TARSOFF AND RISK ASSESSMENT BACKGROUND AND RESOURCES

Attachment A Risk Assessment Background

Assessing risk of violence to others is complicated by the there are many types of violence with different characteristics. For example, some domestic terror incidents reveal, after the fact, meticulous planning, calculation, preparation, and attention to detail, and may have a "cold" emotional quality. On the other end of the spectrum are those intimate partner violence episodes that may be impulsive and have a "hot" emotional quality, with many different variations and combinations in between. There is no consistently observed profile of an individual that always predicts potential violence. Instead, it is important to consider many different factors and weigh risk factors against protective factors.

The following are general principles gleaned from research by the US Secret Service, the Department of Homeland Security, the National Threat Assessment Center, and the Centers for Disease Control. These are by no means exhaustive resources, but can help guide clinical assessment.

General Principles:

1. An individual's right to life and safety outweighs a client's right to privacy. As a result, when necessary to ensure safety, the law requires clinical staff to disclose confidential information to ensure the safety of others.
2. Always complete AND DOCUMENT a thorough risk assessment. If you do not document that you assessed risk, the assumption will be that you did not, and you lose immunity from liability. Failure to assess risk in a manner consistent with sound professional practice exposes you to liability and is a substandard level of care.
3. Consult with team members to be sure you aren't missing important information
4. The risk assessment must clearly document the factors you considered and what contributed to your decision to act or not act. The factors below are meant to help guide your risk assessment and

Risk Assessment Factors:

1. Assess motives and goals:
    - What is driving the threatening behavior? What is it meant to achieve or communicate?
    - Understanding motivation may provide opportunities to intervene to reduce risk or increase protective factors and may help clarify seriousness and imminence of the threat
    - Common motivations cited by the National Threat Assessment Center include:
        - To get help
        - To cause problems for someone else (i.e., a coworker, classmate, family)
        - To avenge a perceived wrong or injustice
        - To bring attention to a problem
        - As a means to end a perceived problem
        - As a means to consider (or commit) suicide (i.e., "suicide-by-cop")

2. Assess values that may increase risk – certain values may be associated with an increased risk of intimate partner violence, including:
    - Limiting beliefs about relationship roles and power
    - Attitudes justifying or accepting violence as a problem-solving strategy
    - Emotional dependence and insecurity
    - Other related factors that may be associated with violence include antisocial thinking or any believe that devalues, dehumanizes, or diminishes the worth of another

3. Assess concerning, unusual, or threatening communications:
   - Direct threats to an identifiable victim may occur in only a minority of instances
   - Indirect threats voiced to others (friends, family members, or to the treatment team) or on social media are more commonly observed
   - Ask collateral informants if they are concerned about client's statements or behaviors

4. Assess interest in weapons, school shooters, mass attacks, or other violence:
   - Important to contextualize this based on age, culture
   - Some post event data suggests an association with violence-themed social media posts, internet searches, and video games, but correlation is not causation
   - This may be more common in certain types of violence than in others

5. Assess recent stressful events (trauma, setbacks, challenges, or losses):
   - Material losses (possessions, finances, etc.)
   - Relationship losses (death, role changes, separations) in family and/or peer group
   - Status losses (changes in occupational or other role changes
   - Changes in self-perception/self-esteem
   - Relationship conflicts including bullying
   - Assess coping skills and status

6. Assess congruence in statements across settings:
   - Look for consistency in statements in a variety of contexts by asking collateral informants. When an individual says in one setting that he is doing well, but, for example, posts contradictory information, the risk for acting out may increase.
   - Concealment/hiding of risk behaviors or plans may be associated with increased risk

