

**The So-Called Duty to Warn:
Protecting the Public versus Protecting the Patient
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If you suspect that one of your clients might be dangerous to someone, do you have a duty to warn anyone? What if your client discloses to you a specific threat against a readily identifiable intended victim? What if your client discloses a vague threat against a readily identifiable target with no clearly identifiable victim? What if your client specifies no one at all? What if you have no ability to control or detain your client after he or she angrily walks out of your office after making a vague threat of violence? These questions represent some of the most complex and troublesome ethical dilemmas that confront mental health professionals. Whereas the reporting of child abuse is mandated by law in all 50 states, the so-called duty to warn is more complex because the decision is usually based on the professional judgment of the therapist rather than on any clear legal statute.

According to American Psychological Association (APA; 2017) Ethical Standard 4.05 (Disclosures), psychologists may disclose confidential information “to protect the client/patient, psychologist, or others from harm” (p. 7). This standard remains unchanged from APA’s (2002, 2010) previous standards. The APA standard is permissive (“may disclose”) rather than mandatory (“shall disclose”). Although the APA standard *permits* disclosure to protect others, it does not *require* disclosures to warn others. In other words, what is often perceived as a duty to *warn* others is in reality a duty to *protect* others.

The American Counseling Association (ACA; 2014a, p. 7) Ethics Section B.2.a. (Serious and Foreseeable Harm and Legal Requirements) states in part that “The general requirement that counselors keep information confidential does not apply when disclosure is *required* to protect clients or identified others from serious and foreseeable harm or when legal requirements *demand* that confidential information must be revealed” (italics added). In contrast to the APA (2017) standard, the ACA standard *permits* disclosure to protect others when such disclosure is *required* (presumably by law). Also in contrast to the current APA standard involving unspecified “harm,” the current ACA (2014) version and previous ACA (2005) version of the ACA standard use the more specific term “serious and foreseeable harm,” which itself stands in contrast to the earlier and more immediate term “clear and imminent danger” (ACA, 1995, p. 5).

Although Georgia is not one of the 19 states that have codified the ACA ethics into their rules and regulations (ACA, 2014b), Section 135-7-.03 (Confidentiality) of the Georgia Composite Board of Professional Counselors, Social Workers, and Marriage and Family Therapists does make an allowance for “revealing the confidence of a client...where there is clear and imminent danger to the client or others, in which case the licensee shall take whatever reasonable steps are necessary to protect those at risk including, but not limited to, warning any identified victims and informing the responsible authorities.” The threshold “clear, imminent danger” is also used in Directive 1 of the *Code of Ethics* the National Board of Certified Counselors (NBCC, 2016, p. 1).

Disclosure laws, which vary from state to state, generally come in two forms. *Statutory laws* are laws that are legislated by state general assemblies and signed into law by the Governor, whereas *case laws* are legal precedents that are adjudicated by appellate courts and signed by Judges. In Georgia, there is no mandatory statutory duty to warn an identifiable third party of harm, nor is there any statutory immunity from legal liability for psychologists who make such warnings. Because Georgia is one of many states that has codified the APA (2017) *Ethics Code* into its licensing board rules, there does exist a permissive standard allowing such discretionary disclosure although this licensing board rule neither mandates such disclosure nor does it provide immunity or protection for psychologists making such disclosures. For example, under Section 4.05 (Disclosures) of Chapter 510-4-.02 (Code of Ethics) of the Georgia Rules of the State Board of Examiners of Psychologists (2004), there is a discretionary allowance for a licensed psychologist to disclose confidential information in order to “protect the client/patient, psychologist, or others from harm” (p. 6). However, licensing board standards do not have the full force of *statutory law* but rather represent *administrative rules* under which licensed psychologists practice.

