NJPA Legislative Notice - The New Jersey Duty to Warn Law for all Mental Health Professionals has been changed. Please read the following update to learn more. NJPA will continue to provide updates and a link to the final law when it is available. These amendments went into effect immediately.

A review: The New Jersey Duty to Warn Law

The New Jersey Duty to Warn Law, (9P.L.1991, Chapter 270, passed in 1991) requires mental health practitioners to take at least one of five actions if they incur a "duty to warn": that is

"(1) The patient has communicated to that practitioner a threat of imminent, serious physical violence against a readily identifiable individual or against himself and the circumstances are such that a reasonable professional in the practitioner's area of expertise would believe the patient intended to carry out the threat; or

(2) The circumstances are such that a reasonable professional in the practitioner's area of expertise would believe the patient intended to carry out an act of imminent, serious physical violence against a readily identifiable individual or against himself."

These courses of action are:

"(1) Arranging for the patient to be admitted voluntarily to a psychiatric unit of a general hospital, a short-term care facility, a special psychiatric hospital or a psychiatric facility, under the provisions of P.L.1987, c.116 (C.30:4-27.1 et seq.);
(2) Initiating procedures for involuntary commitment of the patient to a short-term care facility, a special psychiatric hospital or a psychiatric facility, under the provisions of P.L.1987, c.116 (C.30:4-27.1 et seq.);
(3) Advising a local law enforcement authority of the patient's threat and the identity of the intended victim;
(4) Warning the intended victim of the threat, or, in the case of an intended victim who is under the age of 18, warning the parent or guardian of the intended victim; or
(5) If the patient is under the age of 18 and threatens to commit suicide or bodily injury upon himself, warning the parent or guardian of the patient."

The practitioner who does disclose this confidential information is immune from civil liability in regard to that disclosure.

What has changed?

The new amendment, originating from bill A1181, signed by Governor Phil Murphy *(along with 5 other gun control bills)* on June 13, 2018, adds to the existing duty to warn law by requiring that a licensed practitioner notify the chief law enforcement officer in the municipality/township where the patient resides, or the Superintendent of State Police if the patient resides in a municipality that does not have a full time police department, that a duty to warn and protect has been incurred with respect to the patient and shall provide to the chief law enforcement officer or superintendent, as appropriate, the patient's name and

other nonclinical identifying information. Only patient contact information needs to be given, not clinical information.

The police will then take action with the courts to determine whether to revoke any firearms permit and seek to collect any firearms owned by the patient or that they have access to. There is a process for the patient to seek to reverse these actions once the "duty to warn" situation has passed through a clinical assessment.

The practitioner who does disclose this confidential information is immune from civil liability in regard to that disclosure.

What does this mean for you?

1. In the past, when you felt that there was a "duty to warn" (a threat of imminent, serious physical violence against a readily identifiable individual or against himself), you could choose at least one of the listed options, now you must take at least one appropriate action to address the danger to self or other (i.e., hospitalization, warning the potential victim and/or their family, notifying police to protect the victim) as well as notify the police in the municipality/township where the patient resides and provide patient contact information so a firearms check can occur.

2. You should also ensure that any documents you provide to patients where you discuss disclosure of information contain this update.

If you have any questions, please feel free to contact Central Office to speak with Dr. Judith Glassgold, NJPA's Director of Professional Affairs at 973-243-9800. Dr. Glassgold is in on Tuesdays, 10-4pm.

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.