Time for Tarasoff?
Duty to Protect and Warn

Nancy Pierce, MA, LCSW
Mental Health Crisis Consultants

Duty of Confidentiality
- Ethical code for mental health providers
- Hallmark of trusting relationship
- Protects client from unauthorized disclosures of information made in therapeutic relationship

Confidentiality Exceptions
- Exceptions to privilege & confidentiality exist
- Duty of confidentiality is not absolute and must sometimes give way to protect client or community from imminent danger
- Confidentiality can be broken in cases of child abuse or elder abuse, gravely disabled or when client is a danger to self/others
- Protective privilege ends when public peril begins
5 C’s of Confidentiality Exceptions
- Consent
- Court order
  - Subpoena must be issued by judge
- Continued treatment
- Comply with law
- Communicate threat
  - Danger to self or others, including “duty to warn”
  - Tarasoff exception

When Duty to Protect Applies
- Explicit threat to kill or seriously injure reasonably identifiable person and/or public
- Destroy property likely to lead to injury/death
- Client has intent, ability to carry out threat
- When the boundary of community bumps into sacred seal of confidentiality

History: Duty to Protect and Warn
- Final Tarasoff decision in California
  - Clinicians who know or should know of client’s dangerousness to identifiable 3rd persons have obligation/duty to take all reasonable steps necessary to protect potential victims
- Defined duty more broadly as duty to protect
- Duty comes out of special relationship of trust and confidentiality between clinician/client
Statutes and Case Law

- Tarasoff created 1st exception to confidentiality
  - Protective disclosures or “duty to disclose”
  - Different versions of Tarasoff for most states
  - Statutory laws from legislature
  - Court/judicial law = case law decisions
  - Language often in legal jargon
    - Confusing and ambiguous
  - When to warn & protect different for each case

“Special Relationship”

- Under law, no duty to protect potential victim from negligent or intentional behavior of another
- Law/courts made exception to when special relationship between parties **incurring duty to control conduct of or protect another person**
- Laws/courts declared mental health professional relationship “special” which undermines what makes it special – trust & confidentiality
- Duty arises out of special relationship and supersedes ethical doctrine of confidentiality

From Discretionary to Duty

- Tarasoff changed what was a discretionary act on part of clinician and rendered it a duty
- Duty to exercise reasonable/necessary care to protect
- No study has shown clinician can accurately predict potential dangerousness
  - Highest accuracy rate for violence prediction is 40%
  - Tendency to over-predict
- Not expected to be perfect, show reasonable degree of skill and knowledge of care
Ethical-Legal Dilemma

- Have to make choice between 2 fundamental ethical principles which underlie practice of psychotherapy
  - Confidentiality
  - Non-malfeasance (minimizing/preventing harm)
- Courts have forced solution to ethical dilemma by imposing legal duty = obligation to use reasonable care to protect victims
- Clinician owes duty of care to all who are foreseeably endangered by conduct of client

Forseeability vs. Predictability

- Defined as reasonable anticipation that harm or injury is likely to result from certain acts or omissions
- Not same as predictability
- Not same as preventibility
- Serves as common sense guide when certainty is not available
- Law does not require clinicians to foresee events that are possible, only those that are reasonably foreseeable

Forseeable in Real Life

- Not violent yet, but…
- Behavior I believe will happen in future in context of what I have been seeing/hearing
- Information allows me to break seal of confidentiality creating exception to privilege
- Must defend foreseeability in clinical note
Foreseeable ≠ Identity
- Precise identity of victim does not have to be foreseeable
- Clinician may have a duty to protect from client’s threatened violence towards
  - Any victim
  - Any member of public
- Foreseeability of client’s violent acts that judges and juries will be considering

Forseeability and Courts
- Courts evaluate whether assessment process was reasonable & risk of violence was foreseeable
- Only risk of violence is reasonably foreseeable
  - If you did a complete risk assessment, concluded client isn’t violent, it was not foreseeable that client will commit violence
  - Issue in outpatient settings is whether client should have been hospitalized or detained

