. *I'm going to kill rich people in the suburbs*…);
(8) Situations in which the client threatens a person who may not exist (e.g. *I think my wife is having an affair and if I find out who it is I'll kill him...*");
(9) Situations in which the client threatens to harm a specific identifiable person, but that person is present during the meeting and is aware of the threat;
(10) Situations like (9) where the potential victim does not know of the threat.

Other situations, all of which can involve scenarios like the ones above, but where this issue is **anger or violence potential aimed at you or your colleagues.** For example:

(11) Client is making threats towards a colleague with whom you already have a release to communicate. Where you will not have to breach privacy.
(12) Client is becoming increasingly angry at your or one of your staff and the atmosphere has become violent.
(13) Client is actually threatening you or your family, or during a session has become violent.

RESPONSIBILITIES TO PROTECT PERSONS OTHER THAN YOUR CLIENT

Long before the ***Tarasoff case*** it was known that professionals had duties to protect others which supersede their duties of confidentiality owed to their client (e.g., situations involving a accident due to impaired driving, or a direct assault by a person following discharge from a hospital).

Certainly, most of us would acknowledge a ***moral duty to preserve life***, and few would argue that the client's privacy is more important than the life of another person. This might relate to whether the principle of ***justice (welfare of persons other than your client)*** is more important than the principle of ***autonomy (your client's rights) in a given situation***. However:

(1) Health care professionals cannot reliably predict violence. Typical "duty to warn" statutes do not have standards for assessing risk.

(2) Secondly, the focus of all the attention is not that one undertakes a professional intervention – it is that one contacts either an intended victim or law enforcement or both – a lay solution. This is not a professional technique or method.

Any examination of a situation in which there is potential for violence may include both the use of professional tools to attempt to help, and also the fact that one may contact the police or a

potential victim. **Most situations involving potential violence will be dealt with through professional means and tools – not a warning to the police or an intended victim.**

RISKS

The most common complaint or lawsuit involves the individual, or their heirs, who were harmed by the client who was dangerous. On the horizon may be claims by those who are harmed by the client in some sort of a rampage or attack on an institution (e.g. a school). **From a purely "risk-management" standpoint, one would err on the side of warning.**

However, in the original ***Tarasoff*** case, described later, it can be argued that Ms. Tarasoff is dead because the therapist did call the police, driving the eventual assailant out of therapy. So, for the goal of helping the potential assailant, professional interventions may be better. It is possible that your warning could lead to a confrontation in which the angry client is injured or killed.

Breaking confidentiality carries some risks with it and the professional who violates confidentiality (1) without considering less drastic methods, or (2) when the matter is not urgent, risks being sued for any harm caused. The case of psychologist Anthony Stone in DeKalb Co., Georgia, is such an example. In 1999 a police officer won a $ 280,000 judgment after he lost his job as a result of Dr. Stone contacting his employer about his volatility. The treating psychiatrist did not believe it was that urgent and it was noted that Dr. Stone could have first discussed it with the officer and explored clinical options.[1]

CLINICAL ISSUES WITH DANGEROUSNESS

There are factors which have been associated with client dangerousness. A number of instances involving violence have involved teenagers who are excluded and ridiculed or teased by others. Dealing with the abuse of students by other students is an important prevention. It should be noted that while media accounts often focus on this, as they did with the Columbine High School case, this may be not accurate. It was not with Columbine. (Cullen, 2009; Klebold 2016)

Some people who have exploded in violence have given some indication in writings, posting on the internet, etc. These posts have varied as to whether they were public, or only sent to specific friends or family, or were completely private and only discovered afterwards. If anything, we have good reason to "play it safe" and follow-up on such threats and/or statements of despondency. However, murder-suicides, such those at Virginia Tech, Aurora Colorado, and Sandy Hook all involved persons who were troubled but where there is no evidence of any specific warning of the acts they committed.

Although research has focused on static factors (Elbogen et. al., 2005; Harris et. al, 2004) which predict violence, in recent years there has also been an interest in the role of various medications (Swanson et. al., 2004) and treatments in terms of reducing potential for violence. Some of this has focused on the role of drug abuse and medication non-compliance (Swartz et. al., 1998), or even issues with specific subsets of clients such as schizophrenics (Swanson et. al., 2006).

More recently there has been a study of treatment engagement and the client's perception of

[1] I served as an expert in a case in Oklahoma, a state which does not have statutory protection for duty to warn, in which a professional ignored an assessment by a crisis center that a client was not dangerous, who alerted a campus police force to dangerousness (which was not established) leading to serious career consequences for the client and eventually a large award in a malpractice suit.

treatment effectiveness and the impact on violence in the community (Elbogen et. al., 2006). The degree to which the client believes he/she needs treatment, and is getting it, and the degree of engagement in treatment are all factors which seem to correlate with less violence.

With the focus on duty to warn and protect, it is easy to forget that our major tools are helping the client and that bringing the police in or breaching privacy has a terrible down-side in that it can undermine the ability to maintain a treatment relationship. Research continues and psychologist Ken Pope's website details more than 60 studies from 2012-2016 that have been published or are in press. **http://bit.ly/KenPopeResearchOnAssessingViolenceRisk**

QUESTIONS & APPROACHES TO THIS CHALLENGING PROBLEM.

HOW URGENT IS THE SITUATION?

If it is imminent that harm will occur, you must act. If a serious threat is not immediate, then you should have time to obtain consultation and to plan your actions.

DO YOU HAVE TIME TO OBTAIN CONSULTATION?

You may not have time for consultation. If you do, obtain it and document it.

INTERVENE USING PROFESSIONAL SKILLS & TOOLS

Try to defuse the anger through ventilation, try to dissuade client from violent solutions, ask for permission to discuss the situation with significant others, attempt to get client to give up weapons or to put away weapons and ammunition. Help the family seek solutions. **Be aware of emergency services which can intervene in the person's home if your local county has such a service.**

WITH A MINOR THE PARENT, GUARDIAN, OR SCHOOL MAY BE KEY

When the client is a minor, privacy rights are attenuated & the parent or guardian holds authority to intervene. If parents are the intended victim, this is even more critical. A school or other institution may have some potential control over the situation.

CONTACT THE POLICE FOR AN EMERGENCY HOLD

In both Wisconsin and Minnesota an emergency hold can be placed by a police officer who has reason to believe that the client is mentally ill, developmentally disabled, or chemically dependent AND a danger to self or others. The hold is for up to 72 hours and the requirements are similar to those for involuntary commitment. Don't try to detain the person yourself.

