

Guidelines for Practitioners: A Social Work Perspective on Discharging the Duty to Protect

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Abstract

In situations in which a client is deemed to present a serious risk of violence to another, a responsibility arises for the counselor to use reasonable care to shield the anticipated victim from such danger. Guidelines are provided to assist social workers in ethical practice in “duty to protect” situations while avoiding malpractice.

Keywords: duty to protect, social work, ethical mental health practice, ethical dilemma, client danger to third parties

1. Introduction

The Tarasoff doctrine directs that when the therapist determines, or ought to determine, that the client presents a serious danger of violence to a third party, an obligation arises “to exercise reasonable care to protect the foreseeable victim from that danger” (Tarasoff v. Regents of the University of

California 345, 1976). When a *duty to protect* issue arises in practice, social workers may experience ambivalence and uncertainty with respect to the need to reconcile and integrate the professional ethics of confidentiality and legal mandates of the duty to protect. This article reviews a brief history of the Tarasoff decision. The Tarasoff duty to protect standard and the ensuing uncertainty about the standard’s meaning and application based on inconsistent court opinions will be explored. Social workers’ ethical obligations are addressed as they relate to the duty to protect standard. Finally, guidelines are set forth to assist social workers in ethical practice in duty to protect situations while avoiding malpractice. Typically, in the mental health arena, the duty to protect issue arises either in a hospital/clinic setting or a clinician’s office. This article addresses duty to protect issues that arise in mental health treatment in a clinician’s office. Duty

to protect issues related to clients with communicable diseases, such as HIV or AIDS, or with genetic conditions, are not addressed.

2. The Tarasoff Case

In autumn 1968, Prosenjit Poddar became acquainted with Tatiana Tarasoff at the University of California (Herbert, 2002), and initiated romantic overtures as he believed she was his intended. Poddar asked for Tarasoff's hand in marriage, and Tarasoff rejected the proposal. Fuming, Poddar returned home to his roommate and expressed a desire to kill Tarasoff (Tarasoff v. Regents of the University of California 1974).

Tarasoff left for Brazil in the summer of 1969. After her departure and upon a friend's suggestion, Poddar accessed mental health counseling and assistance through the University. In late summer 1969, Poddar was engaged in counseling with a psychologist, Dr. Lawrence Moore. Poddar revealed to Moore that he planned to murder a girl when she returned from Brazil (Herbert, 2002).

The psychologist sent a letter to the campus police chief and relayed his concern that Poddar had significant mental health problems and posed a danger. Subsequently, Poddar was picked up by campus police. However, the campus police became convinced that he was lucid and no longer a danger to Tarasoff. The officers obtained Poddar's assurance that he would maintain physical distance from Tatiana, and subsequently released him from custody (Tarasoff v. Regents of the University of California 1974).

Poddar stopped seeing Dr. Moore. In late October 1969, Poddar traveled to Tarasoff's home, stabbed her to death, and then called the police to report the killing. Poddar was arrested. Tarasoff's parents brought suit and named the university health service and the campus police as defendants. The consequent court decision on this legal action resulted in what is recognized as the Tarasoff standard (Tarasoff v. Regents of the University of California 1976).

3. The Tarasoff Standard and Confusion that Followed

The standard is best articulated by the Tarasoff court.

When a therapist 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. In sum, the therapist owes a legal duty not only to his patient, but also to his patient's would-be victim (Tarasoff v. Regents of the University of California 345, 1976).

Confusion arises in a number of areas. One area of uncertainty stems from the fact that there were two Tarasoff court rulings. Succinctly stated, in the first Tarasoff ruling, in 1974, the California Supreme Court stated that therapists have a duty to warn prospective victims (Tarasoff v. Regents of the University of California, 1974). A later court decision and what is often called the Tarasoff II ruling, issued by the California Supreme Court, instructs that therapists have a duty to protect prospective victims

(Tarasoff v. Regents of the University of California, 1976). Thus, the legal standard in Tarasoff II moves beyond a counselor's duty to warn to encompass and mandate a duty to protect third parties if the client presents a serious, foreseeable danger of violence to another (Kagel & Kopels, 1994).

