To discharge the duty to protect, Mr P’s treatment team should do which of the following?

A. Call and warn Mr P’s son over his objections
B. Call and warn the police upon Mr P’s discharge
C. Craft a sound risk management plan and communicate it to Mr P’s outpatient providers
D. Do not breach confidentiality – the duty has already been discharged
E. Both A and B are correct
F. Both C and D are correct

Vote
Answer: F. (Both C and D are correct)

Discussion
The California Supreme Court’s decision in the Tarasoff case over 30 years ago has become a standard part of mental health practice. This case influenced the legal requirements governing therapists’ duty to protect third parties in nearly every state in the US. The final ruling in Tarasoff emphasized that therapists have a duty to protect individuals who are being threatened with bodily harm by their patient.1

Because there were 2 Tarasoff decisions, there may be confusion over “duty to warn” versus “duty to protect.” The first decision in 1974 mandated warning the threatened individual, but the 1976 rehearing of the case by the California Supreme Court called for a “duty to protect” the intended victim. There are 2 widely cited quotes from the case. From the 1974 decision: “The protective privilege ends where the public peril begins,” and from the 1976 decision: “When a therapist determines, or 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 from danger.” (see Table 1)

Table 1.

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<th>Tarasoff v. Regents (Calif. SC, 1976)</th>
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<td>• Tarasoff I (1974) – Duty to warn, based on special relationship</td>
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<td>• Tarasoff II (1976) – Duty to protect, standard of reasonableness</td>
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Initially, there was significant concern that this exception to confidentiality would have disastrous effects on psychiatric practice, despite the fact that most therapists had embraced such a duty before the Tarasoff ruling. It became clear that the concerns about the potential loss of confidentiality did not have an adverse impact on psychiatric practice.2 Instead, Tarasoff stimulated “greater awareness of the violent patient’s potential for acting out such behavior, encouraging closer scrutiny and better documentation of the therapist’s examination of this issue.”2

Tarasoff expansion and contraction
The duty to protect articulated in Tarasoff was subsequently interpreted more broadly by several courts so that the duty to protect is not uniform throughout the US. The broadest interpretation occurred in the 1980 case of Lipari v. Sears, Roebuck & Co.3 The case involved a VA patient who shot strangers in a crowded nightclub, without ever threatening a specific person, and a month after terminating psychiatric treatment. The court rejected the Tarasoff limitation to an identified victim, imposing not only a duty on therapists to predict dangerousness, but a duty to protect unidentified but “reasonably foreseeable victims” in the general public.

Two decades after Tarasoff, the courts began to reflect ambivalence about the extension of the duty to protect. Many required that the threat be clearly foreseeable and that the duty extended only to “reasonably foreseeable victims,” and not to the general public. Many states subsequently adopted statutes known as “Tarasoff-limiting statutes,” which lay out specific criteria which typically include a credible threat made against an identifiable victim.

Duty to protect statutes have been passed in all but 13 states.4 In a study of 70 Tarasoff-related cases between 1985 and 2006, statutes that clearly mandated warning a victim appeared to be more protective of clinicians’ legal liability than statutes giving permission-to-warn. New York State is an example of one of the 13 states that has never adopted a specific duty to protect or Tarasoff-like notification law (statutory or case law). However, it is very important to note that in 2 separate provisions of the New York Mental Hygiene Law (MHL section 33.13), practitioners are given the “authority to warn.”

The difference between duty and authority is crucial:

• a Duty implies that there is a legal liability for a breach of the duty, either by failing to carry it out or by carrying it out in an improper manner.5
• Authority, on the other hand, implies permission to do something without legal consequences for failing to do it, or doing it improperly (negligently).

[Also: the “power delegated by a principal to an agent.”5]

It is important for the psychiatrist to have a clear understanding of the duty to protect as they pertain to one’s own state.

Despite the lack of a clear legal duty to protect in New York and a dozen other states, the clinician should consider following the basic Tarasoff rationale. It seems both reasonable and prudent to practice as though there were a Tarasoff-like duty in effect. There are valid reasons for doing so, including patient care and liability management. Most importantly, the psychiatrist should keep in mind the clinical and ethical duty involved where a patient’s intentions flow from a mental illness, and may have devastating repercussions for the rest of his life.

