

## Tarasoff and Duty to Protect in North Carolina

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## Tarasoff and Duty to Protect in North Carolina

A. Keith Mobley, PhD, LPC and Eugene Naughton, JD

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A counselor's duty to warn and protect third parties of threats made by their clients has been a complex, frightening, and confusing topic since the landmark *Tarasoff* case in 1976. Although the implications of this case has been interpreted by a variety of state courts and legislatures, the tension between a counselor's ethical and legal responsibilities creates consternation for many counselors in North Carolina. This article reviews the background and implications of the duty to warn concept to counselors specifically in the state of North Carolina and provides both proactive and reactive suggestions for managing encounters with potentially violent clients.

*Keywords:* duty to warn, confidentiality, ethics

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In 1976, the California Supreme Court handed down its landmark decision in *Tarasoff v. Regents of the University of California*, and the effects of that decision are still felt today across the nation in both the legal and counseling professions. Because any case decided by a state or federal court can create legal ripples that extend beyond the original jurisdiction of the court, one state's court could be applied to another state's cases. Consequently, courts, scholars, and mental health professionals have struggled to understand the implication of the case and its impact on the daily practice of counseling in the years since *Tarasoff*. This case was such an important one that the crux of that decision – that a clinician has an overriding legal duty to break confidentiality when a client makes a viable threat against a third party – remains problematic for many counselors who are untrained in the law

and who do not fully understand the limits of confidentiality in their state (Walcott, Cerundolo, & Beck, 2001), including those in North Carolina.

The extensive implications of the *Tarasoff* decision is further complicated by the fact that neither the North Carolina Court of Appeals (the highest court in the state) nor the state legislature has squarely addressed the *Tarasoff* decision. Our intention with this article is to ease some of the confusion by revisiting what the *Tarasoff* decision entails, how courts and legislatures across the country digested *Tarasoff*, and how North Carolina has dealt with issues raised in that decision to date. We also hope to discuss the ethical and practical implications raised by *Tarasoff* and suggest how counselors in North Carolina can avoid ethical pitfalls that *Tarasoff*-like situations might raise and ensure they are implementing best-

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practices in a proactive fashion.

The goal of this article is to help counselors in NC understand the history and the implications of *Tarasoff* case in our state and to differentiate legal requirements from ethical imperatives in similar situations to that case. We first provide a background of the *Tarasoff* case, describe the implications of the case decision across the nation, and then discuss the interpretation of the case in the state of North Carolina. We conclude this article with suggestions of how a mental health professional in NC can be proactive in dealing with situations involving threats of harm made by a client and review steps one can engage in if risk of harm toward others is assessed.

### **The *Tarasoff* Decisions: Case and Analysis**

To most, the *Tarasoff* case is shorthand for a simple “duty to warn”; however, it is much more. In fact, there are two *Tarasoff* decisions, and “duty to warn” was only the first obligation imposed on clinicians in California. As seen below, the California Supreme Court expanded the obligations imposed on a clinician to a burdensome degree, with many other courts following the California Supreme Court’s lead and applying the same obligations in their own states.

The facts are well known. In 1968, Prosenjit Poddar, a graduate student at the University of California, Berkeley, met fellow student Tatiana Tarasoff at a school dance. Poddar misinterpreted a casual kiss as evidence of a serious relationship, and soon he became fixated with Tarasoff, who rebuffed Poddar’s romantic overtures. Distraught, Poddar sought counseling at the University Health Services. During eight weeks of therapy, Poddar revealed to a staff psychologist, Dr. Moore, that he intended to kill an unnamed woman who was readily identifiable as Tatiana Tarasoff. Moore consulted with supervisors about a course of action and notified campus police of the threat. In a letter to the police,

Moore requested that the police commit Poddar to a mental hospital for observation. Campus police stopped and questioned Poddar but released him after he denied any violent intentions. The police advised Poddar to stay away from Tarasoff. Poddar had no further contact with the police or the University Health Services. Subsequently, Poddar began stalking Tarasoff, and in October 1969, Poddar entered Tarasoff’s home and murdered her with a kitchen knife. He was convicted of second-degree murder, a conviction later reduced to manslaughter and ultimately reversed on error.