Court decisions that followed Tarasoff II were perplexing because of their inconsistency and unpredictability (Kachigian & Felthous, 2004). For instance, in Davis v. Lhim (1983), a patient released from a state hospital subsequently shot and killed his mother. Although there was no past record of violence, the plaintiff's expert witness described him as likely to engage in violence. The plaintiff's sole piece of tangible proof was a notation made in a hospital record documenting that the patient had made threats toward his mother. This documentation occurred two years prior to the mother's death (Kermani & Drob, 1987). The court reasoned that if the treating psychiatrist had reviewed past records, the patient's mother could have been identified as a foreseeable victim. The court adopted the Tarasoff reasoning and held that a psychiatrist owes a duty of reasonable care to a person who is foreseeably endangered by his patient. The court found the psychiatrist negligent for not reviewing a previous record on the patient. This decision in Davis v. Lhim (1983) was later reversed in Canon v. Thumudo (1988) on other grounds, specifically, with reasoning by the Michigan Supreme Court that the psychiatrist's determination that the patient should not be involuntarily hospitalized fell within a scope of immunity from tort liability (p. 698).

In the pursuit of professional clarity and the hope for judicial predictability, protective

disclosure statutes (legislation that attempted to define Tarasoff's duty to protect standard) were passed in 23 states by 2004 (Kachigian & Felthous, 2004). Research reflects that state courts have taken diverse approaches in interpreting their respective protective disclosure statutes, and that only in a few cases did courts construe the statutes to limit the duties owed to third parties (p. 272). Some indicate that there has been a discernable trend to limit the scope of the clinician's Tarasoff II duty to protect in both court cases and through the use of protective disclosure state statutes, which explicitly codify both the duty and how to discharge the duty (Walcott, Cerundolo, & Beck, 2001).

Conversely, some jurisdictions do not mandate a duty to protect. For instance, Florida's statute is permissive and indicates that a confidential communication between the licensed or certified mental health worker and the patient or client is confidential, and *may* be waived, when "there is a clear and immediate probability of physical harm to the patient or client, to other individuals, or to society..." and the licensed professional communicates the information "only to the potential victim, appropriate family member, or ...other appropriate authorities" (Fla. Ann. Stat. 491.0147, 1991). Florida's Court of Appeal in Green v. Ross (1997) held that the permissive language of this statute did not create an affirmative duty to warn, and as a result, no cause of action for failure to warn could be brought against a mental health worker. In so holding, the court relied upon a prior Florida appellate decision, Boynton v. Burglass (1991), which affirmed the dismissal of a plaintiff's complaint for failure to state a cause of action against a psychiatrist under an alleged duty to warn.

The appellate court in Boynton v. Burglass, along with other factors, construed the language of Fla. Stat. 455.2415 (pertaining to psychiatrists) to be permissive in that psychiatrists “may disclose patient communications....” Consequently, no duty to warn arose on which to base a cause of action against the psychiatrist. Thus, the Florida statute permits but does not require breaching of confidentiality to protect a third party from harm.

The Texas Health and Safety Code language on duty to warn is similar to the Florida statute as the language is permissive allowing professional disclosure of confidential information to warn a third party of a patient’s danger to them (611.004). Similarly, Texas courts have declined to construe a duty to warn from their permissive statutory language that a professional “may disclose confidential information...” (Thapar v. Zezulka, 1999; 611.004). Accordingly, in a minority of jurisdictions, there is no affirmative duty to warn or protect, and the disclosure to protect a third party is permissive.

Additionally, social workers should be aware of whether a shield law exists in their jurisdiction that protects the professional, good-faith discloser from liability. For instance, in Texas, the permissive disclosure statute does not shield mental health professionals from civil liability for good faith disclosures when threats are made by a client against another (Barbee, Combs, Ekleberry, & Villalobos, 2007). For this reason, among others, Texas courts have declined to mandate a duty to protect, since no protection from civil liability is provided to mental health professionals when breaching confidentiality under duty to protect circumstances (p. 21).

Because of these differences in state law, clinicians are well-advised to be knowledgeable about the relevant statutes and case law in their states (Kachigian & Felthous, 2004). Additionally, the advice and counsel of a local attorney who is familiar with the relevant duty to protect law is helpful and necessary in providing a full contextual understanding of the law in one’s jurisdiction.