IF DANGER IS VERY HIGH AND THERE ARE NO OTHER OPTIONS CONTACT THE POLICE AND/OR INTENDED VICTIM

Whichever has the best chance of preventing the harm.

THE TARASOFF CASE

In the fall of 1967 Prosenjit Poddar came from India to attend the U. of Calif. at Berkeley. The following fall (1968) he met and fell in love with Tatiana (aka Tanya) Tarasoff whom he met at folk dancing classes. She was nice to him and danced with him, something which emotionally

overwhelmed him. He was a member of the harijan class (the "untouchables") so her kindness reportedly surprised him. Poddar asked for a date but she said "no." Her rebuff helped trigger a severe emotional crisis -- he was depressed, weepy, and withdrawn. His friends were concerned about his emotional state.

Poddar's emotional adjustment reportedly improved during the summer of 1969 when Tanya went to Brazil, and friends convinced him to seek counseling. He sought treatment at Cowell Memorial Hospital, an affiliate of the U. of Calif. at Berkeley, and after seeing a psychiatrist for intake began therapy with a psychologist, Dr. Lawrence Moore.

During a therapy session on Aug. 18, 1969, he told Dr. Moore that he intended to kill Tanya when she returned from Brazil. Two days later Dr. Moore consulted with Drs. Gold and Yandell, psychiatrists, and they agreed that Poddar should be involuntarily committed. (This occurred only two months after the passage of the commitment law and both law enforcement and mental health professionals were inexperienced in its use.)

Dr. Moore asked the campus police to pick up Poddar, and followed up with a letter indicating that he was undergoing an acute and severe paranoid schizophrenic reaction and that he was a danger to others. The campus police detained Poddar but did not commit him, judging that he appeared rational and given the fact that he promised to avoid Tanya. The director of the psychiatry department asked the police to return Dr. Moore's letter, ordered that the case notes be destroyed, and ordered that no more attempts be made to commit Poddar.

Tanya returned to the USA, unaware of any potential danger from Poddar. Poddar, meanwhile, had convinced Tanya's brother to share an apartment only a block from Tanya's residence. On Oct. 17, 1969, Poddar went to her house to speak with her, but she refused. He became insistent and she screamed, at which point he shot her with a pellet gun. She attempted to flee but he caught her and repeatedly stabbed her with a kitchen knife, killing her. He then returned to the house and called the police.

In his trial, Poddar used an insanity defense but was convicted of second degree murder. However, the verdict was reversed on appeal based on an error by the judge in his jury instructions. Poddar was released and returned to India. Forensic psychiatrist Alan Stone (1976) reported that Poddar claimed in a letter to be happily married after his return to India.

The Tarasoff family sued, arguing that the professionals had failed in two duties: (1) duty to commit and (2) duty to warn Tanya. The California Supreme Court issued an opinion in 1974, but reviewed its own decision and issued a second one in 1976 which superseded the first. This is often called *Tarasoff* II and it is the definitive ruling. The defendants were exonerated on the commitment issue, but found to have failed in a duty to warn her of the danger.

VandeCreek & Knapp (2001) note that **such a duty was not new in tort law, citing earlier cases against psychiatric hospitals.** A number of these dealt with things such as failing to warn patients being discharged that the medications they were prescribed would not mix well with alcohol. The patient in such cases then went out, drank, and had a car accident. **However, *Tarasoff* extended this duty to outpatient care**. Brooks (2005) discusses its application in substance abuse programs where different rules apply due to federal rules & statutes.[2]

[2] For many years Ms. Brooks has contributed a very useful analysis of the situation, which was updated every two years. Unfortunately, her series of updated chapters has ceased and thus the best reference is still this older piece of writing. The changes in the federal statute have been few and have not significantly impacted her helpful analysis.

STATUATORY GUIDANCE

Nearly half of the states have enacted statutes which define the responsibilities of professionals for potentially dangerous acts by their clients towards third parties.

Chapter 380 of Minnesota Statutes went into effect on August 1, 1986. This statute created **a duty to warn of or take reasonable precautions to provide protection from violent behavior threatened by a psychotherapy client.** The original law covered psychologists, school psychologists, nurses, chemical dependency counselors, and social workers who are licensed or who performed psychotherapy within a program licensed or established in connection with a state statute.[3]

In 2001, as a result of an effort by the Minnesota Chapter of NASW, the Minnesota legislature passed and the governor signed a bill into law Minnesota Statutes 2000, Section 148B.281 to include social work licensees and their clients in section 148.975. In 2013 a similar provision was added in the licensing law for Licensed Alcohol and drug counselors. **However, because the federal rules governing substance abuse programs give no permission to carry this out, LADCs must ask for client consent in order to be able to carry out this duty.**

Psychologists, social workers, and LADCs are also protected against **any cause of action** arising out of their good faith efforts to discharge this duty. The law specifically protects them from liability for "disclosing confidences to third parties", and other liabilities such as if the warning of an intended victim resulted in that person doing harm to your client. Other counseling professionals would have a good defense in such cases, but not the statutory protection.

With regard to Licensed Professional Counselors, Administrative Rule 2150.7515, Protecting the Privacy of Clients, Subpart 2, private information on clients may be disclosed without the consent of the client "to protect against a clear and substantial risk of imminent serious harm being inflicted by the client on the client or other individual…" "In such cases, the private information may be disclosed only to law enforcement agencies, the potential victim, the family of the client, or appropriate third parties in a position to prevent or avert harm." With regard to Licensed Marriage & Family Counselors identical standards are found in Administrative Rules 5300.0350 Code of Ethics, Subpart 6 Confidentiality & keeping of records, section A.

There is considerable variability around the United States among the states which have statutes that involve a duty to warn or duty to protect. Although a warning to law enforcement is noted by all, some include a warning to the potential victim and some do not. Some give absolute protection for the professional whereas others allow for second-guessing of the decision and a weighing of it against community standards or the standard of care.

Remember that the statute which applies is the one in the state where the professional is practicing. If information is gained from a phone call and the client is in some other state at that time, your own state's rules typically apply. In the end, however, it is rarely the details of the law which make the major difference – it is your job to try to prevent harm.

In a true "duty to warn or protect" situation the focus is on who to warn and how to do it, not the language of a statute.