7. Assess Emotional/Developmental/Mental Illness factors: Clearly, presence of mental illness does NOT predict violence. There is ample research to show that individuals with mental illness are more likely to be victims than perpetrators of violence. Here are key factors to assess:
   - Hopelessness, desperation, or despair – more important than any specific diagnosis as a predictive factor of violence, these factors appear consistently in research about violence!
   - Change from baseline – more important than mere presence of SMI as a predictive factor of violence
   - Psychosis – mixed evidence in the literature about psychosis as a contributing factor. Some evidence suggests that command hallucinations and paranoid ideation are mildly predictive, especially when the client has a history of acting on delusional thinking or complying with a command hallucination (versus resisting or ignoring). When psychotic symptoms are suggestive of increased risk, it is most likely to occur when an exacerbation of symptoms results in poorer overall coping with stressors and a reduced ability to utilize coping mechanisms or protective factors (i.e., when more isolated due to internal preoccupation or when not medication adherent).
   - Impulsivity – mixed evidence, likely because of the huge variety of violent behavior. Some violence is meticulously planned while some is highly impulsive. This factor is important to assess, but also to contextualize. High levels of impulsivity may increase the risk of some violent behaviors.
   - Angry Outbursts – similar to impulsivity in terms of predictive power and implication for risk assessment. Some violence is cold and calculated.

- Capacity for planning – for some types of violent behavior, the ability to plan and follow through with actions increases the risk and must be clearly assessed/documented. As with many other factors in this category, the ability to plan and carry out a threat is more important than a specific diagnosis.
- Role of Trauma – most trauma survivors do not perpetrate abuse, but many perpetrators were themselves victims. It is important to assess the role of trauma in a risk assessment without blaming the victim or creating blind spots in the assessment that might underestimate risk. An empathetic exploration here may create opportunities for treatment of trauma and prevention of violent behavior.

8. Assess Substance Use/Substance Use Disorder: Like mental health concerns described above, the mere presence of substance use or a substance use disorder does not predict violence.
   - Change from baseline is more important than mere presence of SUD as a predictive factor of violence.
   - Some evidence suggests that when substance use is associated with an increase risk in violent behavior it is because substance use may disinhibit behavioral controls, result in poorer overall coping or an increase in risk factors (i.e., loss of job, family, or status), and/or in reduce availability of positive supports (i.e., when sober supports are absent to due to individual's use).

9. Assess access to weapons (not just guns) and resources (means)
   - Access and means increase risk and are key factors in determining whether a threat is "serious" and "imminent"

10. Assess evidence of planning:
   - Evaluate the presence of a plan. Developmental and situational factors may influence whether increased detail predicts greater risk of imminent violence.
   - Evaluate the likelihood of carrying out the plan. Ask about barriers or what would prevent implementing the plan.

11. Assess prior history of violence
   - Past violence to solve problems may be the strongest predictor of future violence, but it is not foolproof
   - Ask about history of using prosocial alternatives
   - Ask about history of attack-related behavior, including any menacing, harassing, and/or stalking-type behavior – is the current threat part of an escalating pattern of behavior

Resources:
ENHANCING SCHOOL SAFETY USING A THREAT ASSESSMENT MODEL
An Operational Guide for Preventing Targeted School Violence
US Dept. of Homeland Security, US Secret Service, National Threat Assessment Center: July 2018
https://www.dhs.gov/sites/default/files/publications/18_0711_USSS_NTAC-Enhancing-School-Safety-Guide.pdfhttps://www.dhs.gov/sites/default/files/publications/18_0711_USSS_NTAC-Enhancing-School-Safety-Guide.pdf

Risk Factors for Intimate Partner Violence Perpetration
https://www.cdc.gov/violenceprevention/intimatepartnerviolence/index.html

Attachment B: Warning Letter Template

COUNTY OF SAN LUIS OBISPO
BEHAVIORAL HEALTH
Health Information Unit
(805) 781-4724 Tel (805) 781-4271 Fax

TARASOFF WARNING LETTER

Date: _____

To:

NAME: _____

ADDRESS: _____

_____

We are authorized by law to inform you that _____
(person making threat)
has made a serious threat to harm you. During an evaluation on _____
(date of evaluation)
the person listed above made the following threat (describe threat made):

_____

_____

_____ was notified of this threat on _____.
(name of law enforcement agency) (date notified)
Officer/Deputy _____ Badge/Id # _____ took the call.
(officer's/deputy's name) (officer's/deputy's badge #)
The phone number for the above listed officer is _____ and the case
(law enforcement agency phone #)
number or log number assigned is _____
(case number or log number)

If the person named above is being detained by San Luis Obispo County Jail, Juvenile Services Center, or the Psychiatric Health Facility and you wish to be informed when they are released, please contact the facility directly at the phone numbers listed below.