Bradley Center v. Wessner (1982)

Although Georgia statutory law does not address the so-called duty to warn, Georgia does have a legal precedent as defined by case law that establishes a duty to protect identifiable third parties (*Bradley Center v. Wessner*, 1982a, 1982b). In *Bradley v. Wessner*, the Georgia Supreme Court upheld an appellate decision that determined a failure to exercise control over a potentially violent inpatient who made a clear threat toward a readily identifiable intended victim. In affirming the appellate decision below, the Georgia Supreme Court

held that the Court of Appeals properly identified the legal duty in this case:

Where the course of treatment of a mental patient involves an exercise of “control” over him by a physician who knows or should know that the patient is likely to cause bodily harm to others, an independent duty arises from that relationship and falls upon the physician to exercise that control with such reasonable care as to prevent harm to others at the hands of the patient. (*Bradley Center v. Wessner*, 161 Ga. App. 576, *supra*, at 581, 1982a)

Because the Bradley case specifically involved a hospitalized patient over whom some control presumably could have been exercised by the inpatient psychiatric hospital, the case may have limited applicability in outpatient settings where less control can be exercised by the individual practitioner. Furthermore, the case did not involve any legal duty to *warn*, but instead involved a duty to *protect*, which is a broader duty than the more narrow duty to warn. The hospital’s duty to protect was breached by the negligent release of a dangerous patient who subsequently carried out his threat to kill a readily identifiable person.

Garner v. Stone (1999)

Although Georgia case law has established a legal precedent for a duty to *protect*, there is no statutory duty to *warn*, nor is there any statutory immunity for a psychologist making such a warning to a third party. In other words, although there is a legally established duty to protect a readily identifiable intended victim from imminent and foreseeable danger, there is no statutory duty to warn the victim nor is there any statutory protection from legal liability for mental health professionals who make such warnings. The absence of statutory immunity means that there is no immunity from professional liability for a psychotherapist

making an unauthorized disclosure of confidential information.

Although the case was never appealed and therefore never established as legal precedent, in *Garner v. Stone* (1999) a six person jury in a DeKalb County, Georgia, state court found in favor of a former police officer with Gwinnett County, Georgia, who sued a psychologist for violating the physician-patient privilege after the psychologist made a warning call to an identifiable third party. This nationally publicized legal case is a matter of public record and has been the subject of discussion in ethics training (e.g., Behnke, 2006; Doverspike & Stone, 2000). According to the court records, during a fitness-for-duty interview conducted by a consulting psychologist on August 30, 1996, the police officer disclosed that he had had a vision of killing his captain and thoughts about killing eight to 10 others including the police chief and a county commissioner. The psychologist took the matter seriously and, after consulting with legal counsel, eventually reported the conversation to the police officer's superiors. Attorneys for the plaintiff argued that their client's conversation with the psychologist was absolutely privileged and that state law provided no exception to the privilege. Attorneys for the defendant psychologist argued that a psychologist has a duty to warn third parties if a patient is likely to cause bodily harm. The defense further argued that Georgia courts have imposed a duty on mental health professionals to use reasonable care to prevent harm to third parties from a dangerous patient, but the courts have not specifically defined a duty to warn third parties in such situations. It is noteworthy that the psychologist's affidavit indicated that he "did not believe the threats to be imminent but considered them to be very serious." Interestingly, the trial judge's charge to the jury included discussion of the discretionary allowance under the Georgia Code of Conduct, which permits psychologist disclosure to prevent harm to the patient or others, as well as discussion of the California

Tarasoff ruling, which is legally binding only in the state of California. Again, it is important to remember that the discretionary allowance of disclosures permitted under the Georgia licensing board *administrative rules* is superceded by *statutory laws*, such as the psychotherapist-patient privilege.