[3] This statute referred to a number of professions but was part of the Psychology Practice Act, which was obviously inappropriate. The Psychology Board changed it in 1996 to include only psychologists.

The basics of the current Minnesota Statutes are presented in the box below.

<u>The threat must be</u>:

(1) a serious specific threat of harm.
(2) against a specific, clearly identified victim

When in the professional's opinion <u>both of the above conditions are present</u>, the duty is to make reasonable efforts to communicate the threat to:

(1) the potential victim, or
(2) to the law enforcement agency closest to the potential victim or the threatening client.

Beyond the statutory language which focuses on a specific victim, if one is confronted by a situation involving a threat to harm a group of people (e.g., blow up a building) one assumes that one still has such a duty.

OTHER CASE LAW SINCE TARASOFF

Nationally, by the beginning of this millennium the *Tarasoff* case had been cited in more than 500 published legal cases. Decisions related to the "duty to warn or protect" have ranged widely, with some courts finding such a duty, some extending it beyond *Tarasoff*, and some not finding it or limiting it to certain circumstances. Courts in Mississippi and Florida have rejected or significantly limited the doctrine. (Hubbard, 2007)

Some limitations have included situations in which only non-specific threats were made, where the intended victim was not specific, where the potential victims could not be foreseen, where the potential victim had pre-existing knowledge of the potential danger, etc. Some decisions have limited those to whom a duty was attributed, holding for example that a school board, teachers, members of a child study team, or parole officers did not have such a duty.

The case which established privilege in federal courts, ***Jaffee v. Redmond (116 S. Ct. 1923 1996)*** has a footnote allowing for an exception to privilege *if a serious threat of harm to the patient or to others can be averted only by means of a disclosure by the therapist.* At least one legal scholar predicted that the application of *Tarasoff* will likely expand to cases where the third party is a pedophile with the potential to commit a sexual offense (Perlin, 1999).

At present, the issue as to whether a particular professional has a duty to warn or protect a third party from harm by a client, and whether this duty overrides confidentiality, is quite unsettled nationally. As an illustration, two cases are worthy of note. In ***Thapar v. Zezulka (994 S.W. 2nd 635 -- Texas Sup. Ct. 1999)*** the Texas Supreme Court declined to impose a duty on mental health professionals to warn third parties of threats of violence because it would conflict with therapist-patient privilege. The court allowed for therapists to use their discretion to breach the privilege if circumstances warrant. [The case involved a psychiatrist who had allegedly failed to warn a man's stepfather that during a psychiatric hospitalization the man had made a threat to kill him -- a threat carried out a month later.] So, **a psychotherapist in Texas *can breach***

confidentiality to warn, but does NOT have a common law duty to do so.

However, the Delaware Supreme Court in ***Bright v. Delaware, Del. Sup. Ct., (1999WL 403607, June 15, 1999)*** ruled that **in Delaware *there WAS a common law duty of a mental health care provider to persons other than the patient involving a duty to warn potential victims when they know their client is a danger to others.*** [The case involved the appeal of a conviction for attempted murder and terroristic threats where the defense had argued that the trial court had erred in admitting the psychiatrist's testimony in violation of the psychotherapist-patient privilege. The psychiatrist had notified the man's wife and the police after he cancelled an appointment and told her that he was going to carry out his plans to murder his former wife.]
In Pennsylvania the decision in *Emerich v. Philadelphia Center for Human Development et.al.* (720 A.2d 1032 (Pa. 1998) created a duty for mental health professionals to warn specific endangered third parties. Because the facts of the case involved a warning having been given and not heeded by the victim, the actual lawsuit was dismissed. The duty is narrow and the court's action has been the subject of criticism for this reason (Wettstein, 1999).

Recently the Pennsylvania situation became potentially more problematic when the Pennsylvania Supreme Court, in a 3 -2, decision in the case of *Maas vs. UPMC Presbyterian Shadyside et.al.* ruled that the duty to warn of danger posed by a client when he/she makes imminent threats of serious bodily injury against a readily identifiable person can include neighbors even if none are specifically named. In this case a psychiatric patient made threats to kill a neighbor but did not disclose a specific person. Ms. Maas was a neighbor who lived on the same floor whom he killed. The Supreme Court simply agreed with lower courts and did not grant a summary judgment on behalf of the defendants. Thus, the case was allowed to go forward. To the best of my knowledge the case has not yet been completed so it is not clear how it will turn out.[4]

A stir was created by a decision by the California Court of Appeals in ***Ewing v. Goldstein (2004), Cal.App.4th [No. B 163112.Second Dist., Div. Eight, Jul. 16, 2004].*** This decision reversed a lower court's rejection of a claim based on a marriage and family therapist having received a communication from the patient's father – not the patient – that indicated that he might pose a danger to his former girlfriend's new boyfriend. The therapist, Dr. Goldstein, had helped get the client hospitalized due to suicide threat, and then based on input from the father tried to dissuade a psychiatrist from discharging him from the hospital.

The murder occurred the day after the discharge. Dr. Goldstein had not known the surname of the victim, and the client had not directly revealed the threat to him, but it was argued that he should have contacted the police. Note that the issue was that the trial court was deemed to have too narrowly defined "communication from a patient" and that the appellate court believed that this might include the information from the father. Thus there is a "triable issue" and the case was sent back for trial. This does not mean that a court will actually find liability.

It should be noted that the Minnesota Statutes, which are discussed in a previous section, are generally clear that the communication can be from the client or someone like a family member, so such a dispute should not arise in a Minnesota case. **This is also a reminder that legal responses to what a therapist does, or does not do, will vary state to state based on differences in case law and statutes. On the other hand, it is important to note that legal principles or standards do not necessarily determine what is the best course of action for the professional.**

[4] For further information: **https://www.pamedsoc.org/detail/article/duty-to-warn-amicus-brief** It is my understanding that professional organizations are lobbying for a statutory solution.

It is important to recognize that case law continues to evolve and that cases are typically very much tied to the past decisions as well as any statutes in a given venue. Furthermore, unless it is a US Supreme Court decision, there can always be a higher court which overturns a decision. In Washington State the decision in *Peterson v. State* (100 Wn.2d 421) ruled that a psychiatrist could have liability in a case where absent a specific threat of harm the psychiatrist should have reasonably known that people were at risk of harm. In this instance there was no connection between the victim and the person who harmed her.

