The So-Called Duty to Warn:
Protecting the Public versus Protecting the Patient
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This purpose of this paper is to provide a review of the literature that has been created and published by other authors—including clerks who write appellant court decisions. The paper is educational in nature and is not intended for distribution, publication, or commercial use. Material cited or quoted in this paper is limited to the purposes of commentary, criticism, reporting, teaching, scholarship, and research. The author's own conceptual model, philosophical commentaries, and societal opinions do not reflect any official opinions or policies of the Georgia Board of Examiners of Psychologists ("licensing board") or the Georgia Psychological Association (GPA) Ethics Committee. This article is designed to be educational in nature and is not intended to provide legal advice. The reader is encouraged to contact an attorney for legal advice regarding state laws governing professional conduct.

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 (2014b) ethical sections into the rules and regulations for professional counselors, Section 135-7-.03 (Confidentiality) of the Georgia Composite Board of Professional Counselors, Social

Workers, and Marriage and Family Therapists (Georgia Composite Board) 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 of a "clear, imminent danger" is also used in Directive 1 of the *Code of Ethics* the National Board of Certified Counselors (NBCC, 2016, p. 1).

A survey of 1,000 psychologists in four different states revealed that majority (76.4%) were misinformed about their state laws, believing that they had a legal duty to warn when they did not, or assuming that warning was their only legal option when other protective actions less harmful to client privacy were allowed (Pabian, Welfel, & Beebe, 2009). Yet despite the inaccuracy of their knowledge, Pabian et al. found that many psychologists were confident that they understood the duty to protect in their own state.

Disclosure laws vary from state to state, and they generally come in two forms: *Statutory laws* are codified statutes 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.

***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). The fascinating details of this tragic tale of romance, obsession, and murder are contained the paperback book *Bad Karma* (Blum, 1986).

A decade after *Tarasoff*, California became the first state to legislate a *limited liability statute*. In order to limit the scope and applicability of the duties imposed by *Tarasoff* and post-*Tarasoff* case law, a bill was introduced to California legislature on February 28, 1985, was signed into law by Governor George Deukmejian on September 17th of that year, and took effect on January 1, 1986. Section 43.92 of the California Civil Code, which defines the duty to protect and sharply limits the liability of psychotherapists when a patient makes a serious threat of violence, includes the following statutory language:

> (a) There shall be no monetary liability on the part of, and no cause of action shall arise against, any person who is a psychotherapist as defined in Section 1010 of the Evidence Code 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.
>
> (b) If there is a duty to warn and protect under the limited circumstances specified above, 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, 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."

Bradley Center v. Wessner (1982)

Although Georgia statutory law does not address any so-called duty to warn, Georgia does have a legal precedent as set by case law that establishes a duty to protect identifiable third parties. In *Bradley Center v. Wessner* (1982a, 1982b), 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, 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 *Bradley* involved a hospitalized patient over whom some control presumably could have been exercised by the hospital, the case may have limited applicability in outpatient settings where less control can be exercised by the individual practitioner. The case did not involve any legal duty to *warn*, but instead involved a duty to *protect*, which is a broader duty than the 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. Although the wife knew of the threats, the facility had the power to refuse a leave request because state law allowed it to detain voluntary patients for 48 hours before a release was mandated.

Allen v. Jenkins (1989)

Although Georgia case law in *Bradley* established a legal precedent for a duty to *protect*, there is no legal precedent or statutory duty to *protect* or to *warn* an unidentifiable third party in the absence of a credible threat towards a readily identifiable person. Although there is no legal precedent, the matter has been litigated in trial courts. The verdict in *Allen v. Jenkins* (1989) has led to some confusion because this civil litigation (which did not establish legal precedent because the trial court decision was never appealed) was preceded by a criminal trial (*State v. Hall*, 1984) and an appellate decision (*State v. Hall*, 1984) of the criminal trial. Following Hall's criminal trial (i.e., *State v. Hall*, 1984), a jury of the Superior Court of Clarke County (Western Judicial Circuit) returned a verdict of guilty on September 19, 1984 and then the following day imposed a life sentence.