Tarasoff v. Board of Regents (1976)

The landmark *Tarasoff* case is so central to the understanding of the duty to protect that it deserves some discussion. *Tarasoff v. Board of Regents* (1976) was the California Supreme Court ruling that was the result of a series of appeals in the civil suit filed by the family of Tatiana (Tanya) Tarasoff, a University of California at Berkeley student who was killed by Prosenjit Poddar on October 27, 1969. What has become known as the Tarasoff decision has been the source of almost endless confusion and misinterpretation, including the fact that there was a criminal court decision, a trial court civil decision, an appellate decision, and a California Supreme Court ruling. Another source of confusion about Tarasoff is that the California Supreme Court issued two separate rulings in the case, the first of which was a "duty to warn" decision and the second of which was a "duty to protect" decision (sometimes referred to as Tarasoff II) that nullified and replaced the first decision.

The facts of the *Tarasoff* case indicate that immediately after Tayna was fatally stabbed with a kitchen knife, Poddar returned to Tanya's house and called the police. Poddar's defense lawyers argued "diminished capacity" and produced one psychologist and three psychiatrists who testified that he was paranoid schizophrenic and could not have harbored "malice with forethought." The prosecution's court-appointed psychiatrist argued that Poddar was only schizoid and therefore a verdict of first or second degree murder was appropriate. After a seemingly straight-forward conviction

based on a 17 day trial, a jury of Superior Court of Alameda County found Poddar guilty and he was convicted of second degree murder. However, the criminal trial court's decision was overturned on appeal on February 7, 1974. The verdict was reversed because the judge had erred in his instructions to the jury by failing to give adequate instructions concerning the defense of "diminished capacity" (*People v. Poddar*, 1974). Poddar was convicted of voluntary manslaughter, confined to the Vacaville medical facility in California, and later released whereupon he returned to his homeland of India. The last information on Poddar was reportedly a letter in which he stated that he "has returned to India, and by his own account is now happily married" (Stone, 1976, p. 358).

A decade after Tarasoff, California became the first state to legislate a *limited liability statute*. In 1985, the California legislature enacted Section 43.92 of the California Civil Code, which limits the liability of psychotherapists when a patient makes a serious threat of violence. When there is a duty to warn and protect under the limited circumstances specified in the California statutory law, "the duty shall be discharged by the psychotherapist making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency" (California Civil Code, Section 43.92, 1985).

Since California enacted the first limited liability statute in 1985, which became effective the following year, 46 states (including the District of Columbia) have passed similar legislation applicable to mental health professionals (National Conference of State Legislatures, 2013). Werth (2009) reports that 11 states (including Georgia) have no statutory duty to protect/warn, 15 states (including the District of Columbia) have permissive duty to protect/warn statutes, and 24 states have mandated duty to protect/warn statutes (although Arizona, Delaware, and Illinois have

different duties for different professions). Four years later, Widgery and Winterfield (2013) report that 29 states require some or all mental health professionals to warn or protect potential victims about credible threats from their patients. Widgery and Winterfield report that 17 states have permissive statutes, four have no statutes, and only one state (Georgia) is described as "other."

As of 2015, Georgia has no statutory law mandating or permitting a duty to protect/warn, nor is there any statutory immunity for those who issue warnings. Georgia does have case law (i.e., *Bradley*, 1982) that establishes a legal precedent to protect, but this duty to protect has been narrowly defined as a "duty to protect when a hospitalized patient makes threats and is released negligently" (National Conference of State Legislatures, 2013, p.1). In other words, the twofold *Bradley* requirements are that the physician exercises "control" over a patient and that the physician "knows or should know that the patient is likely to cause bodily harm to others" *Bradley Center v. Wessner*, 161 Ga. App. 576, supra, at 581, 1982a). Nevertheless, regardless of whether the duty is mandated or permissive, it is noteworthy that neither Georgia nor 29 other states (including the District of Columbia) are described as having any statutory immunity for those making such reports.

Notwithstanding limited liability statutes that exist in some states, there has been little initiative in other states to support a sustained drive for legislation related to statutory immunity. There are also some inherent risks in introducing immunity legislation, which conceivably could erode the protective privilege that currently exists in psychotherapist-patient communications. In Georgia, "The confidential relations and communications between a licensed psychologist and client are placed upon the same basis as those provided by law between attorney and client; and nothing in this chapter shall be construed to require any such privileged communication to be disclosed"

(OCGA §43-39-16). Georgia law includes a more narrowly defined psychotherapy privilege for the communications between a patient and a psychiatrist, licensed psychologist, licensed clinical social worker, clinical nurse specialist in psychiatric/mental health, licensed marriage and family therapist, and licensed professional counselor (OCGA §24-5-501).