WI Case Law Schuster & Altenberg
- Expanded duty to protect from “readily identifiable” victim to broader duty to protect society or client “carry out whatever steps reasonably necessary under circumstances
  - If foreseeable danger, but unforeseeable victim, reasonable action is required
  - Confidentiality can be broken when necessary to protect public
  - Clinicians need to weigh & balance competing interests of confidentiality & public protection
- No answers…only guidelines
Protective Disclosures

HIPAA RANOIA

- Health Insurance Portability Act of 1996 limits disclosure of sensitive information, including HIV status, AoDA use, mental health treatment, domestic violence and sexual assault
- “P” in HIPAA is not for “privacy”
- HIPAA permits disclosure of client information, without consent, with physician referrals and consultations, and in the case of emergency

DEAL with Confidentiality

- Duty: Does clinician have a duty to maintain confidentiality in the context of a treatment relationship or for some other reason?
- Exception: Does an exception exist? (Use Five C’s as guide)
- Ask: Consider asking for help, such as consultation from supervisor/colleague, risk manager, or attorney
- Law: Be familiar with the law of the jurisdiction and confidentiality policy of your agency/facility
### Guidelines to Follow

- **Who** may get information?
- **For what purpose?**
- **What is the minimum information** that needs to be disclosed to get the job done?
  - “Need to know” standard
- **Are there limitations on what records or information** can be released? (AoDA)

### Use Rule of “3”

- Try to discuss difficult decisions with at least 3 colleagues
  - How did you choose these colleagues, and not others?
- Involving colleagues does not guarantee ethically correct decisions, but being unwilling or uncomfortable involving colleagues almost always suggests a problem with the decision

### Who Could be Warned?

- Identifiable victim(s)
- If unable to locate victim, use family/friend/s
- Law enforcement
- Schools, employer
- **Warning is one component of discharging duty**
  - Courts expect clinicians to issue warnings once danger determination made
- Often clinicians act too quickly & unreasonably complying with legal duty over ethical duty (may face liability for violating clinical privilege)
Involving Law Enforcement

- May not know or be familiar or question their role in WI duty to protect and warn
- May help in communicating threat to those involved if you are not able make contact
- Determine if there is imminent risk to others including general public
- Arrest or Emergency Detention?

Tell Client About Warning?

- No legal duty to tell client
- Inform client about types of situations where information may be disclosed
- Give notice when beginning treatment about professional duty to inform when potential for danger

When to Explain Duty to Protect

- Range of approaches depending on practice setting, professional discipline, level of knowledge, legal sophistication or comfort level
- Telling clients at beginning of treatment may have “chilling” effect
- Telling as needed may have “ambush” effect
- Clinically/ethically sound vs. legally prudent?
- Is question of breaching confidentiality being discussed more in legal vs. clinical/ethical terms
Duty to Protect/Warn = Clinical Teeter Totter

- Duty of confidentiality to clients
- Duty to protect 3rd parties from potential violence

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Clinical Teeter Totter

- Balancing right of clients to confidentiality against duty to protect 3rd parties from potential violence from clients
- Start with client privacy outweighing publicity
- Balance and weigh competing interests of confidentiality and public protection
- Mental health professionals have duty to client, but also have duty to others
- Confidentiality must give way to public safety
- Public peril is higher priority than preservation of client trust & confidentiality, so teeter totter shifts
**WI Clinical Teeter Totter**
- WI case law says, if there is foreseeable danger, then need to inform unforeseeable victim and do something to protect
- Forseeability
  - Used when certainty is not available
  - Reasonable anticipation harm or injury likely to result from certain acts or omissions
  - The greater safety concerns are... the fewer confidentiality protections

**Clinical Considerations**
- Remember to stay within professional competence of your training and experience
- Review records for history of violence
- Consult supervisors/senior staff or risk management staff/attorneys
- Meet with client to assess violence potential
- Weigh and balance ethical principles involved
- Choose and take necessary course of action
- Document to show decision-making process

**How to Discharge Your Duty**
- Bring client in decision-making process
- Warn potential victim(s) of threat
  - If reasonable, consider broader warning
- Involve police/probation officer if needed
- Attempt voluntary hospitalization
- Protective Custody to Detox Unit
- Initiate involuntary civil commitment
### Problems Fulfilling Duty
- No clinical standard of care exists for accurate prediction of violence
- Difficulty predicting dangerousness
- Breach of confidentiality which is basis of therapeutic relationship
- Detriment to ongoing therapy because clients won’t disclose violence thoughts/fantasies
- Clinician anxiety over legal sanctions for failure to anticipate violent acts which leads to over-predictions of violence