On September 27, 1984, Hall's attorneys filed a motion for a new trial. On February 13, 1985, Hall's motion for a new trial was denied. On March 15, 1985, Hall filed a notice of appeal, and the appeal was docketed in the Georgia Supreme Court on April 18, 1985. The Georgia Supreme Court granted an extension of time until May 22, 1985 for Hall to file his enumerations of error and brief. On August 23, 1985, Hall submitted his appeal for decision without oral arguments. On December 5, 1985, the Georgia Supreme Court affirmed the trial court's verdict. Footnote 2 in the Georgia Supreme Court decision (*Hall v. State*, 1985) indicates that after he was convicted of murder of Donna Lynn Allen, Hall pled guilty to the December 27 and 28 attacks against two other women, and was then serving a total sentence of 45 years' imprisonment therefor.

Four years after the Georgia Supreme Court came the civil case known as *Allen v. Jenkins* (1989). In this civil action, James Carl Allen and Bernice Allen filed a $3 million lawsuit

against psychologist Jack Jenkins, Ph.D., the Regents of the University of Georgia (UGA), and Warren Reid Hall. The plaintiffs, whose daughter (Donna Lynn Allen) had been murdered by Hall on December 21, 1983, alleged that Dr. Jenkins could have prevented the murder by warning authorities of Hall's homicidal urges. After hearing Jenkins express his desire to kill, Jenkins had Hall placed in a locked psychiatric ward of a hospital. Physicians released Hall six days later after deciding he was not homicidal. During the civil trial, the family's attorneys argued that, had police known about Hall's statements to Jenkins, the police would have revoked his burglary probation and returned him to jail.

On January 10, 1989, the Clarke County Superior Court jury deliberated three hours to find that neither Dr. Jenkins nor UGA was liable for the 1984 murder of Donna Allen. Hall, who had already been convicted of murder after a 1984 criminal trial in Clarke County Superior Court, was ordered to pay the victim's family $1.26 million in damages. The Allen family's attorney described this civil verdict as an "empty victory" because Hall, being an indigent prisoner serving a life sentence for the murder, was unable pay the money (Psychologist not responsible for crimes by patient, 1989).

The defendant's verdict of "found not liable" in *Allen v. Jenkins* (1989) was based in part on the fact that Hall had not voiced any specific threats of violence toward Donna Lynn Allen. Several months prior to the 1983 murder, the Greene County Department of Family and Children Services (DFCS) had referred Hall for treatment to the UGA Psychology Clinic. Hall was treated by Jack Jenkins, Ph.D., a licensed psychologist and tenured professor on the University faculty, who was assisted by a graduate student (Maya Singh). On February 17, 1983, during the course of an interview with the student, Hall made certain damaging admissions, to the effect that he sometimes thought about "finding somebody…and raping them and then killing them." These admissions were sufficient to result in Dr. Jenkins placing Hall in a locked psychiatric ward of a hospital, but not sufficient to justify a breach of confidentiality or notification of any specific target person. As stated in the closing arguments of Alfred Evans, the Assistant State Attorney General who defended Jenkins and the Board of Regents, "If you do not have confidentiality, patients will clam up and a lot of people who really are dangerous will not be detected" (Allen v. Jenkins, 1989).

