

**COMMUNITY RESEARCH FOUNDATION  
ADMINISTRATIVE POLICIES AND PROCEDURES MANUAL**

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**HEALTH AND SAFETY**

**SERIOUS THREAT OF VIOLENCE AND THE TARASOFF DUTY TO PROTECT**

**POLICY**

According to California case law in Tarasoff I (1974) and Tarasoff II (1976), “[w]hen a clinician determines, or pursuant to the standards of his profession should determine, that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of this duty may require the clinician to take one or more of various steps, depending upon the nature of the case. Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.”

California Civil Code Section 43.92, which is the codification of the Tarasoff case law, states:

- 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 protect from a patient’s threatened violent behavior or failing to predict 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) There shall be no monetary liability on the part of, and no cause of action shall arise against, a psychotherapist, who, under the limited circumstances specified subdivision (a), discharges his or her duty to protect by making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency.
- c) It is the intent of the Legislature that the amendments made by the act adding this subdivision only change the name of the duty referenced in this section from a duty to warn and protect to a duty to protect. Nothing in this section shall be construed to be a substantive change, and any duty of a psychotherapist shall not be modified as a result of changing the wording in this section.
- d) It is the intent of the Legislature that a court interpret this section, as amended by the act adding this subdivision, in a manner consistent with the interpretation of this section as it read before January 1, 2013.

Additionally, Section 5328 of the California Welfare and Institutions Code (W&I) states that when, in the opinion of the clinician, a client presents a serious danger of violence to a reasonably foreseeable victim or victims, then records and information obtained during the course of services delivered to the client under the W&I Code may be released to the person or persons potentially at risk of danger. The type and scope of the information so released is left to the discretion of the clinician, but it should be the minimum needed for the protection of the intended victim(s).

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Tarasoff case law and the codification of that case law (Civil Code Section 43.92) establish different duties a clinician must fulfill in order to be protected from liability if a client does carry out a violent act. Therefore, it is the policy of Community Research Foundation (CRF) that, in order to be fully compliant with both the Tarasoff case law and the Tarasoff statute, CRF clinicians will follow these three principles:

1. If a client communicates to a clinician, or a family member of the client tells the clinician that the client told the family member that the client intends to engage in a serious threat of physical violence against a reasonably identifiable victim or victims, and the clinician reasonably believes the client is likely to commit such violence after assessing for it, the clinician can discharge the duty to protect by immediately making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency, which will establish immunity from liability under the *Tarasoff* statute, if the client actually harms such victims. Under no circumstances can notification to a law enforcement agency occur more than twenty four (24) hours from the time the clinician learned of the threat. <sup>1</sup>
2. If a client communicates to a clinician, or a family member of the client tells a clinician that the client told the family member that the client intends to engage in a serious threat of physical violence against a reasonably identifiable victim or victims, and the clinician, after assessing for it, reasonably believes the client is likely to commit such violence, the clinician can also discharge the duty to protect by hospitalizing the client. This action, however, does not establish immunity from liability under the *Tarasoff* statute, but would be a reasonable measure to discharge the duty to protect under *Tarasoff* case law. Instead of having immunity from liability, the clinician's defense would be that they met the standard of care by doing something reasonable under the circumstances to protect the intended victim.
3. If a client does not communicate a serious threat of violence, but after assessment the clinician determines that the client presents a serious danger of violence to another person, the clinician can discharge the duty to protect by warning the reasonably identifiable victim or others likely to apprise the victim of the danger, by immediately notifying the police, or by taking whatever other steps are reasonably necessary under the circumstances, including hospitalization of the client, to discharge the duty to protect under *Tarasoff* case law. <sup>2</sup> Under no circumstances can notification to a law enforcement agency occur more than twenty four (24) hours from the time the clinician learned of the threat.

## **PROCEDURE**

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<sup>1</sup> Section 81059(c) California Welfare and Intuitions Code as amended by SB 127 and effective January 1, 2014. The purpose of SB 127 is to “add certainty and consistency” to the reporting requirements and to remove any confusion or ambiguity in the definition of “immediately” by clarifying that law enforcement must be notified within 24 hours of the time the clinician learns of the threat. However, the prudent and ethical decision is to not wait 24 hours, but to notify law enforcement as soon as possible.

<sup>2</sup> “The Tarasoff Two-Step” *The Clinician* September/October 2012

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Whenever a situation arises that may involve the Tarasoff duty to protect, immediately notify the Program Director, and then notify the CRF Quality Improvement (QI) Department. The Program Director will consult with one or more of the following: the treating psychiatrist; the program's Clinical Supervisor; the On-Call Administrator (if licensed); a licensed Service Line Director; or a licensed Senior Executive. Only after notification to and consultation with a member of the CRF QI Department (or On-Call Administrator if after hours), should the Program Director notify the County Quality Management Department by calling the Serious Incident Report Line at (619) 563-2781.