### Duty and Ethical Dilemmas
- Horns of dilemma: confidentiality vs. protection
- Warnings and reporting have been allowed by ethical standards to prevent violence, but not ethically prescribed
- Failure to protect/warn is more clearly in error if violating case/statutory law rather than if deviation from nonexistent clinical standard
- Must recognize “gray areas” of professional discretion in absence of fixed rules

### Duty to Protect/Warn Criteria Not Met
- After evaluating risk of violence, no clear intent or ability to carry out threat is found
- Client is cooperative with treatment including hospitalization or increased med monitoring
- Support of family/friends
- If anger/aggression remains issue, needs to be addressed in treatment with focus on:
  - Treat/manage psychotic symptoms, mood disorder
  - Anger management skills
  - Substance abuse detoxification
Justify Not Using Warning

- Hospitalization or more secure setting/detoxification
- Intensive outpatient
- Shift focus of treatment
- Change or increase medications
- Collateral sessions with family/friends
- Daily crisis check-ins
- Avoid breakdown/lapses in risk communications
- Breaching confidentiality may be avoided as long as reasonable arguments can be made that steps taken are likely to decrease client’s dangerousness and are documented in file

Can Warnings Help?

- May keep clients from carrying out violent acts which could result in being incarcerated
- Responding to client’s “cry for help”
- Reporting serious threat shows clinician cares enough to set limits on self-destructiveness and demands client act responsibly

Risk Containment = Assessment + Management
Risk Assessment
- Review past/current records
- Gather information from client & significant others
  - Ask questions about violent thoughts and actions
- Assess threat to harm vs. "dangerousness" in general
- Don’t go half way, commit to decision/plan
- Communicate information to proper clinical staff including supervisors and/or crisis unit

Clinical/Context Risk Factors
- History of violence and suicidality
- Current substance abuse or withdrawal
- Mental illness
  - Active symptoms of psychosis
  - Treatment adherence/response
- Personality characteristics/traits
  - Impulsive, unstable mood, narcissism, paranoia
- Similar circumstances/contexts to past violence

Is it Getting Serious?
- Detailed plan of violent action which client reveals
- Having means to do it as threatened
- Specific threat which sounds convincing to clinician
- History of past violent behavior or risk-taking behavior
- Recent "close call" of violence/crossed threshold
- Client is desperate and no longer cares about living or about consequences of action
- “Creeping dangerousness”
Psychotic Symptoms Associated with Risk of Violence

Acting on Command Hallucinations
- Delusions related to hallucinations
- Knowing voice’s identity
- Believing voices to be real and good/caring
- Having few strategies to deal with voices
- Not feeling in control of voices
- Ask if they have ever followed commands or moving towards following them now?

Threatened/Losing Control
- Feel threatened not being under own control
- Under control of external force that determines client’s actions
- Mind dominated by forces beyond their control
- Thoughts being put into their head not their own
- Being followed by others plotting to ruin, poison, do harm, drive them insane
- Ask what would they do if have contact with people who wish to do them harm
Outside Control

- Others control my movements
- Others can insert thoughts into my head/mind
- My thoughts are dominated by external force
- Others can determine my thoughts
- Others have control over me
- My life is being controlled by something or someone other than me

Mental Illness Questions

- Are violent impulses related to mental disorder?
- Recent worsening of ability to control violent impulses?
- Acted violently under past similar circumstances
- Disinhibited due to substance misuse or withdrawal
- Treat violence as a symptom to be assessed, monitored and treated

Risk Management

- Seek consultation from experienced staff
- Try to reduce risk & preserve confidentiality
- Intensify or change focus of treatment
- Increase monitoring and check ins
- Detoxification for substance misuse
- Hospitalization or jail if violating probation
- Check if plan adequate for risk containment
- Implement and monitor plan for adjustments
Clinical Errors

