BHS Policies and Procedures

City and County of San Francisco Department of Public Health San Francisco Health Network BEHAVIORAL HEALTH SERVICES	1380 Howard Street, 5th Floor San Francisco, CA 94103 (628) 754-9500

POLICY/PROCEDURE REGARDING: **Special Situations Governing the Release of Information: Duty to Warn and Protect Third Parties in Response to a Client Threat**

DocuSigned by: Maximilian Rocha EB51A346C32641B... Issued By: Maximilian Rocha, LCSW Director of Systems of Care Effective Date: April 4, 2024	Manual Number: 3.06-09 References: *Tarasoff v. Regents of the University of California*, 17 Cal.3d 425 (Cal. 1976); *Ewing v. Goldstein*, 120 Cal. App. 4th 807 (2004); *Ewing v. Northridge Hospital Medical Center,* 120 Cal. App. 4th 1289 (2004); Civil Code §43.92; Evidence Code §§1010 - 1027; Welfare & Institutions Code §5328(18); and Code of Federal Regulations, Title 42, Part 2.

Minor Substantive Revision. Replaces Policy 3.06-09 dated September 24, 2018.

Equity Statement: The San Francisco Department of Public Health, Behavioral Health Services (BHS) is committed to leading with race and prioritizing Intersectionality, including sex, gender identity, sexual orientation, age, class, nationality, language, and ability. BHS strives to move forward on the continuum of becoming an anti-racist institution through dismantling racism, building solidarity among racial groups, and working towards becoming a Trauma-Informed/Trauma Healing Organization in partnership with staff, clients, communities, and our contractors. We are committed to ensuring that every policy or procedure, developed and implemented, lead with an equity and anti-racist lens. Our policies will provide the highest quality of care for our diverse clients. We are dedicated to ensuring that our providers are equipped to provide services that are responsive to our clients' needs and lived experiences.

Purpose: The purpose of this policy is to provide guidance to staff of San Francisco Behavioral Health Services (BHS) regarding the psychotherapist's duty to warn and to protect a reasonably identifiable target(s) of a BHS member's serious threat of grave physical harm communicated by a member or the member's credible family member to the psychotherapist (formerly referenced as *"Tarasoff Decision"*), to ensure that those BHS staff who meet the definition of "psychotherapist" as defined in Evidence Code §1010 understand and meet their reporting requirements, and to advise non-psychotherapist BHS staff

about their responsibilities to report (to management) information they may receive about a member's serious threats of physical harm communicated by the member or their credible family members.

Background: In review of the case of *Tarasoff v. Regents of the University of California* in 1974, the California Supreme Court established the duty of a psychotherapist to warn when deciding that they bear a responsibility to use reasonable care to give threatened persons such warnings as are essential to avert foreseeable danger arising from a patient's condition. In the 1976 rehearing of the *Tarasoff* case, the California Supreme Court established that *"the protective privilege ends where the public peril begins"* and held that the psychotherapist incurs an obligation to use reasonable care to protect the intended victim against such danger. In review of *Ewing v. Goldstein* in 2004, the California Court of Appeals further expanded the criteria for triggering the duty to warn and protect when deciding that the psychotherapist's obligation also applies to those instances when a member of the patient's family informs the psychotherapist, for purposes of advancing the patient's treatment, that the patient has communicated a serious threat of physical violence against a reasonably identifiable victim or victims. The appellate court decision thus determined that a *"communication from a patient's family member to the patient's therapist,"* which conveys a credible threat of physical violence against an identifiable victim, *"is a 'patient communication' within the meaning of section 43.92"* and therefore imposes upon the psychotherapist a duty to warn. This ruling expanded the interpretation of Civil Code §43.92 to *"include family members as persons covered within the statute who, upon communication to a therapist of a serious threat of physical violence against a reasonably identifiable victim, would trigger a duty to warn."*

The psychotherapist's duty to warn and protect is codified in Civil Code §43.92 which states that a "psychotherapist" has a duty to protect any reasonably identifiable victim or victims of a serious threat of physical violence communicated to the psychotherapist by a patient. This section further states that if there exists a responsibility to protect, the duty shall be discharged by the psychotherapist *"by making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency."* Under this statute, a psychotherapist is provided immunity if a serious threat has been communicated, in any form, by the patient or family member against a "reasonably identifiable" victim or victims, and the psychotherapist discharges their duty by notifying law enforcement and the victim(s).