Relying on the *Peterson* standard, the Court of Appeals, Division Three, in the case of *Volk v. DeMeerlear,* ruled that a psychiatrist, Dr. Ashby might have had a duty to protect persons who were not the subject of any threat from the patient. In this case the patient, who had been in treatment for 9 years, without warning attacked and murdered two people and injured a third. There was no evidence that Dr. Ashby could have known that those people would become targets, or that the patient was violent and dangerous.

OTHER STATES

If you move to or do some practice in another state, research their laws. There is considerable variability state to state.[5] If through telephone or internet interaction you find yourself in a "Duty to warn" situation, follow the rules in your state. The standards in the state where the violence is threatened or where the potential victim resides do not apply to your actions.

MODERN TIMES – PANDEMIC & CIVIL UNREST

At the present time and for at least the near-term future a great deal of service is now provided remotely through phone, computer, with either audio or both visual and audio. It may be more difficult to judge mood or emotion in such delivery modes, but the duty to warn or protect is based on words. If a clinician has any questions about seriousness, they can be asked and verbal feedback should be enough to determine if there is a clear threat or plan to harm.

Civil unrest related to the Black Lives Matter movement and the concern about violent acts by police officers has brought greater complexity to the decision to contact law enforcement. This may be very challenging when the intervention is focused on a member of a racial minority group or certain neighborhoods. But if there is a serious risk of deadly violence against an identified potential victim, there are not at present any options other than police intervention.

Another problem has to do with the fact that during the pandemic it was far more difficult to find ways to have people leave a domestic situation in order to "cool off." One may not be able to go

[5] In states bordering on Minnesota there is wide variability. North Dakota appears to have statutory authority that allows public health officials which appears to include service providers, to release otherwise protected health information if there is a threat to a third party. [Century Code, Chapter 23-01.3 Health Information Protection]. South Dakota also has a permissive standard for all record holders [S.D. Codified Laws Ann. 27A-12-29] although it also appears to have a mandate if a serious threat of physical violence is made against a reasonably identifiable victim [S.D. codified laws 36-33-31 Duty to warn against client's violent behavior]. Iowa has case law: *Anthony v. State* 374 N.W.2d 662 (1985) which deals with harm done by a released prisoner. Although *Tarasoff* is mentioned, the main focus is the Thompson standard: *Thompson v. County of Alameda*, 27 al. 3d 471, 614 P.2d 738, 167 Cal. Rptr. 70, 80 (1980). These are not outpatient cases and are focused on institutional release of dangerous persons. Despite efforts to pass a statute in Wisconsin, the only authority is *Schuster v. Altenberg* 144 Wis. 2d 223, 424 N.W. 2d 159, 163 (1988) allowing for a cause of action based on a failure to take protective action (but to be decided based on a professional negligence theory). Allowance for breaking confidentiality to prevent harm is supported in *State v. Agnacki* 228 Wis. 2d 349, 595 N.W. 2d 31 (1999).

to a friend or relative house if there are concerns about infection. There is also evidence that domestic violence may be on the rise given some of these realities.

Furthermore, access to care is currently more difficult, so that over time more people may be without good treatment access. Added problems are the fact that we do not have a healthcare system – we have a healthcare marketplace. Since a large amount of insurance coverage is tied to employment, as unemployment grows access to care is diminished.

There is also a problem with bad economic conditions in that some in the community are unable to afford medications which may be key to their stability. Sometimes they reduce dosages for monetary reasons, even though this may endanger their adjustment.

INTERNS, TRAINEES, UNLICENSED PERSONS

The issues as to coverage for persons under the supervision of a licensed person became the focus of attention after the findings of the State of Minnesota Court of Appeals in the case of ***Jerry Expose Jr. vs. Thad Wilderson & Associates, P.A. & Nina Mattson*** filed on 4 May 2015 in Ramsey County District Court. (File No. 62-CV-13-5229). The Minnesota Supreme Court reviewed the appellate decision and has affirmed it (December 2015).

This case involved a trainee (unlicensed) in a mental health outpatient practice who made a police report on the dangerousness of a client. After that, she subsequently talked about the client to the police and also testified in court – both times without client consent.[6]

In 2016 & again in 2019 Minnesota amended some of its licensure statutes, offering protection for trainees in a number of counseling fields. The specific extensions for these professions are provided in the box below.

Alcohol & Drug Counseling: includes alcohol & drug counseling practicum students & individuals in a post-degree professional practice in alcohol and drug counseling

Licensed Professional Counselor: includes license applicants, student or intern under supervision

Marriage & Family Therapy: includes students or interns practicing marriage & family therapy under qualified supervision as part of an accredited educational program or under a supervised postgraduate experience in marriage & family therapy required for licensure.

Psychology: includes practicum psychology students, predoctoral psychology interns, & individuals who have earned a doctoral degree in psychology & in the process of completing their postdoctoral supervised psychology employment to qualify for a license.

Social Work: includes "interns and students"

The ***Expose Jr.*** case also serves as a reminder that making a warning does not open the client's

[6] The trainee & clinic argued that she was protected because she was under the supervision of a licensed person, and that the client handout the clinic used warned about this limitation to confidentiality. The court ruled that being under supervision did not offer protection under the law, and that the client handout was not sufficient release. The warning was not what was questioned – Mr. Expose Jr. was convicted. **The issue was that talk to the police and prosecutors required either a release from the client, or a court order.**

files to scrutiny in and of itself. Further police or prosecutor investigation requires client consent or a court order. In addition, eventual testimony about anything other than the warning – that is, information about the client, diagnosis, treatment history, etc. – requires client consent or court order. This is not "new" and has always been the case. All professionals need to be mindful of the slippery slope – a release that is required allows disclosure of a situation but does not then open the client's file or your knowledge of them.

Some immediate consequences of this decision may be that some in supervisory roles should be the persons who make the duty to warn call to intended victim or law enforcement. Except under very rare circumstances, such a decision should be discussed with a supervisor anyway. Secondly, there is an issue as to how much authorization the client disclosure form provides. This is most critical with LADC's in Minnesota since their licensure statute requires them to do this disclosure under the premise that it would permit a duty to warn disclosure not allowed under the federal rules for substance abuse programs (CFR-42).

Editorial: It is essential that persons in the substance abuse field contact their trade organizations such as MARRCH and NADAC as well as the Minnesota licensure board and ask that this issue be dealt with through petitioning the federal government to amend CFR-42 to authorize the duty to warn as well as a duty to do disclosure necessary to prevent suicide, and to authorize compliance with state statutes and rules regarding reporting of neglect/abuse of vulnerable adults (as was done with child abuse reporting in 1987). I have personally given such input to SAHMSA.