The victim’s parents brought suit against the University of California, the campus police, and the University Health Service clinicians. In their complaint, the Tarasoffs alleged that the University clinicians “did in fact predict that Poddar would kill and were negligent in failing to warn” (Ref. 2, p. 345). The trial court dismissed the suit, ruling that no law imposed a duty on a clinician to warn a third party of a danger revealed during confidential therapy. The Tarasoffs appealed and the case eventually worked its way to the California Supreme Court. On December 23, 1974, the Court overturned the dismissal and remanded the case for trial against the University clinicians and police (*Tarasoff v. Regents of the University of California*, 1974). In essence, the Court imposed a new duty on clinicians to warn potential victims of a threat posed by a client-patient:

When a doctor or a psychotherapist, in the exercise of his professional skill and knowledge, determines, or should determine, that a warning is essential to avert danger arising from the medical or psychological condition of his patient, he incurs a legal obligation to give that warning. (Ref .7, p. 555)

Here, the Court assumed that a clinician could accurately discern if a threat was viable and foresee the harm. Thus, a clinician could be liable if he or she recognized the danger or

should have recognized the danger and did not warn the potential victim (Weinstock, Vari, Leong, & Silva, 2006).

The Court's decision (known as *Tarasoff I*) prompted strong responses from the mental health community. The American Psychiatric Association (APA) and other professional organizations filed with the Court an *amicus curiae* brief (i.e., a petition from a third party intended to persuade or otherwise influence a court to act in a certain manner) and requested a rehearing of the matter. In its brief, the APA argued that clinicians could not accurately foresee future acts of violence, nor could they guess all of the potential victims of the client-patient. In addition, the APA argued that the decision eroded the critical tenet of confidentiality, widely assumed to be a precondition for the development of a therapeutic rapport.

In an unusual decision, the California Supreme Court agreed to re-hear the case. In its second opinion (known as *Tarasoff II*, 1976), the Court increased the scope of the clinician's liability, creating a "duty to protect" in place of the narrower "duty to warn." Warning a potential victim was one way of fulfilling the new duty to protect, although not the exclusive means:

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. The discharge of this duty may require the therapist to take one or more various steps, depending on the nature of the case. Thus, it may call for him to warn the intended victim or others likely to apprise the victim of that danger, to notify the police or to take whatever other steps are reasonably necessary under the circumstances (*Tarasoff v. Regents of the University of California*, 1976, p. 340).

Again, the Court required clinicians to accurately discern the violent intent of their clients and identify potential victims. How? The Court relied on clinicians to exercise a "reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of that professional specialty under similar circumstances" (p. 349).

How the Court arrived at its decision has been a matter of considerable debate, especially since the decision has broad implications for all mental health practitioners, regardless of the state in which they are licensed. Commentators have described the Court's reasoning as "convoluted" and "opaque" (Herbert, 2002) and in disagreement with the basic elements of tort law (i.e., civil, not criminal law) (Walcott et al., 2001).

At its heart, the *Tarasoff II* decision rests on two fundamental ideas. First, the Court relied on a quasi-Good Samaritan argument, holding that it was good public policy for a clinician to break confidentiality and warn a potential victim where a client makes a viable threat against them. As Justice Matthew Torbriner famously wrote:

Our current crowded and computerized society compels the interdependence of its members. In this risk-infested society we can hardly tolerate the further exposure to danger that would result from concealed knowledge of the therapist that his patient was lethal ... (*Tarasoff*, 1976, p. 347-248).

Second, the Court held that a clinician and client had a "special" (i.e., legally binding) relationship that imposed duties outlined in the Restatement 2d of Torts:

There is no duty to control the conduct of a third person as to prevent him from causing physical harm to another unless ... a special relation exists between the actor and the third

person which imposes a duty upon the actor to control the third person's conduct, or a special relation exists between the actor and the other which gives the other the right of protect ... (Restatement (Second) of Torts, § 315 (a) (1965)).