- SLO County Jail: (805) 781-4600
- Juvenile Services Center: (805) 781-5352
- Psychiatric Health Facility: (805) 781-4712

If you have any questions, please contact me at: _____
(phone number)
Name/Title: _____
(name and title of person mailing or emailing letter)
CC: _____
(copy of letter sent to)

Attachment C: Sample Warning Letter

COUNTY OF SAN LUIS OBISPO
BEHAVIORAL HEALTH
Health Information Unit
(805) 781-4724 Tel (805) 781-4271 Fax

TARASOFF WARNING LETTER

Date: 04/09/19

To: Stefani Mannicotti
4712 Pacific Coast Highway
Malibu, Ca 90263

We are authorized by law to inform you that Jackson Cooper has made a serious threat to harm you. During an evaluation on 04/08/19, Mr. Cooper stated that he planned to "break into (your) home, sexually assault (you), and then choke (you) to death with my bare hands."

The San Luis Obispo Police Department and the Los Angeles County Sheriff's Department were notified of this threat on 04/08/19. Officer Krupke (SLOPD) and Deputy Vance Badge/Id 24601 & 10451 took the call.

The phone number for the above listed officer is 805- 543-3131 & 213-229-1700 and the case number or log number assigned is 112284 & 71818

If the person named above is being detained by San Luis Obispo County Jail, Juvenile Services Center, or the Psychiatric Health Facility and you wish to be informed when they are released, please contact the facility directly at the phone numbers listed below.

- SLO County Jail: (805) 781-4600
- Juvenile Services Center: (805) 781-5352
- Psychiatric Health Facility: (805) 781-4712

If you have any questions, please contact me at: 805-501-2316

Name/Title: Jaclyn A. Miller, Behavioral Health Clinician III, County of San Luis Obispo
CC: San Luis Obispo Police Department (Case # 112284 & LA County Sheriff (Case # 71818)

Attachment D: Sample BH Crisis Intervention assessment (HI) with Tarasoff notification (complex)

County of San Luis Obispo

Behavioral Health Department

CRISIS INTERVENTION

Client Contact Information (If any client contact information needs to be updated, please launch a Demographics to record updates)

Telephone: 555-5554

Address: 14 Fiction Way Apt:

City/State/Zip: SAN LUIS OBISPO CA 93401

Presenting Problems: (Describe the crisis)

Ct presents at the North County MH clinic today requesting to speak with "someone who can help me." Ct states that he is depressed and distraught over the recent break-up of from his girlfriend of 1 1/2 years.

Collateral Contacts: (What do significant others or credible 3rd parties say? Are they concerned about recent behavior?)

Ct is not accompanied by any friends or family members. Ct states that his parents live out of state and that he has no other family members or close friends living nearby.

Behavioral Observations/Presentation:

Client's gender, age, marital/relationship status, race, other cultural factors

Ct is a 23-year-old white male who recently ended a relationship with his gf of 1.5 years. Ct's appearance is slightly disheveled, though he presents in clean clothing. This writer notes that ct has not shaven recently, which is a departure from his typical clean-cut appearance. Ct presents as anxious, though at times this is expressed as anger. His behavior is slightly disorganized, and he exhibits difficulty staying on topic. Ct is oriented to date, time, and place, but displays a tangential thought process accompanied by loose associations at times. Ct denies AH/VH; however, this writer observes that throughout this assessment ct appears to be responding to internal stimuli, especially when he is asked direct questions regarding his thoughts of harming others. Ct denies SI, but endorses thoughts of,"wanting to hurt them."

