Recent mass shootings heightened the focus on widespread state laws that require or allow psychologists and other mental health professionals to breach confidentiality in order to prevent harm by their potentially violent patients. This article is intended to help practitioners with the challenging task of applying these duty to protect* laws in working with these individuals.

Mandatory versus permissive laws

Most psychologists think of duty to protect laws as those that create a mandatory obligation to take action and impose liability for failing to carry out that duty. But there are closely related laws that give psychologists discretion or permission – but not the duty – to breach patient confidentiality to prevent harm to others or to the patient. Such permissive laws do not impose liability; laws generally create liability only when someone fails to meet a mandatory requirement. This article refers to the two types of laws as “mandatory” and “permissive” duty to protect laws.

Because they do not create liability, permissive duty to protect laws often have a lower threshold for the level of risk that triggers the ability to warn, and they may apply to a wider range of potential victims.

Permissive and mandatory laws frequently differ in the following respects:

Potential victim. Mandatory duty to protect laws usually require an identified or identifiable victim – someone other than the patient. Permissive laws frequently apply to a wider range of potential victims – when there is potential harm to any person (or even the public), including the patient. So, for example, a client’s threat to blow up a shopping mall would often give the psychologist the ability to take action under a permissive law, but would almost never create a duty under a mandatory duty to protect law.

Imminence, certainty and type of harm. Mandatory duty to protect laws typically apply where there is an imminent and/or rather certain threat of harm. They often specify that the harm must be serious physical harm or death. Permissive laws often lack these elements, for example, requiring only some kind of harm, or in one or two cases, even encompassing the risk that the client will simply damage property.

Beyond these general distinctions, there are considerable state-by-state variations in both types of laws. Relevant resources for further information are found in the sidebar (page 4) entitled, “Summaries of mandatory and permissive state duty to protect laws.”

According to Welfel, Werth & Benjamin (2009), among 64 jurisdictions in the U.S. and Canada: 32 states mandate a duty to protect regarding professionals’ responsibility with dangerous clients; 18 states or provinces have permissive duty to protect laws; and the law of 14 jurisdictions remains silent as to whether a duty to protect exists. In some jurisdictions, a duty to protect also exists regarding clients who are dangerous to themselves.

All of these laws serve the same general purpose: to permit or mandate psychologists’ release of confidential information in order to protect potential victims of a client’s violent acts.

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**Duty to Protect**

**Roles and Responsibilities for Psychologists**

In 1976, the California Supreme Court issued its decision in Tarasoff v. Regents of the University of California after a patient carried out a threat to kill a young woman. In that case, the court ruled:

When a therapist determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another [person], he incurs an obligation to use reasonable care to protect the intended victim against such danger . . . [This duty] may call for [the therapist] to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or take whatever other steps are reasonably necessary under the circumstances.

After the Tarasoff case, many states passed legislation defining a “duty to protect”* and the steps needed to discharge that duty. In other states, courts created a duty to protect through case law. Even in states without such a statute or case law, a court could create such a duty and impose liability for failing to meet that duty – for example, if a victim’s family members sue a mental health professional who they believe should have foreseen a patient’s violent behavior.

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**A BRIEF HISTORY OF DUTY TO PROTECT**
**Permissive duty to protect laws**

Permissive duty to protect provisions are typically found as exceptions to the professional obligations found in confidentiality or privilege laws. An example of a permissive duty to protect law is the Illinois Mental Health and Developmental Disabilities Confidentiality Act. The Act’s provisions for disclosure without patient consent include two types of disclosures relevant to duty to protect:

- To initiate a civil commitment or to otherwise protect the patient or another person against a clear, imminent risk of serious injury or death; and
- To warn or protect a specific individual against whom a patient has made a threat of violence.

The Illinois act provides immunity from liability for such disclosures when made in good faith. (Full text of the Act is available at bit.ly/740ILCS.)

The permissive duty to protect provision best known to psychologists is in the APA Ethical Principles of Psychologists and Code of Conduct (“Ethics Code”). Ethics Code Standard 4.05(b) allows disclosure of confidential information without patient consent “where permitted by law for a valid purpose such as to...protect the client/patient, psychologist, or others from harm.”

Further, the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule also specifically permits covered health care providers to disclose protected health information without consent or authorization in order to prevent or lessen a serious and imminent threat to the health or safety of a person (including the patient) or the public. Such disclosures must be consistent with applicable law and ethical standards. They must be made to a person or persons reasonably able to prevent or lessen the threat, including potential victims. (For more information, please see the HIPAA Privacy Rule Primer at apapracticecentral.org/business/hipaa/hippa-privacy-primer.pdf.)

Importantly, the APA Ethics Code provision, the HIPAA provision and state law permitting or requiring disclosure must all be considered together. The Ethics Code and HIPAA provisions only allow disclosure without consent if state law permits it. The HIPAA standard sets a higher bar than the APA Ethics Code in terms of the imminence and type of harm. HIPAA requires a serious and imminent threat to the health and safety of a person. By contrast, the Ethics Code refers simply to protecting the patient, psychologist or others “from harm.” Unlike many mandatory duty to protect laws, the HIPAA provision applies to self-harm and does not require an identifiable victim.

**Mandatory duty to protect laws**

As noted earlier, mandatory duty to protect laws generally create liability for failure to act. Therefore, they often set a higher bar in terms of imminence and certainty, and they generally apply to a narrow range of potential victims. Beyond those generalizations, mandatory laws vary considerably, so it is important to understand the specific requirements in your jurisdiction.

