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Watcha' Talking About Willis? The Duty to Warn Revisited

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Have you ever felt like Arnold of the '70s comedy "Different Strokes"? Or for that matter Willis? To misunderstand someone is sometimes unavoidable. It can have disastrous consequences when a homicidal patient acts out and harms someone else. Inevitably, the question is always presented "He must have told someone?" or "There must have been some sign?" Homicidal patients do not often verbally articulate a specific threat. Often the signs are confusing, and can come from outside sources. What factors does a therapist consider to determine whether a "threat" is truly a "threat?" Further, can statements by implication, indirection or non-literal means constitute a "threat?"

In the seminal case *Tarasoff v. Regents of the University of California* (1976) the patient made a direct verbal threat to his therapist against the victim. (*Id.*) The therapist tried to have the patient committed. (*Id.*) The patient was released and killed the victim. (*Id.*) Our Supreme Court held that therapists owed a duty to warn and protect third parties "once a therapist does in fact determine, or under applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others." (*Id.*) The Supreme Court did not specify what factors determined whether a patient posed a serious danger of violence, and left that up to expert testimony. (*Id.*)

Because of the impossibility of predicting violence, in 1985 the Legislature enacted Civil Code §43.92 in an attempt to provide immunity to the duty to warn and protect except in specified circumstances. The statute states:

> "There shall be no monetary liability on the part of, and no cause of action shall arise against, any person who is a psychotherapist…in failing to warn of and protect from a patient's threatened violent behavior or failing to predict and warn of and protect from a patient's violent behavior except where *the patient has communicated* to the psychotherapist a *serious threat of physical violence* against a reasonably identifiable victim or victims." (Emphasis supplied.)

Thereafter, only an actual threat communicated by a patient triggered a duty to warn. A non-verbal threat did not trigger the duty to warn. For instance, in Barry v. Turek (1990) the defendant provided psychological care to a male Afghani, who suffered severe injuries to the head and neck in the Afghanistan war. He was brought to California for reconstructive surgery. The man was 17 or 18 years old, 5 feet 4 inches tall, and weighed 105 pounds. He wore a mask which covered most of his face. He spoke no English and communicated through interpreters.

The man roamed freely on the hospital. On a number of occasions, he followed nurses in "inappropriately close ways" and "grab[ed] nurses and [tried] to kiss and fondle them." (*Id.*) Defendant and his assistants instructed him not to touch the nursing staff and, on at least one occasion, Jan nodded affirmatively after such instructions were given. He never made verbal threats of violence. However, on June 6, 1986, he came into plaintiff's office and attacked her.

The Court wrestled with the difficult question of whether plaintiff had sufficiently shown that defendant ought to have been aware that non-verbal conduct presented a "serious threat of physical violence". Before the assault, his inappropriate conduct with women was limited to incidents in which he attempted to grab and kiss the nurses. The record shows that the assault on appellant was by far the most serious incident.

The Court nonetheless concluded that there was insufficient evidence to suggest that, based on his prior conduct, the defendant should have been aware he was likely to commit such a serious sexual assault. In sum, because his non-verbal conduct in the hospital prior to the assaults on appellant did not constitute a "serious threat of physical violence." (*Id.*)

Ewing v Goldstein (2004) changed everything. *Ewing* arose against a backdrop of a romantic relationship between Geno Colello, an LAPD officer, and Diana Williams. In 2001, Geno and Ms. Williams broke up and she met and became involved with Keith Ewing. Geno had been under the care of Dr. Goldstein, an MFT, for emotional and physical injuries suffered in the line of duty.

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In June, Geno was told by his sergeant that he was being kicked out of the unit. Geno became increasingly depressed and contacted Dr. Goldstein. Geno agreed to be voluntarily admitted to Northridge Hospital. At no point did Dr. Goldstein have a concern that Geno might harm anyone else, nor was any threat communicated to him by Geno.

Geno was admitted to Northridge Hospital on June 21, 2001, and was assessed by an LCSW and a psychiatrist, who authorized his release after approximately 12 hours in the facility. Geno's father, testified that he had told the psychiatrist that Geno was capable of "conning" him and that the reason Geno wanted to get out of the hospital was to go after Williams' new boyfriend or kill himself. All doctors denied that such statements were made to him. Geno was discharged him on June 22. The father did tell the doctors that he had taken Geno's guns and "locked them up."

On June 23, 2001 Geno accessed a friend's handgun, killed Keith Ewing and shot himself. The tragedy spawned a lawsuit by Keith Ewing's parents for failure to warn Keith.

In *Ewing v. Goldstein,* a panel of the Second District concluded that the trial court had too narrowly interpreted §43.92. The Court concluded that the duty to warn could apply to a situation where a therapist is never told directly by a patient of any intent to harm a third party, but where a family member conveys a threat that the patient has made to the therapist and the therapist concludes or believes that the patient poses a risk of grave bodily injury to another person. (*Id.*)

The case of *Ewing v. Northridge* (2004) further complicated the duty to warn issue. This case, based on the same facts, arose from the hospital being granted a nonsuit at trial based on two theories: (1) that lack of expert testimony required a judgment in its favor; and (2) the immunity under §43.92 applied because there was no evidence of threat directly communicated by Geno to the hospital staff. In reversing the judgment of the trial court, the Court of Appeal created more ambiguity by holding: (1) that expert testimony is not necessary to establish whether §43.92 applied; and (2) that plaintiff does not have to prove a communication, but must persuade the jury that the psychotherapist actually believed or predicted the patient posed a serious risk of inflicting grave bodily injury upon a reasonable identifiable victim or victims. The implication is that serious threats are obvious, can be of non-verbal nature, and require no need for expert testimony. (*Id.*)

These decisions interject severe ambiguity into what was a clear statutory scheme, raise the specter of increased claims against therapists for breach of confidentiality or wrongful death, and raise difficult issues regarding defending these claims. It is clear that not only verbal communications can be used for the purpose of determining a duty to warn, but the courts will also look at the entirety of circumstances, including statements by implication, indirection or non-literal means, or non-verbal conduct.

There are no easy fixes to the problems created by the duty to warn and protect. As part of risk management, we suggest the following to therapists to make sure they don't misunderstand their patients:

1. Modify informed consent forms to specifically state that threats communicated to family members that are then communicated to the psychologist may give rise to the duty to warn;
2. For patients at risk, spend an extra amount of time providing clear, concise notes regarding the session and each contact by phone. Yes, it may take an extra amount of time, but the time spent will be substantially less than the amount of time you will spend meeting with your attorneys, attending depositions and court appearances;
3. Obtain consultation from a well-respected peer if you have a client who you suspect is suicidal or homicidal;
4. Strongly support a medication consult, and maintain monthly contact with the psychiatrist or medical doctor regarding the progress, or lack thereof, of your patient;
5. Know how to involuntarily hospitalize your patient in the community that he lives; and
6. Maintain appropriate limits of insurance for the type of patients you generally see.

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References

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Tarasoff v. Regents of the University of California (1976) 17 Cal.3d 425

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