Appearance:(Manner of dress and hygiene; note any recent or notably significant changes in client's appearance)

☐ Well Groomed ☐ Appropriate ☒ Disheveled ☐ Unkempt ☐ Bizarre ☐ WNL

Attitude/ Behavior: (i.e. ability to make and maintain eye contact, psychomotor functioning and a clinical determination about client's ability to provide reliable information)

☐ Cooperative ☒ Guarded ☒ Suspicious ☒ Belligerent ☐ Uncooperative ☐ WNL

Speech: (i.e. rate, volume, spontaneity, and coherence)

☒ Rapid ☒ Loud ☒ Pressured ☐ Excessive ☐ Slurred ☐ WNL

Mood: (i.e. underlying emotional state)

☐ Euthymic ☐ Elevated ☐ Euphoric ☒ Depressed ☒ Anxious ☒ Irrit ☐ WNL

Affect: (include visible reactions that client is displaying about information being discussed)

Ct's affect throughout crisis assessment notably blunted and incongruent with emotions client reports experiencing.

Thought Process: (i.e. rate and flow of thoughts)

☐ Linear ☐ Circumstantial ☒ Tangential ☒ Loose ☐ Flight of ideas ☐ WNL

Thought Content: (i.e. presence of irrational thought, thought fixations)

☐ Appropriate ☒ Obsessions ☐ Phobia ☐ Illusions ☐ Odd Thoughts ☐ WNL

Hallucinations:

☒ Auditory ☐ Visual ☐ Command ☐ Tactile ☐ Olfactory ☐ None Reported

Delusions:

☐ Grandiose ☐ Persecutory ☐ Somatic ☒ Jealous ☐ Mixed Type ☐ None Reported

Attention/Concentration:

○ Intact ○ Adequate ⊙ Impaired

Orientation: Person: ⊙ Yes ○ No Place: ⊙ Yes ○ No

Time: ⊙ Yes ○ No Purpose: ⊙ Yes ○ No

Insight: (i.e. ability to identify the existence of a problem and to have an understanding of its nature)

○ Intact ○ Adequate ⊙ Impaired

Judgement: (i.e. ability to make logical decisions)

○ Intact ○ Adequate ⊙ Impaired

Impulse Control: (i.e. ability to delay or think through a choice)

○ Intact ○ Adequate ⊙ Impaired

Describe any significant mental status or behavioral observations:

While Ct denies he presence of any AH or VH, this writer observes ct quietly whispered "Shh.." under his breath. Ct became visibly agitated when asked about his anxiety and yelled, "I'm fine!" Ct jumped to his feet and began pacing the rest of session. Ct denied having SI stating, "I don't want to hurt myself. It's not my fault." When asked about HI, client stated, "I just want to hurt them."

Risk Assessment:

Current Suicidal Ideation: ○ Yes ⊙ No

If Yes, describe the ideation.

Current Homicidal Ideation: ⊙ Yes ○ No

If Yes, describe homicidal ideation.

When directly asked about thoughts of HI, ct states, "I just want to hurt them." When this writer asked follow-up questions ct stated that he feels that he is being, "laughed at by all the engineering students," and that he has "fantasized about shutting them up with my gun."

Evidence of planning: (Does client have a plan? How likely is it to occur as planned? What are barriers that would keep it from happening? Are there support persons who can reliably intervene?)

Ct acknowledged owning a firearm and keeping it in his off-campus apartment. Ct stated that he even purchased ammunition for it yesterday. Ct also admitted to, "scoping out the entrance and exit points," in the engineering building in order to ensure, "a quick escape." Ct admits that he continues to be distraught by the recent break-up from his gf but is unwilling to say if she is the target of his fantasy. Ct states that he finds himself drinking to go to sleep, but states that he cannot stay asleep. Ct cannot remember the last time he took his psychiatric medication, though he states that he remembers picking the refill up from the pharmacy.

Access/Means: (Does the client have access to weapons or other means? Taken steps to acquire means? How lethal? Describe steps taken to remove access. Are there support persons who can reliably remove access?)