- Most frequent/serious errors are clinical and not failure to warn or report to police
- Don’t adequately assess and manage risk of potentially violent clients
- Riveted to client’s threats so pay too little attention to assessment and treatment
- Tend to warn vs. hospitalize client
- Remember what is required is "competent" level of professional performance

Applying Duty to Protect

- Often clients make threats in treatment have no intention of acting on them
- Making a threat vs. posing a threat
- Attempt to transfer to clinician responsibility for controlling impulses and consequences
- Bringing client into decision-making process, emphasizes their ultimate responsibility for their actions (and not clinician)
- Involving client in response to their threats minimizes strain on treatment relationship

If Client Threatens in Session
Be Aware of Emotions

- Client
  - Emotions does not equal threat
  - Be careful not to misread client emotions
- Clinician (do ask, do tell)
  - Too much focus on violent thoughts
  - Reluctant to focus on violent thoughts
  - Be aware of countertransference
    - Balance countertransference reactions against actual potential for harm
  - Include other staff to help

Before Breaching Confidentiality

- How immediately dangerous is situation?
- What are consequences of breach?
- What biases does clinician have?
- What actions are reasonable?
- Don’t cave into anxiety & make a hasty decision
- Use consultation whenever possible
- Understand breaking confidentiality isn’t the only way to protect, so consider other steps as well

What Clinicians Should Do

- Good clinical assessment of threat
- Corroborate with family/friends
- Consultation or second opinion
- Involve client in decision whenever possible
- If victim is relative or friend, include in session
- Do what is clinically indicated: hospital, medications, warnings, involving police
- Follow up and monitor
- Document reasoning and why
Incorporate DTP in Treatment

- Involve clients in decision to disclose confidential info can be empowering
- Clients feel less betrayed by clinician
- Warning in presence of client or including potential victim in sessions may allow for interventions
- Ethical dilemma is different when client and clinician agree on course of action
- Clients often ambivalent about violent impulses so appreciate clinician’s help to find nonviolent approaches to problems

Documentation

Documentation is Critical

- Your understanding of the facts
- Your analysis of the problem
- Must include your risk assessment
- Your plan, with justification for the plan
- You do not get successfully sued for making a mistake; you do get sued for not thinking through the problem
- If you did not document it, you did not do it
Document Decision-Making Process in Clinical Note
- Decision-making process more closely scrutinized than decision itself
- Good clinical note lives on as a “second witness” to what actually happened and the process used by clinician
- Demonstrates you performed your professional obligations according to standards of care

Document Protective Disclosure
- Document duty to protect/warn decision in client record
- Specify risk factors and protective interventions
- Record risk information, sources and dates
- Record all contacts, actions and rationale to prevent violence
- State what, why and how decisions were made demonstrating your “reasonableness”
- Don’t change records

Tarasoff Effects
- Did not cause great anticipated disruptions
- Did not prove to increase public safety
- Most clinicians warned victims out of professional ethical obligation regardless of statutory or case law
- Positives involve clinicians talking with clients about threat of violence
- Negatives involve breaching confidentiality without first discussing with client
Tarasoff Helps or Hurts?
- Curtails effective psychotherapy/treatment?
- Therapy works/helps because of confidentiality
- Ethics sanction against breaching confidentiality
- Often clients don’t mean words as threats/violence
- Clients not fully forthcoming, unable to explore or get support for violent urges and avoid treatment
- Over-prediction or under-prediction of violence?
- Weakening treatment’s impact on violence?
- Avoidance of violent clients because of they are “walking lawsuits”

Lessons to Learn in Wisconsin
- Client need not to identify victim directly
- In Wisconsin, duty is owed when generalized statements of dangerous intent are made
- Harm must be imminent
- Broad interpretation of duty to protect/warn means taking all steps reasonably necessary

Final Points to Remember
- Recognize potential conflict between expectation of confidentiality and public safety interests
- Learn statutes/case law and agency rules/policies
- Know your discipline’s ethics and boundaries
- Courts recognize predicting human behavior is difficult, especially violence
- Your professional behavior must be viewed as reasonable which should be documented in note
- Communicate more in note since may be talking about it much later
- Don’t neglect the basic principles of clinical care