One thoughtful and well-reasoned guideline suggests that the clinician has a clinical and ethical duty to intervene when the following criteria are met:6

1. The patient has made an explicit, credible (ie, realistic) threat
2. Against an identifiable third party or property
If these criteria are met, the clinician then has a number of intervention options to consider depending upon the clinical scenario:

- Hospitalization (or escort to a hospital emergency room for evaluation)
- Warming the third party
- Warning police
- Asking the patient to give the warning him/herself
- Increasing the frequency of outpatient appointments

Although danger to third parties is a well-known exception to confidentiality, breaching confidentiality should be viewed as a last option, after all other therapeutic options have been exhausted. Thus, confidentiality should be breached only if reasonable clinical efforts seem unlikely to provide adequate protection or resolution. Even at this point, the breach should only occur after the patient has been advised of the plan. When all reasonable options are untenable, it should be remembered, “Trust – not absolute confidentiality – is the cornerstone of psychotherapy. Talking about a patient or writing about him without his knowledge or consent would be a breach of trust. But imposing control where self-control breaks down is not a breach of trust when it is not deceptive.”

An array of options should be considered, including hospitalization, warnings, more frequent therapy sessions, starting or increasing medication, and various forms of closer monitoring. The clinical approach can be thought of as similar to the management of an acutely suicidal patient, in so far as addressing the risk of a patient acting on dangerous plans. The psychiatrist should not forget to address the threat towards third persons as a therapeutic issue in alliance with the patient. For example, the psychiatrist may explore with the patient what it would mean if the violence were to be acted upon. This approach will not only produce valuable risk assessment data, but will also appropriately address the relevant clinical issues. In the performance of the clinical risk assessment, the psychiatrist should seriously consider contacting collateral sources, such as relatives who may be able to provide important information regarding the patient’s dangerousness.

Past medical records, where applicable, should be reviewed. At the very least, efforts to obtain records should be made and documented. Obtaining and reviewing medical records was at issue in the 1983 case of Jablonski v. United States. In Jablonski, the duty to protect was extended to include a therapist-patient relationship limited to the emergency department (ED) setting. Mr. Jablonski was a violent man who was brought to a VA hospital by his girlfriend after he attempted to rape her mother.

The psychiatrist concluded that the patient was a danger to others, but the patient could not be committed under California’s involuntary commitment statute. Jablonski’s medical records revealed that he had a long history of antisocial and violent behavior; however, these records were not requested at the time of his presentation. The girlfriend was warned to stay away from him if she feared him. Not long after his discharge from the ED, Jablonski killed the girlfriend. The 9th Circuit Court of Appeals concluded, among other things, that the hospital had failed to obtain important prior records and to adequately warn the victim.

Finally, past therapists and referral sources should be queried where appropriate, and consultations may be sought. If this type of careful, reasonable approach is taken (including documentation of the assessment of the pertinent issues and treatment plan), then reasonable professional judgment has been demonstrated and clinician liability becomes very unlikely, even if harm should occur to a third party.

If it is ultimately decided that a warning must be made to intended victims or police, it should be as discreet as possible to protect the patient’s confidentiality, and remain consistent with the statutory requirements. Warnings may include statements made by the patient which are necessary to convey the serious intent of the threat to the victim. Upon deciding to notify police, one should call the police in the precinct nearest to the patient. It is preferable to give oral rather than written warnings.

**Evaluation of threats in Tarasoff situations**

The clinical process of violence risk assessment is beyond the scope of this article, and clinicians are encouraged to review the literature on this subject. When a duty to protect scenario arises in clinical practice, the clinician may find it helpful to consider the topics of questioning listed below, which can be recalled by the mnemonic: “ACTION”: (Attitudes, Capacity, Thresholds, Intent, Others’ reactions, Noncompliance) (see Table 2).

**Table 2. Lines of inquiry in Tarasoff situations**

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<th>A – Attitudes that support or facilitate violence: What is the nature/strength of the patient’s attitude toward the behavior. Condoning, or accepting? The stronger the perceived justification, the greater the likelihood of action. It may be helpful to assess the patient’s appraisals of provocation from others, violent fantasies, and expectations of outcome.</th>
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<td>C – Capacity or means to carry out the violence. Does the patient have the physical or intellectual capability, access to means, access to the victim or opportunity to commit the act? How well does the patient know the victim’s routines, whereabouts, etc.?</td>
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<td>T – Thresholds crossed. Has the patient already engaged in behaviors to further the plan? Acts committed in violation of the law suggest a willingness/ability to engage in the ultimate act.</td>
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I – Intent. Does the patient have mere ideas/fantasies or solid intention? Level of intent may be inferred from the specificity of the plans and thresholds crossed. How committed is the patient to carrying out the act? Does he believe he has “nothing to lose”?

