

## Tarasoff ruling for North Carolina

Tarasoff vs. Regents of the University of California 17 Cal 3d 425,551 P2d 334, 131 Cal Rptr 14 (1976)

“Therapists” that is clinicians, physicians, psychologists have a duty to warn known potential victims of threats by their patient. This is termed a ‘duty of care’ and regular negligence standards apply. The therapist need only exercise that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by member of that professional specialty under similar circumstances in determining whether a patient presents a serious danger of violence. Once the therapist makes this determination, then he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger. Due care varies from case to case. Standard is ‘reasonable care in the circumstances.’

### North Carolina cases

*Currie vs. United States*, 836F 2d 209 (4<sup>th</sup> Circuit), 1987. The 4<sup>th</sup> Circuit did recognize Tarasoff as creating a duty to warn, but limited it to potential identified victims.

*Gregory vs. Kilbride*, 150NC App. 601 (2002). This is the landmark NC case (<http://www.aoc.state.nc.us/www/public/coa/opinions/2002/000667-1.htm>) which represents our current common law. NC does not recognize a psychiatrist’s duty to warn third persons.

### Real Issues to Consider

Tarasoff in NC does not *require* a duty to warn, but the clinician can still do so. That is, you have permission to warn. The ‘best medical practice’ standard applies here. Some guidelines to use whether you warn are:

1. The therapist must have a professional relationship with the patient making the threat.
2. The threat must be made in the presence of the mental health professional. In an inpatient setting, if the threat was made in front of any staff member responsible for care, they would document it, or report it to someone who could document in the chart, and request that the responsible professional release information necessary to warn the potential victim. Threats made prior to admission are problematic, and can trigger permissive release under the statute, if the danger is present.
3. The threat must be toward an identified, or identifiable person.
4. The threat must pose a serious threat of physical harm to the person.
5. The staff must assess the patient for potential dangerousness to that person, which also goes to seriousness of the threat.

### Taking Reasonable Precautions; How to Warn

Although there is no checklist, some guidance can be found in Tarasoff. In that case, the Court found that the doctor could have warned the victim’s family so that they could warn her. The warning goes to the victim, or one who can warn the victim.

In most practical cases, the potential victim themselves must be warned. If the potential victim can't be reached by phone or certified letter, someone close to the potential victim, or law enforcement personnel should be notified.

If the patient is under commitment, the time factor for warning the potential victim is less urgent. If the patient is not in custody, then duty becomes more immediate, and the warning must be given by the quickest means possible.

It is always best to have some verification of the warnings. If warning is done by phone, document number called, time call, person spoke to (have them identify themselves), have a witness on an extension, or have it recorded. If a letter is sent in cases where there is no emergency, send the letter certified, receipt requested. Place the return receipt in the chart with the letter. Document any phone follow up.

The basic factors of giving a warning are:

- ❖ document threat
- ❖ identify potential victim
- ❖ assess seriousness of the threat and potential for harm
- ❖ attempt by expeditions means to notify potential, identifiable victim of the threat of harm.
- ❖ document notification

#### Damned if you do, damned if you don't

If you give a warning to a potential victim you can be sued for violating the patient's confidentiality. There are also criminal consequences in NC for breach of confidentiality.

You can ask the patient for consent to release the information, which therefore negates any possibility of breached confidentiality. But, be careful how you ask, and don't exert pressure on the client to consent. e.g. Do not take away privileges or punish someone who refuses to give such consent.

If the client does not consent, you can still notify the potential victim. Weigh factors such as potential likelihood (e.g. etoh or drug abuse involvement, the mental status of the patient, past history of the patient for committing violent acts, etc.). The general advice is that it is better to err on the side of notification and keep the potential victim alive, then have a dead victim but you have not violated confidentiality.

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You also **may disclose** (which does not mean you have to) if there is "confidential information, and in the opinion of a responsible professional there is an **imminent danger to the health or safety of the client or another individual** or there is a **likelihood of the commission of a felony or violent misdemeanor.**" (NCGS 122C-55(d).

You should note that 'a violent misdemeanor' is never defined, but you can probably interpret it as 'someone being harmed' such as through assault and battery.