DANGEROUSNESS AND CIVIL COMMITMENT

The issue of dangerousness can be examined from the perspective of civil commitment standards. One option for addressing dangerousness is civil commitment. In fact, the *Tarasoff case*, as noted earlier, grew out of a failure to properly execute an emergency civil commitment. The original suit filed by the Tarasoff family alleged a failure to commit, but the court ruled that there was no such course of action. Although it is not required, civil commitment is a commonly used tool when a client is deemed to be dangerous and have a likelihood of violence.

In ***Schuster v. Altenberg***, the Wisconsin Supreme Court allowed for the possibility that a therapist could be held accountable in a professional negligence action if it could be established that the client was a "proper subject for involuntary commitment under the statutory standards…" The issue is not some "duty" to seek commitment, but that this is recognized tool that might be useful in a given situation. **It would appear that actions of any professional will be judged based on a weighing of the alternatives.**

THE FORENSIC EXPERT SITUATION

There has been a longstanding question as to whether professionals acting as forensic experts have the same duties as other practitioners. For example, if a psychologist is assessing someone in a criminal case, and the person being evaluated makes threats, is the reporting duty the same? The major challenge is created by the attorney-client privilege since often the person doing the examination within that context. This privilege adds additional privacy to the situation, even though eventually the results of the examination *may be* revealed in a report, deposition, or court. (The term *may be* refers to the reality that the attorney who hires the expert may decide to not put the professional on the witness stand or not ask for a report, or the fact that the legal matter may be settled in private or without such disclosure.)

In 2013 a California Court of Appeals heard the case of *Elijah W. v. Superior Court [216 Cal. App.4th 140]* which raised the question as to whether attorney client privilege trumped the child abuse reporting statute. A forensic psychologist involved in the case indicated that she would report only to the attorney who employed her. She indicated the same thing about the Tarasoff duty. While this case does not precisely settle the issue, and was focused on the question of mandatory reporting of child abuse and it is at present limited in impact to California. However, it is possible that other states might adopt such a standard and it certainly raises some very key issues. Lareau (2015) provides an excellent discussion of the implications.

There is a complex companion issue in this situation as to Tarasoff type duties of attorneys. If the forensic examiner or expert contacted the attorney who employed them, would that attorney have a duty to take action? In the case of child abuse, the attorney is not a mandated reporter, but what about a "duty to warn" type situation?

The American Bar Association has created *ABA Model Rules of Professional Conduct* which are advisory, but which have been adopted by many states. In the section 1.6 *Confidentiality of Information,* section (b)(1) states that a lawyer may reveal information to the extent that the lawyer reasonably believes it is necessary "to prevent reasonably certain death or substantial bodily harm…." Minnesota has adopted this standard in the *Minnesota Rules of Professional Conduct* in section 1.6 (b)(6) which uses the same language. Thus, attorney – client privilege would not prevent an attorney from attempting to prevent harm even though there is not a statutory "duty to warn or prevent."

PROFESSIONAL ETHICS CODES

Some professional codes of ethics have sections which pertain to the duty to warn or protect. Many ethics codes refer vaguely to breaches of confidentiality in situations in compliance with the law or legal mandates. (Some client handouts use similar vague language) It is unclear whether this is intended to refer to case law as well as statutes.

The ***Ethical Principles of Psychologists and Code of Conduct*** of the American Psychological Assn. (2002 Revision, effective June 1, 2003) indicates in section 4.05 Disclosures that:

> **4.05(a) Psychologists disclose confidential information without the consent of the individual only as mandated by law, or where permitted by law for a valid purpose, such as... (3) to protect the client/patient, psychologist, or others from harm...**

This wording has shifted from the 1992 code to specifically list the psychologist's protection, even though in the previous code the psychologist could be assumed to be one of the "others." The word "or" which used to stand between "permitted by law" and "a valid purpose" is dropped. The new language appears to focus more attention on whether it is required or permitted by law, although still asks that the psychologist consider this a "valid purpose."

Licensure Boards in Iowa, North Dakota, and South Dakota use the American Counseling Association (ACA) Code of Ethics, but Illinois, Minnesota, and Wisconsin do not. However, such a code would be used as a point of reference in any state. The 2014 Revision of the ***ACA Code of Ethics and Standards of Practice*** indicates in section B.2. Exceptions, that include:

> **B.2.a. Danger & Legal Requirements. The general requirement that counselors**

keep information confidential does not apply when disclosure is required to protect clients or identified others from serious and foreseeable harm or when legal requirements demand that confidential information must be revealed. Counselors consult with other professionals when in doubt as to the validity of an exception.

An earlier ACA code utilized the terms "clear and imminent danger" and the revision committee believed that the new language broadened this slightly (David Kaplan. *The end of 'clear and imminent danger'* Counseling Today, January 2006, v. 38, p. 10). The 2005 and more recent 2014 revision also have a new section proposed which is of relevance here:

B.2.c. Contagious, Life-threatening Diseases. When clients disclose that they have a disease commonly known to be both communicable and life-threatening, counselors may be justified in disclosing information to identifiable third parties, if the parties are known to be at serious and foreseeable risk of contracting the disease. Prior to making a disclosure, counselors assess the intent of clients to inform the third parties about their disease or to engage in any behaviors that may be harmful to an identifiable third party. Counselors adhere to relevant state laws concerning disclosure about disease status,

The ***NASW Code of Ethics*** of the National Association for Social Work, in section 1.07 Privacy and Confidentiality, states:

1.07(c) Social workers should protect the confidentiality of all information obtained in the course of professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person...

The ***Code of Ethics*** of the Clinical Social Work Federation, in section III. Confidentiality, states:

III.(b) Clinical social workers know and observe both legal and professional standards for maintaining the privacy of records, and mandatory reporting obligations. Mandatory reporting obligations may include, but are not limited to...the duty to take steps to protect or warn a third party who may be endangered by the client(s)....

The situation in marriage and family therapy is very unclear. The ***AAMFT Code of Ethics***, effective July 1, 2001, does not refer to a duty to warn or protect in any fashion I can discern. It does reference making disclosures "mandated or permitted by law" but there appears to be no mention of protecting third parties from harm. Research "duty to warn" on the website ***www.aamft.org***, "Family therapist's decision-making processes in two duty-to-warn situations" (E. Burkemper (2002) discusses reporting of child abuse and HIV infection.