Here, the Court acknowledged that Poddar was never under the clinician's control or custody (in the sense of being committed) but decided that the fact that a threat was made by Poddar against Tarasoff was enough to trigger the "duty to control the conduct ... or to warn of that conduct" (*Tarasoff*, 1976, p. 342). The Court did not explain what information was needed for the clinician to properly identify a potential victim (Herbert, 2002). However, the decision made by this court resulted in many states either (a) interpreting the *Tarasoff* ruling to relevant state-level cases, effectively creating additional precedent for clinicians to consider or (b) reactively creating statutes by state legislatures to explicitly address a mental health practitioners responsibilities related to *Tarasoff*-type duties to warn and protect. As reviewed in the next section, the resulting case and civil laws have much variability and is idiosyncratic to each state.

### ***Tarasoff* Across the Nation**

Once a legal precedent is set in one jurisdiction, it is often a matter of time before similar or related circumstances allow an opportunity for a judgment of its application may be applied to other jurisdictions. This was the case with *Tarasoff*. The *Tarasoff* II decision was authoritative only in California, i.e., only courts in California were bound by the California Supreme Court's ruling, but courts and legislatures in other jurisdictions have looked to that decision to guide and apply their own case law and statutes. Since the 1976 decision, a number of courts across the country have used the *Tarasoff* case as a model to impose new responsibilities on their own clini-

cians, essentially calling on clinicians to more accurately predict violence and identify potential victims. For example, in *Lipari v. Sears Roebuck & Co.* (1980), the U.S. District Court in Nebraska held that a clinician is to protect not just individuals but the general public from the danger posed by a patient-client. Here, Ulysses Cribbs was a patient-client in treatment at a Veterans Administration (VA) hospital. Cribbs purchased a shotgun from a Sears catalogue, entered a nightclub and fired into a crowd, killing Dennis Lipari. Lipari's estate sued the VA hospital. During trial, it was revealed that Cribbs had never informed the attending clinician of his murderous intent. Although there were no specific threats communicated, the U.S. District Court held that the VA clinician could foresee the patient-client's violent tendencies, and thus had a duty to protect any member of society endangered by those tendencies. In its aftermath, this case effectually brought a duty to warn to any mental health practitioner in Nebraska.

Also, in *Jablonski v. United States* (1983), the U.S. Court of Appeals, Ninth Circuit, held that a patient's general history of violence (absent specific threats) was sufficient for the clinician to predict the danger the patient posed to a particular victim. In this case, Jablonski was brought to a hospital after attempting to rape his girlfriend's mother. The attending psychiatrist concluded that Jablonski was a danger to others but that he did not meet the criteria for involuntary commitment. Less than a week after his release, Jablonski killed his girlfriend. The Ninth Circuit Court held that the hospital failed in its duty to protect the girlfriend, even though Jablonski did not make a specific threat against her. The Court also held that the cursory meeting between Jablonski and the psychiatrist was enough to create the special relationship from which the duty to protect arose, effectively reinforcing the outcome of the *Lipari* case (1980).

Other jurisdictions have provided a more restrictive interpretation of the *Tarasoff* case.

In *Thompson v. County of Alameda* (1980), for example, the California Supreme Court held that a clinician could not be liable for threats made against a large, unidentified public group. Here, James, a troubled youth, regularly visited a clinician pursuant to court order. During therapy, James made general threats against his neighborhood, especially towards the young children there. He did not threaten any particular individual. Upon release from custody, James killed a five-year-old boy. The boy's parents sued, arguing that the clinician had a duty to warn and protect children in the neighborhood. The California Supreme Court disagreed, holding that James's threats were too broad to trigger the clinician's duty to protect. Similarly, in *Leonard v. Iowa* (1992), the Iowa Supreme Court refused to hold a clinician liable when a client made threats against the general public. Other jurisdictions, including Florida, Virginia, Mississippi, Texas, and South Carolina, have explicitly or implicitly rejected the *Tarasoff* duty to protect (Wallcott et al., 2001).

