The Ever-Evolving Duty to Protect in California

Editor:

In a recently published paper in the *Journal*,[1,2] we stated that California legislation now permits flexibility regarding warning a potential victim and notifying the police to satisfy the duty to protect. However, legislation designed to keep mental patients who trigger the Tarasoff duty to protect from possessing guns now mandates notification of the police in these situations, while retaining flexibility on whether to warn potential victims. Some version of this requirement has been present for several years, yet is virtually unnoticed. Revisions have included requiring psychotherapists to report such situations to the police.

Under recent legislation, California Welfare and Institutions Code § 8105(c) (2014) became effective on January 1, 2014. It supplements § 8100(b). Together, they require psychotherapists to report the patient's identity to police within 24 hours, anytime a patient meets the duty-to-protect criteria. The sections mandate a report to prevent the patient from possessing guns regardless of how the duty to protect is satisfied. It remains unclear, though, whether police notification is necessary for a threat initially considered serious but subsequently assessed to represent transient anger. Involuntary hospitalization for danger already precludes inpatients from future gun possession, but a literal reading of the statute may require police notification nonetheless. Communicating a threat to the police could lead to a more thorough attempt to remove guns.

Warning is not a requirement and was eliminated from all relevant statutes, to resolve any ambiguity about a duty to warn in California; the duty is only to protect the victim. However, immunity is granted when the duty to protect is satisfied by both notifying the police and warning the potential victim. Thus, psychotherapists should notify the police and warn the potential victim most of the time.

California Civil Code § 43.92 (2013) clarified that if psychotherapists believe warning the potential victim would increase the danger and another action would be more protective, the option remains not to warn. Standard professional liability criteria would apply with plaintiffs who want to prove the alternative actions negligent.

Although police reports are required for gun purposes, the most risk likely occurs in the context of warning a potential victim and thus inflaming the conflict. Police may mistakenly think that they should warn the potential victim whenever they are notified, to complete the other half of the requirement for psychotherapist immunity. Therefore, if psychotherapists determine that warning the potential victim will increase the danger, efforts should be made to discourage police from contacting potential victims. In most situations, however, the psychotherapist is likely to conclude that warning the potential victim would create no serious problem.

The new gun legislation does not alter the fact that the California duty is to protect as opposed to warn potential victims. The police now must be notified for gun prohibition purposes, but warning the potential victim remains only the way to achieve immunity from liability for the duty to protect. Warning potential victims is still neither required nor is it necessarily the best way to protect potential victims.

References

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DSM-5 and Substance Use Disorders

Editor:

Although Drs. Michael Norko and Lawrence Fitch provide an interesting review of the changes in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)[1] for substance use disorders (SUDs),[2] I disagree with some of their assessments and conclusions about the diagnosis of addiction.

The DSM-5 Substance-Related Disorders Work Group published an article for clinical guidance[3] in which it discussed the various assessments and judgments that went into the criteria for substance use disorders in DSM-5. The decision was made to combine the previously separate categories of abuse and dependence. However, a continuum of severity was to be used based on counting the number of criteria. The more extreme or severe substance use disorder was considered an addiction, although the term was omitted because of the stigma attached to the word (Ref 2, p 485). The idea was that what was formerly considered abuse would now be considered a moderate substance use disorder, and what was formerly considered substance dependence (or addiction) would now be considered a severe substance use disorder. DSM-5 criteria thresholds are used that would yield the best agreement with the prevalence of DSM substance abuse and dependence disorders combined for a diagnosis of substance use disorder.

There were concerns that a threshold of two criteria was too low and that such low severity levels were not true cases (i.e., would not separate case from noncase).[3,4] The two-symptom threshold was too low to separate from no diagnosis.[4] Hence, DSM-5 subsequently used the two- to three-symptom threshold for public health purposes and to help with treatment of unhealthy behavior rather than for a specific abuse or addiction diagnosis.

The Work Group also clarified that craving was not particularly helpful in diagnosing addiction. Some studies have suggested that craving is redundant of the other criteria. The psychometric benefit of adding a craving criterion was equivocal, but the DSM-5 Work Group decided to use a suggested craving query while awaiting the development of biological craving indicators. Three of the SUD criteria (tolerance, withdrawal, and craving) do not specifically identify addicted behavior.

It does not make clinical or scientific sense, in that it lacks specificity, that the diagnosis changes from no diagnosis (2 of 11 criteria in field trials)[4] to the most severe form of the disorder (addiction) with the addition of 2 of 9 criteria/symptoms, if a threshold of 4 of 11 criteria is used. This is not a scientifically sound or clinically helpful method of diagnosing addiction or what was formerly called substance dependence. I would submit that the DSM-5 suggestion of considering addiction as the most severe or extreme form of SUD (Ref 2, p 485) makes the most sense in requiring 6 of 11 SUD criteria.

References

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Reply

We thank Dr. Samuel for continuing the conversation about the changes in the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)[1] related to substance use disorders. Although he expressed his disagreement with our "assessments and conclusions" we first wish to point out that we agree with some of his subsequent comments, as we expressed in our paper.[2] For example, we described the same concern expressed by Dr. Samuel that the new criterion of craving "does not contribute much to the diagnostic exercise and is thus not likely to have clinicolegal significance," but was added "in hopes of future biological treatments targeting craving" (Ref. 2, p 445). We also noted that concerns have been raised about the diagnostic threshold of two criteria for diagnosis of mild use disorder (Ref. 2, p 445) and, in fact, discussed at length the forensic significance of this choice by the DSM-5 Work Group. Hasin and colleagues (Ref. 3, pp 840–1) clearly noted this concern, but dismissed it in stating that the overall prevalence of the Fourth Edition (DSM-IV)[4] abuse and dependence disorders matched very closely with the total prevalence of use disorders when the threshold of two or more criteria is used. The concern expressed by Dr. Samuel in his last paragraph does not describe a disagreement with any of our conclusions, but rather with the decisions reached by the DSM-5 Work Group, about which we remained agnostic and merely descriptive in our paper.