4. Social Work Confidentiality and Duty to Protect

Social workers are held to a “constellation of core values” (National Association of Social Workers [NASW], 2008, preamble). These core values are service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. Inherent in these core values is confidentiality for the client. The Code assists in the ethical practice of social work by providing “broad ethical principles that reflect the profession’s core values and establish a set of specific ethical standards that should be used to help guide ethical practice” (NASW, purpose).

Pursuant to the duty to protect, confidentiality must sometimes be breached to protect third parties. Support for the obligation to comply with specific legal obligations which on limited occasions surpass the client’s primary interest is found in the Code (NASW, 2008). Clients’ interests are most important when considering an ethical dilemma. However, in limited circumstances, the duty to the client may be superseded by specific legal obligations and clients should be so advised (Privacy & Confidentiality).

The Code instructs that respect and promotion of self-determination of clients is primary, while noting that social workers may limit this right to self-determination “when, in the social workers’ professional judgment, clients’ actions or potential actions pose a serious, foreseeable, and imminent risk to themselves or others” (Sec. 1.02). Specifically, the Privacy and Confidentiality section of the Code, under ethical responsibilities to clients indicates that

Social workers should protect the confidentiality of all information obtained in the course of the professional service, except for compelling professional reasons. The general expectation that social workers will keep information confidential does not apply when disclosure is necessary to prevent serious, foreseeable, and imminent harm to a client or other identifiable person (Sec. 1.07c). ...Social workers should inform clients, to the extent possible, about the disclosure of confidential information and the potential consequences, when feasible before the disclosure is made. This applies whether social workers disclose confidential information on the basis of a legal requirement or client consent (1.07d). ...Social workers should discuss with clients... the nature of confidentiality and limitations of clients’ right to confidentiality... [and explain] where disclosure of confidential information may be legally required ... (1.07e).

Significantly, social workers are allowed to breach client confidentiality in order to

comply with laws, court orders, or to prevent serious, foreseeable, and imminent harm to an identifiable third person pursuant to the NASW Code of Ethics. In addition to the serious threat of danger made by the client, most states now require the third party be identifiable, before the therapist can be said to have a duty to this victim. This is consistent with the language in the NASW Code of Ethics.

To breathe life into social work’s ethical code, Dabby, Faisal, Holliman, Karliner, Pearl, & Silverman (2008) review the literature that supports ethics as activity or discourse. These authors cite Goldstein (1998) who sees ethical social work practice as an art and “...like any art, ethical and moral understanding is best learned through the experience of human relationships and its many variations” (p. 242-243). The authors encourage social workers to see themselves as artists who “create with clients, colleagues, environments, and experiences,” and that this view is perhaps more empowering than one of implementers of policy and codes (Dabby, Faisal, Holliman, Karliner, Pearl & Silverman, 2008). This perspective assists in expanding the vision of ethical practice in duty to protect situations.

5. Need for Guidelines

Trends show an increase in the number of lawsuits filed against social workers in the past 25 years (Surface, 2005). Certainly, the fact that a lawsuit is filed does not mean that the complaining party prevails, or that the case ever comes to trial. It behooves social workers to be aware and knowledgeable about their liability exposure from third parties as a result of the Tarasoff II duty to protect. Social workers may find

themselves in a dilemma balancing the duty to protect third parties with the ethical duty of confidentiality in order to maintain trust and therapeutic relationships with clients (Zavez, 2005). Research from a related profession is instructive. Pabian, Welfel, and Beebe (2009) polled 1,000 psychologists, receiving 300 usable responses, on their knowledge of Tarasoff laws in their states. This research found that most psychologists (76.4%) had misunderstandings about their respective state's laws, believing that a legal duty to warn arose when it did not, or believing that a warning was their only legal recourse when other protective options less detrimental to client privacy were permissible.

The varying state law on the duty to protect, the potential legal exposure, and the need for professional clarity in duty to protect situations suggest the need for guidelines to assist social workers in ethical practice.