In response to the plethora of conflicting court decisions related to a clinician's duty to protect, many state legislatures have moved to explicitly define the duties in law. To date, at least 23 states have codified the duty to protect. Five states (Idaho, Michigan, Montana, New Hampshire, and Virginia) have statutes that appear to create a definite duty to warn or protect. Other states (Arizona, Colorado, Delaware, Indiana, Kentucky, Louisiana, Maryland, Massachusetts, Nebraska, New Jersey, Tennessee, and Utah) have statutes that impose a duty to protect providing certain conditions are met, namely, the patient-client explicitly threatens an identifiable person or the patient-client has a history of violence and there is good reason to believe the patient-client will commit serious violence. Two states (Florida and Mississippi) have permissive statutes, providing that the clinician may break confidentiality and warn or protect at their discretion (Kachigan & Felthouse, 2004). Typically, the clinician can satisfy the statute

by warning the potential victim or appropriate authorities or by hospitalizing the patient-client (Wallcott et al., 2001).

Clearly, the multiple interpretations of the original *Tarasoff* cases in various states has contributed to the confusion related to a clinician's duty to warn and protect. Although we review the history of the *Tarasoff* implications and relevant laws in North Carolina in the following section, the issue remains complex and often formidable to many clinicians.

### The Clinician's Duty in North Carolina

What, then, is the duty of the clinician in North Carolina? Has North Carolina adopted a *Tarasoff*-like "duty to protect" any foreseeable victim of harm? The short answer is "No." North Carolina has rejected the broad duties to warn and duty to protect any foreseeable victims found in *Tarasoff* and is one of thirteen states that currently has no statute defining this duty. In other words, the North Carolina General Assembly has not passed laws that explicitly define or outline a mental health care providers requirements to breach confidentiality in these circumstances and has rejected this duty in some rulings. That being said, North Carolina does impose on the clinician a duty to protect third parties in certain narrow circumstances. Clinicians should be aware of these circumstances.

North Carolina's statutes are silent as to a clinician's duty to warn or protect, so it is up to North Carolina courts to determine when a clinician is required to break clinician-client confidentiality (as provided in North Carolina General Statute 8-53.8). It is to the courts that we now turn.

It is apparent from case law that the North Carolina courts reject a *Tarasoff*-styled duty to warn. In *Moye v. United States* (1990), for example, the federal district court for North Carolina held that even if a clinician had a duty to warn third parties about the danger posed by a patient-client, such a duty would not arise where the victim already knew the danger. In

this case, Moye had a history of mental disorders and violence for which he received treatment at the Veterans Administration (VA) hospital. Doctors at the VA determined that Moye was not benefitting from treatment, and eventually Moye transferred to a private facility. He was later discharged for non-compliance. Although they were aware of Moye's violent tendencies, Moye's parents took him into their home. Moye subsequently murdered them. Their estate sued, alleging that the VA was negligent in its duty to warn them of Moye's violent tendencies. In trial, it was revealed that Moye's parents knew of his violence and that they refused to administer the psychiatric medicine prescribed him. The federal district court for North Carolina rejected the estate's claim: "[A]ssuming ... [the duty to warn] exist[s], the duty [does] not arise where the foreseeable victim [knows] of the danger associated with the patient ..." (Walcott et al., citing *Moye*, p. 182).

The court in the 2002 *Gregory v. Kilbride* case was even more explicit. In this case, the estate of the patient and his wife brought suit for negligence after the attending psychiatrist refused to commit the patient. Mark Gregory had threatened to kill his wife Kathryn and himself during the 36 hours that led up to a psychiatric examination by defendant Dr. Kevin Kilbride. Fearing for Mark and Kathryn's safety, Mark's father, Lloyd Davis Gregory, petitioned for Mark's involuntary commitment. Mark was taken to Broughton Hospital where he was evaluated by Dr. Kilbride. Although Dr. Kilbride determined that Mark suffered from adjustment disorder, he concluded that Mark did not meet the conditions for involuntary commitment. Mark was released from the hospital. On the same day of his release, Mark shot and killed Kathryn before turning the weapon on himself. Lloyd Davis Gregory brought suit in his capacity as executor, alleging, among other things, that Dr. Kilbride breached a legal duty to warn Kathryn of Mark's dangerous condition. The trial court granted a partial directed verdict

(i.e., the presiding judge ruled before the case went before a jury) in favor of Dr. Kilbride, holding in part that the doctor had no duty to warn Kathryn of Mark's release. The North Carolina Court of Appeals affirmed the lower court's holding, flatly rejecting a *Tarasoff*-styled duty to warn (pg. 692).