The Tarasoff duty to protect can be compartmentalized into two phases: the first is the assessment phase, and the second phase involves what action should be taken, based upon the assessment. If the clinician's assessment of the client causes the clinician or clinician's supervisor to reasonably determine that the client is dangerous to another person or persons, the duty to protect the reasonably identifiable victim(s) has been triggered, which leads to the action phase.

The clinician shall use the following steps to evaluate the critical issues and options when implementing the assessment and action phases of the Tarasoff analysis. The issues depicted in these steps arise when a client who comes under the protection of confidentiality poses a threat of serious harm to a reasonably identifiable victim or victims.

Note that threats of suicide or threats of destruction of property do not create a Tarasoff duty to protect. However, threats of suicide or property destruction are addressed in California Evidence Code Section 1024 which states: "[t]here is no privilege under this article if the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger." Evidence Code Section 1024 does not create a duty to protect the intended victim. However, it does eliminate the requirement for confidentiality if threats of suicide or threats to personal property occur.

**Consultation and Documentation:** While following the steps below, the Program Director will consult with one or more of the following: the treating psychiatrist; the program's Clinical Supervisor; the On-Call Administrator (if licensed); a licensed Service Line Director; or a licensed Senior Executive in order to create a consulting team. The clinician must be prepared to review the behavioral health care history and the treatment plans of the client being assessed with the consulting team. The clinician, with the support of the consulting team, must establish ample documentation to justify his/her determination and plans. It is important to remember that clinicians will be judged against "the standards of the profession" (Tarasoff II, p. 431) in determining whether they ought to have uncovered the existence of a serious danger. This step is particularly important because courts after Tarasoff have placed heavy emphasis on the diagnostic responsibility of clinicians to recognize danger.

### **Clear Threat of Harm**

**Step 1** The clinician must distinguish between clear threats of harm and vague threats of harm. A vague threat is something like: "If this keeps up, I might do something bad to my mother." In such cases, the clinician must make reasonable inquiry to clarify the client's meaning, but need not conduct an interrogation. A degree of clinical skill and common sense is called for at this point, because the

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clinician can be held liable for making “a reasonable decision according to the standards of the profession” (Tarasoff II, p.431) about whether the threat was, in fact, clear. It is the expectation that clinicians will consult with their supervisor, Program Director, treating psychiatrist and/or CRF QI Department as indicated, to effectively distinguish between a clear and a vague threat. If the threat is seen as clear, the clinician proceeds to Step 2.

**Threat Presents Serious and Actual Danger**

**Step 2** Clinical judgment again comes into play, since the clinician must now decide whether the threat already determined to be clearly expressed presents only marginal danger (for example, because the threat itself is frivolous or because of the capabilities of the person making the threat), or whether it presents a serious and actual danger. The clinician must assess the client’s capacity for committing violence and in doing so should consider the client’s diagnosis and current condition and/or mental status, whether the client’s thoughts are obsessive, the client’s stated intent, the presence of auditory command hallucinations, and the client’s history of violence, among other considerations. Clinicians are encouraged to use standardized assessment tools (e.g. High Risk Assessment form) when making this determination and to seek consultation with supervisors and/or program management. The goal is to arrive at a reasoned and informed judgment about the client’s capacity for committing violence. The clinician must have good reasons for the judgments made, and the clinical records must clearly document those reasons and judgments. Ultimately, those reasons and judgments will come from the clinician’s understanding of the client, from consultation with other professionals, from the clinician’s understanding of human behavior and the factors that can lead to violence.

The clinician need not hear the threat to commit violence directly from the client to trigger the need to assess. If a member of the client’s family reports the threat to the clinician, the need to assess the client’s capacity to carry out the threat has been triggered.

**Reasonably Identifiable Victim(s)**

**Step 3** If it is determined in step 2 that there is serious and actual danger, the clinician, in consultation with the consulting team, must then consider whether there is a reasonably identifiable potential victim(s) of the serious danger threatened. Tarasoff case law and the Tarasoff statute establish different standards for determining who a reasonably identifiable victim is, thus triggering the duty to protect.

Under Tarasoff case law, the duty to protect is triggered when the clinician “determines that a patient presents a serious danger of violence to another.” Under the Tarasoff statute, the duty to protect is triggered when the client communicates to the clinician “a serious threat of physical violence.” Courts have determined that even if no threat of violence is actually expressed by the client, the duty to protect a reasonably identifiable victim can be triggered if the client has a history of violent behavior that the clinician should have identified during his or her assessment. For example if a client has a history of violent behavior toward his past girlfriends, then the duty to

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protect his current girlfriend may be established even if he does not expressly state that he wants to harm her.