Ct states that he owns a firearm that is kept in his apt off campus; however, he is unwilling to answer how many firearms he owns or has access to. Ct states that he recently purchased ammunition at a local sporting goods store, but again refused to answer how much ammunition was purchased or for what purpose.

History of prior violence or self-injury: (Describe past attempts or significant ideation. If evaluating DTO, is there a history of attack-related behavior (i.e., menacing, stalking, threatening, etc.)?)

Ct does acknowledge obsessive thoughts re: whereabouts and activities of ex-girlfriend (i.e. who she is spending time with. what she doing, is she dating other men or women). Ct states that he has, "waiting for her outside some of her classes like I used to do," but states that when his ex has seen him she has refused to speak with him and, "run away from me." Ct also states that he has gone to the sorority house where his ex resides to see what she is doing/who she is with, but has not, "gone up to the door."

Motives and goals: (What drives the behavior? What does the client want?)

Ct states that, "I just want to be able to talk with her [ex-girlfriend] to find out how I can fix this [their relationship]."

Environmental and cultural factors; values that increase risk to self or others. (What are the client's beliefs about self and others that mayincrease or mitigate risk to self or others? Is the client a member of a

subgroup at higher risk ofself-injury (i.e., LGBTQ) or violent behavior?

Ct is a 23-year-old Caucasian male who states that he was raised in a strict sext of the Southern Baptist religion. "We do not believe in sex before marriage, because it is a sin punishable by internal damnation." Ct states that prior to being in this relationship with his ex-girlfriend that he was a virgin and feels as though if he is unable to reconcile with her then he will go to hell.
Having reviewed ct's current and previous tx records, it is worth noting that a substantial amount of work has been done with ct around reality testing to do with his preoccupation about potential consequences he feels he will face from God as a result of his religious beliefs and the faith he was brought up in. It is difficult to ascertain if these beliefs are delusional in nature; however they cause ct significant distress when he feels he has, "committed a transgression."

Communications: (What does the client say or write about DTS/DTO? Do statements match across settings (i.e., in session, with peers or family, social media)?

As noted above, ct states, "I just want to hurt them." Ct states that he feels that he is being, "laughed at by all the engineering students," who are reportedly friends of his ex-friend and acknowledges that he has "fantasized about shutting them up with my gun."

Interest in weapons, violence, or media related to DTS/DTO:

Ct appears to a vast amount of knowledge about firearms, ammunition and their various uses (i.e. self defense, target practice, hunting). According to previous tx records, ct was raised in a family who went hunting recreationally and engaged in target practice for sport. While his knowledge and use of firearms may not be incongruent with how he was raised, it is worth noting that ct's recent statements regarding wanting to hurt others with his guns, acquiring ammunition as recently as yesterday, and his obsessive and ruminating thoughts about his recent break-up coupled with his religious ideology are worrisome and indicate a significant departure from how ct reportedly has handled stressful situations in the past.

Recent stressful events: (Losses, setbacks, relationship changes, conflicts, victim of crime, victim of bullying?)

Ct reports that his girlfriend of 1 1/2 years ended their relationships 2 weeks ago.

Historical trauma: (How has the client coped? What are potential risks or relationship to current crisis?)

Ct denies any history of abuse. This is however incongruent with current treatment records where client discloses being inappropriately touched, "down there," by members of the church he attended as a child. Treatment records state that client was a prepubescent teen and that the abuse was perpetrated by a "respected female member of the church."

Hopelessness, Desperation, Despair: (Assess current state)

Ct presents as desperate to understand what the catalyst was that led to ending of his romantic relationship. He is preoccupied with obsessive and ruminating thoughts regarding the activities and whereabouts of his ex and states that if he is unable to repair the relationship that, "my transgression [sex out of wedlock] will be punishable with eternal damnation."

Presence of psychotic symptoms: (Note any recent exacerbation, how does client cope with intrusive symptoms (i.e., with command hallucinations or paranoid ideation)?)