PROFESSIONAL LICENSURE STANDARDS

Any professional can be disciplined by practicing unethically or below the standards in his/her field. Specifically, in psychology, social work, marriage & family therapy, and professional counseling, the licensed professional can be disciplined for "Gross negligence" which means **performing services which do not comply with an accepted standard of practice.** In Minnesota licensure laws for psychologists, social workers, professional counselors, and

substance abuse counselors have specific standards on duties with regard to threats of violence by a client. This is the only legal standard for such situations in Minnesota.

SUBSTANCE ABUSE EVALUATION & TREATMENT PROGRAMS

Although the focus of attention has been on social workers, psychologists, and psychiatrists, **alcoholism and substance abuse counselors are often in a position to learn of potential violence. Should they receive a threat of violence that they believe to be credible, they are thought by many to have the same duty as psychotherapists who work with mental health clients.** Twenty three percent of reported *Tarasoff* cases, examined in one study, involved clients with a history of alcohol or drug abuse (Egley & Ben-Ari, 1993).

The substance abuse counselor is generally working for ***a program*** which comes under the requirements of 42 Code of Federal Regulations (CFR) based on the Drug Abuse Prevention, Treatment and Rehabilitation Act (42 U.S.C. 290). While limited to "federally assisted" drug abuse treatment programs, that requirement is broad enough to cover virtually all substance abuse programs. [7] This law and rules ***do not authorize*** breaking confidentiality based on a state law or professional mandate to warn of intended violence.

Thus far only one ruling has addressed this potential conflict between state law and federal law (**Hasenie v. United States, 541 F. Supp. 999, D.Md.1982)** and that concluded that the federal rules take precedence.

Psychologists, social workers, nurses, and other healthcare professionals providing services in a substance abuse program are bound by the federal rules which are presumed to over-ride state licensing laws. So the problems with CFR 42 has impact on all persons working in such settings, even those whose license provides other standards.

It has been suggested by some that the federal rules might be circumvented to some degree if the counselor **does not reveal that the person is a client of a drug abuse treatment or assessment program. I do not see how this is lawful, especially in light of the Court of Appeals opinion that was noted in a previous section.[8]** As a practical matter there are a few other options:

> **(1) If the client is a minor who is applying for admission to the program, and you ask them for a release to share the information with their parent or guardian, if you do not believe that he/she is using good judgment in denying permission, you can contact the parents with your concerns about the violence potential.**

[7] It includes any program which receives any funding from a unit of government (local, state, or federal), through direct program funding or payments from Medicaid, Medicare, Security, state or federal treatment funds or grants. It also includes any non-profit which is tax exempt (the feds argue that this is "assistance," even though tax exemption is a status in the state, because the federal government argues that they assist state governments). Furthermore, there is no test as to percentage of clientele whose care is "subsidized." If one has any clients in one of these categories of funding, the entire program operation is covered by CFR-42)

[8] Jerry Expose Jr. vs. Thad Wilderson & Associates and Nina Mattson, filed May 4, 2015 in Ramsey County District Court, in which the court ruled that having a warning in the client handout for incoming clients was not sufficient notice to allow for a breach of confidentiality to do such a warning. Since this was a mental health clinic and case, the issue related to the Medical Records Act, not CFR-42. But the court said that for a release one needed to actually have a signed release. It is the revealing of the client's name and the client's threat which is the breach of confidentiality – not the person's status as a client. However, although this did not involve CFR-42 there is no reason to believe that if it did that the same principle would not apply – namely that releases need to be specific and that simply forewarning the client via a handout is not sufficient.

(2) If the client commits a violent act on premises or threatens to do so to staff of the program, it is permissible to contact law enforcement under the existing rules. (This does NOT permit contact with the potential victim -- only law enforcement.)

(3) If the client is in a criminal-justice connected program with a standing release to talk to a probation officer or some other correctional official, one can talk to the authorized parties.

(4) If the program has a statement in their consent form that such a duty exists so that clients are, in theory at least, consenting to this. The substance abuse counselor licensing law in Minnesota requires that counselors do this, although it remains to be seen if this is "informed consent" since the client does not know they are giving away a privacy right.

WHAT ABOUT CLIENTS WHO ARE MINORS?

The issue of clients who are minors is different from the typical case which is discussed as a "duty to warn" situation. First the privacy rights of minors are less than those of adults, so that the professional is obligated to release information to the parent or guardian. Even in a state like Minnesota where a minor who has special rights due to having born a child, been married, or who is living away from home and managing their own finances, ***there is a presumed authorization to contact parents or guardian if the failure to do so might harm the child***.

This does not mean that there are not important issues to examine in such cases. **The treatment contract with a minor – especially with an adolescent – needs to be considered in terms of not only any promises of privacy but the nature of the relationship. As with the *Tarasoff* case, undermining the treatment relationship can bring about harm in the long run because it removes the professional's best tools and the ability to help.**

As regards ***terroristic threats, such as blowing up a school or killing students and teachers***, **contacting the parents may be of value and importance, but this does not guarantee safety and so the police, school, or other organization may need to be contacted.** The *duty to warn or protect* assumes that there is a threat against a specific person and does not apply, but one needs to undertake an effort at protection nonetheless.

VIOLENCE IN THE SCHOOLS

From the Columbine High School and Virginia Tech killings to the Feb. 2012 shooting in a school in Ohio, there has been a growing concern about violence in both high schools and colleges. The shooter in the Virginia Tech case was receiving mental health care at the time. Although statistically, violent crime in the age groups involved has actually declined in the USA substantially in the last ten years, the high visibility of such killings has led to a great deal of debate and also research.

The Aurora Colorado movie massacre on July 20, 2012, involved a young man who was having serious emotional difficulties and being treated while enrolled as a graduate school student. The shooting incident occurred when he was no longer a student. His problems had caused him to be excluded from the campus and a treating psychiatrist had advised the police about his dangerousness.

Twenty-year-old Adam Lanza who committed the Dec. 14, 2012, Sandy Hook Elementary School shooting in Connecticut also appears to have been emotionally troubled as was the case with the shooter in the killings at Umpqua College in Roseburg, Oregon, on Oct. 2, 2015.

