One of the most anxiety-producing situations for all mental health professionals is working with clients who may be dangerous to others or to themselves. It is likely that in the course of their career, providers of psychological services will be confronted with clients who will threaten to or actually harm others and who will die by suicide. What is the current standard of care for working with these clients? What are the ethical, legal, and professional responsibilities in working with these populations? In a recent study, 90 percent of psychologists were confident of the accuracy of their knowledge of legal responsibilities with dangerous clients, but as many as 75 percent of the sample were misinformed about their legal duties (Pabian, Welfel, & Beebe, 2007).

Partly because of these facts, The Duty to Protect: Ethical, Legal, and Professional Considerations for Mental Health Professionals should be read by every provider of mental health services as well as by those who teach and supervise them. This edited volume is a comprehensive resource for information on how to implement best practices across a broad array of dangerous situations.

One of the most important and basic contributions of The Duty to Protect is the clarification of the distinction between the duty to warn and the duty to protect. The duty to warn applies to the circumstances in which case law or statute requires the mental health professional to make a good-faith effort to contact the identified target of a client’s serious threats of harm and/or to notify law enforcement of the threat.

The duty to protect, on the other hand, applies to situations in which the mental health professional has a legal obligation to take action to protect a threatened third party, but the mental health professional usually has various options, such as intensifying outpatient treatment, hospitalization, modification of medication treatment, or informing law enforcement personnel, in addition to the option of warning the potential victim. The duty to protect allows for the possibility of maintaining client confidentiality, whereas the duty to warn necessitates a disclosure of confidential information to the potential victim.

Most providers do not realize that all 64 jurisdictions in the United States and Canada have different interpretations of these duties, and some have no applicable statute or case law at all (see Chapter 2 by Benjamin, Kent, & Sirikantraporn). To accompany the book, editors James L. Werth Jr., Elizabeth Reynolds Welfel, and G. Andrew H. Benjamin created an online supplementary materials section (available to purchasers at http://www.apa.org/books/resources/dutytoprotect) that is an appendix that provides abbreviated summaries of the statutes, cases, and administrative procedures regarding duty-to-warn or duty-to-protect contexts for all 50 states, the District of Columbia, and 13 Canadian provinces and territories.
This comprehensive list is based on the entire American Psychological Association’s *Law and Mental Health Professionals* series (Benjamin, Rosenwald, Overcast, & Feldman, 1995) and on searches conducted with the Westlaw database for all jurisdictions. Although it is disappointing that the more detailed findings are not provided in the online appendix, this is understandable because the statutes, cases, and administrative procedures regarding duty to protect remain in flux throughout North America. It would be an amazing contribution if the editors could keep these data up to date as changes occur, and this isn’t a goal for this book. On the website mentioned above, the editors do warn that the content reflects the law at the time the Appendix was compiled and that, because statutory and common law can change quickly, readers should seek legal advice about current requirements in their jurisdiction.

Since the 1976 California Supreme Court ruling in *Tarasoff v. Regents of the University of California* (the original duty-to-warn decision), the majority of jurisdictions in which a duty has been created have now created a duty to protect, rather than a duty to warn. A mandatory duty to protect has been created by statute or rule in 24 states, and nine states operate under a common-law duty created by court decisions. This means that the mental health professional must take action to protect third parties from a patient’s threatened violence but may do so in a way that can protect confidentiality of the client.

In 10 other states and eight Canadian provinces or territories, statutes or rules provide a permissive duty to protect; that is, the law allows, but does not require, the mental health professional to breach patient confidentiality to protect third parties from a patient’s threatened violence. Thus, the mental health professional is provided more discretion in defining how to act in a particular case. Only six states require that the professional warn the potential victim and/or law enforcement. The other seven jurisdictions are silent about the duty to protect. A few jurisdictions specify different duties depending on the discipline of the professional. Some jurisdictions also require action when clients make threats against public officials or are engaged in domestic violence.

These emerging laws affect the practitioner. One challenge is that violent behavior is not consistently predictable. Psychologists and other mental health practitioners have mobilized in some states (e.g., Washington) to advocate change in a statute that imposes a standard of foreseeability that is unrealistic and not supported by the extant research on clinical judgment.