In contrast, North Carolina case law does recognize a duty to protect, though this duty is different in quality from the duty to protect envisioned in *Tarasoff*. As noted above, the California Supreme Court created a broad duty to protect imposed on a clinician when a patient-client made a viable threat against a third party. North Carolina refines this duty by holding clinicians and other mental health professionals liable where the patient-client is under the clinician's control. In *Pangburn v. Saad* (1985), Sheri Pangburn brought suit against Dr. M. Saad and Cherry Hospital in Goldsboro for injuries she suffered at the hands of her brother, Daniel Pangburn. Daniel had a long history of mental illness and violent behavior, and he had been committed several times. In 1982, Daniel was involuntarily committed to Cherry Hospital. After confinement for some period of time, Daniel's attending psychiatrist, Dr. Saad, decided to release Daniel, all over the strenuous objections of the Pangburn family. Within 16 hours of his release, Daniel assaulted Sheri Pangburn with a knife, causing severe injury. Sheri sued for damages suffered as a result of wrongful release. Dr. Saad argued that he had no duty to Sheri since he had no contractual relationship with her. On review, the North Carolina Court of Appeals disagreed, holding that so long as a clinician has *some* control over a patient-client, the clinician owes a duty to foreseeable potential victims:

[W]here the course of treatment of a mental patient involves an exercise of "control" over [the patient] by a physician who knows or should know that the patient is likely to cause bodily harm to others, an independent duty

arises from that relationship and falls upon the physician to exercise that control with such reasonable care as to prevent harm to others at the hands of the patient (pg. 338).

This decision was confirmed in another 1985 case, *Currie v. US*. Here, a psychiatrist at the Veterans Administration (VA) hospital in Raleigh was advised that a patient-client, Leonard Avery, had threatened to blow up his place of work, the IBM facility located in Research Triangle Park. The psychiatrist spoke with Avery and secured an agreement for a voluntary commitment, but Avery never showed for commitment. In subsequent conversations between the VA psychiatrist and Avery, Avery continued to make threats against IBM. The VA psychiatrist notified IBM and law enforcement agencies of these threats. VA psychiatrists and the medical staff at IBM discussed involuntary commitment proceedings but determined that Avery did not qualify. Avery later entered the IBM facility and killed an employee, Ralph Glenn. Glenn's estate sued, alleging in part that the VA was negligent for not seeking Avery's involuntary commitment. On appeal, the U.S. Court of Appeals, Fourth Circuit, held for the VA. Applying North Carolina law, the federal court affirmed a *Pangburn* duty to protect when the patient-client is under a clinician's control but also held that a clinician has no duty to commit.

The *Pangburn* decision was affirmed again by the North Carolina Court of Appeals in 1995. In *Davis v. North Carolina Department of Human Resources*, the estate of victim Phillip Davis brought suit against the North Carolina Department of Human Resources after a patient released from Cherry Hospital killed Davis. Dondiago Rivers had a history of hostile and aggressive behaviors and had been committed to state mental institutions on 11 occasions. In 1984, Rivers was involuntarily committed after being found unfit to stand trial for an assault charge. While in Cherry

Hospital, Rivers was involved in several altercations, but with treatment his mood stabilized. In April 1985, Rivers' attending psychiatrist saw enough improvement to recommend that Rivers was fit for trial. The psychiatrist discharged Rivers but also noted in the discharge papers that Rivers was still susceptible to incidents of violence. Upon discharge, Rivers was seen by a psychiatrist at Dorothea Dix hospital, who also concluded that Rivers had a propensity for violence. In August 1985, Rivers killed Davis after a verbal exchange at an intersection in Goldsboro. Davis's estate sued, alleging that the state was negligent in releasing Rivers from Cherry Hospital when it knew or should have known Rivers was violent and posed a danger to others. The trial court found the state liable. The Court of Appeals affirmed, holding that where a person is involuntarily committed for a mental illness, the institution has a duty to exercise control, and thus has a duty to protect third parties from harm caused by the patient-client (pg. 7).