6. Guidelines for Ethical Practice

It is important for social work practitioners to understand that in order for a plaintiff to prevail in court when a lawsuit based on negligence is filed against a mental health professional, the plaintiff must show a duty, a breach of duty, that the breach caused an injury, and damages resulted (Fulero, 1988) from the injury. The breach of a *Tarasoff* duty will be judged by "the standard of the reasonable professional in the community under the circumstances" (p. 186).

The duty to protect has been defined by Parry and Drogin (2007) as the "duty of a therapist or mental health facility to take affirmative steps to prevent an overtly dangerous patient from harming a third

party" (p. 438). Reamer (2006) indicates certain conditions should be satisfied before confidential information is used to protect another. The social worker should have evidence that 1) the client poses a threat of violence to a third person; 2) significant risk exists that the violence will occur; 3) the violent act is imminent or likely to occur in the near future; and, 4) the potential victim is identifiable. However, as to the last condition, some jurisdictions differ on whether the victim must be identifiable.

The four conditions provide a general overview of when the duty to protect is triggered, and confidential information can be used to protect a third party. To provide more specificity for social workers seeking to protect their clients, themselves, and discharge the duty to potential third parties, guidelines are set forth to assist in this process. Previous work in this area by Costa and Altekruze (1994) resulted in guidelines for counselors regarding the duty to protect. With the author's permission, these guidelines have been researched, added to, expanded, updated, and tailored for social workers. The following guidelines should be considered within a deeply contextual understanding of the client and the client's treatment needs.

6.2. Guidelines for Social Workers in Discharging the Duty to Protect

1. Become and stay knowledgeable in the state and federal statutory and case law related to duty to protect in your jurisdiction. Becoming knowledgeable in the pertinent jurisdictional law is vital since the law varies by state and is continually evolving. Thus, it is imperative to know what the law is in the jurisdiction in which practice occurs. For instance, some jurisdictions differ on

whether the potential victim must be identifiable before a duty is triggered. In a minority of jurisdictions, there is no affirmative duty to warn or protect, and a disclosure to protect a third party by the social worker is permissive. For instance, some authors in the counseling field assert that there is a legitimate case to be made in Texas that mental health professionals should not violate confidentiality under any circumstances to protect another, unless it falls under the mandatory child abuse or positive HIV reporting law (Barbee, Combs, Ekleberry & Villalobos, 2007). An alternative social work viewpoint considers the client's interests and those of third parties who may be injured or killed - in conjunction with the NASW Code of Ethics' values and ethical standards. In addition to state law and legal counsel, the NASW Code of Ethics provides direction on reconciling ethical dilemmas, and clinical consultation provides support and assistance in making necessary, ethical decisions.

Thus, knowing the specific legal mandates will be critical in determining what action, if any, is required. The onus is on the social worker to stay knowledgeable in the current and relevant jurisdictional law with respect to duty to protect (Chaimowitz, Glancy & Blackburn, 2000).

2. Plan ahead through consultation and supervision using your knowledge of duty to protect law in your jurisdiction. Seek the input of colleagues, retained attorneys, and other professionals who have expertise in strategizing and dealing with the protection of clients, potential 3rd parties who may be or are in danger, and oneself, as a professional social worker. Seek out guidelines and standards implemented from the jurisdiction of practice regarding duty to

protect, and the advice of local counsel familiar with the duty to protect law in the particular jurisdiction. Independent practitioners may join together to retain an attorney for such consultation prior to an actual duty to protect dilemma arising.

3. Develop a protocol, using the consultations noted above, that outlines how you will proceed if the client threatens to harm someone. Maintain an up-to-date understanding of managing violent patients (Roth, 1987), and include this in the protocol. Use the protocol developed to be able to identify issues, options, and needed information when urgent decisions must be made (Isaacs, 1997).

4. Acquire and review past treatment records. This is an important clinical practice, and one that can provide protection to the client and social worker.

5. Practice within your areas of expertise, and select clients carefully. Determine which presenting problems are best referred to another practitioner, and how you will make these decisions in your practice.

6. Obtain informed consent in writing before initiating the treatment process and explain exceptions to confidentiality, in writing and verbally. Informed consent is the legal standard for medical and other related treatments that requires a patient's decisions to be "competent, voluntary, and knowledgeable" (Parry & Drogin, ABA, 2007). Thus, the consent form should state what the client is consenting to, that the client has asked questions about anything they do not understand, that the client understands the scope of consent, and that the client is making a competent and knowledgeable decision in signing the consent form.