The protective privilege in all 50 states has been considered so important that it has been affirmed by the United States Supreme Court (*Jaffee v. Redmond*, 1996). However, it is interesting to note that the Supreme Court ruling contains a footnote allowing for an exception to privilege “if a serious threat of harm to the patient or to others can be averted only by means of a disclosure by the therapist” (p. 18). Citing from *Jaffee v. Redmond*, Footnote 19 reads as follows:

Although it would be premature to speculate about most future developments in the federal psychotherapist privilege, we do not doubt that there are situations in which the privilege must give way, for example, if a serious threat of harm to the patient or to others can be averted only by means of a disclosure by the therapist. (p. 18)

Consideration of a Legislative Proposal

For several years, Doverspike (2000, 2004, 2005, 2006), has proposed legislative changes to the Official Code of Georgia Annotated (OCGA) using the language crafted by Robert Remar, Legal Counsel for the Georgia Psychological Association (February 11, 2000). If introduced to and subsequently passed by the Georgia General Assembly, the following proposal, based on Remar’s (February 11, 2000) original draft, would represent a change to OCGA. For a more thorough discussion of this proposal, see Doverspike (2015, p. 23).

This proposed code change would (1) define the therapist’s duty and limits of liability in cases involving a serious threat of physical violence against a reasonably identifiable victim or victims, (2) establish statutory immunity from liability for therapists who in good faith comply with this requirement, and (3) identify the licensed practitioners to whom this requirement would apply:

- (a) A psychotherapist shall not be held liable in any civil action for failing to warn of and/ or protect from a patient’s threatened violent behavior or for failing to predict and warn of and/ or protect from a patient’s violent behavior except in those instances where the patient has communicated to the therapist a serious threat of physical violence against a reasonably identifiable victim or victims.
- (b) If a duty arises under subsection (a) of this Code Section, the duty shall be discharged by the psychotherapist making reasonable efforts to communicate the threat to the victim or victims or to a law enforcement agency. Notwithstanding that the patient’s communication to the psychotherapist is otherwise made privileged or confidential by law, a psychotherapist who in good faith communicates the threat to the victim or victims or to a law enforcement agency shall be immune from liability for said communication.
- (c) As used in this Code Section, the term “psychotherapist” shall be defined as a psychiatrist, licensed psychologist, licensed clinical social worker, clinical nurse specialist in psychiatric/ mental health, licensed marriage and family therapist, or licensed professional counselor.

An alternative to the above proposal involves a shorter form that creates no duty to warn but rather creates statutory immunity for those who communicate the threat to the victim or victims or to a law enforcement agency:

Where a patient has communicated to the patient's therapist a serious threat of physical violence against a reasonably identifiable victim or victims, the therapist shall be immune from any liability for communicating the threat to the victim or victims or to a law enforcement agency. As used in this Code Section, the term "therapist" means a psychiatrist, licensed psychologist, licensed clinical social worker, clinical nurse specialist in psychiatric/ mental health, licensed marriage and family therapist, and licensed professional counselor. (Remar, 2000)

Consideration of Ethical, Clinical, and Legal Literature

If you have a reasonable cause to believe that one of your patients presents an imminent risk of foreseeable danger to a readily identifiable third party, do you have a duty to warn? First, keep in mind that your primary duty is to your patient, whereas you may have a secondary duty to protect others only in the specific circumstance in which your patient presents a clear risk of serious danger to others. Secondly, consider the four factors that have been shown to be significant in case law and in research literature (e.g., Monahan, 1981, 1993, Monahan et al., 2005; VandeCreek & Knapp, 1989). These factors include *identifiability* of the victim, *specificity* and clarity of the threat, *foreseeability* of danger, and *ability* to contain and control the patient (e.g., inpatient vs. outpatient). It is the factor of foreseeability that is the most unpredictable variable. In the words of the District Court of Appeal of Florida, Third District, "There is not sufficient science to

allow the accurate prediction of future dangerousness" (Boynton v. Burglass, 1991, 590 So.2d. 452). In the two decades since this appellate finding, the empirical literature suggests that the future still cannot be reliably predicted (e.g., Monahan et al., 2005).