Ct denies he presence of any AH or VH, however this writer observes ct quietly whispered "Shh.." under his breath. Throughout assessment, this writer notes that coupled with ct's obsessive and ruminating thoughts re: his ex and her whereabouts and activities, he seems convinced that she was, "trying to make a fool out of me," and is, "having sex with one of her sorority sisters."

Impulsivity/Angry Outbursts:

Ct became visibly agitated when asked about his anxiety and yelled, "I'm fine!" Ct paced throughout crisis assessment and had difficulty understanding that he may never get an answer from his ex-girlfriend regarding her reasons for ending the relationship. Ct exhibited no insight into his behaviors and how others, including his ex might perceive them as inappropriate or dangerous.

Substance Use: (Recent increase in use or changes in functioning related to use?)

Ct states that he finds himself drinking to go to sleep, but states that he cannot stay asleep. He denies using any other substances or medications (either prescribed or OTC)

Recent change in behavior (include changes in sleep, eating, socializing, or other behaviors)?

Ct reports that he continues to have difficulty falling and staying asleep. Ct states that his appetite is non-existent. He states that he has withdrawn from the few friends he has, preferring to be in his dark bedroom alone.

Review of current and previous treatment records: (Describe steps taken to review treatment records and significant findings)

As noted in various portions of this assessment I was able to review ct's current treatment records from when he began seeking services in 2017. Ct states that prior to moving to Ca he was being seen in his home state of Texas by a private psychologist, Dr. Kathleen Eldridge. Ct refused to sign a ROI; however I contacted the provider and requested previous tx records or a tx summary. That request is pending.

Current Treatment Team: (List current treatment team or program; look at Assignments Tab in Anasazi. Describe results of consultation with current providers or your supervisor(s) here.):

Terri Eliot, MH Therapist
Josh Simpson, Med Manager
Dr. Rogers, current psychiatrist
I reached out ct's current treatment providers, although none of them were immediately available for a consult.

Medication and medication adherence:

Per ct's treatment record

Interventions and Outcome of Risk Assessment (i.e., consultation with other professionals, safety plan, contact w/ MHET):

Given all risk factors present at the time of assessment (i.e. reasonably identifiable victim- i.e. students in engineering dept at school, access to firearms at his home, recent purchase of ammunition for said firearms, increase use of ETOH, inconsistent compliance with psychiatric medication, recent stressor from the break up his romantic relationship, lack of familial and peer support due to isolating behaviors and being away at college, changes to his appearance, reported insomnia, presence of mood sxs (feeling hopeless and depressed), as well as history of psychotic sxs and observation of disorganized thought process, behavior, and response to internal stimuli) this writer contacted the Mental Health Evaluation Team so that ct could be placed on a hold for danger to others.

While ct was being evaluated by MHET crisis worker, this writer consulted with , Rachel McSpadden-Tarver, LMFT and Program Supervisor, Dr. Kathleen Cohen regarding the need to begin a Tarasoff notification.

After consultation, this writer contacted San Luis Obispo Police Department (the law enforcement agency having jurisdiction where ct resides) as well as Cal Poly SLO campus police (law enforcement agency having jurisdiction where the intended victims reside) to notify them that client had made statements of wanting to harm students in the engineering department. This writer detailed ct's statements (i.e. "wanting to hurt them" "fantasized about shutting them up with my gun.") as well as behavior he admits taking in order to carry out his plan (i.e. purchasing ammunition for his legally owned firearm, "scoping out the various entrance and exits to the engineering building to make a clean escape" as well as the recent changes to his behavior, presence of alcohol use, inconsistent compliance with psychiatric medication, and recent life stressor (i.e. break up with a girl who is an engineering major). This writer made it clear to law enforcement agencies in both jurisdictions that she is unable to notify intended victims or client's ex-girlfriend due to lack of information but will contact the engineering department at Cal Poly SLO so that they are able to take any precautions necessary to protect their students.

