Duty to Warn Law - Frequently Asked Questions

On June 13, 2018, the New Jersey Duty to Warn Law for all mental health professionals was amended. Click here to read the NJPA announcement about the original law and the amendment.

Over the years, NJPA’s Committee on Legislative Affairs has been monitoring this requirement of firearms seizure when certain health care professional determines patient poses threat of harm to self or others, and proposed amendments to the bill sponsors, most recently in April 2018, which were not adopted. Since this bill was signed into law, NJPA continues to discuss the best way to communicate with our members about this amended law, the NJPA Committee on Regulatory Affairs is reviewing this matter and monitoring any potential regulations, and we have contacted APA’s Legal and Regulatory Department for their assistance in handling the new requirement.

In an effort to continue to provide information to our members, the below Frequently Asked Questions were prepared by Judith Glassgold, PsyD, NJPA Director of Professional Affairs and James Wulach, PhD, JD, member of NJPA Committee on Regulatory Affairs from questions they responded to on the listserv and by telephone. The questions are broken up into two parts – questions about police notification and questions about when you have a duty to warn. These questions and answers will be updated as more information is received.

I. Police Notification Issues

• What do I say to the Chief of Police in the area of residence of a client?

Provide only the patient’s name, address, and that the threshold duty to warn/protect has been triggered. No clinical information is to be released. Consider memorializing the conversation with a letter (marked confidential) to the Chief of Police providing the same information.

• It seems like I might need to call more than one police department is that correct?

Yes, in certain circumstances. If you decided to call the police to address the imminent danger to life (i.e., 911 or the police where a potential victim lives). Then, a separate call must be made to the police department where the patient lives to provide the necessary contact information.
• I work in a college counseling service, how do I determine what the residence of a patient is? Is it their campus address if they live in a dormitory or permanent residence?

You should work with your college Office of General Counsel as well as the Department of Campus Security/Police to determine procedures to handle these issues. Potentially, you may have to contact both police departments if both addresses are legal residences.

• Do I have to report a minor who is too young to have a gun permit or own a gun in New Jersey?

There is no age limitation in the law. If the duty to warn/protect threshold is met, you will need to notify the chief of police and take any other action required in the law.

• Do I need to notify the police if the minor’s parents don’t own a gun?

If the threshold duty to warn/protect has been met, you must notify the chief of police. You do not have to inquire into access to guns. The police and the courts have their own requirements and process to determine a course of action regarding access to any guns in the house.

• I felt a patient met the threshold duty to warn statute and they were hospitalized involuntarily, will the inpatient unit notify the policy or do I have to?

As the clinician treating the patient and identifying that a duty to warn threshold has been met, you should contact the Chief of Police in their residential area, regardless of whether the inpatient unit does or not.

• Is the call to the police chief required only if the patient specifically says he/she intends to use a gun? Or are we required to call the police chief for any type of suicidal or violent duty to warn situation, regardless of the means expressed by the patient?

The call to the police must be made whenever the duty to warn is triggered, regardless of whether the patient is known to have a gun. Only the patient’s name, address, and that the threshold has been triggered is necessary. The clinician does not have to ask questions about firearms unless it is part of their determination of imminent danger to self or others.

• Are we required to speak personally to the police chief or can we give the information to a second in command if the police chief is not available?

The law refers to the “chief law enforcement officer”. Whoever is acting on the Chief’s behalf in that role would be appropriate, and then document that fact carefully in the medical record. Then, it is good risk management practice to memorialize this notification with a letter to the chief of police marked confidential.
• What about conflicts with other responsibilities, such as confidentiality?
  It is important to update your informed consent and HIPAA disclosure documents when you
  start working with a client. Clear and supportive explanations of these issues are important and
  it may open up some useful clinical issues. Please note that this the release of information
  pursuant to the duty to warn and protect is included in the Psychology Licensing Act 13:42-
  8.5(a).

• What about other potential negative outcomes? Will this harm a security
  clearance, employability, or a citizenship/green card application?
  There is no information available at this time about how this information will be handled by the
  police. When more information is available, this FAQ will be updated. If you feel this situation
  may come up in the near term, please contact the chief of police in your municipality.

II. Clinical Determination Issues: Duty to Warn/Protect
• When is this notification triggered? I work with many depressed clients and we
  work on their suicidality ideation.
  The patient must meet the threshold duty to warn or duty to protect in the statute: “a threat of
  imminent, serious physical violence against a readily identifiable individual or against
  himself“. If not, then the notification requirement is not triggered. This is an immediate risk of
  danger to an individual that will happen in the very near future. Discussing an issue where the
  patient wants to avoid suicide or danger to self or other is generally not an imminent danger.

• What about a depressed patient who needs to be aided in getting him or herself to
  the ER (for example having the patient call a relative during the session and
  asking for a ride to the hospital), but as the psychologist you haven't actual called
  the police or anyone else. Would that still be considered a duty to warn case?
  The threshold of duty to warn/protect would have to be met. In this hypothetical case, the
  patient voluntarily decided to call a relative and go to the hospital, so there is not an imminent
  danger to any person, so there would be no reason for the psychologist to need take any of the
  steps.

• What if an adolescent or adult expresses suicidal ideation but no intent/plan?
  The patient must meet the imminent danger threshold duty to warn or duty to protect in the
  statute. If not, then the notification requirement is not triggered.

• We hospitalize college students frequently as part of our protocol for addressing
  suicidality when there are uncertainties about safety, do we have to notify the
  police in every circumstance?
The call is only required if the duty to warn threshold has been met when the danger is imminent. In many treatment circumstances, individuals are hospitalized when there are concerns about suicidality. A planned voluntary hospitalization most likely does not meet that threshold.

- **I work with client who has had periods of paranoia and angry thoughts. She has expressed a desire to kill the spies who she believes are following her, is the duty to warn threshold met?**

The duty to warn is only triggered when there is an identifiable victim and an imminent danger to another individual. You may wish to assess her threats carefully and periodically to determine if she intends to target a law enforcement office or any specific individuals. It may be helpful to obtain a reliable standard protocol to assess such imminent danger, so one is ready when the need arises.

- **I work with clients who own guns, does this law change my treatment?**

The threshold duty to warn/protect must always be met. It is important to update your informed consent and HIPAA disclosure documents when you start working with any client. Clear and supportive explanations of these issues are important and it may open up some useful clinical issues. If the patient does not have a history of suicidality, or homicidality or dangerousness, this change may not affect them.