Potentially Dangerous Patients: A Review of the Duty to Warn

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Each year, violence causes more than 1.6 million deaths worldwide and is one of the leading causes of death for persons ages 15 to 44 years.[1] As a result of the long-term effects of deinstitutionalization, inadequate community resources, and a substantial number of uninsured persons, many individuals who are in imminent danger of harming themselves or others do not have timely access to mental health care services, forcing them to seek help in emergency departments.[2] Emergency nurses, who are at the frontline of health care, are in a prime position to identify persons at risk for violence and to have an impact on the safety of the patient, the staff, and the community.

The duty for mental health care providers to protect others from potential violent acts of their clients came to the forefront in 1974 (and was later amended in 1976) with the landmark case of Tarasoff v. The Reagents of the University of California decided by the Supreme Court of California.[3] The ruling in this case imposed a legal duty on psychotherapists, enforceable by a civil suit for damages, to warn a person who was the potential targeted victim of a violent act by their patient. The duty to warn ruling triggers action on the part of the health care provider when a patient reveals an intent to inflict physical or bodily harm on an identified victim(s). Once triggered, providers can institute any one or more of the following actions to fulfill the duty: warning the intended target of the threat, alerting law enforcement, or initiating the process of having the patient confined voluntarily or involuntary.[3]

Within a decade of the ruling, various other states began to adopt legislation on this subject matter that became known as the "duty to warn." Although this important piece of legislation in its inception primarily affected psychotherapists, the scope of its legal breadth has since expanded to include nursing and other health care disciplines.

Although almost every state in the union has taken some sort of stand with regard to duty to warn, not all state statutes address registered nurses, whereas other statutes range in inclusion from licensed practical nurses to licensed certified advanced psychiatric nurses. Four main elements are considered in each state's posture toward the duty to warn: professionals named, standard of the threat, standard of the victim, and what party is permitted to be informed.[4]

As of 2014, 33 states impose a mandatory duty to warn. The mandatory states include Arizona, California, Colorado, Delaware, Idaho, Indiana, Kentucky, Louisiana, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New York, Ohio, Pennsylvania, South Carolina, South Dakota, Tennessee, Utah, Vermont, Washington, Wisconsin, Alabama, Georgia, Hawaii, and North Carolina. Eleven states, including Alaska, Connecticut, District of Columbia, Florida, Illinois, New York, Oregon, Rhode Island, Texas, West Virginia, and Wyoming, recognize Tarasoff as a legitimate piece of legislation, allowing but not mandating named professionals to warn potential victims. Six states, including Arkansas, Iowa, Kansas, Maine, Nevada, and North Dakota, have not yet addressed the issue of duty to warn and currently have no law pertaining to the subject. Lastly, only one state, Virginia, does not recognize the duty to warn.

Review of the Literature Regarding Duty to Warn

Methods

SEARCH STRATEGY

An integrative review was conducted to identify and synthesize available empirical evidence on the duty to warn in the adult patient population. Four major databases were searched for this review: Cumulative Index to Nursing and Allied Health Literature (CINAHL), PsychINFO, PubMed, and Dissertation Abstracts. Dates covered included the years from 1975 to 2013. It was determined that starting at 1975 and ending in 2013 would facilitate the most comprehensive Web-based literature search given that 1974 was the year that duty to warn legislation first came into effect. A combination of key terms and phrases including "duty to warn," "duty to protect," "Tarasoff," and "psychiatric nursing" were used.

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TABLE
Summary of the studies included in the integrated review

Study	Purpose	Subjects	Findings
Wise, 1978	To examine the attitudes, knowledge, and experiences of psychotherapists regarding the Tarasoff decision and confidentiality and the perceived effects on practice	1272 psychotherapists in the state of CA	100% knew about the Tarasoff decision; 50% were aware of how it applied to practice; >70% believed that breaching confidentiality was justifiable at times; 50% learned about the Tarasoff decision from professional sources and 9% from legal sources
Jagim, Wittman, & Noll, 1978	To examine the knowledge, attitudes, and beliefs on ethical-legal issues, confidentiality, and disclosure of information to third parties	100 actively practicing mental health professionals in ND (64/100 surveys were used)	98% believe confidentiality is essential to the therapeutic relationship; 44% incorrectly believed the Tarasoff decision applied to them
Weiner, 1983	To examine attitudes and practices around the Tarasoff decision and confidentiality and to examine awareness of general legal and ethical issues in practice	349 psychologists from 6 randomly selected states	73% were familiar with the Tarasoff decision; 91% believed that absolute confidentiality was essential to the therapeutic relationship
Givelber, Bowers, & Blitch, 1984	To determine the accuracy of the statement that the Tarasoff decision compromised therapists' commitment to confidentiality and the effect on treatment of dangerous patients	2875 therapists drawn from directories of APA and NASW of 8 major metropolitan cities	96% therapists from CA knew of the Tarasoff decision; 87% in the other 7 states knew the case by name; 9/10 therapists correctly apply Tarasoff in practice
Beck, 1985	To examine the attitudes, knowledge of, and experience of private practice psychiatrists with regard to the Tarasoff decision and violent patients	34 academic psychiatrists in Boston, MA	91% were familiar with the Tarasoff decision; 79% incorrectly believed that the Tarasoff decision required warning; 12% knew that the Tarasoff decision was not legally binding in MA
Berntsen, 1986	To examine the knowledge and clinical implications of the Tarasoff decision in psychologists' practice	163 psychologists practicing in UT	1/3 falsely believed that the Tarasoff decision applied to them, yet no statute or case law existed at the time of the study
Leedy, 1990	To assess clinicians' knowledge and compliance with the duty to protect	254 psychologists from NJ and MD	48% of MD clinicians thought that the Tarasoff decision superseded confidentiality; 44% of NJ clinicians falsely believed that they were not bound by a Tarasoff principle
Binder & McNeil, 1996	To examine effects of warnings on the therapeutic relationship and the intended victim	46 (2nd- and 3rd-year) psychiatric residents at USF	27 had issued Tarasoff warnings; 23/27 patients were told about the warning; 13/23 accepted the warning; 8/23 patients became angry; 2/23 were thankful the warning was made
Lucca, 1996	To investigate ethical decision-making practices and knowledge of case law regarding confidentiality and the DTW 3rd parties among Federal Bureau of Prisons psychologists	44 psychologists employed by the Federal Bureau of Prisons	Subjects had a predisposition to breach confidentiality in 6/7 scenarios; 6% were concerned with liability

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