This writer then phoned Cal Poly University SLO and spoke with Dr. Amy Fleischer, Dean for the College of Engineering. This writer notified the Dean of the threats made by client against students in the engineering department (i.e. "wanting to hurt them" "fantasized about shutting them up with my gun.") and discussed with the Dean client's stated plan and steps he has taken toward carrying out this threat. This writer also noted that client indicated that his ex-girlfriend, Alyssa is a student in the engineering department, but writer is unable to locate or notify her because her last name at this time is unknown to this writer.

After both law enforcement agencies and Cal Poly SLO, Department of Engineering were notified via phone, this writer completed the necessary Tarasoff letter and faxed it to San Luis Obispo Police Department and Cal Poly Campus Police Department and emailed a separate letter to Dr. Amy Fleischer, Dean for the College of Engineering at the email address she provided during the earlier phone conversation.

This writer consulted with the MHET crisis worker and was notified that client was placed on a 5150 involuntary hold for danger to others and is currently being evaluated at the San Luis Obispo Psychiatric Health Facility.

Safety Plan and Protective Factors:

Disposition and Follow-up:

At this time client is currently on an involuntary hold for danger to others and placed at the local Psychiatric Health Facility. This writer will coordinate inform client's treatment team and assist in discharge planning with PHF staff.

If client is a DTO:

☒ Phone call to intended victim(s)
☒ Tarasoff Notification letters sent
☒ Phone call to Law Enforcement
☒ Tarasoff Worksheet faxed to Law Enforcement

BHCI version 1.04; 05/28/2019

Attachment E Law Enforcement Fax

COUNTY OF SAN LUIS OBISPO
HEALTH AGENCY/BEHAVIORAL HEALTH DEPARTMENT
Health Information Unit
(805) 781-4724 Tel (805) 781-4271 Fax

TARASOFF NOTIFICATION

TO:

	Law Enforcement Office	Fax #	Phone #
	Arroyo Grande	473-2198	473-5100
	Atascadero	461-3702	461-5051
	Cal Poly Campus PD	756-5051	756-7410
	Grover Beach	473-4517	473-4511
	Morro Bay	772-2224	772-6225
	Paso Robles	227-1013	237-6464
	Pismo Beach	773-3505	773-2208
✓	San Luis Obispo PD	543-8108	781-7312
	San Luis Obispo Sheriff	781-1234	781-4550

FROM: San Luis Obispo Behavioral Health Dept
NAME: Jaclyn A. Miller, LMFT
PAGES: 1
DATE: 04/08/19 **TIME:** 2:24 pm
RE: Tarasoff Warning & Notification
PATIENT: Jackson Cooper

This is a written follow up to the verbal Tarasoff Warning given to:

(Officer / Deputy) Krupke **Badge #** 24601 **Report #** 112284

(circle one) *(name)*
On 04/08/19 **at** 1:32 pm **AM / PM** **BY** Jaclyn A, Miller, LMFT
(date) *(time)* *(circle)* *staff member giving report (please print)*

Person making threat: Jackson Maine **Patient ID #** 624051

Residing at: 9340 Flora Lane San Luis Obispo, Ca **Phone #** 805-951-4538

Threats made: Patient threatened to break into the home of Stefani Germanotta (4712 Pacific Coast Highway Malibu, Ca 90263),sexually assault her, and choke her to death with his bare hands.

Intented Victim: Stefani Germanotta **Email:** sjagerman@att.net

Residing at: 4712 Pacific Coast Highway Malibu, Ca 90263 **Phone #** 310- 875-0328

Intended victim notified by (phone / in person)? **YES / NO** **If yes: Date/Time** 04/08/19 1:06 pm

(circle one)
Email letter sent to the intended victim? **YES / NO** **If yes: Date/Time** 04/08/19 1:13 pm

Certified letter mailed to intended victim? **YES / NO** **Copy of the letter attached?** **YES / NO**

If intended victim has not been notified please explain why:

N/A

Additional notes:

CONFIDENTIAL PATIENT INFORMATION – NOT TO BE FORWARDED

This information has been disclosed to you from records that are **confidential** and protected by **state confidentiality law** that protects mental health records (See California Welfare and Institutions Code Section 5328). Information subject to release in accordance with Federal Privacy Act of 1974 (Public Law 93-597). This information has been disclosed to you from records protected by **Federal confidentiality rules** (42 CFR, Part 2, Section 2.32). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. Total pages included:

Attachment F: Codes and Case Law Background Information

DUTY TO PROTECT:
The court ruling in Tarasoff v. Regents of the University of California confirmed that treatment professionals, when made aware of a serious threat of imminent harm, incur a duty toward the reasonably identifiable potential victim or victims of these threats.