Other similar tragedies have followed in a variety of places. On May 1, 2014, police in Waseca, Minnesota, arrested a 17-year-old young man who claimed to have an elaborate plan to replicate the Columbine massacre. However, at first glance this young man did not have any obvious emotional problems. (It is noteworthy that although the initial accounts about Columbine made it sound as though the young men involved were very troubled and outcasts. One of the young men was actually popular. The book **Columbine** (Cullen, 2009) provides a far more complex picture and is worth reading, as is **A Mother's Reckoning** (Kleybold, 2016) by the mother of Dylan, one of the two shooters.

Studies by the US Secret Service, the FBI, and the US Department of Education have advised schools to develop threat assessment teams to respond to apparent threats of violence by students. A useful link to many resources can be found at the website for the Virginia Youth Violence Project at **http://youthviolence.edschool.virginia.edu**

It is important to note that we still lack good tools for predicting violence. After an incident of school violence it is common to have extra scrutiny and focus of student writings in class, postings on the internet, etc. **But at present we are not able to reliably distinguish students who are heading towards violence and those who are not from internet posts alone.**

THE CURRENT SITUATION

There are a number of articles and other resources on the internet which provide advice or guidance for clinicians with the hope of helping prevent violent situations.

On July 18, 2016, the Journal of the American Medical Association published on-line a very useful article entitled "Workplace Violence in Health Care – A critical issue with a promising solution" (Wyatt, Anderson-Drevs, & Van Male, 2016). Approximately 24,000 workplace assaults in health care settings occurred between 2010 and 2013. The rate of such events is on the increase. Among the many helpful suggestions made in the article was the importance of having all such incidents reported and investigated, and the importance of institutional responses to lower the risk of such occurrences.

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Psychiatric violence risk assessment, which often examines the issue of risk of assault by patients in a hospital unit and has looked at assessment tools (e.g. the HCR-20-C) and training to improve the ability to predict violence (Teo et. al, 2012). The Group on Violence Risk Assessment of the APA Council on Psychiatry and Law has produced a useful Resource Document on this issue (Buchanan et. al., 2012).

Fishkind's (2002) "Calming agitation with words, not drugs: 10 commandments for safety. These "commandments" are: I. You shall respect personal space; II. You shall not be provocative; III. You shall establish verbal contact; IV. You shall be concise and repeat yourself; V. You shall identify wants and feelings; VI. You shall listen; VII. You shall agree or agree to disagree; VIII. You shall lay down the law; IX. You shall offer choices; X. You shall debrief the patient and staff.

Each episode of violence which gets national attention leads to a renewed interest in finding ways to prevent such events. Sadly, news media accounts are often misleading and in reality, many of these situations are very complex. While no profession has been shown to be able to predict violence with any degree of certainty, somewhat similar to predicting suicide, one should be mindful of the fact that **some factors would tend to indicate seriousness:**

(1) A detailed plan of violent action which the client reveals to you;
(2) Having the means to do it as threatened (e.g. gun, car, etc.);
(3) A specific threat which seems convincing to you;
(4) A history of past violent behavior, or past careless behavior such as reckless drunken driving which appeared suicidal or homicidal
(5) A "close call" for such behavior in the past
(6) Anything which would indicate desperation or that the client doesn't care about living, or about consequences, anymore

One should disclose as little confidential information as possible to provide for the warning and for protection. Details of therapy or diagnosis are not relevant, but, the client's plan of action, current location, place of residence, or even their current appearance may all be relevant.

In the case of a minor, it is important to warn both the parents/guardian, and whoever might be in charge of security at the site where the violent acts are supposed to occur, such as a school. Bear in mind that with substance abuse counseling clients, there is less protection if you report.

THREATS MADE WHEN THE INTENDED VICTIM IS PRESENT

Unfortunately, the codes of ethics and available law *do not specify that the threat needs to be latent -- that is, not known to the intended victim.* So, if the threat occurs during a session when the intended victim is present, I would recommend the following:

(1) Draw the intended victim's attention to the threat in case they missed it.
(2) Indicate that you hear it as a serious threat and hope that the intended victim takes it seriously, and takes whatever precautions seem in order.
(3) Document clearly in your notes that you carried on this discussion.

The duty when the threat is not latent is unclear, but in circumstances when the intended victim does not seem to be taking it seriously, one can easily argue that there is a duty to try to impress upon them the risk that you perceive. Then one can engage in the discussion of "safety plans." In domestic violence situations safety plans are a normal part of treatment intervention.

Are there additional actions you should take if, for example, the potential victim does not seem to comprehend the risk, despite your efforts to make it clear? My answer is "Yes." There are times when one can follow-up with an additional contact, perhaps by phone, inquiring further about the situation and whether the person has given more thought to the risk, or personal safety.

Case Example: In a family session, a young adult male says that he is angry at his father and thinking about chopping his head off, and in fact sharpening an ax in the basement. The parents, who are present in the session, do not react. In a series of questions, the therapist establishes that (a) the parents sleep in an unlocked bedroom upstairs; (b) there is such an ax, and they are aware of their son's sharpening it; (c) that their son normally "does do things he says he'll do." None of this generates any apparent anxiety or interest in talking about the dangers of the situation. A follow-up phone call to the parents also fails to generate any action.

WHAT HAPPENS NEXT? THE AFTERMATH OF THE WARNING

The NASW Code of Ethics which went into effect at the beginning of 1997, when referring to duty to warn and protect type situations, states in part: **1.07(c)...In all instances social workers should disclose the least amount of confidential information necessary to achieve the desired purpose; only information that is directly relevant to the purpose for which the disclosure is made should be revealed.**

This sounds reasonable and would be consistent with codes of ethics for other professions. In practice it is far more difficult to judge what information is "directly relevant." Unforeseen in ethics codes and statutes is the terrorizing effect that such a warning may have on the person being warned. Receiving such a warning may have some very negative side-effects. The story below is true with a few details changed for disguise:

> ***Mr. Smith picked up the phone. A man claiming to be a therapist, whose name he didn't recognize, was on the phone. The man indicating that he was calling because of some sort of ethical (or was it legal?) duty to warn him of a serious threat. He said that a woman named "Joan Dawes" said she was going to shoot him and his family.***
>
> ***Mr. Smith was bewildered and frightened, and didn't know who "Joan Dawes" was.***
>
> ***He tried to get more information but the "therapist" appeared reluctant to say much else. Finally, he got him to reveal that "Joan Dawes" was his estranged stepdaughter who had apparently changed her name. He had no idea that she was back in town....and immediately wondered where she lived and worked. He asked about precautions, the seriousness of the threat, why the therapist had not had Joan committed on a 72 hr. hold, etc. but the therapist would say no more.***
>
> ***A week has gone by and Mr. Smith and his family are living in terror. They have barely slept. Calling the police did not help much. What little the police were able to get out of the therapist didn't provide grounds to take any action. In fact, even if they were to have a "talk" with "Joan Dawes" they indicated that this might only serve to make her angrier at them, at Mr. Smith, and at the therapist.***