O – Others' reactions & responses. What reactions does the patient anticipate from others? Does the social network reduce or enhance the risk? Do social contacts believe the patient is serious?

N – Noncompliance with risk reduction. Is the patient willing to participate in risk management interventions? What is the patient's history of compliance/adherence to previous plans? How much insight into the situation does the patient have?

The risk management plan
A risk management plan should be crafted immediately after the clinical risk assessment has been completed. It may be necessary to obtain collateral data from mental health records, family members, or other social contacts. Keep in mind that in the case of a psychiatric emergency (eg, risk of suicide or violence) the need to preserve life supersedes the need to obtain consent from the patient. In most circumstances, this will mean that obtaining the patient's consent to contact family is not necessary, but this exception to consent should be documented contemporaneously.

The basic principle behind the risk management plan is to identify all those risk factors that are amenable to treatment interventions (dynamic risk factors), and target them with reasonable treatment interventions. Below is a sample violence risk management plan in the case of Mr P. Note how each dynamic risk factor is targeted with interventions that are reasonable and appropriate to the patient's clinical situation.

The clinician should document that the option of involuntary hospitalization has been considered, and the clinical basis for rejecting, or proceeding with that option. Document all assessments, evaluations, and actions taken (and why) and those rejected (and why), so that evidence of your reasoning will be contemporaneous and thus more credible. The risk assessment documentation should include some form of analysis of risk factors, and a general estimate of overall risk level. This should be followed by a treatment plan (or risk management plan – see below) that directly addresses relevant dynamic risk factors.

It is also desirable to document instructions and information given to the patient and the family. Note whether or not they agree with the treatment decisions, as well as non-compliance with treatment recommendations. Stress responsibility to patients and their families. Where appropriate, attempt to get family members involved so that they clearly understand their obligations to deal with potential violence. As noted above, if the decision is made to give warnings, this should be clearly documented along with the justification.

Outcome
Mr P’s treatment team requested a consult to address, among other things, his clinical violence risk and their duty to warn his son. After a thorough clinical evaluation and systematic violence risk assessment, Mr P was found to have an overall low to low-moderate risk of violence, with dynamic factors that could easily be addressed. As there was no longer a Tarasoff issue (ie, no specific threat against an identifiable party), it was concluded that there was no longer a duty to protect, nor did there exist any further reason to breach confidentiality by warning Mr P’s son or the police.

In essence, the duty had been discharged by the clinical intervention of Mr P’s inpatient hospitalization – which had then resolved the Tarasoff situation by virtue of good psychiatric treatment. A risk reduction plan was crafted by Mr P’s team which addressed all of his dynamic risk factors. The team obtained and documented Mr P’s willingness to follow the plans. The clinical risk assessment and management plans were communicated to Mr P’s outpatient providers with his consent.

Specifically, they were made aware that Mr P, when acutely ill, had plans to kill both himself and his son. Mr P was told by his treatment team that communication of this information to his outpatient providers was necessary to ensure a good continuum of care. Mr P expressed that he understood this rationale and gave his consent. The patient was discharged to a partial hospitalization program, and after several months, he was discharged to outpatient care in his community. Clinicians never informed P’s son about his former homicide-suicide plans. Through an employment specialist, Mr P was able to find a part-time job. He remained adherent to treatment and required no further inpatient hospitalizations.

References
5. Also: a legal definition is the “duty to take some action to prevent harm to another, and for the failure of which one may be liable depending on the relationship of the parties and circumstances.” Black’s Law Dictionary, 7th Ed., B. Garner (Ed.). St. Paul, Minn: West Group, 1999.
8. Jabionski by Pahls v. United States, 712 F.2d 391 (9th Cir. 1983).
10. When a therapist makes a warning, the warning may include statements made by the patient which the therapist believes are necessary to convey the seriousness intent of threat to the victim. Menendez v. Superior Court (1992) 3 Cal.4th 435, 11 Cal.Rptr.2d 92; 834 P.2d 786.