7. Obtain professional liability insurance. Seek and carry sufficient professional insurance. Verify and understand what is and is not covered in the liability insurance policy to be an informed consumer.

8. Access appropriate consultation (Fulero, S.M., 1988) when the duty to protect is triggered. The consultation must include clinical issues (Walcott, Cerundolo, & Beck, 2001) and should incorporate Appelbaum's (1985) suggested three step procedure of assessment of danger, formulating a treatment plan, and ensuring the treatment plan is implemented.

First, assess dangerousness as accurately as possible which involves such considerations such as past threats of violence, a past history of violent behavior, current threats to harm others, accessibility of weapons, relationship with the intended victim, membership in a group that condones violence, and lack of adherence to treatment. (Steinberg, Duggal, & Ogrodniczuk, 2008). The counselor must remain up-to-date with current, effective practices in assessing dangerousness (Simon, 1987; Harris & Rice, 1997).

Second, formulate an individualized treatment plan which involves determining which options are appropriate for the client and situation. Part of the treatment plan is determining whether the patient should be hospitalized as a danger to others. This can be done voluntarily by the client, or involuntarily through the court system. By initiating civil commitment proceedings (involuntary hospitalization) the burden of decision-making is shifted to the court (Mills, Sullivan, & Eth, 1987). Some in psychiatry believe, "It is difficult if not impossible to envision a clinically realistic

situation requiring a warning in which involuntary commitment is not also called for, as the levels of danger that are conditions for the two actions are indistinguishable" (Gutheil, 1995). However, one study showed that about half of the clients were hospitalized after the Tarasoff II notification for protection occurred (McNiel, Binder & Forrest, 1998). These findings suggest that a different interpretation was made by clinicians for civil commitment and for a Tarasoff II duty to protect third parties (p. 1100). This California study also suggests that of the clients who made threats that resulted in notification, half had records of arrest and of these "31% (N=70) had arrests for violent crimes and 21% (N=49) for drug-related offenses" (p.1098, para 9). Mental health courts that exist in some jurisdictions may be an option (Lamb & Weinberger, 2008). Others options include assuring that a psychiatrist reviews current medication or prescribes any needed medication for the patient since changing medications, beginning medications, or increasing the dosage may be appropriate. Additionally, the frequency of appointments may be increased, and the client referred to a structured program. (Steinberg, Duggal, & Ogrodniczuk, 2008).

The treatment plan should include warning the intended victim and/or his relatives. It may include warning friends or others likely to apprise the victim of the danger. Notify the police, and take whatever steps are reasonably necessary. Again, the need to be knowledgeable about jurisdictional law and consult with legal counsel is critical. For instance, in Texas, the professional *may* disclose confidential information to medical or law enforcement personnel if the professional determines there is a probability of imminent physical injury by

the patient to others (Tex. Health & Safety Code Sec. 611.004, 2009). There is no authorization in this Texas statute to disclose confidential information to the victim or the victim's family.

The preceding is not meant to be an exhaustive listing of individualized treatment options. Each client and client situation must be individually considered within the context of best treatment practices, the NASW Code of Ethics and jurisdictional law.

Third, ensure the client treatment plan is implemented (Steinberg, Duggal, & Ogrodniczuk, 2008). It may be necessary for the social worker to take multiple actions quickly.

9. Engage the client in the needed protective action when possible. This is actually a part of formulating the treatment plan; however, it warrants singular attention due to its importance. When it is apparent to the counselor that harm is imminent to a third party, a duty to protect becomes imperative. (Presuming the jurisdictional law mandates a duty to protect.) Explain this duty and involve the client in the process of protecting the third party when appropriate. A strengths-based approach may be useful when engaging the client (Rapp, 1998). Consider warning with the client present (Walcott, Cerundolo, & Beck, 2001). Avoid surprising clients with third party warnings when possible. Some suggest involving the client in the notification process which may have a therapeutic effect for the client, and on the therapeutic relationship (Walcott, Cerundolo, & Beck, 2001 citing Wulsin, Bursztain, & Gutheil, 1983). At least one group of psychotherapists assert that having the client

provide the Tarasoff protective warning is the best alternative option (Ginsberg, 2004 citing Wulsin, Bursztain, & Gutheil, 1983). In such a situation, the social worker should be present with the client, for instance, in a conference call during the actual notification. However, remember that the social worker's duty to warn the third party is paramount and should occur whether the client assists or not. In addition, "obtaining the permission of the client (written or taped) to warn the intended victim removes any violation of confidentiality" (Fulero, 1988).