In summary, North Carolina does not have a *Tarasoff*-like duty to warn (either established by statute or through case law), but North Carolina case law does impose a duty to protect third parties where a patient-client is under the clinician's control in a mental health capacity. Furthermore, Licensed Professional Counselors in North Carolina do not have the authority to involuntarily commit or release from commitment (i.e., control) a patient-client hospitalized for their propensity for violence. Moreover, the lack of legal duty for a clinician to break confidentiality and warn an intended recipient of violence by a patient-client must be distinguished from the ethical considerations for a clinician. The following section will review those ethical implications that are consistent with extant case law in NC and those that contradict current practice.

### **Ethical Duties for Counselors in North Carolina**

Although the interpretation of legal prece-

dents is often confusing and nuanced for professional counselors in North Carolina, it is imperative that counselors understand their expectations, requirements and allowances from the legal perspective. As noted above, there is no statute or legal precedent that would compel a counselor to disclose threats of violence made by their client to an intended victim in North Carolina, although the case law (i.e., law created by the courts interpretations) does impose the duty to warn/protect when the client is in the physical and legal custody of the clinician (i.e., hospitalized). In fact, existing statute requires communication with clients to remain confidential. However, the ethical principles upon which our profession is based expects us to allow no harm to others, creating a legal and ethical mismatch and a dilemma for professional counselors to navigate. How might professionals handle situations in which we could prevent harm to another who is not our client? What of our ethical obligation and the legal requirement that we abide by our ethical code?

The American Counseling Association Ethical Codes (2005), which are adopted by the NC Board of Licensed Professional Counselors, has established ethical principles that inform guidelines for duty to warn – autonomy, beneficence, nonmaleficence, justice, fidelity, and veracity. Although all of these principles apply to duty to warn cases, the most relevant to duty to warn issues are the *autonomy* of both the client and intended victim and the principle of *nonmaleficence*, which requires counselors to allow no harm to others. These have been translated into code in B.2.a Danger and Legal Requirements (ACA, 2005):

The general requirement that counselors keep information confidential does not apply when disclosure is required to protect clients or identified others from serious and foreseeable harm or when legal requirements demand that confidential information

must be revealed. Counselors consult with other professionals when in doubt as to the validity of an exception.

Because there is no legal requirement that demands confidential information be revealed in duty to warn scenarios in North Carolina (as evidenced in the preceding section), there is a disconnect between what is expected legally in North Carolina and what our ethical codes require. Although counselors may be justified ethically for breaking confidentiality in cases of threats of violence from a client toward a third party, there is no legal requirement or expectation to do so. In other words, counselors are expected to act as a reasonable professional would if they assess a client to be violent or dangerous to others, but this may or may not involve warning the potential victim if they are identifiable, based upon (a) the absence of statute requiring us to do so, (b) the statute deeming communications between a counselor and client confidential and privileged, and (c) the contradictory ethical aspiration to protect others. Therefore, the key question is “How do counselors fulfill their ethical duties when no legal requirement exists?” In the next section, we suggest steps that consider both the ethical principles and codes for our profession and the statutes in existence in North Carolina.

### **Steps a Clinician in North Carolina Can Take To Protect Themselves**

North Carolina has no statute to guide clinicians in their duties to warn or protect third parties from patient-clients. The situation can be dire. “The problem, of course, with a legal vacuum on so ubiquitous an issue is that the clinician is continuously in jeopardy: warn, and face breach-of-confidentiality exposure; keep silent, and risk a *Tarasoff* suit” (Herbert & Young, 2002, p. 280), or possibly a violent act toward a third party. The clinician can look to the courts, but case law is constantly evolving,

and what is true today may not be true in six months. However, our ethical codes, principles, and standards of practice – as well as the case law described above - can inform, guide, and even protect our practice to avoid such vexing circumstances and perhaps even minimize any conflicts between ethical imperatives and legal considerations. In this section, we have synthesized and outlined suggested steps for mental health counselors to take in order to protect themselves from legal or ethical dilemmas and remain therapeutic when dealing with circumstances of violent clients that may lead to intentional breaches of confidentiality. For clarity and assistance in prioritizing these steps, we divide them into two categories, proactive and reactive (adapted from Borum & Reddy, 2001; Costa & Altekruze, 1994).