“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 of various steps, depending upon the nature of the case. Thus, it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances.”

Notification of the intended victim and law enforcement is the minimum action necessary to meet the “reasonable” care standard. Other additional actions might include involuntary hospitalization, for example, but hospitalization or incarceration of the person making the threat does not replace notification of the intended victim and law enforcement.

Originally, the duty to protect was only triggered when a client communicated a threat to the therapist. In Ewing v. Goldstein, the court ruled that treatment professionals are required to take action to protect reasonably identifiable victims when a client’s family members or credible third parties report that the client made a serious threat of imminent harm.

Thompson v. County of Alameda added two conditions under which a Tarasoff warning applies: 1) The intended victim(s) must be reasonably identifiable and 2) The peril must be foreseeable.

Menendez v. Superior Court of Los Angeles allows psychotherapist making Tarasoff warnings to include statements made by the client in order to convey the seriousness of the threat to the intended victim(s).

Jablonski v. US made psychotherapists responsible for reviewing all current and previous treatment records in determining the seriousness of a threat. The ruling also includes the responsibility of the psychotherapist to thoroughly document the risk assessment performed in the client’s record and communicate with other treatment providers responsible for and assuming care to ensure continuity of care.

People v. Wharton determined that the content of the Tarasoff warning and the communication that led the psychotherapist to determine that the client was dangerous are admissible in court.

Mavroudis v. Superior Court of San Mateo ruled that imminence is necessary for a Tarasoff duty to exist: “The therapist's duty is further limited by his patient's interest in privacy. The (therapist's) duty to preserve the privacy of his patient requires that he not disclose a confidence of his patient unless such disclosure is necessary to avert danger to others. An assessment of the necessity of the disclosure which gives rise to the therapist's duty must take into account the imminence of the danger posed by the patient. If the patient does not pose an imminent threat of serious danger to a readily identifiable victim, a disclosure of the patient's confidence would not be necessary to avert the threatened danger and the therapist would be under no duty to make such a disclosure.”

And this: “The therapist need not render a perfect performance but merely exercise "'that reasonable degree of skill, knowledge, and care ordinarily possessed and exercised by members of [that professional specialty] under similar circumstances.”

LIABILITY:
California Civil Code 43.92 focuses on when a provider is potentially liable for failure to protect and immune from liability for taking protective action. California Civil Code §43.92 states:

(a) “There shall be no monetary liability on the part of, and no cause of action shall arise against, any person who is a psychotherapist as defined in Section 1010 of the Evidence Code in failing to protect from a patient's threatened violent behavior or failing to predict and protect from a patient's violent behavior except if the patient has communicated to the psychotherapist a serious threat of physical violence against a reasonably identifiable victim or victims.

(b) There shall be no monetary liability on the part of, and no cause of action shall arise against, a psychotherapist who, under the limited circumstances specified in subdivision (a), discharges his or her duty to protect by making reasonable efforts to communicate the threat to the victim or victims and to a law enforcement agency.”

Hedlund v. Superior Court of Orange County expanded therapist’s liability to include harm to foreseeable bystanders if the therapist does not fulfill Tarasoff responsibility.

EXCEPTION TO CONFIDENTIALITY:
HIPAA (CFR, Title 45, §164.512 (j)) and California law allow information to be disclosed as necessary to a reasonably foreseeable intended victim and to law enforcement without client authorization. Welfare & Institutions Code §5328(18) states:
“When the patient, in the opinion of his or her 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.”

Evidence Code 1024: “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.”