Another source of confusion with respect to *State v. Hall* (1984) related to the matter of the so-called "umbrella privilege." According to the Clarke County Superior Court Order signed by Joseph J. Gaines on July 9, 1984, it was ordered that a transcript of the relevant portion of a tape recording made in February 1983 between graduate student, Maya Singh, and Warren Reid Hall be furnished to counsel for the State and counsel for the defense (Hall). According to the Court Order, no psychologist/patient privilege existed in the instant case for two reasons. First of all, Hall had not entered therapy voluntarily. Instead, he was referred by a state agency, the Greene County DFCS. Shortly thereafter, he executed a waiver of the privilege in favor of the Department. Secondly, it did not appear to Judge Gaines that the communication in question was made to a psychiatrist or psychologist pursuant to either OCGA §43-19-16 or OCGA §24-9-21(5) (re-enumerated as OCGA §24-5-501 effective January 1, 2013). According to the record, Maya Singh, to whom the communication was made, was neither a psychiatrist nor a psychologist but a graduate assistant employed by the UGA Psychology Clinic. According to Judge Gaines, the psychotherapist/patient privilege could not be extended to all counselors, social workers, or psychological associates because of the number

of persons engaged in such various capacities is so great, it would be difficult to say what relationship and conversations fall within the privilege. Accordingly, the privilege should only extend to communications made to a psychiatrist or a licensed psychologist.

Before the criminal trial, Hall's attorneys had moved *in limine* to exclude the graduate student's transcript of the interview on the ground that it was a privileged communication under OCGA §43-39-16, which at that time provided that "t[he] confidential relationship and communications between a licensed applied 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 privileges [sic] communication to be disclosed." The trial court denied Hall's motion, and Hall appealed this ruling (*Hall v. State*, 1985). In reviewing the matter, the Georgia Supreme Court decided "we need not consider these arguments, for, assuming arguendo that the admission into evidence of Hall's statement to the graduate student was erroneous, the contents of his December 28 and 30, 1983 statements, which included his statement that he murdered Ms. Allen, made it highly probable that the error did not contribute to the verdict, and therefore did not harm the appellant." Therefore, *Hall v. State* (1985) not only did not establish any legal precedent for a so-called umbrella privilege, but in fact strengthens a conservative interpretation of the psychotherapy privilege as extending only to those licensed psychotherapists specifically enumerated in evidentiary statutes.

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.

As of 2018, 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)

***Jablonski v. United States* (1983)**

In some jurisdictions, there may be a duty to protect an intended victim notwithstanding the intended victim's knowledge of the danger. *Jablonski by Pahls v. United States* (1983) basically involved a failure to commit a dangerous individual resulted in duty to review records and commit. Although the case is extraordinarily complex, the Ninth U.S. Circuit Court of Appeals summarized these facts: A minor child (Meghan Jablonski) brought forth a civil suit for the wrongful death of her mother (Melinda Kimball) who was murdered by the man with whom she was living (Philip Jablonski). The lawsuit charged that psychiatrists at the Loma Linda Veterans Administration Hospital committed malpractice proximately resulting in the mother's death.

Several weeks prior to the murder, Philip Jablonski attempted to rape Melinda Kimball's mother (Isobel Pahls, who later filed the suit on behalf of her grandchild), and the police referred the man to the VA Hospital and warned the psychiatrist of his dangerousness. The hospital physician determined that there was no emergency and no basis for involuntary commitment. Later, Kimball again accompanied Jablonski to the hospital and expressed fears for her own safety. At that time Jablonski refused hospitalization and refused the release of prior records. The physician told Kimball that she should leave Jablonski, saying, "You should consider staying away from him." The physician concluded there was no basis for involuntary hospitalization and released Jablonski. Melinda Kimball did leave Jablonski but he murdered her shortly thereafter when she returned to their apartment. The Ninth U.S. Circuit Court of Appeals upheld the judgment against the psychiatrists, noting that it was not enough to have told Kimball to leave him. The court concluded, "The warnings ...were totally unspecific and inadequate under the circumstances."