In discharging one's duty to protect, consider that there are several reasonable actions that a practitioner can take in order to exercise the ethical duty to protect others without actually warning others (e.g., intensification of treatment, hospitalization, involuntary commitment, removing access to weapons, collateral interventions, seeking the assistance of others, using secondary monitors, target hardening, and so forth). In other words, the duty to protect others involves clinical management of the patient, the last option of which may require the psychotherapist to breach confidentiality by making a third-party warning. The warning call should be the last step---not the first step---in the management of the dangerous patient. As with any clinical question, always consult a colleague before making a decision. As with any legal question, always consult an attorney before making a decision.

Practitioners employed by agencies, hospitals, and institutions can contact their institution's legal counsel, although the primary duty of an institution's attorney is to protect the institution. Independent and self-employed practitioners often forget that professional liability carriers often have a national risk management department that can be contacted for formal legal consultations. In addition, state professional associations (SPA) often have legal consultation plans that allow members to schedule a legal consultation with the SPA's legal counsel or attorney on retainer. SPA attorneys are usually familiar with state-specific mental health laws and regulations. When retaining a private attorney, be sure that the attorney has expertise and experience with the

jurisdiction's mental health laws and regulations.

Consideration of Consequential Analysis of Response Options

In considering response options during ethical decision-making, one useful approach is the 2 x 2 factorial matrix (Doverspike, 2005, 2006, 2015). In making the most ethically justifiable decision, carefully consider the benefits and risks of warning vs. not warning the intended victim(s). For example, some possible *benefits of warning* the intended victim might include protecting the intended victim and thereby protecting the patient from committing an action that could eventually harm the patient (e.g., retaliatory aggression, prison sentence, and so forth). On the other hand, the *benefits of not warning* the intended victim might include protecting the patient's privacy interests, maintaining confidentiality, building trust in the therapeutic relationship, and possibly reducing the risk of the intended victim engaging in preemptive violence toward the patient. The *risks of warning* the intended victim might include violating the patient's privacy, breaching confidentiality, eroding trust in the therapeutic relationship, and possibly precipitating the intended victim's preemptive strike against the patient. Conversely, the *risks of not warning* the intended victim might include allowing harm to befall the intended victim and thereby creating harm to the patient (e.g., arrest, prison sentence, living with feelings of guilt, and so forth). In considering overarching moral principles, Anders and Terrell (2006) state, "Though most therapists struggle with the idea of breaching confidentiality, one should keep in mind that the right to life of a third party supercedes the right of the client to keep trust, as the latter can be regained (albeit with difficulty) and the former cannot" (p. 15). A careful analysis of risks and benefits of various actions may help clarify the best course of action in a worst-case scenario.

If you do decide to make a third-party warning, consider enlisting the patient's cooperation by obtaining his or her permission and written authorization before making any notification or warning to a third party, which in some cases may be possible. If the patient does not provide authorization, then consider making the call in the presence of the patient, which may help preserve trust in the therapeutic relationship and which may strengthen the patient's reality-testing abilities and impulse control (Doverspike & Stone, 2000). If there is the possibility that such a call might precipitate preemptive violence by target person, then consider contacting law enforcement. Finally, know the statutory laws and legal precedents in your local jurisdiction. As with any legal question, always consult an attorney for legal advice before making a decision.

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Resources

For a more detailed discussion of this topic, see pages 215-255 in *Risk Management* (Doverspike (2015).

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