In the first section of the book, Foundational Issues, a helpful, up-to-date summary of the scientific evidence and methods of violence prediction is provided in Chapter 2 by Benjamin, Kent, and Sirikantraporn. The works of Monahan (2006; Monahan et al., 2001), Scott and Resnick (2006), and others are briefly reviewed, and various risk assessments are mentioned as resources. A framework for evaluating and intervening effectively with dangerous clients is provided and includes the following recommendations: (a) disclosure and informed consent before evaluation and treatment begin, (b) therapeutic alliance, (c) assessment of the threat, (d) peer consultation, and (e) documentation.

The ethical standards of four professional organizations are reviewed in Chapter 3, and the authors conclude that the ethics codes of the American Psychological Association (APA; 2002), the American Counseling Association (2005), the National Association of Social Workers (1999), and the American Psychiatric Association (2008) do not mandate breach of confidentiality with dangerous clients but do permit the breach of client privacy in some circumstances. In addition, the first study to review duty-to-protect issues of 34 ethics codes internationally is presented by Mark Leach (Chapter 4). Leach concludes that all the ethics codes he examined include general disclosure statements and that 70 percent of them include specific reference to duty-to-protect concerns. Many of the codes were developed on the basis of the APA code and other Western codes and used many of their ethical guidelines.

In the second section of the book, titled Harm to Others, Truscott and Evans present an intensive case to illustrate how to protect others from homicide and serious harm. They also address issues of risk assessment, violence prevention, diversity considerations, and supervision and consultation. Other chapters in this section address risk assessment and duty to protect in cases involving intimate partner violence, the stalking offender, threats against public officials, driving and operating other equipment, and communicable diseases.

The chapter authors provide a wealth of evidence-based information for understanding and assessing issues involved in decision making when mental health professionals are faced with dilemmas with those situations. Only some chapters
address diversity considerations, and while those are informative, they would have been more so had all contributors addressed unique issues of diverse populations.

The section Harm to Self addresses the duty to protect as it applies to suicidal clients, clients who self-injure, and clients dealing with end-of-life decisions. All states in the United States have an explicit expectation of the duty to protect when clients pose an imminent danger to themselves, as Jobes and O’Connor point out in Chapter 11, yet suicidal risk is still inherently difficult to assess in valid and reliable ways, and the field’s knowledge base about effective treatments remains remarkably limited (Linehan, 2005).

Annually, one out of six suicides in the United States involves a person receiving psychotherapy at the time of his or her death, and one half had received prior psychotherapeutic treatment. In providing services for ethnic minorities, mental health professionals should be mindful that recent immigrants have increased rates of suicide compared with those in their country of origin, and the risk generally increases for their offspring (Hjern & Allebeck, 2002). There is also evidence of increased suicidal ideation among adult gay men and lesbians; age has been shown to moderate the risk of suicidal behaviors of gay and bisexual men, with young men being at an increased risk for exhibiting self-harm behaviors and symptoms of depression (Paul et al., 2002).

In the final section of the book, Additional Considerations, the importance of self-care for mental health professionals is addressed by Brems and Johnson. Physical and emotional burn-out symptoms, including emotional exhaustion, that potentially lead to impairment are risks that clinicians have in working with this clientele. The authors outline professional strategies for self-care that include self-protection, consultation and supervision, networking, and continuing education; personal strategies include self-exploration and awareness, relaxation and centeredness, and healthful personal habits.

Policy and practice considerations about the directions and future of the duty to protect are thoughtfully addressed by Werth, Welfel, Benjamin, and Sales in the last chapter. While they conclude that the duty to protect makes sense clinically and as public policy, they express concern about the broad expansion of the duty into other realms, given that the therapeutic alliance and confidentiality are cornerstones to effective treatment. They provide fundamental practice considerations for clinicians to assist them in their work and to protect them from liability in the context of the duty to protect. They also call for increased research to improve the foundation of knowledge, as well as for the development of a comprehensive training model for educating students about the duty to protect. This book is a very good contribution to those ends.

References