Federal Rules and Regulations

According to the U.S. Department of Health and Human Services (HHS; n.d., p. 6), the HIPAA Privacy Rule permits a health care provider to disclose necessary information about a patient to law enforcement, family members of the patient, or other persons, when the provider believes the patient presents a serious and imminent threat to self or others. These provisions may be found in the Privacy Rule at 45 CFR § 164.512(j). According to HHS (2013), the scope of this permission is provided in a letter to the nation's health care providers, as signed by Leon Rodriguez, Director, Office for Civil Rights. The following information is an excerpt from the HHS letter:

> When a health care provider believes in good faith that such a warning is necessary to prevent or lessen a serious and imminent threat to the health or safety of the patient or others, the Privacy Rule allows the provider, consistent with applicable law and standards of ethical conduct, to alert those persons whom the provider believes are reasonably able to prevent or lessen the threat. Further, the provider is presumed to have had a good faith belief when his or her belief is based upon the provider's actual knowledge (i.e., based on the provider's own interaction with the patient) or in reliance on a credible representation by a person with apparent knowledge or authority (i.e., based on a credible report from a family member of the patient or other person). These provisions may be found in the Privacy Rule at 45 CFR § 164.512(j). (HHS, 2013, p. 1)

Considerations in Threat Assessment

In her 46-page threat assessment report to the FBI on school shooters, FBI Supervisory Special Agent Mary Ellen O'Toole, Ph.D. (2000), one of the most senior profilers until her retirement in 2009, provides some useful assessment guidelines. Threats can be classified into four categories: *direct* (a specific act against a specific target), *indirect* (ambiguous, unclear, and vague), *veiled* (strongly implies but does not explicitly threaten violence), or *conditional* (warning of what will happen unless certain demands or terms are met, such as in extortion cases).

Precipitating stressors include external factors (i.e., incidents or situations that can trigger a threat), whereas *pre-disposing factors* include internal factors (i.e., underlying personality traits and temperament) that must be considered together within the context of other information. With regard to threat assessment, it is the specificity of threat that is most important.

When assessing the risk that a threat will be carried out, the most critical factors in evaluating a threat include specific, plausible details. Such details can include "the identity of the victim or victims; the reason for making the threat; the means, weapon, and method by which it is to be carried out; the date, time, and place where the threatened act will occur; and concrete information about plans or preparations that have already been made" (O'Toole, 2000, p. 7). In contrast, although the emotional content of a threat may reveal important clues about the threatener's mental state, emotionally charged threats are not typically a measure of danger. According to O'Toole, "no correlation has been established between the emotional intensity in a threat and the risk that it will be carried out" (p. 8). In their popular book, *Dangerous Instincts*, O'Toole and Bowman (2012) describe how gut feelings may betray the person assessing a threat. The authors provide an algorithm for making everyday life decisions, such as how to safely respond to another person who might be dangerous.

With regard to levels of risk, O'Toole (2000, pp. 8-9) recognizes three levels of threats:

- **Low level of threat** poses a minimal risk to the victim and public safety. Such threats are vague and indirect. Information contained within the threat may be inconsistent, implausible or lacking in detail.

- **Medium level of threat** is one that could be carried out, although it may not appear entirely realistic. Such threats are more direct and concrete than low level threats, and they include some evidence that the threatener has given some thought to how the threated act will be carried out (e.g., a general indication of a time and place, but not necessarily a detailed plan of action).

- **High level of threat** is one that appears to pose an imminent and serious danger to the safety of others. Such threats are direct, specific, and plausible. The threat may suggest concrete steps have been taken toward carrying it out (e.g., acquisition or practice with a weapon, having the target or victim under surveillance).

In analyzing a wide range of threatening communications, the National Center for the Analysis of Violent Crime (NCAVC) suggests that, "in general, the more direct and detailed a threat is, the more serious the risk of its being acted on. A threat that is assessed as high level will almost always require immediate law enforcement intervention" (O'Toole, 2000, p. 9). Based on this reasoning, it is the "high level

of threat" that would correspond most closely to the Georgia Composite Board's use of the term "clear and imminent danger" (Ga. Comp. R. & Regs. r. 135-7) and the NBCC's use of the term "clear, imminent danger" (NBCC, 2016, p. 1).