Be aware of variables in these laws such as:

- How imminent and certain must the threat be?
- Must the potential victim be identifiable?
- How is the duty discharged? Are required methods of warning or protecting specified, such as hospitalizing the patient, warning the potential victim or notifying the police?
- To which types of mental health and/or other professionals does the duty apply?
- Is immunity provided for good faith efforts to discharge the duty?
- Is the duty established by statute or case law?

**Clinical and ethical considerations**

Dr. Stephen Behnke, APA Ethics Director, notes that whether or not practitioners have a mandatory or permissive duty to protect in a potentially dangerous client situation, it is important to always “keep their clinical hat on.” While duty to protect laws direct when a practitioner can and must take action, Dr. Behnke notes that clinical judgment informs both a psychologist’s assessment of risk and how he or she carries out legal duties and options.

For example, unless mandated by state law, warning the intended victim is only one of several possible interventions you should consider. Other less intrusive, therapeutic options that don’t involve a breach of confidentiality should be considered first. For example, you may be concerned that a patient is increasingly angry and impulsive, and may become violent, but the danger does not rise to a reportable level in your state. In this situation, you might decide to increase the frequency or intensity of treatment, get a medication consult or urge the patient to seek voluntary hospitalization.
Alternatively, you may be able to address safety concerns without breaching confidentiality through a combination of:

- informed consent procedures
- establishing and maintaining a good therapeutic alliance
- carefully assessing for violence and suicide, and
- implementing an appropriate treatment plan.

Involving the patient in decisions about treatment and needed interventions is often helpful. For example, a patient may agree to be evaluated at a hospital if he or she understands that otherwise an involuntary admission may become necessary.

If you do need to warn a potential victim or otherwise reveal confidential information, it is generally preferable to discuss the situation with your patient in advance, if doing so is possible, safe and clinically appropriate. Your patient will better understand the rationale for your actions if you explain your legal obligations and emphasize the goal of preventing violence that could have devastating consequences for your patient and potential victims.

Remember also to limit the information disclosed to that which you believe is needed for the immediate goal of protecting individuals from potential harm.

If you have concerns about a potentially dangerous client, take prompt action to address the situation. Confidentiality and clinical issues are very important, but if you truly believe someone is in immediate, serious danger, protecting your patient or another from harm will likely become even more critical.

If you are concerned about the safety of others, you should also consider issues such as whether your patient may be suicidal, may be abusing a child, or may endanger you or your colleagues. (For additional information, see our Good Practice magazine articles, “Dealing with Threatening Client Encounters” (Winter 2012) and “Reporting Child Abuse and Neglect” (Spring/Summer 2013).

In all of these situations, clinical and/or legal consultation is advisable, as is risk management consultation with your professional liability insurer. In addition, be sure to keep careful documentation.

Informed consent

The prior section discusses informed consent discussions you may want to have with your client after a duty to protect issue arises. It is also important to include these issues in your informed consent procedures at the start of therapy. You should address, preferably both in writing and verbally, exceptions to confidentiality such as duty to protect. A thorough informed consent process will make it easier to work with your patients if you are later confronted with a situation in which you need to make disclosures for safety reasons. Your patient is already aware that you may have to breach confidentiality in this situation.

APA Ethics Code Standard 4.02 states: “Psychologists discuss with persons…with whom they establish a scientific or professional relationship…the relevant limits of confidentiality.” Standard 10.01 states: “When obtaining informed consent to therapy…psychologists inform clients/patients as early as is feasible in the therapeutic relationship about … limits of confidentiality.”
Sample informed consent forms, including language explaining possible duty to warn/protect limits to confidentiality, are available online from the APA Insurance Trust at apait.org/apait/download.aspx. (Similar provisions are the therapist-patient agreement contained in HIPAA for Psychologists, the APA Practice Organization/Insurance Trust HIPAA Privacy Rule course/compliance product. It is available at the APA Practice Organization’s website: apapracticentral.org.)

Be prepared

Duty to protect issues are complex and difficult. They can be particularly stressful if a practitioner is not prepared to respond when a patient expresses violent thoughts or intentions. It is important for practitioners to be familiar with their legal, ethical and clinical responsibilities when treating a potentially dangerous patient. Many mental health professionals do not receive extensive training in managing behavioral emergencies in graduate school.

The following actions will help you reduce the risk that a duty to protect situation will arise, and let you respond more appropriately if it does occur:

- reading more about these issues (see sidebar at right, “Additional References and Resources”)
- taking continuing education on topics such as violence assessment and risk management
- consulting with expert colleagues or attorneys about patients who concern you, and
- learning and staying up-to-date on laws in your state.

Practitioners with further questions about duty to protect may contact the Legal and Regulatory Affairs Department at praclegal@apa.org or call the APA Practice Organization’s toll-free Practitioner Helpline at 800-374-2723.

* The terms “duty to protect” and “duty to warn” are often used interchangeably. However, some authors use the term “duty to warn” to refer specifically to a duty to warn an identified victim, whereas the term “duty to protect” is broader and allows for alternative means of protection from violence, such as notifying the police or initiating hospitalization.

Please note: Legal issues are complex and highly fact-specific and require legal expertise that cannot be provided by any single article. In addition, laws change over time and vary by jurisdiction. The information in this article should not be used as a substitute for obtaining personal legal advice and consultation prior to making decisions regarding individual circumstances.

ADDITIONAL REFERENCES AND RESOURCES