Some proactive steps to take with every client include:

1. Obtain informed consent. Counselors must provide thorough and accurate information to their clients about clients' rights and counselors' responsibilities. Therefore, counselors must educate themselves on the letter of the law regarding the requirements and exceptions around client confidentiality and privileged communication. Because North Carolina assumes a nuanced approach, making agreements with the client about the counselor's philosophy, policy, and practice related to the communication of threatening communications from clients toward third parties should be reviewed explicitly in advance. In effect, informed consent is considered a contractual agreement with a client, which should include all potential exceptions to confidentiality. In fact, the North Carolina Board for Licensed Professional Counselors (NCBLPC) requires every Licensed Professional Counselor to whom it grants a license to include a copy of their Professional Disclosure Statement, which includes a section on the limits and excep-
2. Know your clients. Once a thorough and accurate presentation of informed consent is obtained from your clients, clinical assessment is a critical process. This assessment is two-fold: historical and current. Historical factors that must be explored include, but are not limited to, the client's legal history, relationship history, presenting problems, and/or skills related to coping with anger or controlling impulses. Current factors may be related to specific triggers or cues to violent behavior, concurrent substance abuse, crossing interpersonal boundaries (e.g., excessive phone calls, unwelcomed visits), or preoccupation with weapons. A comprehensive biopsychosocial assessment can assist a clinician in deciding whether the client's presenting concerns are within the scope of competence, if the acuity of one's caseload would allow a client with substantial risk

tions to confidentiality dated on the initial date of service in every client's file. This statement is to be signed by the client and be dated on the first date of service. However, this constitutes the minimum related to informed consent procedures and North Carolina counselors should aspire to provide more. Informed consent must be considered across multiple dimensions: it is both an event and an ongoing process, it is both verbal and in writing, and it involves the rights and responsibilities of both the counselor and the client. Furthermore, descriptions of the informed consent process within the case notes and signed copies of professional disclosure can further inform and protect the counselor in duty to warn scenarios. Thorough and accurate informed consent is considered by these authors to be the strongest and most critical of the proactive elements related to the tension among a counselor's responsibilities to the client, the public, the profession, the law, and to themselves.

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for safety, or if a referral to another clinician is appropriate and ethically tenable.

3. Understand assessment procedures for violence. Although a thorough description of the assessment of violence is beyond the scope of this article, an article by Haggard-Grann (2007) is a useful resource.
4. Develop contingency plans. Decide how you will respond before a scenario occurs. How will you intervene with a client? What resources will you access or leverage to help make your decision? While no one response pattern will be appropriate for every scenario regarding dangerousness, consider different protocols for how you will respond to overt threats to others during a session with a client versus less clear clusters or patterns of symptoms that are suggestive of violence, but less concrete. You may want to write out a sample script for reminding clients of your contract with them regarding exceptions to confidentiality and practice it with other counselors. Keeping a list of areas to assess for violence, paper and pencil measures that can lend to your decision-making, and sample "Commitment to Treatment Statements" may also be helpful in developing contingencies (for more detailed information, see Rudd, Mandrusiak, & Joiner, 2006). Also, outlining a procedure for you to follow (e.g., assessment procedures, the order of interventions from least to most restrictive, numbers to call, directions to a magistrate's office) if such a case were to arise is suggested.
5. Prepare for supervision and consultation. To guard against isolation and to build professional resources, all practitioners are well-served by developing a network of other practitioners, supervisors, liability insurance, professional association consultation services, or even an attorney who can assist in making comprehensive, dili-

gent, and objective decision-making. Counselors must always be familiar with relevant statutes and follow emergency procedures or policies within agencies (or develop them if needed).

### Reactive Steps

When counselors do assess clients to be dangerous to others, we have summarized some relevant steps present in the literature and relevant to the expectations of all counselors: (Costa & Altekruze, 1994).

