LETTERS TO THE EDITOR
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Mitigating Nursing Biases in Management of Intoxicated and Suicidal Patients

Dear Editor:

Carmen Brosinski and Autumn Riddell should be commended for their recent article “Mitigating Nursing Biases in Management of Intoxicated and Suicidal Patients.” The patients described are some of the most difficult to handle in the emergency department, and the nurses caring for these patients may not have the required education to effectively cope with this patient population. Nurses and other health care professionals typically do not receive in-depth training on alcohol dependence in their academic programs. The authors stated that nurses should be provided additional education and screening tools to more accurately assess these patients and that current screening varies from facility to facility. Screening, Brief Intervention, Referral, and Treatment (SBRIT) was briefly mentioned as a way to standardize care for these patients, but the authors failed to mention that there are currently more than 3 forms of this program. They do mention that a number of other screening tools are available. Additionally, the authors did not address an asset available to a growing number of nurses in the emergency department, the ED case manager. Typically, ED case managers are social workers assigned to the emergency department to assist with placement, equipment, and/or social issues for the ED patient. Working in conjunction with ED nurses, social workers could play a large part in more accurate screening, as well as possible referral to appropriate programs if the patient is deemed medically stable. If necessary, social workers can also assist the nurse with associated paperwork such as emergency detention forms or Order of Protective Custody forms, as well as assisting the ED nurses and physicians to make an initial report to Adult Protective Services when necessary.—Jill Y. Scott, BSN, RN, CCM, Director, Case Management, San Antonio, TX; E-mail: rxbsn@att.net

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REFERENCES

Potentially Dangerous Patients: A Review of the Duty to Warn

Dear Editor:

I would like to comment on the article “Potentially Dangerous Patients: A Review of the Duty to Warn.” I applaud Ms. Henderson’s work in highlighting the potential impact that emergency nurses may have on the safety of the individual, staff, and community by identifying patients who pose a risk for violence.

In the review, lists are provided of states that mandate a duty to warn, allow but do not mandate named professionals to warn, or have no duty to warn. The reference to state-specific information is said to be current as of 2014, but more states mandate a duty to warn than are identified by Henderson. The review, published in 2015, misrepresents legal statutes for several states that were enacted up to 9 years ago. A recent search revealed that 5 states have been presented inaccurately: Arkansas, Iowa, Kansas, North Carolina, and Virginia. New York is listed twice, and no reference is made to the legal positions in New Mexico or Oklahoma.

Arkansas Code § 17-27-311, enacted in 2010, states that specific professionals have a permissive duty to report. Historically, Iowa and Kansas have ruled in favor of mandatory reporting but currently do not have a law requiring it. The North Carolina courts have not always upheld the duty to warn and have no specific law mandating reporting. The Commonwealth of Virginia enacted Code § 54.1-2400.1 in 2006, which obligates mental health service providers to take precautions to protect third parties.

To clarify the legal code in New York, in 2013 New York enacted the Mental Hygiene Law § 9.46, which
identified specific professional groups as having an obligation to warn others.

According the National Conference of State Legislatures, New Mexico does have a law regarding the duty to warn, but the specifics of this law are unclear. Finally, Oklahoma’s Title 59 § 1376, enacted in 2004, requires reporting of imminent threat but is more restrictive when permitted to breach patient confidentiality.

Because of the legal implications and potential for physical harm to individuals that may result from using erroneous and/or out-of-date information, having correct data regarding duty to warn is paramount.—Deanna Settelmeyer, MSN, RN, CEN, Doctor of Nursing Practice Candidate, University of Virginia, North Garden, VA; E-mail: drs5eq@virginia.edu

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REFERENCES

Potentially Dangerous Patients: A Review of the Duty to Warn

Dear Editor:

I want to bring an error in a recent article to your attention. I was reading the article Potentially Dangerous Patients: A Review of the Duty to Warn by Elizabeth Henderson,1 and a major error jumped out at me. The article states that Texas recognizes “...Tarasoff as a legitimate piece of legislation, allowing but not mandating named professionals to warn potential victims.” This statement is completely false. Some of the other states mentioned are not exactly as portrayed either, but I am most familiar with Texas because I am a licensed psychologist here and teach the doctoral classes in ethics at Southern Methodist University. In Thapar v Zezulka (1999), the Supreme Court of Texas found that there is no duty to warn and that mental health professionals cannot warn a potential victim. The Texas Supreme Court found that mental health professionals may contact the police or other health experts in cases of dangerousness but that our statutes (611.004) are permissive, not required reporting, and as such, it is possible that a civil case could be brought against a health practitioner for breaking confidentiality even when reporting dangerousness to police or another health professional. But the Texas Supreme Court justices were clear in Thapar v. Zezulka that there is no duty to warn (and we cannot warn another person because that breaks confidentiality and is not allowed in our statutes), and they completely denied the findings of Tarasoff as fitting with the statutes of Texas.

A study performed a few years ago showed that 76% of therapists in Texas thought that Tarasoff was the law in Texas, and this myth is perpetuated by articles such as the one in JEN. This is a huge problem because the information is incorrect. Please make corrections and recheck the other states. I have seen many errors and misinterpretations on different online sites regarding states’ duty to warn. I do not know where the author got her information, because the article included no specific citations for the statements about which states require reporting.

Thank you for your attention to this matter.—James D. Calvert, PhD, MSCP, CE Director, APA Division 55 (Pharmacotherapy), and Lecturer, Department of Psychology, Southern Methodist University, Dallas, TX; E-mail: jcalvert@mail.smu.edu

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REFERENCE

Response

Dear Editor:

I very much appreciate receiving the feedback from interested readers and would like to respond to some of the comments and concerns that have been voiced. I will preface my response by saying that it is thanks to the thoughtful and insightful comments of interested readers like you that articles such as this can have an impact.

The intent of the article was not to be an inclusive review of all 50 state statutes on the duty to warn, and hence not every state is mentioned in the article. Concerns expressed regarding potential errors within the article as to the categorization of some states’ duty to warn legislation as mandatory or permissive is also appreciated and important. I very much respect the need for accuracy in any article and wish to apologize to readers for any potential inaccuracy in these categorizations, as that was never my intention.