

DUTY TO WARN

Warn and protect

In this case, several unavailable facts may have supported the successful negligence claim. For example, why was Mr. B dismissed from the group? Did he threaten someone in the group? Did he tell the group or the group leader about thoughts of violence or homicide? If so, perhaps a violent event was foreseeable.

Was Mr. B dismissed because of delusional or paranoid thoughts? What was done to help him, and were appropriate referrals in place? Instituting the right interventions requires clinicians to walk a fine line between preserving doctor-patient confidentiality and protecting other patients and the general public.

Doctor-patient confidentiality is deeply rooted in medical ethics and protected by law—in various forms—in all jurisdictions. Directives requiring a physician to reveal information without a patient's consent are either legislated—and tend to be clear—or are based on court precedent, which is more open to interpretation. These mandated exceptions are purpose-specific and intended to preserve overall doctor-patient confidentiality.[1,2](#)

Tarasoff. Two cases—called Tarasoff I and II—set the precedent for a physician's duty to warn and protect others from potentially violent patients.[3](#) The cases involve a psychologist who believed his patient would kill a university student. The therapist notified the campus police, who apprehended and then released the patient. Two months later the patient murdered the student.

In Tarasoff I, the court ruled that when a clinician has information from a patient that an identified victim is at risk, he or she has a duty to warn the victim, even if it violates doctor-patient confidentiality. In fact, not breaking confidentiality may be illegal and against the profession's standards of practice.

Tarasoff II extended the first case and established the clinician's duty to protect—not simply to warn—a potential victim. The ruling states that a clinician must “exercise reasonable care to protect the foreseeable victim.” This means that warning the intended victim might not be enough and may not be necessary if the clinician takes reasonable care to protect the potential victim by admitting the patient to a secure psychiatric facility, for example.

Although the duty to warn often is standard among jurisdictions, not all states have adopted the protection standard. Clinicians should be familiar with laws in their jurisdictions ([Box 1](#)).

Warn and protect / potential victims statutes by state

Require clinicians to warn potential victims

Arizona, California, Colorado, Delaware, Idaho, Indiana, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, Ohio, Oklahoma, Pennsylvania, South Carolina, Tennessee, Utah, Vermont, Washington, Wisconsin

Allow clinicians to warn potential victims but do not require it

Alaska, Connecticut, District of Columbia, Florida, Illinois, New York, Oregon, Rhode Island, Texas, West Virginia

No definitive law on a clinician's duty to warn and protect

Alabama, Arkansas, Georgia, Hawaii, Iowa, Kansas, Maine, Nevada, New Mexico, North Carolina, North Dakota, South Dakota, Wyoming, Virginia*

*Rejected the "warn and protect" provisions of the Tarasoff rulings

Source: Herbert PB, Young KA. Tarasoff at twenty-five. J Am Acad Psychiatry Law 2002;30:275-81.

Mandatory Duty to Warn

Many social workers are unaware that duty to warn laws vary from state to state and that a few states have not established a statutory duty to warn. Twenty-two states have statutes applicable to social workers that establish a mandatory duty to warn. These are: Arizona, California, Colorado, Delaware, Idaho, Illinois, Indiana, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Montana, Nebraska, New Hampshire, New Jersey, Ohio, Tennessee, Utah, Virginia, and Washington. A number of these states also have court decisions that have interpreted the duty to warn laws.

"Permissive" Standard

A second group of states give permission in state statutes for social workers to warn of serious threats. These states are: Alaska, Arkansas, District of Columbia, Florida, Hawaii, Iowa, Mississippi, Missouri, New Mexico, New York, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Texas, Virgin Islands, West Virginia, and Wyoming. In some states, such as Texas, the permission to warn is limited to notifying medical or law enforcement personnel, not the threatened person or persons.

No Statutory Standard

A third set of states does not provide any statutory language for social workers addressing the duty to warn, but some of these have implemented the duty through court decisions.

Connecticut, Pennsylvania, Vermont and Wisconsin do not have statutory provisions, but have established a duty to warn through court decisions. States that are silent as to the social worker's duty to warn are Georgia, Kansas, Maine, Nevada, North Dakota, and Puerto Rico.

Protecting potential victims

In general, clinicians should exercise their duty to warn and protect when:

- a clearly identifiable person or group is at risk
- risk of harm includes severe bodily injury, death, or psychological harm
- danger is imminent and creates a sense of urgency.²

The clinician must first identify if a potential victim is at risk (Box 2). Predicting risk requires assessing several factors including:

- likelihood of injury
- nature of potential harm
- when it may occur

When documenting your clinical decision, be sure to include:

- what the patient said
- an assessment of the seriousness of the threat
- the patient's history as it pertains to the threat
- your actions in response such as calling the police or detaining the patient

Risk factors for patient violence

- **History of violence** is the single most predictive factor
- **Gender:** Men are 10 times more likely to be violent than women
- **Substance abuse** increases the likelihood of violence by reducing inhibitions
- **Mental incapacity** interferes with judgment
- **Having an organized plan;** look for a clear plan of how the violence will be perpetrated
- **Unavailability of support group;** patients with more support are less likely to be violent
- **A violent environment,** such as within a family or circle of risky friends, increases the likelihood of violence

Group therapy guidelines

Often negligence that occurs during group therapy is caused by the group leader's failure to render proper services; in other words, the leader did not follow standard practices. If you use group therapy techniques that are not consistent with those used by other group leaders, you need to justify your practices in your notes to protect yourself from a possible malpractice claim.

In group therapy, the therapist works for the good of the group. Therefore, duties to warn and protect apply to the group. The leader must take reasonable action and inform authorities when a group member's condition indicates a clear and imminent danger to other members of the group.⁸

A safe and trusting environment is essential to the group therapy process. The American Counseling Association's ethical guidelines for group counselors⁹ state that group leaders need to protect members against physical threats, intimidation, coercion, and undue peer pressure as is reasonably possible. Part of this protection may occur at the selection process. Counselors should screen participants and select individuals whose needs and goals are compatible with those of the group and will not impede the therapeutic process.⁸ Group leaders can also create policies—such as prohibiting personal or sexual relationships between group members—at the start of therapy, which would be grounds for dismissal if violated.

Group therapy standards of care

- **Techniques** should be congruent with the group's goals and purposes
- **Group leaders** must recognize their competencies and work only with groups they are trained and experienced to work with; collaborating with an experienced co-leader may reduce potential risks
- **Give potential group members** enough information to make informed choices about participating in the group; this might include discussing the inclusion of emotionally disturbed individuals in the group
- **Adequately screen**, select, and prepare members for the group
- **Keep specific treatment notes** for each group member
- **Use written contracts** for members to comply with group rules regarding harm to other members; contracts will not discharge Tarasoff I or II responsibilities but will document that members' rights and safety were considered
- **When a person poses a threat**, document any intervention and its basis

Dismissal from a group

Therapists also can protect patients during the dismissal stage of group therapy, an issue involved in this case.

Be alert for signs and symptoms of decompensation such as tardiness or increased absences from the group, depression, or a noticeable decrease in a patient's ability to function or care for himself. Make provisions to help a group member leave, such as providing pretermination counseling and arranging for continuing care.[8](#)