1. Remind the client. Again, informed consent is not only an event but a process. Although reminding a client of your agreements related to breaching confidentiality related to their dangerousness may mitigate further disclosure, we must uphold the principles of autonomy (allowing client to make their decisions, as they are capable), veracity (being truthful about how we may respond), and fidelity (displaying loyalty toward our clients). Of course in situations where a client's mental status is compromised, we aren't able to legally re-obtain consent or remind them of our previous agreements and must proceed according to our clinical judgment.
2. Involve the client. In addition to reminding the client of the implications of their disclosures or of the response to your risk assessment, engage the client as you are able in any part of your course of action, as long as the client does not display cognitive impairment and mental status appears to be intact. Perhaps the motivation for their disclosure of intense emotions or violent thoughts, plans, or intentions is to receive assistance or regain self-control. Sometimes it is difficult for clinicians to distinguish expressions of violence and desperation from intentions of violence. Clients may be willing to sign a release of information for you to make a disclosure,

make phone calls themselves, and/or commit themselves to treatment or to hospitalization.

3. Develop a safety plan. When risk factors are vague or diffuse, clinicians may decide to engage clients in developing a Commitment to Treatment Statement or No-Violence Contract, making arrangements to surrender weapons, or involve family members. If the risk of violence appears high or imminent, a plan for hospitalization should be developed.
4. Use collaterals/key people. When implementing your plan, you may need to inform supervisors, mental health authorities, legal counsel, or law enforcement.
5. Obtain supervision/consultation. As an extension of the proactive preparation of a network of other clinicians, consultation can serve to obtain objective input. In anxiety-provoking or threatening situations, we may not consider all of the variables, possibilities, questions to ask, or courses of action, and colleagues and supervisors can be valuable supports and resources.
6. Document carefully. Thorough and objective documentation is critical to all clinical practice but especially important in dealing with decisions to either maintain confidentiality in cases of potential dangerousness or intentional breaches of confidentiality. In other words, whether or not a clinician determines a duty to warn or protect exists, they must document the circumstances, the rationale or thought process that led to the clinical assessment, and all of their courses of action and client response. Although SOAP notes (subjective, objective, assessment, and plan) is a common format, we recommend a modified version that may better organize linearly this type of clinical encounter. DART

notes include Description, Assessment, Response, and Treatment Plan. Specifically, the Description section might include client statements, client behavior, and other relevant circumstances, Assessment will document all of the relevant factors or measures used to determine risk and justify action. Response should be inclusive of responses and actions of both clinician and client, including course of action while Treatment Plan will include long term needs beyond the immediate crisis. DART formatting is less subjective and places more emphasis on objective descriptions and clinician response. Other documentation should include relevant releases of information, clinical measures used, phone messages, and/or chronological description of contacts with third parties, as applicable.

One important caveat is that counselors should never place themselves in harms way. It is not within our scope of practice or legal responsibility to remain in dangerous situations with violent clients or to restrain, delay, or otherwise block the egress of a client for whom we have safety concerns. We should, however, enlist assistance to whatever degree is possible, beginning with the client and moving toward our colleagues, the family members of the client, other mental health providers, supervisors, and ultimately to law enforcement, as needed.

### Summary

In this article, we have reviewed the landmark *Tarasoff* cases and compared their implications to the existing statutes relevant to professional counselors in NC. We highlighted that there are no statutes requiring counselors to break disclosure when a client either verbalizes or poses a threat to another. However, there are court decisions in our state that would support a counselor's attempts to protect potential victims based upon their deci-

sion that a client is at high risk to commit violence. Furthermore, our ethical codes place priority over the safety and protection of others to the preservation of a violent client's confidentiality. In other words, counselors may be legally justified in either protecting the confidentiality of a client who poses or verbalizes a threat or in breaching this confidentiality and warning a third party of such a threat. The response depends on the diligence the counselor provides in systematically preparing for a situation in which they may choose to disclose in order to warn and/or protect a third party and their conscientiousness in weighing and applying the ethical principles. If an ounce of prevention is indeed worth a pound of cure, counselors will do well to ensure each of these steps is integrated into their counseling practice. However, access to legal counsel is always recommended to discuss

specific circumstances and develop the most appropriate course of action.

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