10. Discharge the duty to protect by implementing the protocol with contemporaneous consultation and legal advice. Since each client situation is different, the protocol will need to be individualized to each client and the threatened third party in conformity with the jurisdictional law. Inform your supervisor, attorney, law enforcement, and the intended victim or others who may need to protect the intended victim.

11. Document thoroughly (Fulero, 1988) all the information conveyed to a client about the clinician's duty to warn a foreseeable third party about harm or violence directed towards them. Document a mental status exam, verbatim statements and behavior of the client from which you determine the client is a threat to a third party. Explain clinical choices in writing, and why one option was chosen over another. Document related consultations and professional actions to protect your client and the third party. Document in a timely fashion, and avoid over-documentation in crisis situations. Also, avoid anticipatory documentation, which is documenting what the social worker anticipates will occur, as this negatively

impacts professional credibility in the event of legal action. Proper and thorough documentation serves as protection from liability. If a case is litigated, courts will review whether the social worker acted reasonably and took proper actions to prevent harm.

Thorough records are critical to document that the therapist understood the nature of the situation and that reasonable steps were taken in light of the facts. Consultation provides evidence of professional consensus about the action taken. A therapist is not liable for a negative outcome unless his or her actions fall below the expected standard of care (p. 186).

12. Be self-aware and use self care. A social worker may hesitate to seek legal advice or inform third parties. As a result, the professional may be erroneously concerned about breaching client confidentiality if not knowledgeable about the limits of confidentiality. Additionally, the professional may inflexibly and incorrectly place a higher priority on client confidentiality than on a third party's need for protection. A helping professional may utilize what Racker (1968) has characterized as a manic defense, feeling they can and should manage the threatening client on their own without outside help or guidance (Steinberg, Duggal, & Ogrodiczuk, 2008). The professional may become so preoccupied by the threats of harm to a third party that the client's treatment suffers. Practical and counter-transference ramifications of the threat must be dealt with if the client and social worker are to maintain a treatment relationship (p.17).

The above guidelines provide a basic structure and strategy in preparing for and resolving the duty to protect dilemma (Costa & Altekruze, 1994). Notable for social workers, is the advice of Steinberg, Duggal & Ogrodiczuk (2008) that

the anxiety, financial cost, and potential guilt and grief involved in not appropriately seeking legal advice when a threat is followed by a physical attack or even murder exceed out of all proportion whatever discomfort and cost may be incurred by seeking legal advice and appropriately informing third parties (p.15).

7. Conclusion

The Tarasoff doctrine instructs that when a therapist determines, or pursuant to professional standards ought to determine, that the client presents a serious risk of violence to another, the therapist "incurs an obligation to use reasonable care to protect the intended victim against such danger". The Tarasoff doctrine known as the duty to protect standard, and its interpretation has caused practitioners uncertainty about the standard's meaning and application. The challenges have been complicated by varying court decisions and statutes in different jurisdictions. The language and obligations set forth by the NASW Code of Ethics provide a duty to protect exception to the imperative of confidentiality. Guidelines are offered to assist social workers in ethical practice in duty to protect situations. Some key suggestions are to understand the jurisdictional law, plan ahead through legal consultation, develop a protocol, limit practice to areas of expertise, be selective about clients, acquire and

review past records, obtain the client's informed consent, obtain professional liability insurance, involve the client in the decision to protect when possible, discharge the duty to protect by implementing the protocol developed, document, and be self-aware. Maintaining a current understanding of the law is critical as the law is ever evolving. Discharging the duty to protect can be a life altering decision for the client and an intended victim; accordingly, informed preparation, appropriate guidance and consultation, critical thinking, and ethical action are paramount.

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