The literature does not discuss what should be communicated and what the outcome of doing this might be. **So, put yourself in the position of the person receiving the call and think about what information might help them deal with what they are about to be told.[9]**

THREATS AGAINST THE PRESIDENT OR MEMBER OF CONGRESS

A **plot** against federal officials can be reported to the local police, but can also be reported to the FBI or Secret Service. A serious threat of harm against the President or some key official is no different than any other similar situation; except that it may be that the avenues for warning are different. If the target is a member of congress, one might end up informing their office – it may not be possible to reach the official directly on the phone.

[9] One of the challenges is a situation where a call goes through but nobody answers so that a message must be left on an answering machine or a cell phone. There can be risks caused by leaving a message that might be heard or accessed by someone other than the person you are calling. It is challenging to decide what information to leave by way of a warning.

However, **any verbal threat against the President, Vice President, or members of their immediate families, is a felony.** (If either is deceased, the same would apply to the Speaker of the House and his/her family.) Even if the threat is one that you do not think will be carried out, the US Secret Service has argued that since a verbal threat against the President, Vice President, or members of their immediate families is a felony, professionals should report such threats and to not do so might be construed as misprision of a felony. (I have not heard of any case where this actually occurred and a professional was charged.)

While some highly regarded professionals such as Dr. Walter Menninger have written and spoken favorably about their experiences in making reports to the Secret Service, it is hard to believe that a verbal threat, as opposed to a plan or plot (which would be more of a "duty to warn or protect") would be sufficient grounds to violate confidentiality. The Warren Commission (on the assassination of President John Kennedy) files on "Threats Against the President" contain many cases reported and investigated which involved statements in bars and psychiatric wards by persons who appeared to be drunk or psychotic where no real threat of action was apparent.[10]

ACCESS TO GUNS

There has been considerable discussion of the topic of clinician inquiry about the presence of guns in connection with the issue of suicide. A number of professionals who testify in wrongful death cases consider it essential to question clients carefully about the presence of guns in the home. They note that some gun-owners will not consider a gun as a "weapon" so that it is important to specifically inquire about **guns of any type. Screening for the presence of guns as part of a clinical intake or risk assessment is now considered the standard of care by a number of experts. In cases of potential violence inquiry about weapons is inevitable.** (e.g., McCourt & Vernick, 2018)

It is beyond the scope of this discussion to review struggles around the United States regarding attempts to restrict questioning about guns in the household, or in the possession of a given individual. In a number of areas of the country the National Rifle Association or other groups focused on Second Amendment Rights have lobbied for prohibitions against physicians or other healthcare providers inquiring about guns in the household. Florida passed such a law which was later overturned.[11] A similar effort was attempted in Texas but failed.[12]

Guns account for a very large percentage of suicide deaths in the United States. One of the main reasons for the higher rate of male deaths by suicide, as compared to female deaths, is that men use guns more frequently in their attempts. It is important to note that there are cases where it appears that a person has acquired a gun, through purchase or borrowing, specifically in order to

[10] Commission Documents 1179-I and 1179-II are both huge files with hundreds of cases detailed in them.

[11] For example, in 2011 the State of Florida passed a law entitled the *Firearms Owner Privacy Act*, partly in response to a situation in which a pediatrician who told a woman who refused to answer a question about firearms in the home that she needed to find a new physician. The law, among other things, forbid a physician to ask about guns in the home unless the physician "reasonably believed" that the information sought was relevant to medical care or safety. It had a vague proscription against "harassment" of gun owners, and forbid recording the information in the chart unless it was necessary for care or safety. Many medical groups opposed the statute, and a lawsuit, nicknamed "Does vs. Glocks" was filed. The law was struck down in 2017 based on an argument that it attenuated the doctor's first amendment rights, and it was thrown out after Governor Scott failed to appeal the court finding.

[12] In 2015 a bill made its way in the Texas legislature to try to mirror the Florida law, which at the time was still in the appellate courts. However, although there was considerable discussion generated by this bill, it did not pass.

kill themselves. On the other hand, long term gun owners and collectors may use their guns for suicide. While handguns are the most common weapons used for suicide, there are cases where hunting rifles or shotguns are used.

MURDER/SUICIDE

Unfortunately, there are situations where someone murders someone as part of a suicide. This can occur accidentally, of course, in a situation where someone is reckless and brings about the death of someone (e.g., car crash) but it can also be a murder.

The Minnesota Supreme Court gave an opinion in ***Smits v. Park Nicollet Health Services*** on September 7, 2022, which addressed such a situation. The case involved Brian Short, a nurse and business owner who was struggling with some stressors and went for help, receiving treatment (medications & some counseling) over a three-month period for anxiety and depression. He deteriorated and eventually killed himself, his wife, and his three children with a shotgun. The case involved a summary judgement motion in an action brought by the estates of the wife and children.

The Supreme court agreed with the appellate court that there was no duty to the family members who were killed on the part of the care providers. There had been no threat or warning so this was not a "duty-to-warn" nor was there a duty to protect. However, the Supreme Court also affirmed the appellate court's opinion that the defendants did owe a duty of care to Mr. Short and that part of the case could move forward. The plaintiff's experts questioned the medication management and decision-making as well as several other elements of the care provided. They also noted that the high level of agitation made Mr. Short a higher risk, even though he denied any suicide plan or that he was high risk.

A FINAL WARNING

There is a tendency for professionals to focus on legal standards for taking action. However, standards set out in case law, statute, and codes of ethics rarely address the complex situations we find ourselves in from time to time. **First and foremost is to consider what might be the best clinical response to the situation.**

Situations of "creeping dangerousness" are more common than true "duty to warn" situations in which a failure to act quickly could have fatal results. **Most of the time we need to be focused on what is occurring and how we intend to intervene clinically. Obtaining consultation and identifying and considering options are usually the best route for the appropriate handling of a volatile situation.** The central task in such situations is to prevent or diffuse harm while not losing the working relationship with the client (Knapp & VandeCreek, 2003)

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