The legal privilege for communications between a psychotherapist and a patient is codified in California Evidence Code §§1010 - 1027. Evidence Code §1024 states that *"there is no privilege under this article if the psychotherapist has reasonable cause to believe that the patient is in such mental or emotional condition as to be dangerous to himself or to the person or property of another and that disclosure of the communication is necessary to prevent the threatened danger."*

Section 5328(18) of the Welfare & Institutions Code states that *"if the patient, in the opinion of the patient's psychotherapist, presents a serious danger of violence to a reasonably foreseeable victim or victims, then any of the information or records specified in this section may be released to that person or persons and to law enforcement agencies and county child welfare agencies as the psychotherapist determines is needed for the protection of that person or persons."* The protected health information

released about the member should be the minimum necessary to enable the potential victim(s) to recognize the seriousness of the threat and to take the proper precautions for protection.

Scope: This policy applies to all staff within Behavioral Health Services, including both non-psychotherapists (i.e., non-clinical staff) and psychotherapists. **"Psychotherapist"** is defined in California Evidence Code §1010 as:

> (a) A person authorized to practice medicine in any state or nation who devotes, or is reasonably believed by the patient to devote, a substantial portion of their time to the practice of psychiatry.
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> (b) A person licensed as a psychologist under Chapter 6.6 (commencing with Section 2900) of Division 2 of the Business and Professions Code.
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> (c) A person licensed as a clinical social worker under Chapter 14 (commencing with Section 4991) of Division 2 of the Business and Professions Code, when they are engaged in applied psychotherapy of a nonmedical nature.
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> (d) A person who is serving as a school psychologist and holds a credential authorizing that service issued by the state.
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> (e) A person licensed as a marriage and family therapist under Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code.
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> (f) A person registered as a registered psychological associate who is under the supervision of a licensed psychologist as required by Section 2913 of the Business and Professions Code, or a person registered as an associate marriage and family therapist who is under the supervision of a licensed marriage and family therapist, a licensed clinical social worker, a licensed professional clinical counselor, a licensed psychologist, or a licensed physician and surgeon certified in psychiatry, as specified in Section 4980.44 of the Business and Professions Code.
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> (g) A person registered as an associate clinical social worker who is under supervision as specified in Section 4996.23 of the Business and Professions Code.
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> (h) A psychological intern as defined in Section 2911 of the Business and Professions Code who is under the primary supervision of a licensed psychologist.
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> (i) A trainee, as defined in subdivision (c) of Section 4980.03 of the Business and Professions Code, who is fulfilling their supervised practicum required by subparagraph (B) of paragraph (1) of subdivision (d) of Section 4980.36 of, or subdivision (c) of Section 4980.37 of, the Business and Professions Code and is supervised by a licensed psychologist, a board certified psychiatrist, a licensed clinical social worker, a licensed marriage and family therapist, or a licensed professional clinical counselor.
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> (j) A person licensed as a registered nurse pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code, who possesses a master's degree in

psychiatric-mental health nursing and is listed as a psychiatric-mental health nurse by the Board of Registered Nursing.

(k) An advanced practice registered nurse who is certified as a clinical nurse specialist pursuant to Article 9 (commencing with Section 2838) of Chapter 6 of Division 2 of the Business and Professions Code and who participates in expert clinical practice in the specialty of psychiatric-mental health nursing.

(l) A person rendering mental health treatment or counseling services as authorized pursuant to Section 6924 of the Family Code.

(m) A person licensed as a professional clinical counselor under Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code.

(n) A person registered as an associate professional clinical counselor who is under the supervision of a licensed professional clinical counselor, a licensed marriage and family therapist, a licensed clinical social worker, a licensed psychologist, or a licensed physician and surgeon certified in psychiatry, as specified in Sections 4999.42 to 4999.48, inclusive, of the Business and Professions Code.

(o) A clinical counselor trainee, as defined in subdivision (g) of Section 4999.12 of the Business and Professions Code, who is fulfilling their supervised practicum required by paragraph (3) of subdivision (c) of Section 4999.32 of, or paragraph (3) of subdivision (c) of Section 4999.33 of, the Business and Professions Code, and is supervised by a licensed psychologist, a board-certified psychiatrist, a licensed clinical social worker, a licensed marriage and family therapist, or a licensed professional clinical counselor.