Problems With Predictions

The *base rate effect* refers to the difficulty of predicting a behavior that occurs at a low frequency or base rate. Monahan (1981) states that the most common and most significant error made by clinicians in predicting violent behavior involves ignoring information regarding the base rate of violence in the general population. The base rate dilemma is illustrated in the following example provided by Livermore, Malmquist, and Meehl (1968):

> Assume that one person out of a thousand will kill. Assume also that an exceptionally accurate test is created which differentiates with 95 percent effectiveness those who will kill from those who will not. If 100,000 people were tested, out of the 100 who would kill, 95 would be isolated. Unfortunately, out of the 99,900 who would not kill, 4,995 people would also be isolated as potential killers. (p. 84)

Consideration of a Legislative Proposal

For several years, former GPA President and Ethics Committee member William Doverspike (2000, 2004, 2005, 2006, 2007), proposed changes to OCGA using language crafted by Robert Remar, Legal Counsel for GPA (February 11, 2000). Doverspike (2007) also made an official legislative proposal to the Georgia Mental Health Coalition at a meeting held on Friday, August 24, 2007, at the Central Office of the Georgia Psychological Association in Atlanta. The proposed statutory language was based largely on the California Civil Code Section 43.92 (1985).

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 in Georgia law. For a thorough discussion of the long and short versions, see Doverspike (2008, 153; 2015, p. 230). The proposed 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 three decades since this appellate finding, the empirical literature suggests that the future still cannot be reliably predicted (e.g., Monahan et al., 2005; Phillips, 2012). As observed by forensic psychiatrist, "In reality, no one can predict future dangerousness precisely and with absolute certainty" (Phillips 2012, p. 474).

Managing the Duty to Protect

As a starting point, clinicians should remember to take actions to protect target victims even when they may be self-warned (e.g., *Jablonski v. United States*, 1983). When threats are made during a session in which intended victim is present, consider Schoener's (2000, p. 8) recommendations:

1. Draw the intended victim's attention to the threat in the unlikely event that he or she may have missed it.
2. Indicate that you consider the threat to be serious, and encourage the intended victim to take the threat seriously.
3. Encourage the intended victim to take whatever precautions seem in order.
4. Document clearly in your notes that you carried on this discussion.

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.

About the Author

Dr. Doverspike is a former President of the Georgia Psychological Association (GPA). He served for 12 years as a member of the GPA Ethics Committee (1995-2008), from which he resigned after being appointed to the Georgia Board of Examiners of Psychologists (State Licensing Board). He was coordinator of the Consulting With Colleagues series of ethics workshops, which evolved out of his inpatient and outpatient work as a licensed psychologist in Georgia. As a clinical psychologist, much of his clinical assessment and intervention work over two decades involved suicidal and homicidal threat assessment while consulting in several state and private psychiatric hospitals in the Atlanta area. He is the author of Risk Management (2015) and Ethical Risk Management (2012), both of which are published by Professional Resource Press (PRP). For a more detailed discussion of this topic, see Risk Management (Doverspike, 2015, pp. 215-255).

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The Historical Clinical Risk Management-20, Version 3 (Douglas, Hart, Webster, & Belfrage, 2013), also known as HCR-20V3, or simply V3, is a comprehensive set of professional guidelines for the assessment and management of violence risk. It is known as the world's leading violence risk assessment instrument. The HCR-20V3 embodies and exemplifies the Structured Professional Judgment (SPJ) model of violence risk assessment. Its most common applications are within correctional, forensic, and general or civil psychiatric settings, whether in the institution or in the community. It is applicable to adults aged 18 and above who may pose a risk for future violence.

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This paper contains an HCR-20 V2 risk factor literature review.

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This paper contains an HCR-20 V3 risk factor literature review and rationale.

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