Likewise, Tarasoff case law and the Tarasoff statute use different language to describe potential victims. Case law stresses “intended victims,” while the statute stresses “reasonably identifiable victims.” Therefore, even if the client does not identify a specific victim when making a threat of violence, if the victim(s) are foreseeable or reasonably identifiable, then the duty to protect has been triggered. For example, if the client states that “tonight people are going to die and tomorrow I’m going to be famous,” but refuses to tell the clinician exactly who will die, the duty to protect may be triggered if the clinician reasonably believes the client is capable of going out and committing mass murder. There may be no identifiable victims, but there may be intended/foreseeable victims. In this example, the duty to protect could be fulfilled by immediately contacting a law enforcement agency or the Psychiatric Emergency Response Team (PERT). Under no circumstances can notification to a law enforcement agency occur more than twenty four (24) hours from the time the clinician learned of the threat.

When a specific victim(s) has been named, or when the reasonably identifiable victim is able to be discovered “upon a moment’s reflection” (Tarasoff II, p. 439) – the clinician proceeds to Step 4. But, if after inquiry, there is still no reasonably identifiable victim(s) and there is no history of violent behavior, the clinician has no Tarasoff obligations. However, careful assessment should continue. Prudence requires that the clinician consult with supervisors/program management and extensively document his/her reasons for deciding that a reasonably identifiable victim(s) cannot be determined.

**Imminent Threat of Danger**

**Step 4** The decision involved in Step 4 concerns the imminence of the serious threat of danger to a reasonably identifiable victim(s). If the threat of danger is serious but not imminent, the reasons why the danger is not considered imminent must be clearly documented in the client’s medical record. The treatment plan should be aimed at reducing the client’s potential for violence, and it should be reviewed for progress by a clinical supervisor and/or program management. If, after consultation, the clinician determines that the danger is imminent, he/she proceeds with the documentation and treatment, but also continues on to Step 5.

**Public Official**

**Step 5** Here, the person threatened is distinguished as a member of one of two different groups: public officials; or family members, significant others, or all other people. If a public official is threatened seriously and imminently with harm, the next step is very clear. The police must be contacted immediately. A public official is defined as any elected or appointed person holding a public office and having duties relating to the sovereign powers of government. The term does not apply to public employees having purely ministerial duties. If the threat is to family members, significant others, or any other person, then the clinician proceeds to Step 6.

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**Actions to Protect**

**Step 6** This step provides several options. The clinician may request that PERT or the police respond by calling 911 and requesting that the client be evaluated for involuntary commitment to a locked psychiatric hospital as “dangerous to others”. The clinician can warn the victim(s), warn the relatives of the victim(s), and immediately call the police, in any combination. Indeed, the clinician may be obligated to do one or all of these things, depending on what seems to provide reasonable care for the safety of the person or persons threatened. Under no circumstances can notification to a law enforcement agency occur more than twenty four (24) hours from the time the clinician learned of the threat. The victim(s) and immediate relatives of the victim(s) should be warned by telephone call and/or by a letter sent both by certified mail with return receipt requested and by regular United States mail. The clinician can also take any other actions that seem reasonable which have been identified during the process of consultation, separately or in combination with the options already mentioned. Note that if a letter is sent and it is returned, staple the returned letter (still in the envelope) to the copy of the letter in the client’s medical record. Doing so will document that the letter was sent and returned.

If the threat(s) of violence are being made against a minor, it may be necessary to notify both the victim and the victim’s parent or guardian, or just the victim’s parent or guardian, of the threat. For example, if the threat is made toward a three year old child, it may not be appropriate to warn the intended victim, but to warn the parent/guardian in addition to filing a CPS report. However, if the child is twelve years old and has the capacity to understand the situation, it may be appropriate to warn the intended victim, parent/guardian, and the child’s school. Situations involving threats against a minor must be evaluated on a case by case basis in conjunction with consulting team and the QI Department.

In any case, care must be taken to clearly document the actions that are taken, including the persons consulted and the rationale for the decision. The rationale is important, because clinicians are held to a standard of reasonable care, not a standard of successful performance. Whatever choice the clinician makes in Step 6, it is important for the clinician to follow-up on the results of the choice, both for the safety of the client and for the potential victim(s).

Authority:

Tarasoff v. Regents of the University of California, 17 Cal. 3rd, 425, 551 P. 2nd. 334, 131 Cal. Rptr. 14 (1976) (Tarasoff II), vacating 13 Cal. 3rd. 117, 529 P.2nd, 553, 118 Cal. Rptr. 129 (1974) (Tarasoff I).

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California Civil Code 43.92

California Welfare and Institutions Code 5328 and 8105 (c)

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