Policy: Behavioral Health Services must take action to protect reasonably identifiable potential victims from BHS members consistent with applicable law, including provisions of the Welfare & Institutions Code, the Civil Code, the Evidence Code, and the requirements of the *Tarasoff* decision and subsequent case law. When a BHS member or their family member communicates to any staff of a BHS program that the member has made a serious threat of physical violence against a reasonably identifiable victim or victims, then actions pursuant to applicable law must be implemented in order to protect the third party. Staff should consult with the clinical supervisor or Program Director throughout this process. If questions remain, such as whether the communication made triggers a duty to warn, who is considered a "family member," or if the victim is "reasonably identifiable," BHS providers are encouraged to consult with their SOC Program Manager, the BHS Risk Manager, or the agency's legal counsel. Decisions made as to how the situation will be handled should be carefully documented in the medical record. At minimum, documentation should address each of the conditions which serve as the basis for the duty to warn and protect: that the member communicated to the psychotherapist a threat of serious physical violence or the psychotherapist obtains information of such a threat having been made by the member from a credible family member; that the threat of physical violence was serious and plausible; and that the victim or victims were reasonably identifiable.

The steps indicated below are applicable to all BHS staff when a member or the member's family member communicates to staff a member's serious threat of physical violence against a reasonably identifiable victim or victims.

- BHS staff, including non-clinical staff, must immediately report any such communication to a clinical supervisor or Program Director to determine the most appropriate action.
- Clinical staff, bearing in mind the potential urgency of the danger, shall review the available history and treatment of the member to determine level of risk, and discuss the information with the clinical supervisor or Program Director to decide whether or not the member presents a serious danger to a reasonably identifiable victim or victims.
- If the communication is received from a family member, staff shall determine the nature of the relationship to verify that the individual meets the definition of a family member, determine whether the family member made the communication in furtherance of the member's treatment, and determine whether the communication conveys a credible serious threat of violence.
- If it is decided that the member does not present a serious danger to a reasonably identifiable victim or victims, then this fact must be documented in the medical record, including the rationale. In such instances where the member does not meet the threshold for issuing a warning, staff should continue monitoring the level of dangerousness through ongoing risk assessment and safety planning and identify and implement interventions that may decrease the risk.
- If it is decided that the member does present a serious danger to a reasonably identifiable victim or victims, the following actions shall be taken as soon as is practically possible:

  1. Initiate an evaluation for involuntary detention if the danger posed by the member to other(s) appears to be the result of a mental health disorder and the member can be located**.** If the member cannot be located, notify local law enforcement for assistance. The receiving LPS-designated facility shall be informed by the staff initiating the involuntary detention of the efforts to notify law enforcement and to warn a potential victim. Document all efforts in the member's medical record.

  2. Make reasonable efforts to notify the intended victim or victims whether or not the member is hospitalized. Involuntary hospitalization of the member does not negate the duty to warn and protect the potential victim or victims. Contact may be made through whatever means is indicated, such as by telephone, in writing, or visitation. Documentation in the member's medical record is required and should include specific efforts to contact the potential victim, times and dates of these attempts, and copies of any written correspondence.

  Only the minimum amount of information necessary to protect the intended victim or victims shall be released. This exception to member confidentiality must be carried out with care and consideration with the maintenance of the public safety and therapeutic relationship as objectives. When issuing warnings, Substance Use Disorder Services' (SUDS) providers are encouraged to consult with their program management as to how to best safeguard the confidentiality of clients receiving Substance Use Disorder Services. As a reminder, SUDS

providers should not reveal that they are employed in a SUDS program nor identify that the member is receiving SUDS (42 CFR, Part 2).

A verbal or written warning to the potential victim(s) should include the following information: that you have a professional relationship with the member, that this member has communicated a serious threat of physical violence to the intended victim(s), that you are required by law to warn the victim(s), a description of the threat, and that the victim(s) should take steps to ensure one's own protection.

3. Contact the local law enforcement agency having jurisdiction where the potential victim resides. Involuntary hospitalization of the member does not discharge the duty to notify law enforcement. Enter in the medical record the name of the person to whom the report was made with the date, time, and information released. As stated above, SUDS providers must safeguard the confidentiality of SUDS members throughout the reporting process.

4. Quality of Care Report - Per BHS policy 1.04-4, a QOC report must be completed and submitted when a duty to warn and protect has been initiated. The QOC report should include the name of the staff member issuing the warning, the names of any other persons involved in the decision, law enforcement and victim notification information, and any relevant circumstances surrounding the warning. A fillable pdf version of the QOC Report can be accessed on the DPH public website at:
https://www.sfdph.org/dph/files/CBHSdocs/fillable_pdf_QoC_Reporting_Form_4-20.pdf
The QOC Report should be submitted by secure email to BHSQualityofCareReport@sfdph.org or by fax to 415-252-3001 or by mail to BHS Quality Management, 1380 Howard Street, 2nd Floor, San Francisco, CA 94103.

Contact Person:
Risk Manager, Behavioral Health Services, 628-754-9225

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